VICNISS HEALTHCARE ASSOCIATED INFECTION SURVEILLANCE

VICNISS Healthcare Associated Infection Surveillance Coordinating Centre
10 Wreckyn Street North Melbourne VIC 3051
Tel: 03 9342 2605 Fax: 03 9342 2633
email: vicniss@mh.org.au web: www.vicniss.org.au

VICNISS Procedure Groups, ICD10-AM Codes, and CMBS Codes

Participating hospitals have a choice to undertake VICNISS surveillance of surgical site infections on a select number of procedure groups. This list helps to ensure sufficient numbers of procedures are available to allow calculation of valid aggregate infection rates within a shorter time frame.

CMBS codes are now included here in addition to ICD10 as these are often used in theatre databases accessed by SHIINe. While there is sometimes a correlation between codes and they may be similar, there is not a one to one correlation between them. Both groups of codes presented here are intended to include the same procedures. CMBS codes listed here are the ones the SHIINe software uses to obtain data from the theatre database for VICNISS procedure groups included in your surveillance plan.

ABDOMINAL AORTIC ANEURYSM REPAIR

Procedure Group: *AAA*

Description: *Resection of abdominal aorta with anastomosis or replacement*

ICD10-AM Codes	ICD10-AM Description	CMBS Codes	CMBS Description
3311200	Replacement of suprarenal abdomino-aortic aneurysm with graft	33112	Suprarenal abdominal aortic aneurysm, replacement by graft including re-implantation of arteries
3311500	Replacement of infrarenal abdoino-aortic aneurysm with graft	33115	Infrarenal abdominal aortic aneurysm, replacement by tube graft, not being a service to which item 33119 applies
		33116	Infrarenal abdominal aortic aneurysm, replacement by tube graft using endovascular repair, excluding associated radiological services
3311800	Replacement of infrarenal abdoino-aortic aneurysm with bifurcation graft to iliac arteries	33118	Infrarenal abdominal aotric aneurysm, replacement by bifurcation graft to iliac arteries(with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies
		33119	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services
3312100	Replacement of infrarenal abdomino-aortic aneurysm with bifurcation graft to femoral arteries	33121	Infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both femoral arteries (with or without excision or bypass of common iliac aneurysms)
3315100	Replacement of ruptured suprarenal abdomino-aortic aneurysm with graft	33151	Ruptured suprarenal abdominal aortic aneurysm, replacement by graft
3315400	Replacement of ruptured infrarenal abdomino-aortic aneurysm with tube graft	33154	Ruptured infrarenal abdominal aortic aneurysm, replacement by tube graft

ICD10-AM Codes	ICD10-AM Description	CMBS Codes	CMBS Description
3315700	Replacement of ruptured infrarenal abdomino-aortic aneurysm with bifurcation graft to iliac arteries	33157	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms)
3316000	Replacement of ruptured infrarenal abdomino-aortic aneurysm with bifurcation graft to femoral arteries	33160	Ruptured infrarenal abdominal aortic aneurysm, replacement by bifurcation graft to one or both femoral arteries

APPENDIX SURGERY

Procedure Group: *APPY*

Description: *Operation of appendix (not incidental to another procedure)*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3057100	Appendicectomy	30571	Appendicectomy, not being a service to which item 30574 applies
3057200	Laparoscopic appendicectomy	30572	Laparoscopic appendicectomy
3037530	Caecoappendicostomy; Malone antegrade continence enema proceure	30574	Appendicectomy
9031100	Anastomosis of appendix;Closure of appendiceal fistula	30394	Laparotomy for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess or for peritonitis from any cause, with or without appendicectomy

BREAST SURGERY

Procedure Group: *BRST*

Description: *Excision of lesion or tissue of breast including radical, modified or quadrant resection, lumpectomy, incisional biopsy or mammoplasty*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3150000	Excision of lesion of breast	31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histology (Anaes.)
3150001	Open biopsy of breast	--	open surgical biopsy or excision of, with or without frozen section histology (Anaes.)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of (Anaes.) (Assist.)
		31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of (Anaes.) (Assist.)
		31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology (Anaes.)
		31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology (Anaes.) (Assist.)
3151500	Re-excision of lesion of breast	31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour (Anaes.) (Assist.)
3151800	Simple mastectomy,unilateral	31518	BREAST (female), total mastectomy (Anaes.) (Assist.)
3151801	Simple mastectomy, bilateral	31521	BREAST (male), total mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.)
3152400	Subcutaneous mastectomy, unilateral	31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.)
3152401	Suncutaneous mastectomy, bilateral	31527	BREAST (male), subcutaneous mastectomy, not being a service associated with a service to which item 45585 applies (Anaes.) (Assist.)
3155700	Excision of duct (central) of breast	31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) impalpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which items 31539, 31545 or 31548 apply
4552100	Reduction mammoplasty, unilateral	31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using advanced breast biopsy instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which item 31530, 31536 or 31548 applies (Anaes.)
4552101	Reduction mammoplasty, bilateral	45520	Reduction mammoplasty (unilateral) with surgical repositioning of nipple
4552102	Reduction mammoplasty with nipple repositioning, unilateral	45522	Reduction mammoplasty (unilateral) without surgical repositioning of nipple, excluding the treatment of gynaecomastia
4552103	Reduction mammoplasty with nipple repositioning, bilateral		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4552104	Reduction mammoplasty with reconstruction of nipple, unilateral		
4552105	Reduction mammoplasty with reconstruction of nipple, bilateral		
4552400	Augmentation mammoplasty, unilateral	45524	Maamoplasty, augmentationm for significant breast asymmetry where the augmentation is limited to one breast
4552700	Augmentation mammoplasty, following mastectomy, unilateral	45527	Mammoplasty, augmentation(unilateral) following mastectomy
4552701	Augmentation mammoplasty following mastectomy, bilateral		
4552800	Augmentation mammoplasty, bilateral	45528	Mammoplasty, augmentation, bilateral, not being a sercvice to which item 45527 applies, where it can be demonstrated that surgery is indicated because of malformation of breast tissue (excluding hypomastia), disease or trauma of the breast (other than trauma resulting from previous elective cosmetic surgery).
4553000	Reconstruction of breast using myocutaneous flap	45530	Breast reconstruction (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer, not being a service to which items 30165, 30168, 30171, 30174 or 30177 applies
4553001	Reconstruction of breast using omental flap		
4553300	Reconstruction of breast using breast sharing technique, first stage	45533	Breast reconstruction using breast sharing technique (first stage) including breast reductionm transfer of complex skin and breast tissue glap, split skin graft to pedicle of flap or other similar procedure
4553600	Reconstruction of breast using breast sharing technique, second stage	45536	Breast reconstruction using breast sharing technique (second stage) including division of pedicule, insetting of breast flap, with closure of donor site or other similar procedure
4553900	Reconstruction of breast with insertion of tissue expander	45539	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections
4554200	Removal of breast tissue expander and insertion of permanent prosthesis	45542	Breast reconstruction (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis
4554800	Removal of breast prosthesis	45548	Breast prosthesis, removal of, as an independent procedure
4554801	Removal of breast tissue explander		
4555100	Removal of breast prosthesis with complete excision of fibrous capsule	45551	Breast prosthesis, removal of, with excision of fibrous capsule
4555200	Removal of breast prosthesis with complete excision of fibrous capsule and replacement of prosthesis	45552	Breast prosthesis, removal of, with excision of fibrous capsule and replacement of prosthesis

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		45553	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation).
4555400	Removal of breast prosthesis with complete excision of fibrous capsule and replacement of prosthesis and formation of new pocket	45554	Breast prosthesis, removal and replacement with another prosthesis, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule
4555500	Removal of silicone breast prosthesis and replacement with other than silicone prosthesis	45555	Silicone breast prosthesis, removal of and replacement with prosthesis other than silicone gel prosthesis
4555600	Mastopexy	45556	Breast ptosis, correction of by mastopexy (unilateral) to match the position of the contralateral breast
		45557	Breast ptosis, correction of by mastopexy of (unilateral), following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove
		45558	Breast ptosis, correction of by mastopexy of (bilateral) following pregnancy and lactation, when performed not less than 1 year, and not more than 7 years after the end of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove

CARDIAC SURGERY

Procedure Group: *CARD*

Description: *Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3845601	Open valvotomy of pulmonary valve	38456	Intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this group applies
3845610	Open valvotomy of aortic valve		
3845611	Open valvotomy of tricuspid valve		
3845612	Other intrathoracic procedures on septum without cardiopulmonary bypass		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3845613	Other intrathoracic procedures on atrium without cardiopulmonary bypass		
3845614	Other intrathoracic procedures on ventricle of heart without cardiopulmonary bypass		
3845615	Other intrathoracic procedures on aortic valve without cardiopulmonary bypass		
3845616	Other intrathoracic procedures on mitral valve without cardiopulmonary bypass		
3845617	Other intrathoracic procedures on tricuspid valve without cardiopulmonary bypass		
3845618	Other intrathoracic procedures on pulmonary valve without cardiopulmonary bypass		
3847500	Mitral valve annuloplasty	38475	Valve annuloplasty without insertion of ring, not being a service to which item 38480 or 38481 applies.
3847501	Tricuspid valve annuloplasty		
3847502	Aortic valve annuloplasty		
3847700	Mitral valve annuloplasty with ring insertion Mitral valve annuloplasty with Cosgrove (Edwards) ring insertion	38477	Valve annuloplasty with insertion of ring not being a service to which item 38478 applies
3847701	Tricuspid valve annuloplasty with ring insertion Tricuspid valve annuloplasty with Cosgrove (Edwards) ring insertion		
3847702	Aortic valve annuloplasty with ring insertion Aortic valve annuloplasty with Cosgrove (Edwards) ring insertion	38478	Valve annuloplasty with insertion of ring performed in conjunction with item 38480 or 38481
3848000	Repair of aortic valve, 1 leaflet	38480	Valve repair, 1 leaflet
3848001	Repair of mitral valve,1 leaflet		
3848002	Repair of tricuspid valve, 1 leaflet		
3848100	Repair of aortic valve, >=2 leaflets	38481	Valve repair, 2 or more leaflets
3848101	Repair of mitral valve, >= 2 leaflets		
3848102	Repair of tricuspid valve, >=2 leaflets		
3848300	Decalcification of aortic valve leaflet	38483	Aortic valve leaflet or leaflets, decalcification of, not being a service to which item 38475, 38477, 38480, 38481, 38488 or 38489 applies.
3848500	Reconstruction of mitral valve annulus	38485	Mitral annulus, reconstruction of, after decalcification when performed in association with valve surgery

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3848501	Decalcification of mitral valve		
3848700	Open valvotomy of mitral valve	38487	Mitral valve, open valvotomy of
3848800	Replacement of aortic valve with mechanical prosthesis	38488	Valve replacement with bioprosthesis or mechanical prosthesis
3848801	Replacement of aortic valve with bioprosthesis		
3848802	Replacement of mitral valve with mechanical prosthesis		
3848803	Replacement of mitral valve with bioprosthesis		
3848804	Replacement of tricuspid valve with mechanical prosthesis		
3848805	Replacement of tricuspid valve with bioprosthesis		
3848806	Replacement of pulmonary valve with mechanical prosthesis		
3848807	Replacement of pulmonary valve with bioprosthesis		
3848900	Replacement of aortic valve with homograft	38489	Valve replacement with allograft (subcoronary or cyclindrical implant) or unstented xenograft
3848901	Replacement of aortic valve with unstented heterograft		
3848902	Replacement of mitral valve with homograft		
3848903	Replacement of tricuspid valve with homograft		
3848904	Replacement of pulmonary valve with homograft	38490	Sub-valvular structures, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement
3848905	Replacement of pulmonary valve with unstented heterograft	38506	Left ventricular aneurysm, plication of
3849300	Re-operation for other cardiac procedure, not elsewhere classified	38493	Operative management of acute infective endocarditis, in association with heart valve surgery
3850700	Left ventricular aneurysmectomy	38507	Left ventricular aneurysm, resection with primary repair
3850800	Left ventricular aneurysmectomy with patch graft	38508	Left ventricular aneurysm resection with patch reconstruction of the left ventricle
3850900	Repair of ventricular septal rupture Repair of post infarction (ischaemic) ventricular septal defect Includes: resection of myocardium	38509	Ischaemic ventricular septal rupture, repair of
3851200	Division of accessory pathway involving one atrial chamber	38512	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only
3851500	Division of accessory pathway involving both atrial chambers	38515	Division of accessory pathway, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
			and including curative surgery for atrial fibrillation
3851800	Ventricular muscle ablation	38518	Ventricular arrhythmia with mapping and muscle ablation, with or without aneurysmeotomy
3855300	Repair of ascending thoracic aorta with aortic valve repair	38553	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair without implantation of coronary arteries
3855301	Repair of ascending thoracic aorta with aortic valve replacement		
3855600	Repair of ascending thoracic aorta with aortic valve repair and implantaion of coronary arteries	38556	Ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair and implantation of coronary arteries
3855601	Repair of ascending thoracic aorta with aortic valve replacement and implantaion of coronary arteries		
3856200	Repair of aortic arch and ascending thoracic aorta with aortic valve	38562	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair without implantation of coronary arteries
3856201			
3856500		38565	Aortic arch and ascending thoracic aorta, repair or replacement of, with aortic valve replacement or repair and implantation of coronary arteries
3856501			
3865000	Cardiac myotomy	38650	Myectomy or myotomy for hypertrophic obstructive cardiomyopathy
3865301	Other intrathoracic procedures on atrium with cardiopulmonary bypass	38653	Open heart surgery, not being a service to which another item in this group applies
3865302	Other intrathoracic procedures on ventricle of heart with cardiopulmonary bypass		
3865303	Other intrathoracic procedures on septum with cardiopulmonary bypass		
3865304	Other intrathoracic procedures on aortic valve with cardiopulmonary bypass		
3865305	Other intrathoracic procedures on mitral valve with cardiopulmonary bypass		
3865306	Other intrathoracis procedures on tricuspid valve with cardiopulmonary bypass		
3865307	Other intrathoracic procedures on pulmonary valve with cardiopulmonary bypass		
3867000	Excision of lesion of atrial wall or interatrial septum Excludes: that with reconstruction of atrium by: conduit (3867301) patch graft (3867300)	38670	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3867300	Excision of lesion of atrial wall or interatrial septum with reconstruction by patch graft	38673	Cardiac tumour, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit
3867301	Excision of lesion of atrial wall or interatrial septum with reconstruction by conduit		
3867700	Partial thickness excision of lesion of ventricular myocardium	38677	Cardiac tumour arising from ventricular myocardium, partial thickness excision of
3868000	Full thickness excision of lesion of ventricular muocardium with repair or reconstruction	38680	Cardiac tumour arising from ventricular myocardium, full thickness excision of including repair or reconstruction
3873900	Atrial septectomy or septostomy	38739	
3874202	Closure of atrial septal defect	38742	
3874500	Intra-atrial transposition of venous return Arterial switch procedure Insertion of intra-atrial baffle Mustard procedure Senning procedure	38745	Intra-atrial baffle, insertion of, for congenital heart disease
3874800	Ventricular septectomy	38748	Ventricular septectomy, for congenital heart disease
3875102	Closure of ventricular septal defect	38751	Ventricular septal defect, closure by direct suture or patch, for congenital heart disease
3875400	Intraventricular baffle procedure	38754	Intraventricular baffle or conduit, insertion of, for congenital heart disease
3875401	Creation of intraventricular conduit		
3875700	Creation of extracardiac conduit between right ventricle and pulmonary artery creation of shunt between right ventricle and pulmonary artery (distal)	38757	Extracardiac conduit, insertion of, for congenital heart disease
3875701	Creation of extracardiac conduit between left ventricle and aorta Creation of apicoaortic shunt Shunt between apex of left ventricle and aorta		
3875702	Creation of extracardiac conduit between atrium and pulmonary artery		
3876000	Replacement of extracardiac conduit between right ventricle and pulmonary artery Replacement of shunt between right ventricle and pulmonary artery (distal)	38760	Extracardiac conduit, replacement of, for congenital heart disease
3876001	Replacement of extracardiac conduit between left ventricle and aorta Replacement of shunt apicoaortic between apex of left ventricle and aorta		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3876002	Replacement of extracardiac conduit between atrium and pulmonary artery		
3876300	Left ventricular myectomy	38763	Ventricular myectomy, for relief of ventricular obstruction, right or left, for congenital heart disease
3876301	Right ventricular myectomy		
3876600	Left ventricular augmentation	38766	Ventricular augmentation, right or left, for congenital heart disease
3876601	Right ventricular augmentation	38700	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease
9020000	Revision of cerebrospinal fluid shunt at atrial site Revision of shunt: cisternoatrial, atrial site ventriculoatrial, distal site	38703	Patent ductus arteriosus, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease
9022400	Repair of transposition of great vessels Arterial switch procedure Excludes: creation of shunt between right ventricle and pulmonary artery (3875700) intra-atrial baffle procedure (3974500)	38706	Aorta, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease
		38709	Aorta, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease
		38712	Aortic interruption, repair of, for congenital heart disease
		38715	Main pulmonary artery, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease
		38718	Main pulmonary artery, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease
		38721	Vena cava, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease
		38724	Vena cava, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease
		38727	Intrathoracic vessels, anastomosis or repair of, without cardiopulmonary bypass, not being a sercie to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724 applies, for congenital heart disease
		38730	Intrathoracic vessels, anastomosis or repair of, with cardiopulmonary bypass, not being a sercie to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721, 38724 applies, for congenital heart disease

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		38733	Systemic pulmonary or cavo-pulmonary shunt, creation of, without cardiopulmonary bypass, for congenital heart disease
		38736	Systemic pulmonary or cavo-pulmonary shunt, creation of, with cardiopulmonary bypass, for congenital heart disease
		38739	Atrial septectomy, with or without cardiopulmonary bypass, for congenital heart disease
		38742	Atrial septal defect, closure by open exposure direct suture or patch, for congenital heart disease

CORONARY ARTERY BYPASS GRAFT – CHEST AND DONOR

Procedure Group: *CBGB*

Description: *Chest procedure to perform direct revascularisation of the heart; includes obtaining suitable vein from donor site for grafting*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		38496	Artery harvesting(other then internal mammary) for coronary artery bypass
3849700	Coronary artery bypass, using 1 saphenous vein graft	38497	Coronary artery bypass with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with a service to which items 38498, 38500, 38501, 38503 or 38504 apply
3849701	Coronary artery bypass, using 2 saphenous vein grafts		
3849702	Coronary artery bypass, using 3 saphenous vein grafts		
3849703	Coronary artery bypass, using >= 4 saphenous vein grafts		
3849704	Coronary artery bypass, using 1 other venous graft		
3849705	Coronary artery bypass, using 2 other venous grafts	38498	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497, 38500, 38501, 38503 or 38504 or 38600 apply
3849706	Coronary artery bypass, using 3 other venous grafts		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3849707	Coronary artery bypass, using >= 4 other venous grafts		
3850002	Coronary artery bypass, using 1 radial artery graft	38500	Coronary artery bypass with cardiopulmonary bypass, using single arterial graft , with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply
3850003	Coronary artery bypass, using 1 epigastric artery graft	38501	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service to which items 38497, 38498, 38500, 38503, 38504 or 38600 apply
3850004	Coronary artery bypass, using 1 other arterial graft		
3850302	Coronary artery bypass, using >= 2 radial artery grafts	38503	Coronary artery bypass with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, inclduing harvesting of internal mammary artery or vein graft material where performed, not being a service to which items 38497, 38498, 38500, 38501 or 38504 apply
3850303	Coronary artery bypass, using >= 2 epigastric artery grafts		
3850304	Coronary artery bypass, using >= 2 other arterial grafts		
3863700	Reoperation for reconstruction of coronary artery graft	38504	Coronary artery bypass with the aid of tissue stabilisers, performed without cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery

CORONARY ARTERY BYPASS GRAFT – CHEST ONLY

Procedure Group: *CBGC*

Description: *Chest procedure to perform direct revascularisation of heart using, for example, the internal mammary (thoracic) artery*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3850000	Coronary artery bypass, using 1 LIMA gft	38500	Coronary artery bypass with cardiopulmonary bypass, using single arterial graft , with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497, 38498, 38501, 38503 or 38504 apply
3850001	Coronary artery bypass, using 1 RIMA gft	38501	
3850300	Coronary artery bypass, >= 2 LIMA gft	38503	
3850301	Coronary artery bypass, >= 2 RIMA gft	38504	
9020100	Coronary artery bypass, using 1 other material graft, not elsewhere classified		
9020101	Coronary artery bypass, using 2 other material graft, not elsewhere classified		
9020102	Coronary artery bypass, using 3 other material graft, not elsewhere classified		
9020103	Coronary artery bypass, using >= 4 other material graft, not elsewhere classified		

CAROTID ENDARTERECTOMY

Procedure Group: *CEA*

Description: *Carotid endarterectomy*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3350000	Carotid endarterectomy	33500	Artery or arteries of neck, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertken through 1 anteriotomy incision)
3270300	Resection of carotid artery with reanastomosis- includes endarterectomy	32703	Internal carotid artery, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy

GALLBLADDER SURGERY

Procedure Group: *CHOL*

Description: *Chloecystectomy and cholecystotomy; includes procedures performed using the laparoscope.*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3037505	Cholecystostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037526	Cholecystotomy		
3044300	Cholecystectomy	30443	Cholecystectomy
3044500	Laparoscopic cholecystectomy	30445	Laparoscopic cholecystectomy
3044600	Laparoscopic cholecystectomy proceeding to open cholecystectomy	30446	Laaroscopic cholecystectomy when procedure is complicated by laparotomy
3044800	Laparoscopic cholecystectomy with removal of common bile duct calculus via cystic duct	30448	Laparoscopic cholecystectomy involving removal of common duct calculi via the cystic duct
3044900	Laparoscopic cholecystectomy with removal of common bile duct calculus bia laparoscopic choledochotomy	30449	Laparoscopic cholecystectomy involving removal of common duct calculi via laaparoscopic choledochotomy
3045401	Cholecystectomy with choledochotomy	30454	Choledochotomy(with or without cholocystecomy) with or without removal of calculi
3045500	Cholecystectomy with choledochotomy and biliary intestinal anastomosis	30455	Choledochotomy(with or without cholocystectomy) with removal of calculi including biliary intestinal anastomosis

COLORECTAL SURGERY

Procedure Group: *COLO*

Description: *Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis.*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		30373	Laparotomy, exploratory, including associated biopsies, where no other abdominal procedure is performed
3037500	Caecostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037502	Colotomy		
3037504	Other colostomy	30376	Laparotomy involving division of peritoneal adhesions (where no other abdominal procedure is performed)
3037514	Biopsy of large intestine	30378	Laparotomy involving division of adhesions in conjuction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours
3037525	Suture of laceration of large intestine	30379	Laparotomy with division of extensive adhesions (duration greater than 2 hours) with or without insertion of long intestinal tube
3037528	Temporary colostomy	30382	Enterocutaneous fistula, radical repair of, involving extensive dissection and resection of bowel
3038202	Radical repair of enterocutaneous fistula of large intestine	30387	Laparotomy involving operation on abdominal viscera (including pelvic viscera)
3056202	Closure of loop colostomy	30388	Laparotomy for trauma involving 3 or more organs
3056203	Closure of colostomy with restoration of bowel continuity	30392	Radical or debulking operation for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure
3056205	Closure of other stoma of large intestine	30393	Laparoscopic division of adhesions in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes
3056301	Revision of stoma of large intestine	30563	Colostomy or ileostomy, refashioning of
3200000	Limited excision of large intestine with formation of stoma	32000	Large intestine, resection of , without anastomosis, including right hemicolectomy (including formation of stoma)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3200001	Right hemicolectomy with formation of stoma		
3200300	Limited excision of large intestine with anastomosis	32003	Large intestine, resection of , without anastomosis, including right hemicolectomy
3200301	Right hemicolectomy with anastomosis		
3200400	Sub-total colectomy with formation of stoma	32004	Large intestine, subtotal colectomy(resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies.
3200401	Extended right hemicolectomy with formation of stoma		
3200500	Subtotal colectomy with anastomosis	32005	Large intestine, subtotal colectomy(resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies.
3200501	Extended right hemicolectomy with anastomosis		
3200600	Left hemicolectomy with anastomosis	32006	Left hemicolectomy, including the descending and sigmoid colon (including formation of stoma)
3200601	Left hemicolectomy with formation of stoma		
3200900	Total colectomy with ileostomy	32009	Total colectomy and ilesotomy
3201200	Total colectomy with ileorectal anastomosis	32012	Total colectomy and ielorectal anastomosis
3201500	Total proctolectomy with ileostomy	32015	Total colectomy with excision of rectum and ileostomy
		32018	Total colectomy with excision of rectum and ileostomy, combined synchronous operation;abdominal resection
		32021	Total colectomy with excision of rectum and ileostomy, combined synchronous operation;perineal resection
3202400	High restorative anterior resection of rectum with intraperitoneal anastomosis	32024	Rectum, high restorative anterior resection with intraperitoneal anastomosis(of the rectum) greater than 10cm from the anal verge excluding resection of sigmoid colon alone not being a sercice associated with a sercice to which item 32013, 32014 or 32016 applies.
3202500	Low restorative anterior resection of rectum with extraperitoneal anastomosis	32025	Rectum, low restorative anterior resection with extraperitoneal anastomosis (of the rectum) less than 10 cm from the anal vergem with or without covering stoma not being a sercice associated with a service to which item 32013, 32014 or 32016 applies.

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3202600	Low restorative anterior resection of rectum with coloanal anastomosis	32026	Rectum, ultra low restorative resection, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge.
3202800	Ultra low restorative anterior resection of rectum with sutured coloanal anastomosis	32028	Rectum, low or ultra low restorative resection, with peranal sutured coloanal anastomosis, with or without covering stoma.
3202900	Construction of colonic reservoir		
3202901	Revision of colonic reservoir		
3203000	Rectosigmoidectomy with formation of stoma - Hartmann's procedure	32030	Rectosigmoidectomy (Hartmann's operation)
3203300	Restoration of bowel continuity after Hartmann's procedure	32033	Restoration of bowel following Hartmann's or similar operation, including dismantling of the stoma.
3203900	Abdominoperineal proctectomy	32039	Rectum and anus, abdominoperineal resection of 1 surgeon
		32042	Rectum and anus, abdominoperineal resection of, combined synchronous operation abdominal resection
		32045	Rectum and anus, abdominoperineal resection of, combined synchronous operation perineal resection
		32046	Rectum and anus, abdomino-perineal resection of, combined synchronous operation - perineal resection wheer the perineal surgeon also provides assistance to the abdominal surgeon
3204700	Perineal proctectomy	32047	Perineal proctectomy
3205100	Total proctolectomy with ileo-anal anastomosis	32051	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ielostomy 1 surgeon
3205101	Total proctocolectomy with ileo-anal anastomosis and formation of temporary ileostomy	32054	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ielostomy conjoint surgery, abdominal surgeon(including aftercare)
		32057	Total colectomy with excision of rectum and ieloanal anastomosis with formation of ileal reservoir, with or without creation of temporary ielostomy conjoint surgery, perineal surgeon
3206000	Restorative proctectomy	32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon
		32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon
3209600	Full thickness biopsy of rectum'	32096	Rectal biopsy, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility
3209900	Per anal sub mucosal excision of lesion or tissue of rectum		
3210800	Trans-sphincteric excision of lesion or tissue of rectum	32108	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate
3211200	Perineal rectosigmoidectomy		
4399301	Definitive intestinal resection and pull-through anastomosis		
9034100	Other excision of lesion of rectum		
9095900	Excision of other lesion of large intestine		

CRANIOTOMY

Procedure Group: *CRAN*

Description: *Incision through the skull to excise, repair, or explore the brain; does not include taps or punctures*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3901200	Burr holes - burr holes for brachytherapy, inspection purpose,intracranial exploration	39012	Burr-hole, single, preparatory to ventricular puncture of for inspection purposes
3960000	Drainage of intracranial haemorrhage - extradural, intracerebral, subdural	39600	Intracranial haemorrhage, burr hole craniotomy for - including burr holes
3960300	Removal of intracranial haematoma via osteoplastic craniotomy	39603	Intracranial haemorrhage, osteoplastic craniotomy or extensive craniectomy and removal of haematoma
3960301	Removal of intracranial haematoma with craniectomy	39612	Fractured skull, compound, depressed or complicated, with dural penetration and brain laceration, operation for
3961500	Repair of dura of brain via craniotomy	39615	Fractured skull, with rhinorrhoea or otorrhoea, cranioplasty and repair of
3961501	Repair of dura of brain via craniotomy with cranioplasty		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3964000	Removal of tumour involving anterior cranial fossa	39640	Tumour involving anterior cranial fossa, removal of, involving craniotomy, radical excision of the skull base, and dural repair
3964200	Removal of tumour involving anterior cranial fossa with clearance of paranasal sinus extension	39642	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy, with lateral rhinotomy for clearance of parasinal sinus extension (intracranial procedure)
3964600	Removal of tumour involving anterior cranial fossa with radical clearance of paranasal sinus and orbital fossa extensions	39646	Tumour involving anterior cranial fossa, removal of, involving frontal craniotomy, with lateral rhinotomy and radical clearance of parasinal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve (intracranial procedure)
3965000	Removal of tumour involving middle cranial and infratemporal fossae	39650	Tumour involving middle cranial fossa and infra-temporal fossa, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure)
3965300	Removal of petroclival and clival tumour	39653	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure) not being a service to which item 39654 or 39656 applies)
3965800	Excision of clival tumour, transoral approach	39654	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure) ,conjoint surgery, principal surgeon
3965801	Excision of clival tumour, transmaxillary approach	39656	Petro-clival and clival tumour, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure) ,conjoint surgery, co-surgeon
		39658	Tumour involving the clivus, radical or sub-total radical excision of, involving trans-oral or transmaxillary approach
3966000	Excision of tumour of cavernous sinus	39660	Tumour or vascular lesion of cavernous sinus, radical excision of, involving craniotomy with or without intracranial carotid artery exposure
3966001	Excision of tumour of cavernous sinus with intracranial carotid artery exposure		
3966002	Excision of vascular lesion of cavernous sinus		
3966003	Excision of vascular lesion of cavernous sinus, with intracranial carotid artery exposure		
3966200	Excision of tumour of foramen magnum, transcondylar approach	39662	Tumour or vascular lesion of foramen magnum, radical excision of, via transcondylar or far lateral suboccipital approach
3966201	Excision of tumour of foramen magnum, far lateral suboccipital approach		
3966202	Excision of vascular lesion of foramen magnum, transcondylar approac		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3966203	Excision of vascular lesion of foramen magnum, far lateral suboccipital approach		
3970300	Biopsy of brain via burr holes	39703	Intracranial tumour, cyst or other brain tissue, burr-hole and biopsy of or drainage of, or both
3970301	Drainage of intracranial lesion or cyst		
3970302	Biopsy of cerebral meninges via burr holes		
3970303	Aspiration of brain cyst		
3970600	Biopsy of brain via osteoplastic craniotomy	39706	Intracranial tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap
3970601	Decompression of intracranial tumour via osteoplastic craniotomy includes osteoplastic flap		
3970602	Biopsy of cerebral meninges via osteoplastic craniotomy		
3970900	Removal of tumour of cerebrum	39709	Craniotomy for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this sub-group applies
3970901	Removal of tumour of brain stem		
3970902	Removal of tumour of cerebellum		
3971200	Removal of tumour of cerebral meninges	39712	Craniotomy for removal of meningioma, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tunour, not being a service to which another item in this sub-group applies
3971201	Removal of tumour of pineal body		
3971202	Removal of craniopharyngioma		
3971203	Removal of intraventricular tumour		
3971204	Removal of other intracranial tumour		
3971500	Removal of tumour of pituitary gland via transcranial approach	39715	Pituitary tumour, removal of, by transcranial or transsphenoidal approach
3971501	Removal of tumour of pituitary gland via transsphenoidal approach		
3971800	Removal of brain cyst	39718	Arachnoidal cyst, craniotomy for

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3972100	Postoperative re-opening of craniotomy or craniectomy site Postoperative: decompression of oedema drainage of haemorrhage, infection removal of abscess, heamatoma includes removal of skull flap and that via osteoplastic flap	39721	Craniotomy, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling etc
3980000	Clipping of cerebral aneurysm	39800	Aneurysm, clipping or reinforcement of sac
3980001	Reinforcement of cerebral aneurysm		
3980300	Excision of intracranial arteriovenous malformation	39803	Intracranial arteriovenous malformation, excision of
3980600	Clipping of intracranial proximal artery	39806	Anuerysm, or arteriovenous malformation, intracranial proximal artery clipping of
3981200	Ligation of cervical vessel for intracranial aneurysm	39812	Intracranial aneurysm or arteriovenous fistula, ligation of cervical vessel or vessels
3981500	Obliteration of carotid cavernous fistula	39815	Carotid-cavernous fistula, obliteration of - combined cervical and intracranial procedure
3981800	Extracranial to intracranial bypass with superficial temporal artery graft	39818	Extracranial to intracranial bypass using superficial temporal artery
3982100	Extracranial to intracranial bypass with saphenous vein graft	39821	Extracranial to intracranial bypass using saphenous vein graft
3990000	Drainage of intracranial infection - drainage of infected brain cyst, intracranial abscess	39900	Intracranial infection, drainage of, via burr-hole - including burr-hole
3990300	Removal of intracranial abscess	39903	Intracranial abscess, excision of
3990600	Craniectomy for infection of skull	39906	Osteomyelitis of skull or removal of infected bone flap, craniectomy for
4001500	Subtemporal decompression	40015	Subtemporal decompresssion
4010600	Hind brain decompression of Arnold-Chiari malformation, Chiari malformation	40106	Arnold-Chiari malformation
4010601	Posterior cranial fossa decompression - decompression for suringomyelia includes duroplasty		
4010900	Repair of encephalocele	40109	Encephalocoele
		40600	Cranioplasty
4070000	Anterior section of corpus callosum	40700	Corpus callosum, anterior section of, for epilepsy
4070300	Corticectomy of brain	40703	Corticectomy, topiectomy or partial lobectomy for epilepsy
4070301	Topectomy		
4070302	Partial lobectomy of brain		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4070600	Hemispherectomy	40706	Hemispherectomy for intractable epilepsy
4070900	Placement of intracranial electrode via burr holes	40709	Burr-hole placement of intracranial depth or surface electrodes
4070901	Removal of intracranial electrode via burr holes		
4071200	Placement of intracranial electrode via craniotomy	40712	Intracranial electrode placement via craniotomy
4071201	Removal of intracranial electrode via craniotomy		
4080100	Functional intracranial stereotactic procedure	40801	Functional stereotactic procedure including compyuter assisted anatomical localisation
		40850	Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical localisation, physiological localisation including twist drill, burr hole craniotomy or craniectomy and insertion of electrodes
		40851	Deep brain stimulation (bilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, functional stereotactic procedure including computer assisted anatomical lo
		40852	Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, subcutaneous placement of neurostimulator receiver or pulse generator
		40854	Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, revision or removal of brain electrode
		40856	Deep brain stimulation (unilateral) for Parkinson's disease where the patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, removal or replacement of neurostimulator generator or pulse generator
		40858	Deep brain stimultaion (unilateral) for Parkinsons disease where he patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, placement, removal or replacement of extension lead

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		40860	Deep brain stimulation (unilateral) for Parkinsons disease where he patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, target localisation incorporating anatomical and physiological techniques, including intra-operative clinical evaluation, for the insertion of a single neurostimulation wire
		40862	Deep brain stimultaion (unilateral) for Parkinsons disease where he patient's response to medical therapy is not sustained and is accompanied by unacceptable motor fluctuations, electronic analysis and programming of neurostimulator pulse generator
		40903	Neuroendoscopy, for inspection of an intraventricular lesion, with or without biopsy including burr hole
		40905	Craniotomy, performed in association with items 45767, 45776, 45782, 45785 for the correction of craniofacial abnormalities
4157500	Removal of cerebellopontine angle tumour	41575	Cerebello pontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare)
		41576	Cerebello pontine angle tumour, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies
		41578	Cerebello pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon
		41579	Cerebello pontine angle tumour, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon
4158100	Removal of lesion involving infratemporal fossa	41581	Tumour involving infra-temporal fossa, removal of, involving craniotomy and radical excision of
		41584	Partial temporal bone resection for removal of tumour involving mastoidectomy with or without decompression of facial nerve
		41587	Total temporal bone resection for removal of tumour
9000600	Extracranial to intracranial bypass with radial artery graft		
9000702	Other procedures on brain or cerebral meninges		
9004300	Other procedures on pineal gland		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
9004400	Other procedures on pituitary gland		
9004800	Partial excision of pituitary gland, transcranial approach		
9004801	Partial excision of pituitary gland, transsphenoidal approach		
9004802	Total excision of pituitary gland, transcranial approach		
9004803	Total excision of pituitary gland, transsphenoidal approach		

CAESAREAN SECTION

Procedure Group: *CSEC*

Description: *Obstetrical delivery by Caesarean section*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
1652000	Elective classical caesarean section	16520	Caeserean section and postoperative care for 7 days where the patients care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care
1652001	Emergency classical caesarean section		
1652002	Elective lower segment caesarean section		
1652003	Emergency lower segment caesarean section	16522	Management of labour and delivery or delivery alone, (including caesarean section) where in the course of antenatal supervision or intrapartum management 1 or more of the following conditisions is present including postnatal care for 7 days - multiple pregnancy etc etc
3564900	Hysterotomy	35649	Hysterotomy or uterine myectomy, abdominal
		16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days

FEMORO-POPLITEAL OR FEMORO-TIBIAL BYPASS

Procedure Group: *FPOP*

Description: *Femoro-popliteal and femoro-tibial bypass grafts. NB: This procedure differs from NHSN*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.)
		32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.)
		32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.)
3273900	Femero-popliteal bypass using vein, above knee anastomosis ; excludes composite(vein and synthetic) graft	32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.)
3274200	Femero-popliteal bypass using vein, below knee anastomosis; excludes composite(vein and synthetic) graft	32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.)
3274500	Femoral to proximal tibial or peroneal artery bypass using vein, anastomosis of distal end of bypass to tibio-peroneal trunk, excludes composite (vein and synthetic) graft	32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or peroneal artery (Anaes.) (Assist.)
3274800	Femoral to distal tibial or peroneal artery bypass using vein, anastomosis of distal end of bypass to tibio-peroneal trunk, excludes composite (vein and synthetic) graft	32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of of the ankle joint (Anaes.) (Assist.)
3275100	Femero-popliteal bypass using synthetic material, above knee anastomosis, excludes composite (vein and synthetic) graft	32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.)
3275101	Femero-popliteal bypass using synthetic material, below knee anastomosis, excludes composite (vein and synthetic) graft		
3275102	Femoral to proximal tibial or peroneal artery bypass using synthetic material, anastomosis of distal end of bypass to tibio-peroneal trunk, excludes composite (vein and synthetic) graft		
3275103	Femoral to distal tibial or peroneal artery bypass using synthetic material, anastomosis of distal end of bypass to tibio-peroneal trunk, excludes composite (vein and synthetic) graft		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3275400	Femero-popliteal bypass using composite graft, above knee anastomosis - femero-femoral bypass using synthetic and vein graft	32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.)
3275401	Femero-popliteal bypass using composite graft, below knee anastomosis - femero-popliteal bypass using composite graft NOS, femero-popliteal bypass using synthetic and vein graft		
3275402	Femoral totibial or peroneal artery bypass using composite graft includes anastomosis of distal end of bypass to rtbio-peroneal trunk		
		32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to seperately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.)
		33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.)
		33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.)

SPINAL FUSION

Procedure Group: *FUSN*

Description: *Immobilisation of spinal column (note: cannot compare this group to NHSN)*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4866000	Anterior spinal fusion, 1 level		
4866900	Anterior spinal fusion, ≥ 2 levels	40321	Posterior spinal fusion
4864200	Posterior spinal fusion, 1 or 2 levels	40324	Partial or total laminectomy followed by posterior fusion performed by nueurosurgeon and orthopaedic surgeon operating together - laminectomy including aftercare
4864500	Posterior spinal fusion, ≥ 3 levels	40327	partial or total laminectomy followed by posterior fusion performed by nueurosurgeon and orthopaedic surgeon operating together - posterior fusion including aftercare

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4864800	Posterlateral spinal fusion, 1 or 2 levels	40332	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level
4865100	Posterlateral spinal fusion, ≥ 3 levels	40335	Cervical decompression of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level
4865400	Posterior spinal fusion with laminectomy, 1 level	48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation)
4865700	Posterior spinal fusion with laminectomy, ≥ 2 levels	48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar)
4865401	Posterlateral spinal fusion with laminectomy, 1 level	48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches
4865701	Posterlateral spinal fusion with laminectomy, ≥ 2 levels	48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation
		48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels
		48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels
		48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis
		48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement
		48632	SCOLIOSIS, congenital, vertebral resection and fusion for
		48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation
		48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches
		48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels
		48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels
		48648	SPINE, bone graft to (postero-lateral fusion) - 1 or 2 levels
		48651	SPINE, bone graft to (postero-lateral fusion) - more than 2 levels

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		48654	SPINAL FUSION (posterior interbody), with partial or total laminectomy, 1 level
		48657	SPINAL FUSION (posterior interbody), with partial or total laminectomy, more than 1 level
		48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level, not being a service associated with artificial intervertebral total disc replacement
		48663	SPINAL FUSION (anterior interbody) to cervial, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon
		48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon
		48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level, not being a service associated with artificial intervertebral total disc replacement
		48672	SPINAL FUSION (anterior interbody) to cervival, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon
		48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon
		50620	SCOLIOSIS, in a child or adolescent, revision of failed scoliosis surgery, involving more than 1 of osteotomy, fusion, removal of instrumentation or instrumentation
		50624	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - not more than 4 levels
		50628	SCOLIOSIS, in a child or adolescent, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels
		50632	SCOLIOSIS OR KYPHOSIS, in a child or adolescent, requiring segmental instrumentation and fusion of the spine down to and including the pelvis or sacrum
		50640	SCOLIOSIS, in a child or adolescent, congenital, resection and fusion of abnormal vertebra via an anterior or posterior approach

GASTRIC SURGERY

Procedure Group: *GAST*

Description: *Incision or excision of stomach; includes subtotal or total gastrectomy, does not include vagotomy and fundoplication*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3037506	Gastrotomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037510	Suture of perforated ulcer	30388	Laparotomy for trauma involving 3 or more organs
3037512	Reduction of gastric volvulus		
3037513	Pyloroplasty		
3037515	Gastrotomy with removal of foreign body		
3049601	Selective vagotomy with pyloroplasty	30496	Vagotomy, truncal or selective, with or without pyloroplasty or gastroenterostomy
3049602	Selective vagotomy with gastro-enterostomy		
3049700	Selective vagotomy with partial gastrectomy and gastroduodenal anastomosis	30497	Vagotomy and antrectomy
3049701	Selective vagotomy with partial gastrectomy and gastrojejunal anastomosis		
3049702	Selective vagotomy with partial gastrectomy and Roux-en-Y reconstruction		
3050000	Highly selective vagotomy with duodenoplasty	30500	Vagotomy, highly selective with duodenoplasty for peptic stricture
3050200	Highly selective vagotomy with dilation of pylorus	30502	Vagotomy, highly selective with dilatation of pylorus
3050300	Partial gastrectomy with gastroduodenal anastomosis following previous procedure for peptic ulcer disease	30503	Vagotomy or antrectomy, or both, for peptic ulcer, folowing previous operation for peptic ulcer
3050301	Partial gastrectomy with gastrojejunal anastomosis following previous procedure for peptic ulcer disease		
3050302	Partial gastrectomy with Roux-en-Y reconstruction following previous procedure for peptic ulcer disease		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3050303	Selective vagotomy with partial gastrectomy and gastroduodenal anastomosis following previous procedure for peptic ulcer disease		
3050304	Selective vagotomy with partial gastrectomy and gastrojejunal anastomosis following previous procedure for peptic ulcer disease		
3050305	Selective vagotomy with partial gastrectomy and Roux-en-Y reconstruction following previous procedure for peptic ulcer disease		
3050500	Control of bleeding peptic ulcer	30505	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision
		30506	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy
		30508	Bleeding peptic ulcer, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy
3050900	Control of bleeding peptic ulcer by gastric resection	30509	Bleeding peptic ulcer, control of, involving gastric resection (other than wedge resection)
3051100	Gastric reduction	30511	Morbid obesity, gastric reduction of gastroplasty for, by any method
3051101	Laparoscopic adjustable gastric banding (LAGB)		
3051200	Gastric bypass	30512	Morbid obesity, gastric reduction of gastroplasty for, by any method including anastomosis
3051201			
3051202			
3051400	Surgical reversal of procedure for morbid obesity	30514	Morbid obesity, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies
3051500	Gastro-enterostomy	30515	Gastroenterostomy (including gastroduodenostomy) or enterocolostomy or enteroenterostomy
3051700	Reconstruction of pyloroplasty	30517	Gastroenterostomy, pyloroplasty or gastroduodenostomy, reconstruction of
3051701	Reconstruction of gastroenterostomy		
3051800	Partial distal gastrectomy with gastroduodenal anastomosis	30518	Partial gastrectomy
3051801	Partial distal gastrectomy with gastrojejunal anastomosis		
3051802	Partial proximal gastrectomy with oesophagogastric anastomosis		
3052000	Local excision of gastric lesion	30520	Gastric tumour, removal of, by local excision, not being a service to which item 30518 applies

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3052100	Total gastrectomy	30521	Gastrectomy, total, for benign disease
3052300	Subtotal gastrectomy	30523	Gastrectomy, subtotal radical, for carcinoma (including splenectomy when performed)
3052400	Radical gastrectomy	30524	Gastrectomy, total radical, for carcinoma (including extended node dissection and distal pancratectomy and splenectomy when performed)
		30526	Gastrectomy, total, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus (including splenectomy when performed)
9030400	Other repair of stomach		
9033900	Closure of gastrostomy		
9034202	Suture of laceration of stomach		

HERNIORRHAPHY

Procedure Group: *HERN*

Description: *Repair of inguinal, femoral, umbilical, or anterior abdominal wall hernia; does not include repair of diaphragmatic or hiatal hernia or hernias at other body sites*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3040300	Repair of incisional hernia	30403	Ventral, incisional, or recurrent hernia or burst abdomen, repair of with or without mesh
3040301	Repair of other abdominal wall hernia		
3040500	Repair of incisional hernia with muscle transposition	30405	Ventral or incisional hernia,(excluding recurrent inguinal or femoral hernia), repair of, requiring muscle transpositionj, mesh hernioplasty or resection of strangulated bowel
3040501	Repair incisional hernia with prosthesis		
3040502	Repair of incisional hernia with resection of strangulated intestine		
3040503	Repair of other abdominal wall hernia with muscle transposition		
3040504	Repair of other abdominal wall hernia with prosthesis		
3040505	Repair of other abdominal wall hernia with resection of strangulated intestine		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3060900	Laparoscopic repair of femoral hernia, unilateral	30609	Femoral or inguinal hernia, laparoscopic repair of, not being a service associate with a service to which item 30612 or 30614 applies
3060901	Laparoscopic repair of femoral hernia, bilateral		
3060902	Laparoscopic repair of inguinal hernia, unilateral		
3060903	Laparoscopic repair of inguinal hernia, bilateral	30612	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies
3061400	Repair of femoral hernia, unilateral	30614	Femoral or inguinal hernia or infantile hydrocele, repair of, not being a service to which item 30403 or 30615 applies
3061401	Repair of femoral hernia, bilateral		
3061402	Repair of inguinal hernia, unilateral		
3061403	Repair of inguinal hernia, bilateral	30616	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age
3061700	Repair of umbilical hernia	30617	Umbilical, epigastric or linea alba hernia, repair of, in a person under 10 years of age
3061701	Repair of epigastric hernia	30620	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over
3061702	Repair of linea alba hernia	30621	Umbilical, epigastric or linea alba hernia, repair of, in a person 10 years of age or over
		44108	Inguinal hernia repair at age less than 3 months
		44114	Inguinal hernia repair at age less than 3 months, including orchidopexy when performed

HIP PROSTHESIS

Procedure Group: *HPRO*

Description: *Arthroplasty of hip; includes total, partial and revision arthroplasties; does not include Birmingham hip resurfacing*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4752200	Hemiarthroplasty of femur - Austin Moore arthroplasty	47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.)
4931500	Partial arthroplasty of hip	49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4931800	Total arthroplasty of hip, unilateral, total joint replacement of hip	49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.)(Assist.)
4931900	Total arthroplasty of hip, bilateral	49319	HIP, total replacement arthroplasty of, including minor bone grafting, if performed - bilateral (Anaes.)(Assist.)
		49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining a graft (Anaes.) (Assist.)
4932400	Revision of total arthroplasty of hip	49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.)
4932700	Revision of total arthroplasty of hip with bone graft to acetabulum	49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.)
4933000	Revision of total arthroplasty of hip with bone graft to femur	49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.)
4933300	Revision of total arthroplasty of hip with bone graft to acetabulum and femur	49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.)
		49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.)
4933900	Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum	49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.)
4934200	Revision of total arthroplasty of hip with anatomic specific allograft to femur	49342	HIP, revision total replacement of, requiring anatomic specific allograftof acetabulum (Anaes.) (Assist.)
4934500	Revision of total arthroplasty of hip with anatomic specific allograft to acetabulum and femur	49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.)
4934600	Revision of partial arthroplasty of hip	49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shel (Anaes.) (Assist.)
5021700	Arthroplasty of joint, not elsewhere classified	50127	Joint or joints, arthroplasty of, by any technique and not being a service to which another time applies
5021503	En bloc resection of lesion of soft tissue affecting the long bones of lower limb, with intercalary reconstruction using prosthesis	50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with intercalary reconstruction (prosthesis, allograft or autograft)

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
5021803	En boc resection of lesion of long bone of lower limb with replacement of adjacent joint	50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint
		50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement

ABDOMINAL HYSTERECTOMY

Procedure Group: *HYST*

Description: *Removal of uterus through an abdominal incision*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3565300	Subtotal abdominal hysterectomy	35653	Hysterectomy, abdominal, subtotal or total, with or without removal of uterine adnexae
3565301	Total abdominal hysterectomy		
3565302	Abdominal hysterectomy with unilateral salpingo-oophorectomy		
3565303	Abdominal hysterectomy with bilateral salpingo-oophorectomy		
3565304	Total abdominal hysterectomy and removal of adnexa		
3566100	Abdominal hysterectomy with extensive retroperitoneal dissection	35661	Hysterectomy, abdominal, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries
3566400	Radical abdominal hysterectomy with radical excision of pelvic lymph nodes	35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without removal of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where perfomed
3566700	Radical abdominal hysterectomy	35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where perfomed
3567000	Abdominal hysterectomy with radical excision of pelvic lymph nodes	35670	Hysterectomy, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae
		35750	Laparoscopically assisted hysterectomy, including any associated laparoscopy

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: sapingectomy, oophrectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy
		35754	Laparoscopically assisted hysterectomy wihich requires dissection of endometriosis,o r other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophrectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies
3575600	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy	35756	Laparoscopically assisted hysterectomy, when procedure is completed by open hysterectomy, including any associated laparoscopy
3575601	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy with unilateral salpingo-oophorectomy		
3575602	Laparoscopically assisted vaginal hysterectomy proceeding to abdominal hysterectomy with bilateral salpingo-oophorectomy		
9044800	Subtotal laparoscopic abdominal hysterectomy		
9044801	Total laparosopic abdominal hysterectomy		
9044802	Total laparosopic abdominal hysterectomy with removal of adnexa		

KNEE PROSTHESIS

Procedure Group: *KPRO*

Description: *Arthroplasty of knee*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4951700	Hemiarthroplasty of knee	49517	Knee, hemiarthroplasty of
4951800	Total arthroplasty of knee, unilateral	49518	Knee,total replacement arthroplasty of
4951900	Total arthroplasty of knee, bilateral	49519	Knee, total replacement arthroplasty of, including associated minor grafting, if performed- bilateral
4952100	Total arthroplasty of knee with bone graft to femur, unilateral	49521	Knee, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
4952101	Total arthroplasty to knee with bone graft to femur, bilateral		
4952102	Total arthroplasty to knee with bone graft to tibia, unilateral		
4952103	Total arthroplasty to knee with bone graft to tibia, bilateral		
4952400	Total arthroplasty of knee with bone graft to femur and tibia, unilateral	49524	Knee, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft
4952401	Total arthroplasty of knee with bone graft to femur and tibia, bilateral		
4952700	Revision of total arthroplasty of knee	49527	Knee, total replacement arthroplasty of, revision procedure, including removal of prosthesis
4953000	Revision of total arthroplasty of knee with bone graft to femur	49530	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis
4953001	Revision of total arthroplasty of knee with bone graft to tibia		
4953300	Revision of total arthroplasty of knee with bone graft to femur and tibia	49533	Knee, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis
4953400	Total replacement arthroplasty of patellofemoral joint of knee	49534	Knee, patello-femoral joint of, total replacement arthroplasty as a primary procedure
4955400	Revision of total arthroplasty of knee with anatomic specific allograft	49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur
		49554	Knee, revision of total replacement of, by anatomic specific allograft of tibia or femur
5021700	Arthroplasty of joint, not elsewhere classified	50127	Joint or joints, arthroplasty of, by any technique and not being a service to which another time applies
5021503	En bloc resection of lesion of soft tissue affecting the long bones of lower limb, with intercalary reconstruction using prosthesis	50215	Malignant or aggressive soft tissue tumour affecting the long bones of leg or arm, enbloc resection of, with intercalary reconstruction (prosthesis, allograft or autograft)
5021803	En boc resection of lesion of long bone of lower limb with replacement of adjacent joint	50218	Malignant tumour of long bone, enbloc resection of, with replacement or arthrodesis of adjacent joint
		50227	Malignant bone tumour, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement

LAMINECTOMY

Procedure Group: *LAM*

Description: *Exploration or decompression of spinal cord through excision or incision into verterbral structures*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
		40300	Interverterbral disc or discs, partial or total laminectomy for removal of
		40301	Interverterbral disc or discs, microsurgical partial or total laminectomy for removal of
		40303	recurrent disc lesion or spinal stenosis, or both, partial or total laminectomy for - 1 level
		40306	spinal stnosis, partial or total laminectomy for, involving more than 1 verterbral interspace
		40309	Extradural tumour or abscess, partial or total laminectomy for
		40312	Intradural lesion, partial or total laminectomy for
		40318	Intramedullary tumour or arteriovenous malformation, parital or total laminectomy and radical excision of
		40330	Spinal rhizolysis involving exposure of spinal nerve roots - for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extnsive epidural fibrosis, at 1 or more levels - with or without partial or total laminectomy

REFUSION OF SPINE

Procedure Group: *RFUSN*

Description: *Refusion of spine*

Please contact the VICNISS Coordinating Centre before undertaking RFUSN surveillance or for further information regarding codes.

SMALL BOWEL SURGERY

Procedure Group: *SB*

Description: *Incision or resection of the small intestine; does not include small-to-large bowel anastomosis*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3007513	Biopsy of small intestine		
3037501	Other enterostomy	30375	Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystectomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Merckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas.
3037503	Enterotomy of small intestine		
3037509	Excision of Meckel's diverticulum		
3037519	Other repair of small intestine		
3037524	Suture of small intestine		
3037529	Temporary ileostomy		
3038200	Radicla repair of enterocutaneous fistula of small intestine		
3047805	Percutaneous endoscopic jejunostomy (PEJ)		
3051501	Enterocolostomy - ileocolonic anastomosis		
3051502	Enteroenterostomy - Roux-en-Y reconstruction		
3056200	Closure of loop ileostomy	30562	Enterostomy or colostomy, closure of not involving resection of bowel
3056201	Closure of ileostomy with restoration of bowel continuity, withour resection	30563	Colostomy or ileostomy, refashioning of
3056204	Closure of other stoma of small intestine		
3056300	Revision of stoma of small intestine		
3056400	Strictureplasty of small intestine	30564	Small bowel strictureplasty for chronic inflammatory bowel disease
3056500	Resection of small intestine with formation of stoma	30565	Small intestine, resection of, without anastomosis (including formation of stoma)
3056600	Resection of small intestine with anastomosis	30566	Small intestine, resection of, with anastomosis
3056800	Endoscopic examintation of small intestine via interoperative enterotomy		
3058000	Excision of lesion of duodenum		

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3058101	Exploration of duodenum		
3146200	Insertion of feeding jejunostomy tube	31462	Operative feeding jejunostomy performed in conjunction with major upper gastro-intesinal resection
		32060	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileasl reservior, with or without temporary loop ileostomy
		32063	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileasl reservior, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare)
		32066	Ileostomy closure with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileasl reservior, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (including aftercare)
3206900	Formation of ileostomy reservoir	32069	Ileostomy reservoir, continent type, creation of, including conversion of existing ileostomy where appropriate
3206901	Revision of ileostomy reservoir		
4380700	Duodenoduodenostomy		
4381000	Repair of small intestine with anastomosis		
4381001	Repair of small intestine with multiple anastomoses		
9030600	Laparoscopic insertion of feeding jejunostomy tube		
9030700	Other procedures on small intestine		
9034000	Closure of fistula of small intestine		

THORACIC SURGERY

Procedure Group: *THOR*

Description: *Noncardiac, nonvascular chest surgery; includes pneumonectomy and diaphragmatic or hiatal hernia repair*

Please contact the VICNISS Coordinating Centre before undertaking THOR surveillance.

VAGINAL HYSTERECTOMY

Procedure Group: *VHYS*

Description: *Vaginal approach with uterine removal*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3565700	Vaginal hysterectomy	35657	Hysterectomy, vaginal, with or without uterine curettage, not being a service to which item 35673 applies
3566401	Radical vaginal hysterectomy with radical excision of pelvic lymph nodes	35664	Radical hysterectomy with radical excision of pelvic lymph glands (with or without removal of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where perfomed
3566701	Radical vaginal hysterectomy	35667	Radical hysterectomy without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving uterolysis where perfomed
3567300	Vaginal hysterectomy with unilateral salpingo-oophorectomy	35673	Hysterectomy, vaginal, (with or without uterine curettage), with salpingectomy, oophrectomy or excision of ovarian cyst, 1 or more, or both sides
3567301	Vaginal hysterectomy with bilateral salpingo-oophorectomy		
3575000	Laparoscopically assisted vaginal hysterectomy	35750	Laparoscopically assisted hysterectomy, including any associate laparoscopy
3575300	Laparoscopically assisted vaginal hysterectomy with unilateral salpingo-oophorectomy	35753	Laparoscopically assisted hysterectomy with one or more of the following procedures: sapingectomy, oophrectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy
3575301	Laparoscopically assisted vaginal hysterectomy with bilateral salpingo-oophorectomy	35754	Laparoscopically assisted hysterectomy wihich requires dissection of endometriosis,o r other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophrectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies

VENTRICULAR SHUNT

Procedure Group: *VSHN*

Description: V*entricular shunt operations, including revision and removal of shunt*

ICD10-AM Codes	Description	CMBS Codes	CMBS Description
3901500	Insertion of external ventricular drain	39015	Ventricular reservoir, external ventricular drain or intracranial pressure monitoring device, insertion of - including burr-hole
3901501	Insertion of ventricular reservoir	39018	
4000000	Ventriculocisternostomy	40000	Ventriculo-cisternostomy (Torkildsen's operation)
4000300	Insertion of ventriculo-atrial shunt	40003	Cranial or cisternal shunt diversion, insertion of
4000301	Insertion of ventriculopleural shunt		
4000302	Insertion of ventriculoperitoneal shunt		
4000303	Insertion of ventricular shunt to other extracranial site		
4000304	Insertion of cisternal shunt		
4000600	Insertion of spinal shunt	40006	Lumbar shunt diversion, insertion of
4000900	Revision of ventricular shunt	40009	Cranial, cistrnal or lumbar shunt, revision or removal of
4000901	Revision of cisternal shunt		
4000902	Revision of spinal shunt		
4000903	Removal of ventricular shunt		
4000904	Removal of cisternal shunt		
4000905	Removal of spinal shunt		
4001200	Endoscopic third ventriculostomy	40012	Third ventriculostomy (open or endoscopic) with or without endoscopic septum pellucidotomy
4001201	Third ventriculostomy	40018	Lumbar cerebrospinal fluid drain, insertion of
9000101	Removal of ventricular reservoir		