Guide for clients

Basic Nomenclature

+ Services
+ Well-Being
+ Welfare

FasiOpen

Open Fund for Supplementary Health Care

*Modern and efficient **Supplementary Health Care** for your company's employees and their families*

WARNINGS

Dear Members, Companies and Healthcare Facilities,

Please remember that, to request a refund for healthcare expenditure from FasiOpen, you must submit the expenditure documentation via the member homepage and no longer by sending the originals/photocopies in printed form. For this purpose there is an ONLINE procedure on the Company website for submitting indirect provision refund requests, while for refund requests relating to direct provision services, healthcare facilities belonging to the network recognised by FasiOpen will be able to use a dedicated telematic app.

FasiOpen continues, though in limited cases, to allow refund requests for services to be sent by post, attaching only a copy of the required documentation. With regard to this we again remind you that requests should be sent in printed form only when it is impossible to send them electronically, and that any documentation sent to the Fund (regardless of whether it is a copy or the original) cannot be returned.

The information that follows, along with the specific branch introductions, provides further support (valid for both direct and indirect provision services) to help you correctly submit requests for services, and summarises additional information to that provided in the individual guides to the Fund's Health Plans.

This Nomenclature lists services only for Medicine, Surgery and Dentistry, which FasiOpen regards as its area of activity in contributing towards costs.

The Fund will refund the healthcare services listed if they are included in the cover provided by a member's individual Health Plan, within the limits of the provisions of the individual cover and within the limits of the expenditure incurred.

The Nomenclature is divided into 21 sections:

- ✓ **SECTION B.** - SPECIALIST CONSULTATIONS
- ✓ **SECTION C.** - HOSPITALISATION AND SUPPLEMENTARY SERVICES
- ✓ **SECTION D.** - MATERIALS AND MEDICINES
- ✓ **SECTION E.** - MEDICAL DEVICES AND PROSTHESES
- ✓ **SECTION F.** - PROFESSIONAL COSTS AND FEES FOR TRANSFUSION SERVICES DURING OVERNIGHT HOSPITALISATION
- ✓ **SECTION G.** - USE OF DEDICATED ROOMS - USE OF OPERATING THEATRE - USE OF SPECIAL EQUIPMENT IN THE OPERATING THEATRE - USE OF HIGH-COST INSTRUMENTS
- ✓ **SECTION H.** - MEDICAL TEAM ASSISTANCE DURING OVERNIGHT HOSPITALISATION IN MEDICAL WARDS
- ✓ **SECTION I.** - MEDICAL ONCOLOGY - CHEMOTHERAPY
- ✓ **SECTION L.** - HYPERBARIC MEDICINE
- ✓ **SECTION M.** - LITHOTRIPSY
- ✓ **SECTION N.** - THERAPIES
- ✓ **SECTION O.** - SURGICAL OPERATIONS DURING OVERNIGHT HOSPITALISATION, DURING DAYTIME HOSPITALISATION (DAY SURGERY)
- ✓ **SECTION P.** - DIAGNOSTIC TESTS

- ✓ **SECTION Q.** - PHYSIOKINESIS THERAPY
- ✓ **SECTION R.** - DENTISTRY SERVICES
- ✓ **SECTION T.** - SPA TREATMENTS
- ✓ **SECTION U.** - PUBLIC HEALTHCARE CHARGES
- ✓ **SECTION V.** - SURGICAL PACKAGES
- ✓ **SECTION Z.** - PREVENTION
- ✓ **OTHER SERVICES**
- ✓ **SERVICES AVAILABLE ONLY BY INDIRECT PROVISION**

Items not shown in the Basic Nomenclature should be considered not included in the Fund's area of activity and therefore non-refundable. The items included will be refunded only if included in the covers provided by the Health Plan and optioned by the client/member, within the limits of the regulation itself and always within the limits of the expenditure actually incurred.

Autonomous coding due to similarity of services/treatments is not allowed, regardless of whether these are provided by a directly affiliated professional/healthcare facility and/or by a professional offering indirect provision services.

Listed below are some of the specifications valid for all health plans provided by FasiOpen, which will be added to those provided for in the specific Section Introductions of the Basic Nomenclature and those subsequently specified in the individual guides identifying the different types of coverage.

Specialist consultations

The expenditure documentation must clearly show the doctor's academic qualification of specialisation (which must be relevant to the pathology that made the consultation necessary), his/her personal details and VAT number.

If a specialist consultation is invoiced by a healthcare facility, regardless of whether or not it has a direct affiliation with the Fund, as well as the facility's details and VAT number the physician's academic specialisation qualification must also be specified which, in this case also, must be relevant to the pathology that made the consultation necessary.

Excluded from refund are: consultations provided by a medical dentist other than those provided for and if provided for by the specific Dental Cover of the Health Plan; hygiene and preventive medicine specialists; breast health consultations; those pertaining to occupational medicine; legal medicine; radiological consultations; nuclear medicine; sports medicine; aerospace medicine; medical hydrology; general medicine services and/or consultations (injections, phleboclysis, vaccinations, medicines and/or substances used for allergy tests, sclerosing injections); consultations carried out by a psychologist; dietology and/or nutritionist consultations regardless of whether these are carried out by a physician specialising in food science; homeopathic and/or alternative medicine consultations and/or services; osteopathic consultations and/or services; physiokinesis therapy (other than physiatric consultations). Also not refundable are medical-surgical consultations for the purposes of personal aesthetics (and/or attributable to these) regardless of whether they are carried out by reconstructive plastic surgeons; medical examinations for the purpose of issuing certificates (driving licence, sports fitness, etc.). Consultations carried out by persons other than graduates in medicine and surgery who are duly registered with the Italian Board of Physicians (also indicating the professional's specialisation/s) are not refundable. Psychotherapy/psychological support sessions, on the other hand (not equatable to specialist consultations), are refundable within the limits specified by the Cover that includes them, solely if carried out by the professionals specified within the item itself.

Specialist oncological care is exclusively defined as that provided by specialists during infusional chemotherapy sessions regardless of the basis upon which these are carried out, or that provided by specialist oncologists only during night-time hospitalisation and without chemotherapy. Specialist oncology care cannot be summed with other medical care during hospitalisation and/or any type of specialist consultation. Please remember that the healthcare documentation must explicitly specify the type of therapy given and the basis upon which the therapy itself was carried out (where provided for by the Health Plan).

Medical care during hospitalisation means care provided on a daily basis by the entire medical team during hospitalisations without surgical operations. Medical care received during hospitalisation cannot be summed with another type of specialist care and/or specialist consultation, with the exception of consultations by a professional with a different specialisation to that for which the hospitalisation was requested.

Hospitalisation charges

If not otherwise provided for and regulated by the Covers in the individual Health Plan, the daily hospitalisation fee is refundable for a maximum of 90 days in the calendar year, the calendar year being the period of 365 days prior to each single day of hospitalisation.

The hospitalisation fee (any) applies within the limits of the expenditure effectively incurred for stays in medical or surgical wards of public health facilities, non-accredited private facilities or accredited nursing homes, for the resolution of events in the acute phase. Hospitalisation in intensive care units, sub-intensive care units and the use of a room equipped for radiometabolic therapies count towards the maximum number of 90 days per year.

Refunds for day hospitals/day surgeries are recognised only in the event of surgical operations, chemotherapy and pain therapy services documented in the medical records. Hospitalisation for diagnostic tests or other reasons is therefore strictly excluded. Refunds for day surgery fees are excluded for package-based operations (e.g. cataract package, gastroenterology packages, etc.).

Please note that, since some tests/check-ups/operations can be carried out on an outpatient basis regardless of whether performed with deep sedation, approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a request, for the hospitalisation basis (any) to be recognised, detailed medical documentation must be attached to the request in which the reasons for the choice of this type of hospitalisation basis is highlighted.

Hospitalisation fees for intensive care wards, coronary units and sub-intensive therapy are inclusive, in addition to ordinary hospitalisation fees, also of continuous medical and nursing care (24 hours) and the use of special equipment, and also count towards the total of 90 days of hospitalisation per year. In this case, therefore, the hospitalisation fee cannot be summed with the code/fee for any inpatient care.

Medicines - Healthcare Materials

Only eligible for refund, to the extent provided for in the individual Health Plans, are those medicines used during hospitalisation (night-time or daytime) and duly specified on the invoice issued by the healthcare facility, including blood and its derivatives which must be debited according to the current regulations regarding this specific matter.

All healthcare materials used during hospitalisation (night-time or daytime) in the healthcare facility and duly specified on the invoice are refundable to the extent specified in the individual Health Plans.

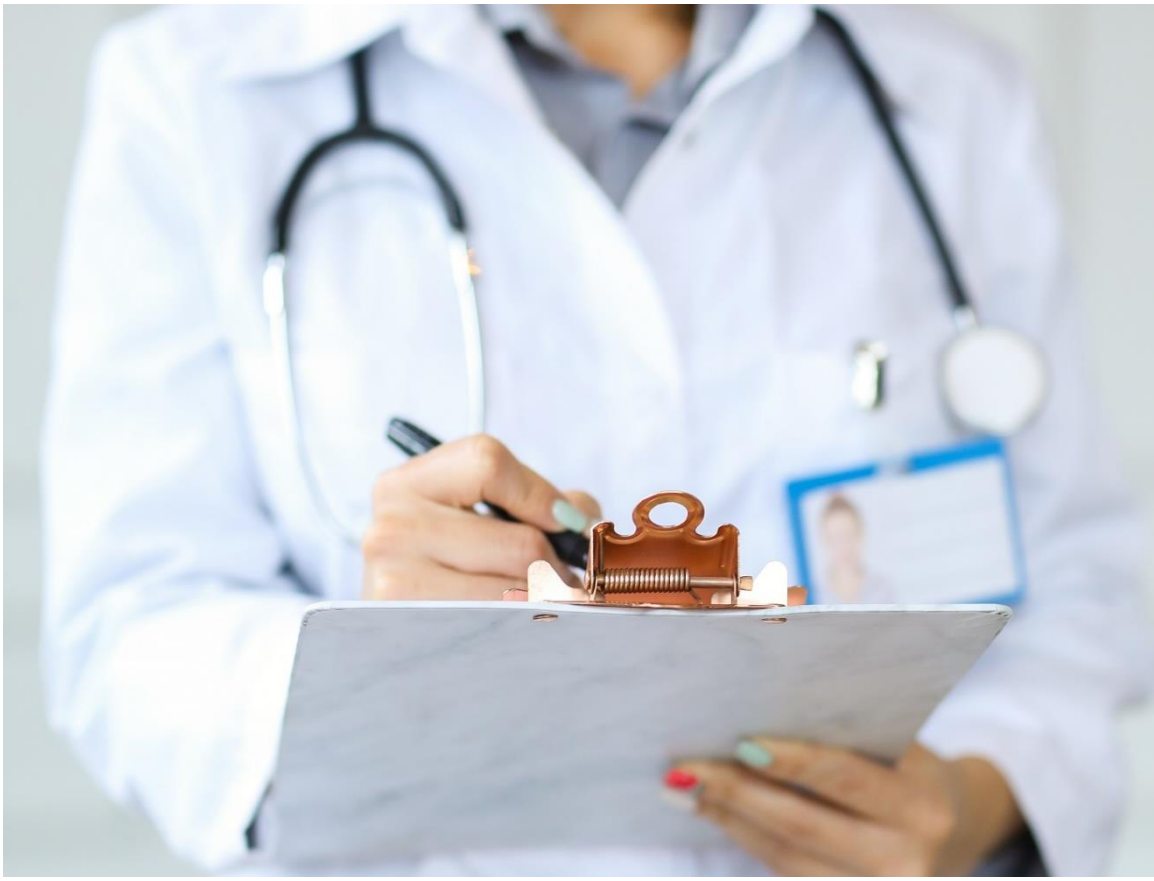
For operations and/or procedures carried out on an outpatient basis (outpatient operating theatre), materials, medicines and instruments are included in the fees for the operating theatres themselves.

Please note that, in the case of “packages” received by direct provision, the amount accepted by the healthcare facility in the signed affiliation is the maximum that can be invoiced for that specific procedure/surgical operation.

No type of device and/or prosthesis can be equated with the materials code.

As regards materials and medicines used during dental surgery, the costs involved are included in the maximum refund fees for the services themselves and are not payable even if specified on the invoice, regardless of whether they are related to the operating theatre and/or to any stay in hospital.

FasiOpen reserves the right to request details of the materials and/or medicines for which a refund request has been submitted.



Medical Devices and Prostheses

Medical devices and/or prostheses will be refunded only if duly provided for in your Health Plan (limited to the context of the Covers that include these), if prescribed by a physician specialised in the relevant pathology, or if used during hospitalisation with day or night stay as shown in detail in the medical records and the respective invoice issued by the healthcare facility.

Please note that refunds relate to the entire device and/or prosthesis, always within the terms of any time limits and to the maximum extent of the contribution towards costs indicated in your Health Plan; i.e. refunds are not recognised for the replacement and/or repair of parts that are damaged or subject to wear and tear.

The Fund will not contribute towards the cost of devices/prostheses/healing aids other than those listed in the relevant Section of the Basic Nomenclature in force at the time of the balance invoice.

No type of device and/or prosthesis can be equated with the materials code.

The Fund reserves the right to request further details of the items shown on the invoice and the certificate of conformity of the items as specified by EU regulations (European Regulation 2017/745 - former Directive 93/42/EEC).

Use of operating theatres

For Health Plans that provide for a case-by-case refund, the use of the operating theatre is recognised for refund according to the maximum fee shown for the code identified within the Basic Nomenclature. The operating theatre category is defined by the amount or sum of amount/s recognised for the operation/s carried out in the same operating session, without prejudice to the rules for approving surgical operations. Following identification the debit will be allowed, obviously again limited to the expenditure actually incurred; the refund is then added to that recognised for the operation itself.

The operating theatre fee (night/day hospitalisation) includes the use of any equipment, excepting that included in individual procedures (e.g. endoscopic procedures include use of the endoscope and related disposable materials connected with the instrument/equipment), and also excepting that specifically described under high-cost instruments.

Refunds for the outpatient room are inclusive of medication, medical materials and any equipment unless otherwise indicated.

Please note that refunds for the use of the operating theatre during hospitalisation (overnight or daytime), or for use of the outpatient room, are related to the request for a surgical and/or medical procedure; any refund request for use of the theatre/room only will therefore be at the sole discretion of the Fund. In such cases, therefore, we urge you to provide reports and/or documentation to give the Fund all the means necessary to make the above evaluation.

The Fund will not contribute towards the cost of outpatient room charges for dental procedures.

Medical Record

For refunds for hospitalisation with both night-time and daytime stay, with or without surgery, a complete copy of the relevant medical record must be sent, if possible in digital format.

The medical record must show documentation regarding specialist consultations other than those of the treating medical-surgical team, including the diagnostic issue for which they were requested and the relevant medical reports/references of the specialists consulted.

If the documentation is not legible, FasiOpen reserves the right to request a transcript of the medical record.

In the event of hospitalisation (any type) for the purpose of carrying out procedures/tests normally performed on an outpatient basis (regardless of whether carried out under deep sedation), for the service to be refunded a medical record must be submitted from which the client's clinical picture can be identified, with this needing to be compatible with the request to carry out the procedures on an inpatient basis. The Fund will assess its suitability for this, reserving the right to grant or not grant the refund corresponding to the type of hospitalisation requested.

In case of hospitalisation for surgery, the medical record must contain an operating theatre register and/or report showing the type of surgery carried out.

Surgical Operations

The provisions for individual items in the individual Health Plans, regardless of the type of operation and the basis on which it is carried out, is all-inclusive of the services performed by all those taking part in the surgical procedure/s (operator/s, aids, assistants, anaesthetists, technicians, etc.), as shown in the operating theatre report in the medical record, and of the assistance provided by the entire surgical team during hospitalisation until discharge.

For surgical operations carried out using special instruments/equipment, regardless of the type of instrumentation and/or equipment, everything applicable to traditionally performed operations is recognised as refundable except for anything specified in the "Use of high-cost instruments" section (e.g: endoscopic procedures include use of the endoscope and related disposable materials connected with the instrument/equipment), and exclusively for those indicated (again inclusive of disposable materials connected with the instrumentation/equipment) only if explicitly shown in the medical record/operating theatre report.

Where provided for by the Health Plan/its Covers, and in particular for direct provision services, in the case of concurrent and simultaneous surgical operations, regardless of the type of operation and the basis on which it is carried out (overnight/day/outpatient hospitalisation) and even if the access route is different but performed in the same operating session, the maximum fee for the main or most financially costly operation is recognised - obviously within the limits of the expenditure incurred - while for the other one or for the other operations the relevant maximum fee is reduced by 50%.

Thus the identification of the operating theatre category (for direct provision services and where a case-by-case refund is provided for) will take place based on the maximum fee for the operation or - in the case of concurrent operations - based on the sum of the main (or most costly) operation and that of 50% of the other operations (excepting concurrent fees for "package-based operations).

In all cases, the type of operation carried out must be unequivocally shown by the operating theatre record within the medical record (in cases of overnight/day hospitalisation) and/or in the operating theatre report (in cases of surgery carried out in an outpatient operating theatre, where refundable).

To clarify further, regardless of the applicable Health Plan for the individual member/client, please note that the actual recognition of refund for procedures, whether surgical (inpatient or outpatient where applicable) or relating to tests and/or other, especially for direct provision services and/or anything communicated in advance by operators at the request of the client him/herself for presumed refund, can be confirmed only and exclusively at the end of the process. Only, therefore, upon examination of the expenditure documentation, the medical records/operators' reports/medical reports/referrals, etc., will it be possible to ascertain the actual conformity of the procedures carried out with the items/services requested for refund (direct provision services) and/or anything communicated by telephone to the operators (member/client).

As regards minor surgical operations carried out on an outpatient basis (outpatient room), the physician's appropriate and detailed certification/report must be provided, on headed paper, regarding the type of operation carried out by him/her.

For operations for the removal of **malignant tumours**, carried out on an outpatient basis and where included in the Health Plan, since the nature of the neoplasm can only be

identified by histological examination **the relevant histological examination report and the pre- and post-operative photograph must also be sent** to obtain recognition of the refund, if provided for by the Health Plan.

For any type of intervention, FasiOpen reserves the right to request additional documentation to that specified.

The following items are strictly excluded from refund (except as and if explicitly appearing in the Nomenclature in force at the time of invoice and if included in the Covers of your Health Plan): surgical procedures and/or medical therapies connected with male or female infertility and/or sterility; surgical procedures for male impotence and female frigidity; all treatments and/or tests and/or operations of an aesthetic nature and all services and/or surgical operations connected to these or consequent to any previous surgical operations or treatments. Excluded from refund are any type of treatment or surgical operation for treating myopia, astigmatism, hypermetropia, presbyopia, corneal corrections using any method and equipment, and any other laser treatment in ophthalmology other than those indicated in the relevant branch in the "Laser treatments" paragraph.

Diagnostic Tests

Diagnostic tests are recognised as refundable within the limits of whatever is provided for (if anything) by the Covers of the individual Health Plans.

To obtain the specified refunds you must send, together with the relevant invoices, details of the services carried out as well as the **prescription of the specialist physician and/or treating general practitioner indicating the type of pathology (obligatory) that made the tests themselves essential**.

FasiOpen reserves the right, however, to request a copy of the diagnostic reports should the need arise for further inspection.

In view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R. (Italian Regional Health Services), with both appearing on the same healthcare receipt, you must ask the healthcare facility to specify the amount (and therefore the services) relating solely to the public healthcare charges.

Since refunds for preventive medicine services are excluded (excepting FasiOpen Prevention Packages within the limits of what it provides for and the terms of the member's/client's Health Plan), the Fund reserves the right to assess the relevance of the tests to the stated pathology on a case-by-case basis.

All laboratory analyses contained in the Basic Nomenclature are refundable solely and exclusively if included in your Health Plan and if correctly invoiced by authorised analysis laboratories. Please remember that venous sampling is included in the services themselves. Requests for the taking of samples at home, if provided for by the Health Plan, as an additional amount to the service itself and limited to those expressly covered by the Basic Nomenclature at the time of invoicing, must be clearly mentioned in the medical prescription and must be in-line with the pathology indicated in it, i.e. the clinical picture that made taking samples at home necessary must be shown.

All tests are refunded, as set out and within the limits indicated in this Nomenclature if they are included in the Covers your Health Plan, including genetic analyses (only those indicated in the Nomenclature and included in the Health Plan) carried out solely for diagnostic-therapeutic purposes and according to the diagnostic protocols sanctioned by conventional medicine.

Preventive (predictive) medicine, experimental and/or research and/or alternative services are strictly ineligible for refund.

For radiological tests and diagnostic tests using nuclear medicine, the items relate to complete examinations of projections and the number of x-rays needed for an exhaustive test to be provided.

The items also include the professional fees of radiologists or nuclear medicine

specialists and other specialists/technicians, where involved, the contrast media, materials, medicines and other items except as expressly stated in the specific conditions of the branch displayed for each sub-section. Please note that, for Health Plans *without refunds on a case-by-case basis*, the contrast medium is considered to be a service in its own right; therefore any fixed and percentage excesses will also be applied to the "contrast medium" item, and this too will partly reduce the refund ceiling envisaged, if any, by the Cover.

Any anaesthesiological care for diagnostic and/or invasive tests, where necessary, is included in the item specified for the individual test, except as specifically described by FasiOpen.

For some diagnostic tests, if included in your Health Plan and in particular for direct provision services regardless of the Health Plan, there is a 50% reduction on the second test (or the financially less expensive one) carried out during the same session, as is explained in more detail in the respective "Specific Branch Introductions".

Please note that the term "during the same session" means during the same access to the healthcare facility; thus, in the case of two tests carried out, the 50% reduction (where applicable) will be applied if a different moment of access is not unequivocally detectable (different day of the test being carried out).

Molecular genetic tests are included in the Diagnostic Tests section. With regard to this, please note that tests are refundable only and exclusively if included in your Health Plan within the individual Covers (and limited to the contents of these). Only Molecular Genetics tests explicitly mentioned in the Basic Nomenclature (and if provided for by your Health Plan) are refundable, and only if carried out for diagnostic-therapeutic purposes (thus excluding those relating to research and/or experimentation and/or prevention and/or prediction).

Molecular Genetics and/or cytogenetic tests pre- and post childbirth are refundable only if prescribed by a Physician-Surgeon specialising in Medical Genetics (clinical genetics) or specialising in Oncology. No other possibilities are available.

The tests, even if of considerable importance and included in the Covers of the individual Health Plans, will not be recognised as refundable if prescribed by professionals, regardless of specialisation, other than those expressly specified.

Finally, please note that, since the results of many Molecular Genetics tests do not change over time, these will be recognised as refundable only once; we therefore recommend that a copy of these results is retained (the Fund cannot provide copies of any that it is sent in relation to refund requests).

Physiokinesis therapy

For Health Plans that provide for case-by-case refunds, those relating to expenditure on physiokinesis therapy are limited to a total of 80 services (not sessions) per year (1 January - 31 December) per client for neurological, neuromotor and osteo-articular pathologies regardless of type, technique, instrumentation, and the anatomical district treated.

Items relating to the Rehabilitation section, for which the term “per session” is explicitly shown, cannot be combined with other services/items in the Physiokinesis therapy section since they are already included in Rehabilitation.

Anatomical district means the entire spinal column, or the upper or lower limbs.

The limits specified above are not applicable in a quantitative sense for acupuncture, spinal manipulation and focal shock waves, which have their own annual limits but count towards calculation of the maximum of 80 services per year.

If provided for in your Health Plan and within the limits stated therein, equipment hire - which is also subject to annual limits - does not count towards calculation of the maximum annual limits.

The items are all-inclusive of consumables and medications.

Therapies for aesthetic purposes and/or ascribable to these are not refundable.

To obtain the specified refunds you must send - as well as everything specified (if specified) in the individual Covers - together with photocopies of the relevant invoices, details of the therapies carried out (type and number) along with the **medical prescription with the corresponding definite diagnosis of the pathology (not to be confused with the symptomatology)** that made them necessary and essential.

For therapies carried out at centres authorised to provide rehabilitation services (with this authorisation issued by the competent authorities), the specialisation of the centre itself must also be clearly shown as well as, in all cases, the professional physiokinesis therapy qualification of the person who carried out and invoiced the services.

Please note that services with “manu medica” in their description will be recognised as refundable, if included in specific Covers in the Health Plan, only and exclusively if carried out by a specialised physician, in other words they cannot be recognised if carried out by a professional figure other than a physician with the respective specialisation (relevant to the pathology and the therapy given).

Please remember that the professional qualification of rehabilitation physiotherapist is not held, for example, by kinesiologists, aesthetic and/or sports masseurs, ISEF/IUSM graduates, shiatsu practitioners, chiropractic graduates, reflexologists, posturologists, naturopaths, etc.

The Fund does not refund services provided by masseurs and massage therapists at hydrotherapy/spa establishments.

The same rules, relevant maximum rates and limitations apply to home treatments as those specified in the Basic Nomenclature in force at the time of invoicing, i.e. no additional sharing of the cost is recognised for any fees charged for the provision of these services (any) at home. If shown in the expenditure/healthcare documentation, this additional charge will be separated out and will be non-refundable.

"Occupational therapy" is recognised as refundable by the Fund for clients/members suffering from pre-existing cognitive, physical or mental disabilities, while "Neuromotor rehabilitation for acute and chronic neurodegenerative pathologies" is recognised by the Fund in cases of disabling neurological damage and - therefore - therapy for the recovery of functional motor or neuromotor skills recently reduced and/or lost due to illness or trauma and/or chronic-degenerative pathologies (e.g. cerebral strokes, Parkinson's disease, multiple sclerosis, etc.). The above items are defined as being per session, regardless of the number of therapies/services carried out within the same session, i.e., the above items/services cannot be summed with other items/therapies/services in the same Physiokinesis therapy section. For refunds of "Occupational Therapy" to be recognised, the qualification of the practitioner who carried out the treatment/services must be clearly indicated.

Moreover, without prejudice to the above as regards the annual limits to refundability, in order to safeguard clients suffering from serious symptomatological pictures and/or pathologies, if provided for by their Health Plan (limited to the MOSAIC Health Plan), upon explicit request by the member/client and at the sole discretion of the Fund, **limitations to the number of refundable services** (with the exception of limitations for acupuncture, spinal manipulations, equipment hire and focal shock waves, which remain confirmed and cannot be exceeded) **will not apply if the relevant treatments are necessary and connected to the symptomatological pictures and/or pathologies described below**.

- ✓ complete paralysis, partial paralysis, paralysis of single nerves, progressive paralysis of the muscle/s;
- ✓ spasticity;
- ✓ traumatic (tetra, paraplegia) and non-traumatic myelopathies (amyotrophic lateral sclerosis, plaques, etc.);
- ✓ infantile cerebropathies (spastic, etc.);
- ✓ intrinsic neurological pathologies (Huntington's chorea, Parkinson's disease, etc.);
- ✓ rehabilitation of amputees;
- ✓ intrinsic muscular pathologies (progressive muscular dystrophy, etc.).

To this end all documentation for the expenditure incurred, dating from the first request of the year if included in the Health Plan (and at the conditions specified therein) and for each refund request for physiokinesis therapy services (regardless of how they are received) must be accompanied by an **up-to-date and detailed report from the specialist physician qualified to make the diagnosis highlighting the clinical picture and the therapeutic procedure, particularly in relation to the number and type of physiokinesis therapy services needed to maintain/stabilise the clinical picture itself**.

We underline that, solely for Health Plans with case-by-case refunds (MOSAIC), following surgical operations (excluding bloodless reductions) such as:

- ✓ knee replacement or tibiotarsal or humerus replacement;
- ✓ surgery for capsular ligament injuries of the knee, ankle or shoulder;
- ✓ cervical, dorsal or lumbar hernias or vertebral stabilisations (spondylolisthesis);

upon explicit request of the client (or the healthcare facility in agreement with the member/client), physiokinesis therapy treatments (limited to those that can be unequivocally linked to a surgical operation among those mentioned immediately above) received and invoiced in the 90 days following the day of surgery (the day of surgery itself, not the day of discharge from hospital) may be recognised as refundable regardless of the limit of 80 services per year (again with the exception of acupuncture, spinal manipulation, focal shock waves and equipment rental, for which the limits for services remain valid).

To temporarily waive the limit during the period mentioned above, and regardless of whether the services are received with direct or indirect provision, you must attach a copy of the medical record, even if previously sent with another refund request, supported by the hospital discharge letter and an up-to-date report from the physician-surgeon who carried out the operation confirming the actual number and type of physiokinesis therapy treatments needed to resolve the event.

A possible temporary waiver of the limit of 80 services per year may be granted by the Fund at its sole discretion, once only per pathology/operation/traumatic event.

FasiOpen reserves the right, both before and after the provision of the services, to make administrative and health checks also by means of consultations by doctors appointed by the Fund and/or checks on the academic/specialisation qualifications of the professional who carried out the services, including by consulting the lists registered with the Professional Boards and/or Registers.

Nursing Care

FasiOpen recognises refunds for Nursing Care during overnight hospitalisation if this is explicitly provided for in your Health Plan. By Nursing Care during overnight hospitalisation we mean private and individual assistance provided by nursing staff in addition to that regularly provided by the healthcare facility as a part of its nursing care in the ward (non-hospital activities).

For the refund to be recognised it must be clear that the aforementioned nursing care does not overlap with other hospital activities and that it is unequivocally restricted to the individual member/client. Any refund, if envisaged by the Health Plan, is understood to be daily (24h) for a minimum number of 6 hours of care (whether daytime or night-time).

Dentistry Services

The Fund does not refund hospitalisation (of any type) for dental services.

Dental services are recognised as refundable to the extent and within the limits provided for by individual Covers in the Health Plans.

Please note that dental services, regardless of the Health Plan, are subject to time limits for refund, and that for certain items there is a mandatory requirement to submit pre- and post-treatment documentation as well as a preventive treatment plan (using the specific indirect provision form where applicable). There is no need to wait for the outcome of the preventive treatment plan assessment to begin any treatment that you need; the Fund's assessment procedure is purely administrative, and in no way enters into the merits of the treatment decision made by your dentist and/or the healthcare facility.

The outcome of the treatment plan assessment is intended to highlight any medical-administrative incompatibilities between the service codes identified, particularly with regard to the contents of the “Specific branch and sub-branch introductions”, “Services not included in the Fund”, “time limits for refund” and “mandatory requirements” specified for the individual services.

To clarify further, please note that dental services are attributed to the individual teeth/sites/arches/hemiarches based on the invoice date for the balance of the services themselves. Thus, for example only, if a filling is refundable once every 3 years on a certain tooth and is refunded with an invoice dated 3/03/2021, this will not be recognised as refundable again before 04/03/2024.

The evaluation of time limits and/or compatibility between service codes/items is made based on services being requested simultaneously (those already settled at the time of examining the “Treatment Plan” sent), and clearly cannot consider requests still being prepared and/or those that have not yet arrived at the Fund and/or those that are not shown in any obligatory healthcare documentation.

For this reason, in limited cases, even if a service has a positive outcome from the medical assessment of the treatment plan, it may come up as non-payable when the

refund request is examined because it “exceeds the limits” or because the service shown on the treatment plan is different from that carried out or incompatible with the services paid for or those appearing in the medical documentation.

Please remember that refund requests must be fully completed and sent to FasiOpen within and no later than 3 months after the date of invoice for the balance of the services for which you wish to request a refund from the Fund.

While reminding you that expenditure documentation must always be in the name of the client for whom the treatment has been carried out (in the case of minors, even if the invoice is in the name of the FasiOpen membership holder, the name of the minor receiving treatment must be clearly indicated on the invoice since the main person must always be identifiable as required by the tax regulations), and that it is not possible to submit an expenditure receipt for expenses relating to services received by more than one family member/client, we underline that invoices for payments on account are not refundable:

- ✓ *An invoice on account* is an invoice with no particular correlation between payments and the treatments carried out and completed, and must be sent together with that for the partial balance or balance of the treatments themselves. Example: the dentist issues a quotation to the member/client for 2 fillings at € 100.00 each. Total treatments quoted at € 200.00. The member/client pays an invoice of € 150.00. This latter invoice is a payment on account for the treatment plan agreed with the dentist because it is higher than the value of one filling but less than the value of both the treatments planned. In this example, therefore, the invoice for € 150.00 is for a payment on account which must be submitted together with the balancing invoice (of € 50.00).
- ✓ *A partial balance invoice* is an invoice that specifically refers to part of the treatment already carried out and completed, although others are still under way. We therefore call your attention to the fact that, although an invoice has “on account” in its description, it is considered to be a “partial balance” if an exact correlation between the amount and the completed services can be identified. Example (based on the previous example): the member/client pays an invoice on account of € 100.00 and the invoice includes the words “on account”. This, according to the previous example, appears to be a payment on account in the context of the relationship between the member/client and the dentist, but is actually a partial balance invoice because it is strictly associable with a completed treatment (a filling costing € 100.00). This invoice must therefore be submitted within 3 months from the date of issue.
- ✓ *A balance invoice* is an invoice that closes the accounts for treatments carried out and completed. Continuing with the examples given previously: a balance invoice of € 50.00 to be associated with the invoice on account (first example) of € 150.00, to be sent within 3 months from the date of issue of the balance invoice. Or another example: invoice for € 200.00 (total value of the 2 fillings) to be sent within 3 months from the date of issue.

Additional information will be shown in the appropriate section of the Nomenclature and, if provided for by the Health Plan, in the dedicated Cover.

Spa Treatments

Refunds for spa treatments are recognised only if these are provided for by the member's/client's Health Plan and if they have been carried out at authorised establishments equipped for this purpose located in spa resorts.

Mud therapy and balneotherapy treatments are refundable for a maximum of 12 days per year per client.

Hydropinic and inhalation therapies are refundable for a **maximum of 10 days a year and for no more than 3 years per client**.

For simultaneous treatments with mud therapy or balneotherapy treatments and hydropinic or inhalation therapies, the higher fee only is applied.

To obtain a refund for spa treatments a specific medical prescription must be sent certifying the need for the treatment itself, specifying the pathology (not the symptomatology) currently suffered and including expenditure documentation for entry to the spa facility. Refunds strictly exclude any accommodation costs and/or other accessory costs

Public Healthcare Charges

Public Healthcare Charges, which must always display details of the services provided, are refundable - within the maximum limits specified by the individual Covers of the individual Health Plans - only if they relate to the specialist services expressly included in the member's/client's Health Plan, and are subject to the same quantity and/or time limitations as those envisaged for each service (as also specified in the Nomenclature).

Please note that Public Healthcare Charges are a different item of expenditure to the Fixed Fee introduced in the 2011 Budget and the Additional Fixed Prescription Fee Contribution.

In view of the different Regional laws, in the event of the simultaneous payment of public healthcare charges and private services not recognised by the S.S.R., with both appearing on the same healthcare receipt, you must ask the healthcare facility to indicate which amount refers only to the public healthcare charges and/or which amount refers to privately received services.

Surgery Packages

In order to streamline procedures for sending refund requests on the part of clients and healthcare structures belonging to the network recognised by FasiOpen, surgical packages have been introduced for some procedures already included in the Fund's area of activities. For Health Plans that provide for case-by-case refunds, please note that the Surgical Packages identify the maximum amount of the Fund's contribution towards the procedures since, within these, all the envisaged competences have been financially calculated - i.e. the packages are all-inclusive of: the medical team, the operating theatre, the client's stay in the facility, materials, medicines, any prostheses (for operations involving these), analyses and checks relating to the operation itself intra-hospitalisation, and initial post-surgery and intra-hospitalisation rehabilitation treatments where applicable.

For Cover-based Health Plans nothing changes with respect to the previous valuation, since Packages still operate according to and within the limits of what - if anything - is provided for by the Covers that include them.

The Package approach, for direct provision services, enables access to surgical procedures at more financially favourable rates for the member/client.

"Package-based" services are treated as being related to a surgical operation as a single stage, i.e. the hospitalisation/surgical procedure is the only procedure carried out during a hospital stay. If the operation/procedure is instead carried out during hospitalisation for another surgical operation (for which the package approach is not available), an additional item called a "concurrent operation" will be available in the Nomenclature that provides for a different monetary sum (ascribable if the operation is not the main phase of the surgical procedure). In this case, and only for this type of operation, the valuation for refund purposes will be 100%. The procedures for which the "Package" approach is available (if included in the member's/client's individual Health Plan and within the limits of the respective Covers) are:

- ✓ CATARACT PACKAGE, removal and implantation of artificial lens in anterior or posterior chamber (any technique - eye). Refund includes: medical team, operating theatre, time spent in the facility, materials, medicines, lens prosthesis;
- ✓ SURGICAL PACKAGE (Traditional Technique) total hip replacement (arthroprostheses: total hip - complete treatment). Refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, diagnostic tests and in-patient physiotherapy;
- ✓ SURGICAL PACKAGE (Robotic Surgery - RAS) total hip prosthesis (arthroplasty: total hip - complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests and physiotherapy;
- ✓ SURGICAL PACKAGE (Traditional Technique) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first surgery was carried out. Refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, diagnostic tests and in-patient physiotherapy;
- ✓ SURGICAL PACKAGE (Robotic Surgery - RAS) total hip revision prosthesis (arthroplasty: total hip revision - complete treatment) surgery for removal and replacement or repositioning carried out in the same hospital in which the first

surgery was carried out. Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests and physiotherapy;

- ✓ SURGERY PACKAGE (Traditional Technique) hip prosthesis removal and repositioning carried out subsequently to the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, hospital stay, materials, medicines, joint prosthesis, diagnostic tests and in-patient physiotherapy;
- ✓ SURGERY PACKAGE (Robotic Surgery - RAS) hip prosthesis removal and repositioning carried out subsequently to the first hospitalisation (complete treatment). Refund includes: medical team, operating theatre, use of computer-assisted surgery equipment (any), hospital stay, materials, medicines, joint prosthesis, in-patient diagnostic tests and physiotherapy.

The Package format is also available envisaged for gastroenterological procedures, for which the same information as for Surgical Packages remains valid:

- ✓ DIAGNOSTIC ESOFAGOGASTRODUODENOSCOPY PACKAGE (including outpatient room, medical team, any histological examinations)
- ✓ DIAGNOSTIC PANCOLONSCOPY WITH FIBRE OPTICS PACKAGE (including outpatient room, medical team, any histological examinations)
- ✓ ESOFAGOGASTRODUODENOSCOPY AND PANCOLONSCOPY - BOTH DIAGNOSTIC - PACKAGE (including outpatient room, medical team, any histological examinations)
- ✓ OPERATIVE ESOFAGOGASTRODUODENOSCOPY PACKAGE INCLUDING POLYPECTOMY, INSERTION OF PROSTHESES, REMOVAL OF EXTRANEOUS BODIES, ARGON LASER, ETC. (including outpatient operating theatre, medical team, any histological examinations)
- ✓ OPERATIVE PANCOLONSCOPY PACKAGE INCLUDING RECTAL-COLIC POLYPECTOMY, REMOVAL OF EXTRANEOUS BODIES, HAEMOSTASIS OF NON-VARICOSE LESIONS (including outpatient operating theatre, medical team, any histological examinations)
- ✓ ESOFAGOGASTRODUODENOSCOPY AND PANCOLONSCOPY - BOTH OPERATIVE - PACKAGE (including outpatient operating theatre, medical team, any histological examinations)
- ✓ OPERATIVE ESOFAGOGASTRODUODENOSCOPY AND DIAGNOSTIC PANCOLONSCOPY PACKAGE (including outpatient operating theatre, medical team, any histological examinations)
- ✓ OPERATIVE PANCOLONSCOPY AND DIAGNOSTIC ESOFAGOGASTRODUODENOSCOPY PACKAGE (including outpatient operating theatre, medical team, any histological examinations)

Please note that, for Health Plans providing for case-by-case refunds, the package-based formats fully replace the individual case-by-case items/codes (except for concurrent procedures). The documentation to enclose with the refund requests for Package procedures (where the services are foreseen by the Health Plans and Covers) is the same as that foreseen for surgical operations/procedures and/or investigations foreseen within the hospitalization and/or outpatient procedures.

Prevention

For Health Plans that have them, the Fund has expanded the range of Prevention Packages.

The member/client can freely choose 1 Prevention Package per year from those listed below (if included in his/her Health Plan), bearing in mind that 1 prevention package is refundable per year but that the same package is not refundable before another 2 years have elapsed.

The Prevention Packages are:

- ✓ Cardiovascular Prevention for Women - age 45 or over
- ✓ Cardiovascular Prevention for Men - age 45 or over
- ✓ Oncological Prevention for Women - age 45 or over
- ✓ Oncological Prevention for Men - age 45 or over
- ✓ Ophthalmic Prevention (Men/Women) - age 40 or older
- ✓ Thyroid Cancer Prevention (Men/Women) - age 45 or over
- ✓ Melanoma Prevention (Men/Women) - age 50 or over
- ✓ Dysmetabolic Syndrome Prevention (Men/Women) - age 50 or over
- ✓ Cancer of the Oral Cavity Prevention (only in the dental context, direct provision services - if envisaged by your Health Plan) - age 45 or over

For details of tests included in the individual packages, please refer to your Health Plan (if it envisages these).

Other Services

Where provided for by the individual Health Plan, FasiOpen recognises a contribution towards the cost of “Transport by Ambulance”, limited to indirect provision services and exclusively within Italy. Transportation by Ambulance is recognised as refundable only for serious pathologies in which clients/patients cannot be transported, with own means, from their home to the chosen healthcare facility for hospitalisation and vice versa. Hospitalisation means an overnight stay in a nursing home or hospital. Therefore, without prejudice to the fact that the only means of transport recognised as refundable is an ambulance, no transport is recognised for ongoing therapies such as (but not limited to) chemotherapy, dialysis, physiokinesis therapy, etc.

Please also note that the service recognised as refundable does not refer to emergency transport, but only to planned hospitalisations.

No contribution to the cost of transport is recognised as refundable for transfers from one nursing home or hospital to another nursing home or hospital.

Services available only by Indirect Provision

In a way limited to specific Health Plans, and wherever and within the limits individually provided for by them, FasiOpen recognises refunds exclusively in relation to indirect provision services for:

- ✓ Childbirth Hospitalisation Allowance
- ✓ Allowance in lieu of overnight hospitalisation following Surgery (specified by your Health Plan).

We underline that these refunds are recognised only when hospitalisation took place with the S.S.N (Italian National Health Service) and no refund is required and/or has not been requested from FasiOpen in relation to overnight hospitalisation and/or services connected with hospitalisation for surgery (diagnostics, specialist consultations, therapies, pre- and post-operation tests, transport by ambulance, etc.). The above allowance/daily allowance items will not be recognised as refundable in cases of surgical hospitalisation that are not included among the operations specified in Cover 1 and/or 1.2 (if provided for) in your Health Plan.

To clarify further, please remember that a refund for an allowance (whatever type) is recognised only for the client receiving treatment, i.e. only and exclusively for the person directly receiving the treatment/therapy, if he/she belongs to the family unit registered with the Fund when hospitalisation began, regardless of the “patient's” age, i.e., no additional allowance is recognised for any family member staying in hospital to assist the patient.

The refund request for the allowance, where provided for in the Health Plan and without prejudice to the requirements for recognition of the request, must be received within and no later than 3 months after the date of discharge. With regard to this please remember that you must also attach with the application a copy of the medical record relating to surgery with overnight hospitalisation.

Again for indirect provision services and again if provided for by the individual Health Plan, FasiOpen recognises a contribution toward the cost of:

Lenses and Spectacles

With regard to this, please note that refunds are recognised only for lenses or spectacles fitted for the correction of visual disturbances or eye pathologies, upon presentation of a prescription issued by a physician specialising in ophthalmology, not later than 6 months from the date of purchase of the lenses themselves.

The refund request must be accompanied by fiscally valid expenditure documentation (with the buyer's data and detailed amounts for the individual items/services) and a certificate of conformity pursuant to EU regulations (European Regulation 2017/745 - former Directive 93/42/EEC).

Refunds for Lenses and Spectacles will not be refunded earlier than 12 months following the previous balance invoice, and only after a change in eyesight has been confirmed.

No refunds are available for frames, spectacles and/or contact lenses for cosmetic purposes, single-use (daily) contact lenses, accessory products for the care of lenses and/or spectacles, lenses and spectacles before expiry of the refund period, or if there has been no change in eyesight.

Exclusions

The Fund does not issue refunds for:

Invoices on account if not accompanied by the respective partial balance/balance invoices; services/treatments exceeding the limits specified for the services (with no exceptions); services/treatments for which the expenditure documentation (regardless of the amount of expenditure) is submitted erroneously and/or after the deadline for submission; diagnostic and/or surgical services/treatments/therapies/procedures not included in the individual Health Plan; diagnostic and/or surgical services/treatments/therapies/procedures not expressly included in the individual Covers (even if generically included in the Health Plan); expenditure that is in excess of that for services/treatments provided directly; services/treatments not included in the individual member's Health Plan/Covers even though they fall within the Fund's area of activity.

No refunds are available for: consultations carried out by a dentist beyond any included in the specific Dentistry Cover of the Health Plan; those carried out by a hygiene and preventive medicine specialist; those carried out for breast examinations; for occupational medicine; for forensic medicine; for radiology; for nuclear medicine; for sports medicine; for aerospace medicine; for applied pharmacology; for medical hydrology; general medicine services and/or consultations (injections, phlebotomies, vaccinations, medicines and/or substances used for allergy tests, sclerosing injections); consultations carried out by a psychologist; by a dietologist and/or nutritionist, regardless of whether this is a physician specialised in food science; biologist; homeopathic and/or alternative and/or experimental medicine consultations and/or services; osteopathic consultations and/or services; physiokinesis therapy (other than physiatric consultations).

Also not refundable are: medical-surgical consultations for the purpose of personal aesthetics (and/or related to these), regardless of whether carried out by reconstructive plastic surgeons; surgical procedures and/or medical therapies and/or diagnostic tests connected with male or female infertility and/or sterility and therapies, surgical procedures and/or treatments/therapies for male impotence and female frigidity and/or related to all of these; services/treatments/therapies/procedures and all activities for the purpose of assisted reproduction and/or related to these; haemodialysis; thermographic examinations; occupational medicine services and/or related to these; check-ups regardless of type and/or reason; any type of treatment and/or surgery for myopia, astigmatism, hypermetropia, presbyopia, correction of the cornea carried out with any method and equipment; any other ophthalmology laser treatments beyond those indicated in the appropriate branch in the “laser treatments” paragraph; medical consultations for the purpose of issuing certificates (driver's license, sports fitness, etc.); secretarial fees, administrative fees, stamp duties, medicine storage costs, the issuing of copies of medical records, the issuing of copies of X-rays (any type, on any medium), copies of reports; travel expenses and expenses for accompanying persons if not included in the hospitalisation fee; for medicines, excepting those administered during stays in a nursing home and shown on the relevant invoice; stays in private nursing homes for self-sufficient elderly people; stays in extended care residences for non self-sufficient people (including elderly), in long-term care facilities; medical therapies carried out in Day Hospitals and on an outpatient basis with the exception of oncological therapies (chemotherapy, radiotherapy, pain therapy); stays in nursing homes dedicated to personal well-being; orthotics; devices and prostheses beyond those

explicitly included in the individual Covers and limited to major surgery.

Consultations carried out by persons other than graduates in medicine and surgery who are duly registered with the Italian Board of Physicians (also indicating the professional's specialisation/s) are not refundable.

Also excluded are diagnostic and/or surgical treatments/services/therapies/procedures for: the elimination or correction of physical defects or malformations pre-existing at the time of joining FasiOpen, except those included in “Newborn Protection” Cover; the treatment of mental illnesses and mental disorders in general, including neurotic behaviour, psychiatrist consultations; the treatment of illnesses resulting from the abuse of alcohol and psychotropic drugs, and the non-therapeutic use of narcotics or hallucinogens; the direct and/or indirect consequences of transmutation by the nucleus of the atom of radiation caused by the artificial acceleration of atomic particles and overexposure to ionizing radiation, apart from radiation caused by radiotherapy; the consequences of war, insurrections, political, football or sporting events, earthquakes and volcanic eruptions, pandemics, epidemics, tidal waves, electrical storms, floods and/or all related to these; injuries resulting from the practice of airborne sports in general or any extreme sports or any sport participated in professionally and/or related to these; injuries resulting from participation in motor races or competitions, motorcycle or speedboat competitions and related trials and/or training; injuries resulting from speleological activities; dentures (fixed and mobile), implants, dental surgery (any type), maxillofacial surgery, orthodontic therapy, conservative, endodontic, gnathological treatments, dental radiology, pedodontic treatments in addition to those explicitly provided for and/or if not explicitly provided for and included in a specific Cover within the Health Plan.

Fasiopen Basic Nomenclature

SECTION B. SPECIALIST CONSULTATIONS			
Only specialist consultations for diagnostic purposes are eligible for refund, excluding those needed to resolve the pathological event (check-ups/follow-ups). Refunds for specialist consultations given by the entire medical-surgical-anaesthesiological team during hospitalisation with night-time or daytime stay (day hospitals-day surgeries) with or without surgery, are included in those recognised for each individual medical operation or care. SPECIALIST CONSULTATIONS DURING OVERNIGHT HOSPITALISATION WILL ONLY BE RECOGNISED AS REFUNDABLE IF CARRIED OUT BY A PROFESSIONAL WITH A DIFFERENT SPECIALISATION TO THAT FOR WHICH THE HOSPITALISATION WAS REQUESTED. They must be specified in the medical record showing the DIAGNOSTIC QUERY OF THE PRIMARY TEAM AND THE REPORT OF THE NEW CONSULTANT CALLED IN. In this case too, only the specialist consultation for diagnostic purposes is recognised as refundable. Excluded from refund are: consultations provided by a medical dentist other than those provided for and if provided for by the specific Dental Cover of the Health Plan; hygiene and preventive medicine specialists; breast health consultations; those pertaining to occupational medicine; legal medicine; radiological consultations; nuclear medicine; sports medicine; aerospace medicine; medical hydrology; those carried out by a psychologist; dietology consultations regardless of whether these are carried out by a physician specialising in food science; biologist. Also not refundable are medical-surgical consultations for the purposes of personal aesthetics (and/or attributable to these) and anything else specified in the “Exclusions” paragraph in the Guide and in the “Services not covered by FasiOpen” paragraph (within the individual healthcare plans). Consultations carried out by persons other than graduates in medicine and surgery who are duly registered with the Italian Board of Physicians (also indicating the professional's specialisation/s) are not refundable. Psychotherapy/psychological support sessions, on the other hand (not equatable to specialist consultations), are refundable within the limits specified by the Cover that includes them, solely if carried out by the professionals specified within the item itself.			
10017	1	SPECIALIST OUTPATIENT OR IN-HOME VISITS, OR CONSULTATIONS PERFORMED DURING NIGHT-TIME HOSPITALISATION BY A SPECIALIST PHYSICIAN WHO IS NOT A MEMBER OF THE MEDICAL-SURGICAL-ANAESTHESIOLOGICAL TEAM TREATING THE PATIENT.	
78024	6625	PSYCHOTHERAPY SESSIONS (IF CARRIED OUT BY A PHYSICIAN SPECIALISING IN PSYCHIATRY OR CLINICAL PSYCHOLOGY OR IF CARRIED OUT BY PSYCHOLOGISTS OR PSYCHOTHERAPISTS DULY REGISTERED WITH THE BOARD. THESE THERAPIES MUST BE GIVEN IN A SPECIALIST CLINICAL FACILITY).	

SECTION C. HOSPITALISATION AND SUPPLEMENTARY SERVICES			
Branch introductions			**Limitations**
If the Health Plan provides for the case-by-case refund of services/items, please note that: all hospitalisation fees count towards the calculation of the maximum limit of 90 days recognised. Hospitalisation fees for intensive care wards or coronary units are inclusive, in addition to ordinary hospitalisation fees, also of continuous medical and nursing care (24 hours) and the use of special equipment, in the same way as for sub-intensive care. The daily hospitalisation (day hospital) fee is limited to cancer treatments, pain therapy and chemotherapy, while day surgery is limited to surgical operations. It is therefore strictly excluded for hospitalisation for diagnostic tests and/or other reasons. Please note that refunds are not recognised for the delivery of medicines/chemotherapy drugs in the day hospital context or for package-based procedures (Cataract Package and Gastroenterological procedures). Please note that some procedures can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any type) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health, In these cases, therefore, for the hospitalisation to be recognised (if the service falls within the cover/guarantee), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.			
30031	2	OVERNIGHT HOSPITALISATION FEE WITH OR WITHOUT SURGERY IN A ROOM WITH SINGLE BED AND A SECOND BED OR SOFA BED FOR AN ACCOMPANYING PERSON - PER NIGHT.	
30049	3	DAILY USE OF THE BED OR SOFA BED FOR THE ACCOMPANYING PERSON	

30098	4	OVERNIGHT HOSPITALISATION FEE WITH OR WITHOUT SURGERY APPLIED FOR THE DIFFERENCE IN CLASS (HOTEL COMFORT) SUPPLEMENTING THE ITALIAN NATIONAL HEALTH SERVICE PER SINGLE ROOM WITH BED OR SOFA BED FOR ACCOMPANYING PERSON - USE OF BED FOR THE ACCOMPANYING PERSON INCLUDED IN THE FEE SHOWN - PER NIGHT	
30072	5	DAILY DAYTIME HOSPITALISATION FEE (DAY HOSPITAL) FOR CHEMOTHERAPY, CANCER TREATMENTS AND PAIN THERAPY, OR FOR SURGERY (DAY SURGERY - WITH HOSPITALISATION OF NO LESS THAN 4 HOURS)	
30106	7	NIGHT HOSPITALISATION FEE FOR THE USE OF A ROOM EQUIPPED FOR RADIOMETABOLIC THERAPIES - PER NIGHT - EXCLUDING SERVICES LISTED IN THE SUB-SECTION: RADIONUCLIDE THERAPIES. EXCLUDES: MATERIALS – MEDICINES – DIAGNOSTIC TESTS. REPLACES THE NORMAL HOSPITALISATION FEE.	
30056	8	NIGHT HOSPITALISATION FEE IN INTENSIVE CARE/REANIMATION UNIT/CORONARY UNIT/ASEPTIC ROOM FOR TRANSPLANTS (INCLUDING 24 H ASSISTANCE FROM THE MEDICAL/NURSING TEAM WITH THE PATIENT USUALLY INTUBATED) - PER NIGHT - THE FEE IS ALL-INCLUSIVE WITH THE EXCEPTION OF MATERIALS, MEDICINES AND DIAGNOSTIC TESTS. REPLACES THE NORMAL HOSPITALISATION FEE.	
30114	9	OVERNIGHT HOSPITALISATION FEE IN SUB-INTENSIVE CARE UNIT - PER NIGHT (INCLUDING 24 H PARAMEDICAL ASSISTANCE, 24 H MONITORING/TELEMETRY, NON-CONTINUOUS ASSISTANCE BY THE MEDICAL TEAM WITH NON-INTUBATED PATIENTS). THE FEE IS ALL-INCLUSIVE WITH THE EXCEPTION OF MATERIALS, MEDICINES AND DIAGNOSTIC TESTS. REPLACES THE NORMAL HOSPITALISATION FEE.	
REANIMATION: PROFESSIONAL REANIMATION-RELATED SERVICES			
30007	10	MECHANICAL CIRCULATION ASSISTANCE (AS A SINGLE SERVICE)	
40089	11	EXTERNAL ELECTRICAL DEFIBRILLATION (AS A SINGLE SERVICE)	
40097	12	INTERNAL ELECTRICAL DEFIBRILLATION (AS A SINGLE SERVICE)	
30028	13	CVC REMOVAL (AS A SINGLE SERVICE)	
30018	14	REMOVAL OF IMPLANTABLE VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE)	
30023	15	CVC IMPLANTATION (AS A SINGLE SERVICE)	
30015	16	IMPLANTATION OF VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE) WITH POSSIBLE ULTRASOUND GUIDANCE	
31021	17	THERAPEUTIC HYPOTHERMIA (AS A SINGLE SERVICE)	

SECTION D. MATERIALS AND MEDICINES			
Recognised for refund, to the extent provided for in the individual Health Plans, are all materials and medicines used during hospitalisation (night-time or daytime) in healthcare facilities duly specified on the invoice (with the exception of materials and medicines used during dental procedures, the costs of which are already included in the amount payable for the services). For operations and carried out on an outpatient basis (where and if included in the Health Plan) materials, medicines and instruments are included in the fees for the operating theatres. For package-based procedures/surgery, materials and drugs are already included in the maximum amount recognised by the Fund (for Health Plans with case-by-case refunds). Please note that it is not possible to assimilate items attributable to devices and prostheses with materials.			
60020	18	MATERIALS USED IN THE OPERATING THEATRE AND THE WARD DURING OVERNIGHT OR DAY HOSPITALISATION	
60012	19	MEDICINES USED IN THE OPERATING THEATRE AND THE WARD DURING OVERNIGHT OR DAY HOSPITAL STAYS	

SECTION E. MEDICAL DEVICES AND PROSTHESES			
For cover-based Health Plans, services are only recognised for refund in the event of hospitalisation for major surgery. For Health Plans with case-by-case refunds, services are recognised for refund if prescribed by a specialist physician or if used during day or overnight hospitalisation, clearly described in the medical file and duly shown in the expenditure documentation; for package-based procedures, prostheses are calculated within the package to the maximum extent recognised by the Fund. No refunds are available for additional types of prostheses or devices beyond those explicitly stated in the section. For the purposes of refund, the Fund reserves the right to request certification of conformity as governed by EU regulation 2017/745.			
85159	20	LARYNGOPHONE	
85027	21	ORTHOPAEDIC CORSET	
85019	22	ORTHOPAEDIC CORSET FOR SCOLIOSIS	
85209	23	CARDIAC DEFIBRILLATOR	
85191	24	CONTINUOUS INFUSION OF ANTI-BLASTIC DRUGS	
85118	25	PACEMAKER COMPLETE WITH ACCESSORIES	
85134	26	UNILATERAL (RIGHT OR LEFT) HEARING AID FOR HEARING LOSS	Refundable once per body part every 3 years (ref. invoice). Cannot overlap (at the same time as and/or within the year and/or within a three-year period) with bilateral hearing prosthesis
85217	27	BILATERAL HEARING AID	Refundable once per body part every 3 years (ref. invoice). Cannot overlap (at the same time as and/or within the year and/or within a three-year period) with unilateral hearing prosthesis
85092	28	JOINT PROSTHESIS	
85035	29	LOWER LIMB PROSTHESIS	
85043	30	UPPER LIMB PROSTHESIS	
85167	31	PROSTHESIS OF THE CRYSTALLINE LENS	
85100	32	BREAST PROSTHESIS (EACH)	
85142	33	PROSTHETIC EYE (FALSE EYE)	
85183	34	TESTICULAR PROSTHESIS	

85175	35	VASCULAR PROSTHESIS	
85506	36	VASCULAR STENTS	
85514	37	STENTS, OTHER TYPES OF	
85050	38	LOWER LIMB FUNCTION BRACE	
85068	39	UPPER LIMB FUNCTION BRACE	
85076	40	FUNCTION BRACE: TRUNK	
85084	41	RESTING OR POSITIONAL BRACE	
85126	42	HEART VALVE	

SECTION F. PROFESSIONAL COSTS AND FEES FOR TRANSFUSION SERVICES DURING OVERNIGHT HOSPITALISATION

THERAPEUTIC APHERESIS

Services can be carried out with any technique, equipment and/or instrumentation.

56812	43	ERYTHROAPHERESIS WITH MULTIPLE BAGS	
56820	44	THERAPEUTIC ERYTHROCYTEPHERESIS	
56838	45	THERAPEUTIC LEUKOPHERESIS	
56846	46	THERAPEUTIC PLATELETPHERESIS	
56854	47	THERAPEUTIC PLASMAPHERESIS	

PROFESSIONAL SERVICES

Fees are per session for the entire medical team. Services can be carried out with any technique, equipment and/or instrumentation.

50187	48	PROFESSIONAL SERVICES FOR INTRAOPERATIVE BLOOD RECOVERY	
50005	49	PROFESSIONAL SERVICES FOR TRANSFUSIONS	
59006	50	BLOOD, BLOOD PRODUCTS ACCORDING TO CURRENT REGULATIONS	

SECTION G. - USE OF DEDICATED ROOMS - USE OF OPERATING THEATRE - USE OF SPECIAL EQUIPMENT IN THE OPERATING THEATRE - USE OF HIGH-COST INSTRUMENTS			
USE OF DEDICATED ROOMS			
The outpatient room is inclusive of medication, medical materials and any instruments and/or equipment, unless already included in the individual procedures. For services provided in outpatient clinics, a report of the procedure drawn up by the specialist physician (specifying the surgical procedure and diagnosis) must be submitted. Please note that outpatient rooms are already included in package-based procedures. Outpatient rooms are not recognised for refund, under any Health Plan, for dental services (even if carried out during any hospitalisation).			
56069	51	USE OF A DEDICATED OUTPATIENT ROOM FOR MINOR SURGERY/ENDOSCOPIES (INCLUDING COMMONLY USED MATERIALS AND MEDICINES AND POSSIBLE USE OF LOCAL ANAESTHETICS/DEEP SEDATION), IF CARRIED OUT IN HOSPITALS, NURSING HOMES, DAY HOSPITALS, DAY SURGERIES	
50195	52	USE OF GESSI ROOM	
50203	53	USE OF DELIVERY ROOM FOR NATURAL CHILDBIRTH	
USE OF THE OPERATING THEATRE DURING OVERNIGHT HOSPITALISATION FOR SURGERY AND INVASIVE OPERATIONS CARRIED OUT UNDER GENERAL, PERIPHERAL SPINAL (SUBDURAL OR PERIDURAL) OR PLEXIC, TRUNCULAR, INFILTRATION ANAESTHETIC, INCLUDING THE USE OF ANY EQUIPMENT NOT SPECIFICALLY DESCRIBED, IF CARRIED OUT IN HOSPITALS, NURSING HOMES, DAY HOSPITALS, DAY SURGERIES. THE COSTS OF MATERIALS AND MEDICINES ARE EXCLUDED FROM THE FEES SHOWN			
For Health Plans with case-by-case refunds and for direct provision services, the operating theatre code is identified by the amount or sum of refunds specified for the procedure carried out in the same operating session. Following identification the amount will be recognised, again limited to the expenditure actually incurred and/or that provided for by the Health Plan. Therefore, in the case of analytical refunds, the maximum refund allowable for the operating theatre is that relating to the code identified and is therefore summed with that recognised for the operation itself. The fee for the operating theatre (night/day hospitalisation) includes the use of any equipment, excepting that included in individual procedures and also excepting that specifically described. The operating theatre is already included in Surgical Packages. Refunds for surgery during hospitalisation (night or day) are not recognised in the case of diagnostic procedures and/or minimally invasive procedures. Please note that refunds for the use of the operating theatre during hospitalisation (overnight or daytime) are related to the claim for a surgical procedure; any refund claim for use of the theatre/room only will therefore be at the sole discretion of the Fund. In such cases, therefore, we urge you to provide reports and documentation to give the Fund all the means necessary to make the above evaluation.			
59915	54	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION UP TO 550 EURO	
59923	55	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 550 EURO TO 1,050 EURO	
59931	56	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 1,051 EURO TO 1,550 EURO	
59956	57	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 1,551 EURO TO 2,070 EURO	
59964	58	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 2,071 EURO TO 2,590 EURO	
59949	59	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 2,591 EURO TO 3,620 EURO	
59972	60	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 3,621 EURO TO 4,650 EURO	
59980	61	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION OVER 4,650 EURO	
59998	62	USE OF OPERATING THEATRE FOR INVASIVE EXAMINATIONS/PROCEDURES (HAEMODYNAMICS - ANGIOGRAPHY - INTERVENTIONAL RADIOLOGY - INTERVENTIONAL CARDIOLOGY) REQUIRING ITS USE. THE FEE IS IN LIEU OF AND NOT IN ADDITION TO THE NORMAL RELEVANT FEE FOR THE USE OF THE OPERATING THEATRE.	

43885	63	USE OF OPERATING THEATRE FOR CARDIAC SURGERY IN C.E.C. (INCLUDING USE OF SPECIAL EQUIPMENT). THE FEE IS IN LIEU OF AND NOT IN ADDITION TO THE OTHER RELEVANT FEE FOR THE USE OF THE OPERATING THEATRE.	
USE OF THE OPERATING THEATRE DURING DAY SURGERY FOR OPERATIONS OR INVASIVE PROCEDURES CARRIED OUT UNDER GENERAL, PERIPHERAL SPINAL (SUBDURAL OR PERIDURAL) OR PLEXIC, TRUNCULAR, INFILTRATION ANAESTHETIC, UNLESS OTHERWISE DESCRIBED, IF CARRIED OUT IN HOSPITALS, NURSING HOMES, DAY HOSPITALS, DAY SURGERIES. THE COSTS OF MATERIALS AND MEDICINES ARE EXCLUDED FROM THE FEES SET OUT IN THE INDIVIDUAL HEALTH PLANS.			
The operating theatre in Day Surgery is not recognised for refund if this is absent. Please note that some procedures can be carried out on an outpatient basis, so that any recognition for refund in Day Surgery using the relevant operating theatre will be subject to evaluation of the documented systemic pictures as set out in the Introduction to this Guide.			
59816	64	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION UP TO 550 EURO	
59824	65	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 550 EURO TO 1,050 EURO	
59832	66	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 1,051 EURO TO 1,550 EURO	
59840	67	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION FROM 1,551 EURO TO 2,070 EURO	
59857	68	USE OF OPERATING THEATRE WITH RELEVANT FEE FOR THE OPERATION OVER 2,071 EURO	
USE OF HIGH-COST INSTRUMENTS BELONGING TO THE HEALTHCARE FACILITY			
Refunds envisaged for high-cost instruments should be regarded as inclusive of whatever is necessary to carry out the procedure (disposable materials relating to the instrument/equipment). The use of a lithotripter, shock wave equipment, a phacoemulsifier, and endoscopic equipment are included in the fees for the relevant procedures.			
59717	69	USE OF **BRILLIANCE AMPLIFIER** IN THE OPERATING THEATRE	
59725	70	USE OF SPECIAL EQUIPMENT FOR TRANSFUSIONS IN THE EVENT OF SURGERY	
50500	71	USE OF ARTHROSCOPE	
59733	72	USE OF HYSTEROSCOPE	
59741	73	USE OF LAPAROSCOPE	
59758	74	USE OF PORTABLE ELECTRONIC PUMP FOR CONTINUOUS OR CIRCADIAN INFUSION FOR MONO - POLYCHEMOTHERAPY (PER DAY)	

SECTION H. MEDICAL TEAM ASSISTANCE DURING OVERNIGHT HOSPITALISATION IN MEDICAL WARDS			
The fees set out in the individual Health Plans are inclusive of the professional services provided by the entire medical team during a overnight hospitalisation without surgery. Inpatient care is not equatable to specialist consultations, cannot be summed with the latter, and is not refundable in the case of surgery. No other possibilities are available. Refunds for in-patient care in cases of day hospitalisation for any type of pathology are excluded, with the exception of services for oncological chemotherapy and pain therapy, as described in section I, Medical Oncology. By Nursing Care during overnight hospitalisation we mean private and individual assistance provided by nursing staff in addition to that regularly provided by the healthcare facility as a part of its nursing care in the ward (non-hospital activities). For the refund to be recognised it must be clear that the aforementioned nursing care does not overlap with other hospital activities and that it is unequivocally restricted to the individual member/client. Any refund, if envisaged by the Health Plan, is understood to be daily (24h) for a minimum number of 6 hours of care (whether daytime or night-time).			
10066	75	CARE BY THE MEDICAL TEAM DURING HOSPITALIZATION WITHOUT SURGERY WITH OVERNIGHT STAY: FROM THE FIRST TO THE TENTH DAY	

10082	77	CARE BY THE MEDICAL TEAM DURING HOSPITALIZATION WITHOUT SURGERY WITH OVERNIGHT STAY: BEYOND THE TENTH DAY	
7000	7000	NURSING CARE DURING HOSPITALISATION (PRIVATE - EXTRA-HOSPITAL ACTIVITY)	

SECTION I. MEDICAL ONCOLOGY - CHEMOTHERAPY

Specialist oncological care is defined as that provided by specialists during infusional chemotherapy sessions on an outpatient basis, at home, in day hospitals or with night-time hospitalisation; or that provided by specialist oncologists only during night-time hospitalisation and without chemotherapy. Specialist oncological care is not equatable to specialist consultations, cannot be summed with the latter, and is not recognised for refund in the event of delivery of chemotherapy drugs for home therapy only. The fees set out in the individual Health Plans are inclusive of the professional services provided by the entire medical-oncological team. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.

31083	78	CVC REMOVAL (AS A SINGLE SERVICE)	
10128	79	REMOVAL OF IMPLANTABLE VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE)	
31098	80	CVC IMPLANTATION (AS A SINGLE SERVICE)	
10124	81	IMPLANTATION OF VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE) WITH POSSIBLE ULTRASOUND GUIDANCE	
10058	82	SERVICES OF THE MEDICAL ONCOLOGY TEAM IN DAY HOSPITAL OR OUTPATIENT OR IN-HOME CARE FOR ANTIBLASTIC MONO-POLYCHEMOTHERAPY AND/OR HYPERTHERMIA, WITH CONTINUOUS OR CIRCADIAN INFUSION USING PORTABLE PROGRAMMABLE ELECTRONIC PUMPS AND POSSIBLE REFILLS OF DRUGS AND CLINICAL CONTROLS OR FOR ANTINEOPLASTIC THERAPIES OR CHEMOTHERAPY WITH RAPID OR PROLONGED INFUSION OF DRUGS: PER SESSION	
10090	83	SERVICES OF THE MEDICAL ONCOLOGY TEAM DURING HOSPITALISATION WITH OVERNIGHT STAY FOR ANTIBLASTIC MONO-POLYCHEMOTHERAPY, WITH PERFUSION THERAPY: PER DAY	
10116	85	SERVICES OF THE MEDICAL ONCOLOGY TEAM DURING HOSPITALISATION WITH OVERNIGHT STAY FOR DRUG INFUSION IN NATURAL CAVITIES WITH OR WITHOUT EVACUATION OF BIOLOGICAL/PATHOLOGICAL LIQUIDS OR ENDOVESCICAL THERAPY WITH CATHETERISATION, INCLUSIVE OF ANY MEDICAL PROCEDURE: SINGLE SESSION	
10262	86	SERVICES BY THE MEDICAL ONCOLOGY TEAM DURING HOSPITALIZATION WITHOUT CHEMOTHERAPY WITH OVERNIGHT STAY: FROM THE FIRST TO THE TENTH DAY	
10284	88	SERVICES BY THE MEDICAL ONCOLOGY TEAM DURING HOSPITALIZATION WITHOUT CHEMOTHERAPY WITH OVERNIGHT STAY: BEYOND THE TENTH DAY	

SECTION L. HYPERBARIC MEDICINE			
The item shown, where included in Health Plans, is all-inclusive of medical - surgical, nursing and/or technical assistance and is recognisable for refund upon presentation of a medical prescription with diagnosis showing the definite pathology that made the treatment necessary. Sessions are not recognised for experimental therapies or solely dental pathologies of the oral cavity, i.e. they are recognised for refund only in the context of the activities of the Cover that provides for them.			
80176	89	HYPERBARIC MEDICINE - COST PER SINGLE OR GROUP SESSION FOR ANY PATHOLOGY (ANY DURATION) INCLUDING TECHNICAL, MEDICAL-SURGICAL AND NURSING ASSISTANCE.	Sessions are not recognised for experimental therapies or solely dental pathologies of the oral cavity, i.e. they are recognised for refund only in the context of the activities of individual Areas that provides for them.

SECTION M. LITHOTRIPSY			
Kidney Lithotripsy			
49478	90	EXTRACORPOREAL LITHOTRIPSY FOR UNILATERAL KIDNEY STONES - COMPLETE TREATMENT - INCLUDING PUSH-UP IF NECESSARY	
55731	91	EXTRACORPOREAL LITHOTRIPSY FOR BILATERAL KIDNEY STONES - COMPLETE TREATMENT - INCLUDING PUSH-UP IF NECESSARY	
55749	92	EXTRACORPOREAL LITHOTRIPSY FOR UNILATERAL KIDNEY AND URETERAL STONES - COMPLETE TREATMENT - INCLUDING PUSH-UP IF NECESSARY	
55756	93	EXTRACORPOREAL LITHOTRIPSY FOR BILATERAL KIDNEY AND URETERAL STONES - COMPLETE TREATMENT - INCLUDING PUSH-UP IF NECESSARY	
Ureter Lithotripsy			
55798	94	EXTRACORPOREAL LITHOTRIPSY FOR UNILATERAL URETERAL STONES (COMPLETE TREATMENT)	
55806	95	EXTRACORPOREAL LITHOTRIPSY FOR BILATERAL URETERAL STONES (COMPLETE TREATMENT)	
Liver and Biliary Tract Lithotripsy			
42606	96	EXTRACORPOREAL LITHOTRIPSY FOR MAIN AND ACCESSORY BILIARY TRACT STONES (COMPLETE TREATMENT)	

SECTION N. THERAPIES

Radiotherapy

The fees set out are for Health Plans with case-by-case refunds (if provided for in the Covers) per session, regardless of whether carried out on an outpatient basis or with hospitalisation (daytime or night-time). They include:

Use of equipment, preparation of the treatment plan, check-up consultations (not equatable to specialist consultations) and assessment systems during treatment, dosimetry in vivo, contrast mediums and anaesthesiological care, commonly-used materials, where necessary, except as specifically described.

All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.

85530	99	HADRONTHERAPY (PER SESSION)	
80580	100	SURFACE BETATHERAPY WITH ARTIFICIAL RADIOISOTOPES (PER SESSION)	
59022	101	INTERSTITIAL BRACHYTHERAPY WITH PERMANENT IMPLANTATION OF RADIOACTIVE SEEDS IN THE PROSTATE (INCLUDING COST OF SEEDS)	
80952	102	INTERSTITIAL OR ENDOCAVITARY OR CORONARY BRACHYTHERAPY (COURIETHERAPY) (FIRST SESSION)	
80572	103	INTERSTITIAL OR ENDOCAVITARY OR CORONARY BRACHYTHERAPY (COURIETHERAPY) (SUBSEQUENT SESSIONS)	
80945	104	SUPERFICIAL BRACHYTHERAPY (COURIETHERAPY) (MOULDED APPLIANCES)	
85568	105	CONTOURING OF TARGET AND CRITICAL ORGANS FOR 3D PLANS, RADIOTHERAPY ASSESSMENT OF 3 D PLANS AND VALIDATION (WHOLE TREATMENT)	
85576	106	CONTOURING OF TARGET AND CRITICAL ORGANS FOR IMRT PLANS, RADIOTHERAPY ASSESSMENT OF IMRT PLANS AND VALIDATION (WHOLE TREATMENT)	
85584	107	VERIFICATION FILM DURING TREATMENT (MAXIMUM ONE PER WEEK)	
85592	108	IMMOBILISATION WITH STEREOTACTIC HELMET (INCLUDING ANAESTHETIST)	
80960	109	HYPERTHERMIA COMBINED WITH RADIOTHERAPY (PER SESSION)	
80978	110	INTRAOPERATIVE IRRADIATION (IORT)	
80531	111	PLESIOROENTGENTHERAPY (PER SESSION)	
85600	112	PLACEMENT OF PLAQUES FOR RADIOTHERAPY OF CHOROIDAL MELANOMA INCLUDING OPHTHALMOLOGIST SERVICE	
85618	113	DYNAMIC CONFORMAL RADIOTHERAPY WITH MICRO-MULTI-LEAF COLLIMATOR (PER SESSION)	
81026	114	RADIOTHERAPY WITH SPECIAL TECHNIQUES (OVERALL TREATMENT): TOTAL SKIN IRRADIATION WITH ELECTRONS (TSEBI)	
81018	115	RADIOTHERAPY WITH SPECIAL TECHNIQUES (OVERALL TREATMENT): HEMICORPOREAL IRRADIATION (HBI)	
80994	116	RADIOTHERAPY WITH SPECIAL TECHNIQUES (OVERALL TREATMENT): PANIRRADIATION (TBI) FIRST OR SINGLE SESSION	
81000	117	RADIOTHERAPY WITH SPECIAL TECHNIQUES (OVERALL TREATMENT): FRACTIONAL PAN-IRRADIATION (TBI), EACH SUBSEQUENT SESSION	
85626	118	RADIOTHERAPY IMRT (PER SESSION)	
80986	119	STEREOTACTIC RADIOTHERAPY (OVERALL TREATMENT, ALSO CYBER KNIFE)	

85634	120	PLURIFRACTIONATED STEREOTACTIC RADIOTHERAPY: FIRST FRACTION (ALSO CYBER KNIFE)	
85642	121	PLURIFRACTIONATED STEREOTACTIC RADIOTHERAPY: SUBSEQUENT FRACTIONS (ALSO CYBER KNIFE)	
80515	122	NON-ONCOLOGICAL SUPERFICIAL ROENTGENTHERAPY (PER SESSION)	
81463	123	SHIELDING, BEAM MODIFIERS, CUSTOMIZED IMMOBILISATION SYSTEMS (SINGLE SERVICE)	Refundable once per case
85650	124	SIMULATION WITH FUSION OF TC AND RMN IMAGES	
81059	125	TREATMENT SIMULATION: THROUGH MRI	
81042	126	TREATMENT SIMULATION: THROUGH CAT	
81034	127	TREATMENT SIMULATION: TRADITIONAL RADIOLOGY	
81067	128	SIMULATION FOR STEREOTACTIC RADIOTHERAPY WITH ANGIOGRAPHY	
81075	129	SIMULATION FOR STEREOTACTIC RADIOTHERAPY WITH CAT	
85668	130	IMMOBILIZATION SYSTEM FOR 3D AND DYNAMIC RADIOTHERAPY	Refundable once per case
81471	131	DOSIMETRIC STUDY	
80556	132	KINETIC TELECOBALT THERAPY (PER SESSION)	
80549	133	TELECOBALT THERAPY OR OTHER GAMMA SOURCES - STATIC (PER SESSION)	
80606	134	THERAPY WITH LINEAR ACCELERATOR PHOTONS OR ELECTRONS (PER SESSION)	
81489	135	CONFORMAL THERAPY FOR THE PROSTATE OR OTHER ORGANS, WHERE NECESSARY (PER SESSION)	
85676	136	PET TOMOTHERAPY (PER SESSION)	
81551	137	TARGETED THERMOFREQUENCY TREATMENT (PER SESSION)	
Antalgic therapy			
Items are inclusive of care by the medical team (not equatable to specialist consultations) during hospitalisation. Services are refundable only if provided for in the individual Health Plans, at the conditions set out by the single Covers and only if carried out during day or night or outpatient hospitalisation. The need to carry the services set out below must be certified/prescribed by the specialist physician in Anaesthesia and Resuscitation (Intensive and Pain Therapy) or by the Neurosurgery specialist. No other possibilities are available. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
85850	1473	UPPER LARYNGEAL NERVE ALCOHOLIZATION	Refundable once in a lifetime
81083	138	ANALGESIC AND PERIPHERAL NERVE BLOCKS: CONTINUOUS SACRAL EPIDURAL ANALGESIA (FOR THE FIRST DAY OF TREATMENT)	
81091	139	ANALGESIC AND PERIPHERAL NERVE BLOCKS: CONTINUOUS SACRAL EPIDURAL ANALGESIA (FOR EACH SUBSEQUENT DAY)	
81109	140	ANALGESIC AND PERIPHERAL NERVE BLOCKS: CONTINUOUS PERIDURAL ANALGESIA (FOR THE FIRST DAY OF TREATMENT)	
81117	141	ANALGESIC AND PERIPHERAL NERVE BLOCKS: CONTINUOUS PERIDURAL ANALGESIA (FOR EACH SUBSEQUENT DAY)	
45112	142	ANALGESIC AND PERIPHERAL NERVE BLOCKS: TRIGEMINAL BRANCHES	
81125	143	ANALGESIC AND PERIPHERAL NERVE BLOCKS: GASSER'S GANGLION, LUMBAR SYMPATHETIC GANGLION, CELIAC GANGLION	

81133	144	ANALGESIC AND PERIPHERAL NERVE BLOCKS: SPHENOPALATINE GANGLION, STELLATE GANGLION	
45104	145	ANALGESIC PERIPHERAL NERVE BLOCKS: CERVICAL NERVES	
81141	146	ANALGESIC PERIPHERAL NERVE BLOCKS: CRANICAL NERVES	
81158	147	ANALGESIC PERIPHERAL NERVE BLOCKS: LUMBAR SYMPATHETIC NERVES	
45138	148	ANALGESIC AND PERIPHERAL NERVE BLOCKS: INTERCOSTAL NERVES	
81166	149	ANALGESIC PERIPHERAL NERVE BLOCKS: DORSAL SPINAL NERVES	
81174	150	ANALGESIC PERIPHERAL NERVE BLOCKS: OBTURATORY NERVE	
81182	151	PROLONGED NERVE BLOCKS (NEUROLYSIS): SUBARACHNOID BLOCK	
81190	152	PROLONGED NERVE BLOCKS (NEUROLYSIS): TRANS-SACRAL BLOCK	
81208	153	PROLONGED NERVE BLOCKS (NEUROLYSIS): VERTEBRAL FACET JOINT DENERVATION	
81216	154	PROLONGED NERVE BLOCKS (NEUROLYSIS): GASSER GANGLION	
81224	155	PROLONGED NERVE BLOCKS (NEUROLYSIS): IMPLANTATION OF SPINAL CORD ELECTRODES FOR ELECTROSTIMULATION	
81232	156	PROLONGED NERVE BLOCKS (NEUROLYSIS): IMPLANTATION OF ELECTRODES FOR PERCUTANEOUS ELECTROSTIMULATION IN PERIDURAL SPACE	
81240	157	PROLONGED NERVE BLOCKS (NEUROLYSIS): ANAESTHETIC INFILTRATION OF VERTEBRAL FACET JOINTS	
81257	158	PROLONGED NERVE BLOCKS (NEUROLYSIS): CERVICAL NERVES	
81265	159	PROLONGED NERVE BLOCKS (NEUROLYSIS): CRANICAL NERVES	
81273	160	PROLONGED NERVE BLOCKS (NEUROLYSIS): CELIAC PLEXUS	
81281	161	PROLONGED NERVE BLOCKS (NEUROLYSIS): SYMPATHETIC CERVICAL OR LUMBAR	
45120	162	PITUITARY BLOCKAGE	
85684	163	PLEXIC CATHETERISATION FOR CONTINUOUS BLOCKAGE	
59030	164	IMPLANTATION OF SPINAL CORD ELECTRO-STIMULATOR, SURGERY FOR	
85692	165	PERIDURAL LYSIS (PERIDUROLYSIS WITH RACZ CATHETER)	
85700	166	POSITIONING OF TOTALLY IMPLANTABLE DEVICE FOR INTRATHECAL/SUBARACHNOID DRUG DELIVERY	
85718	167	SUBARACHNOID/INTRATHECAL DRUG DELIVERY (TEST)	
85726	168	REPLACEMENT OF SPINAL CORD ELECTROSTIMULATOR	
81299	169	ANALGESIC THERAPY THROUGH INTRAVENOUS INFUSION (FOR EACH DAY OF TREATMENT DURING OVERNIGHT HOSPITALISATION)	

Radionuclide therapies

The items for the therapies listed below, if and to the extent provided for by individual Health Plans, are inclusive of fees for professional services, scintigraphic examinations, specific materials and medicines. The fees do not include the daily overnight or day hospital fee or the use of a specific room equipped and dedicated to radiometabolic therapies.

81497	170	MALIGNANT PHEOCHROMOCYTOMAS AND NEUROBLASTOMAS - WITH 131I - MIBG - COMPLETE TREATMENT - DURING OVERNIGHT HOSPITALISATION	
81505	171	RADIOSYNOSYNTHESIS - COMPLETE TREATMENT FOR ONE JOINT DISTRICT - IN DAY HOSPITAL	
81513	172	RADIOSYNOSYNTHESIS - COMPLETE TREATMENT FOR SEVERAL JOINT DISTRICTS - IN DAY HOSPITAL	
81521	173	PAIN THERAPY FOR BONE METASTASES - COMPLETE TREATMENT - IN DAY HOSPITAL - SINGLE SESSION	
81539	174	RADIOMETABOLIC THERAPY OF THYROID NEOPLASMS - COMPLETE TREATMENT - DURING OVERNIGHT HOSPITALISATION	
81547	175	RADIOMETABOLIC THERAPY FOR THYROTOXIC THYROID PATHOLOGY (HYPERTHYROIDISM) - COMPLETE TREATMENT	

SECTION O. SURGICAL OPERATIONS DURING OVERNIGHT HOSPITALISATION, DURING DAYTIME HOSPITALISATION (DAY SURGERY)

The provisions for the individual items in this Section, if included in the Cover of individual Health Plans and regardless of the type of operation/performance and the regime in which this is carried out, are all-inclusive of the services/competences: of all participants in the surgical/medical procedure (operator/s, aids, assistants, anaesthetists, technicians, etc.) recorded in the operating theatre report within the medical record and in the medical record itself; of care provided by the entire surgical team during hospitalisation until discharge (without exceptions) and, where envisaged by the procedure/item itself, also of any standby. It follows that anaesthesia (any type), sedation and/or conscious sedation are included in the services/care given (without exceptions). For services/procedures carried out outside the operating theatre/outpatient room, if included in the individual member's/client's cover, submission of a detailed medical report is obligatory.

Please note that operations/procedures included in this section are inclusive of instruments/equipment and everything needed for the execution of the procedures themselves (disposable materials related to the instruments/equipment), excepting anything included in the respective operating theatres and excepting anything stated in the "high-cost instruments" paragraph.

All operations/services are all-inclusive of all phases of the standard procedures involved in the surgical technique.

In any intraoperative switch from a "closed procedure" to an "open procedure", being the technique with which the operation is completed, only the "open technique" (i.e. only one procedure) is recognised as refundable.

A biopsy is defined as being regardless of the number of samples/fragments taken in the same session, i.e. it is refundable only once per session of surgery if carried out on the same organ, internal tissue or portion of skin.

For diagnostic/exploratory procedures carried out together with operative procedures with the same access route, if included in an individual member's/client's cover, only the operative procedure is deemed refundable, with the diagnostic procedure regarded as a preparatory act.

Please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also deemed to be diagnostic endoscopies.

For operations/services that "can be carried out on an outpatient basis", approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached to the claim, as well as that already specified, in which the reasons for receiving the services during hospitalisation is highlighted.

Strictly excluded from refund, regardless of Health Plan, are all treatments, surgical operations and/or medical therapies and/or tests connected with infertility, sterility, impotence, frigidity and/or related to these; and all treatments and/or surgical operations and/or medical therapies and/or tests of an aesthetic nature and/or related to these and/or consequent to any previous treatments/therapies.

Also excluded from refund are any type of treatment or surgical operation for treating myopia, astigmatism, hypermetropia, presbyopia, corneal corrections using any method and equipment, any other laser treatment in ophthalmology other than those specifically indicated in the relevant "laser treatments" section and/or anything explicitly provided for by the Nomenclature in force at the time of the invoice for the balance (if included in the Covers of the individual Health Plan).

Should the Fund perceive the need for further investigations in the context of the envisaged and normal checks, it reserves the right to request additional documentation even if this is not explicitly mentioned. We therefore urge you to arrange in advance for pre and post-operative photographs in the case of minor operations, with particular reference to general surgery, dermatology, reconstructive plastic surgery and ophthalmology.

Heart surgery

All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
56085	176	STANDBY CARDIAC SURGERY (ATTENDED BY THE ENTIRE MEDICAL TEAM) FOR INTERVENTIONAL CARDIOLOGY OPERATIONS, EXCEPTING THE CASES DESCRIBED ABOVE IN WHICH THE REFUND IS ALREADY INCLUDED IN THE FEES SHOWN	
43802	177	MULTIPLE CORONARY ARTERY BYPASSES (C.E.C.)	
43786	178	SINGLE CORONARY ARTERY BYPASS (C.E.C.)	
43836	179	OPEN HEART SURGERY, WHETHER ADULT OR NEONATAL, INCLUDING ANEURYSMS OR MULTIPLE VALVE REPLACEMENTS OR AORTIC REPLACEMENT OR PLASTIC AORTIC VALVE (C.E.C.), EXCEPTING THOSE OPERATIONS DESCRIBED	
43711	180	CLOSED HEART SURGERY (WITHOUT C.E.C.) ADULT OR NEONATAL - OPERATIONS FOR, EXCEPTING THE OPERATIONS DESCRIBED	
40006	181	CYSTS OF THE HEART OR PERICARDIUM	
43851	182	COMMISSUROTOMY FOR MITRAL STENOSIS	
40113	183	AORTIC COUNTERPULSATION BY ARTERIAL CANNULATION	
40121	184	PERICARDIAL DRAINAGE	
40139	185	EMBOLECTOMY WITH FOGARTY	
43729	186	WOUNDS OR FOREIGN BODIES OR TUMOURS OF THE HEART OR TAMPONADE, SURGERY FOR	
40147	187	ARTERIOVENOUS FISTULAS OF THE LUNG, SURGERY FOR	
40154	188	INTERNAL HEART MASSAGE	
43760	189	PARTIAL PERICARDIECTOMY	
43778	190	TOTAL PERICARDIECTOMY	
43901	191	PERICARDIOCENTESIS	
40162	192	REINTERVENTION WITH RESTORATION OF CEC	
43737	193	SECTION OR LIGATION OF THE DUCTUS ARTERIOSUS OF BOTALLO	
59860	194	VALVE REPLACEMENT WITH MINIMALLY INVASIVE SURGERY (HEART PORT)	
43810	195	SINGLE VALVE REPLACEMENT (CEC)	
40170	196	VALVE REPLACEMENTS WITH CORONARY ARTERY BYPASS (CEC)	
43968	197	CARDIAC TRANSPLANTATION (INCLUSIVE OF ALL SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
43844	198	CARDIAC VALVULOPLASTY	
Cardiology Operations			
All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
44016	199	TRANSCATHETER ABLATION	

40188	200	SINGLE-VESSEL CORONARY ANGIOPLASTY WITH OR WITHOUT THROMBOLYSIS INCLUDING CORONARY STUDY, ANY CARDIAC SURGERY STANDBY AND APPLICATION OF STENTS	
40196	201	MULTIPLE VESSEL CORONARY ANGIOPLASTY WITH OR WITHOUT THROMBOLYSIS INCLUDING CORONARY STUDY, ANY CARDIAC SURGERY STANDBY AND APPLICATION OF STENTS	
40444	202	RIGHT ENDOMYOCARDIAL BIOPSY	
40451	203	LEFT ENDOMYOCARDIAL BIOPSY	
40469	204	RIGHT AND LEFT CATHETERISATION AND CALCULATION OF FLOW RATES AND GRADIENTS WITH CORONAROGRAPHY + RIGHT AND LEFT VENTRICULOGRAPHY	
73833	205	ELECTRONIC MONITORING OF THE IMPLANTED PACEMAKER AND/OR DEFIBRILLATOR (ICD) (INCLUDING CONSULTING ENGINEER) IN THE POST-IMPLANTATION PHASE	
40477	206	CORONAROGRAPHY + LEFT VENTRICULOGRAPHY + LEFT CATHETERISATION	
40485	207	NATIVE CIRCULATION CORONAROGRAPHY + SELECTIVE VENOUS AND ARTERIAL BYPASS STUDY + LEFT VENTRICULOGRAPHY + LEFT CATHETERISATION	
56862	208	DEFIBRILLATOR (ICD) WITH OR WITHOUT PACEMAKER, PERMANENT IMPLANTATION INCLUDING ANY IMPLANTATION/EXPLANTATION OF TEMPORARY DEVICE	
78006	209	THERAPEUTIC ELECTRIC DEFIBRILLATION TO INTERRUPT ARRHYTHMIAS (CARDIOVERSION)	
56870	210	ENDOCAVITARY ELECTROMECHANICAL MAPPING, INCLUDING REPOSITIONING AND/OR REMOVAL OF VENTRICULAR ELECTROCATHETERS, ANY METHOD	
43752	211	PACEMAKER, PERMANENT IMPLANTATION INCLUDING ANY IMPLANTATION/EXPLANTATION OF TEMPORARY PACEMAKER + ANY REPOSITIONING OF ELECTROCATHETERS AND ELECTRONIC PROGRAMMING OF THE PACEMAKER	
43976	212	PACEMAKER, TEMPORARY IMPLANTATION AND REMOVAL (AS A SINGLE OPERATION)	
40493	213	ELECTRONIC REPROGRAMMING OF PACEMAKER AND/OR DEFIBRILLATOR (ICD) WITH CARDIAC THRESHOLD MEASUREMENT USING A NON-INVASIVE METHOD	
56888	214	MYOCARDIAL REVASCULARIZATION, ANY METHOD	
40501	215	REPLACEMENT OF PERMANENT PACEMAKER GENERATOR	
40790	216	STANDBY CARDIAC SURGERY (ATTENDED BY THE ENTIRE MEDICAL TEAM), EXCEPTING THE CASES DESCRIBED IN WHICH THE REFUND IS INCLUDED IN THE FEES SHOWN	
40808	217	ENDOCAVITARY ELECTROPHYSIOLOGICAL STUDY	
41046	218	NON-CARDIAC VALVULOPLASTY	

Breast Surgery

All refunds for demolitive surgery are inclusive of plastic breast reconstruction (excluding prostheses).

Refunds for surgery to position or replace breast implants is recognised only following demolitive surgical operations for neoplasia. All services for aesthetic purposes and/or ascribable to these and/or resulting from these are excluded.

All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

43075	219	MAMMARY ABSCESS, INCISION OF	
59049	220	STEREOTACTIC INCISIONAL/EXCISIONAL BIOPSY	
56093	221	TISSUE EXPANSION FOR POST-DEMOLITION SURGERY SCARRING FOR THE INTRODUCTION OF BREAST PROSTHESIS (COMPLETE TREATMENT)	
56101	222	AXILLARY LYMPHADENECTOMY (AS A SINGLE OPERATION)	
59057	223	SENTINEL LYMPH NODE, REMOVAL OF (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST) (AS A SINGLE OPERATION)	
43042	224	RADICAL MASTECTOMY, ANY TECHNIQUE, WITH ASSOCIATED LYMPHADENECTOMIES	
43034	225	SIMPLE TOTAL MASTECTOMY WITH ANY LYMPHADENECTOMIES	
43109	226	SUBCUTANEOUS MASTECTOMY (COMPLETE TREATMENT)	
43018	227	BENIGN NEOPLASMS AND/OR CYSTS, REMOVAL OF (INCLUDING PLASTIC BREAST RECONSTRUCTION)	
43091	228	POSITIONING OF REPERE POINTS OR FIDUCIALS (AS A SINGLE SERVICE)	
41053	229	QUADRANTECTOMY WITH SEARCH FOR AND REMOVAL OF THE SENTINEL LYMPH NODE AND ASSOCIATED LYMPHADENECTOMIES, ANY TECHNIQUE (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST)	
59065	230	QUADRANTECTOMY WITH SEARCH FOR AND REMOVAL OF THE SENTINEL LYMPH NODE, ANY TECHNIQUE (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST), WITHOUT OTHER ASSOCIATED LYMPHADENECTOMIES	
43026	231	QUADRANTECTOMY, INCLUDING "NIPPLE-SPARING" TECHNIQUE, WITHOUT ASSOCIATED LYMPHADENECTOMIES	
56119	232	BREAST RECONSTRUCTION AFTER RADICAL MASTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
56127	233	BREAST RECONSTRUCTION AFTER SIMPLE TOTAL MASTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
56135	234	BREAST RECONSTRUCTION AFTER SUBCUTANEOUS MASTECTOMY OR QUADRANTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
56143	235	REMOVAL AND POSSIBLE REPLACEMENT OF BREAST PROSTHESIS IMPLANTED IN PREVIOUS MASTECTOMY OR QUADRANTECTOMY SURGERY (AS A SINGLE OPERATION)	
59073	236	TUMOURECTOMY WITH SENTINEL NODE RESECTION (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST)	
59081	237	TUMOURECTOMY WITH SENTINEL NODE RESECTION AND ASSOCIATED LYMPHADENECTOMIES (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST)	
Hand Surgery			
Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation. Missing items in Hand Surgery: see also Orthopaedics and Traumatology, and Reconstructive Plastic Surgery. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
41061	238	CARPAL AMPUTATIONS	
41079	239	PHALANGEAL AMPUTATIONS	

41087	240	METACARPAL AMPUTATIONS	
48793	241	APONEURECTOMY, DUPUYTREN'S DISEASE	
41095	242	CARPAL ARTHRODESIS	
41103	243	METACARPOPHALANGEAL AND/OR INTERPHALANGEAL ARTHRODESIS	
41350	244	ARTHROPLASTY	
41368	245	CARPAL ARTHROPLASTY	
41376	246	METACARPOPHALANGEAL AND/OR INTERPHALANGEAL ARTHROPLASTY	
59878	247	CYSTS OR TENDON AND/OR ARTHROGENIC GANGLIA, REMOVAL OF	
59886	248	SYNOVIAL CYSTS, REMOVAL OF	
56150	249	LOOP DEFORMITY OF THE HAND	
56168	250	HAMMERFINGER	
41384	251	FRACTURES AND DISLOCATIONS OF THE METACARPALS AND PHALANGES, INVASIVE TREATMENT	
41392	252	FRACTURES AND DISLOCATIONS OF THE METACARPALS AND PHALANGES, NON-INVASIVE TREATMENT	
41400	253	FRACTURES AND DISLOCATIONS OF THE WRIST, INVASIVE TREATMENT	
41582	254	FRACTURES AND DISLOCATIONS OF THE WRIST, NON-INVASIVE TREATMENT	
56176	255	MICROSURGICAL SKIN FLAPS	
56184	256	SKIN LESIONS, RECONSTRUCTIONS OF (V/Y, Y/V, Z PLASTY)	
56192	257	TRAUMATIC AND NON-TRAUMATIC NERVE DAMAGE OF THE HAND	
41590	258	TENDON INJURIES OF THE HAND, SURGERY FOR TENORRHAPHY	
41608	259	SPASTIC HAND - FLACCID PARALYSIS, SURGICAL TREATMENT FOR	
48553	260	NOTTA'S DISEASE (CLICKING FINGER), DE QUERVAIN'S DISEASE, TENOSYNOVITIS	
41780	261	OSTEOTOMIES (AS A SINGLE OPERATION)	
41798	262	PSEUDOARTHROSIS OF THE LONG BONES	
41806	263	PSEUDARTHROSIS OF THE CARPAL SCAPHOID	
46813	264	SECONDARY RECONSTRUCTION OF THE THUMB OR OTHER FINGERS BY MICROSURGERY	
42093	265	FINGER STIFFNESS	
42101	266	REVASCULARIZATION OF A LIMB OR SEGMENT (AS A SINGLE OPERATION)	
56200	267	RIZOARTROSI	
48801	268	CANALICULAR SYNDROMES COMPLETE TREATMENT (CARPAL TUNNEL, GUYON'S SYNDROME, COMPRESSION OF THE ULNAR NERVE AT THE EPITROCLEO-OLEOCRANIAL SHOWER, ETC.)	
42192	269	SYNOVECTOMY (AS A SINGLE OPERATION)	
42200	270	MICROSURGICAL TREATMENT OF BRACHIAL PLEXUS LESIONS	

56226	271	TUMOURS OF ANY TYPE, EXERESIS OR EXCISION EN BLOC	
Foot Surgery			
Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation. Missing items in Foot Surgery: see also Orthopaedics and Traumatology, and Reconstructive Plastic Surgery. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
59573	272	HALLUX RIGIDUS INCLUDING SURGICAL CORRECTION OF ASSOCIATED INTERPHALANGEAL DEFORMITIES INCLUDING POSSIBLE ARTHROPLASTY (COMPLETE TREATMENT)	
48496	273	HALLUX VALGUS INCLUDING SURGICAL CORRECTION OF ASSOCIATED INTERPHALANGEAL DEFORMITIES INCLUDING POSSIBLE ARTHROPLASTY (COMPLETE TREATMENT)	
59994	274	TARSAL AMPUTATION	
59766	275	PHALANGEAL AMPUTATIONS	
59774	276	METATARSAL AMPUTATIONS	
59581	277	PLANTAR APONEURECTOMY	
59782	278	METATARSOPHALANGEAL ARTHRODESIS	
59790	279	ARTHRODESIS OF TARSAL BONES (ISOLATED SUBASTRAGALIC; SUBASTRAGALIC AND ASTRAGALUS-SCAPHOID-CUNEIFORM; ASTRAGALUS-SCAPHOID AND ASTRAGALUS-SCAPHOID-CUNEIFORM, LISFRANC; ETC.)	
59808	280	TIBIO-TARSAL ARTHRODESIS (TIBIO-TARSAL AND SUBASTRAGALIC; TIBIO-TARSAL AND SUBASTRAGALIC AND CHEILOPLASTY; ETC.)	
57139	281	TIBIO-TARSAL ARTHROPLASTY (COMPLETE TREATMENT)	
57147	282	REMOVAL OF ACCESSORY SCAPHOID BONE	
54627	283	CALCANEO-STOP	
57155	284	SYNOVIAL CYSTS, REMOVAL OF	
57163	285	CYSTS OR TENDON AND/OR ARTHROGENIC GANGLIA, REMOVAL OF	
59598	286	CORRECTION OF FLAT FOOT, SOFT PARTS AND/OR BONES	
48512	287	CORRECTION OF CONGENITAL CLUBFOOT, SOFT AND/OR BONE PARTS	
55228	288	BOUTONNIERE DEFORMITY OF THE TOES	
48504	289	HAMMERTOE INCLUDING POSSIBLE ARTHROPLASTY (COMPLETE TREATMENT)	
59606	290	PLANTAR FASCIOTOMY WITH REMOVAL OF CALCANEAL SPUR	
57171	291	BIMALLEOLAR FRACTURE WITH OR WITHOUT TIBIO-ASTRAGALIC DISLOCATION INVASIVE TREATMENT AND POSSIBLE CAPSULAR LIGAMENT SUTURE	
57180	292	HEEL FRACTURE INVASIVE TREATMENT WITH OR WITHOUT GRAFT	
57198	293	ISOLATED TIBIAL MALLEOLUS FRACTURE INVASIVE TREATMENT	
57206	294	ISOLATED FRACTURE OF PERONEAL MALLEOLUS INVASIVE TREATMENT	
57214	295	TRIMALLEOLAR FRACTURE WITH OR WITHOUT TIBIO ASTRAGALIC DISLOCATION INVASIVE TREATMENT	

57222	296	TALUS FRACTURES INVASIVE TREATMENT	
48314	297	NECK-FOOT JOINT LIGAMENTS (ANY TECHNIQUE), RECONSTRUCTION OF	
57230	298	LYSIS OF DISTAL TIBIAL PERONEAL SYNDESMOSIS	
56622	299	MORTON'S NEUROMA, SURGERY FOR	
54866	300	METATARSAL REALIGNMENT WITH MULTIPLE METATARSAL OSTEOTOMIES	
56630	301	CANALICULAR SYNDROMES OF THE FOOT	
57249	302	RETINACULUM LESION, SUTURE OR RECONSTRUCTION SURGERY	
57257	303	TENOPLASTY	
57265	304	TENO-VAGINOLYSIS (AS A PHASE OF THE MAIN SURGERY)	
57273	305	TENO-VAGINOLYSIS (AS A SINGLE OPERATION)	
57281	306	TENDON TRANSPOSITIONS AND TRANSPLANTS	
57298	307	SURGICAL TREATMENT OF FRACTURES AND DISLOCATIONS IN THE TARSUS AND METATARSUS BONES	
57306	308	SURGICAL TREATMENT OF FRACTURES AND DISLOCATIONS OF THE PHALANGES	

Dermatological surgery - Cryotherapy - Laser therapy

Nerve mapping is included in specialist consultations and/or treatments. All aesthetic treatments (peelings, dermabrasion, fillers and others) and/or anything related to these and/or resulting from previous aesthetic treatments are excluded, even if the items are referred to in this section. Superficial tumours are defined as suprafascial neoplasms; deep tumours are defined as subfascial neoplasms. In the case of outpatient operations for the removal of malignant tumours, if included in the Cover of the individual Health Plan and regardless of the surgical technique used, submission of the histological examination report is also mandatory for the refund to be recognised. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for the removal of benign tumours; as set out under Warnings and in the introductions to this section, we therefore urge you to arrange in advance for these to be taken. The items apply to surgical operations carried out using any technique instrumentation instrumentation/equipment. Please note that the term “single session” is meant regardless of the location (body part) and number of removals. Please also note that dermabrasion is equatable solely with the code/service of diathermocoagulation and/or cryotherapy.

Laser and/or surgical treatments for telangiectasia, cherry angiomas, spider angiomas and similar are not deemed to be refundable services regardless of location and Health Plan (with no exceptions). Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted. For missing items in Dermatological Surgery: also see Reconstructive Plastic Surgery (for which the same specifications apply).

49999	309	LASER REMOVAL OF BENIGN TUMOURS OF THE SKIN OR MUCOUS MEMBRANES OF THE TRUNK/HEAD, EXCLUDING ANGIOMAS, SPIDER ANGIOMAS AND BLEMISHES (SINGLE SESSION)	Refundable maximum 5 sessions per year (1 January - 31 December)
55178	311	DIATHERMOCOAGULATION OR CRYOTHERAPY FOR ONE OR MORE LESIONS, ALTERATIONS, NON-VIRAL NEOFORMATIONS EXCEPT FOR THE CASES DESCRIBED (PER SESSION)	Refundable maximum 5 sessions per year (1 January - 31 December)
58331	6011	DIGITAL EPILUMINESCENCE, ANY EQUIPMENT INCLUDING DERMATOLOGICAL EXAMINATION	Refundable once a year (1 January - 31 December). Not refundable in the same year as Melanoma Prevention (where included in the Health Plan)
57314	313	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH SMALL ROTATIONAL OR SLIDING SKIN FLAP	
57322	314	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH LARGE ROTATIONAL OR SLIDING SKIN FLAP	

51060	315	LASER TREATMENT OF VIRAL SKIN ALTERATIONS (WARTS, CONDYLOMAS, ETC.) - PER SESSION REGARDLESS OF THE TYPE OF VIRAL SKIN ALTERATION AND/OR THE NUMBER OF ALTERATIONS TREATED PER SESSION	Refundable maximum 5 sessions per year (1 January - 31 December)
57330	317	SUPERFICIAL MALIGNANT CUTANEOUS TUMOUR OF THE TRUNK/LIMBS, SURGERY FOR	
57349	318	SUPERFICIAL OR SUBCUTANEOUS BENIGN TUMOUR OR CYST OR LIPOMA OF THE TRUNK/LIMBS, WARTS, REMOVAL OF	
55095	319	LASER TREATMENT FOR CUTANEOUS MALIGNANCIES (COMPLETE TREATMENT, INCLUDING ALL SESSIONS)	
57357	320	DEEP CUTANEOUS MALIGNANT TUMOUR OF THE HEAD, REMOVAL OF	
57365	321	DEEP CUTANEOUS MALIGNANT TUMOUR OF THE TRUNK/LIMBS, REMOVAL OF	
57373	322	SUPERFICIAL MALIGNANT CUTANEOUS TUMOUR OF THE HEAD, SURGERY FOR	
57381	323	SUPERFICIAL TUMOUR OR BENIGN CYST OF THE HEAD, SURGERY FOR	

General Surgery

Minor surgical operations

Superficial tumours are defined as suprafascial neoformations; deep tumours are defined as subfascial neoformations; deep extracavitary tumours are defined as: tumour of the skeletal muscle, tumour or fibrous tumour-like lesion. Therapeutic injection treatments are defined as: treatment using botulinum toxin for anal fissures and treatment using sclerosing agents for haemorrhoids (no other types are included). In the case of outpatient operations for the removal of malignant tumours, if included in the Cover of the individual Health Plan and regardless of the surgical technique used, submission of the histological examination report is also mandatory for the refund to be recognised. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for the removal of benign tumours; as set out under Warnings and in the introductions to this section, we therefore urge you to arrange in advance for these to be taken. The items relate to surgical operations carried out using any technique (traditional, endoscopic or with other instruments/equipment).

Dressings (simple and/or advanced) for any type of wound or skin ulcer are not refundable if provided on an out-patient basis regardless of the Health Plan, while during hospitalisation (any) they are included within the relevant procedures.

Please note that some tests, set out in the sub-sections, can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

42390	324	PERIPHERAL ACCESS FOR POSITIONING OF VENOUS CATHETER	
40816	325	NEEDLE ASPIRATION/AGOBIOPSIES, OF ANY ANATOMICAL PART, EXCEPTING THE CASES DESCRIBED IN THE RESPECTIVE SECTIONS	
40295	326	DIFFUSE ABSCESS OR PHLEGMON, INCISION OF	
40303	327	SUBAPONEUROTIC ABSCESS OR PHLEGMON, RADICAL SURGICAL TREATMENT OF	
40287	328	SUPERFICIAL AND CIRCUMSCRIBED ABSCESS OR PHLEGMON, INCISION OF	
40329	329	BIOPSY AS A SINGLE SURGICAL PROCEDURE, ANY ANATOMICAL PART, EXCEPTING THE CASES DESCRIBED IN THE RESPECTIVE SECTIONS	
40246	330	SYNOVIAL CYSTS, REMOVAL OF	
40279	331	DEEP EXTRACAVITARY FOREIGN BODY, EXTRACTION OF	
40261	332	SUPERFICIAL FOREIGN BODY, EXTRACTION OF	

40402	333	SCALP, LARGE WOUND AND REMOVAL OF	
40352	334	SUPERFICIAL HAEMATOMA, EMPTYING OF	
42408	335	EXTRACAVITARY DEEP HEMATOMAS, EMPTYING OF	
42598	336	EXPLANTATION OF PERITONEAL CATHETER	
59106	337	CVC REMOVAL (AS A SINGLE SERVICE)	
59114	338	REMOVAL OF IMPLANTABLE VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE)	
40428	339	DEEP WOUND OF THE FACE, SUTURING OF	
40360	340	DEEP WOUND, SUTURING OF	
40410	341	SUPERFICIAL WOUND OF THE FACE, SUTURING OF (EXCLUDING THOSE OF OPHTHALMIC RELEVANCE)	
40378	342	SUPERFICIAL WOUND, SUTURE OF (EXCLUDING THOSE OF RELEVANT TO OPHTHALMOLOGY)	
45443	343	PERIPHERAL ARTERIOVENOUS FISTULA, PREPARATION OF	
42978	344	SURGICAL IMPLANTATION OF PERITONEAL CATHETER	
42986	345	CVC IMPLANTATION (AS A SINGLE SERVICE)	
57398	346	IMPLANTATION OF VENOUS SYSTEMS SUCH AS PORT-A-CATH, GROSHONG AND SIMILAR (AS A SINGLE SERVICE) WITH POSSIBLE ULTRASOUND GUIDANCE	
40345	347	DEEP AND BONE WHITLOW, SURGERY FOR	
40337	349	SUPERFICIAL WHITLOW, SURGERY FOR	
40238	350	EXTRACAVITARY DEEP TUMOUR, REMOVAL OF	
59122	351	DEEP CUTANEOUS MALIGNANT TUMOUR OF THE TRUNK/LIMBS, REMOVAL OF	
40220	352	SUPERFICIAL CUTANEOUS MALIGNANT TUMOUR OF THE TRUNK/LIMBS, REMOVAL OF	
40212	353	SUPERFICIAL OR SUBCUTANEOUS BENIGN TUMOUR OR CYST OR LIPOMA OF THE TRUNK/LIMBS, WARTS, REMOVAL OF	
40386	354	INGROWN TOENAIL, REMOVAL OF (INCLUDING PLASTIC - COMPLETE TREATMENT)	
Neck			
40832	356	ABSCESSES, FAVI, PHLEGMONAE, INCISION AND DRAINAGE OF	
40824	357	PRESCALENIC BIOPSY	
40873	358	CONGENITAL CYST OR FISTULA, REMOVAL OF	
42994	359	OESOPHAGO-TRACHEAL FISTULA, SURGERY FOR	
40923	360	UNILATERAL CERVICAL LYMPHADENECTOMY (AS A SINGLE OPERATION)	
41038	361	BILATERAL CERVICAL LYMPHADENECTOMY (AS A SINGLE OPERATION)	
40931	362	SUPRACLAVICULAR LYMPHADENECTOMY (AS A SINGLE OPERATION)	
41012	363	LYMPH NODES, SURGICAL REMOVAL OF FOR DIAGNOSTIC PURPOSES (AS A SINGLE OPERATION)	

40949	364	PARATHYROIDS - COMPLETE TREATMENT, OPERATION ON	
43000	365	PARATHYROIDS, REINTERVENTIONS	
40881	366	THYROID, ENUCLEATION OF CYSTIC TUMOURS OR SOLITARY ADENOMAS	
43463	367	THYROID, LOBECTOMIES	
40956	368	SUBTOTAL THYROIDECTOMY	
56234	369	TOTAL THYROIDECTOMY, OR TOTAL THYROIDECTOMY, ANY ROUTE OF ACCESS, WITHOUT LATEROCERVICAL EMPTYING	
59130	370	TOTAL THYROIDECTOMY FOR MEDIASTINAL GOITER, SURGERY FOR	
43497	371	TOTAL THYROIDECTOMY FOR MALIGNANT NEOPLASMS WITH UNILATERAL LATEROCERVICAL EMPTYING	
40980	372	TOTAL THYROIDECTOMY FOR MALIGNANT NEOPLASMS WITH BILATERAL LATEROCERVICAL EMPTYING	
43646	373	TRACHEOSTOMY, CLOSURE AND PLASTIC	
40105	374	TRACHEOTOMY WITH EMERGENCY TRACHEOSTOMY	
43653	375	TRACHEOTOMY WITH ELECTIVE TRACHEOSTOMY	
40840	376	LARYNGO-TRACHEAL AND PHARYNGO-OESOPHAGEAL TUBE, SURGERY FOR WOUNDS OF	
40899	377	MALIGNANT TUMOUR OF THE NECK, REMOVAL OF (EXCLUDING DESCRIBED CASES)	
Oesophagus			
41137	378	CERVICAL OESOPHAGEAL DIVERTICULA (INCLUDING MYOTOMY), SURGERY FOR	
41145	379	DIVERTICULA OF THE THORACIC OESOPHAGUS, SURGERY FOR	
41210	380	TOTAL OESOPHAGECTOMY WITH OESOPHAGOPLASTY, IN ONE SESSION, INCLUDING LYMPHADENECTOMY	
41129	381	OESOPHAGITIS, OESOPHAGEAL ULCER (INCLUDING ANTIREFLUX PLASTIC AND/OR VAGOTOMY), SURGERY FOR	
41202	382	CERVICAL OESOPHAGUS, RESECTION OF, WITH OESOPHAGOSTOMY	
41186	383	OESOPHAGUS, PARTIAL RESECTION OF, WITH OESOPHAGOSTOMY	
41509	384	TOTAL OESOPHAGUS-GASTRECTOMY, VIA THORACIC-LAPAROTOMY AND POSSIBLE LYMPHADENECTOMY	
56242	385	OESOPHAGOMYOTOMY (ALSO ENDOSCOPIC - AS A SINGLE OPERATION)	
41194	386	OESOPHAGOSTOMY (AS A SINGLE OPERATION)	
41111	387	TRAUMATIC OR SPONTANEOUS LESIONS, FOREIGN BODIES, BENIGN TUMOURS, BIOPSY AND NON-ENDOSCOPIC CAUTERISATION	
41244	388	MEGAOESOPHAGUS, SURGERY FOR	
41251	389	MEGAOESOPHAGUS, REINTERVENTION FOR	
41269	390	ENDO-OESOPHAGEAL PROSTHESES, PLACEMENT OF	
41335	391	OESOPHAGEAL PROBING FOR GRADUAL DILATATION - FIRST SESSION	
41343	392	OESOPHAGEAL PROBING FOR GRADUAL DILATATION - SUBSEQUENT SESSIONS	

43661	393	BENIGN STENOSIS OF THE OESOPHAGUS, SURGERY FOR	
43679	394	OESOPHAGEAL STENOSIS, ENDOSCOPIC LASER TREATMENT	
41160	395	OESOPHAGEAL VARICES: TRANSTHORACIC OR ABDOMINAL SURGERY	
Stomach - Duodenum			
59149	396	GASTRIC BANDING FOR THE TREATMENT OF MORBID OBESITY, ANY TECHNIQUE	
43695	397	DUMPING SYNDROME, RECONVERSION SURGERY FOR	
42333	398	HIATAL HERNIA, SURGERY FOR (INCLUDING ANTI-REFLUX PLASTIC AND/OR DIAPHRAGMATIC PILLAR PLASTIC)	
41533	399	GASTRO-DIGIUNAL-COLIC FISTULA, SURGERY FOR	
56259	400	PARTIAL OR SUBTOTAL GASTRECTOMY (INCLUDING POSSIBLE LYMPHADENECTOMY)	
41491	401	TOTAL GASTRECTOMY WITH LYMPHADENECTOMY, INCLUDING EXTENDED	
57414	402	TOTAL GASTRECTOMY WITH EXTENDED LYMPHADENECTOMY WITH ASSOCIATED LEFT SPLENOPANCREASECTOMY	
41483	403	TOTAL GASTRECTOMY FOR BENIGN PATHOLOGY	
41566	404	PYLOROPLASTY (AS A SINGLE OPERATION)	
59165	405	POSITIONING OF BIB (BIOENTERYCS INTRAGASTRIC BALLON) FOR MORBID OBESITY	
43703	406	GASTRO DUODENAL RESECTION	
41525	407	GASTRO-DIGIUNAL RESECTION FOR ANASTOMOTIC PEPTIC ULCER	
59173	408	REMOVAL OF BIB (BIOENTERYCS INTRAGASTRIC BALLON) FOR MORBID OBESITY	
41574	409	SELECTIVE AND/OR SUPERSELECTIVE VAGOTOMY WITH POSSIBLE PYLOROPLASTY	
57422	410	SELECTIVE AND/OR SUPERSELECTIVE VAGOTOMY WITH POSSIBLE PYLOROPLASTY (AS MAIN PHASE OF SURGERY)	
56267	411	GASTRIC VARICES (SURGICAL HAEMOSTASIS)	
Intestine: Jejunum - Ileum - Colon - Rectum - Anus			
41988	412	MILES ABDOMINAL-PERINEAL RESECTION, COMPLETE TREATMENT	
41715	413	PRETERNATURAL ANUS, CLOSURE, CONTINUITY RECONSTRUCTION	
56283	414	ANOPLASTY AND PERINEOPLASTY (AS A SINGLE OPERATION)	
41624	415	APPENDECTOMY WITH DIFFUSE PERITONITIS	
41616	416	SIMPLE COLD APPENDECTOMY (ANY TECHNIQUE)	
41913	417	ABSCESS OR FISTULA OF THE ISCHIO-RECTAL CAVITY, SURGERY FOR	
41905	418	PERIANAL ABSCESS, SURGERY FOR	
44024	419	GASTROINTESTINAL OR INTESTINAL BYPASS FOR MALIGNANT DISEASES	
44032	420	INTESTINAL BYPASS FOR THE TREATMENT OF MORBID OBESITY	

41954	421	DERMOID CYST, SACRO-COCCYGEAL FISTULA (INCLUDING RECURRENT), SURGERY FOR	
41632	422	SEGMENTAL COLECTOMY (INCLUDING POSSIBLE OSTOMY)	
41640	423	SEGMENTAL COLECTOMY WITH LYMPHADENECTOMY AND POSSIBLE COLOSTOMY	
41657	424	TOTAL COLECTOMY (INCLUDING POSSIBLE OSTOMY)	
41665	425	TOTAL COLECTOMY WITH LYMPHADENECTOMY (INCLUDING POSSIBLE OSTOMY)	
44040	426	COLOTOMY WITH COLORRAPHY (AS A SINGLE OPERATION)	
56291	427	PERINEAL-ANAL CONDYLOMA ACUMINATA, SURGERY FOR (ANY TECHNIQUE, COMPLETE TREATMENT)	
44057	428	CONSTRUCTION OF ARTIFICIAL ANUS (AS A SINGLE OPERATION)	
44065	429	CONSTRUCTION OF CONTINENT ILEOSTOMY (AS A SINGLE OPERATION)	
41871	430	FOREIGN BODIES IN THE RECTUM, SIMPLE NATURAL EXTRACTION OF	
41897	431	FOREIGN BODIES IN THE RECTUM, ABDOMINAL EXTRACTION OF	
41889	432	FOREIGN BODIES IN THE RECTUM, EXTRACTION WITH SPHINCTEROTOMY OF (INCLUDING ANOPLASTY)	
44073	433	DIJUNOSTOMY (AS A SINGLE OPERATION)	
44081	434	MECKEL'S DIVERTICULA, RESECTION OF	
44099	435	DUODENAL JEJUNOSTOMY (AS A SINGLE OPERATION)	
41731	436	RIGHT HEMICOLECTOMY WITH LYMPHADENECTOMIES	
41749	437	LEFT HEMICOLECTOMY WITH LYMPHADENECTOMIES AND POSSIBLE COLOSTOMY (HARTMANN AND OTHERS)	
55079	438	HAEMORRHOIDS (CRYOSURGERY OR DIATHERMOCOAGULATION COMPLETE TREATMENT)	
44685	439	HAEMORRHOIDS (LASER SURGERY COMPLETE TREATMENT)	
44107	440	HAEMORRHOIDS AND FISSURES (CRYOSURGERY COMPLETE TREATMENT)	
44669	441	HAEMORRHOIDS AND FISSURES (LASER SURGERY COMPLETE TREATMENT)	
44651	442	HAEMORRHOIDS AND RHAGADES, RADICAL SURGERY FOR (INCLUDING MUCOUS PROLAPSE TREATMENT - ALSO RECTAL, SPHINCTEROTOMY - ANOPLASTY) - ANY METHOD, ANY EQUIPMENT / INSTRUMENTATION	
44677	443	HAEMORRHOIDS: THERAPEUTIC INJECTION TREATMENTS AND/OR ELASTIC LIGATION - PER SESSION	
41962	444	HAEMORRHOIDS, RADICAL SURGERY (INCLUDING MUCOUS PROLAPSE TREATMENT - ALSO RECTAL, SPHINCTEROTOMY - ANOPLASTY) - ANY METHOD, ANY EQUIPMENT / INSTRUMENTATION	
41699	446	ENTEROSTOMY (AS A SINGLE OPERATION)	
41939	447	EXTRASPHINCTERIC ANAL FISTULA	
41921	448	INTRASPHINCTERIC ANAL FISTULA	
44701	449	ANAL FISTULAS (LASER SURGERY, COMPLETE TREATMENT)	
42077	450	ANAL INCONTINENCE, SURGERY FOR (COMPLETE TREATMENT)	
41764	451	INVAGINATION, VOLVULUS, INTERNAL HERNIAS, SURGERY FOR	

41772	452	MEGACOLON, SURGERY FOR	
46219	453	MEGACOLON: COLOSTOMY	
44727	454	MIKULICZ, EXTRINSIC SEC.	
44735	455	RECTO-COLON POLYPECTOMY VIA LAPAROTOMY	
57430	456	TRANSANAL RECTAL POLYP, REMOVAL OF (AS A SINGLE OPERATION) - ANY TECHNIQUE, ANY INSTRUMENTATION/EQUIPMENT	
59181	457	POSITIONING OF COLON PROSTHESIS	
59198	458	POSITIONING OF RECTAL PROSTHESIS	
44743	459	TOTAL PROCTO-COLECTOMY WITH ILEAL POUCH	
42002	460	RECTAL PROLAPSE INCLUDING TREATMENT OF HAEMORRHOIDS, TRANSANAL SURGERY FOR (AS A SINGLE OPERATION) - ANY TECHNIQUE - ANY INSTRUMENTATION/EQUIPMENT	
44750	461	RECTAL PROLAPSE INCLUDING TREATMENT OF HAEMORRHOIDS, LAPAROTOMY SURGERY FOR	
41970	462	ANAL RHAGADE, SURGICAL TREATMENT WITH SPHINCTEROTOMY	
44768	463	RHAGADES, CRYOSURGERY FOR (COMPLETE TREATMENT)	
44776	464	RHAGADES, LASER SURGERY FOR (COMPLETE TREATMENT)	
59206	465	RESECTION OF THE SIGMA-RECTUM FOR BENIGN PATHOLOGY	
59214	466	RESECTION OF THE SIGMA-RECTUM FOR MALIGNANT PATHOLOGY WITH POSSIBLE ASSOCIATED LYMPHADENECTOMIES	
59222	467	ANTERIOR RECTO-COLIC RESECTION (ALSO ULTRA-LOW) INCLUDING LYMPHADENECTOMY AND POSSIBLE COLOSTOMY	
59230	468	RECTUM, AMPUTATION OF, FOR NEOPLASM OF THE ANUS, INCLUDING POSSIBLE BILATERAL INGUINAL LYMPHADENECTOMY	
41996	469	SPHINCTEROTOMY (AS A SINGLE OPERATION)	
56309	470	MALIGNANT TUMOUR OF THE RECTUM, VIA TRANSANAL OR TRANSANAL ENDOSCOPIC MICROSURGERY (TEM), REMOVAL OF	
41756	471	EXTENDED VISCEROLYSIS (ENTEROPLICATION), SURGERY FOR (AS A SINGLE OPERATION)	
57449	472	EXTENDED VISCEROLYSIS (ENTEROPLICATION), SURGERY FOR (AS THE MAIN OPERATION STAGE)	
Abdominal wall			
44800	473	CYSTS, HAEMATOMAS, ABSCESSES, PHLEGMON ABDOMINAL WALL	
42374	474	DIASTASIS RECTI (AS A SINGLE OPERATION), SURGERY FOR	
42275	475	RECURRENT CRURAL HERNIA (INCLUDING MESH REMOVAL)	
42259	476	SIMPLE CRURAL HERNIA	
42267	477	STRANGULATED CRURAL HERNIA	
42309	478	EPIGASTRIC HERNIA	

42317	479	STRANGULATED OR RECURRENT EPIGASTRIC HERNIA (INCLUDING MESH REMOVAL)	
42234	480	INGUINAL HERNIA WITH TESTICULAR ECTOPIA	
42242	481	RECURRENT INGUINAL HERNIA (INCLUDING MESH REMOVAL)	
42218	482	SIMPLE INGUINAL HERNIA	
42226	483	STRANGULATED INGUINAL HERNIA	
42283	484	UMBILICAL HERNIA	
44966	485	RECURRENT INGUINAL HERNIA (INCLUDING MESH REMOVAL)	
42358	486	RARE HERNIAS (ISCHIAL, OBTURATOR, LUMBAR, PERINEAL)	Refundable once per surgical operation
42366	487	LAPAROCELE, SURGERY FOR	
42143	488	UNILATERAL INGUINAL OR CRURAL LYMPHADENECTOMY (AS A SINGLE OPERATION)	
42184	489	BILATERAL INGUINAL OR CRURAL LYMPHADENECTOMY (AS A SINGLE OPERATION)	
56317	490	LAPAROTOMIC LYMPHADENECTOMY (AS A SINGLE OPERATION)	
59249	491	SENTINEL LYMPH NODE, REMOVAL OF (INCLUDING SERVICES OF NUCLEAR MEDICINE PHYSICIAN/RADIOLOGIST) (AS A SINGLE OPERATION)	
42325	492	DIAPHRAGMATIC PROLAPSE, SURGERY FOR	
Peritoneum			
42424	493	DOUGLAS ABSCESS, DRAINAGE	
42416	494	SUBPHRENIC ABSCESS, DRAINAGE	
42432	495	EXPLORATORY/DIAGNOSTIC LAPAROSCOPY (INCLUDING BIOPSIES)	
42499	496	LAPAROTOMY WITH LESION TO INTERNAL PARENCHYMAL ORGANS REQUIRING HAEMOSTASIS	
42515	497	LAPAROTOMY WITH INTESTINAL RESECTION (INCLUDING OSTOMY)	
42457	498	EXPLORATORY LAPAROTOMY AND/OR LYSIS OF ADHESIONS (AS A SINGLE OPERATION)	
44974	499	EXPLORATORY LAPAROTOMY AS MAIN OPERATION FOR UNRESECTABLE NEOPLASMS OR FOR STAGING OF LYMPHADENOPATHIES	
42481	500	LAPAROTOMY FOR CONTUSIONS AND WOUNDS TO THE ABDOMEN WITHOUT LESIONS TO INTERNAL ORGANS	
44982	501	LAPAROTOMY FOR LESIONS OF INTERNAL PARENCHYMAL ORGANS REQUIRING EXCISION	
42507	502	LAPAROTOMY FOR GASTRO-INTESTINAL LESIONS REQUIRING SUTURING	
42465	503	LAPAROTOMY FOR DIFFUSE PERITONITIS	
42473	504	LAPAROTOMY FOR SACCATE PERITONITIS	
44990	505	DIAGNOSTIC PERITONEAL LAVAGE	
56325	506	LAPAROSCOPIC LYMPHADENECTOMY (AS A SINGLE OPERATION)	
42549	507	INTESTINAL OBSTRUCTION WITH RESECTION	

42531	508	INTESTINAL OBSTRUCTION WITHOUT RESECTION	
56896	509	OMENTECTOMY AND/OR PERITONECTOMY (AS THE MAIN PHASE OF SURGERY)	
42580	510	PARACENTESIS (WITH OR WITHOUT ENDOCAVITARY DRUG ADMINISTRATION)	
42523	511	RETROPERITONEAL TUMOUR OR FIBROSIS (INCLUDING URETEROLYSIS AND EXTENSIVE VISCEROLYSIS), SURGERY FOR (COMPLETE TREATMENT)	
Liver and Biliary Tract			
42804	512	NEEDLE BIOPSY/NEEDLE ASPIRATION (ANY NUMBER OF SAMPLES)	
42895	513	PORTOCAVAL OR SPLENIC-RENAL OR MESENTERIC-CAVA ANASTOMOSIS	
42614	514	ABSCESSES, CYSTS (OF ANY KIND), CAVERNOUS ANGIOMAS, SURGERY FOR	
45005	515	LIVER BIOPSY (AS A SINGLE OPERATION)	
45153	516	INTRAHEPATIC STONES, SURGERY FOR	
42648	517	SIMPLE LAPAROSCOPIC CHOLECYSTECTOMY (INCLUDING LYSIS OF ADHESIONS)	
57457	518	LAPAROSCOPIC CHOLECYSTECTOMY WITH INTRAOPERATIVE CHOLANGIOGRAPHY AND EXPLORATION OF THE BILIARY TRACT AND POSSIBLE STONE EXTRACTION (INCLUDING RADIOLOGIST ASSISTANCE) (INCLUDING LYSIS OF ADHESIONS)	
57465	519	LAPAROSCOPIC CHOLECYSTECTOMY WITH CHOLEDOCHOLITHOTOMY AND STONE EXTRACTION (INCLUDING CHOLANGIOGRAPHY AND RADIOLOGIST ASSISTANCE) (INCLUDING LYSIS OF ADHESIONS)	
56333	520	LAPAROTOMIC CHOLECYSTECTOMY (INCLUDING LYSIS OF ADHESIONS)	
42663	521	CHOLECYSTOGASTROSTOMY OR CHOLECYSTENTEROSTOMY	
42705	522	CHOLECYSTOSTOMY FOR UNRESECTABLE NEOPLASMS	
42697	523	CHOLEDOCAL/HEPATIC/DIGIUNAL/DUODENOSTOMY WITH OR WITHOUT CHOLECYSTECTOMY	
42689	524	CHOLEDOCAL-HEPATIC JEJUNOSTOMY WITH OR WITHOUT CHOLECYSTECTOMY	
42671	525	CHOLEDOCAL-HEPATIC DUODENOSTOMY WITH OR WITHOUT CHOLECYSTECTOMY	
42655	526	CHOLEDOCHOTOMY AND CHOLEDOCHOLITHOTOMY (AS A SINGLE OPERATION)	
45179	527	HEPATIC DEARTERIALISATION, WITH OR WITHOUT CHEMOTHERAPY	
42911	528	AZYGOS-PORTAL DECONNECTION BY ABDOMINAL ROUTE	
45187	529	INTRA-HEPATIC DIGESTIVE BILE DRAINAGE	
42747	530	HEPATIC ARTERY CANNULATION FOR ANTIBLASTIC PERFUSION	
45195	531	PAPILLA OF VATER, EXERESIS	
57473	532	PAPILLA OF VATER, AMPULLECTOMY FOR CANCER WITH RE-IMPLANTATION OF WIRSUNG DUCT AND COMMON BILE DUCT	
42713	533	PAPILLOSTOMY, VIA TRANSDUODENAL ROUTE AND POSSIBLE REMOVAL OF STONES (AS A SINGLE OPERATION)	
42721	534	PAPILLOTOMY, ENDOSCOPIC (AS A SINGLE OPERATION)	

42630	535	MAJOR HEPATIC RESECTIONS	
45203	536	MINOR HEPATIC RESECTIONS	
56341	537	SURGICAL REPAIR FOR LACERATION OF THE HEPATIC PARENCHYMA	
59257	538	RADIOFREQUENCY THERMOABLATION OF PRIMARY HEPATIC TUMOURS, ANY ACCESS ROUTE	
45260	539	LIVER TRANSPLANT (ALL-INCLUSIVE OF SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
45708	540	BILIARY TRACT, PALLIATIVE INTERVENTIONS	
42739	541	BILIARY TRACT, REINTERVENTIONS	
Pancreas - Spleen			
42960	542	NEEDLE BIOPSY/ PANCREATIC ASPIRATION	
45716	543	PANCREATIC ABSCESSES AND/OR CYSTS, DRAINAGE OF	
45724	544	BIOPSY OF THE PANCREAS (AS A SINGLE OPERATION)	
45740	545	CEPHALODUODENUM PANCREASECTOMY INCLUDING POSSIBLE LYMPHADENECTOMY	
45732	546	PANCREATIC DENERVATION (AS A SINGLE OPERATION)	
42812	547	PANCREATIC-WIRSUNG DIGESTIVE DERIVATIVES	
42853	548	PANCREATIC FISTULA, SURGERY FOR	
56358	549	INTERNAL OR EXTERNAL MARSUPIALIZATION OF PANCREATIC CYSTS	
42945	550	SPLEEN, CONSERVATIVE SURGERY (SPLENORRHAPHY, SPLENIC RESECTIONS)	
45757	551	ENDOCRINE PANCREATIC NEOPLASMS, SURGERY FOR	
45765	552	LEFT PANCREATECTOMY INCLUDING SPLENECTOMY AND POSSIBLE LYMPHADENECTOMY	
42861	553	TOTAL PANCREATECTOMY (INCLUDING POSSIBLE LYMPHADENECTOMY)	
45773	554	ACUTE PANCREATITIS, CONSERVATIVE SURGERY	
45781	555	ACUTE PANCREATITIS, DEMOLITION SURGERY	
42838	556	PSEUDOCYST WITH DIJUNOSTOMY OR OTHER SHUNT, SURGERY FOR	
42929	557	SPLENECTOMY	
45799	558	TRANSPLANTATION OF PANCREAS (INCLUSIVE OF ALL SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
Oral - maxillo - facial surgery			

All services/operations listed below are understood as being carried out by a specialist in maxillofacial surgery using any technique, equipment/instrumentation (inclusive), at an authorised healthcare facility for day surgery or overnight hospitalisation.

For certain surgical procedures carried out on an outpatient basis at a clinic/surgery/medical facility/authorised dental service for dentistry and dental prostheses (for the MOSAIC Plan limited to those with direct affiliation), even if carried out by a surgeon specialising in oral-maxillofacial surgery, reference should be made to the provisions of the Dentistry section if these are included in the services provided by the Fund and/or your Health Plan.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

56366	559	BIOPSY OF THE SALIVARY GLANDS	
57481	560	TEMPORO MANDIBULAR ARTHROCENTESIS WITH OR WITHOUT INTRODUCTION OF MEDICATION, REGARDLESS OF WHETHER UNILATERAL OR BILATERAL	Refundable maximum 3 sessions per year (1 January - 31 December).
57498	561	REMOVAL OF SOLID AND/OR CYSTIC BENIGN SUPERFICIAL OR DEEP NEOFORMATIONS OF THE TONGUE OR ORAL CAVITY	
57506	562	BIOPSY OR REMOVAL OF SUPERFICIAL NON-CUTANEOUS TUMOURS	
40774	563	SALIVARY CALCULUS, REMOVAL OF	
57514	564	CATHETERISATION OF SALIVARY DUCT	
40675	565	CYSTS OF THE JAW, OPERATION FOR	
56374	566	CYSTS AND FISTULAS OF THE SALIVARY GLANDS, INCISION AND/OR DRAINAGE	
40527	567	CONDYLECTOMY WITH CONDYLOPLASTY FOR ANKYLOSIS OF THE TEMPOROMANDIBULAR JOINT, UNILATERAL	
46334	568	CONDYLECTOMY WITH CONDYLOPLASTY FOR ANKYLOSIS OF THE TEMPOROMANDIBULAR JOINT, BILATERAL	
46342	569	DEEP FOREIGN BODIES OF SOFT TISSUE, ORAL CAVITY AND/OR FACE, REMOVAL OF	
46359	570	SUPERFICIAL FOREIGN BODIES OF THE SOFT TISSUES OF THE ORAL CAVITY AND/OR FACE, REMOVAL OF	
57522	571	DACRYOCYSTORHINOSTOMY OR INTUBATION	
57530	572	TEMPOROMANDIBULAR DYSFUNCTION, SURGICAL THERAPY FOR	
46367	573	LABIAL OUTCOMES OF CLEFT LIP AND PALATE	
46375	574	NASAL OUTCOMES OF CLEFT LIP AND PALATE	
57549	575	EXENTERATIO ORBITAE	
40717	576	STENONE DUCT FISTULA, SURGERY FOR	
46391	577	ORO-NASAL AND/OR MAXILLARY FISTULA	
56382	578	ZYGOMATIC FRACTURE, ORBIT, SURGICAL THERAPY FOR	
40543	579	MAXILLARY FRACTURES, SURGICAL THERAPY FOR	
57557	580	FRONTAL SINUS FRACTURES, SURGICAL THERAPY FOR	
46672	581	FRACTURES OF THE MANDIBLE AND CONDYLE, SURGICAL THERAPY FOR (INCLUDING POSSIBLE FIXATION WITH FERRULES)	
40519	582	MANDIBULAR FRACTURES, REDUCTION WITH FERRULES	
40626	583	FRENULOTOMY WITH UPPER AND LOWER FRENULOPLASTY	
40857	584	SUBMAXILLARY GLAND, REMOVAL FOR CHRONIC INFLAMMATION OR BENIGN NEOPLASMS	

57565	585	SUBMAXILLARY GLAND, REMOVAL FOR MALIGNANT NEOPLASMS, INCLUDING POSSIBLE LYMPHADENECTOMY	
57606	586	OPERATION FOR THE HORIZONTAL AND/OR VERTICAL ENLARGEMENT OF THE ALVEOLAR RIDGE OF THE MANDIBLE OR UPPER JAW WITH REMOVAL OF EXTRAORAL AUTOLOGOUS BONE AND GRAFTING, INCLUDING POSSIBLE INSERTION OF GRAFT MATERIAL, INCLUDING POSSIBLE OTHER SURGICAL TEAM. COMPLETE TREATMENT IN AN AUTHORIZED HEALTHCARE FACILITY BY DAY SURGERY OR WITH OVERNIGHT HOSPITALISATION, CARRIED OUT BY A SPECIALIST IN MAXILLOFACIAL SURGERY - PER HEMIARCH.	
57614	587	OPERATION FOR SMALL OR LARGE MAXILLARY SINUS LIFT (COMPLETE TREATMENT) WITH EXTRAORAL AUTOLOGOUS BONE HARVESTING AND GRAFTING, INCLUDING ANY GRAFT MATERIAL; INCLUDING POSSIBLE OTHER SURGICAL TEAM. COMPLETE TREATMENT IN AN AUTHORIZED HEALTHCARE FACILITY BY DAY SURGERY OR WITH OVERNIGHT HOSPITALISATION, CARRIED OUT BY A SPECIALIST IN MAXILLOFACIAL SURGERY - PER HEMIARCH.	
46680	588	UNILATERAL CLEFT LIP AND PALATE	
46698	589	BILATERAL CLEFT LIP AND PALATE	
46789	590	CYSTIC LYMPHANGIOMA OF THE NECK, REMOVAL FOR	
46854	591	TONGUE AND ORAL FLOOR, SURGERY FOR MALIGNANT TUMOURS WITH FUNCTIONAL OR RADICAL LATERO-CERVICAL DRAINAGE	
46797	592	TONGUE AND ORAL FLOOR, SURGERY FOR MALIGNANT TUMOURS WITHOUT DRAINAGE OF THE SUBMAXILLARY LOGGIA	
40576	593	TONGUE, PARTIAL AMPUTATION FOR BENIGN TUMOURS, ANGIOMAS, MACROGLOSSIA	
57573	594	MANDIBULAR DISLOCATION, MANUAL REDUCTION OF	
40535	595	MANDIBULAR DISLOCATION, SURGICAL THERAPY FOR	
46862	596	DENTO-MAXILLOFACIAL MALFORMATIONS OF THE MANDIBLE AND MAXILLA (PROGENISM, MICROGENIA, PROGNATHISM, MICROGNATHIA, MANDIBULAR LATERODEVIATIONS, ETC.), INCLUDING MENTOPLASTY ON THE UPPER JAW OR MANDIBLE (COMPLETE TREATMENT)	
40691	597	MANDIBLE, PARTIAL RESECTION FOR NEOPLASIA OF THE, INCLUDING POSSIBLE UNILATERAL RADICAL OR FUNCTIONAL LATERO-CERVICAL EMPTYING	
56390	598	MANDIBLE, PARTIAL RESECTION FOR NEOPLASIA OF THE, INCLUDING POSSIBLE BILATERAL RADICAL OR FUNCTIONAL LATERO-CERVICAL EMPTYING	
40667	599	UPPER MAXILLARY FOR NEOPLASMS, INCLUDING POSSIBLE UNILATERAL RADICAL OR FUNCTIONAL LATERO-CERVICAL EMPTYING, RESECTION OF THE	
56408	600	UPPER MAXILLARY FOR NEOPLASMS, INCLUDING POSSIBLE BILATERAL RADICAL OR FUNCTIONAL LATERO-CERVICAL EMPTYING, RESECTION OF THE	
40709	601	FACIAL SKELETON, TUMOUR DEMOLITION SURGERY WITH ORBITAL EMPTYING	
46888	602	LARGE ENDOSSEOUS NEOPLASMS, EXERESIS OF	
46896	603	SMALL ENDOSSEOUS NEOPLASMS (OSTEOMAS, CEMENTOMAS, ODONTOMAS, PALATINE AND MANDIBULAR TORUS), EXCISIONS OF	
40600	604	MALIGNANT NEOPLASMS OF THE LIP/CHEEK WITH EMPTYING OF THE SUBMAXILLARY LOGGIA, REMOVAL OF	
46904	605	MALIGNANT NEOPLASMS OF THE LIP/CHEEK WITHOUT EMPTYING OF THE SUBMAXILLARY LOGGIA, REMOVAL OF	

46912	606	LIMITED MALIGNANT NEOPLASMS OF THE LIP OR SOFT TISSUES OF THE ORAL CAVITY, REMOVAL OF	
57581	607	ORBIT, UNILATERAL INFERIOR DECOMPRESSION SURGERY	
57598	608	ORBIT, BILATERAL INFERIOR DECOMPRESSION SURGERY	
20248	609	CIRCUMSCRIBED OSTEITIS OF THE JAWS, TREATMENT OF	
46920	610	ANTERIOR, POSTERIOR CLEFT PALATE OF THE SOFT PALATE	
46615	611	TOTAL CLEFT PALATE	
46938	612	DYNAMIC OR STATIC FACIAL NERVE PALSY, PLASTIC SURGERY FOR	
40733	613	PARTIAL PAROTIDECTOMY WITH POSSIBLE SPARING OF THE FACIAL NERVE	
40741	614	TOTAL OR SUBTOTAL PAROTIDECTOMY	
46961	615	RECONSTRUCTION WITH BONE GRAFTS OF THE MAXILLA WITH EXTRAORAL BONE HARVESTING	
46979	616	RECONSTRUCTION WITH ALLOPLASTIC MATERIALS OR PROSTHESES OF THE JAWS	
56416	617	RECONSTRUCTIONS WITH MUCOSAL FLAPS	
56424	618	RECONSTRUCTIONS WITH MUSCLE FLAPS	
56432	619	RECONSTRUCTIONS WITH OSTEOMUSCULAR FLAPS	
56440	620	RECONSTRUCTIONS WITH REVASCULARIZED FLAPS	
59265	621	SIALECTOMY (AS THE MAIN OPERATION PHASE)	
59273	622	SIALECTOMY (AS A SINGLE OPERATION)	
40683	623	MAXILLARY SINUS, OPENING FOR ALVEOLAR PROCESS (COMPLETE TREATMENT) OR REMOVAL OF MAXILLARY SYNTHESIS MEDIA	
Paediatric Surgery			
For missing items in Paediatric Surgery: refer also to the other surgical branches. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described. PLEASE REMEMBER ONCE AGAIN, AS FOR ALL THE SERVICES LISTED IN THE BASIC NOMENCLATURE, THAT SERVICES ARE RECOGNISED AS REFUNDABLE BY FASIOPEN ONLY AND EXCLUSIVELY IF THEY ARE INCLUDED IN YOUR HEALTH PLAN UNDER THE FINANCIAL CONDITIONS AND LIMITS SPECIFIED WITHIN IT.			
46185	624	WILMS TUMOUR REMOVAL	
46102	625	ATRESIA OF THE ANUS WITH RECTO-URETHRAL, RECTO-VULVAR FISTULA: ABDOMINAL PERINEAL DESCENT	
46086	626	SIMPLE ATRESIA OF THE ANUS: ABDOMINO-PERINEAL DESCENT	
46094	627	ATRESIA OF THE ANUS: PERINEAL SURGERY	
46995	628	BILIARY TRACT ATRESIA, EXPLORATIONS	
45815	629	CEPHALOHEMATOMA, ASPIRATION OF	
47001	630	ANTERIOR BOWEL CYSTS (ENTEROGENIC AND BRONCHOGENIC), SURGERY FOR	
45823	631	CRANIUM BIFIDUM WITH MENINGOCELE	
45831	632	CRANIUM BIFIDUM WITH MENINGOENCEPHALOCELE	
45849	633	CRANIOSTENOSIS	

46136	634	DILATATION DUE TO CONGENITAL STENOSIS OF THE ANUS	
45997	635	BOCHDALEK DIAPHRAGMATIC HERNIA	
46003	636	MORGAGNI DIAPHRAGMATIC HERNIA	
45955	637	OESOPHAGUS (COMPLETE TREATMENT), ATRESIA OR CONGENITAL FISTULAS OF THE	
46243	638	ESONPHALON OR GASTROSCHISIS	
46276	639	UMBILICAL FISTULA AND CYST: FROM THE OMPHALOMESENTERIC CANAL WITH INTESTINAL RESECTION	
46284	640	UMBILICAL GRANULOMA, CAUTERISATION	
47126	641	ABDOMINAL NEUROBLASTOMA	
47134	642	ENDOTHORACIC NEUROBLASTOMA	
47142	643	PELVIC NEUROBLASTOMA	
47159	644	NEWBORN INTESTINAL OBSTRUCTION, ATRESIA (NEED FOR ANASTOMOSIS)	
47167	645	NEWBORN INTESTINAL OBSTRUCTION WITH INTESTINAL RESECTION	
47175	646	NEWBORN INTESTINAL OBSTRUCTION WITHOUT INTESTINAL RESECTION	
46045	647	NEWBORN INTESTINAL OBSTRUCTION-ILEOMECONEAL: SIMPLE ILEOSTOMY	
46060	648	NEWBORN INTESTINAL OBSTRUCTION-ILEOMECONEAL: RESECTION WITH PRIMARY ANASTOMOSIS	
46052	649	NEWBORN INTESTINAL OBSTRUCTION-ILEOMECONEAL: RESECTION ACCORDING TO MICKULICZ	
45989	650	PYLORUS, CONGENITAL STENOSIS OF THE	
46144	651	ANAL PLASTIC SURGERY FOR CONGENITAL STENOSIS	
45914	652	BRACHIAL PLEXUS, NEUROLYSIS FOR OBSTETRICAL PARALYSIS OF THE	
46318	653	VEIN PREPARATION FOR IV THERAPY AND TRANSFUSION	
46110	654	RECTUM, PROLAPSE WITH ANAL CERCLAGE OF THE	
46128	655	RECTUM, PROLAPSE WITH ABDOMINAL OPERATION OF THE	
46193	656	SPINA BIFIDA: MENINGOCELE	
46201	657	SPINA BIFIDA: MYELOMENINGOCELE	
46151	658	SACROCOCCYGEAL TERATOMA	
Reconstructive plastic surgery			

Regardless of Health Plan, no treatments carried out for aesthetic purposes and/or anything related to these and/or resulting from previous aesthetic treatments can be refunded, even if the items are referred to in this section.

Superficial tumours are defined as suprafascial neoplasms; deep tumours are defined as subfascial neoplasms. In the case of outpatient operations for the removal of malignant tumours, if included in the Cover of the individual Health Plan and regardless of the surgical technique used, submission of the histological examination report is also mandatory for the refund to be recognised. As regards to the surgical removal of keloids or scars you must, for the purposes of a refund, submit an Accident and Emergency (first aid) report if the service is a consequence of prior traumatic events, or an operative report if it is a consequence of surgical procedures causing a functional limitation. FasiOpen nonetheless reserves the right to request pre and post-surgery photographic documentation also for any removal of benign tumours; as set out under Warnings and in the introductions to this section, we therefore urge you to arrange in advance for these to be taken.

Laser and/or surgical treatments for telangiectasia, cherry angiomas, spider angiomas and similar are not deemed to be refundable services regardless of location and Health Plan (with no exceptions).

The above applies to surgical operations carried out using any technique (any instrumentation/equipment).

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

For missing items in reconstructive plastic surgery also see dermatological surgery (for which the same specifications apply).

46417	659	PREPARATION OF PEDICLED FLAP	
47191	660	SMALL INFANTILE HEMANGIOMAS OF THE FACE (LESS THAN 4 CM.), SURGERY FOR	
47183	661	LARGE INFANTILE HEMANGIOMAS OF THE FACE (FROM 4 CM. UPWARDS), SURGERY FOR	
47209	662	SMALL/MEDIUM INFANTILE HEMANGIOMAS OF TRUNK AND LIMBS (LESS THAN 7 CM.), SURGERY FOR	
46524	663	LARGE INFANTILE HEMANGIOMAS OF TRUNK AND LIMBS (FROM 7 CM. UPWARDS), SURGERY FOR	
46755	664	VAGINAL APLASIA, RECONSTRUCTION FOR	
47399	665	SMALL KELOIDS, SURGICAL REMOVAL OF	A pre and post treatment photo must be submitted
46490	666	LARGE KELOIDS, SURGICAL REMOVAL OF	A pre and post treatment photo must be submitted
47407	667	SMALL SCARS OF THE TRUNK OR LIMBS, SURGICAL CORRECTION OF	A pre and post treatment photo must be submitted
46771	668	LARGE SCARS OF THE TRUNK OR LIMBS, SURGICAL CORRECTION OF	A pre and post treatment photo must be submitted
47597	669	SMALL FACIAL SCARS, SURGICAL CORRECTION OF	A pre and post treatment photo must be submitted
46516	670	LARGE FACIAL SCARS, SURGICAL CORRECTION OF	A pre and post treatment photo must be submitted
56457	671	TISSUE EXPANSION FOR POST-DEMOLITION SURGERY SCARRING FOR THE INTRODUCTION OF BREAST PROSTHESIS (COMPLETE TREATMENT)	
46722	672	UNILATERAL GYNECOMASTIA	
47605	673	BILATERAL GYNECOMASTIA	
47613	674	INTRACHELOID INJECTION OF DRUGS (CORTISONE, ANTIBIOTICS, ANTI-INFLAMMATORIES ONLY)	
47621	675	COMPOSITE GRAFTS	
46441	676	EPIDERMAL OR ADIPOSE DERMAL OR FREE CUTANEOUS OR MUCOUS MEMBRANE GRAFT	
46466	677	FASCIA LATA OR MUSCLE GRAFT	
47639	678	NERVE OR TENDON GRAFT	
46458	679	BONE OR CARTILAGE GRAFT	

47647	680	PUSH-BACK SURGERY AND PHARYNGOPLASTY	
46573	681	MALFORMATIONS OF THE LIPS (COMPLETE TREATMENT), RECONSTRUCTIVE PLASTIC SURGERY OF	
46714	682	AREOLA AND NIPPLE MALFORMATION, SURGERY FOR OR RECONSTRUCTION OF THE NIPPLE AFTER CANCER SURGERY	
46805	683	SIMPLE MALFORMATION OF THE HANDS OR FEET (SYNDACTYLY, POLYDACTYLY)	
47654	684	COMPLEX MALFORMATIONS OF THE HANDS OR FEET (COMPLETE TREATMENT)	
47662	685	IN SITU FLAP SHAPING	
46623	686	AURICLE, RECONSTRUCTIVE PLASTIC SURGERY OF THE	
47670	687	V-Y, Y-V PLASTY (EXCEPT IN THE CASES DESCRIBED)	
46433	688	Z PLASTY OF THE FACE	
47688	689	Z PLASTY IN OTHER LOCATION (EXCEPT IN THE CASES DESCRIBED)	
46839	690	CICATRICIAL RETRACTION OF FINGERS WITHOUT GRAFT	
46847	691	CICATRICIAL RETRACTION OF THE FINGERS WITH GRAFT	
47696	692	BREAST RECONSTRUCTION AFTER SIMPLE TOTAL MASTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
46730	693	BREAST RECONSTRUCTION AFTER SUBCUTANEOUS MASTECTOMY OR QUADRANTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
46748	694	BREAST RECONSTRUCTION AFTER RADICAL MASTECTOMY WITH INTRODUCTION OF PROSTHESIS, INCLUDING MUSCLE FLAP IF NEEDED	
56465	695	REMOVAL AND POSSIBLE REPLACEMENT OF BREAST PROSTHESIS IMPLANTED IN PREVIOUS MASTECTOMY OR QUADRANTECTOMY SURGERY (AS A SINGLE OPERATION)	
46482	696	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH SMALL ROTATIONAL OR SLIDING SKIN FLAP	
47704	697	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH LARGE ROTATIONAL OR SLIDING SKIN FLAP	
47837	698	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH FASCIOCUTANEOUS FLAP	
47845	699	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE WITH MYOFASCIAL CUTANEOUS FLAP	
46508	700	REPAIR OF LOSS OF CUTANEOUS SUBSTANCE OR SCARRING OUTCOMES BY TISSUE EXPANSION (ANY ANATOMICAL PART)	
46763	701	Intersexual states, surgery for	
48587	702	CLEANING OF SMALL BURNS	
48579	703	CLEANING OF LARGE BURNS	
48595	704	MICROVASCULAR FREE FLAP TRANSFER	
46425	705	PEDICLE FLAP TRANSFER	
57622	706	SUPERFICIAL MALIGNANT CUTANEOUS TUMOUR OF THE TRUNK/LIMBS, SURGERY FOR	
57630	707	SUPERFICIAL OR SUBCUTANEOUS BENIGN TUMOUR OR CYST OR LIPOMA OF THE TRUNK/LIMBS, WARTS, SURGERY OF	
48603	708	DEEP MALIGNANT CUTANEOUS TUMOUR OF THE HEAD, SURGERY FOR	

57649	709	DEEP MALIGNANT CUTANEOUS TUMOUR OF THE TRUNK/LIMBS, SURGERY FOR	
40550	710	SUPERFICIAL MALIGNANT CUTANEOUS TUMOUR OF THE HEAD, SURGERY FOR	
48660	711	SUPERFICIAL TUMOUR OR BENIGN CYST OF THE HEAD, SURGERY FOR	
Thoracic - pulmonary surgery			
All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described. Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.			
43117	712	PLEURAL NEEDLE BIOPSY/EXPLORATORY PUNCTURE	
43208	713	ABSCESSES, SURGERY FOR	
48678	714	BILOBECTOMY SURGERY (INCLUDING POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
48686	715	LATEROCERVICAL BIOPSY	
59281	716	LUNG BIOPSY	
48694	717	SUPRACLAVICULAR BIOPSY	
43414	718	ENDOSCOPIC BRONCHOINSTILLATION	
43281	719	CYSTS (ECHINOCOCCUS OR OTHERS OF ANY KIND), REMOVAL OF	
43323	720	PULMONARY PLEURAL DECORTICATION, SURGERY FOR	
48702	721	DRAINAGE OF ACUTE OR CHRONIC MEDIASTINITIS OR ABSCESSES	
48827	722	PLEURAL DRAINAGE FOR ANY EFFUSION INCLUDING THORACENTESIS	
43638	723	PLEURAL DRAINAGE FOR TRAUMATIC PNEUMOTHORAX	
43620	724	PLEURAL DRAINAGE FOR SPONTANEOUS PNEUMOTHORAX	
48835	725	BULLOUS EMPHYSEMA, SURGERY FOR (ANY TECHNIQUE - ANY EQUIPMENT/INSTRUMENTATION)	
59298	726	PERICARDIAL FENESTRATION	
48843	727	TRAUMATIC DIAPHRAGMATIC HERNIAS	
43448	728	THORACO-ABDOMINAL WOUND WITH VISCERAL LESIONS	
43430	729	THORACO-ABDOMINAL WOUND WITHOUT VISCERAL LESIONS	
43265	730	WOUNDS WITH VISCERAL DAMAGE TO THE CHEST	
43356	731	BRONCHIAL STUMP FISTULAS AFTER EXERESIS OR SIMILAR SURGERY, SURGERY FOR	
48850	732	BRONCHOESOPHAGEAL AND/OR TRACHEOESOPHAGEAL FISTULAS, OPERATIONS FOR	
48868	733	RIB OR STERNAL FRACTURES, SURGICAL TREATMENT	
48876	734	RIB OR STERNAL FRACTURES, CONSERVATIVE TREATMENT	
43133	735	ISOLATED ENDOPLEURAL MEDICATIVE INSTILLATION	
48884	736	ENDOSCOPIC BRONCHOALVEOLAR LAVAGE	

43125	737	PLEURAL LAVAGE	
59306	738	THORACIC DUCT LIGATION	
48892	739	MOBILE CHEST FLAP, SURGICAL TREATMENT OF (FLYIN CHEST)	
43224	740	MEDIASTINAL LYMPHADENECTOMY (AS A SINGLE OPERATION)	
43190	741	DIAGNOSTIC MEDIASTINOSCOPY	
48918	742	OPERATIVE MEDIASTINOSCOPY	
48926	743	LOCALISED BENIGN NEOFORMATIONS OF THE RIBS	
43422	744	BENIGN NEOFORMATIONS OF THE DIAPHRAGM	
48934	745	BENIGN NEOFORMATIONS OF THE TRACHEA	
48942	746	MALIGNANT NEOPLASMS OF THE RIBS AND/OR STERNUM (INCLUDING POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
59314	747	MALIGNANT NEOPLASMS OF THE DIAPHRAGM (AS MAIN OPERATION PHASE)	
48959	748	MALIGNANT NEOPLASMS OF THE TRACHEA (INCLUDING PLASTIC SURGERY AND POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
43216	749	MALIGNANT NEOPLASMS AND/OR CYSTS OF THE MEDIASTINUM (INCLUDING POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
43174	750	PLEURECTOMIES (INCLUDING POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
43331	751	PLEUROPNEUMECTOMY (INCLUDING POSSIBLE LYMPHADENECTOMY AND/OR BIOPSY)	
43166	752	PLEUROTOMY AND DRAINAGE (WITH RESECTION OF ONE OR MORE RIBS), SURGERY FOR	
43315	753	PNEUMECTOMY SURGERY (INCLUDING LYMPHADENECTOMY AND/OR BIOPSY)	
57657	754	PNEUMECTOMY WITH RESECTION OF TRACHEA AND TRACHEO-BRONCHIAL ANASTOMOSIS	
43240	755	STERNAL OR MEDULLARY PUNCTATE	
43257	756	EXPLORATORY PUNCTURE OF THE LUNG	
48967	757	RELAXATIO DIAPHRAGMATICA	
43364	758	BRONCHIAL RESECTION WITH REIMPLANTATION	
43158	759	SUPERNUMERARY RIB RESECTION	
43307	760	SEGMENTAL RESECTION OR LOBECTOMY (INCLUDING POSSIBLE LYMPHADENECTOMIES)	
48975	761	SINGLE OR MULTIPLE ATYPICAL SEGMENTAL LUNG RESECTIONS (INCLUDING POSSIBLE LYMPHADENECTOMIES)	
48983	762	TYPICAL SEGMENTAL RESECTIONS (INCLUDING POSSIBLE LYMPHADENECTOMIES)	
59322	763	RETHORACOTOMY FOR HAEMOSTASIS	
48991	764	UPPER THORACIC STRAIT SYNDROMES	
56904	765	PLEURAL TALC, ANY METHOD	
43455	766	TIMECTOMY	

43182	767	PECTUS CARINATUM OR EXCAVATUM, CORRECTIVE SURGICAL TREATMENT	
43141	768	THORACENTESIS (WITH OR WITHOUT ENDOCAVITARY DRUG ADMINISTRATION)	
43596	769	THORACOPLASTY, FIRST STAGE	
43604	770	THORACOPLASTY, SECOND STAGE	
43513	771	DIAGNOSTIC THORACOSCOPY (AS A SINGLE OPERATION)	
59330	772	OPERATIVE THORACOSCOPY INCLUDING ANY BIOPSIES AND PLEURODESIS	
43299	773	EXPLORATORY THORACOTOMY INCLUDING BIOPSIES (AS A SINGLE OPERATION)	
43398	774	DIAGNOSTIC TRACHEO-BRONCHOSCOPY WITH POSSIBLE AUTOFLUORESCENCE	
43406	775	OPERATIVE TRACHEO-BRONCHOSCOPY	
49007	776	LUNG TRANSPLANT (INCLUSIVE OF ALL SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
Vascular Surgery			
The above applies to surgical operations carried out using any technique, method, instrumentation/equipment.			
45385	777	ABDOMINAL OR THORACIC AORTA ANEURYSMS PLUS DISSECTION: RESECTION AND PROSTHETIC GRAFTING (OPEN)	
45229	778	DISTAL LIMB ARTERY ANEURYSMS, RESECTION AND/OR PROSTHETIC GRAFT (OPEN)	
59349	779	VISCERAL ARTERY ANEURYSMS, EMBOLIZATION	
45278	780	ANEURYSMS, RESECTION AND PROSTHETIC GRAFTING: ILIAC, FEMORAL, POPLITEAL, HUMERAL, AXILLARY AND GLUTEAL ARTERIES, VISCERAL ARTERIES AND SUPRA-AORTIC TRUNKS (OPEN SURGERY)	
49072	781	ANGIOPLASTY OF VISCERAL ARTERIES (AS A SINGLE OPERATION)	
40204	782	APPLICATION OF STENTS, ANY ANATOMICAL DISTRICT, ANY NUMBER EXCEPT IN THE CASES DESCRIBED WHERE IT IS ALREADY INCLUDED IN THE ITEM ITSELF	
40436	783	SECOND APPLICATION OF STENT ON THE SAME ARTERY	
49098	785	AORTO-ANONIMAL, AORTO-CAROTID, CAROTID-SUCCLAVICULAR BYPASS	
45351	786	AORTO-ILIAC OR AORTO-FEMORAL BYPASS	
45369	787	AORTO-RENAL OR AORTO-MESENTERIC OR CELIAC BYPASS AND POSSIBLE TEA AND VASCULAR PLASTY	
45336	788	PERIPHERAL ARTERY BYPASS: FEMORO-TIBIAL, AXILLO-FEMORAL, FEMORO-FEMORAL, FEMORO-POPLITEAL	
59357	789	LOWER LIMB VENOUS BYPASS (AUTOLOGOUS OR HETEROLOGOUS) FOR CHRONIC DEEP VENOUS OBSTRUCTION	
45534	790	ELEPHANTIASIS OF THE LIMBS (LYMPHATIC-VENOUS ANASTOMOSIS)	
45393	791	ARTERIAL OR DEEP VEIN EMBOLECTOMY AND/OR THROMBECTOMY, EXCEPT IN THE CASES DESCRIBED	
49106	792	DECOMPRESSIVE FASCIOTOMY	
45476	793	LIGATION OF COMMUNICATING VEINS (AS A SINGLE OPERATION)	

45435	794	LIGATION AND/OR SUTURING OF LARGE VESSELS: AORTA-CAVA-ILIAC-CAROTID-VERTEBRAL-SUCCLAVIAN-ANONYMOUS	
45245	795	LIGATION AND/OR SUTURING OF MEDIUM VESSELS: FEMORAL-POPLITEAL-HUMERAL-INNER MAMMARY-BRACHIAL-AXILLARY-GLUTEAL	
45211	796	LIGATION AND/OR SUTURING OF SMALL VESSELS: TIBIAL-LINGUAL-THYROID-JAW-TEMPORAL-FACIAL-RADIAL-CUBITAL-LIMB PALMAR/PEDIDIAL- INGUINAL-PERINEAL	
45302	797	POST-TRAUMATIC OR IATROGENIC PSEUDOANEURYSMS	
56473	798	REVASCULARIZATION OF A LIMB OR SEGMENT (AS A SINGLE OPERATION)	
58668	6200	TOTAL OR PARTIAL LARGE AND/OR SMALL SAPHENECTOMY AND VARICECTOMY AND THROMBECTOMY AND POSSIBLE LIGATION OF BILATERAL COMMUNICATING VEINS (AS A SINGLE OPERATION)	
58684	6202	TOTAL OR PARTIAL SAPHENECTOMY OF THE GREAT AND/OR SMALL SAPHENOUS VEIN AND VARICECTOMY AND THROMBECTOMY AND POSSIBLE LIGATION OF BILATERAL COMMUNICATING VEINS (AS A SINGLE OPERATION)	
49874	801	NEUROVASCULAR SYNDROMES OF THE LOWER LIMBS	
57665	802	VEIN REPLACEMENT WITH HOMOLOGOUS OR HETEROLOGOUS DEEP VEIN PROSTHESIS OF LOWER LIMB	
59365	803	STANDBY CARDIAC SURGERY (PRESENCE OF WHOLE MEDICAL TEAM), EXCEPT FOR THE CASES DESCRIBED WHERE REMUNERATION IS INCLUDED IN THE FEE SHOWN	
59373	804	TREATMENT WITH VASCULAR ENDOPROSTHESIS OF ABDOMINAL AORTIC ANEURYSMS	
59381	805	ENDOVASCULAR TREATMENT OF ANEURYSMS OR DISSECTING ANEURYSMS OF THE THORACIC AORTA	
57673	806	ENDOVASCULAR TREATMENT OF ILIAC ARTERY ANEURYSMS	
57681	807	ENDOVASCULAR TREATMENT OF COMMON ILIAC ARTERY ANEURYSMS AND HYPOGASTRIC ARTERY EMBOLIZATION	
45401	808	SUPERFICIAL VENOUS THROMBECTOMY (AS A SINGLE OPERATION)	
45682	809	AORTO-ILIAC THROMBOENDARTERIECTOMY AND POSSIBLE VASCULAR PLASTY	
45328	810	THROMBOENDARTERECTOMY AND BYPASS AND/OR EMBOLECTOMY OF SUPRA-AORTIC TRUNKS	
49882	811	THROMBOENDARTERECTOMY AND PATCHING AND/OR EMBOLECTOMY OF SUPRA-AORTIC TRUNKS	
49890	812	THROMBOENDARTERECTOMY WITH FEMORAL ARTERY PATCHING	
49908	813	THROMBOENDARTERECTOMY AND PROSTHETIC GRAFTING AND/OR EMBOLECTOMY OF SUPRA-AORTIC TRUNKS (ANY TECHNIQUE)	
57698	814	CROSS SAPHENOUS-FEMORAL VALVULOPLASTY WITH OR WITHOUT PATCHING INCLUDING INTRAOPERATIVE DOPPLER	
57706	815	VALVULOPLASTY FOR UNILATERAL CHRONIC DEEP VENOUS INSUFFICIENCY OF THE LOWER LIMBS	
57714	816	VALVULOPLASTY FOR BILATERAL CHRONIC DEEP VENOUS INSUFFICIENCY OF THE LOWER LIMBS	
49973	817	VARICECTOMY (AS A SINGLE OPERATION)	
49981	818	VARICECTOMY WITH LIGATION OF COMMUNICATING VEINS (AS A SINGLE OPERATION)	
45526	819	RECURRENT VARICES	

Gastroenterology (diagnostics, invasive activities)

All services/operations listed below, if included in the Cover of the individual Health Plan, can be carried out with any technique, equipment/instrumentation, except in the cases described.

Anoscopy and proctoscopy are included in the consultation.

For diagnostic/exploratory procedures carried out together with operative procedures with the same access route, only the operative procedure is deemed refundable, with the diagnostic procedure regarded as a preparatory act.

Please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also deemed to be diagnostic endoscopies.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

If provided for in the Cover of the individual Health Plan and within the limits and conditions specified, oesophagogastroduodenoscopy (diagnostic and operative) and pancolonoscopy (diagnostic and operative) procedures are only recognised as refundable within the "package" format, which fully replaces the items/codes listed in previous editions of the Nomenclature. For the above-mentioned procedures carried out at the same time as, and therefore concurrently with, other main operations/procedures, their respective "concurrent" items are available for which, in an exception to the regulations for operations, the valuation for refund purposes is 100%.

51102	820	JEJUNAL BIOPSY WITH DIAGNOSTIC EQUIPMENT WITH SUCTION CAPSULE	
59157	821	ENDOSCOPIC CYSTOGASTROSTOMY OR CYSTODUODENOSTOMY	
59398	822	GRADUAL DILATION OF THE COLON (COMPLETE TREATMENT)	
42069	823	GRADUAL DILATION OF THE RECTUM (PER SESSION)	
57722	824	JEJUNAL ILEOSCOPY	
57730	825	GRADUAL DILATION OF THE ANUS (PER SESSION)	
59406	826	ESOPHAGOGASTRODUODENAL ECHO-ENDOSCOPY	
59414	827	ECHO-ENDOSCOPY OF THE RECTUM	
59422	828	BILIO-PANCREATIC ECHO-ENDOSCOPY (INCLUDING BIOPSIES IF NECESSARY)	
57749	829	ENDOSCOPIC HAEMOSTASIS OF NON-VARICOSE OESOPHAGOGASTRIC LESIONS	
57757	830	HAEMOSTASIS AND/OR ENDOSCOPIC SCLEROSIS OF OESOPHAGOGASTRIC VARICOSE LESIONS (ANY TECHNIQUE, ANY EQUIPMENT/INSTRUMENTATION)	
57765	831	ENTEROSCOPY WITH VIDEO CAPSULE	
41319	832	ESOPHAGOGASTRODUODENOSCOPY INCLUDING USE OF DILATION PROBE (FIRST SESSION)	
41327	833	ESOPHAGOGASTRODUODENOSCOPY INCLUDING USE OF DILATION PROBE (SUBSEQUENT SESSIONS)	
56499	836	HYDRO COLON THERAPY PER SESSION	Maximum 4 sessions per year (1 January - 31 December)
51433	837	ANORECTAL MANOMETRY	
51441	838	COLONIC MANOMETRY	
51458	839	OESOPHAGEAL OR GASTROESOPHAGEAL MANOMETRY	
51466	840	GASTRIC MANOMETRY	
51474	843	PH OUTPATIENT MANOMETRY WITH 24-HOUR RECORDING	
51482	844	OESOPHAGEAL PHMETRY	
57773	845	POSITIONING OF PEG (PERCUTANEOUS ENDOSCOPIC GASTROSTOMY)	
42028	846	DIAGNOSTIC RECTOSCOPY WITH RIGID INSTRUMENT	

42036	847	OPERATIVE RECTOSIGMOIDOSCOPY (INCLUDING POLYPECTOMIES) OR LASER PHOTOCOAGULATION	
42044	848	DIAGNOSTIC FIBRE-OPTIC RECTOSIGMOIDOSCOPY (INCLUDING BIOPSIES)	
57781	849	REMOVAL AND/OR REPLACEMENT OF PEGS (PERCUTANEOUS ENDOSCOPIC GASTROSTOMY)	
72942	850	DUODENAL PROBING	
72959	851	GASTRIC PROBING	
51508	852	FRACTIONATED GASTRIC PROBING WITH STIMULATION TESTS	
57798	855	ENDOSCOPIC TREATMENT FOR GASTROESOPHAGEAL REFLUX DISEASE	
59430	856	OESOPHAGEAL OR GASTRIC OESOPHAGEAL VARICES, ENDOSCOPIC LIGATION	
56275	857	GASTRIC VARICES (ENDOSCOPIC HAEMOSTASIS)	
46533	6587	DIAGNOSTIC OESOPHAGOGASTRODUODENOSCOPY (INCLUDING BIOPSIES) AND POSSIBLE RAPID H. PYLORI TEST (PROCEDURE CONCURRENT WITH ANOTHER MAIN ONE)	Code payable only if carried out in the same operation session as another main operation.
46534	6588	OPERATIVE OESOPHAGOGASTRODUODENOSCOPY (PROCEDURE CONCURRENT WITH ANOTHER MAIN ONE) FOR: POLYPECTOMIES, INTRODUCTION OF PROSTHESES, REMOVAL OF FOREIGN BODIES, ARGON LASER, ETC.	Code payable only if carried out in the same operation session as another main operation.
46535	6589	FIBRE-OPTIC DIAGNOSTIC PANCOLONOSCOPY (INCLUDING BIOPSIES) AND POSSIBLE ILEOSCOPY (PROCEDURE CONCURRENT WITH ANOTHER MAIN PROCEDURE)	Code payable only if carried out in the same operation session as another main operation.
46536	6590	OPERATIVE PANCOLONSCOPY PACKAGE INCLUDING RECTAL-COLIC POLYPECTOMY, REMOVAL OF FOREIGN BODIES, HAEMOSTASIS OF NON-VARICOSE LESIONS (PROCEDURE CONCURRENT WITH ANOTHER MAIN ONE)	Code payable only if carried out in the same operation session as another main operation.

Gynaecology

All surgical operations listed below, if included in the Cover of the individual Health Plan, can be carried out with any access route, technique, equipment/instrumentation, except in the cases described.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

51680	858	ADHESIOLYSIS (AS A SINGLE OPERATION)	
56912	859	ADHESIOLYSIS (AS MAIN OPERATION PHASE)	
51698	860	NEEDLE BIOPSY/NEEDLE ASPIRATION DEEP ANATOMICAL PARTS	
51706	861	UNILATERAL ADNEXA, CONSERVATIVE SURGERY ON	
51870	862	BILATERAL ADNEXA, CONSERVATIVE SURGERY ON	
50757	863	UNILATERAL ADNEXA, DEMOLITION SURGERY ON	
50765	864	BILATERAL ADNEXA, DEMOLITION SURGERY ON	
50518	865	VULVAR GLAND ABSCESSES OR BARTHOLIN GLAND CYSTS, INCISION AND DRAINAGE OF	
51888	866	ABSCESSES OR DIVERTICULA OR PARAURETHRAL CYSTS (INCLUDING BARTHOLIN GLAND), SURGICAL TREATMENT FOR	
51896	867	PELVIC ABSCESS, SURGICAL TREATMENT FOR	

56920	868	BIOPSY OF THE PORTIO, ENDOMETRIUM (AS A SINGLE OPERATION)	
51003	869	BIOPSY OF VULVA, VAGINA	
50831	870	INTRAMEDULLARY OVARIAN CYST, REMOVAL OF	
51904	871	VAGINAL CYSTS, REMOVAL OF	
50609	872	COLPOPERINEORRHAPHY FOR PERINEAL TEARS (AS A SINGLE OPERATION)	
50617	873	COLPOPERINEORRHAPHY FOR PERINEAL TEARS INVOLVING THE RECTUM	
51029	874	COLPOSCOPY INCLUDING VULVOSCOPY (FULL EXAMINATION)	
50898	875	COLPOTOMY AND EMPTYING OF HAEMATIC AND PURULENT DRAINAGE	
59449	876	PERINEAL-ANAL AND/OR VAGINAL CONDYLOMATA ACUMINATA, SURGERY FOR (ANY TECHNIQUE, COMPLETE TREATMENT)	
50534	877	CONIZATION AND TRACHELOPLASTY	
50930	878	DIATHERMOCOAGULATION OF THE UTERINE PORTIO OR VULVA	
50815	879	PELVIC EVISCERATION	
50674	880	URETEROVAGINAL FISTULAS, SURGERY FOR (ANY TECHNIQUE)	
59457	881	URETHROVAGINAL FISTULAS, SURGERY FOR (ANY TECHNIQUE)	
56507	882	VESICOVAGINAL OR RECTOVAGINAL FISTULAS, SURGERY FOR	
50641	883	HYMENOTOMY-IMENECTOMY (AS A SINGLE OPERATION)	
50625	884	URINARY INCONTINENCE IN WOMEN, VAGINAL OR ABDOMINAL SURGERY	
50807	885	RADICAL LAPAROTOMIC OR VAGINAL HYSTERECTOMY WITH PELVIC AND/OR LUMBAR/AORTIC LYMPHADENECTOMY, INCLUDING ANTERIOR AND/OR POSTERIOR VAGINAL PLASTIC SURGERY	
50708	886	RADICAL HYSTERECTOMY VIA LAPAROTOMIC OR VAGINAL ROUTE WITHOUT LYMPHADENECTOMY, INCLUDING ANTERIOR AND/OR POSTERIOR VAGINAL PLASTIC SURGERY	
50724	887	SIMPLE TOTAL HYSTERECTOMY WITH OR WITHOUT MONO/BILATERAL ADNEXIECTOMY VIA LAPAROTOMIC OR VAGINAL ROUTE, INCLUDING ANTERIOR AND/OR POSTERIOR VAGINAL PLASTIC SURGERY	
50906	888	HYSTEROPEXES	
51045	889	DIAGNOSTIC HYSTEROSCOPY AND POSSIBLE BIOPSIES (AS A SINGLE EXAMINATION)	
52050	890	OPERATIVE HYSTEROSCOPY: ENDOMETRIAL ABLATION, SURGERY FOR	
52068	891	OPERATIVE HYSTEROSCOPY: FOREIGN BODIES, REMOVAL OF	
50880	892	OPERATIVE HYSTEROSCOPY: SYNECHIAE-SEPTUM-FIBROIDS-POLYPS, SURGERY FOR	
52076	893	DIAGNOSTIC LAPAROSCOPY AND/OR SALPINGOCROMOSCOPY INCLUDING BIOPSIES IF NECESSARY (AS A SINGLE OPERATION)	
57806	894	OPERATIVE LAPAROSCOPY WITH ABLATION OF ENDOMETRIOSIS CYSTS OR OTHER, LASERVAPORIZATION OF ENDOMETRIOSIS FOCI, LYSIS, SYNECHIAE ETC.	

52092	895	EXPLORATORY LAPAROTOMY WITH SELECTIVE PELVIC LUMBAR AORTIC LYMPHADENECTOMY AND BIOPSY (AS A SINGLE OPERATION)	
52084	896	EXPLORATORY LAPAROTOMY AND/OR LYSIS OF ADHESIONS (AS A SINGLE OPERATION)	
51276	897	LAPAROTOMY FOR UTERINE WOUNDS AND RUPTURES	
52134	898	VAGINAL OR VULVAR OR PORTIO LASER THERAPY - PER SESSION	Refundable maximum 3 sessions per year (1 January - 31 December).
57814	899	LEEP (LOOP ELECTROSURGICAL EXCISION PROCEDURE) INCLUDING COLPOSCOPY	
52142	900	LAPAROTOMIC LYMPHADENECTOMY (AS A SINGLE OPERATION)	
52159	901	METROPLASTY (AS A SINGLE OPERATION)	
50849	902	MYOMECTOMIES WITH OR WITHOUT PLASTIC RECONSTRUCTION OF THE UTERUS (AS A SINGLE OPERATION)	
52175	903	NEOFORMATIONS OF THE VULVA, REMOVAL	
50583	904	PLASTIC SURGERY WITH WIDENING OF THE INTROITUS (INCLUDING VAGINISMUS SURGERY)	
50567	905	ANTERIOR AND POSTERIOR VAGINAL PLASTIC SURGERY, (AS A SINGLE OPERATION)	
50542	906	ANTERIOR VAGINAL PLASTIC SURGERY (AS A SINGLE OPERATION)	
50559	907	POSTERIOR VAGINAL PLASTIC SURGERY (AS A SINGLE OPERATION)	
50914	908	CERVICAL POLYPS, REMOVAL OF	
52191	909	EXTERNAL URETHRAL ORIFICE POLYPS	
52209	910	VAGINAL DOME PROLAPSE OR COLPOPEXY, ABDOMINAL OR VAGINAL SURGERY	
52290	911	MUCOUS PROLAPSE EXTERNAL URETHRAL ORIFICE, SURGICAL TREATMENT OF	
50682	912	EXPLORATORY PUNCTURE OF THE DOUGLAS CAVITY	
50922	913	DIAGNOSTIC OR THERAPEUTIC ENDOUTERINE SCRAPING	
50781	914	UNILATERAL OVARIAN RESECTION FOR DYSFUNCTIONAL PATHOLOGY	
50799	915	BILATERAL OVARIAN RESECTION FOR DYSFUNCTIONAL PATHOLOGY	
52308	916	UNILATERAL SALPINGECTOMY	
52381	917	BILATERAL SALPINGECTOMY	
50989	918	SALPINGOPLASTY	
52399	919	VAGINAL SEPTUM, SURGICAL REMOVAL	
52407	920	TRACHELOPLASTY (AS A SINGLE OPERATION)	
52530	921	BILATERAL CONSERVATIVE SURGICAL TREATMENT OF ABDOMINAL-PELVIC-ANNEXAL ENDOMETRIOTIC LOCALIZATIONS	
52647	922	CONSERVATIVE SURGICAL TREATMENT FOR EXTRAUTERINE PREGNANCY	
52522	923	UNILATERAL CONSERVATIVE SURGICAL TREATMENT OF ABDOMINAL-PELVIC-ANNEXAL ENDOMETRIOTIC LOCALIZATIONS	
52555	924	BILATERAL SURGICAL TREATMENT OF ABDOMINAL-PELVIC-ANNEXAL ENDOMETRIOTIC LOCALIZATIONS	

51268	925	DEMOLITION SURGERY FOR EXTRAUTERINE PREGNANCY	
52548	926	UNILATERAL SURGICAL TREATMENT OF ABDOMINAL-PELVIC-ANNEXAL ENDOMETRIOTIC LOCALIZATIONS	
50690	927	MALIGNANT VAGINAL TUMOURS WITH LYMPHADENECTOMY, RADICAL SURGERY FOR	
52654	928	MALIGNANT VAGINAL TUMOURS WITHOUT LYMPHADENECTOMY, RADICAL SURGERY FOR	
52712	929	V.A.B.R.A. FOR DIAGNOSTIC PURPOSES	
50856	930	PARTIAL VULVECTOMY	
52720	931	PARTIAL VULVECTOMY WITH BILATERAL DIAGNOSTIC LYMPHADENECTOMY OF SUPERFICIAL INGUINAL LYMPH NODES, SURGERY FOR	
50872	932	EXTENSIVE RADICAL VULVECTOMY WITH INGUINAL AND PELVIC LYMPHADENECTOMY, SURGERY FOR	
52738	933	SIMPLE VULVECTOMY (LOCAL OR CUTANEOUS), SURGERY FOR	
50864	934	TOTAL VULVECTOMY	

Neurosurgery

All surgical operations listed below, if included in the Cover of individual Health Plans, can be carried out with any access route, technique, equipment/instrumentation, except in the cases described. Tract is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract (example: in the case of an intervention on 2 vertebrae in the same tract, the refund value is 1 in relation to the corresponding operation code). Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

45088	935	SPINO-FACIAL ANASTOMOSIS AND SIMILAR	
44479	936	INTRA-EXTRA CRANIAL VESSEL ANASTOMOSIS	
59465	937	ANTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
59473	938	POSTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
59481	939	ANTERIOR AND POSTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
44248	940	INTRACRANIAL ABSCESS OR HAEMATOMA, SURGERY FOR	
59498	941	OPEN VERTEBRAL BIOPSY	
44297	942	ENDOCRANIAL CAROTID, LIGATION OF	
56938	943	EPIDURAL AND/OR DURAL CATHETER, IMPLANTATION OF	
44206	944	ATLANTO-OCCIPITAL JOINT, SURGERY FOR ANTERIOR OR POSTERIOR MALFORMATIONS	
44636	945	CHORDOTOMY, RHIZOTOMY AND VARIOUS MYELORADICULAR AFFECTIONS, SURGERY ON	
44131	946	INTRACRANIAL FOREIGN BODY, REMOVAL OF	
44180	947	CRANIOPLASTY - INCLUDING POSSIBLE REMOVAL OF SYNTHETIC MATERIAL	

44172	948	CRANIOTOMY FOR DECOMPRESSIVE/EXPLORATORY PURPOSES (INCLUDING BIOPSIES)	
44156	949	CRANIOTOMY FOR EXTRADURAL HAEMATOMA	
44164	950	CRANIOTOMY FOR TRAUMATIC INTRACEREBRAL LESIONS	
52746	951	CRANIOTOMY FOR CEREBELLAR TUMOURS, INCLUDING BASAL	
44289	952	DIRECT AND INDIRECT CSF DERIVATION, SURGERY FOR	
59506	953	DIRECT AND INDIRECT CSF DERIVATION, REVISION SURGERY FOR	
59514	954	CHRONIC UNILATERAL SUBDURAL HAEMATOMA, SURGERY FOR	
59522	955	CHRONIC BILATERAL SUBDURAL HAEMATOMA, SURGERY FOR	
44305	956	ENCEPHALOMENINGOCELE, SURGERY FOR	
44230	957	FOCAL EPILEPSY, SURGERY FOR	
44503	958	HERNIATED DORSAL OR LUMBAR DISC INCLUDING POSSIBLE DECOMPRESSIVE LAMINECTOMY INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
57822	959	HERNIATED DORSAL OR LUMBAR DISC, SURGERY FOR RECURRENCE (LEVEL AND LATERAL) INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
44511	960	TRANS-THORACIC HERNIATION OF THE DORSAL DISC, INCLUDING UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (COMPLETE TREATMENT) - (AS A SINGLE OPERATION)	
52753	961	CERVICAL INTERVERTEBRAL DISC HERNIATION, MYELOPATHIES, RADICULOPATHIES INCLUDING UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES	
44529	962	HERNIATED DISC WITH INTERBODY ARTHRODESIS, ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
52803	963	CEREBROSPINAL FLUID FISTULA	
44461	964	ARTERIOVENOUS FISTULAS, SURGICAL THERAPY WITH LIGATION OF EXTRA-CRANIAL AFFERENT VESSELS	
44453	965	ARTERIOVENOUS FISTULAS, SURGICAL THERAPY WITH LIGATION OF INTRA-CRANIAL AFFERENT VESSELS	
44446	966	ARTERIOVENOUS FISTULAS, DIRECT ATTACK SURGICAL THERAPY	
52852	967	LUMBAR GANGLIECTOMY AND SPLANCHNICECTOMY	
56946	968	SPINAL CORD STIMULATOR IMPLANT	
44412	969	PITUITARY GLAND, TRANSSPHENOIDAL ADENOMA SURGERY	
44347	970	EXPLORATORY, DECOMPRESSIVE AND EXTRADURAL LAMINECTOMY (AS A SINGLE OPERATION)	
44354	971	LAMINECTOMY FOR EXTRAMEDULLARY INTRA-DURAL TUMOURS	
44362	972	LAMINECTOMY FOR INTRAMEDULLARY TUMOURS	
44438	973	INTRACRANIAL ANEURYSMAL MALFORMATION (SACCULAR	

		ANEURYSMS, CAROTID ANEURYSMS, OTHER ANEURYSMS)	
56515	974	ANEURYSMAL OR ANGIOMATOUS MALFORMATION WITH ROOT AND/OR SPINAL CORD COMPRESSION	
44313	975	MYELOMENINGOCELE, SURGERY FOR	
44115	976	ENDOCRANIAL NEOPLASMS, REMOVAL OF	
44370	977	NEOPLASMS, CHORDOTOMIES, RADICOTOMIES AND MENINGOMIDEAL AFFECTIONS, ENDORACHID SURGERY	
59530	978	NEUROLYSIS (AS MAIN OPERATION PHASE)	
45047	979	NEUROLYSIS (AS A SINGLE OPERATION)	
45013	980	PRIMARY NEURORRHAPHY (AS A SINGLE OPERATION)	
45054	981	SIMPLE NEUROTOMY (AS A SINGLE OPERATION)	
44388	982	RETROGASSERIAN NEUROTOMY, INTRACRANIAL SECTION OF OTHER NERVES (AS A SINGLE OPERATION)	
45096	983	BRACHIAL PLEXUS, SURGERY ON	
52878	984	EPIDURAL PUNCTURE (UNLESS OTHERWISE DESCRIBED OR WHERE NOT INCLUDED)	
44602	985	SUB-OCCIPITAL PUNCTURE FOR CSF COLLECTION OR INTRODUCTION OF DRUGS OR CONTRAST MEDIUM	
44560	986	RACHYCENTESIS FOR ANY INDICATION	
44537	987	CONTINUOUS RECORDING OF INTRACRANIAL PRESSURE	
44545	988	RHIZOTOMIES AND ENDOCRANIAL ROOT MICRODECOMPRESSION	
44263	989	SCHEGGECTOMY AND CRANIECTOMY FOR SKULL VAULT FRACTURE	
52886	990	SCHEGGECTOMY AND CRANIECTOMY FOR SKULL VAULT FRACTURE WITH PLASTIC SURGERY	
44842	991	SYMPATHETIC CERVICAL: ENERVATION OR REMOVAL OF THE CAROTID SINUS, OPERATION ON	
44818	992	SYMPATHETIC CERVICAL: GANGLIECTOMY, SURGERY ON	
44834	993	SYMPATHETIC CERVICAL: STELLECTOMY, SURGERY ON	
44867	994	SYMPATHETIC DORSAL: THORACIC GANGLIECTOMY, SURGERY ON THE	
44875	995	SYMPATHETIC DORSAL: ASSOCIATED OPERATION ON THE SYMPATHETIC THORACIC AND SPLANCHNIC NERVES	
44891	996	SYMPATHETIC LUMBAR: LUMBAR GANGLIECTOMY, SURGERY ON	
44958	997	SYMPATHETIC LUMBAR: PRESACRAL NERVE RESECTION, SURGERY ON	
44925	998	SYMPATHETIC LUMBAR: PERIARTERIAL SYMPATHECTOMY, SURGERY ON	
44933	999	SYMPATHETIC LUMBAR: POSTGANGLIONIC SYMPATHECTOMY, SURGERY ON	
44941	1000	SYMPATHETIC LUMBAR: SYMPATHETIC PELVIC, SURGERY ON	
44917	1001	SYMPATHETIC LUMBAR: SPLANCHNICECTOMY, SURGERY ON	
57830	1002	REPLACEMENT OR REMOVAL OF SPINAL CORD STIMULATOR	
52894	1003	LEVEL 1 LUMBAR VERTEBRAL STENOSIS INCLUDING POSSIBLE UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (EXCEPT FOR DESCRIBED CASES) AS A SINGLE OPERATION	

57849	1004	MULTI-LEVEL LUMBAR VERTEBRAL STENOSIS INCLUDING POSSIBLE UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (EXCEPT AS DESCRIBED) AS A SINGLE OPERATION	
44644	1005	STEREOTAXY, INTERVENTION BY	
59549	1006	BRAIN STIMULATOR FOR PARKINSON'S DISEASE AND MOVEMENT DISORDERS, IMPLANTATION SURGERY	
59557	1007	BRAIN STIMULATOR FOR PARKINSON'S DISEASE AND MOVEMENT DISORDERS, REPLACEMENT SURGERY	
52902	1008	TEARS AND BLOCKS OF PERIPHERAL TRUNKS OF THE TRIGEMINAL AND OTHER CRANIAL NERVES	
44339	1009	THALAMOTOMY, PALLIDOTOMY AND OTHER SIMILAR OPERATIONS	
44552	1010	THERMO-THORACOTOMY OF THE TRIGEMINAL OR OTHER CRANIAL NERVES	
44271	1011	CRANIAL DRILLING FOR VENTRICULAR PUNCTURE AND DRAINAGE	
45039	1012	TRANSPLANTS, GRAFTS AND OTHER PLASTIC SURGERY OPERATIONS (AS A SINGLE OPERATION)	
56954	1013	SURGICAL TREATMENT OF HERNIATED DISCS ENDOSCOPICALLY AND/OR PERCUTANEOUSLY, ANY TECHNIQUE - ANY EQUIPMENT/INSTRUMENTATION (OZONE, I.D.E.T, CHEMONUCLEOLYSIS, LASERDISCECTOMY ETC.)	
44495	1014	ANTERIOR VERTEBRO-MEDULLARY TRAUMA, SURGERY FOR	
52910	1015	POSTERIOR VERTEBRO-MEDULLARY TRAUMA, SURGERY FOR	
44123	1016	ORBITAL TUMOUR, ENDOCRANIAL EXCISION	
45146	1017	PERIPHERAL NERVE TUMOURS, REMOVAL OF (EXCLUDING TRAUMATIC AND NON-TRAUMATIC NERVE LESIONS OF THE HAND AND FOOT)	
44214	1018	CRANIAL BASE TUMOURS, TRANS-ORAL SURGERY	
44222	1019	ORBITAL TUMOURS, SURGERY FOR	

Ophthalmology

Fees are for surgery performed with any technique, method and instrument/equipment, excluding laser (not refundable by FasiOpen).

Ophthalmologic operations performed with lasers recognised as refundable, if they are included in the Covers of the individual Health Plans, are only described in the “Laser treatments” paragraph.

No type of treatment or surgery for myopia, astigmatism, hypermetropia, presbyopia, corneal correction, performed with any method or equipment, is refundable unless explicitly listed in the Nomenclature and included in the Cover of your Health Plan.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

Should the Fund perceive the need for further investigations in the context of the envisaged and normal checks, it reserves the right to request additional documentation even if this is not explicitly mentioned. We therefore urge you to arrange in advance for pre and post-operative photographs in the case of minor operations (pre and post-procedure photographs are obligatory for eyelid ptosis operations).

Orbit

52928	1020	ORBITAL BIOPSY	
46565	1021	ORBITAL CAVITY, PLASTIC SURGERY FOR (AS A SINGLE OPERATION)	

52027	1022	DEEP CYSTS OR NEOPLASMS AROUND THE ORBIT, REMOVAL OF	
52936	1023	INTRAORBITAL FOREIGN BODIES, REMOVAL OF	
52035	1024	EXENTERATIO ORBITAE	
52019	1025	ENDORBITAL INJECTION EXCLUDING INTRAVITREAL INJECTION FOR WET MACULAR DEGENERATION (SEE RETINA)	
52043	1026	KRONLEIN'S OPERATION OR ORBITOTOMY	
52944	1027	ORBIT, UNILATERAL INFERIOR DECOMPRESSION SURGERY	
57857	1028	ORBIT, BILATERAL INFERIOR DECOMPRESSION SURGERY	
Eyebrow			
52951	1029	CYSTS, REMOVAL OF	
56523	1030	FOREIGN BODIES, REMOVAL OF	
46540	1031	PLASTIC SURGERY BY GRAFTING	
52977	1032	PLASTIC SURGERY BY SLIDING	
52985	1033	WOUND SUTURE	
Eyelids			
To be able to access refunds for the services indicated below, pre- and post-operative photographic documentation must be submitted as an integral part of the medical certification.			
51813	1034	EYELID ABSCESS, INCISION OF	
51714	1035	CHALAZION	
51789	1036	CANTHOPLASTY	
51763	1037	ENTROPION-ECTROPION	
51771	1038	EPICANTHIC FOLD-COLOBOMA	
51805	1039	SMALL TUMOURS OR CYSTS, REMOVAL OF	
53348	1040	REOPENING OF ANKYLOBLEPHARON	
51722	1041	EYELID SKIN SUTURE (AS A SINGLE OPERATION)	
51730	1042	SUTURE FOR FULL-THICKNESS WOUNDS (AS A SINGLE OPERATION)	
51862	1043	TARSORRHAPHY (AS A SINGLE OPERATION)	
51755	1044	TUMOURS, REMOVAL WITH PLASTIC SURGERY BY GRAFTING	
51748	1045	TUMOURS, REMOVAL WITH PLASTIC SURGERY BY SLIDING	
51854	1046	SIMPLE XANTHELASMA, REMOVAL OF	
53355	1047	XANTHELASMA, EXCISION WITH PLASTIC SURGERY BY SLIDING	
Tear Ducts			
51664	1048	TEAR DUCT CLOSURE	

53363	1049	TEAR DUCT CLOSURE WITH PROSTHESIS	
51656	1050	DACRYOCYSTORHINOSTOMY OR INTUBATION	
59565	1051	OPERATIVE TEAR ENDOSCOPY WITH FIBRE OPTICS	
53371	1052	FISTULA, REMOVAL	
51623	1053	PHLEGMON, INCISION OF (AS A SINGLE OPERATION)	
51672	1054	SILICONE TUBE IMPLANTATION IN TEAR DUCT STENOSIS	
51649	1055	LACRIMAL SAC OR LACRIMAL GLAND, REMOVAL OF THE	
53389	1056	LACRIMAL SAC, INCISION OF (AS A SINGLE OPERATION)	
51615	1057	LACHRYMAL PROBING OR WASHING (PER SESSION)	Refundable once a year (ref. invoice)
51631	1058	STRICTUROTOMY (AS A SINGLE OPERATION)	
53397	1059	TEAR DUCTS, RECONSTRUCTION	
Conjunctiva			
To be able to access refunds for the services indicated below, pre- and post-operative photographic documentation must be submitted as an integral part of the medical certification.			
51516	1060	FOREIGN BODIES, REMOVAL OF	Pre and post-operation photographs must be submitted (as well as everything already specified)
51532	1061	SUBCONJUNCTIVAL INJECTION	
51581	1062	CONJUNCTIVAL NEOPLASMS, REMOVAL WITH GRAFTING	Pre and post-operation photographs must be submitted (as well as everything already specified)
51573	1063	CONJUNCTIVAL NEOPLASMS, REMOVAL WITH PLASTIC SURGERY BY SLIDING	Pre and post-operation photographs must be submitted (as well as everything already specified)
51524	1064	SMALL CYSTS, SUTURE WITH PLACENTAL GRAFT	Pre and post-operation photographs must be submitted (as well as everything already specified)
51565	1065	CONJUNCTIVAL PLASTIC SURGERY BY GRAFTING	Pre and post-operation photographs must be submitted (as well as everything already specified)
51557	1066	CONJUNCTIVAL PLASTIC SURGERY BY SLIDING	Pre and post-operation photographs must be submitted (as well as everything already specified)
51540	1067	PTERYGIUM OR PINGUECULA	Pre and post-operation photographs must be submitted (as well as everything already specified)
53405	1068	CONJUNCTIVAL WOUND SUTURE	Pre and post-operation photographs must be

			submitted (as well as everything already specified)
Cornea			
Any endothelial cell counts are included in the relevant services. Excluded from refund, regardless of the Health Plan, is any type of treatment or surgery for myopia, astigmatism, hypermetropia, presbyopia or corneal correction, performed using any method or equipment			
53785	1070	FULL THICKNESS KERATOPLASTY	
53793	1071	LAMELLAR KERATOPLASTY	
51912	1073	FOREIGN BODIES IN THE CORNEA, EXTRACTION OF	
51953	1074	FOREIGN BODIES IN THE ANTERIOR CHAMBER, EXTRACTION OF	
53801	1075	CORNEAL CRYOAPPLICATIONS	
53991	1076	EPIKERATOPLASTY	
57865	1077	IMPLANTATION OF INTRASTROMAL RINGS IN KERATOCONUS	
57873	1078	AMNIOTIC MEMBRANE GRAFT/APPOSITION	
54007	1079	BIOLOGICAL LENTICULE, APPOSITION FOR THERAPEUTIC PURPOSES	
54262	1080	ODONTOKERATOPROSTHESIS	
51920	1081	ANTERIOR CHAMBER PARACENTESIS (AS A SINGLE OPERATION)	
51946	1082	CORNEAL SUTURE (AS A SINGLE OPERATION)	
51938	1083	CORNEAL TATTOO	
51979	1084	FULL THICKNESS CORNEAL TRANSPLANT	
51961	1085	LAMELLAR CORNEAL TRANSPLANT	
57881	1086	LIMBAL STEM CELL TRANSPLANT	
57898	1087	LIMBAL STEM CELL TRANSPLANT COMBINED WITH AMNIOTIC MEMBRANE APPOSITION	
Crystalline lens			
Operations can be carried out with any technique, equipment or instrumentation, except in the cases described. Any endothelial cell counts are included in the relevant services. Concurrent cataract surgery (if provided for by the Health Plan) can be associated with the Cataract Package code (again if provided for by the Health Plan) only and exclusively if it is carried out at the same time as the Package itself (in which case the calculation for refund purposes will be the same as the value of the Package, to which only the concurrent cataract surgery and the lens prosthesis relating to the concurrent cataract may be added. There are no other possibilities).			
52472	1088	ASPIRATION OF CATARACT MASSES (AS A SINGLE OPERATION)	
52423	1093	SECONDARY CATARACTS, DISCISSION OF	
52514	1095	ARTIFICIAL LENS, SECONDARY IMPLANT IN ANTERIOR CHAMBER	
54288	1096	ARTIFICIAL LENS, SECONDARY IMPLANT IN POSTERIOR CHAMBER	
54296	1097	ARTIFICIAL LENS, REMOVAL FROM ANTERIOR CHAMBER (AS A SINGLE OPERATION)	
54304	1098	ARTIFICIAL LENS, REMOVAL FROM THE POSTERIOR CHAMBER (AS A SINGLE OPERATION)	

52449	1099	DISLOCATED LENS, EXTRACTION OF	
52464	1100	LENS, EXTRACTION IN HIGH MYOPIA (FUKALA)	
54312	1102	FUKALA SURGERY AND ARTIFICIAL LENS IMPLANTATION IN ANTERIOR OR POSTERIOR CHAMBER	
10089	3248	CATARACT, REMOVAL AND IMPLANTATION OF ARTIFICIAL LENS IN ANTERIOR OR POSTERIOR CHAMBER (ANY TECHNIQUE) (OPERATION CONCURRENT TO ANOTHER MAIN OPERATION PERFORMED IN THE SAME OPERATING SESSION OR HOSPITALISATION)	Code payable only if carried out in the same operation session as another main operation.
Sclera			
52126	1103	SCLERECTOMY	
52118	1104	SCLEROTOMY (AS A SINGLE OPERATION)	
52100	1105	SCLERAL SUTURE	
Operation for glaucoma			
54320	1106	CILIARY NERVE ALCOHOLIZATION, SURGERY FOR	
52282	1107	CYCLODIALYSIS	
52225	1108	PERFORATING CYCLO-DIATHERMY	
54338	1109	ANTIGLAUCOMATOUS CRYO-APPLICATION, AS A SINGLE OPERATION	
52266	1110	GONIOTOMY	
52233	1111	IRIDOCYCLORETRACTION (AS A SINGLE OPERATION)	
52217	1112	MICROSURGERY OF THE CAMERULAR ANGLE (AS A SINGLE OPERATION)	
52274	1113	FISTULIZING OPERATION (AS A SINGLE OPERATION)	
57914	1114	DEEP SCLERECTOMY WITH OR WITHOUT IMPLANTS (AS A SINGLE OPERATION)	
52258	1115	TRABECULECTOMY (AS A SINGLE OPERATION)	
54346	1116	TRABECULECTOMY + CATARACT REMOVAL, COMBINED OPERATION	
54353	1117	TRABECULECTOMY + CATARACT REMOVAL + ARTIFICIAL LENS IMPLANTATION, COMBINED OPERATION	
52241	1118	TRABECULOTOMY (AS A SINGLE OPERATION)	
57922	1119	VISCOCANALOSTOMY (AS A SINGLE OPERATION)	
57930	1120	VISCOCANALOSTOMY + CATARACT REMOVAL, COMBINED OPERATION	
57949	1121	VISCOCANALOSTOMY + CATARACT REMOVAL + ARTIFICIAL LENS IMPLANTATION, COMBINED OPERATION	
Iris			
52332	1122	IRIS CYSTS, REMOVAL AND PLASTY OF	
52316	1123	IRIDECTOMY	
52340	1124	IRIDO-DIALYSIS, SURGERY FOR	

54361	1125	IRIDOPLASTY	
52324	1126	IRIDOTOMY (AS A SINGLE OPERATION)	
54379	1127	IRIS PROLAPSE, REDUCTION	
52357	1128	SYNECHIOTOMY	
52365	1129	IRIS SUTURE	
Retina			
52639	1130	REMOVAL, CERCLAGE, REMOVAL AND/OR REPLACEMENT OF MATERIALS USED DURING THE DETACHMENT OPERATION	
52605	1131	CRYOTREATMENT (AS A SINGLE OPERATION)	
52563	1132	RETINAL DIATHERMOCOAGULATION FOR DETACHMENT (AS A SINGLE OPERATION)	
56531	1133	UPPER TEMPORAL ARTERY LIGATION (AS A SINGLE OPERATION)	
56549	1134	RETINA, OPERATION FOR DETACHMENT, CRYO + CERCLAGE (AS A SINGLE OPERATION)	
52597	1135	RETINA, DETACHMENT SURGERY, INCLUDING ALL PHASES	
57957	1136	TRANSPUPILLARY THERMOTHERAPY	
52506	1137	ANTERIOR OR POSTERIOR VITRECTOMY, INCLUDING REMOVAL OF THE EPIRETINAL MEMBRANES	
Muscles			
52662	1138	EXTERNAL RECTUS OR INTERNAL RECTUS MUSCLES, ADVANCEMENT	
52670	1139	UPPER OR LOWER OR OBLIQUE MUSCLES, ADVANCEMENT	
52696	1140	EYELID PTOSIS, SURGERY FOR (EXCLUDING AESTHETIC PURPOSES)	Refundable maximum once per body part - eye (per case) per year (1 January - 31 December). Pre- and post-operation photography and pre-operation campimetry must be submitted.
52704	1141	RECESSION-RESECTION-KINKING, TREATMENT OF	
52688	1142	PARALYTIC STRABISMUS, SURGERY FOR	
Eyeball			
52787	1143	MAGNETISABLE INTRABULBAR FOREIGN BODY, EXTRACTION OF	
52795	1144	NON-MAGNETISABLE INTRABULBAR FOREIGN BODY, EXTRACTION OF	
52761	1145	ENUCLEATION OR EXENTERATION	
52779	1146	ENUCLEATION WITH MOBILE PROSTHESIS GRAFT	
54387	1147	EVISCERATION WITH INTRAOCULAR IMPLANT	
Laser Treatments			

54403	1148	LASER THERAPY OF THE ADNEXA, CONJUNCTIVA, NEOVASES OR CORNEAL NUBULES (PER SESSION)	
54411	1149	LASER THERAPY OF GLAUCOMA AND ITS COMPLICATIONS (PER SESSION)	
54429	1150	LASER THERAPY OF VASCULOPATHIES AND/OR RETINAL MALFORMATIONS (PER SESSION)	
52373	1151	IRIS LASER THERAPY (PER SESSION)	
52621	1152	RETINAL LESIONS LASER THERAPY (PER SESSION)	
54437	1153	LASER THERAPY IN DIABETIC RETINOPATHY (PER SESSION)	
56962	1154	PHOTODYNAMIC THERAPY INCLUDING ANY TYPE OF MEDICATION (PER TREATMENT)	Refundable once a year (1 January - 31 December).
54445	1155	LASER TREATMENTS FOR SECONDARY CATARACTS (PER SESSION)	

Orthopaedics and traumatology

Joints are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibial-peroneal-astragalic); small (the remainder).

Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder).

Section is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract (example: in the case of an intervention on 2 vertebrae in the same tract, the refund value is 1 in relation to the corresponding operation code).

For surgical operations involving articular ligaments, any harvesting for autologous ligament grafting must be regarded as included (considered as a phase of the reconstruction).

The items, if included in the Covers of the individual Health Plans, are for surgical operations carried out with any technique and instrumentation/equipment.

Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation, except as specifically described.

Total hip replacement/revision total hip replacement operations (any type shown in the Basic Nomenclature and if included in the Health Plans) are only refundable within the “package” format, which fully replaces the individual case-by-case items/codes listed in previous editions of the Nomenclature. For the above-mentioned procedures carried out at the same time as, and therefore concurrently with, other main operations/procedures, their respective “concurrent” items are available for which, in an exception to the regulations for operations, the valuation for refund purposes is 100%.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

Bandages

47076	1156	ZINC GLUE BANDAGE: THIGH, LEG AND FOOT	
47084	1157	ZINC GLUE BANDAGE: LEG AND FOOT	
47035	1158	SCHANZ COLLAR BANDAGE	
47050	1159	BANDAGE WITH CAST IMMOBILISATION: ELBOW AND WRIST	
47043	1160	BANDAGE WITH CAST IMMOBILISATION: FOR UPPER LIMB	
47068	1161	BANDAGE WITH CAST IMMOBILISATION: FOR LOWER LIMB	
54452	1162	BANDAGE WITH DRESSING (FOLLOWING SURGERY)	
56970	1163	ELASTOCOMPRESSIVE OR FUNCTIONAL BANDAGES	
47100	1164	DESSAULT BANDAGE: STARCHED OR PLASTERED	
47092	1165	DESSAULT BANDAGE: SIMPLE	

47019	1166	SIMPLE BANDAGE WITH COTTON WOOL AND GAUZE	
47027	1167	CHEST BANDAGE WITHOUT UPPER LIMB	
56988	1168	SPLINT	
47118	1169	ZIMMER SPLINT FOR FINGER, APPLICATION OF	
Plastered appliances			
47332	1170	LOWER LIMB: THIGH, LEG AND FOOT	
47340	1171	LOWER LIMB: LEG AND FOOT	
47324	1172	LOWER LIMB: KNEE BAND	
47274	1173	UPPER LIMB: FOREARM AND HAND	
47266	1174	UPPER LIMB: ARM, FOREARM AND HAND	
47258	1175	UPPER LIMB: CHEST AND UPPER LIMB	
54460	1176	PLASTER CAST FOR PROSTHETIC LIMBS	
47225	1177	CORSET WITH SHOULDERS	
47233	1178	CORSET WITHOUT SHOULDERS	
47365	1179	SPECIAL CORSET FOR SCOLIOSIS AND/OR KYPHOSIS	
47217	1180	MINERVA-TYPE CORSET	
54478	1181	DELBET	
47381	1182	GYPSOTOMY	
47316	1183	PELVI-CONDYLOID	
54486	1184	BILATERAL PELVI-CONDYLOID	
47308	1185	PELVI-MALLEOLAR	
54494	1186	BILATERAL PELVI-MALLEOLAR	
47290	1187	PELVI-PEDIDIUM	
54502	1188	BILATERAL PELVI-PEDIDIUM	
47282	1189	FINGER SPLINT	
Dislocations and fractures			
47571	1190	APPLICATION OF TRANSKELETAL WIRE OR NAIL	
54510	1191	APPLICATION OF SKIN TRACTION	
47480	1192	NON-INVASIVE REDUCTION OF FRACTURES - DISLOCATIONS: SPINAL COLUMN	
47472	1193	NON-INVASIVE REDUCTION OF FRACTURES - DISLOCATIONS: LARGE JOINTS	
47464	1194	NON-INVASIVE REDUCTION OF FRACTURES - DISLOCATIONS: MEDIUM JOINTS	
47456	1195	NON-INVASIVE REDUCTION OF FRACTURES - DISLOCATIONS: SMALL JOINTS	

47522	1196	NON-INVASIVE REDUCTION OF FRACTURES: SPINAL COLUMN	
47514	1197	NON-INVASIVE REDUCTION OF FRACTURES: LARGE SEGMENTS	
47506	1198	NON-INVASIVE REDUCTION OF FRACTURES: MEDIUM SEGMENTS	
47498	1199	NON-INVASIVE REDUCTION OF FRACTURES: SMALL SEGMENTS	
47449	1200	NON-INVASIVE REDUCTION OF TRAUMATIC DISLOCATION: SPINAL COLUMN	
47431	1201	NON-INVASIVE REDUCTION OF TRAUMATIC DISLOCATION: LARGE JOINTS	
47423	1202	NON-INVASIVE REDUCTION OF TRAUMATIC DISLOCATION: MEDIUM JOINTS	
47415	1203	NON-INVASIVE REDUCTION OF TRAUMATIC DISLOCATION: SMALL JOINTS	
Non-invasive surgery			
47795	1204	NON-INVASIVE MOBILISATION OF STIFFNESS: LARGE JOINTS	
47829	1205	NON-INVASIVE MOBILISATION OF STIFFNESS: MEDIUM JOINTS	
47787	1206	NON-INVASIVE MOBILISATION OF STIFFNESS: SMALL JOINTS	
47753	1208	CONGENITAL CLUBFOOT, MANUAL CORRECTION OF	
47738	1209	REDUCTION OF PAINFUL PRONATION IN CHILDREN	
47712	1210	NON-INVASIVE REDUCTION OF CONGENITAL HIP DISLOCATION: UNILATERAL	
47720	1211	NON-INVASIVE REDUCTION OF CONGENITAL HIP DISLOCATION: BILATERAL	
54528	1212	NON-INVASIVE REDUCTION OF CONGENITAL HIP DISLOCATION: UNI AND BILATERAL, SUBSEQUENT OCCASIONS	
47761	1213	TORTICOLLIS AND SCOLIOSIS ON SPECIAL BED, CORRECTION OF	
47555	1214	OBSTETRIC LOWER LIMB TRAUMA, TREATMENT OF	
47548	1215	OBSTETRIC UPPER LIMB TRAUMA, TREATMENT OF	
Invasive Surgery			

Joints are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibial-peroneal-astragalic); small (the remainder).

Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder).

Section is defined as: cervical column or dorsal column or lumbo-sacral column.

Total hip replacement/revision total hip replacement operations (any type shown in the Basic Nomenclature and if included in the Health Plans) are only refundable within the “package” format, which fully replaces the individual case-by-case items/codes listed in previous editions of the Nomenclature. For the above-mentioned procedures carried out at the same time as, and therefore concurrently with, other main operations/procedures, their respective “concurrent” items are available for which, in an exception to the regulations for operations, the valuation for refund purposes is 100%.

The fees apply to surgical operations carried out using any technique and instrumentation/equipment.

Complete treatment also includes any arthrolysis, neurolysis and/or synovectomy and/or tenolysis within the context of the main operation, except as specifically described.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

54536	1216	ANTERIOR ACROMIOPLASTY (COMPLETE TREATMENT)	
54544	1217	BONE NEEDLE ASPIRATION	
54551	1218	UPPER AND/OR LOWER LIMB STRETCHING (PER SEGMENT, COMPLETE TREATMENT)	
47944	1219	LARGE SEGMENT AMPUTATION (FULL TREATMENT)	
48140	1220	MEDIUM SEGMENT AMPUTATION (FULL TREATMENT)	
48165	1221	ARTHRODESIS	
48173	1222	ARTHRODESIS WITH INTRODUCTION OF MEDICATION	
54569	1223	ANTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS (AS A SINGLE OPERATION)	
54577	1224	POSTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS (AS A SINGLE OPERATION)	
48645	1225	ANTERIOR AND POSTERIOR VERTEBRAL ARTHRODESIS ALSO FOR SPONDYLOLISTHESIS INCLUDING POSSIBLE LUMBAR STENOSIS (AS A SINGLE OPERATION)	
48348	1226	ARTHRODESIS: LARGE JOINTS	
48330	1227	ARTHRODESIS: MEDIUM JOINTS	
48363	1228	ARTHROLYSIS: LARGE	
48355	1229	ARTHROLYSIS: MEDIUM	
48371	1230	ARTHROLYSIS: SMALL	
48256	1231	ARTHROPLASTY: LARGE (ANY MATERIAL)	
48264	1232	ARTHROPLASTY: MEDIUM (ANY MATERIAL)	
48272	1233	ARTHROPLASTY: SMALL (ANY MATERIAL)	
48462	1234	ARTHROPROSTHESIS: SHOULDER, PARTIAL	
54585	1235	ARTHROPROSTHESIS; SHOULDER, TOTAL	
48421	1236	ARTHROPROSTHESIS: PARTIAL HIP (COMPLETE TREATMENT)	
48447	1240	ARTHROPROSTHESIS: KNEE	
48454	1241	ARTHROPROSTHESIS: ELBOW	
56580	1242	ARTHROPROSTHESIS: REMOVAL AND REPLACEMENT OF SEPTIC ARTHROPROSTHESIS SUBSEQUENTLY TO THE FIRST OPERATION (PARTIAL OR TOTAL) AS A SINGLE OPERATION, EXCEPT IN THE CASES DESCRIBED	
48520	1243	DIAGNOSTIC ARTHROSCOPY UNSPECIFIED SITE (AS A SINGLE OPERATION)	
54593	1244	COLD ABSCESS, DRAINAGE OF	
48199	1245	JOINT BIOPSY	
47860	1246	BONE BIOPSY	
54601	1247	TRANSPEDUNCULAR VERTEBRAL SOMA BIOPSY	
54619	1248	OPEN VERTEBRAL BIOPSY	

56598	1249	BURSECTOMY (AS PHASE OF MAIN OPERATION)	
48157	1250	BURSECTOMY (AS SINGLE OPERATION)	
56996	1251	BAKER'S CYST, REMOVAL OF	
54643	1252	MENISCAL OR PARAMENISCAL CYSTS, REMOVAL OF	
57965	1253	SYNOVIAL CYSTS, REMOVAL OF	
57004	1254	CHONDRECTOMY - CHONDROABRASION AND/OR JOINT DEBRIDEMENT (AS PHASE OF MAIN OPERATION)	
54650	1255	CHONDRECTOMY - CHONDROABRASION AND/OR JOINT DEBRIDEMENT (AS SINGLE OPERATION)	
48413	1256	INTRA-ARTICULAR FOREIGN AND MOBILE BODIES (AS SINGLE OPERATION), REMOVAL OF	
48041	1257	CERVICAL RIB AND "OUTLET SYNDROME", SURGERY FOR	
48223	1258	THORACIC INTERSCAPULAR DISARTICULATION	
54668	1259	DISARTICULATIONS, LARGE	
48215	1260	DISARTICULATIONS, MEDIUM	
54676	1261	DISARTICULATIONS, SMALL	
54684	1262	ELSMIE-TRILLAT PROCEDURE	
48231	1263	HEMIPELVECTOMY	
54692	1264	INTERNAL HEMIPELVECTOMIES WITH LIMB SALVAGE	
54700	1265	EPIPHYSIODESIS	
48611	1266	HERNIATED DORSAL OR LUMBAR DISC INCLUDING POSSIBLE DECOMPRESSIVE LAMINECTOMY INCLUDING POSSIBLE LUMBAR STENOSIS, UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (AS A SINGLE OPERATION)	
47878	1267	SIMPLE EXOSTOSIS, REMOVAL OF	
47563	1268	EXPOSED FRACTURE, SURGICAL CLEANING OF	
56606	1269	DEEP JOINT, MUSCLE AND BONE INFECTIONS (SURGICAL TREATMENT - SINGLE OPERATION)	
48561	1270	ECHO-X RAY GUIDED JOINT INFILTRATIONS (SHOULDER-KNEE-HIP-ELBOW-WRIST-ANKLE) INCLUDING ECHO-X RAY REGARDLESS OF THE NUMBER OF JOINTS TREATED	Refundable maximum 5 sessions per year (1 January - 31 December)
59614	1271	GRAFTING OF AUTOLOGOUS CULTURED CARTILAGE MATERIAL, INCLUDING JOINT DEBRIDEMENT IF NECESSARY	
54742	1272	LATERAL RELEASE	
54759	1273	LIGAMENTS AND RETINACULAE OF THE KNEE, RECONSTRUCTION OF (AS A SINGLE OPERATION)	
54767	1274	LIGAMENTS AND RETINACULAE OF THE KNEE WITH MENISCECTOMY (AS A SINGLE OPERATION), RECONSTRUCTION OF	
48306	1275	RECURRENT DISLOCATIONS OF THE SHOULDER OR KNEE (ALSO ARTHROSCOPIC), PLASTIC SURGERY FOR (COMPLETE TREATMENT)	
54775	1276	MENISCECTOMY (ARTHROSCOPIC) (COMPLETE TREATMENT - INCLUDING POSSIBLE REMOVAL OF MOBILE BODIES)	
54783	1277	MENISCECTOMY (ARTHROSCOPIC) + POSSIBLE CHONDROABRASION + POSSIBLE MOSAICOPLASTY (COMPLETE TREATMENT - INCLUDING POSSIBLE REMOVAL	

		OF MOBILE BODIES)	
48405	1278	MENISCECTOMY (TRADITIONAL TECHNIQUE) (COMPLETE TREATMENT)	
48124	1279	BONE MARROW, EXPLANTATION OF	
47910	1280	OSTEOMYELITIS (COMPLETE TREATMENT), SURGERY FOR	
58947	1207	OSTEOCLASIA	
48629	1281	VERTEBRAL OSTEOSYNTHESIS	
47993	1282	OSTEOSYNTHESIS: LARGE SEGMENTS	
47985	1283	OSTEOSYNTHESIS: MEDIUM SEGMENTS	
48017	1284	OSTEOSYNTHESIS: SMALL SEGMENTS	
47894	1285	COMPLEX OSTEOTOMY (PELVIS, VERTEBRAL) INCLUDING ABLATION OF SPINAL OSTEOPHYTES (BY SECTION)	
47886	1286	SIMPLE OSTEOTOMY OF ANY SEGMENT (AS PHASE OF MAIN OPERATION)	
47928	1287	BOECK PERFORATION	
56614	1288	POTT, FOCAL SURGERY WITH OR WITHOUT VERTEBRAL ARTHRODESIS	
59622	1289	REMOVAL OF CARTILAGE FROM THE KNEE ARTHROSCOPICALLY, SURGERY FOR (AS A SINGLE OPERATION)	
48116	1290	BONE GRAFT HARVESTING WITH GRAFT	
47977	1291	LARGE SEGMENT OR CONGENITAL PSEUDOARTHROSIS OF THE TIBIA (COMPLETE TREATMENT)	
54825	1292	PSEUDOARTHROSIS OF MEDIUM SEGMENTS (COMPLETE TREATMENT)	
47969	1293	PSEUDOARTHROSIS OF SMALL SEGMENTS (COMPLETE TREATMENT)	
48132	1294	TIBIAL OR ILIAC PUNCTATE	
54833	1295	RADIODISTAL, RESECTION WITH FIBULA JOINT GRAFT, PRO-RADIO	
54841	1296	RE-IMPLANTATION OF A LIMB OR ITS SEGMENT	
48207	1297	JOINT RESECTION (AS A SINGLE OPERATION)	
54858	1298	RESECTION OF THE SACRUM (AS A SINGLE OPERATION)	
47902	1299	BONE RESECTION (AS A SINGLE OPERATION)	
54874	1300	SURGICAL REDUCTION AND CONSTRICTION OF TRAUMATIC SPINAL DISLOCATION	
54882	1301	SURGICAL REDUCTION AND CONTAINMENT OF TRAUMATIC DISLOCATION OF LARGE JOINTS	
54890	1302	SURGICAL REDUCTION AND CONTAINMENT OF TRAUMATIC DISLOCATION OF MEDIUM/SMALL JOINTS	
48389	1303	SURGICAL REDUCTION OF CONGENITAL HIP DISLOCATION	
48108	1304	REMOVAL OF SYNTHETIC MATERIAL: LARGE SEGMENTS	
57973	1305	REMOVAL OF SYNTHETIC MATERIAL: MEDIUM SEGMENTS	

57981	1306	REMOVAL OF SYNTHETIC MATERIAL: SMALL SEGMENTS	
54908	1307	TORN SHOULDER ROTATOR CUFF, REPAIR OF (INCLUDING TREATMENT OF THE LONG HEAD OF THE BICEPS BRACHII) (COMPLETE TREATMENT)	
48652	1308	SCOLIOSIS, SURGERY FOR (COMPLETE TREATMENT)	
57012	1309	SYNOVECTOMY OF LARGE OR MEDIUM-SIZED JOINTS (AS MAIN OPERATION PHASE)	
48249	1310	SYNOVECTOMY OF LARGE OR MEDIUM-SIZED JOINTS (AS A SINGLE OPERATION)	
57020	1311	SYNOVECTOMY OF SMALL JOINTS (AS MAIN OPERATION PHASE)	
54916	1312	SYNOVECTOMY OF SMALL JOINTS (AS A SINGLE OPERATION)	
54924	1313	SHOULDER, COMPLETE RESECTIONS TICKHOR-LIMBERG	
54932	1314	LEVEL 1 LUMBAR VERTEBRAL STENOSIS INCLUDING POSSIBLE UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (EXCEPT FOR DESCRIBED CASES) AS A SINGLE OPERATION	
57990	1315	MULTI-LEVEL LUMBAR VERTEBRAL STENOSIS INCLUDING POSSIBLE UNCOFORAMINOTOMY, VERTEBROTOMY AND REMOVAL OF OSTEOPHYTES (EXCEPT AS DESCRIBED) AS A SINGLE OPERATION	
54940	1316	EMPTYING OF METASTATIC FOCI AND REINFORCEMENT WITH SYNTHETIC MATERIAL PLUS CEMENT	
48397	1317	COTYLOID ROOF, RECONSTRUCTION OF	
54957	1318	SURGICAL CLEANING AND SMALL SUTURES	
57038	1319	BONE MARROW TRANSPLANT (ALL-INCLUSIVE OF SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
54965	1320	TRANSLATION OF SHOULDER CUFF AND ROTATOR MUSCLES	
48066	1321	BONE TUMOURS AND PSEUDO-TUMOURS, LARGE SEGMENTS OR JOINTS, REMOVAL OF	
54973	1322	BONE TUMOURS AND PSEUDO-TUMOURS, MEDIUM-SIZED SEGMENTS OR JOINTS, REMOVAL OF	
54981	1323	BONE TUMOURS AND PSEUDO-TUMOURS, SMALL SEGMENTS OR JOINTS, REMOVAL OF	
47852	1324	BONE TUMOURS AND PSEUDO-TUMOURS, VERTEBRAL TUMOURS, REMOVAL OF	
54999	1325	UNCOFORAMINOTOMY OR VERTEBROTOMY (COMPLETE TREATMENT)	
55004	1326	VOKMANN, SURGERY FOR ISCHEMIC RETRACTIONS	
3249	3249	TOTAL HIP ARTHROPROSTHESIS (TOTAL HIP ARTHROPROSTHESIS - ANY TECHNIQUE - CONCURRENT OPERATION) REFUNDABLE IN THE SAME OPERATING SESSION OR HOSPITALISATION NOT CONNECTED WITH THE TOTAL HIP PROSTHESIS PACKAGE)	Refundable only once per body part (hip). Code payable only if carried out in the same operation session as another main operation.
3250	3250	ARTHROPROSTHESIS: TOTAL HIP REVISION CARRIED OUT IN THE SAME HOSPITAL IN WHICH THE FIRST OPERATION WAS CARRIED OUT (TOTAL HIP REVISION ARTHROPLASTY - ANY TECHNIQUE - CONCURRENT OPERATION, REFUNDABLE IN THE SAME OPERATING SESSION OR HOSPITALISATION NOT CONNECTED WITH THE TOTAL HIP REVISION PACKAGE)	Refundable only once per body part (hip). Code payable only if carried out in the same operation session as another main operation.
53301	6599	TOTAL HIP ARTHROPROSTHESIS (COMPLETE TREATMENT - OPERATION CONCURRENT TO ANOTHER MAIN ONE): FOR REMOVAL AND REPOSITIONING PERFORMED SUBSEQUENTLY TO THE FIRST HOSPITALISATION	Code payable only if carried out in the same operation session as another main operation.

Tendons - Muscles - Aponeuroses - Peripheral Nerves			
"Neurolysis" and "tenolysis" procedures cannot be combined with all procedures defined as a "complete treatment", since they are already included in them.			
48819	1327	MUSCLE BIOPSY	
48777	1328	CYSTS OR TENDON AND/OR ARTHROGENIC GANGLIA, REMOVAL OF	
54809	1329	NEURINOMAS, SURGICAL REMOVAL OF	
59649	1331	NEUROLYSIS (AS MAIN OPERATION PHASE)	
59630	1330	NEUROLYSIS (AS A SINGLE OPERATION)	
56648	1332	TENOLYSIS (AS MAIN OPERATION PHASE)	
48785	1333	TENOLYSIS (AS A SINGLE OPERATION)	
48736	1334	TENOPLASTY, MYOPLASTY, MYORRHAPHY	
48728	1335	COMPLEX TENORRHAPHY - SUTURING OF MULTIPLE TENDONS (EXCEPT IN THE CASES DESCRIBED)	
48710	1336	SIMPLE TENORRHAPHY - SUTURE OF ONE TENDON (EXCEPT IN THE CASES DESCRIBED)	
48744	1337	TENOTOMY INCLUDING POSSIBLE TENORRHAPHY, MYOTOMY, APONEUROTOMY (AS A SINGLE OPERATION)	
48769	1338	CONGENITAL MYOGENIC TORTICOLLIS, PLASTIC SURGERY FOR	
48751	1339	TENDON AND MUSCLE OR NERVE TRANSPLANTS (COMPLETE TREATMENT)	
Obstetrics			
Items include the cost of the obstetrician and neonatological care during the entire duration of the mother's hospitalisation. All services/operations listed below, if included specific in the Cover of the individual Health Plans, can be carried out with any technique, equipment/instrumentation, except in the cases described. Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.			
51243	1340	THERAPEUTIC ABORTION	
51151	1341	AMNIOCENTESIS, INCLUDING ANY PROFESSIONAL AND INSTRUMENTAL SERVICE, ANY NUMBER OF SAMPLES TAKEN	
51169	1342	AMNIOSCOPY	
51425	1343	ASSISTED DELIVERY BY CONSERVATIVE OR DEMOLITION CAESAREAN SECTION - INCLUDING ANY MYOMECTOMIES PERFORMED DURING THE OPERATION (INCLUDING ASSISTANCE TO THE MOTHER DURING HOSPITALISATION, ASSISTANCE OF THE MIDWIFE AND NEONATAL ASSISTANCE).	
51417	1344	ASSISTED EUTOCYTIC, DYSTOCYTIC, MULTIPLE, BREECH, PREMATURE, PILOTED DELIVERY (INCLUDING ANY MANUAL/INSTRUMENTAL AFTERBIRTH ASSISTANCE, ANY SURGICAL OPERATION, NORMAL ASSISTANCE TO THE MOTHER DURING HOSPITALISATION, ASSISTANCE OF THE MIDWIFE AND NEONATAL ASSISTANCE)	
51409	1345	CHORIONIC VILLUS BIOPSY	
56655	1346	CARDIOTOCOGRAPHY (AS SINGLE EXAMINATION)	Examination performed not as part of specialist consultation (cannot be

			combined with another cardiotocography)
56663	1347	CARDIOTOCOGRAPHY (DURING CONSULTATION)	Examination performed during a specialist consultation (cannot be combined with another cardiotocography)
51193	1348	CERVICAL CERCLAGE	
51219	1349	COLPOPERINEORRHAPHY FOR SUTURE DEHISCENCE, SURGERY	
55236	1350	CORDOCENTESIS	
55244	1351	FETOSCOPY	
55251	1352	FETAL FLOWMETRY	
51334	1353	CERVICAL LACERATION, SUTURE OF	
55269	1354	EXPLORATORY LAPAROTOMY AND/OR LYSIS OF ADHESIONS (AS A SINGLE OPERATION)	
55277	1355	EXPLORATORY LAPAROTOMY WITH DEMOLITION SURGERY	
55285	1356	PUERPERAL MASTITIS, SURGICAL TREATMENT	
51300	1357	REVISION OF DELIVERY ROUTES, SURGERY FOR	
55293	1358	REVISION OF THE UTERINE CAVITY FOR MISCARRIAGE-POST-ABORTION-IN-PUERPERIUM, SURGERY FOR	
51326	1359	MANUAL REDUCTION FOR UTERINE INVERSION BY LAPAROTOMY, SURGERY	
51318	1360	MANUAL REDUCTION FOR VAGINAL INVERSION OF THE UTERUS, SURGERY	

Otolaryngology

The items apply to surgical operations carried out using any technique, method and instrumentation/equipment. Some of the services listed in this branch (and related sub-branches), if included in the Covers of the Health Plan, are refundable by the Fund - at the conditions set out in the Health Plan - exclusively during the relevant specialist consultation (which must also be included in the relevant Health Plan Cover), i.e. they are not refundable if carried out in separate sessions and/or by different operators. Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

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53181	1362	ANTHROACTICOTOMY WITH LABYRINTHECTOMY	
53231	1363	BRAIN ABSCESS, OPENING VIA TRANSMASTOID	
53041	1364	DUCT ABSCESS, INCISION OF	
53223	1365	EXTRADURAL ABSCESS, TRANSMASTOID OPENING	
53108	1366	COMPLETE CONGENITAL AURIS ATRESIA	
55301	1367	INCOMPLETE CONGENITAL AURIS ATRESIA	
53132	1368	TUBAL CATHETERISATION (PER SESSION)	
53017	1369	FOREIGN BODIES FROM DUCT, REMOVAL BY NATURAL MEANS WITH FLUSHING	

53025	1370	FOREIGN BODIES FROM DUCT, INSTRUMENTAL REMOVAL WITH MICROSCOPE (OTOMICROSCOPY)	
53033	1371	FOREIGN BODIES, SURGICAL REMOVAL RETROAURICULARLY	
55319	1372	TRANSTYMPANIC DRAINAGE	
53058	1373	PAVILION HAEMATOMA, INCISION OF	
53199	1374	MASTOIDECTOMY	
53314	1375	RADICAL MASTOIDECTOMY	
55327	1376	INTRA-AURICULAR MYRINGOPLASTY	
55335	1377	RETRO-AURICULAR MYRINGOPLASTY	
53140	1378	MYRINGOTOMY (AS SINGLE OPERATION)	
53090	1379	PAVILION NEOPLASM, EXERESIS OF	
55343	1380	DUCT NEOPLASMS, EXERESIS	
53280	1381	VESTIBULAR NERVE, SECTION OF	
53298	1382	EIGHTH NERVE NEUROMA	
53082	1383	OSTEOMAS OF THE DUCT, REMOVAL OF	
55350	1384	PETROSECTOMY	
53215	1385	SUPPURATED PETROSITES, TREATMENT OF	
53066	1386	AURICULAR OR RETROAURICULAR POLYPS OR CYSTS, REMOVAL OF	
53207	1387	REVISION OF RADICAL MASTOIDECTOMY, SURGERY OF	
53264	1388	ENDOLYMPHATIC SAC, SURGERY OF	
53256	1389	STAPEDECTOMY	
55368	1390	STAPEDOTOMY	
53330	1391	EARWAX PLUGS, EXTRACTION OF	Refundable once per year (1 January - 31 December) regardless of number
53157	1392	TYMPANOPLASTY WITH MASTOIDECTOMY	
53249	1393	TYMPANOPLASTY WITHOUT MASTOIDECTOMY	
55376	1394	TYMPANOPLASTY, SECOND TIME OF	
53124	1395	EXPLORATORY TYMPANOTOMY	
53306	1396	TUMOURS OF THE MIDDLE EAR, REMOVAL OF	
Nose and Paranasal Sinuses			
Rhinoseptoplasty and septoplasty operations for aesthetic purposes, or following surgical aesthetic corrections or attributable to these, regardless of Health Plan, are never refundable even if they are described case-by-case in the Nomenclature and even when they are concurrent with other refundable operations provided for in the Plan itself. For rhinoseptoplasty and septoplasty operations, if provided for in your Health Plan and regardless of Health Plan, submission of pre- and post-operation photographs and pre-operation rhinomanometry (or pre-operation CT scan) is obligatory in order to exclude their being for aesthetic purposes.			
53835	1397	ADENOIDECTOMY	

53843	1398	ADENOTONSILLECTOMY	
53579	1399	CHOANAL ATRESIA, SURGERY FOR	
53728	1400	FRONTAL SINUS CATHETERISATION	
53512	1401	CYSTS AND SMALL BENIGN TUMOURS OF THE NASAL CAVITIES, REMOVAL OF	
53447	1402	FOREIGN BODIES, REMOVAL OF	
53686	1403	CHOANAL BONE DIAPHRAGM, REMOVAL BY TRANSPALATINE ROUTE	
53439	1404	HAEMATOMA, SEPTAL ABSCESS, DRAINAGE	
53595	1405	ETHMOID, UNILATERAL RADICAL DRAINAGE (AS A SINGLE OPERATION)	
53603	1406	ETHMOID, BILATERAL ROOT DRAINAGE (AS A SINGLE OPERATION)	
55384	1407	ORAL-ANTRAL FISTULAS	
53538	1408	NASAL BONE FRACTURES, REDUCTION OF	
53736	1409	SINUS INSTILLATION (PER THERAPY CYCLE)	
53520	1410	OZENA, SURGICAL TREATMENT OF	
53587	1411	NASAL OR CHOANAL POLYPS, SIMPLE REMOVAL OF	
55392	1412	RHINOPHYMA, OPERATION	
53561	1413	RHINOSEPTOPLASTY WITH FREE BONE GRAFTS (EXCLUDING AESTHETIC PURPOSES, PROVEN BY PREOPERATIVE RHINOMANOMETRY)	
53553	1414	RECONSTRUCTIVE OR FUNCTIONAL RHINOSEPTOPLASTY WITH TURBINOTOMY (EXCLUDING AESTHETIC PURPOSES, PROVEN BY PREOPERATIVE RHINOMANOMETRY)	
55400	1415	RHINOSEPTOPLASTY, REVISION OF FUNCTIONAL OR RECONSTRUCTIVE SURGERY (EXCLUDING AESTHETIC PURPOSES, PROVEN BY PREOPERATIVE RHINOMANOMETRY)	
55418	1416	PARANASAL SINUSES, MUCOCELE SURGERY	
53660	1417	PARANASAL SINUSES, RADICAL SURGERY OR UNILATERAL FESS (FUNCTIONAL ENDOSCOPIC SINUS SURGERY)	
55426	1418	PARANASAL SINUSES, RADICAL SURGERY OR BIILATERAL FESS (FUNCTIONAL ENDOSCOPIC SINUS SURGERY)	
53645	1419	FRONTAL SINUS, EXTERNAL EMPTYING	
53637	1420	FRONTAL SINUS, NASAL EMPTYING (AS A SINGLE OPERATION)	
53744	1421	MAXILLARY SINUS, DIAMEATIC PUNCTURE OF THE	
53611	1422	MAXILLARY SINUS, UNILATERAL RADICAL SINUS EMPTYING (AS A SINGLE OPERATION)	
55434	1423	MAXILLARY SINUS, BILATERAL RADICAL SINUS EMPTYING (AS A SINGLE OPERATION)	
53652	1424	SPHENOIDAL SINUS, TRANSNASAL OPENING (AS A SINGLE OPERATION)	
55442	1425	CONSERVATIVE NEUROVASCULAR DECOMPRESSIVE SEPTAL-ETHMOIDOPHENOTOMY WITH FUNCTIONAL TURBINOTOMIES	
55459	1426	FIRST AND SECOND DEGREE UNILATERAL EXTENDED RADICAL NEUROVASCULAR DECOMPRESSIVE SEPTAL-ETHMOIDOPHENOTOMY	

55467	1427	THIRD DEGREE UNILATERAL EXTENDED RADICAL NEUROVASCULAR DECOMPRESSIVE SEPTAL-ETHMOIDOPHENOTOMY	
53504	1428	RECONSTRUCTIVE OR FUNCTIONAL SEPTOPLASTY WITH TURBINOTOMY	
53454	1429	NASAL SYNECHIAE, REMOVAL OF	
53488	1430	SPURS OR SEPTAL RIDGES, REMOVAL OF	
53413	1431	ANTERIOR NASAL TAMPONADE	
53421	1432	ANTERO-POSTERIOR NASAL TAMPONADE	
53710	1433	BENIGN TUMOURS OF THE PARANASAL SINUSES, REMOVAL OF	
53678	1434	MALIGNANT TUMOURS OF THE NOSE OR SINUSES, REMOVAL OF	
53769	1435	LOWER TURBINATES, FUNCTIONAL EMPTYING (AS A SINGLE OPERATION)	
53462	1436	TURBINATES, CAUTERIZATION OF (AS A SINGLE OPERATION)	
53470	1437	TURBINOTOMY (AS A SINGLE OPERATION)	
53496	1438	SEPTAL VARICES, CAUTERIZATION TREATMENT	
Pharynx and Oral cavity			
53850	1439	PERITONSILLAR ABSCESS, INCISION.	
53918	1440	RETROPHARYNGEAL OR LATERO-PHARYNGEAL ABSCESS	
53926	1441	ENDOPHARYNGEAL FOREIGN BODIES, REMOVAL OF	
59657	1442	PARTIAL PHARYNGECTOMY	
53884	1443	NASOPHARYNGEAL FIBROMA	
55475	1444	LEUKOPLAKIA, REMOVAL	
55483	1445	PARAPHARYNGEAL NEOPLASMS	
53819	1446	TONSILLECTOMY	
53868	1447	BENIGN PHARYNGOTONSILLAR TUMOUR, REMOVAL OF	
53876	1448	MALIGNANT PHARYNGOTONSILLAR TUMOUR, REMOVAL OF	
53983	1449	UGULOTOMY	
53959	1450	VELOPHARYNGOPLASTY OR HYOID BONE ADVANCEMENT	
Larynx and hypopharynx			
54163	1451	ADDUCTORS, SURGERY FOR PARALYSIS OF	
54056	1452	ABSCESS OF THE EPIGLOTTIS, INCISION	
54205	1453	LARYNGOSCOPY BIOPSY	
54213	1454	MICROLARYNGOSCOPY BIOPSY	
54197	1455	ENDOLARYNGEAL CAUTERIZATION	

54247	1456	VOCAL CORDS, MICROLARYNGOSCOPY DECORTICATION	
54106	1457	CORDECTOMY	
55491	1458	LASER CORDECTOMY	
54031	1459	FOREIGN BODIES, REMOVAL BY LARYNGOSCOPY	
54155	1460	LARYNGEAL DIAPHRAGM, EXCISION WITH PLASTIC SURGERY RECONSTRUCTION	
54221	1461	LARYNGEAL DILATION (PER SESSION)	
59665	1462	EPIGLOTTISECTOMY	
54114	1463	PARTIAL LARYNGECTOMY	
55509	1464	PARTIAL LARYNGECTOMY WITH UNILATERAL LATEROCERVICAL EMPTYING	
55525	1465	TOTAL LARYNGECTOMY WITHOUT LATEROCERVICAL EMPTYING	
54122	1466	TOTAL LARYNGECTOMY WITH UNILATERAL LATEROCERVICAL EMPTYING	
55517	1467	TOTAL LARYNGECTOMY WITH BILATERAL LATEROCERVICAL EMPTYING	
55533	1468	LARYNGOCELE	
54130	1469	TOTAL LARYNGOPHARYNGECTOMY	
54015	1470	BENIGN NEOFORMATIONS, REMOVAL BY LARYNGOSCOPY	
54023	1471	BENIGN NEOFORMATIONS, REMOVAL BY MICROLARYNGOSCOPY	
55541	1472	BENIGN NEOFORMATIONS, ORGANIC AND FUNCTIONAL STENOSIS IN LARYNGEAL MICROSURGERY WITH CO2 LASER	
54072	1474	LARYNGEAL PAPILLOMA	
54064	1475	PERICHONDRITIS AND PERILARYNGEAL ABSCESS	
56671	1476	NASOLARYNGOSCOPY WITH FLEXIBLE FIBRE OPTIC FIBERSCOPE DURING THE EXAMINATION	
Interventional radiology			
The items, if provided for and to the extent provided for by the Health Plan, include the entire medical-surgical-radiological-anaesthesiological team, the use of contrast, the necessary X-rays (all necessary projections) and the professional fee for the possible application of stents (except in the cases described). There are no exceptions. Any high-cost special materials, if provided for by the Health Plan - except as set out case-by-case in this Nomenclature or as considered included - and any medications are refunded as described in the relevant Section D. - Medications and Materials. Tract is defined as: cervical column or dorsal column or lumbo-sacral column. For refund purposes, therefore, the valuation of the operation/s will be equal to 1 if the procedure itself involves the same tract. All services/operations listed below can be carried out with any technique, equipment/instrumentation, except in the cases described.			
80796	1477	ABDOMINAL AND ILIAC AORTA ARTERIOGRAPHY PLUS ANGIOPLASTY	
80804	1478	ABDOMINAL AORTA ARTERIOGRAPHY PLUS RENAL ARTERY ANGIOPLASTY	
80812	1479	ABDOMINAL AORTA ARTERIOGRAPHY PLUS SELECTIVE COMPLEX EMBOLIZATION (ANGIOMAS OR ARTERIOVENOUS FISTULAS OR ANEURYSMS)	
80820	1480	ABDOMINAL AORTA ARTERIOGRAPHY PLUS SIMPLE EMBOLIZATION OF TUMOURS	
59673	1481	ARTERIOGRAPHY WITH ALCOHOLIZATION OF LESIONS OF ANY ORGAN	
59681	1482	ARTERIOGRAPHY WITH EMBOLIZATION OF PERIPHERAL	

		ARTERY ANEURYSMS	
80838	1483	CAVOGRAPHY WITH TEMPORARY OR PERMANENT ENDOLUMINAL CAVAL FILTER PLACEMENT (INCLUDING SUBSEQUENT REMOVAL)	
58009	1484	KYPHOPLASTY OR VERTEBROPLASTY	
80846	1485	PERCUTANEOUS OPERATIVE CHOLANGIOGRAPHY WITH UNILATERAL OR BILATERAL BILIARY DRAINAGE FOR ANY BENIGN OR MALIGNANT PATHOLOGY	
58017	1486	PERCUTANEOUS OPERATIVE CHOLANGIOGRAPHY WITH UNILATERAL OR BILATERAL BILIARY DRAINAGE FOR ANY BENIGN OR MALIGNANT PATHOLOGY WITH GALLSTONE REMOVAL, BILIOPLASTY, MULTIPLE ENDOPROSTHESIS PLACEMENT	
80853	1487	PERCUTANEOUS OPERATIVE CHOLANGIOGRAPHY WITH DOUBLE BILIARY DRAINAGE OR WITH ENDOPROSTHESIS	
59698	1488	CHOLANGIOPANCREATOGRAPHY (ERCP) WITH PAPILLOSPHINCTEROTOMY AND POSSIBLE STONE REMOVAL, INCLUDING POSSIBLE NASO-BILIARY PROBE	
58025	1489	CHOLANGIOPANCREATOGRAPHY (ERCP) WITH PAPILLOSPHINCTEROTOMY AND LITHOTRIPSY AND SUBSEQUENT STONE REMOVAL INCLUDING POSSIBLE NASO-BILIARY PROBE	
59706	1490	CHOLANGIOPANCREATOGRAPHY (ERCP) WITH PAPILLOSPHINCTEROTOMY, WITH PROSTHESIS (METAL OR PLASTIC)	
58033	1491	DIAGNOSTIC CHOLANGIOPANCREATOGRAPHY (ERCP)	
80861	1492	OPERATIVE CHOLANGIOPANCREATOGRAPHY WITH POSSIBLE PLACEMENT AND/OR REMOVAL OF PROSTHESIS, INCLUDING EXAMINATION	
80879	1493	PERCUTANEOUS CT/ECHO-GUIDED DRAINAGE OF ABSCESSES AND/OR COLLECTED THORACIC OR ABDOMINAL FLUID OR MUSCLE INFILTRATIONS FOR MYOFASCIAL SYNDROME (INCLUDING EXAMINATIONS AND RADIOLOGY)	
57054	1494	PERCUTANEOUS DILATATION OF URETERAL STENOSIS WITH OR WITHOUT STENT PLACEMENT	
42796	1495	ENDOSCOPIC BILIARY DRAINAGE	
58041	1496	UNILATERAL TUBAL UNBLOCKING	
58058	1497	BILATERAL TUBAL UNBLOCKING	
58066	1498	UTERINE FIBROMAS EMBOLIZATION	
80887	1499	EMBOLIZATION OF MALFORMATIONS AND/OR ANEURYSMS AND/OR CEREBRAL VASCULAR FISTULAS OR ENDOCRANIAL TUMOURS	
80895	1500	FIBRINOLYSIS ARTERIAL OCCLUSION	
80903	1501	PHLEBOGRAPHY WITH ENDOLUMINAL SCLEROSIS OF THE INTERNAL SPERMATIC VEIN OR UNILATERAL OVARIAN VEIN	
80911	1502	PHLEBOGRAPHY WITH ENDOLUMINAL SCLEROSIS OF THE INTERNAL SPERMATIC VEIN OR BILATERAL OVARIAN VEIN	
80929	1503	UNILATERAL PERCUTANEOUS OPERATIVE PYELOGRAPHY WITH DRAINAGE	
80937	1504	BILATERAL PERCUTANEOUS OPERATIVE PYELOGRAPHY WITH DRAINAGE	
58074	1505	PERCUTANEOUS PSEUDOCYSTOGASTROSTOMY WITH STOMACH PUNCTURE AND TRANSHEPATIC DRAINAGE	

57062	1506	PLACEMENT OF GASTROINTESTINAL STENTS (OESOPHAGEAL, DUODENAL, COLIC, ETC.)	
58082	1507	CAROTID STENT PLACEMENT WITH CEREBRAL PROTECTION SYSTEM FOR CAROTID STENOSIS TREATMENT	
57070	1508	PLACEMENT OF TRACHEAL STENTS	
58090	1509	ULTRASOUND-GUIDED HEPATIC ARTERIAL PORT-A-CATH PLACEMENT WITH HEPATIC ARTERIOGRAPHY AND GASTRODUODENAL ARTERY EMBOLIZATION	
58109	1510	PERCUTANEOUS PSEUDOCYSTOGASTROSTOMY FOR REMOVAL OF TRANSGASTRIC DRAINAGE AND PLACEMENT OF PSEUDOCYSTOGASTRIC ENDOPROSTHESIS	
58117	1511	THERMOABLATION OR CRYOABLATION OF PRIMARY OR METASTATIC NEOPLASMS	
58125	1512	TRANSCROTAL + RETROGRADE AND ANTEROGRADE INTERNAL SPERMATIC PHLEBOGRAPHY, MICROSURGERY FOR	
58133	1513	ENDOVASCULAR TREATMENT OF ILIAC ARTERY ANEURYSMS	
58141	1514	ENDOVASCULAR TREATMENT OF COMMON ILIAC ARTERY ANEURYSMS AND HYPOGASTRIC ARTERY EMBOLIZATION	
58158	1515	TIPS (PORT-SUPERHEPATIC SHUNT)	

Urology

Any high-cost special materials, if provided for by the Health Plan - except as set out case-by-case in this Nomenclature or as considered included - and any medications are refunded as described in the relevant Section D. - Medications and Materials.

All services/operations listed below, if provided for and within the limits of the Health Plan, can be performed using any technique, equipment/instrumentation, except as described.

Endoscopic procedures include instrumentation/equipment (disposable materials related to the instrumentation), any urethrotomy, lysis of transurethral adhesions, and incision of the bladder neck.

Please note that the term “single session” is meant regardless of the number of services carried out.

Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.

Small operations and urological diagnostics

49056	1516	CHANGING OF CYSTOSTOMY TUBE	
49064	1517	CHANGING OF PYELOSTOMY TUBE	
55558	1518	BLADDER CATHETERISATION IN WOMEN (AS A SINGLE SERVICE)	
49015	1519	BLADDER CATHETERISATION IN MEN WITH STENOTIC PATHOLOGY (AS A SINGLE SERVICE)	
56689	1520	CYSTOMANOMETRY	
57089	1521	DILATION OF THE URETHRAL MEATUS (AS A SINGLE SERVICE)	
73692	1522	COMPLETE URODYNAMIC EXAMINATION	
73700	1523	URODYNAMIC EXAMINATION PLUS PHARMACOLOGICAL TESTS	
56697	1524	BLADDER INSTILLATION WITH CHEMOTHERAPY (PER SESSION, INCLUDING BLADDER CATHETERISATION)	
50419	1525	PARAPHIMOSIS, NON-INVASIVE REDUCTION OF	
49049	1526	PROSTATE, MASSAGE OF (FOR DIAGNOSTIC PURPOSES)	

49031	1527	URETHRA, DILATION WITH SOFT OR RIGID PROBES (PER SESSION)	
73643	1528	UROFLOWMETRY (SERVICES AVAILABLE ON OUTPATIENT BASIS - SEE INTRODUCTION)	
Diagnostic endoscopy			
55574	1529	CYTOLOGICAL BRUSHING IN CYSTOSCOPY (AS A SINGLE OPERATION)	
49148	1530	CHROMOCYSTOSCOPY AND UNILATERAL URETERAL CATHETERISATION	
49155	1531	CHROMOCYSTOSCOPY AND BILATERAL URETERAL CATHETERISATION	
49130	1532	CHROMOCYSTOSCOPY FOR FUNCTIONAL EVALUATION	
57097	1533	DIAGNOSTIC PERCUTANEOUS PYELOURETEROSCOPY	
49205	1534	URETEROSCOPY AND/OR URETERORENOSCOPY (ALL-INCLUSIVE)	
49122	1535	SIMPLE URETHROCYSTOSCOPY (AS SINGLE DIAGNOSTIC PROCEDURE)	
56705	1536	SIMPLE URETHROCYSTOSCOPY UNDER SEDATION INCLUDING ANAESTHETIST (AS SINGLE DIAGNOSTIC PROCEDURE)	
49213	1537	URETHROCYSTOSCOPY WITH BIOPSY(S) (AS A SINGLE OPERATION)	
Operative Endoscopy			
Endoscopic procedures include instrumentation/equipment (disposable materials related to the instrumentation), any urethrotomy, lysis of transurethral adhesions, and incision of the bladder neck. Please note that the term “single session” is meant regardless of the number of services carried out. Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.			
49254	1538	URETERAL STONES, EXTRACTION WITH SPECIAL PROBES	
55582	1539	BLADDER NECK, ENDOSCOPIC UNBLOCKING OPERATIONS	
49247	1540	FOREIGN BODIES IN BLADDER, CYSTOSCOPIC EXTRACTION OF	
57105	1541	DIATHERMOCOAGULATION OF BLADDER DIVERTICULA	
49221	1542	ELECTROCOAGULATION OF SMALL BLADDER TUMOURS - PER SESSION	
58166	1543	ENDOPELOLITHOTOMY FOR STENOSIS OF THE PYELO-URETERAL JOINT	
49197	1544	URETERAL FORMATIONS, ENDOSCOPIC RESECTION OF	
55590	1545	URINARY INCONTINENCE, OPERATION (TEFLON)	
55608	1546	URETERAL LITHOTRIPSY WITH ULTRASOUND, LASER, ETC.	
49270	1547	LITHOTRIPSY, ENDOSCOPIC BLADDER LITHOLAPAXY	
49171	1548	URETERAL MEATOTOMY (AS A SINGLE OPERATION)	
49163	1549	URETHRAL MEATOTOMY (AS A SINGLE OPERATION)	
49304	1550	BLADDER NEOPLASM, ENDOSCOPIC RESECTION OF	

57113	1551	OPERATIVE PERCUTANEOUS PYELOURETEROSCOPY	
56713	1552	PROSTATE, SURGERY WITH LASER OR INTERSTITIAL METHODS	
49296	1553	PROSTATE, ENDOSCOPIC RESECTION OR VAPORISATION OF (ANY TECHNIQUE AND EQUIPMENT, EXCLUDING CASES DESCRIBED)	
55632	1554	URETERAL BLADDER REFLUX, ENDOSCOPIC OPERATION (TEFLON)	
56721	1555	URETERAL STENTS, REMOVAL OF	
55640	1556	UNILATERAL URETERAL STENTING (AS A SINGLE OPERATION)	
55657	1557	BILATERAL URETERAL STENTING (AS A SINGLE OPERATION)	
49189	1558	URETEROCELE, ENDOSCOPIC SURGERY FOR	
49262	1559	ENDOSCOPIC URETHROTOMY (AS A SINGLE OPERATION)	
55665	1560	URETHRAL VALVE, ENDOSCOPIC RESECTION (AS A SINGLE OPERATION)	
55673	1561	WALL STENT FOR URETHRAL STENOSIS INCLUDING CYSTOSTOMY	
55681	1562	WALL STENT FOR ENDOSCOPIC URETHRAL STENOSIS (UROLUMEN)	
Urology - Surgical procedures			
Please note that some tests can be carried out on an outpatient basis, so that approval of these within the context of hospitalisation (any) will be subject to an assessment of the documented systemic pictures of critical relevance to the patient's health. In the context of a claim, for services received during hospitalisation (any), detailed medical documentation must be attached in which the reasons for the choice to use hospitalisation is highlighted.			
Kidney			
49502	1563	PERCUTANEOUS RENAL NEEDLE BIOPSY	
49346	1564	SURGICAL BIOPSY OF THE KIDNEY (AS A SINGLE OPERATION)	
55699	1565	PERCUTANEOUS RENAL CYST, PUNCTURE OF	
55707	1566	RENAL CYST, PERCUTANEOUS EVACUATION PUNCTURE WITH INJECTION OF SCLEROSING SUBSTANCES	
55715	1567	RENAL CYST, RESECTION	
55723	1568	HEMINEPHRECTOMY	
49353	1569	LUMBOTOMY FOR PARARENAL ABSCESSES	
49379	1570	WIDER NEPHRECTOMY FOR TUMOUR WITH POSSIBLE TREATMENT OF CAVAL THROMBUS (INCLUDING SURRENECTOMY)	
55764	1571	POLAR NEPHRECTOMY	
49361	1572	SIMPLE NEPHRECTOMY	
56739	1573	UNILATERAL PERCUTANEOUS NEPHROLITHOTRIPSY	
56747	1574	BILATERAL PERCUTANEOUS NEPHROLITHOTRIPSY	
49320	1575	NEPHROPESSES	
55624	1576	UNILATERAL PERCUTANEOUS NEPHROSTOMY	

55616	1577	BILATERAL PERCUTANEOUS NEPHROSTOMY	
55772	1578	RADICAL NEPHROURETERECTOMY WITH LYMPHADENECTOMY PLUS POSSIBLE SURRENECTOMY, SURGERY FOR	
49411	1579	RADICAL NEPHROURETERECTOMY (INCLUDING POSSIBLE SURRENECTOMY)	
49437	1580	PYELOCALICULOTOMY (AS A SINGLE OPERATION)	
49494	1581	PYELOCENTESIS (AS A SINGLE OPERATION)	
55780	1582	COMPLEX PYELONEPHROLITHOTOMY (NEPHROTOMY AND/OR BIVALVE), SURGERY OF	
49445	1583	PLASTIC PIELOURETER FOR STENOSIS OF THE JOINT	
49452	1584	SURRENECTOMY (COMPLETE TREATMENT)	
49460	1585	KIDNEY TRANSPLANT (INCLUSIVE OF ALL SERVICES AND MEDICAL EXPLANTATION AND IMPLANTATION OPERATIONS)	
Ureter			
56754	1586	URETERO-INTESTINAL FISTULA, SURGERY FOR (ANY TECHNIQUE)	
56762	1587	URETERO-INTESTINAL FISTULA, OPERATION WITH INTESTINAL RESECTION AND ANASTOMOSIS (ANY TECHNIQUE)	
56770	1588	URETEROVAGINAL FISTULAS, SURGERY FOR (ANY TECHNIQUE)	
58174	1589	MEGAURETER, REMODELLING SURGERY	
49650	1590	TRANSURETERO-URETEROANASTOMOSIS (AS A SINGLE OPERATION)	
57121	1591	SEGMENTAL URETERECTOMY	
49627	1592	UNILATERAL URETEROCYSTONEOSTOMY (AS A SINGLE OPERATION)	
49635	1593	BILATERAL URETEROCYSTONEOSTOMY (AS A SINGLE OPERATION)	
49544	1594	UNILATERAL URETEROCUTANEOSTOMY	
49551	1595	BILATERAL URETEROCUTANEOSTOMY	
49510	1596	URETEROENTEROPLASTY WITH CONTINENT POCKETS (UNILATERAL), SURGERY OF	
49866	1597	URETEROENTEROPLASTY WITH CONTINENT POCKETS (BILATERAL), SURGERY OF	
49569	1598	UNILATERAL URETERO-ILEO-ANASTOMOSIS (AS A SINGLE OPERATION)	
49577	1599	BILATERAL URETERO-ILEO-ANASTOMOSIS (AS A SINGLE OPERATION)	
55814	1600	NON-CONTINENT URETERO-ILEOCUTANEOSTOMY	
49585	1601	URETEROLYSIS PLUS OMENTOPLASTY	
49536	1602	LOMBO-ILIAC URETEROLITHOTOMY	
49528	1603	PELVIC URETEROLITHOTOMY	
49601	1604	UNILATERAL URETEROSIGMOIDOSTOMY	
49619	1605	BILATERAL URETEROSIGMOIDOSTOMY	

Bladder			
49775	1606	ABSCESS OF THE RETZIUS PREVESICAL SPACE	
55822	1607	PARTIAL CYSTECTOMY WITH URETEROCYSTONEOSTOMY	
49692	1608	SIMPLE PARTIAL CYSTECTOMY	
49718	1609	TOTAL CYSTECTOMY INCLUDING LYMPHADENECTOMY AND PROSTATOVESICULECTOMY OR UTEROANNESSIECTOMY WITH ILEUM OR COLOBLADDER	
55848	1610	TOTAL CYSTECTOMY INCLUDING LYMPHADENECTOMY AND PROSTATOVESICULECTOMY OR UTEROANNEXECTOMY WITH RECTAL NEOBLADDER INCLUDED	
55830	1611	TOTAL CYSTECTOMY INCLUDING LYMPHADENECTOMY AND PROSTATOVESICULECTOMY OR UTEROANNESSIECTOMY WITH BILATERAL URETEROSIGMOIDOSTOMY OR URETEROCUTANEOSTOMY	
56788	1612	CYSTOCENTESIS (AS A SINGLE OPERATION)	
55855	1613	CYSTOLITHOTOMY (AS A SINGLE OPERATION)	
49684	1614	CYSTOPEXY	
49726	1615	CYSTORRHAPHY FOR TRAUMATIC RUPTURE	
49676	1616	SUPRAPUBIC CYSTOSTOMY (AS A SINGLE OPERATION)	
49767	1617	BLADDER NECK, Y/V PLASTY (AS A SINGLE OPERATION)	
49742	1618	DIVERTICULECTOMY	
55863	1619	BLADDER EXTROPHY (COMPLETE TREATMENT)	
49809	1620	FISTULA AND/OR CYST OF THE URACHUS, SURGERY FOR	
49825	1621	SUPRAPUBIC FISTULA, SURGERY FOR (AS THE ONLY OPERATION)	
49791	1622	VESICO-INTESTINAL FISTULA WITH INTESTINAL RESECTION AND/OR CYSTOPLASTY, SURGERY FOR	
49783	1623	VESICO-VAGINAL OR VESICO-RECTAL FISTULA, SURGERY FOR	
56796	1624	URINARY INCONTINENCE IN WOMEN, VAGINAL OR ABDOMINAL SURGERY	
49817	1625	BLADDER, PLASTIC SURGERY FOR ENLARGEMENT (COLON/ILEUM)	
49841	1626	BILATERAL ANTIREFLUX VESICOPLASTY	
49833	1627	UNILATERAL ANTIREFLUX VESICOPLASTY	
Prostate			
49965	1628	ULTRASOUND-GUIDED NEEDLE PROSTATE ASPIRATION/AGOBIOPSY (ANY NUMBER OF SAMPLES, PROVEN BY HISTOLOGICAL EXAMINATION REPORT)	
49957	1629	TREATMENT FOR PROSTATE DISEASE USING PROSTATHERMER (PER ANNUAL TREATMENT CYCLE)	Refundable once a year (ref. invoice)
56804	1630	LAPAROTOMIC LYMPHADENECTOMY (AS A SINGLE OPERATION)	
49924	1631	RADICAL PROSTATECTOMY FOR CARCINOMA WITH LYMPHADENECTOMIES, INCLUDING POSSIBLE LIGATION OF THE VAS DEFERENS (ANY ACCESS AND TECHNIQUE)	

49916	1632	SUBCAPSULAR PROSTATECTOMY FOR ADENOMA	
Urethra			
50039	1633	STONES OR FOREIGN BODIES, REMOVAL OF	
55871	1634	URETHRAL CARUNCLE	
50013	1635	CYSTS OR DIVERTICULA OR PARAURETHRAL ABSCESSES, SURGERY FOR	
55889	1636	DIATHERMOCOAGULATION OF URETHRAL CONDYLOMAS WITH FLAT URETHRAL PLACEMENT	
50104	1637	EPISPADIAS OR BALANIC HYPOSPADIAS AND URETHROPLASTY, SURGERY FOR	
50112	1638	EPISPADIAS OR PENILE HYPOSPADIAS AND URETHROPLASTY, SURGERY FOR	
55897	1639	URETHRAL FISTULAS	
50153	1640	URINARY INCONTINENCE, APPLICATION OF ARTIFICIAL SPHINCTERS	
50120	1641	SCROTAL OR PERINEAL HYPOSPADIAS, SURGERY FOR (COMPLETE TREATMENT-PLASTY)	
50088	1642	MEATOTOMY AND MEATOPLASTY	
50021	1643	MEATUS POLYPS, COAGULATION OF	
55905	1644	URETHRAL MUCOSAL PROLAPSE	
50062	1645	URETHRAL RESECTION AND PENILE ANTERIOR URETHRORRHAGE	
50070	1646	URETHRAL RESECTION AND POSTERIOR MEMBRANOUS URETHRORRHAGE	
55913	1647	TRAUMATIC RUPTURE OF THE URETHRA	
50161	1648	MICTURITION REHABILITATION THERAPY (INPATIENT, PER SESSION)	
57046	1649	SEGMENTAL URETHRECTOMY	
55921	1650	TOTAL URETHRECTOMY	
55939	1651	URETHROPLASTIES (IN ONE SESSION), SURGERY OF	
50096	1652	URETHROPLASTY (FREE OR PEDUNCULATED FLAPS), COMPLETE TREATMENT	
50054	1653	PERINEAL URETHROSTOMY	
Male Genital System			
A peniscopy, regardless of Health Plan, is included in the specialist consultation (if this is provided for and in any case under the conditions specified).			
50435	1654	APPLICATION OF TESTICULAR PROSTHESIS (AS A SINGLE OPERATION)	
55947	1655	UNILATERAL TESTICULAR BIOPSY	
55954	1656	BILATERAL TESTICULAR BIOPSY	
50369	1657	CYSTS OF THE FUNICULUS AND EPIDIDYMIS, EXERESIS	
56002	1658	CORPOROPLASTY (AS A SINGLE OPERATION)	

50245	1659	TOTAL HAEMASCULATIO AND POSSIBLE LYMPHADENECTOMY	
50344	1660	EPIDIDYMECTOMY	
50211	1661	PHIMOSIS WITH FRENULUM PLASTIC SURGERY, CIRCUMCISION FOR	
55962	1662	SCROTAL OR INGUINAL FISTULAS	
55970	1663	FRENULOTOMY AND FRENULOPLASTY	
50377	1664	FUNICULUS, SURGICAL DETORSION OF THE	
50260	1665	HYDROCELE, SURGERY FOR	
50252	1666	HYDROCELE, PUNCTURE OF	
50294	1667	UNILATERAL ORCHIDOPEXY	
50492	1668	BILATERAL ORCHIDOPEXY	
50328	1669	WIDER ORCHIDECTOMY WITH UNILATERAL ABDOMINAL OR RETROPERITONEAL LYMPHADENECTOMY	
58182	1670	WIDER ORCHIDECTOMY WITH BILATERAL ABDOMINAL OR RETROPERITONEAL LYMPHADENECTOMY	
50302	1671	BILATERAL SUBCAPSULAR ORCHIDECTOMY	
50336	1672	UNILATERAL ORCHIEPIDIMECTOMY WITH POSSIBLE PROSTHESIS	
50427	1673	BILATERAL ORCHIEPIDIMECTOMY WITH POSSIBLE PROSTHESIS	
50401	1674	PARAPHIMOSIS, OPERATION FOR (AS THE ONLY OPERATION)	
50229	1675	PENIS, PARTIAL AMPUTATION OF	
50237	1676	PENIS, TOTAL AMPUTATION WITH LYMPHADENECTOMY	
56010	1677	PENIS, TOTAL AMPUTATION OF	
50468	1678	PRIAPISM (PERCUTANEOUS), SURGERY FOR	
56028	1679	PRIAPISM (SHUNT), SURGERY FOR	
55996	1680	BUCK'S FASCIA SCLEROSIS, SURGERY FOR (ANY TREATMENT)	
50393	1681	SCROTUM, RESECTION OF THE	
56036	1682	TESTICLE TRAUMA, REPAIR SURGERY FOR	
56051	1683	VARICOCELE WITH MICROSURGICAL TECHNIQUE	
50278	1684	VARICOCELE, SURGERY FOR	

SECTION P. DIAGNOSTIC TESTS

The Fund refunds all tests listed and within the limits of this Nomenclature only if they are provided for by the individual Covers of the Health Plans (as provided for by these), only if carried out for diagnostic-therapeutic purposes and according to the diagnostic protocols validated by conventional medicine. Tests related to research and/or clinical trials are excluded.

To obtain a refund you must, in addition to the expenditure documentation, submit details of the services performed as well as the prescription of the specialist and/or general practitioner, together with obligatory specification of the type of pathology and/or the diagnostic query that made the tests necessary. The Fund does not refund services related to check-ups regardless of the Health Plan, the type or the reason for which they are carried out.

FasiOpen reserves the right to: evaluate, on a case-by-case basis, the relevance of the tests carried out to the stated pathology; request a copy of the diagnostic reports, as well as the case records that already provide for it, should there be a need for further investigation.

Please remember that diagnostic tests are refundable, even if received upon payment of public healthcare charges, if the latter explicitly refer to services covered by the Nomenclature and included in the provisions of your Health Plan; i.e. if the service is covered by the FasiOpen Basic Nomenclature but is not listed among the outpatient diagnostic tests covered in your Health Plan, it cannot be refunded even if received upon payment of public healthcare charges. In the event of simultaneous payment of public healthcare charges for services in affiliation with the S.S.R. (Italian Regional Health Service) and private services, you must ask the healthcare facility to indicate not only the type of service but also the breakdown of the amounts between the those relating to public healthcare charges and those relating to private services. Please note that any quantitative and/or time limits for services will also apply to those subject to the payment public healthcare charges only.

As regards clinical analyses, please note that the taking of samples is included in the services themselves. Any claim for the taking of samples at home (if provided for by the Covers of the Health Plan), as an additional item to the test itself and limited to those covered by the Nomenclature and included in your Health Plan, must be clearly mentioned in the medical prescription and must be in-line with the pathology, i.e. it must be compatible with the clinical picture that made taking samples at home necessary.

For radiological tests and/or diagnostic tests using nuclear medicine, the relevant fees relate to complete examinations of projections and the number of x-rays needed for an exhaustive investigation to be provided. They also include radiologist fees and/or those of the nuclear medicine specialist and/or other specialists (e.g. anaesthetist/anaesthesiologist), of the technical staff and, where not otherwise expressly provided for in the specific branch introductions, also contrast media, materials, medicines and anything else necessary for the purposes of the test. Please also note that, for Cover-based Health Plans, the contrast medium is deemed to be a separate item so that any fixed and percentage excesses will also be applied to this item.

It is therefore excluded that healthcare facilities will charge clients of the Fund for the above services in addition to for the tests themselves.

For some diagnostic tests, a reduction of 50% is applicable on the second test (or, in any case, on the least costly one), as mentioned in the respective “Specific Branch Introductions”. As regards the above, the term “during the same session” means during the same access to the healthcare facility (documented or detectable); thus, in the case of 2 tests carried out, the 50% reduction (where applicable) will be applied if a different access occasion is not unequivocally detectable.

Clinical Analyses

The taking of samples is included in the test referred to, except for in cases specifically described in the “Taking of Samples” section. In the latter case, please note that any claim for “sample taking at home”, if provided for in the Health Plan, must be indicated in the medical prescription and must be supported by a clinical picture that is compatible with the claim itself. Analyses can be carried out with any technique or method and the fee is for each analysis except as specified for the individual items.

Unless otherwise specified, tests relate to any type of liquid or biological tissue.

The Fund reserves the right to assess, on a case-by-case basis, the relevance of the tests carried out to the stated pathology.

Laboratory analyses and medical-surgical procedures envisaged for the treatment of stem cells are only payable if included in the Nomenclature and therefore in the Covers of the individual Health Plans and, in any case, within the limits set out by these.

All laboratory analyses listed in this Nomenclature are payable only and exclusively if provided for by the Covers of the individual Health Plan (within the relevant application context) and if invoiced by duly authorised analysis laboratories and accompanied by the relevant medical prescription with diagnosis. No other possibilities are available. All tests listed in the Nomenclature, including genetic analyses, if provided for by the Covers of the Health Plan and within the limits and conditions specified therein, are refunded if carried solely out for diagnostic-therapeutic purposes and according to the diagnostic protocols sanctioned by conventional medicine. Strictly excluded from refund are preventive medicine services (other than those expressly provided for in the FasiOpen prevention packages), experimental and/or research services, and anything else set out in “Exclusions” and in the ““Services not covered by FasiOpen” paragraph within the Guides of the individual Health Plans.

Please note that “Total Proteinemia” tests are included within “Serum Protein Electrophoresis” tests.

72199	1685	11 TOTAL CORTICOSTEROIDS	
73007	1686	17 ALPHA HYDROXY PROGESTERONE (17 OHP)	
72231	1687	17 HYDROXYCORTICOSTEROIDS	

72223	1688	17 KETOSTEROIDS	
73908	1689	5 HYDROXYINDOLEACETIC (5 HIAA)	
73882	1690	5 NUCLEOTIDASE	
65038	1691	ACETYLCHOLINESTERASE	
71217	1692	ACETONE OR ACETONURIA	
71266	1693	BILIARY ACIDS	
71183	1694	FREE FATTY ACIDS (NEFA)	
73916	1695	URINARY CITRIC ACID	
71274	1696	DELTA AMINO LEVULINIC ACID (ALA)	
72751	1697	NATIVE DEOXYRIBONUCLEIC ACID (NDNA)	
70086	1698	HIPPURIC ACID/METHYLLIPURIC ACID	
65046	1699	HYALURONIC ACID (HA)	
71191	1700	LACTIC ACID	
73924	1701	MANDELIC ACID	
73932	1702	HOMOVANILLIC ACID	
70084	1703	PARA-AMINO-HIPPURIC ACID (PAI)	
71209	1704	PYRUVIC OR PHENYLPYRUVIC ACID	
73940	1705	SIALIC ACID	
73957	1706	VALPROIC ACID	
72306	1707	VANILMANDELIC ACID	
72371	1708	ACTH (CORTICOTROPIC HORMONE)	
73965	1709	CYCLIC ADENOSINE MONOPHOSPHATE (AMPC)	
76547	1710	ADH (ANTIDIURETIC HORMONE)	
71449	1711	AGGLUTINATION FOR OTHER STRAINS OF GERMS	
73981	1712	PERTUSSIS AGGLUTINATION	
69991	1713	COLD AGGLUTININS	
69983	1714	ERYTHROCYTE ALA-DEHYDRASE	
73953	1715	SERUM ALBUMIN (OR ALBUMIN COLON TEST)	
65054	1716	ALBUMIN 24H (URINE)	
74005	1717	ALCOHOLIMETRY	
74039	1718	SERUM ALDOLASE (OR OTHER UNSPECIFIED ENZYMES)	
72215	1719	BASAL ALDOSTERONE	
65062	1720	ALDOSTERONE CLINOSTATISM OR ORTHOSTATISM	
72553	1721	ALPHA 1 ANTITRYPSIN	

71035	1722	ALPHA 1 FETOPROTEIN IN BLOOD	
65719	1723	ALPHA 1 FETOPROTEIN IN AMNIOTIC FLUID	
74047	1724	ALPHA 1 ACID GLYCOPROTEIN	
74054	1725	ALPHA 1 MICROGLOBULIN	
69975	1726	ALPHA 2 ANTIPLASMIN	
74195	1727	ALPHA 2 MACROGLOBULIN	
74203	1728	3 ALPHA ANDROSTENEDIOL	
74351	1729	AMYLASE ISOENZYMES (PANCREATIC FRACTION)	
70946	1730	SERUM OR URINARY AMYLASE	
69967	1731	AMINO ACIDS, SINGLE DOSAGE	
71308	1732	TOTAL AMINO ACIDS (S/U)	
74358	1733	URINARY AROMATIC AMINES (BENZOL AND ITS DERIVATIVES AND INORGANIC SOLVENTS)	
74450	1734	AMMONIA IN URINE	
70961	1735	PLASMA AMMONIUM	
74468	1736	ANAEROBIOSIS, CULTURE TEST IN	
69934	1739	ANDROSTENEDIOL GLUCURONIDE	
74476	1740	SERUM ANDROSTENEDIONE (D4)	
74484	1741	AMPHETAMINE	
74492	1742	ANGIOTENSIN CONVERTING ENZYME (A.C.E.)	
65070	1743	BASAL ANGIOTENSIN I	
74494	1744	BASAL ANGIOTENSIN I AND AFTER STIMULATION WITH FUROSEMIDE	
74496	1745	ANTIARRHYTHMICS, DOSAGE (AMIODARONE, DISOPYRAMIDE, FLECAINIDE, LIDOCAINE, PROCAINAMIDE, ETC.)	
71316	1746	ANTIBIOGRAM (AT LEAST 10 ANTIBIOTICS)	
74500	1747	ANTIBIOGRAM FOR MYCOBACTERIA (AT LEAST 3 ANTIBIOTICS)	
74502	1748	ANTIBIOTICS, SERUM DOSAGE (AMOXICILLIN, AMPICILLIN, PENICILLIN, GENTAMICIN, KANAMYCIN, NETILMICIN, STREPTOMYCIN, VANCOMYCIN AND OTHERS)	
69926	1749	ACQUIRED ANTICOAGULANTS, RESEARCH	
71811	1750	ANTIBODIES TO ADENOVIRUS	
72892	1751	ANTIBODIES TO CYTOPLASMIC ANTIGENS (HIP)	
74682	1752	ANTIBODIES TO TOTAL BORDETELLA PERTUSSIS OR IGG OR IGM	
74690	1753	ANTIBODIES TO BORRELIA BURGDOFERI	
65089	1754	ANTIBODIES TO BRUCELLA	
69918	1755	ANTIBODIES TO CALCIUM CHANNEL	

75002	1756	ANTIBODIES TO CARDIOLIPIN IGA OR IGM	
69900	1757	ANTIBODIES TO GASTRIC PARIETAL CELLS (PCA)	
69891	1758	ANTIBODIES TO CENTROMERE	
75143	1759	ANTIBODIES TO CHLAMYDIA	
75150	1760	ANTIBODIES TO CYTOMEGALOVIRUS TOTAL IG OR IGG OR IGM	
69883	1761	ANTIBODIES TO NEUTROPHIL CYTOPLASM (HIP)	
65097	1762	ANTIBODIES TO COLON	
65105	1763	ANTIBODIES TO SALIVARY DUCT	
69875	1764	ANTIBODIES TO ENDOMYSIUM	
69867	1765	ANTIBODIES TO ENDOTHELIAL	
72900	1766	ANTIBODIES TO COXSAKIE (EACH)	
75176	1767	ANTIBODIES TO ECHINOCOCCUS (ECHINOTEST)	
75184	1768	ANTIBODIES TO ECHOVIRUS	
74591	1769	ANTIBODIES TO ENA	
75192	1770	ANTIBODIES TO ENTOMOAMEBA OR OTHER PARASITES	
74609	1771	ANTIBODIES TO EPSTEIN BARR VIRUS IGM AND IGM (VCA AND/OR EBNA AND/OR EA)	
72090	1773	COLD-ACTIVATED ANTIBODIES TO ERYTHROCYTICS (CRYOAGGLUTININS)	
72058	1774	ANTIBODIES TO ERYTHROCYTES OR LEUKOCYTES OR PLATELETS (DIRECT OR INDIRECT DIXON TEST) RESEARCH AND POSSIBLE TITER	
75200	1775	ANTIBODIES TO INTRINSIC FACTOR	
69859	1776	ANTIBODIES TO FACTOR VIII	
65113	1777	ANTIBODIES TO GANGLIOSIDES	
65727	1778	ANTIBODIES TO Q FEVER	
74658	1779	ANTIBODIES TO GIARDIA LAMBLIA	
74666	1780	ANTIBODIES GLIADIN IGA OR IGG	
71670	1781	ANTIBODIES TO HAV IGG/HAV IGM	
10043	3208	ANTIBODIES TO HBCAG OR HBCAGIGM OR HBEAG OR HBSAG	
71779	1782	ANTIBODIES TO HCV	
74674	1783	ANTIBODIES TO HDV/HDV IGM	
69842	1784	ANTIBODIES TO HEV (HEPATITIS E VIRUS)	
69834	1785	ANTIBODIES TO HGV/GBV-C (HEPATITIS G VIRUS)	
69826	1786	ANTIBODIES TO HLA (SINGLE SPECIFICITY TITRATION)	
75259	1787	ANTIBODIES TO HELICOBACTER PYLORI	
75267	1788	ANTIBODIES TO HERPES VIRUS (TYPE 1 OR 2) IGG OR IGM	

72884	1789	ANTIBODIES TO HIV	
71845	1790	ANTIBODIES TO INFLUENZA A OR B	
75275	1791	ANTIBODIES TO PANCREATIC ISLETS	
75283	1792	ANTIBODIES TO INSULIN (AIAA)	
69818	1793	ANTIBODIES TO INTERFERON	
69800	1794	ANTIBODIES TO HISTONES	
75291	1795	ANTIBODIES TO LACTOGLOBULIN IGG	
75309	1796	ANTIBODIES TO LEGIONELLA	
75432	1797	ANTIBODIES TO LEISHMANIA	
75440	1798	ANTIBODIES TO LEPTOSPIRA	
75457	1799	ANTIBODIES TO LISTERIA	
69791	1800	ANTIBODIES TO MAG	
69783	1801	ANTIBODIES TO BASAL MEMBRANE	
75465	1802	ANTIBODIES TO MYCETES (RESEARCH)	
75473	1803	ANTIBODIES TO MYCOBACTERIA IGM OR IGM	
75481	1804	ANTIBODIES TO MYCOPLASMAS	
69775	1805	ANTIBODIES TO LIVER AND KIDNEY MICROSOMES (LKMA)	
75499	1806	ANTIBODIES TO MICROSOMES (ABTMS) OR PEROXIDASE (ABTPO)	
65121	1807	ANTIBODIES TO MYELIN	
75507	1808	ANTIBODIES TO MITOCHONDRIA	
72868	1809	ANTIBODIES TO MEASLES (TOTAL IG OR IGM)	
75564	1810	ANTIBODIES TO SMOOTH MUSCLE	
75572	1811	ANTIBODIES TO STRIATED MUSCLE (HEART)	
72041	1812	ANTIBODIES TO NDNA	
72044	1813	ANTIBODIES TO NEISSERIA GONORRHEA	
71852	1814	ANTIBODIES TO NUCLEUI	
75580	1815	ANTIBODIES TO ORGANS	
69767	1816	ANTIBODIES TO OVARIES	
72876	1817	ANTIBODIES TO MUMPS (IGG OR IGM)	
75598	1818	ANTIBODIES TO MUMPS IG TOTAL	
75606	1819	ANTIBODIES TO POLYSACCHARIDE C STREPTOCOCCUS B HEMOL. GR A	
69759	1820	ANTIBODIES TO PARVOVIRUS B19	
65138	1821	ANTIBODIES TO PNEUMOCOCCUS	

69740	1822	ANTIBODIES TO ACETYLCHOLINE RECEPTOR	
75614	1823	ANTIBODIES TO TSH RECEPTOR	
69732	1824	ANTIBODIES TO RETICULIN	
69724	1825	ANTIBODIES TO RETROVIRUSES (HTLV1 - HTLV2)	
65146	1826	ANTIBODIES TO RIBOSOMES	
75622	1827	ANTIBODIES TO RICKETTSIA	
65154	1828	ANTIBODIES TO RNA	
72850	1829	ANTIBODIES TO RUBELLA (TOTAL IG OR IGM)	
75648	1830	ANTIBODIES TO SCHISTOSOMES	
75655	1831	ANTIBODIES TO SPERMATOZOA	
69716	1832	ANTIBODIES TO STREPTOCOCCUS (DNASE B)	
69708	1833	ADRENAL ANTIBODIES	
75663	1834	ANTIBODIES TO TISSUES	
65735	1835	ANTIBODIES TO TESTICLES	
75671	1836	ANTIBODIES TO THYROGLOBULIN (ABTG)	
72048	1837	ANTIBODIES TO CLOSTRIDIUM TETANI TOXIN	
69691	1838	ANTIBODIES TO TOXOCARA	
75689	1839	ANTIBODIES TO TOXOPLASMA (TOTAL IG OR IGM OR IGA)	
65162	1840	ANTIBODIES TO TISSUE TRANSGLUTAMINASE (TTG)	
71621	1841	ANTIBODIES TO TREPONEMA P (IGG FTA OR IGM FTA)	
75697	1842	ANTIBODIES TO TRYPANOSOMA CRUZI	
75705	1843	ANTIBODIES TO VARICELLA ZOSTER VIRUS (TOTAL IG OR IGG OR IGM)	
71829	1844	ANTIBODIES TO RESPIRATORY SYNCYTIAL VIRUS	
75713	1845	ANTI-PLASMODIUM ANTIBODIES	
69683	1846	SERUM ANTI-CYTOSKELETON ANTIBODIES	
75721	1847	OTHER ANTIBODIES TO	
75723	1848	TRICYCLIC ANTIDEPRESSANTS, DOSAGE	
71761	1849	AUSTRALIA ANTIGEN (HBSAG)	
72108	1854	DELTA ANTIGEN (HDV AG)	
72181	1855	HEPATITIS B VIRUS AND ANTIGEN (HB AND AG)	
65170	1856	HELICOBACTER PYLORI ANTIGEN IN STOOLS	
65189	1857	LEGIONELLA PNEUMOPHILA ANTIGEN	
69675	1861	CELLULAR AND EXTRACELLULAR BACTERIAL ANTIGENS AND/OR METABOLIC PRODUCTS, RESEARCH AND IDENTIFICATION	

75762	1862	NON-RH ERYTHROCYTE ANTIGENS (EACH)	
69667	1863	HLA ANTIGENS (EACH)	
69659	1864	CD55/CD59 ERYTHROCYTE ANTIGENS	
69640	1865	VIRAL ANTIGENS, DIRECT DETECTION AND IDENTIFICATION	
75770	1866	ANTIMICOGRAM	
70490	1867	ANTITHROMBIN III	
75772	1868	ANTITHROMBOPLASTIN	
75788	1869	APOLIPOPROTEIN A AND B (EACH)	
75796	1870	HAPTOGLOBIN	
75804	1871	ASBESTOSIS, SEARCH FOR CORPUSCLES IN THE SPUTUM	
69632	1872	TISSUE PLASMINOGEN ACTIVATOR (TPA)	
70730	1873	AZOTEMIA	
75812	1874	NITROGEN IN 24-HOUR URINE	
71340	1875	KOCK BACILLUS, BACTERIOLOGICAL OR CULTURE EXAMINATION	
71324	1876	DIPHTHERIA BACILLUS, CULTURE EXAMINATION	
72009	1877	DIPHTHERIA BACILLUS, MICROSCOPIC EXAMINATION	
70144	1878	BARBITURATES	
69624	1879	ANAEROBIC BACTERIA, RESEARCH AND IDENTIFICATION	
69616	1880	BACTERIA, MICROSCOPIC RESEARCH	
75822	1881	BENCE JONES, PROTEIN OF	
70151	1882	BENZODIAZEPINES	
75820	1883	BETA 2 GLYCOPROTEIN 1 (SP1)	
75838	1884	URINARY AND PLASMA BETA 2 MICROGLOBULIN	
72330	1885	BETA HCG (PLASMA AND URINARY CHORIONIC GONADOTROPIN OR BETA SUBUNIT)	
72332	1886	BETA THROMBOGLOBULINS	
71043	1887	BICARBONATES	
75846	1888	BILIRUBIN IN AMNIOTIC FLUID (SPECTROPHOTOMETRIC CURVE)	
70847	1889	DIRECT BILIRUBINEMIA	
70839	1890	TOTAL BILIRUBINEMIA	
65743	1892	UREA BREATH TEST FOR HELICOBACTER PYLORI	
75855	1893	HYDROGEN BREATH TEST FOR FOOD MALABSORPTION	
73059	6226	LACTOSE BREATH TEST FOR LACTOSE INTOLERANCE	
75861	1894	BRONCHOASPIRATE, CULTURE EXAMINATION	

75879	1895	C PEPTIDE	
75887	1896	C PEPTIDE AFTER GLUCOSE LOADING (4 DOSES)	
75895	1897	C1 ESTERASE INHIBITOR	
75911	1898	CADMIUM	
75929	1899	CALCIUM IN 24-HOUR URINE	
75937	1900	IONIZED CALCIUM	
72827	1901	CALCITONIN	
72413	1902	STONES AND CONCRETIONS, EXAMINATIONS	
70037	1903	URINARY STONES, EXAMINATION	
75947	1905	CANNABINOIDS	
75960	1906	CARBAMAZEPINE (DRUG DOSING)	
75978	1907	CARBOXYHEMOGLOBIN (CO HAEMOGLOBIN)	
75952	1916	CARNITINE	
73973	1917	SERUM CATECHOLAMINES	
76000	1918	URINARY CATECHOLAMINES (ADRENALINE OR NORADRENALINE)	
72298	1919	TOTAL URINARY CATECHOLAMINES	
76574	1920	KAPPA AND LAMBDA CHAINS, RATIO OF	
75905	1921	CBG (CORTICOSTEROID HORMONE BINDING PROTEIN OR TRANSCORTIN)	
76598	1923	L.E. CELLS RESEARCH IN PERIPHERAL BLOOD	
76570	1924	CERULOPLASMIN	
75903	1925	CH50	
76588	1926	CHYMOTRYPSIN IN FAECES + TRYPTIC POWER	
76596	1927	QUINIDINE (CARDIAC DRUG DOSAGE)	
76604	1928	CICLOSPORIN	
70102	1929	CYSTINURIA	
69608	1930	CYTOTOXICITY WITH SPECIFIC ANTIGENS, CTL, LAK, SPONTANEOUS NAK, ETC. (EACH)	
76646	1931	CHLAMYDIA (RESEARCH AND IDENTIFICATION)	
69591	1932	CLOSTRIDIUM DIFFICILIS (RESEARCH AND IDENTIFICATION)	
76661	1933	COCAINE (ABUSED DRUGS)	
76606	1934	COENZYME Q10	
70755	1935	ESTERIFIED CHOLESTEROL	
70763	1936	HDL OR LDL CHOLESTEROL	
70748	1937	TOTAL CHOLESTEROL OR CHOLESTEROLEMIA	

70771	1938	CHOLINESTERASE (CHE)	
71282	1939	CHOLINESTERASE WITH DIBUCAINE NUMBER	
76679	1940	ERYTHROCYTE CHOLINESTERASE	
69583	1941	COLLAGEN CROSS LINKING	
69575	1942	CULTURE OF AMNIOCYTES	
69567	1943	CULTURE OF CELLS FROM OTHER TISSUES	
69559	1944	CULTURE OF HEMATOPOIETIC CELLS: BFU-E, CFU-GM, CFUGEMM (EACH)	
69540	1945	CULTURE OF FIBROBLASTS	
69532	1946	CULTURE OF STABILIZED CELL OR LYMPHOCYTE LINES	
69524	1947	CULTURE OF FOETAL OR PERIPHERAL LYMPHOCYTES	
69516	1948	MIXED LYMPHOCYTE CULTURE	
71332	1949	CULTURE, OTHER TESTS NOT DESCRIBED	
71787	1950	COMPLEMENT FRACTION C1Q	
71795	1951	COMPLEMENT FRACTION C3	
76687	1952	COMPLEMENT FRACTION C3 ATT.	
76695	1953	COMPLEMENT FRACTION C4	
70128	1955	ADDIS COUNT	
76729	1961	COPROPORPHYRINS	
69491	1962	KETONE BODIES	
72280	1963	URINARY OR PLASMA CORTISOL	
71167	1964	CREATINE KINASE (CPK)	
76737	1965	CREATINE KINASE ISOENZYMES (CPK - MB)	
69483	1966	CREATINE KINASE ISOFORM	
72603	1967	CREATININE CLEARANCE (INCLUDING CREATINURIA DOSAGE)	
76745	1968	CREATININE IN AMNIOTIC FLUID	
70870	1969	CREATININEMIA	
72282	1970	CREATININEURIA ON 24 H SAMPLE (SINGLE TEST)	
69475	1971	CRYOPRESERVATION OF CELL CULTURES (FOR MARROW TRANSPLANT ONLY, FOR DOCUMENTED ONGOING DISEASE)	
69467	1972	CRYOPRESERVATION OF CELLS AND TISSUES (FOR MARROW TRANSPLANT ONLY, FOR DOCUMENTED ONGOING DISEASES)	
69459	1973	CRYOPRESERVATION OF STEM CELLS (FOR MARROW TRANSPLANT ONLY, FOR DOCUMENTED ONGOING DISEASES)	
69440	1974	CRYOPRESERVATION OF LYMPHOCYTE SUSPENSIONS (FOR MARROW TRANSPLANT ONLY, FOR DOCUMENTED ONGOING PATHOLOGIES)	
76752	1975	CRYOGLOBULINS (RESEARCH AND DOSAGE)	

70615	1976	SEX OR BARR CHROMATIN	
71373	1977	CHROMIUM, DOSAGE	
70722	1979	GLYCAEMIC LOAD CURVE	
72702	1980	LOAD INSULINEMIC CURVE AFTER DRUG TESTS	
76760	1981	LH AND FSH CURVE AFTER GNRH ADMINISTRATION (MINIMUM 5 DOSES)	
76786	1982	PROLACTIN CURVE AFTER TRH ADMINISTRATION	
76778	1983	TSH CURVE AFTER STIMULATION WITH TRH (MINIMUM 5 DOSES)	
72284	1984	D-DIMERO	
76794	1987	DEHYDROEPIANDROSTERONE (DEA) OR DEAS	
72704	1988	DESFERRIOXAMINE TEST	
70599	1989	DETERMINATION OF VARIOUS ANTIGENS (KELL, DUFFY, ETC.)	
70318	1990	MEAN DIAMETER AND VOLUME OF BLOOD CELLS (SINGLE TEST)	
71746	1991	DIGOXINE	
76802	1992	DIHYDROTESTOSTERONE (DHT)	
70706	1993	PLASMA OR URINARY DOPAMINE	
72706	1994	ELASTASE, DOSAGE	
70805	1995	ELECTROPHORESIS OF LIPOPROTEINS	
70904	1996	ELECTROPHORESIS OF SERUM PROTEINS (INCLUDING TOTAL PROTEIN DOSAGE)	
65213	1997	URINARY PROTEIN ELECTROPHORESIS (INCLUDING TOTAL PROTEIN DOSAGE)	
72708	1998	HAEMOGLOBIN ELECTROPHORESIS	
70821	1999	ELECTROLYTES: CALCIUM OR CHLORINE OR PHOSPHORUS OR POTASSIUM OR SODIUM (IN BLOOD AND URINE)	
71748	2000	FOETAL BLOOD COUNTS, FOETAL	
76810	2001	HAEMOCOLTURE	
70227	2002	HAEMOCHROMOCYTOMETRIC AND MORPHOLOGICAL (HB,GR,GB, PLATELETS, DER. ERYTHROCYTE INDICES F.L.)	
72728	2004	HAEMOGAS ANALYSIS (PH, PCO2, PO2 AND DERIVED PARAMETERS)	
76828	2005	HAEMOGAS ANALYSIS DURING RESPIRATION OF O2 AT LOW OR HIGH CONCENTRATION	
76836	2006	HAEMOGAS ANALYSIS BEFORE AND AFTER HYPERVENTILATION	
76844	2007	HAEMOGLOBIN A2	
70417	2008	FOETAL HAEMOGLOBIN (DOSAGE)	
71050	2009	GLYCOSYLATED HAEMOGLOBIN HBA1C	
76851	2010	HAEMOGLOBIN HB	
76869	2011	HAEMOGLOBIN IN AMNIOTIC FLUID	

69416	2012	HAEMOGLOBIN, RESEARCH, GLOBIN CHAIN MUTATIONS	
69408	2013	ABNORMAL HAEMOGLOBINS (HBS, HBD, HBH, ETC.)	
76877	2014	ACID HAEMOLYSIN (HAM TEST)	
76885	2015	BIPHASIC HAEMOLYSIN (DONATH-LANDSTAINER TEST)	
76893	2016	NEURON-SPECIFIC ENOLASE (NSE)	
76901	2017	ENTEROBACTERIA, CULTURE TEST	
69391	2018	LEUKOCYTE ENZYMES (CYTOCHEMICAL MARKERS)	
71365	2019	HEPARIN	
65238	2020	ERYTHROCYTES, DOSAGE OF SODIUM OR POTASSIUM OR CALCIUM OR MAGNESIUM	
71744	2021	ERYTHROPOIETIN ON SERUM OR URINE	
71894	2022	SPUTUM, CULTURE TEST	
72447	2023	EXUDATES AND TRANSUDATES, CHEMICAL AND MICROSCOPIC TEST (P.S., RIVALTA, DOS. PROT.)	
72264	2024	ESTRADIOL - 17 BETA ESTRADIOL	
72256	2025	ESTRIOL	
72207	2026	TOTAL ESTROGENS	
76887	2027	ESTRONE	
76889	2028	ETHANOL	
76919	2029	ETHOSUXIMIDE (DRUG DOSAGE)	
76927	2030	F.D.P. (X.D.P.) PLASMA OR URINE	
69383	2031	ANTI-INFLAMMATORY DRUGS, DOSAGES (ACETAMINOPHEN, ACETAMINOPHEN, SALICYLATES, ETC.)	
69375	2032	ANTI-TUMOUR DRUGS, DOSAGE (CYCLOPHOSPHAMIDE, METHOTREXATE, ETC.)	
69367	2034	TUMOUR NECROSIS FACTOR (TNF)	
69359	2035	ATRIAL NATRIURETIC FACTOR	
76935	2036	PLATELET FACTOR 4 (PF4)	
71548	2037	RHEUMATOID FACTOR OR RHEUMATEST	
70607	2038	RH FACTOR, GENE STRUCTURE	
70516	2039	COAGULATION FACTORS (F, II, V, VII, VIII, IX, X, XI, XII, XIII)	
72116	2040	FAECES, CHEMICAL, MICROSCOPIC AND PARASITOLOGICAL EXAMINATION	
76943	2041	FAECES, CULTURE TEST (STOOL TEST)	
72124	2042	FAECES, PARASITOLOGICAL TEST	
72140	2043	FAECES, OCCULT BLOOD DETECTION (ANY METHOD)	
76950	2044	PHENYLALANINE	
71258	2045	PHENYTOIN (AND OTHER ANTIEPILEPTIC DRUGS - DEPAKIN, TEGRETOL, ZARONTIN), DOSAGE	

76968	2046	PHENOBARBITAL (DRUG DOSAGE)	
76976	2047	URINARY PHENOLES	
65254	2048	L.E. PHENOMENON	
76984	2049	RH PHENOTYPE (INCLUDING DU)	
72835	2050	FERRITIN	
65262	2051	URINARY IRON	
70987	2052	FIBRINOGEN	
76992	2053	FIBRINOPEPTIDE A	
77008	2054	FIBRONECTIN	
71860	2056	MICROBIAL FLORA, MICROSCOPIC EXAMINATION	
77016	2057	FLUORIDE, DOSAGE	
70938	2058	ACID PHOSPHATASE	
77024	2060	ALKALINE PHOSPHATASE	
77005	2061	ALKALINE PHOSPHATASE ISOENZYMES (ALSO LEUKOCYTE)	
65751	2062	PHOSPHATE CLEARANCE	
77040	2063	PHOSPHOHEXOSE ISOMERASE (PHI)	
77057	2064	PHOSPHOLIPASE A	
77065	2065	PHOSPHOLIPIDEMIA	
65289	2067	FREE BETA/MSA-FP SCREENING (13.2-22.3 WEEKS)	
65297	2068	FREE BETA/PAPP-A SCREENING (8.5-13.2 WEEKS)	
77081	2069	FRUCTOSAMINE (GLYCATED PROTEINS)	
77099	2070	FRUCTOSE	
72322	2071	FSH (FOLLICLE STIMULATING HORMONE)	
72761	2072	GALACTOSYLHYDROXYLYSINE	
72769	2073	GALACTOSE	
72637	2074	GALACTOSE (LOAD TEST)	
71068	2075	GAMMA GLUTAMYL TRANSPEPTIDASE (GAMMA GT)	
65768	2076	GAMMA GLUTAMYL TRANSPEPTIDASE ISOENZYMES (GAMMA GT)	
71753	2077	GASTRIN	
70714	2078	GLYCAEMIA	
69340	2079	HISTIDINE-RICH GLYCOPROTEIN	
70169	2080	24-HOUR GLYCOSURIA	
77107	2081	SEX HORMONE BINDING GLOBULIN (SHBG)	
77115	2082	THYROXINE-BINDING GLOBULIN (TBG)	

77123	2083	GLUCAGON	
71134	2084	GLUCOSE 6 PHOSPHATE DEHYDROGENASE (G 6 PDH)	
77131	2085	GLUCOSE IN AMNIOTIC FLUID	
71142	2086	GLUTAMATE DEHYDROGENASE (GLDH)	
77149	2087	GLUTATHIONE REDUCTASE	
70383	2088	BLOOD GROUP AB0 AND RH FACTOR (WITH 2 ANTIBODIES)	
65305	2089	HBSAG WITH TITRATION	
65313	2090	HBV DNA	
69322	2091	HBV DNA - POLYMERASE	
69314	2092	HBV NUCLEIC ACIDS, HYBRIDIZATION	
72806	2093	HCV GENOTYPE	
72811	2094	HCV RIBA	
72823	2095	QUALITATIVE HCV RNA	
72831	2096	QUANTITATIVE HCV RNA	
72840	2097	HCV SUBTYPES	
69306	2098	SERUM HEV RNA	
69298	2099	SERUM HIV RNA	
65321	2100	QUALITATIVE AND/OR QUANTITATIVE HIV	
77164	2101	HERPES SIMPLEX, DIRECT RESEARCH	
77156	2102	HPL (PLACENTAL LACTOGENIC HORMONE OR SOMATOMAMMOTROPIN)	
77170	2103	HPV (PAPILLOMAVIRUS)	
77177	2104	HPV TYPING SUBTYPES	
69273	2106	IDENTIFICATION OF ANTI HLA SPECIFICITY AGAINST LYMPHOCYTE PANEL	
71076	2107	HYDROXYBUTYRATE DEHYDROGENASE (HBDH)	
77172	2108	URINARY HYDROXYPROLINE	
77180	2109	HYDROXYTRYPTAMINE (SEROTONIN)	
65338	2110	IGF-1 OR IGF-2	
77206	2111	IMMUNE ANTI HAEMOLYSINS ANTI A AND/OR B	
71720	2112	IMMUNE ANTIBODIES TO A AND/OR B AND ANY TITRATION	
77222	2113	CIRCULATING IMMUNE COMPLEXES	
77214	2114	IMMUNE COMPLEXES HBSAG/HBSAB - IGM	
77248	2115	SERUM OR URINE IMMUNOELECTROPHORESIS	
77255	2116	SECRETORY IMMUNOGLOBULINS IN SALIVA OR OTHER BODY FLUIDS	

71605	2117	IMMUNOGLOBULINS AND SPECIFIC IMMUNOGLOBULINS (RAST) (ANY NUMBER OF DOSAGES FOR FOOD OR INHALANTS)	
71571	2118	IMMUNOGLOBULIN IG TOTAL OR IGA OR IGD OR IGG OR IGM	
71589	2119	TOTAL IGE IMMUNOGLOBULINS (PRIST) (ANY NUMBER OF DOSAGES FOR FOOD OR INHALANTS)	
69265	2120	IMMUNOGLOBULIN IGG SUBCLASS 1, 2, 3, 4 (EACH)	
69257	2121	SURFACE LYMPHOCYTE IMMUNOGLOBULINS	
77263	2122	ERYTHROCYTE INCLUSIONS	
72686	2124	ZOJA INDEX	
69249	2125	PLASMINOGEN ACTIVATOR INHIBITOR (PAI I)	
72694	2126	INSULIN	
77271	2127	INTERFERON	
77289	2128	INTERLEUKIN 2	
10045	3210	INTERLEUKIN 6	
72454	2129	INTRADERMAL CASONI REACTION	
72421	2130	INTRADERMAL TUBERCULIN TEST (TINE TEST)	
69230	2131	INTRADERMAL REACTION WITH PPD, CANDIDA, STREPTOKINASE AND MUMPS (EACH)	
65354	2132	IODIUM	
69222	2133	SERUM ISOCITRATE DEHYDROGENASE (ICDH)	
72462	2134	MILK: CHEMICAL AND MICROSCOPIC TEST	
70920	2135	LACTIC DEHYDROGENASE (LDH)	
77291	2136	LACTIC DEHYDROGENASE ISOENZYMES	
77339	2137	LACTOSE	
71928	2138	LE TEST	
71159	2139	LEUCINE ARYL PEPTIDASE (LAP)	
69214	2140	LEVODOPA	
77321	2141	LH	
71084	2142	LIPASE	
70797	2143	LIPEMIA	
77347	2144	LIPOPROTEIN A	
77354	2145	LIPOPROTEIN X	
72777	2146	AMNIOTIC FLUID, CULTURE TEST	
69206	2147	AMNIOTIC FLUID, PHOSPHOLIPIDS OR LECITHIN/SPHINGOMYELIN RATIO	
72066	2148	CEPHALIC SPINAL FLUID, CHEMICAL, MICROSCOPIC AND MORPHOLOGICAL TEST	

77362	2149	CEPHALO-RACHID FLUID, CULTURE TEST	
72025	2150	SEMINAL FLUID, CULTURE TEST	
71985	2151	SEMINAL FLUID, TEST WITH FERTILITY INDEX AND BIOCHEMICAL DETERMINATIONS	
69198	2152	SYNOVIAL FLUID, CHEMICAL, PHYSICAL AND MICROSCOPIC TEST	
77372	2153	LYSOZYME	
71100	2154	LITHIUM	
77375	2155	LSD	
77370	2156	ANTI-COAGULANT LUPUS (LAC)	
72785	2157	MAGNESIUM S/U	
69181	2158	SERUM MALATE DEHYDROGENASE (MDH)	
72793	2159	MANGANESE	
72033	2160	MECONIUM - TEST	
77396	2161	MELANURIA	
72801	2162	MERCURY	
70185	2163	METHADONE	
77415	2164	METHAEMOGLOBIN OR SULPHOHAEMOGLOBIN	
77418	2165	URINARY METANEPHRINES	
77404	2166	MYCETES, CULTURE TEST (INCLUDING RESEARCH AND IDENTIFICATION)	
77412	2167	UROGENITAL MYCOPLASMAS (RESEARCH AND IDENTIFICATION)	
77420	2168	MICROALBUMINURIA, CLINOSTATISM OR ORTHOSTATISM	
77438	2169	BONE MARROW, CULTURE TEST	
69173	2170	BONE MARROW, APPOSITION AND/OR SMEAR TEST (CHARACTERIZATION OF PATHOLOGICAL CELLS BY CYTOCHEMICAL AND CYTOENZYMATIC REACTIONS)	
77446	2171	MYOGLOBIN (DOSAGE)	
69155	2172	SOLUBLE FIBRIN MONOMERS (FS TEST)	
71704	2173	MONONUCLEOSIS (SINGLE TEST)	
69147	2174	URINARY MUCOPOLYSACCHARIDES (GLYCOSAMINOGLYCANS)	
70995	2175	MUCOPROTIDEMIA	
77453	2176	NEOPHERINE	
77481	2177	URINARY NITRATES	
77479	2178	PLASMA NORADRENALINE	
77461	2179	URINARY NORADRENALINE	
77491	2180	HOMOCYSTEINE	

70177	2182	OPIATES (ABUSED DRUGS)	
71092	2183	ORNITHYL CARBAMYL TRANSFERASE (OCT)	
77487	2184	PLASMA OR URINARY OSMOLARITY	
71290	2185	OSSALATES	
70330	2186	OXYTOCIN	
72819	2187	OSTEOCALCIN	
72843	2188	TORCH PANEL (TOXO, CYTO, RUBEO, HERPES) IGG OR IGM	
77032	2189	PAP (TUMOUR MARKER)	
70334	2190	MALARIAL OR OTHER PARASITES IN THE BLOODSTREAM	
77495	2191	PARATHORMONE (PTH)	
69139	2192	PARATHORMONE RELATED PEPTIDE	
71902	2193	HAIR AND SKIN SCALES, TEST FOR MYCOSIS	
70337	2194	PEPSYNOGEN I	
71399	2195	BLOOD PH (SINGLE TEST)	
77511	2196	PHADIATOP	
71118	2197	LEAD	
69120	2198	PYRIDINOLINE (HP) - DEOXYPYRIDINOLINE (LP) - EACH	
77529	2199	ERYTHROCYTE PYRUVATEKINASE	
69112	2200	SERUM PLASMIN	
77503	2201	PLASMINOGEN	
69104	2202	VASOACTIVE INTESTINAL POLYPEPTIDE (VIP)	
69096	2203	SERUM PANCREATIC POLYPEPTIDE (PP)	
69088	2204	PORPHYRINS, QUALITATIVE AND QUANTITATIVE RESEARCH	
70052	2205	PORPHYRINS, TOTAL	
77563	2206	URINARY PORPHOBILINOGEN	
65784	2207	PLASMA PREALBUMIN	
72272	2208	PREGNANEDIOL	
77545	2209	PREGNANETRIOL	
77567	2210	PRIME TEST	
77552	2211	PRIMIDONE (DRUG DOSAGE)	
65362	2212	PROCALCITONIN	
77560	2213	PROGESTERONE	
72348	2214	PROLACTIN (PRL)	
77631	2215	PROSTAGLANDIN	

69071	2216	ANTICOAGULANT C PROTEIN	
77555	2217	PLASMA C PROTEIN	
71514	2218	C-REACTIVE PROTEIN (QUALITATIVE AND/OR QUANTITATIVE)	
77639	2219	EOSINOPHIL CATIONIC PROTEIN (ECP)	
69063	2220	WALDESTROM PROTEIN	
77559	2221	PLASMA PROTEIN S ANTIGEN, FREE OR TOTAL	
77578	2222	TOTAL PROTEIN IN AMNIOTIC FLUID	
70078	2223	URINARY PROTEINS (DOSAGE)	
70896	2224	TOTAL PROTEINEMIA	
69055	2225	ERYTHROCYTE PROTOPORPHYRIN IX	
65370	2226	TOTAL PROTOPORPHYRINS	
69047	2227	PROTHROMBIN, FRAGMENTS 1, 2	
70649	2229	CROSS-TRANSFUSION COMPATIBILITY TEST	
69039	2230	PLATELET CROSS TEST	
72652	2231	LOAD TEST WITH AMINO ACIDS	
72660	2232	VITAMIN K LOAD TEST	
69020	2233	PRE-TRANSPLANT MOLECULAR COMPATIBILITY TEST	
69011	2234	PRE-TRANSPLANT SEROLOGICAL COMPATIBILITY TEST	
70367	2235	HAEMOGENIC TESTS (DRIP TIME, CLOTTING TIME, CAPILLARY FRAGILITY, ETC.)	
69003	2236	PURINES AND THEIR METABOLITES	
71233	2238	COPPER (CUPREMIA)	
71506	2239	PAUL-BUNNEL REACTION	
71555	2240	WAALER-ROSE REACTION	
71456	2241	WASSERMAN REACTION	
77586	2242	WASSERMAN REACTION + 2 FLOCCULATION REACTIONS	
70060	2243	IMMUNOLOGICAL REACTION OF PREGNANCY	
77696	2244	OESTROGEN OR PROGESTERONE RECEPTORS, DOSAGE	
72355	2245	RENIN OR ANGIOTENSIN II	
70326	2246	ERYTHROCYTE OSMOTIC RESISTANCE (SIMMEL TEST)	
70284	2247	RETICULOCYTES, COUNT (SINGLE EXAMINATION)	
70441	2248	CLOT RETRACTION	
71738	2249	SEARCH FOR ROSETTES AND	
65800	2250	ROTAVIRUS, SEARCH IN THE FAECES	

71225	2251	SALICYLATE	
70268	2252	ARNETH TEST (SINGLE TEST)	
77699	2253	SCOTCH TEST (SEARCH FOR PINWORM EGGS)	
70862	2256	SIDEREMIA	
77602	2257	URINARY SULPHATES	
77610	2258	SOMATOMEDIN	
65405	2259	SOMATOSTATIN	
77628	2260	SORBITOL DEHYDROGENASE	
68987	2261	AMYLOID SUBSTANCE, RESEARCH	
71993	2262	SPIROCHAETE, MICROSCOPIC TEST	
77636	2263	STAPHYLOCOCCI AND STREPTOCOCCI, CULTURE TEST	
72397	2264	STH (PLASMA OR URINARY SOMATOTROPIC HORMONE)	
77644	2265	STREPTOZYME, TEST	
72579	2266	DUODENAL JUICE, CHEMICAL AND MICROSCOPIC EXAMINATION	
72561	2267	GASTRIC JUICE, CHEMICAL AND MICROSCOPIC EXAMINATION	
77651	2268	T3 REVERSE	
77669	2269	T3 UPTAKE	
77677	2270	EAR SWAB (UNILATERAL), CULTURE TEST	
77685	2271	CONJUNCTIVAL SWAB (UNILATERAL), CULTURE TEST	
77693	2272	NASAL SWAB, CULTURE TEST	
77701	2273	OROPHARYNGEAL SWAB, CULTURE TEST	
77719	2274	URETHRAL SWAB, CULTURE TEST	
77727	2275	VAGINAL SWAB, CULTURE TEST	
65413	2276	TELOPEPEPTIDS	
70482	2277	PROTHROMBIN CONSUMPTION TIME	
70557	2278	CLOT LYSIS TIME OR FIBRINOLYSIS	
77735	2279	EUGLOBULIN LYSIS TIME	
70458	2280	PROTHROMBIN TIME (PT)	
70466	2281	PARTIAL PROTHROMBIN TIME (PTT)	
70474	2282	RESIDUAL PROTHROMBIN TIME	
77743	2283	RECALCIFICATION TIME (HOWELL)	
77750	2284	THROMBIN TIME (TT)	
77851	2285	ACTIVATED THROMBOPLASTIN TIME (APTT)	

77768	2286	THEOPHYLLINE	
77753	2287	BROMOCRIPTINE TEST	
65421	2288	METHACHOLINE TEST	
65438	2289	SECRETIN TEST	
77858	2290	TOLBUTAMIDE TEST	
77757	2291	SWEAT TEST, STIMULATION WITH PILOCARPINE (DOSAGE OF CHLORINE, SODIUM AND POTASSIUM)	
77784	2292	PLATELET ADHESIVENESS TEST	
70425	2293	PLATELET AGGREGATION TEST	
77792	2294	SELF-HAEMOLYSIS TEST	
68979	2295	HAM TEST	
68960	2296	KLEIHAUER TEST (SEARCH FOR FOETAL BLOOD CELLS)	
70391	2297	MORESCHI DIRECT COOMBS TEST	
70409	2298	MORESCHI INDIRECT COOMBS TEST	
68952	2299	KWEIM'S TEST (SARCOIDOSIS)	
77800	2300	SICKLING TESTS	
77776	2301	LITTLE-KATZ TEST (LEUKOCYTURIA AFTER PRE-DIVISION)	
77937	2302	NELSON MAYER OR IMMOBILIZATION TEST	
77929	2303	NORDIN TEST	
68944	2304	ACTIVATED PROTEIN C RESISTANCE TEST	
68936	2305	STH (GH) STIMULATION TEST - 5 DOSAGES	
68928	2306	ACTH (OR SYNACTHEN) RAPID STIMULATION TEST (THREE DOSAGES)	
70201	2307	LYMPHOCYTE STIMULATION TEST (PHYTOHAEMAGGLUTINATION OR OTHER) - BLASTOGENESIS	
65446	2308	FREE TESTOSTERONE	
70433	2309	THORN TEST WITH ACTH STIMULUS	
72363	2310	PLASMA OR URINARY TESTOSTERONE	
77818	2311	A-B-0 ANTIGEN TYPING	
77826	2312	BIOCHEMICAL OR SEROLOGICAL TYPING OF GERMS OR SALMONELLAE	
65819	2313	HAEMOPOIETIC CELL TYPING (UP TO 6 ANTIGENS)	
70698	2316	LYMPHOCYTE TYPING (ANY NUMBER OF SUBPOPULATIONS)	
68895	2317	SEROLOGICAL TYPING HLA CLASS I AND II	
77834	2318	THYROGLOBULIN	
77842	2319	FREE THYROXINE (FT4)	
77859	2320	TOTAL THYROXINE (T4)	

71530	2321	ANTI STAPHYLOLYSIN TITRE (TAF)	
77970	2322	ANTI STREPTOKINASE TITRE	
77981	2323	ANTI STREPTOJALURONIDASIC TITRE	
71522	2324	ANTI STREPTOLYSIN TITRE (TAS OR ASLO)	
71696	2325	TPHA	
70912	2326	GLUTAMIC OXALOACETIC (GOT) OR GLUTAMIC PYRUVIC (GPT) TRANSAMINASE	
78009	2327	TRANSCOBALAMIN	
71126	2328	TRANSFERRIN (IRON-BINDING CAPACITY)	
65827	2329	CARBOHYDRATE DEFICIENT TRANSFERRIN (CDT)	
77867	2330	TOTAL TRANSFERRIN	
65454	2331	TISSUE TRANSGLUTAMINASE (TTG)	
72017	2332	TRICHOMONAS: SEARCH	
70789	2333	TRIGLYCERIDES	
76034	2334	FREE OR TOTAL TRIIODOTHYRONINE (FT3 OR T3)	
65835	2335	TRIIODOTHYRONINE UPTAKE (T3 UPTAKE)	
72544	2336	TRIPSINE S/U	
78018	2337	TRITEST OR BITEST	
68887	2338	THROMBIN - ANTITHROMBIN III COMPLEX (TAT)	
65843	2339	THROMBIN COAGULASE	
78029	2340	THROMBOELASTOGRAM	
68879	2341	TROMBOSSANO B2	
68860	2342	TROPONIN I O T CARDIO SPECIFIC	
72389	2343	TSH (THYROID STIMULATING HORMONE)	
65851	2344	URATE CLEARANCE	
72595	2345	UREA CLEARANCE	
70813	2346	URICEMIA	
77875	2347	24-HOUR URICURIA	
70011	2348	URINE, COMPLETE CHEMICAL AND MICROSCOPIC TEST	
77883	2349	URINE, PARTIAL TEST (ACETONE AND GLUCOSE QUANT.)	
65868	2350	URINE: CONCENTRATION AND/OR DILUTION TEST (AS A SINGLE TEST)	
77891	2351	URINE CULTURE	
78091	2352	UROPORPHYRIN	
70300	2353	HAEMATOCRIT VALUE (SINGLE TEST)	

71472	2354	VDRL	
70342	2355	SEDIMENTATION RATE OF THE HAEMATINS	
65876	2356	CHOLERA VIBRIO IN FAECES (DIRECT SEARCH)	
68852	2357	VIRUS CULTURE TEST	
68844	2358	VIRUS NUCLEIC ACID HYBRIDIZATION	
65884	2359	RESPIRATORY SYNCYTIAL VIRUS (DIRECT SEARCH)	
68836	2360	BLOOD VISCOSITY	
68828	2361	PLASMA VISCOSITY	
78101	2362	VITAMIN A (RETINOL)	
77909	2363	VITAMIN B12 OR FOLATES (FOLIC ACID)	
65462	2364	VITAMIN D (1-25 OH)	
77917	2365	VITAMIN D3 (25 OH VIT. D3)	
68811	2366	FAT-SOLUBLE OR WATER-SOLUBLE VITAMINS, PLASMA DOSAGE	
73999	2367	WEIL-FELIX, (PETECHIAL TYPHUS) AGGLUTINATION FOR	
77925	2368	WESTERN BLOT - CONFIRMATION TEST FOR VIRAL INFECTIONS	
78141	2369	WIDAL (TYPHUS AND PARATYPHUS A AND B), AGGLUTINATION BY	
71423	2370	WIDAL-WRIGHT (TYPHUS, PARATYPHUS AND MELITENSE), AGGLUTINATION BY	
77933	2371	XYLOSIUM	
77941	2372	ZINC (OR OTHER UNSPECIFIED METALS - ALUMINIUM, NICKEL, SELENIUM, ETC.), DOSAGE	
68803	2373	ZINCOPROTOPORPHYRIN	

Tumour markers

For this branch, the limitations set out “Diagnostic Tests” in general and “Clinical Analyses” remain valid.

75739	1850	CARBOHYDRATE ANTIGEN (CA 15.3, CA 19.9, CA 50, CA 54.9, CA 72.4, CA 125, CA 195, CYFRA 21, MCA, NSE, TA4 OR SCC)	
71563	1853	EMBRYONIC CARCINO ANTIGEN (CEA)	
75747	1858	TISSUE-SPECIFIC POLYPEPTIDE ANTIGEN (TPA) (TPS)	
75754	1859	SPECIFIC PROSTATIC ANTIGEN (PSA)	
75729	1860	FREE PROSTATE SPECIFIC ANTIGEN (FREE-PSA)	
75945	1904	CAM 26 OR CAM 29 (TUMOUR MARKER)	
65197	1922	ACTIVATED CD 95	
65205	1978	SERUM CHROMOGRAMINE	
77001	2059	PROSTATIC ACID PHOSPHATASE (ENZYMATIC)	

Cytogenetics (prenatal and postnatal)			
Only the pre-natal and post-natal cytogenetic tests shown below are refundable, if included in the Covers of the individual Health Plans, within the limits set out in these and in all cases only with a prescription from a Physician specialising in medical genetics (clinical genetics). No other possibilities are available.			
69959	1737	CYTOGENETIC ANALYSIS TO SEARCH FOR FRAGILE SITES, SISTER CHROMATID EXCHANGES, CHROMOSOMAL FRAGILITY PATHOLOGY	Refundable once a year (1 January - 31 December).
69942	1738	CYTOGENETIC ANALYSIS TO STUDY CHROMOSOMAL MOSAICISM, INDUCED CHROMOSOMAL REARRANGEMENTS	Refundable once a year (1 January - 31 December).
73975	1911	KARYOTYPE FROM SYNCHRONIZED CELLS	
70623	1908	KARYOTYPE FROM LYMPHOCYTES ON PERIPHERAL BLOOD	
75949	1909	KARYOTYPE FROM BONE MARROW ASPIRATE	
76002	1910	KARYOTYPE FROM CHORIONIC TROPHOBLAST CELLS	
72290	1912	KARYOTYPE FROM FIBROBLASTS	
76572	1913	KARYOTYPE FROM FOETAL LYMPHOCYTES ON PERIPHERAL BLOOD	
75986	1914	FOETAL KARYOTYPE ON AMNIOTIC FLUID (INCLUDING ALPHA-FETOPROTEIN DOSAGE)	
75994	1915	KARYOTYPE ON ABORTION MATERIAL	
Molecular Genetics			
The services in this section are refundable only if included in the Covers of your Health Plan (within the limits set out therein) upon submission of a prescription issued by a Physician specialising in Medical Genetics (clinical genetics) or Oncology (no other possibilities are available). Since the results of many tests do not change over time we recommend that you keep these results, since the Fund does not release copies of anything that it may receive. The safe-keeping of the test result is the responsibility of the client.			
69508	1954	STORAGE OF DNA OR RNA SAMPLES	
69424	1986	DNA, SEGMENT ANALYSIS BY SEQUENCING	Refundable once only
75853	1891	MOLECULAR BIOLOGY, ANY KIND OF RESEARCH	Refundable once a year (1 January - 31 December).
69432	1985	DNA, DISEASE MUTATION ANALYSIS	Refundable once only
65221	2003	HAEMOPHILIA A AND B	Refundable once only
65246	2033	FACTOR V MUTATIONS (LEIDEN, CAMBRIDGE, HONG KONG)	Refundable once only
65270	2055	CYSTIC FIBROSIS (MUTATION STUDY, LEVEL I SCREENING (50 OR MORE MUTATIONS)	Refundable once only
77045	2066	CHROMOSOMAL FRAGILITY	Refundable once only
69281	2105	IN SITU HYBRIDIZATION ON METAPHASES AND/OR INTERPHASE NUCLEI, TISSUES (FISH)	Refundable once a year (1 January - 31 December).
65346	2123	GENETIC TESTS FOR MUSCULAR ATROPHIES AND DYSTROPHIES, HUNTINGTON'S DISEASE, ANGELMAN OR PRADER-WILLI SYNDROME	Refundable once only
65776	2181	MTHFR MUTATION	Refundable once only
65792	2228	FACTOR II/PROTHROMBIN MUTATIONS	Refundable once only
65389	2254	SCREENING FOR SICKLE CELL ANAEMIA	Refundable once only
65397	2255	SCREENING FOR THALASSEMIA TAY SACHS	Refundable once only

68911	2314	GENOMIC TYPING HLA-A, HLA-B, HLA-C EACH (ONLY IN CASE OF DOCUMENTED ORGAN TRANSPLANTATION)	
10075	3237	HLA-DQA1, HLA-DQB1, HLA-DRB GENETIC PREDISPOSITION TEST FOR CELIAC DISEASE	
Cyto/histological/immunohistochemical tests			
Cytological Tests			
Tests can be carried out using any technique or method. Please note that, within the context of this Nomenclature, “Cytology tests for tumour diagnosis (Pap Tests)” are refundable, if provided for in the Cover for diagnostic tests in your Health Plan (and within the limits specified therein) in the case of both standard “Pap Tests” and “Thin Prep” tests.			
76681	2374	CYTOLOGICAL (SMEAR) FOR VAGINAL BACTERIOLOGICAL RESEARCH (SINGLE TEST)	
71944	2375	CYTOLOGICAL FOR HORMONAL DIAGNOSTICS	
76693	2376	CYTOLOGICAL FOR TUMOUR DIAGNOSTICS (BRONCHIAL ASPIRATE, SPUTUM, SYNOVIAL FLUIDS OR BIOLOGICAL FLUIDS, EXCEPT URINE)	
71936	2377	CYTOLOGICAL FOR CANCER DIAGNOSTICS (PAP TEST) OR ENDOCERVICAL CYTOLOGICAL - PLUS VAGINAL BACTERIOLOGICAL SMEAR	
76621	2378	CYTOLOGICAL FOR URINE TUMOUR DIAGNOSTICS (1 SAMPLE)	
76623	2379	CYTOLOGICAL FOR URINE TUMOUR DIAGNOSTICS (3 SAMPLES)	
76707	2380	CYTOLOGICAL ON BREAST, THYROID OR LYMPHOGLANDULAR NEEDLE ASPIRATED	
76638	2381	TESTICULAR CYTOLOGICAL	
Histological/immunohistochemical tests			
Tests can be carried out using any technique or method. “Histological (1 anatomical part or neoplasm)” means an examination carried out on a single anatomical part/neoplasm, while “Histological, each additional inclusion” relates to “Histological (1 anatomical part or neoplasm)” and therefore a further examination carried out on partial samples of the same, illustrated by the following example: assuming 1 neoplasm, a “histological (1 anatomical part or neoplasm)” is carried out and 2 further histological examinations of parts/fragments of this same neoplasm are carried out - i.e. 2 “histological, each additional inclusion” examinations are carried out; assuming 2 different neoplasms, the histological examination of both neoplasms is carried out, i.e. 2 “histological (1 anatomical part or neoplasm)” examinations are carried out.			
76713	2382	IMMUNOPHENOTYPE OF NEOPLASTIC CELL POPULATIONS, BY SINGLE ANTIBODY USED (CYTOKERATIN, VIMENTIN, EMA, S-100, HMB45, GFAP-1)	
76739	2383	IMMUNOPHENOTYPE OF NEOPLASTIC CELL POPULATIONS: EACH ANTIBODY SUBSEQUENT TO THE FIRST	
76747	2384	IMMUNOPHENOTYPE OF LYMPHOCYTE POPULATIONS FOR LYMPHOMA DIAGNOSIS	
76762	2385	PARAFFIN IMMUNOHISTOCHEMISTRY: OESTROGEN OR PROGESTERONE OR CELL PROLIFERATION INDEXES	
71951	2386	HISTOLOGICAL (1 PER ANATOMICAL PART OR NEOFORMATION)	
76788	2387	HISTOLOGICAL, ANY ADDITIONAL INCLUSION	
71969	2388	HISTOLOGICAL DURING SURGERY (IMPROMPTU) (1 PER ANATOMICAL PART OR NEOFORMATION)	
76804	2389	HISTOLOGICAL DURING SURGERY (IMPROMPTU) (EACH ADDITIONAL INCLUSION)	

Taking of Samples			
Please note that, regardless of Health Plan, taking of samples is included in the services themselves and is therefore not refundable (or chargeable by affiliated healthcare centres) as a separate item, even if included within public healthcare charges (in the case of services provided in affiliation with the S.S.R. (Italian Regional Health Service). Any claim for the taking of samples at home, as an additional item to the test itself and limited to those covered by the Nomenclature and included in the Covers of your Health Plan, must be clearly mentioned in the medical prescription and must be in-line with the pathology, i.e. it must be compatible with the critical clinical picture that made taking samples at home necessary.			
77958	2390	ARTERIAL SAMPLING AT HOME	
72975	2391	VENOUS OR CAPILLARY SAMPLING AT HOME	
77982	2392	DUODENAL JUICE SAMPLING	
77990	2393	GASTRIC JUICE SAMPLING	
77966	2394	PROSTATE SAMPLING AT HOME	
77974	2395	RECTAL SAMPLING AT HOME	
72991	2396	URETHRAL OR VAGINAL SECRETION SAMPLING AT HOME	
Cardiology			
The items described, if included in the Covers of your Health Plan, always include the use of equipment and professional fees. Basic ECGs always require a doctor's prescription with a definite or presumed diagnosis, unless carried out during a cardiological consultation, in which case the professional's report is sufficient. Please note that “ergometric tests” are inclusive of the basic ECG, i.e. the tests cannot be summed together. There are no refunds for tests for the purposes of issuing certificates (driving licence, sports fitness, etc.), or anything else specified in “Exclusions” or the “Services not covered by FasiOpen” paragraph within the individual Health Plan Guides.			
76806	2397	CARDIOTOCOGRAPHY (AS SINGLE EXAMINATION)	
76853	2398	CARDIOTOCOGRAPHY (DURING CONSULTATION)	
73072	2399	ECG BASIC	
78014	2400	ECG BASIC AND POST-STRESS (MASTER TEST)	
73098	2401	ECG BASIC AND POST-STRESS TREADMILL	
73106	2402	ECG DYNAMIC HOLTER TEST (24 H)	
73080	2403	ECG IN-HOME	
73726	2404	CONTINUOUS DYNAMIC BLOOD PRESSURE MONITORING (24 H)	
78030	2405	DIAGNOSTIC OR THERAPEUTIC TRANSESOPHAGEAL ELECTROPHYSIOLOGICAL STUDY	
73718	2406	ERGOMETRIC TEST (EXERCISE TEST WITH CYCLE ERGOMETER OR TREADMILL), INCLUDING PROFESSIONAL FEE	Inclusive of the basic ECG
76855	2407	ERGOMETRIC TEST (EXERCISE TEST WITH CYCLE ERGOMETER OR TREADMILL) WITH DETERMINATION OF O2 CONSUMPTION, INCLUDING PROFESSIONAL FEE	Inclusive of the basic ECG
68795	2408	TILT TEST	

Diagnostic imaging			
Angiography			
Items are refundable only and exclusively within the limits of the provisions of the single Covers (if any) of your Health Plan and include the entire medical-radiological-anaesthesiological team, technical/auxiliary staff, the contrast, the necessary X-rays (complete with the projections and the number of X-rays required). Special materials and any medications, if provided for by your Health Plan, are regulated as described in the relevant section D. For each additional service beyond the first during the same session, the fee will be reduced by 50% (of the least expensive test/s). Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer.			
75010	2409	CAROTID OR VERTEBRAL INTRACRANIAL ANGIOGRAPHY	
78048	2410	BONE MARROW ANGIOGRAPHY (1 DISTRICT)	
78055	2411	BONE MARROW ANGIOGRAPHY (2 DISTRICTS)	
78063	2412	BONE MARROW ANGIOGRAPHY (3 DISTRICTS OR COMPLETE)	
75127	2413	ABDOMINAL OR THORACIC AORTA ARTERIOGRAPHY	
75044	2414	ABDOMINAL AORTO ARTERIOGRAPHY + SELECTIVE ARTERIOGRAPHY	
65011	2415	AORTO-ABDOMINAL ARTERIOGRAPHY + ILIAC AND LOWER LIMBS	
75077	2416	AORTIC ARCH ARTERIOGRAPHY AND EPIAORTIC VESSELS	
78071	2417	AORTIC ARCH ARTERIOGRAPHY, EPIAORTIC VESSELS AND THORACIC AORTA (INCLUDING UPPER LIMBS)	
78097	2418	UNILATERAL LOWER LIMB ARTERIOGRAPHY (SINGLE TEST)	
78105	2419	ILIAC ARTERIOGRAPHY AND FEMORAL ARTERIES INCLUDING LOWER LIMBS	
78113	2420	PULMONARY ARTERIOGRAPHY	
78121	2421	PULMONARY ARTERIOGRAPHY AND CAVOGRAPHY	
78089	2422	TOTAL BODY ARTERIOGRAPHY OF THE AORTA (SUPRA-AORTIC-THORACIC-ABDOMINAL DISTRICT)	
75093	2423	LOWER OR UPPER CAVOGRAPHY	
78139	2424	TIPS MONITORING	
78147	2425	UPPER LIMB PHLEBOGRAPHY AND CAVOGRAPHY	
75085	2426	PHLEBOGRAPHY OF UPPER OR LOWER LIMBS	
78154	2427	ORBIT PHLEBOGRAPHY	
78162	2428	PHLEBOGRAPHY OF A LIMB	
78170	2429	UNILATERAL OVARIAN PHLEBOGRAPHY	
78188	2430	BILATERAL OVARIAN PHLEBOGRAPHY	
78196	2431	UNILATERAL SPERMATIC PHLEBOGRAPHY	
78204	2432	BILATERAL SPERM PHLEBOGRAPHY	
78212	2433	SPINAL PHLEBOGRAPHY	

75119	2434	LYMPHOGRAPHY	
78220	2435	BRAIN PANANGIOGRAPHY	

Ultrasounds

Items are refundable only and exclusively if explicitly provided for in the specific Cover (if any) of your Health Plan.

All services can be carried out using any technique, method or equipment and, where necessary, are inclusive of medicines/drugs. For tests carried out during the same session, or at the same time as tests included in the vascular diagnostics section, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Tests are inclusive of any anaesthetic treatment and, where specified in the service code, also include the contrast medium.

Upper abdomen is defined as: liver, pancreas, spleen, abdominal vessels.

Lower abdomen-pelvis is defined as: kidneys, bladder, prostate and seminal vesicles (for men); kidneys, uterus, appendages and bladder (for women).

For lymph node ultrasound scans, 1 test per lymph node district is recognised as refundable regardless of whether the test is unilateral or bilateral (example: an ultrasound of the axillary lymph nodes corresponds to 1 single code 2448 etc.).

78238	2436	LOWER ABDOMINAL-PELVIS (COMPLETE TEST)	
78246	2437	UPPER ABDOMINAL (COMPLETE TEST)	
78253	2438	LOWER ABDOMEN-PELVIS AND UPPER ABDOMEN WITH BOWEL EVALUATION (COMPLETE TEST)	
76857	2439	OVULATORY CYCLE (UP TO 8 TESTS)	
78519	2440	DOPPLER ECHOCARDIOGRAM OR TRANSESOPHAGEAL COLOUR DOPPLER	
73742	2441	M MODE 2D ECHOCARDIOGRAM	
65892	2442	FOETAL COLOUR DOPPLER ECHOCARDIOGRAM	
76859	2443	M MODE 2D DOPPLER AND COLOUR DOPPLER ECHOCARDIOGRAM, WITH POSSIBLE PHARMACOLOGICAL OR STRESS TESTS (ECHOCARDIOSTRESS)	
78501	2444	M MODE 2D AND DOPPLER ECHOCARDIOGRAM, WITH POSSIBLE PHARMACOLOGICAL OR STRESS TESTS (ECHOCARDIOSTRESS)	
65470	2445	ENDOBRONCHIAL ULTRASOUND	
78493	2446	INTRAOPERATIVE ULTRASOUND FOR ANY OPERATION	
73544	2447	TEST IN PREGNANCY ALSO TWIN (ANY WEEK)	
73178	6231	ULTRASOUND IN PREGNANCY WITH NUCHAL TRANSLUCENCY	
73157	6097	MORPHOLOGICAL ULTRASOUND IN PREGNANCY (OBSTETRIC ULTRASOUND ALSO TWIN AND MORPHOLOGICAL TEST)	Cannot be summed with the normal ultrasound in pregnancy.
73144	6096	FLOWMETRIC ULTRASOUND IN PREGNANCY (OBSTETRIC ULTRASOUND, INCLUDING TWIN AND FOETAL FLOWMETRY)	Cannot be summed with the normal ultrasound in pregnancy.
73551	2448	LIVER AND BILIARY TRACT - BILATERAL SALIVARY GLANDS - LARGE VESSELS - INTESTINAL - MONO/BILATERAL LYMPH NODES - UNILATERAL OR BILATERAL BREAST - MEDIASTINAL OR HEMITHORACIC - SPLEEN - MUSCULAR, TENDINOUS OR ARTICULAR - OCULAR AND ORBITAL - PANCREATIC - SOFT TISSUE - PELVIC (UTERUS, ADNEXA AND BLADDER) - PENIS - PROSTATE AND BLADDER, SUPRAPUBIC - RENAL AND ADRENAL BILATERAL - TESTICULAR (BILATERAL) - THYROID AND PARATHYROID - BLADDER (INCLUDING POSSIBLE USE OF CONTRAST MEDIUM)	For lymph node ultrasound scans, 1 examination per lymph node district is recognised as refundable regardless of whether unilateral or bilateral

73809	2449	PROSTATIC AND BLADDER OR ANAL AND RECTAL, TRANSRECTAL	
78428	2450	RENAL, BILATERAL ADRENAL AND BLADDER	
78436	2451	SCROTAL AND INGUINAL FOR DETECTING UNDESCENDED TESTICLE	
78469	2452	TRANSESOPHAGEAL FOR GASTROENTEROLOGY	
78261	2453	TRANSFONTANELLAR ENCEPHALIC	
78477	2454	TRANSVAGINAL WITH POSSIBLE COLOUR DOPPLER	
78485	2455	PERMINATIONAL BLADDER OR TRANSURETHRAL INTRACAVITARY	

Mineralometry - Bone densitometry

Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan.
Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder).
Section is defined as: cervical column or dorsal column or lumbo-sacral column.

78527	2456	LUMBAR DENSITOMETRY WITH C.T.	
73783	2457	TOTAL BODY DENSITOMETRY	
73585	2458	COMPUTERIZED BONE MINERALOMETRY (ONE SEGMENT OR TRACT)	
76879	2459	COMPUTERIZED BONE MINERALOMETRY (MULTIPLE SEGMENTS OR TOTAL BODY)	

Traditional radiology

Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan.
Tests are considered to be complete with all projections, all necessary x-rays, any contrast and/or gas insufflation used and any necessary professional services, including assistance with diagnostic equipment. Please note that contrast medium for “Traditional Radiology” services only, being considered to be included in the tests, will not have any fixed or percentage excesses applied during payment as is the case for other diagnostic tests.
Section is defined as: cervical column or dorsal column or lumbo-sacral column.
A “pelvis for hip” examination corresponds to a single pelvis X-ray code and is not summed with the hip X-ray code. A “hip” study or “comparative hip study” is not equatable with a “pelvis for hip” examination and corresponds to the summation of “right hip” and “left hip” radiographs.
Radiological tests carried out by a dentist or dental facility can only be claimed within the context of the specific dental procedure and only if provided for in the specific Cover of your Health Plan.

74211	2460	ABDOMEN: DIRECT EXAMINATION	
78535	2461	FEMALE GENITALIA, DIRECT EXAMINATION	
78543	2462	MALE GENITAL APPARATUS, DIRECT EXAMINATION	
74518	2463	URINARY APPARATUS, DIRECT EXAMINATION	
74948	2464	LIMBS AND JOINTS: HUMERUS, ELBOW, FOREARM, FEMUR, KNEE, LEG, HIP	
74922	2465	LIMBS AND JOINTS: WRIST, HAND, ANKLE, FOOT, FINGERS	
78550	2466	LOWER LIMBS UNDER LOAD WITH PELVIS	
78568	2467	TEMPOROMANDIBULAR JOINT, DIRECT EXAMINATION	
75341	2468	ARTHROGRAPHY	
78576	2469	UNILATERAL TEMPOROMANDIBULAR JOINT ARTHROGRAPHY	

78584	2470	BILATERAL TEMPOROMANDIBULAR JOINT ARTHROGRAPHY (COMPARATIVE)	
74831	2471	PELVIS	Usable for “pelvis for hip”
75390	2472	BRONCHOGRAPHY, UNILATERAL OR BILATERAL	
78592	2473	CAVERNOSOGRAPHY	
78600	2474	CAVERNOSOGRAPHY WITH MANOMETRY	
74567	2475	CYSTOGRAPHY	
78618	2476	DOUBLE CONTRAST CYSTOGRAPHY	Inclusive of contrast medium
74559	2477	MICTURATING CYSTOURETHROGRAPHY	
78626	2478	CLAVICLE	
74294	2479	OPAQUE CYST WITH DOUBLE CONTRAST	Inclusive of contrast medium
78642	2480	CHOLANGIOGRAPHY THROUGH KEHR'S TUBE OR POST-OPERATIVELY	
74401	2481	INTRAVENOUS CHOLANGIOGRAPHY (WITH POSSIBLE PHARMACOLOGICAL TESTS)	
74435	2482	INTRA-OPERATIVE CHOLANGIOGRAPHY	
74419	2483	PERCUTANEOUS CHOLANGIOGRAPHY	
78634	2484	RETROGRADE CHOLANGIOGRAPHY	
74443	2485	DIAGNOSTIC CHOLANGIOPANCREATOGRAPHY (ERCP ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY)	
74385	2486	CHOLECYSTOGRAPHY PER OS WITH OR WITHOUT BRONNER'S TEST	
74898	2487	CERVICAL, DORSAL, LUMBOSACRAL, SACROCOCCYGEAL SPINAL COLUMN (BY SECTION)	
74914	2488	COMPLETE SPINAL COLUMN	
78659	2489	COMPLETE SPINAL COLUMN PLUS PELVIS UNDER LOAD	
78667	2490	SPINAL COLUMN, MORPHOMETRIC EXAMINATION (BY SECTION)	
75366	2491	FOREIGN BODIES, LOCALIZATION	
74716	2492	SKULL AND/OR PARANASAL SINUSES	
78691	2494	DACRYOCYSTOGRAPHY	
78709	2495	DEFECOGRAPHY	
78717	2496	CSF DERIVATIONS, RADIOLOGICAL CONTROL	
65489	2497	DETERMINATION OF PELVIC DIAMETERS	
74815	2498	HEMIMANDIBLE	
74021	2499	RADIOLOGICAL EXAMINATION AT THE PATIENT'S HOME (AS WELL AS THE EXAMINATION)	
74013	2500	RADIOLOGICAL EXAMINATION AT THE PATIENT'S BEDSIDE (AS WELL AS THE EXAMINATION) - DURING OVERNIGHT HOSPITALISATION	
76895	2501	RADIOLOGICAL EXAMINATION IN THE OPERATING THEATRE (AS WELL AS THE EXAMINATION)	

74237	2502	OESOPHAGUS WITH OPAQUE CONTRAST	Inclusive of contrast medium
78725	2503	OESOPHAGUS WITH DOUBLE CONTRAST	Inclusive of contrast medium
78733	2504	BONE AGE (HAND AND WRIST OR KNEE, ETC.)	
74096	2505	PHARYNX: DIRECT EXAMINATION	
74302	2506	OPAQUE PHARYNGOGRAPHY	
75325	2507	FISTULOGRAPHY	
78741	2508	OPTIC FORAMENS	
78758	2509	GALACTOGRAPHY	
74310	2510	SALIVARY GLANDS, DIRECT EXAMINATION	
78766	2511	LOADED KNEE	
74625	2512	HYSTEROSALPINGOGRAPHY (INCLUDING DIRECT EXAMINATION) - INCLUDING SERVICES OF RADIOLOGIST/GYNAECOLOGIST	
78782	2513	LARYNX, DIRECT EXAMINATION	
74104	2514	OPAQUE LARYNGOGRAPHY	
74120	2515	UNILATERAL MAMMOGRAPHY	
74138	2516	BILATERAL MAMMOGRAPHY	
74757	2517	MASTOID	
75234	2518	CERVICAL OR DORSAL MYELOGRAPHY	
78790	2519	ORBIT, DIRECT EXAMINATION	
65497	2520	ORTHOPANTOMOGRAPHY OF ONE OR BOTH DENTAL ARCHES	
74732	2521	NASAL BONES, DIRECT EXAMINATION	
78808	2522	LOADED FEET	
78816	2523	UNILATERAL RETROGRADE PYELOGRAPHY	
78824	2524	BILATERAL RETROGRADE PYELOGRAPHY	
78832	2525	TRANSPIELOSTOMIC PYELOGRAPHY	
78840	2526	PERCUTANEOUS PYELOURETHROGRAPHY	
78857	2527	BREAST PNEUMOCYSTOGRAPHY	
78865	2528	RADICOLOGRAPHY	
78873	2529	BLADDER REGION, DIRECT EXAMINATION	
78881	2530	PETROSE ROCKS	
76897	2531	PATELLA	
76846	2532	AXIAL PATELLA AT 30°, 60°, 90°	
74963	2533	SCAPULA	
74856	2534	UNILATERAL THORACIC RIB CAGE	

78899	2535	BILATERAL THORACIC RIB CAGE	
74328	2536	SIALOGRAPHY	
74740	2537	SELLA TURCICA, DIRECT EXAMINATION	
78907	2538	SHOULDER	
78915	2539	LOADED SHOULDER	
74872	2540	STERNUM	
78923	2541	STOMACH WITH DOUBLE CONTRAST	Inclusive of contrast medium
74245	2542	STOMACH, DUODENUM	
78931	2543	OPEN AND CLOSED MOUTH STRATIGRAPHY OF THE TMJ, UNILATERAL	
78949	2544	OPEN AND CLOSED MOUTH STRATIGRAPHY OF THE TMJ, BILATERAL	
78956	2545	RESTING LARYNX AND PHONATION STRATIGRAPHY	
78964	2546	MEDIASTINAL STRATIGRAPHY	
78972	2547	CHEST STRATIGRAPHY, UNILATERAL	
78980	2548	CHEST STRATIGRAPHY, BILATERAL	
74153	2549	STRATIGRAPHY OF ANY ANATOMICAL DISTRICT OR SEGMENT, EXCEPT IN THE DESCRIBED CASES	
65023	2550	STUDY OF INTESTINAL TRANSIT TIMES	
78998	2551	SELECTIVE STUDY OF LAST LOOP	
79004	2552	HEART TELE-RADIOGRAPHY WITH BARIUM OESOPHAGUS	
65701	2553	TELERADIOGRAPHY OF THE SKULL (ANY NUMBER OF PROJECTIONS)	
79012	2554	SMALL INTESTINE, DOUBLE-CONTRAST WITH SELECTIVE STUDY	Inclusive of contrast medium
74260	2555	SMALL INTESTINE, SERIAL TEST	
79020	2556	SOFT TISSUE, DIRECT EXAMINATION	
79038	2557	THYROID, DIRECT EXAMINATION	
79046	2558	THYROID, CERVICAL ESOPHAGOGRAM	
74070	2559	TRADITIONAL OR EQUALIZED CHEST AND/OR TELECORE	
79061	2560	TRACHEA, DIRECT EXAMINATION	
74336	2561	DIGESTIVE TRACT: FIRST DUCTS (OESOPHAGUS, STOMACH, DUODENUM)	
74252	2562	DIGESTIVE TRACT: SECOND DUCTS (SMALL INTESTINE, COLON)	
74278	2563	DIGESTIVE TRACT: COMPLETE (STOMACH, DUODENUM, COLON, OESOPHAGUS)	
74542	2564	ASCENDING AND MICTURATING URETHROCYSTOGRAPHY	
74534	2565	UROGRAPHY (COMPLETE EXAMINATION)	
79079	2566	VESSELS, DIRECT EXAMINATION	

79087	2567	VESICO-DEFERENTOGRAPHY	

Nuclear Magnetic Resonance

Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan.

Tests are considered to be complete with all necessary acquisition sequences, any anaesthesiological services where necessary (regardless of the type of anaesthesia or sedation) and any other medical and/or technical professionals involved. For any further examination or tract examined in addition to the first one during the same session, a rate reduced by 50% is applied (to the least expensive examination/s). The fee for any examination carried out “with contrast” or “without and with contrast” will be increased by the relevant fee specified for the contrast (only one contrast medium code will be recognised regardless of the number of examinations carried out in the same session). Please also note that, for Cover-based Health Plans, the contrast medium is deemed to be a separate item so that any fixed and percentage excesses will also be applied to this item.

Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder).

Joints or joint areas are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibioperoneal-astragalic); small (the remainder).

Section is defined as: cervical column or dorsal column or lumbo-sacral column.

Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer.

Tests can be carried out with any equipment/instrumentation.

Please also note that “Total Body” tests also include the “neck” section, so that no additional "MRI Neck” tests are recognised. Also in this edition of the Nomenclature, the “Cine MRI Heart” test is recognised as “MRI Heart” and therefore is not equatable with the “Cine MRI as a functional study of joints” test.

76715	2701	USE OF ANY CONTRAST MEDIUM	
79160	2702	MR ANGIO (ANY VASCULAR DISTRICT - PER DISTRICT, EXCEPT AS DESCRIBED)	
73216	6099	MR ANGIO ENDOCRANIAL CIRCULATION, INCLUDING MR BRAIN	
73234	6101	MR ANGIO SUPRA-AORTIC TRUNKS (OF 1 OR 2 SUPRA-AORTIC TRUNKS)	
76994	2703	BILATERAL TMJ	
79178	2704	CINE MRI AS A FUNCTIONAL STUDY OF JOINTS	
76848	2705	CHOLANGIO AND/OR WIRSUNG NMR, INCLUDING UPPER ABDOMINAL STUDY	
79186	2706	MR UPPER AND LOWER ABDOMEN - PELVIS	
76899	2707	MR UPPER OR LOWER ABDOMEN - PELVIS	
79202	2708	MR JOINT AND 1 BONE SEGMENT (KNEE - SHOULDER - ELBOW - NECK - FOOT - ETC.)	
76903	2709	MR EVERY JOINT AND BONE SEGMENT IN ADDITION TO THE FIRST	
76978	2710	MR BRAIN AND/OR PITUITARY GLAND	
65900	2711	MR HEART	
76905	2712	MR RACHIS AND SPINAL CORD (1 SECTION)	
79244	2713	MR RACHIS AND SPINAL CORD (2 SECTIONS)	
79269	2714	MR RACHIS AND SPINAL CORD (3 SECTIONS)	
79319	2715	MR TOTAL BODY TO SEARCH FOR FOCAL LESIONS: SKULL, THORAX, UPPER AND LOWER ABDOMEN - PELVIS	
79335	2716	STUDY OF CEREBRAL CSF FLOWS, INCLUDING MR BRAIN	
10077	3239	MR PELVIS	
10078	3240	MR NECK OR FACIAL MASS OR PHARYNX OR ACOUSTIC NERVES	

10079	3241	MR THORAX AND MEDIASTINUM	
10080	3242	MR BILATERAL BREAST	
10081	3243	PET-MR ANY DISTRICT (INCLUDING RADIOISOTOPE AND ANY TRANSPORT)	

Computerised Axial Tomography

Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan.

Tests are considered to be complete with all necessary acquisition sequences, any anaesthesiological services where necessary (regardless of the type of anaesthesia or sedation) and any other medical and/or technical professionals involved. For any further examination or tract examined in addition to the first one during the same session, a rate reduced by 50% is applied (to the least expensive examination/s). The fee for any examination carried out “with contrast” or “without and with contrast” will be increased by the relevant fee specified for the contrast (only one contrast medium code will be recognised regardless of the number of examinations carried out in the same session). Please also note that, for Cover-based Health Plans, the contrast medium is deemed to be a separate item so that any fixed and percentage excesses will also be applied to this item.

Bone segments are defined as: large (femur, humerus, tibia); medium (clavicle, sternum, patella, radius, ulna, fibula); small (the remainder).

Joints or joint areas are defined as: large (hip, knee, shoulder); medium (elbow, wrist, tibioperoneal-astragalic); small (the remainder).

Section is defined as: cervical column or dorsal column or lumbo-sacral column.

Vascular district is defined as the study of the cerebral, supraortic, thoracic, abdominal-splanchnic vessels or of a limb or spinal metamer.

Tests can be carried out with any equipment/instrumentation.

Please also note that “Total Body” tests also include the “neck” section, so that no additional “CT spinal column” tests: 1 segment with a minimum of 3 intersomatic spaces”: are recognised as refundable. In “CT of the spinal column”, the segment refers to the tract/s specified in the codes themselves.

76986	2717	USE OF ANY CONTRAST MEDIUM	
76655	2718	ANGIO CT OF ANY DISTRICT - PER VASCULAR DISTRICT WITH ANY 3D RECONSTRUCTION - EXCEPT FOR THE CASES DESCRIBED	
73424	6107	ANGIO CT ABDOMINAL AORTA AND LOWER LIMB ARTERIES	
73446	6109	ANGIO CT THORACIC AND/OR ABDOMINAL AORTA	
73458	6110	ANGIO CT RENAL ARTERIES OR SPLANCHNIC VESSELS	
73465	6111	ANGIO CT OF 1 OR 2 UPPER OR LOWER LIMBS	
73474	6112	ANGIO CT ENDOCRANIAL CIRCULATION	
73482	6113	ANGIO CT OF THE HEART	
73499	6114	ANGIO CT OF THE CORONARY ARTERIES	
73507	6115	ANGIO CT CHEST (PULMONARY ARTERIES OR VEINS)	
79400	2719	ARTHRO-CT OCT JOINT DISTRICTS/BONE SEGMENTS	
65505	2720	VIRTUAL BRONCHOSCOPY (PERFORMED WITH CT PLUS 3D RECONSTRUCTION PLUS VIRTUAL ENDOSCOPY)	
65513	2721	VIRTUAL COLONOSCOPY (PERFORMED WITH TC PLUS 3D RECONSTRUCTION PLUS VIRTUAL ENDOSCOPY)	
79418	2722	DENTASCAN OR CONE BEAM VOLUMETRIC TOMOGRAPHY: 1 ARCH	
79426	2723	DENTASCAN OR CONE BEAM VOLUMETRIC TOMOGRAPHY: 2 ARCHES	
79434	2724	MIELO-CT: 1 SPINAL COLUMN SECTION	
79442	2725	MIELO-CT: 2 SPINAL COLUMN SECTIONS	
79459	2726	MIELO-CT: 3 SPINAL COLUMN SECTIONS	

65521	2727	O.C.T. – OPTICAL COHERENCE TOMOGRAPHY	
79467	2728	CT UPPER AND LOWER ABDOMEN - PELVIS	
76907	2729	CT PELVIS AND SACRUM	
79491	2730	CT SPINAL COLUMN: 1 SEGMENT WITH A MINIMUM OF 3 INTERSOMATIC SPACES	
79517	2731	CT SPINAL COLUMN: 2 SEGMENTS (CERVICAL AND DORSAL OR LUMBOSACRAL AND SACROCOCCYGEAL)	
79533	2732	CT SPINAL COLUMN: 3 SEGMENTS (CERVICAL AND DORSAL AND LUMBOSACRAL OR SACROCOCCYGEAL)	
76988	2733	CT SKULL AND/OR ORBITS OCT SKULL AND/OR SELLA TURCICA OCT SKULL AND/OR PETROUS ROCKS OCT SKULL AND/OR MASTOIDS OR FACIAL MASSIF OCT	
65919	2734	MAXILLARY TC INCLUDING UPPER OR LOWER COMPUTERISED PROCESSING	
76663	2735	CT THORAX OR UPPER OR LOWER ABDOMEN - PELVIS	
79566	2736	CT TOTAL BODY: SKULL, THORAX, UPPER AND LOWER ABDOMEN - PELVIS	

Vascular Diagnostics

Doppler ultrasonography - echo doppler - echo colour doppler

Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan.

Tests relate to both sides, including examination of the arterial and venous circulation, and double charging is therefore not recognised. The items shown are also valid for any Doppler examination combining other techniques and methods such as lasers, etc.

For tests carried out during the same session, or at the same time as ultrasound investigations, items for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Bilateral upper limb tests carried out in the same session as bilateral lower limb tests correspond to a four-limb test, for which reference should be made to the relevant code.

Doppler echocardiograms and/or cardiac Echo Colour Dopplers are not equatable with the items in this section.

For such services, please refer to the Ultrasound section.

73593	2737	UPPER OR LOWER LIMBS (BILATERAL): DOPPLER	
73874	2738	UPPER OR LOWER LIMBS (BILATERAL): ECHO DOPPLER	
79574	2739	UPPER OR LOWER LIMBS (BILATERAL): ECHO COLOUR DOPPLER	
79582	2740	UPPER AND LOWER LIMBS (FOUR LIMBS): DOPPLER	
79590	2741	UPPER AND LOWER LIMBS (FOUR LIMBS): ECHO DOPPLER	
79608	2742	UPPER AND LOWER LIMBS (FOUR LIMBS): ECHO COLOUR DOPPLER	
76665	2743	ECHO COLOUR DOPPLER OF ANY OTHER NON-DESCRIBED ARTERIAL-VENOUS DISTRICT OR VASCULAR SEGMENT	
79616	2744	PENILE OR TESTICULAR: DOPPLER	
79624	2745	PENILE OR TESTICULAR: ECHO DOPPLER	
79632	2746	PENILE OR TESTICULAR: ECHO COLOUR DOPPLER	
79640	2747	COMPLETE TRANSCRANIAL: ECHO DOPPLER	
79657	2748	COMPLETE TRANSCRANIAL: ECHO COLOUR DOPPLER	
79665	2749	COMPLETE TRANSCRANIAL WITH SPECTRAL ANALYSIS	

79673	2750	SUPRA-AORTIC TRUNKS: DOPPLER	
79681	2751	SUPRA-AORTIC TRUNKS: ECHO DOPPLER	
79699	2752	SUPRA-AORTIC TRUNKS: ECHO COLOUR DOPPLER	
79707	2753	VISCERAL: DOPPLER	
79715	2754	VISCERAL: ECHO DOPPLER	
79723	2755	VISCERAL: ECHO COLOUR DOPPLER	
Nuclear medicine (scintigraphy)			
Items are refundable only and exclusively if explicitly provided for in the Cover (if any) of your Health Plan. Fees are inclusive of medicines, indicators, consumables, cardiological and anaesthesiological services (where necessary) and technical staff. Fees are inclusive of any pharmacological and ergometric tests and any type of provocative diagnostic procedure.			
Circulatory system			
76909	2756	FIRST-PASS ANGIOCARDIOSCINTIGRAPHY	
79798	2757	BALANCE ANGIOCARDIOSCINTIGRAPHY	
79806	2758	ANGIOSCINTIGRAPHY OF ARTERIAL OR VENOUS DISTRICTS	
76717	2759	MYOCARDIAL SCINTIGRAPHY AT REST (SPECT)	
76323	2760	MYOCARDIAL SCINTIGRAPHY AT REST (PLANAR)	
76721	2761	MYOCARDIAL SCINTIGRAPHY AT REST AND AFTER STIMULUS (PET)	
79830	2762	MYOCARDIAL SCINTIGRAPHY AT REST AND AFTER STIMULUS (PLANAR)	
65538	2763	MYOCARDIAL SCINTIGRAPHY FOR IDENTIFICATION OF VIABLE MYOCARDIUM BY REINJECTION	
76815	2764	SCINTI OR TOMO MYOCARDIAL SCINTIGRAPHY AT REST AND AFTER STIMULUS (SPECT)	
65927	2765	STUDY OF GLOBAL AND REGIONAL VENTRICULAR FUNCTION (GATED-SPECT)	
Digestive system			
79855	2766	SEARCH FOR ECTOPIC GASTRIC MUCOSA	
76117	2767	SCINTIGRAPHY OF SALIVARY GLANDS	
73588	6122	SCINTIGRAPHIC STUDY OF OESOPHAGO-GASTRO-DUODENAL TRANSIT	
79863	2768	EVALUATION OF GASTRO ENTERORRHAGES	
Haemopoietic system			
76141	2769	DETERMINATION OF THE SURVIVAL TIME OF THE ERYTHROCYTES	
76174	2770	DETERMINATION OF PLASMA VOLUME AND ERYTHROCYTE VOLUME	
76240	2771	DETERMINATION OF PLATELET KINETICS	
76208	2772	DETERMINATION OF INTESTINAL ABSORPTION OF VITAMIN B12 (SCHILLING TEST)	

76422	2773	SEGMENTAL LYMPHOSCINTIGRAPHY	
76125	2774	MEASUREMENT OF INTESTINAL ABSORPTION OR PERMEABILITY	
76166	2775	COMPREHENSIVE STUDY OF FERROKINETICS	
Osteo-articular apparatus			
76824	2776	PET-MR ANY DISTRICT (INCLUDING RADIOISOTOPE AND ANY TRANSPORT)	
76471	2777	GLOBAL SKELETAL SCINTIGRAPHY	
76831	2778	SEGMENTAL BONE OR JOINT POLYPHASIC SCINTIGRAPHY	
76463	2779	BONE OR SEGMENTAL JOINT SCINTIGRAPHY	
Respiratory system			
79848	2780	LUNG SCINTIGRAPHY WITH POSITIVE INDICATOR	
76364	2781	PULMONARY PERFUSION SCINTIGRAPHY (PLANAR)	
76861	2782	PULMONARY PERFUSION SCINTIGRAPHY (SPECT)	
76349	2783	VENTILATORY PULMONARY SCINTIGRAPHY	
Urinary system			
76874	2784	DIRECT CYSTOSCINTIGRAPHY	
76273	2785	RENAL SCINTIGRAPHY WITH DMSA (PLANAR)	
76915	2786	RENAL SCINTIGRAPHY WITH DMSA (SPECT)	
76265	2787	SEQUENTIAL RENAL SCINTIGRAPHY WITH TRACER RAPID EXCRETION AND PROCESSING AND EVALUATION OF SEMI-QUANTITATIVE AND/OR QUANTITATIVE PARAMETERS AND MEASUREMENT OF GLOMERULAR FILTRATE	
Liver and biliary tract and spleen			
76922	2788	LIVER SCINTIGRAPHY (SPECT)	
76091	2789	LIVER SCINTIGRAPHY WITH POSITIVE INDICATOR (PLANAR)	
76932	2790	LIVER SCINTIGRAPHY WITH POSITIVE INDICATOR (SPECT)	
65546	2791	SEQUENTIAL HEPATOBILIARY SCINTIGRAPHY	
76075	2792	HEPATOSPLENIC SCINTIGRAPHY (PLANAR)	
76947	2793	HEPATOSPLENIC SCINTIGRAPHY WITH FLOWMETRY AND KUPPHERIAN CLEARANCE	
76216	2794	SPLENIC SCINTIGRAPHY WITH AUTOLOGOUS ERYTHROCYTES	
Central Nervous System			
76372	2795	BRAIN SCINTIGRAPHY (PLANAR)	
76953	2796	BRAIN SCINTIGRAPHY (SPECT)	

79764	2797	PLANAR BRAIN SCINTIGRAPHY WITH ANGIOSCINTIGRAPHY	
76962	2798	QUALITATIVE BRAIN SCINTIGRAPHY (PET)	
76971	2799	QUANTITATIVE BRAIN SCINTIGRAPHY (PET)	
76224	2800	TOTAL BODY BONE MARROW SCINTIGRAPHY	
Thyroid and parathyroid			
76018	2801	THYROID UPTAKE	
76042	2802	PARATHYROID SCINTIGRAPHY (INCLUDING THYROID SCINTIGRAPHY)	
76026	2803	THYROID SCINTIGRAPHY	
79772	2804	THYROID SCINTIGRAPHY WITH POSITIVE INDICATOR	
79780	2805	GLOBAL BODY SCINTIGRAPHY TO SEARCH FOR THYROID TUMOUR METASTASES	
Other organs			
79889	2806	IMMUNOSCINTIGRAPHY	
79897	2807	SEARCH FOR INFLAMMATORY FOCI WITH LABELLED AUTOLOGOUS LEUKOCYTES	
65554	2808	SENTINEL LYMPH NODE RESEARCH (RADIO-GUIDED SURGERY) (INCLUDING THE SERVICES OF THE NUCLEAR DOCTOR-RADIOLOGIST)	
76497	2809	SCINTIGRAPHY OF THE MALE GENITAL APPARATUS	
76521	2810	GLOBAL BODY SCINTIGRAPHY FOR NEOPLASTIC LOCALISATION WITH POSITIVE INDICATORS	
76513	2811	BILATERAL BREAST SCINTIGRAPHY	
76562	2812	ADRENAL SCINTIGRAPHY	
Neurology			
Services are refundable only if they are included in the Covers of your Health Plan. The need to receive the services specified below must be certified/prescribed by a physician specialising in neurology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the claim according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Fees are all-inclusive of consumables and medicines.			
79905	2813	BRAIN MAPPING	
79913	2814	SLEEP THERAPY (COMPLETE THERAPY)	
73346	2815	ELECTROENCEPHALOGRAM	
79921	2816	ELECTROENCEPHALOGRAM WITH PHARMACOLOGICAL SLEEP	
73767	2817	DYNAMIC ELECTROENCEPHALOGRAM 24 HOURS	
65935	2818	ELECTROENCEPHALOGRAM (INTRAOPERATIVE MONITORING)	
73361	2819	COMPLETE ELECTROMYOGRAPHY WITHOUT DISTINCTION OF SEGMENT	

79939	2820	ELECTRONEUROGRAPHY WITH MOTOR AND SENSORY CONDUCTION VELOCITY (PER LIMB)	
80267	2821	ELECTROSHOCK WITH NARCOSIS AND SPASMOLYSIS (EACH APPLICATION)	
73379	2822	CHRONAXIMETRIC ELECTRODIAGNOSTIC TEST (PER LIMB)	
73353	2823	SIMPLE ELECTRODIAGNOSTIC TEST (PER LIMB)	
79947	2824	SLEEP POLYPHYSIOGRAPHY (1 CYCLE)	
79954	2825	SLEEP POLYPHYSIOGRAPHY (WHOLE NIGHT)	
73817	2826	EVOKED POTENTIALS (BAERS - PES - PEV)	
65562	2827	MOTOR EVOKED POTENTIALS BY CORTICAL MAGNETIC STIMULATION	
79962	2828	MULTIMODAL EVOKED POTENTIALS	
79988	2829	INSULIN SHOCK	
79996	2830	SHOCK WITH OTHER MEDICINES	
80002	2831	NEUROPHYSIOLOGICAL STUDY OF THE PELVIC FLOOR	
80341	2832	REFLEXOLOGICAL STUDY OF THE BRAIN STEM (BLINK-REFLEX, MANDIBULAR REFLEXES AND STUDY OF MASSETER SILENT PERIODS)	
73825	2833	APHASIA TEST (APHASIA DIAGNOSTICS)	
65570	2834	L-DOPA TEST FOR DIAGNOSIS OF PARKINSON'S DISEASE	
65589	2835	DESMEDT TEST (OR REPETITIVE STIMULATION TEST) FOR MYASTHENIA GRAVIS	

Ophthalmology

Services are refundable only if they are included in the Covers of your Health Plan.

The need to receive the services specified below must be certified/prescribed by a physician specialising in ophthalmology. For prescriptions issued by professionals with a different specialisation from that indicated, the Fund will accept these at its own discretion on the basis of its unchallengeable assessment of the relevance of the request according to the specialisation and the diagnostic query provided (obligatory). For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Materials and medicines are included in the fees shown. Transillumination tests, Shirmer's tests, Fundus Oculi tests, Shirmer's tests, BUT tests and Hess Screen tests are included in the consultation. Photographs of the ocular fundus are refundable only if taken by a physician specialising in ophthalmology and only together with the specialist consultation, i.e. the service must be included in the diagnostic tests included in your Health Plan and the specialist consultation must be included in the appropriate Cover (or in that of the tests themselves). Tonometry is refundable only if it is carried out in a separate session to the specialist consultation (it must therefore be included in your Health Plan Cover), otherwise it is regarded as being included in the consultation itself. Preliminary tests prior to cataract surgery (as part of a package) will only be refunded if included in the Cover for the tests and if the surgery itself is included in your Healthcare Plan.

65943	2836	ULTRASOUND BIOMICROSCOPY (UBM)	
73411	2837	KINETIC OR STATIC CAMPIMETRY - PERIMETRY	
73775	2838	COMPUTERISED CAMPIMETRY (VCP)	
77011	2839	ENDOTHELIAL CELL COUNT (EXCEPT IN THE CASES DESCRIBED)	
77023	2840	ECHOBIOMETRY (CRYSTALLINE LENS)	
80366	2841	ELECTROMYOGRAPHY	

80374	2842	ELECTRONYSTAGMOGRAPHY	
73841	2843	ELECTROOCULOGRAM	
73395	2844	ELECTRORETINOGRAM	
73387	2845	FULL ORTHOPTIC EXAMINATION (ORTHOPTIST)	
80275	2846	ORTHOPTIC EXERCISES (PER SESSION) (ORTHOPTIST)	
80390	2847	ANTERIOR SEGMENT FLUORANGIOGRAPHY	
80408	2848	RETINAL FLUORESCEIN FLUORANGIOGRAPHY	
65597	2849	RETINAL FLUORANGIOGRAPHY WITH INDOCYANINE GREEN	
73437	2850	FLUORANGIOSCOPY, ANTERIOR SEGMENT ANGIOSCOPY, FLUORESCENCE CIRCULATION TIME	
73429	2851	PHOTOGRAPH OF THE BASE OR ANTERIOR SEGMENT IN COLOUR OR BLACK AND WHITE	
65951	2852	HEIDELBERG RETINA TOMOGRAPHY (CONFOCAL LASER OPHTHALMOSCOPY) WITH MORPHOMETRIC ANALYSIS OF THE OPTIC NERVE	
65605	2853	GDX (RETINAL LASER POLARIMETRY SCANNING)	
73460	2854	GONIOSCOPY	
65613	2855	MICROPERIMETRY	
80416	2856	OPHTHALMODYNAMOMETRY	
73858	2857	CORNEAL PACHYMETRY	
80424	2858	VISUAL EVOKED POTENTIALS	
73452	2859	PUPILLOGRAPHY	
73445	2860	RETINOGRAPHY	
65960	2861	S.C.O. (EXAMINATION OF THE OPTIC DISC AND RETINAL NERVE FIBRES)	
73403	2862	TONOGRAPHY AND PROVOCATION TEST	
73601	2863	TONOMETRY, ORBITOTONOMETRY (IF ONLY ONE MEDICAL PROCEDURE; OTHERWISE INCLUDED IN THE EXAMINATION)	
77036	2864	CORNEAL TOPOGRAPHY	
65978	2865	OCULAR BLOOD FLOW ASSESSMENT (OBF)	
65621	2866	NICTOEMERAL EVALUATION OF EYE PRESSURE (TONOMETRIC CURVE)	
Otolaryngology			
Services are refundable only if they are included in the Covers of your Health Plan. The need to receive the services specified below must be certified/prescribed by a physician specialising in otorhinolaryngology. For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Materials and medicines are included in the tariffs for the individual Health Plans.			
80440	2867	ELECTROCOCHLEOGRAPHY (ECOG)	
80457	2868	AUDIOMETRIC TEST FOR PROSTHETIC FITTING	
73494	2869	TONAL AND VOCAL AUDIOMETRIC TEST	

73791	2870	PHONIATRIC TEST (SPEECH THERAPIST)	
65638	2871	VESTIBULAR TEST WITH VNG RECORDING (VIDEO NYSTAGMOGRAPHY)	
65646	2872	VESTIBULAR TEST WITH VNS RECORDING (VIDEO NYSTAGMOSCOPY)	
65654	2873	VESTIBULAR TEST WITH VNS RECORDING (VIDEO NYSTAGMOSCOPY) AND VNG (VIDEO NYSTAGMOGRAPHY)	
80465	2874	VESTIBULAR TEST WITH PENDULAR STIMULATION	
80473	2875	VESTIBULAR TEST WITH ROTATORY STIMULATION	
73502	2876	VESTIBULAR TEST WITH THERMAL STIMULATION	
80481	2877	VESTIBULAR TEST WITH THERMAL AND ROTATORY STIMULATION	
80499	2878	VESTIBULAR TEST WITH THERMAL, PENDULAR AND ROTARY STIMULATION	
80283	2879	PHONIATRIC EXERCISES (PER SESSION) (SPEECH THERAPIST)	
73528	2880	GUSTOMETRY	
73635	2881	IMPEDANCEMETRY	
81406	2882	ENDOTYMPANIC INSUFFLATIONS (NOT PERFORMED IN SPAS)	
81430	2883	NASAL IRRIGATIONS (NOT PERFORMED IN SPAS)	
65986	2884	FREEING PROCEDURES FOR CANALICULITIS	
73510	2885	OLFACTOMETRY	
80507	2886	ACOUSTIC EVOKED POTENTIALS	
80614	2887	RHINOMANOMETRY (ANTERIOR AND POSTERIOR)	
65994	2888	DYNAMIC STABILOMETRY	
66002	2889	STATIC STABILOMETRY	
Pneumology			
Services are refundable only if they are included in the Covers of your Health Plan. The need to receive the services specified below must be certified/prescribed by a physician specialising in pneumology. For tests carried out during the same session, fees for tests subsequent to the first one are reduced by 50% (applied to the least expensive test/s). Fees are inclusive of consumables and any medicines.			
80317	2890	AEROSOL THERAPY (NOT PERFORMED IN SPAS)	
40048	2891	BRONCHOISTILLATION-BRONCHOSPIRATION	
73049	2892	CAPNOGRAPHY	
73064	2893	STATIC AND DYNAMIC PULMONARY COMPLIANCE	
80150	2894	BREATHING EXERCISES AND OTHER PROCEDURES (DRAINAGE) (PER SESSION)	
73304	2895	ARTERIAL OXIMETRY (PAO2 OR SAO2)	
80622	2896	BODY PLETHYSMOGRAPHY (MEASUREMENT OF VGT, RESISTANCE, VOLUMETRY)	
80630	2897	INDUCTIVE THORACIC PLETHYSMOGRAPHY	
73056	2898	PNEUMOTACHOGRAPHY (FLOW-VOLUME CURVE) (SINGLE TEST)	

80648	2899	BASIC PNEUMOTACHOGRAPHY AND AFTER BRONCHOCONSTRICTION/DILATATION TEST (SINGLE TEST)	
81455	2900	INTERMITTENT POSITIVE PRESSURE BREATHING	
73015	2901	SIMPLE SPIROMETRY (WITH VITALOGRAPH)	
73031	2902	SPIROMETRY WITH STRESS TEST	
80655	2903	SPIROMETRY WITH STRESS TEST AND DIFFUSION TEST	
80663	2904	SPIROMETRY WITH STRESS TEST AND CONTINUOUS OXIMETRY	
80671	2905	SPIROMETRY WITH DIFFUSION TEST AND PULMONARY DUCTANCE COEFFICIENT	
80689	2906	SPIROMETRY WITH DRUG-DYNAMIC TESTS	
80697	2907	RESIDUAL VOLUME SPIROMETRY	
80705	2908	SEPARATE SPIROMETRY (BRONCHOSPIROMETRY)	
80754	2909	STEADY STATE DIFFUSION TEST	
80762	2910	SINGLE-BREATH DIFFUSION TEST	
80770	2911	STRESS DIFFUSION TEST	
80788	2912	PULMONARY DUCTANCE TEST	
80168	2913	VENTILOTHERAPY (PER SESSION)	
Allergometric tests/Allergology			
Services are refundable only if they are included in the Covers of your Health Plan. Fees represent professional fees and include consumables. Medicines and/or the substances used for tests (series of allergens) are excluded from refunds. Fees are per session, to which the fee for the consultation can be added once only per course of sessions/therapies and only if provided for by the Health Plan. The expenditure documentation must always be accompanied by a medical certificate showing precisely: the diagnosis and the number of sessions/therapies considered necessary. The services in this section are not equatable with vaccines (of any type).			
72488	2914	SPECIFIC INJECTION IMMUNOTHERAPY OR SPECIFIC IMMUNOTHERAPY WITH HYMENOPTERA VENOM	
72520	2915	PATCH TEST - GIRDCA SERIES (INSTANT READ - ANY NUMBER OF HAPTENS)	
70193	2916	PRICK TEST FOR INHALANTS AND FOOD (IMMEDIATE READING - ANY NUMBER OF ALLERGENS) OR PRICK TEST AND SCALAR INTRADERMAL TEST FOR HYMENOPTERA VENOM	
77053	2917	CONJUNCTIVAL ALLERGEN-SPECIFIC OR NASAL ALLERGEN-SPECIFIC OR BRONCHIAL ALLERGEN-SPECIFIC (ANY NUMBER OF ALLERGENS) OR BRONCHIAL NON-SPECIFIC (METHACHOLINE, HISTAMINE, ETC.) PROVOCATION TEST	
77061	2918	INJECTION TOLERANCE TEST FOR LOCAL ANAESTHETICS OR GENERAL ANAESTHETICS (ANY NUMBER OF DRUGS) OR FOR BETALACTAMINES (WITH SIDE CHAINS OR FOR PENICILLINS) OR FOR OTHER DRUGS	
72736	2919	ORAL TOLERANCE TESTING FOR DRUGS (ANY NUMBER OF DRUGS) OR FOOD (ANY NUMBER OF FOODS) OR FOOD AND DRUG ADDITIVES (ANY NUMBER OF ADDITIVES)	

SECTION Q. PHYSIOKINESIS THERAPY

Services are refundable only if included in the specific Cover of your Health Plan and within the limits specified therein.

Refunds, for Health Plans with case-by-case refunds, are limited to a total of 80 services per year (1 January - 31 December) per patient (acupuncture, spinal manipulation, focal shock waves have their own annual limits within these 80 services/year. Equipment rental also has its own annual limits but does not count towards the maximum limits for physiotherapy services), regardless of type, technique, instrumentation, or the anatomical district treated. Anatomical district means the entire spinal column, or the upper or lower limbs. Fees are all-inclusive of consumables and medications. Therapies for aesthetic purposes and/or ascribable to these are not refundable.

The same rules, maximum fees and limitations apply to in-home care as to physiokinesis therapy services provided in a health facility authorised by the competent authorities.

Furthermore, “Occupational Therapy” is recognised as refundable by the Fund, if provided for by the Cover of your Health Plan, for members/clients suffering from pre-existing cognitive, physical or mental disabilities, while “Neuromotor rehabilitation for acute and chronic neurodegenerative pathologies” is recognised by the Fund, again if provided for by the Cover of your Health Plan, in cases of disabling neurological damage and - therefore - therapy for the recovery of functional motor or neuromotor skills recently reduced and/or lost due to illness or trauma and/or chronic-degenerative pathologies (e.g. cerebral strokes, Parkinson's disease, multiple sclerosis, etc.). The above items are defined as being per session, regardless of the number of therapies/services carried out within the same session, i.e. the above items/services cannot be summed with other items/therapies/services in the same physiokinesis therapy section.

For refunds of “Occupational Therapy” to be recognised, the qualification of the practitioner who carried out the treatment/services must be clearly indicated.

Items with “manu medica” are refundable by the Fund, within the context of the provisions of the Health Plan, only if performed by a physician qualified in the European Union.

Please remember that, to be refunded for physiokinesis therapy services, you must submit the specialist medical prescription for the pathology showing the certain diagnosis (not to be confused with the symptomatology) and including details of the therapies to be followed specifying the type, the number of sessions, the number of services per session and their frequency.

FasiOpen reserves the right to request a copy of the daily physiokinesis therapy diary signed by the client in the case of out-patient and in-home services (please note that, in the case of hospitalisation, the daily physiokinesis therapy diary is an integral part of the medical record) and/or reserves the right to perform administrative-health checks and/or checks on the academic qualification/specialisation of the professional providing the services also by reference to registrations listed at the Professional Boards and/or Registers.

78022	2920	CARDIAC RE-EDUCATION (PER SESSION)	
79970	2921	NEUROMOTOR REHABILITATION FOR ACUTE AND CHRONIC NEURODEGENERATIVE DISEASES (PER SESSION)	
Physiotherapy (therapy with physical equipment)			
80036	2922	RADIAL SHOCK WAVES - DIATHERMY: SHORTWAVE/MICROWAVE/RADAR THERAPY	
80093	2923	ANTALGIC ELECTROTHERAPY (DIADYNAMIC OR TENS)	
80119	2924	ELECTROTHERAPY OF NORMAL OR DENERVATED MUSCLES (ELECTROSTIMULATION, FARADIC, GALVANIC, HYDROGALVANIC, INTERFERENTIAL)	
80069	2925	INFRARED IRRADIATION	
80101	2926	IONTOPHORESIS	
81422	2927	SEGMENTAL HYPERTHERMIA	
80259	2928	ANTALGIC LASER THERAPY	
80127	2929	MAGNETOTHERAPY	
56070	98	FOCAL SHOCK WAVES-MANU MEDICA - OUTPATIENT TREATMENTS FOR OSTEO-ARTICULAR TISSUES OR SOFT TISSUES, WITHOUT ANAESTHETICS, ALL-INCLUSIVE OF PROFESSIONAL FEES, USE OF THE HEALTH FACILITY AND ANY MATERIALS AND MEDICINES - PER SESSION/SERVICE	A maximum of 6 services per year (1 January - 31 December) can be refunded within the maximum limits for services in the physiotherapy section.
80242	2930	PRESSOTHERAPY OR INTERMITTENT DEPRESSOTHERAPY OR MANUAL LYMPHODRAGE (LIMITED TO CASES OF LYMPHOEDEMA, AXILLARY/INGUINAL LYMPHADENECTOMY OR IN CASES OF HIP PROSTHESIS SURGERY IN THE CONTEXT OF POST-HOSPITALISATION THERAPY).	

85522	2931	TECAR THERAPY	
80051	2932	ULTRAVIOLET LIGHT OR PUVA THERAPY (PER SESSION)	
80226	2933	ULTRASOUND THERAPY	
Kinesiotherapy (movement therapy)			
80218	2934	ACUPUNCTURE (MANU MEDICA)	A maximum of 10 services per year (1 January - 31 December) can be refunded within the maximum limits for services in the physiotherapy section.
81364	2935	ASSISTED EXERCISES IN WATER (PER SESSION)	
81555	2936	EXERCISES WITH ISOKINETIC EQUIPMENT (PER SESSION)	
80135	2937	POSTURAL EXERCISES	
80192	2938	MOTOR AND PROPRIOCEPTIVE REHABILITATION	
80184	2939	SPINAL MANIPULATIONS OR CHIROTHERAPY (MANU MEDICA)	A maximum of 10 services per year (1 January - 31 December) can be refunded within the maximum limits for services in the physiotherapy section.
80143	2940	MASSAGE THERAPY	
80325	2941	LOCALISED MASSAGE THERAPY - REFLEXOLOGY (MANU MEDICA)	
81563	2942	JOINT MOBILISATIONS	
81571	2943	SPINAL MOBILISATIONS	
81356	2944	OCCUPATIONAL THERAPY (PER SESSION)	
80200	2945	MECHANICAL SPINAL TRACTIONS (PER SESSION)	
77069	2946	EQUIPMENT HIRE FOR IN-HOME THERAPY FOR: ACTIVE OR PASSIVE KINESIOTHERAPY OR ELECTROTHERAPY (IONTOPHORESIS, DIADYNAMIC, ELECTROSTIMULATION, TENS, ULTRASOUND THERAPY) OR MAGNETOTHERAPY OR PRESSOTHERAPY, LIMITED TO INJURIES FROM FRACTURES OR SURGERY WITHIN 365 DAYS OF THE EVENT AS PROVEN BY MEDICAL RECORDS; OR FOR ASSISTED VENTILATION DURING SLEEP FOR SLEEP APNEA SYNDROME; OR FOR VACUUM THERAPY FOR SKIN ULCERS	Refundable for a maximum of 60 days per year

SECTION R. DENTISTRY SERVICES

Services are refundable only if included in the specific Cover of your Health Plan and within the limits specified therein. Regardless of Health Plan, dentistry services are subject to time limits for refunds in addition to those set out in the individual Covers of Health Plans that include them. For the calculation of time limits (shown on a case-by-case basis and valid for all Health Plans), the services shown are per tooth (if referring the individual tooth/site) and/or per arch and/or hemiarch. Each item/service involving an attribution unequivocally indicates how this is decided and, consequently, when making a claim you will need to indicate the relevant tooth/site and/or arch and/or hemiarch.

Please also note that, for certain services listed below - if provided for in your Health Plan - you must submit a Preventive Treatment Plan form to the Fund. For these services, pre-treatment documentation (at the Treatment Plan stage) and post-treatment documentation (at the refund claim stage) must also be submitted. For each service code, the type of obligatory pre-treatment and post-treatment documentation will be specified. Since it is not the intention of the Fund to impose operational protocols on treating professionals, please note that - where provided for - intraoral photographs may be submitted as an alternative to X-rays. Refunds for intraoral photographs and/or instrumental diagnostics (X-rays) invoiced by the Dentist or Dental Surgery are possible only if included in the Dentistry Cover in your Health Plan. X-rays invoiced by Radiology Centres, Outpatient Clinics, etc. (i.e. non-dental health facilities) will be included, if provided for in the conditions, in the Cover for diagnostic tests in your Health Plan.

Refunds are not available for items/treatments/services beyond those provided for in the Nomenclature or, therefore, beyond those provided for in your Health Plan; autonomous coding due to similarity of services/treatments is not allowed, therefore, and refunds for services cannot be granted before expiry of the time limits. Services attributable to permanent and/or deciduous teeth cannot overlap on the same dental sites; in the same way, the same and/or different items relating to different age groups cannot overlap for the same person. Time limits apply regardless of age.

Periodontology

Periodontal surgery services cannot overlap on the same arches or hemiarches regardless of the age of the member/client. Codes 2585-30313 are not refundable in conjunction with code 2616 (sinus lift surgery) if the hemiarch involved is edentulous. Progressive code 2587 includes the correction of slight bone defects by means of the insertion of biomaterials to preserve the post-extraction alveolar bone, the covers for implant coils exposed during surgery, the treatment of peri-implantitis, and periodontal surgery (biomaterials, membranes and any fixing screws are included in the code itself). Code 2587 is not refundable in the same quarter in which code 2616 is claimed for the same hemiarch. Code 2587 is only refundable in conjunction with implant services under a Cover-based Health Plan. Code 2589, “Interdental splinting”, can only be used in the event of periodontal problems from age 25 upwards or more and cannot, therefore, be used to support orthodontic therapy or be equated with orthodontic retainer. Codes 2588-30315, “Root planing”, cannot overlap with or be equated with tartar removal or oral hygiene (services provided with specific codes and limitations) and cannot be refunded together with code 6137.

20776	2583	GINGIVAL SURGERY PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same arch (regardless of age)
20784	2584	MUCOGINGIVAL OR FORNIX LOWERING SURGERY, PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same arch (regardless of age)
20826	2585	BONE SURGERY (INCLUDING ANY TYPE OF ACCESS FLAP - INCLUDING SUTURE) COMPLETE TREATMENT PER HEMIARCH - FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same hemiarch (regardless of age)
20768	2586	GENGIVECTOMY AS A SINGLE SERVICE - PER HEMIARCH - FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same hemiarch (regardless of age)
20792	2587	INSERTION OF BIO-COMPATIBLE MATERIAL (INCLUDING ANY TYPE OF FLAP) - PER HEMIARCH	Refundable once every 5 years (ref. invoice) for the same hemiarch (regardless of age) - TREATMENT PLAN OBLIGATORY
20735	2588	ROOT PLANING AND GINGIVAL CURETTAGE (PER HEMIARCH) - FROM 17 YEARS OF AGE	Refundable once every 2 years (ref. invoice) for the same hemiarch (regardless of age)
20743	2589	INTERDENTAL SPLINTING - ANY MATERIAL USED - ONLY FOR PARODONTAL PROBLEMS FROM 25 YEARS OF AGE - PER	Refundable once every 5 years (ref. invoice) for the

		HEMIARCH	same hemiarch (regardless of age)
7006	6130	SPECIALIST DENTAL CONSULTATION WITH ANY TREATMENT PLAN	Refundable once a year only for direct provision service
7007	6137	ORAL HYGIENE: DEBRIDEMENT	Refundable twice a year (1 January - 31 December).

Oral Surgery

Post-extraction haemorrhage treatments, surgical dressings are included in the respective services/treatments. Code 2591 cannot be equated with to apical repositioning (lengthening of clinical crown). Code 2592 is refundable only if accompanied by the relevant histological report (no exceptions are possible). Codes 2593-30317 are already inclusive of the orthodontist's services for anchorage; if a claim is made concurrently to the orthodontic treatment, therefore, detailed pre-treatment documentation for codes 2593-30317 and documentation showing the entire orthodontic treatment must be submitted. Codes for extractions apply only to natural teeth (they cannot be equated with extraction/implant removal) in their entirety (extractions of fragments are not refundable). Code 2595 is refundable only for natural teeth that have never erupted in the arch, while code 2596 is refundable only for partially erupted teeth (cannot be equated with the extraction of fractured teeth). The removal and subsequent re-implantation of a natural tooth is not refundable. Code 2597 is refundable only for prior or concurrent permanent removable dentures. Codes 2600 and 2601, which can only be used on multi-rooted and endodontically treated teeth, are not compatible on the same tooth. Code 2600 is already inclusive of root extraction. Code 2645 applies to minor oral surgery not included in the other sub-branches. Code 2645 cannot be used for uncovering implants (included in the service itself). FasiOpen reserves the right to request additional documentation and/or details and/or medical reports relating to operations relating to code 2645. General anaesthesia (including professional fees and the respective drugs/medicines) is only refundable for in-patient dental surgery if your Healthcare Plan provides for refunding of in-patient dental treatment. No refunds are available for any type of anaesthesia, other than general anaesthesia; in all other cases the cost of anaesthesia is included in the refund fees for the dental services themselves. Included within the individual services, where necessary, are sutures of any kind, materials and medicines.

20024	2590	GENERAL ANAESTHESIA - ONLY DURING HOSPITALISATION (FROM 17 YEARS OF AGE - PER HOSPITALISATION)	Refundable once, only during hospitalization (per hospitalisation) only for indirect provision services.
20180	2591	APICECTOMY INCLUDING RETROGRADE FILLING - PER TOOTH - ANY NUMBER OF ROOTS - FROM 17 YEARS OF AGE	Refundable once per tooth
20305	2592	BIOPSIES, ANY TYPE, ANY NUMBER, ANY REGION OF THE ORAL CAVITY INCLUDING THE TONGUE, OR REMOVAL OF MUCOUS CYSTS, SMALL NEOPLASMS OR SMALL NEOPLASM-LIKE LESIONS, EXCLUDING HISTOLOGICAL EXAMINATION	Refundable once per case (regardless of the number)
20321	2593	DISINCLUSION OF RETAINED TEETH PER TOOTH (INCLUDING ORTHODONTIST'S SERVICES FOR ANCHORAGE) - FROM 21 YEARS OF AGE	Refundable once per tooth - OBLIGATORY TREATMENT PLAN with pre-treatment radiography
20115	2594	EXTRACTION OF TOOTH OR ROOT (SIMPLE OR COMPLEX) OF PERMANENT TOOTH INCLUDING ANY SUTURES - PER NATURAL TOOTH	Refundable once per tooth
20156	2595	EXTRACTION OF TOTALLY BONE-IMPACTED TOOTH, INCLUDING 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH (EXCLUDING GERMECTOMY) - INCLUDING ANY SUTURES PER NATURAL TOOTH	Refundable once per tooth/tooth location OBLIGATORY: TREATMENT PLAN with pre-treatment radiography - Refund Stage post-treatment radiography
20149	2596	EXTRACTION OF PARTIALLY BONE-IMPACTED 3RD MOLAR - ONLY FOR TEETH THAT HAVE NEVER ERUPTED IN THE DENTAL ARCH - INCLUDING ANY SUTURES PER NATURAL TOOTH	Refundable once per tooth OBLIGATORY: TREATMENT PLAN with pre-treatment radiography - Refund Stage post-treatment radiography
20198	2597	PRE-PROSTHETIC SURGERY IN CASES OF PARTIAL OR TOTAL EDENTULISM - ONLY IF PATIENT HAS PREVIOUS OR CONCURRENT PERMANENT MOBILE DENTURES - PER HEMIARCH.	Refundable once every 5 years (ref. invoice) per hemiarch
20263	2598	FRENOTOMY OR FRENECTOMY, PER ARCH FROM 17 YEARS OF AGE	Refundable once per arch regardless of age
20297	2600	RHIZECTOMY (INCLUDING ACCESS FLAP AND ROOT EXTRACTION) ONLY FOR ENDODONTICALLY TREATED MULTIPLE-ROOT TEETH - PER TOOTH	Refundable once per tooth

20206	2601	RHIZOTOMY (INCLUDING ACCESS FLAP) ONLY FOR ENDODONTICALLY TREATED MULTIPLE-ROOT TEETH - PER TOOTH	Refundable once per tooth
21886	2645	ORAL SURGERY OPERATIONS FROM 17 YEARS OF AGE	
23012	2653	SALIVARY CALCULUS, REMOVAL OF	Service provided only by direct-provision at selected facilities. Refundable once per case regardless of the number of removals OBLIGATORY: pre-treatment images showing the presence of salivary calculus
23038	2655	CYSTS OF THE JAW, OPERATION FOR	Service provided only by direct-provision at selected facilities. OBLIGATORY: Pre-treatment picture showing the presence of the cyst or intraoral image in the event of diagnosis after suppuration
23061	2658	SMALL ENDOSSEOUS NEOPLASMS (OSTEOMAS, CEMENTOMAS, ODONTOMAS, PALATINE AND MANDIBULAR TOURUS), EXCISIONS OF	Service provided only by direct-provision at selected facilities. OBLIGATORY: Pre Treatment - pre treatment image showing the presence of the neoplasm. Post-treatment statement by the treating dentist specifying the type of endosseous neoplasm removed.
23079	2659	CIRCUMSCRIBED OSTEITIS OF THE JAWS, TREATMENT OF	Service provided only by direct-provision at selected facilities. OBLIGATORY: Pre-Treatment: pre-treatment image showing the presence of the inflammatory pathology that affected the bone.
23103	2661	MAXILLARY SINUS, OPENING FOR ALVEOLAR PROCESS	Service provided only by direct-provision at selected facilities. Not refundable in the same quarter as “Maxillary sinus lift and/or vertical or alveolar ridge expansion”. Not refundable in conjunction with “Insertion of biocompatible material” and “Bone or cartilage graft” codes. The service includes the grafting/insertion of material (biocompatible, bone or cartilage). OBLIGATORY: PRE-TREATMENT: OPT or Dentascan or Pre-operative cone beam tomography. POST-TREATMENT: Post-operative OPT or Intra-operative photo. Detailed description of the operation carried out
23112	2662	BONE OR CARTILAGE GRAFT	Service provided only by direct-provision at selected facilities. Not refundable in conjunction with items

			"Maxillary sinus, opening for alveolar process" and/or "Maxillary sinus lift and/or vertical or horizontal expansion of alveolar ridge" and/or "Insertion of biocompatible material" (and in all cases not refundable during the same three-month period in which biocompatible material is inserted). The item is inclusive of all phases of the surgery (harvesting and grafting). OBLIGATORY: POST-TREATMENT: Statement by the treating dentist specifying the purpose of the treatment, the procedure, the type of biomaterial grafted and any batch.
Conservative			
If covered by your Health Plan, only one filling per tooth is refundable every 3 years regardless of class, age, and whether deciduous/permanent. The following are included in the respective services/treatment: positioning of the dam; reattachment of fragment; chemical treatment for hypersensitivity; fillings, any type, together with code 2609, 30326 and/or root canal treatment (any code) and/or endodontic re-treatment (any number of roots - any code) of the same tooth regardless of age/type of tooth (deciduous/permanent). Fillings, of any class and/or type, are not refundable together with codes 2603, 2632 and 30323 required for the same tooth; likewise, no fillings (any class and code) are refundable in conjunction with codes 2591 "Apicoectomy", 2613-30329 "Pulpotomy", or 2623-30331 "Core reconstruction". Codes 2609-30326 are refundable only on devitalized teeth (treated concurrently or previously), therefore any refund of codes 2609-30326 implies that the tooth has been treated (whether paid by the Fund or not). Codes 2609, 30326, 2603, 2632, 30323 and fillings of any class/code are not refundable with regard to teeth for which a "Post and core" has been paid for or rehabilitated. 2622 (regardless of the material used). Codes 2603, 2632, 30323 are not refundable with regard to the anterior group (canine to canine) and cannot be equated with prosthetic veneers and/or ¾ prosthetic crowns, whether permanent or temporary. Codes 2602-30322 and fillings, of any class/code cannot be equated with dental sealants. Codes 2602-30322 cannot be equated with the treatment of Apexification and Apexogenesis (which are not refundable).			
20529	2602	DIRECT-INDIRECT PULP CAPPING - PER PERMANENT TOOTH FROM 17 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age and regardless of whether deciduous or permanent)
21063	2603	INLAY IN INTEGRAL PRECIOUS ALLOY (GOLD) OR CERAMIC INLAY OR ONLAY INCLUDING BUILD UP AND TEMPORARY - PER PERMANENT TOOTH - INDIRECT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
20537	2609	TOOTH RECONSTRUCTION WITH SCREW OR PIN ANCHORING OF DECIDUOUS OR PERMANENT DEVITALIZED TEETH (AT THE SAME TIME OR PREVIOUSLY TREATED) PER TOOTH FROM 17 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age and regardless of whether deciduous or permanent)

21280	2632	INLAY IN RESIN OR CAD CAM COMPOSITE - INLAY OR ONLAY INCLUDING BUILD UP AND TEMPORARY - PER PERMANENT TOOTH - DIRECT/INDIRECT - FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: Certification of Compliance at refund stage issued by the dental technician's laboratory stating the ITCA number. If the product is made with CAD/CAM technique, also a copy of the batch of material used in its construction
20439	2650	FILLING OF CAVITIES, CLASS 1 - 3 - 5 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age, class or whether deciduous or permanent
23151	2667	FILLING OF CAVITIES, CLASS 2 - 4 - ANY MATERIAL - PER PERMANENT TOOTH FROM 17 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age, class or whether deciduous or permanent
Endodontics			
The following services/treatments are included in the respective services/treatments: positioning of the dam; treatment of perforations with endodonto-parodontal communication; fillings of any type/code together with root canal treatment (any code) and/or endodontic re-treatment (any code) of the same tooth; pre-endodontic coronal reconstruction. Apexification treatments and endodontic first aid dressings are not refundable. Codes 2613 - 30329 are not refundable in conjunction with codes 2614-2668-2669-30330. Codes 2614-2668-2669-30330 cannot overlap on the same tooth element and are not refundable in conjunction with root canal treatment (any code).			
20545	2610	COMPLETE ROOT CANAL TREATMENT OF 1 CANAL (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
20594	2611	COMPLETE ROOT CANAL TREATMENT OF 2 CANALS (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
20552	2612	COMPLETE ROOT CANAL TREATMENT OF 3 OR MORE CANALS (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
20560	2613	PULPOTOMY AND FILLING OF THE PULP CHAMBER OR PULPECTOMY AND TEMPORARY FILLING FOR ANY NUMBER OF CANALS - PER PERMANENT TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth
20602	2614	ENDODONTIC RETREATMENT OF TOOTH WITH 1 CANAL (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
23152	2668	ENDODONTIC RETREATMENT OF TOOTH WITH 2 CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments

23153	2669	ENDODONTIC RETREATMENT OF TOOTH WITH 3 OR MORE CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER PERMANENT TOOTH INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
Implantology			
Pre-surgical and/or radiological templates are not refundable and cannot be equated with any type of splint or removable prosthesis of any kind. Only one code 2615 is refundable per tooth location (nominal and anatomical) regardless of the number of roots of the natural tooth to be replaced and regardless of the size of the space to be rehabilitated. Code 2615 cannot be used for mini-orthodontic implants (non-refundable). Implant types other than osseointegrated implants are not refundable. The location for the attribution of Code 2615 is that occupied where the fixture “emerges”. The reconstruction mesostructure on implants (abutment) is not refundable. Code 2616 refers to small and large maxillary sinus lifts, horizontal and/or vertical ridge expansions, and block grafts for severe atrophy requiring regenerative treatment in preparation for or concurrent to the insertion of implant fixtures (biomaterials, membranes and any fixing screws are included in the code). Code 2616 is not refundable in the same quarter in which code 2587 is claimed for the same hemiarch.			
21089	2615	OSSEOINTEGRATED IMPLANTS (ANY TYPE INCLUDING ZYGOMATIC OR PTERYGOID IMPLANTS EXCLUDING MINI-ORTHODONTIC IMPLANTS OR IMPLANTS OTHER THAN OSSEOINTEGRATED) PER DENTAL LOCATION	Refundable once per physical and nominal tooth location (regardless of the edentulous space to be rehabilitated). OBLIGATORY: TREATMENT PLAN with pre-treatment radiography - Refund Stage post-treatment radiography
21121	2616	MAXILLARY SINUS LIFT (SMALL OR LARGE) AND/OR HORIZONTAL AND/OR VERTICAL ALVEOLAR CREST EXPANSION (ANY TECHNIQUE). COMPLETE TREATMENT INCLUDING INTRAORAL OR EXTRAORAL AUTOLOGOUS BONE HARVESTING AND ANY GRAFT MATERIAL - OUTPATIENT PROCEDURE - PER HEMIARCH.	Refundable once per hemiarch. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography - Refund Stage post-treatment radiography and detailed description of the operation
Prostheses			

Any prosthetic service (regardless of age or type) is not refundable for the same tooth location (natural tooth or implant replacing the tooth itself) until 5 years have elapsed from the date of invoice for the service previously paid for regardless of the reasons for the need to reconstruct or replace the prosthesis. In the case of permanent total prostheses, no other type of permanent prosthetic rehabilitation can be refunded before 5 years have elapsed on the same arch, even if innovative therapeutic systems are used. Code 2626, “Removable partial dentures”, is refundable only and exclusively as a partial permanent rehabilitation and is not refundable, on the same arch, before 5 years have elapsed from the refund of code 2674 (and vice versa). Items regarding partial permanent removable prostheses, removable partial dentures, and total prostheses are not refundable simultaneously on the same arch and are in any case subject to time limits. No other possibilities are available. Services/treatments include: any diagnostic wax-up; any milling/counter milling; provisional and/or permanent cementing of fixed prostheses. Reconstruction mesostructure for implants is not refundable and cannot be equated with code 2622 “Post and core” or code 2633 “Precision attachment”. Permanent fixed prostheses (permanent crowns and inlays of any code) can be performed with CAD/CAM techniques directly by the dentist if the appropriate machinery is available; in this case, as specified by the Ministry of Health, the dentist is required to provide (in addition to obligatory requirements), specific written certification containing warnings, contraindications, materials used, the batch number of the block of material (CE/EU marked), traceability of materials and the type of machinery used to produce the item. Code 2620, “Provisional reinforced or reinforced crown”, is refundable only upon presentation of a certificate from the dental laboratory (refunds are not recognised if the dental practitioner certifies that the crown was made using the CAD/CAM technique). Telescopic prostheses and/or double crowns cannot be equated with full crowns (any type), i.e. only one full crown (any type/code) per tooth/implant (nominal and anatomical site) is refundable within the limitations set by the Nomenclature and therefore by the Health Plan Cover that includes them (if it does include them). For telescopic prosthesis please refer to code 2633. Maryland Bridges are not refundable and cannot be equated with prosthetic crowns (any type/code) or inlays (any type/code). Code 2633 is not refundable on implants without a fixed prosthesis, i.e. only the precision attachment positioned on a permanent fixed complete prosthetic crown is refundable (it cannot be associated, however, with a fixed pedodontic prosthesis). Code 2633 cannot be equated to brackets for orthodontic treatment. Although it comes complete with male-female components, code 2633 must be indicated at the location of the last permanent crown on which the male section is positioned. Prosthetic veneers and/or ¾ prosthetic crowns are not refundable and cannot be equated with codes 2625-2671-2618-2619-30332 (regardless of the technique used). Codes for Relining refer solely to removable prostheses and cannot be equated to the repair/modification of pre-existing prostheses. Refunds for code 2622 preclude subsequent refunds for code 2609-2603-2632-30323-30326-30331 and fillings, of any class/code, and root canal treatments (for the latter unless the claim is made simultaneously) of any code regardless of the number of canals. Please note that codes relating to “Partial removable prostheses - per hemiarch”, whether permanent or provisional, must be allocated according to the edentulous zone regardless of the size of the prosthesis. Please also remember that code 2626, “Removable partial dentures”, can only be claimed for permanent partial dentures complete with an alloy reinforcement structure (not to be confused with the reconstruction bar on implants).

Fixed prostheses

21022	2618	PERMANENT CROWN IN BIOMEDICAL ALLOY/RESIN/COMPOSITE CERTIFIABLE AS PERMANENT MATERIAL (ANY TYPE) - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo
21055	2619	PRECIOUS ALLOY AND CERAMIC CROWN - METAL-FREE CROWN (CERAMIC OR INTEGRAL/MONOLITHIC CERAMIC MATERIALS - CAD CAM SYSTEMS) PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo
21162	2620	PROVISIONAL REINFORCED CROWN - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21113	2622	FUSED POST AND CORE IN NON-PRECIOUS OR PRECIOUS ALLOY OR CERAMIC - FOR NATURAL TOOTH	Refundable once every 5 years (ref. invoice) per tooth location OBLIGATORY: Certification

			of Compliance at refund stage issued by the dental laboratory stating the ITCA number or certification by the dentist if in carbon fibre or glass ceramic
21139	2623	CORE RECONSTRUCTION WITH COMPOSITE MATERIAL, GIC, AMALGAM ONLY FOR PERMANENT NATURAL TEETH TO BE REHABILITATED WITH PROSTHETIC CROWNS (FIXED PROSTHESES) - PER TOOTH FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo
21097	2624	REMOVAL OF CROWNS PER SINGLE POST. NOT REFUNDABLE IN RELATION TO REQUESTS FOR EXTRACTIONS OR OSTEO-INTEGRATED IMPLANTS OR IN INTERMEDIATE BRIDGE LOCATIONS OR FOR CROWN EXTENSIONS	Refundable once every 5 years (ref. invoice) per tooth location
21147	2625	REPAIR OF A SINGLE PERMANENT PROSTHETIC CROWN WITH CERAMIC OR RESIN (ONLY FOR TEETH THAT HAVE PREVIOUSLY BEEN FITTED WITH COMPLETE, PERMANENT PROSTHETIC CROWNS - CANNOT BE EQUATED WITH PROSTHETIC VENEERS)	Refundable once every 2 years (ref. invoice) per tooth (cannot be equated with prosthetic veneers or the repair of removable dentures). OBLIGATORY: TREATMENT PLAN with pre-treatment intraoral photo showing the individual prosthetic crown to be repaired.
23155	2671	POLYMER-COATED, METAL-FREE, CERAMIC-FREE PERMANENT CROWN, CERTIFIABLE AS PERMANENT MATERIAL - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo
23156	2672	PROVISIONAL CROWN IN RESIN, DIRECT OR INDIRECT - PER TOOTH/IMPLANT FROM 17 YEARS OF AGE	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age
Removable dentures			
21253	2626	REMOVABLE PARTIAL DENTURES (NON-PRECIOUS OR PRECIOUS ALLOY STRUCTURE, INCLUDING TEETH - FOR REHABILITATING PARTIALLY EDENTULOUS ARCHES) - PER ARCH	Refundable once every 5 years (ref. invoice) per arch. Cannot overlap with another permanent rehabilitation. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21220	2627	REMOVABLE PERMANENT PARTIAL DENTURE, INCLUDING CLASPS AND TEETH (UNILATERAL PARTIAL EDENTULISM) PER HEMIARCH	Refundable once every 5 years (ref. invoice) per hemiarch, cannot overlap with other permanent partial rehabilitation (any type) per arch.

			OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21212	2628	REMOVABLE PROVISIONAL PARTIAL DENTURE, INCLUDING CLASPS AND TEETH (UNILATERAL PARTIAL EDENTULISM) PER HEMIARCH	Refundable once every 5 years (ref. invoice) per hemiarch, cannot overlap with other provisional partial rehabilitation (any type) per arch. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21238	2629	REMOVABLE PERMANENT TOTAL DENTURE WITH RESIN OR CERAMIC TEETH (PER ARCH) - CANNOT BE COMBINED WITH A PERMANENT PROSTHESIS SUCH AS A BAR-ANCHORED OVERDENTURE/PERMANENT PROSTHESIS/EDENTULOUS PREVENTION	Refundable once every 5 years (ref. invoice) per arch regardless of the type of permanent total denture. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21154	2630	REMOVABLE PROVISIONAL IMMEDIATE TOTAL DENTURE (PER ARCH) - CANNOT BE COMBINED WITH A PROVISIONAL PROSTHESIS SUCH AS AN OVERDENTURE/EDENTULOUS PREVENTION	Refundable once every 5 years (ref. invoice) per arch regardless of the type of provisional total denture. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21279	2631	RELINING OF REMOVABLE DENTURES, PER ARCH - INDIRECT SYSTEM	Refundable once a year (ref. invoice) per arch, cannot overlap with another type of relining. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21261	2633	SINGLE PRECISION ATTACHMENT IN NON-PRECIOUS OR PRECIOUS ALLOY OF ANY TYPE, MAXIMUM 1 PRECISION ATTACHMENT PER HEMIARCH (COMPLETE MALE-FEMALE COMPONENTS) ONLY FOR PROSTHETIC TEETH WITH PERMANENT PROSTHETIC CROWN (ATTACHMENT ON CROWNS - LAST CROWN PLUS MESIAL OR DISTAL REST TO EDENTULOUS SADDLE) OR FOR TELESCOPIC PROSTHESES ON NATURAL TEETH. NOT REFUNDABLE FOR IMPLANTS AND CANNOT BE COMBINED WITH POST AND CORE, CORE RECONSTRUCTION OR ANCHORED RECONSTRUCTION	Refundable once every 5 years (ref. invoice). OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21993	2647	RELINING OF REMOVABLE DENTURES, PER ARCH - DIRECT SYSTEM	Refundable once a year (ref. invoice) per arch, cannot overlap with another type of relining

23158	2674	REMOVABLE PERMANENT PARTIAL DENTURE, INCLUDING CLASPS AND TEETH (BILATERAL PARTIAL EDENTULISM) PER ARCH	Refundable once every 5 years (ref. invoice) per hemiarch, cannot overlap with other partial rehabilitation (any type) per arch. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
23159	2675	REMOVABLE PROVISIONAL PARTIAL DENTURE, INCLUDING CLASPS AND TEETH (BILATERAL PARTIAL EDENTULISM) PER ARCH	Refundable once every 5 years (ref. invoice) per hemiarch, cannot overlap with other partial rehabilitation (any type) per arch. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
030305	30305	BAR-ANCHORED REMOVABLE TOTAL DENTURE (INCLUDING BAR AND RETAINERS) SUPPORTED BY IMPLANTS - PER ARCH	Refundable once every 5 years (ref. invoice) per arch regardless of the type of permanent total denture. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
Gnathology			
The following items are not refundable: any recording of intermaxillary relations and studying of the case in an articulator; any recording with electronic or electromyographic equipment and studying of the case; repair of diagnostic plate or splint. Codes 2635, 2648 and 30336 are not refundable in combination with each other and are also subject to time limits (cannot be equated with pre-surgical templates, orthodontic treatment, orthodontic retainers of any kind, Froggy Mouth and/or pacifier-bite and similar). Codes 2635, 2648 and 30336 are not refundable in the same year during which orthodontic treatment is claimed or in the presence of 2 total prostheses in the 2 arches. Codes 2634 and 30335 cannot be equated with dental sealants (which are not refundable).			
20750	2634	PARTIAL OR TOTAL SELECTIVE GRINDING, MAXIMUM 1 SESSION (REGARDLESS OF ARCH) - FROM 17 YEARS OF AGE	Refundable once a year (ref. invoice) regardless of age

21295	2635	DIAGNOSTIC PLATE OR ORTHOTIC OR BITE - DIRECT SYSTEM - REGARDLESS OF ARCH AND NOT REFUNDABLE IN THE SAME YEAR AS THE DENTAL TREATMENT OR IN THE PRESENCE OF 2 TOTAL DENTURES IN THE 2 ARCHES - FROM 21 YEARS OF AGE	Refundable once every 2 years (ref. invoice) regardless of arch, method and age. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number
21320	2648	DIAGNOSTIC PLATE OR ORTHOTIC OR BITE - DIRECT SYSTEM - REGARDLESS OF ARCH AND NOT REFUNDABLE IN THE SAME YEAR AS THE DENTAL TREATMENT OR IN THE PRESENCE OF 2 TOTAL DENTURES IN THE 2 ARCHES FROM 21 YEARS OF AGE	Refundable once every 2 years (ref. invoice) regardless of arch, method and age. OBLIGATORY: PREVENTIVE TREATMENT PLAN - Certification of Compliance at refund stage issued by the dental laboratory stating the ITCA number

Dental radiology

X-rays beyond those described are not refundable. Complete endoral x-rays (16/21) are not refundable. If images are provided on media or digitally, these must show: name, surname, date, right-side and left-side references (or reference quadrant) both on the file within the media and on the image itself. For endoral x-rays and intraoral photographs (regardless of code), refunds are available for a maximum of 6 images per year. One pre-treatment image (endoral X-ray or intraoral photo) and one post-treatment image (endoral X-ray or intraoral photo) are refundable per code up to the maximum limit. For codes 2637-2638-2663-2664 FasiOpen, independently of the type of services claimed and in the context of the usual controls, reserves the possibility to ask to see examinations for which claims have been submitted or for which refunds have already been obtained.

20420	2637	ORTHOPANTOMOGRAPHY OF THE TWO ARCHES	Refundable twice a year (1 January - 31 December).
20438	2638	TELECRANIUM (ANY NUMBER OF PROJECTIONS)	Refundable twice a year (1 January - 31 December).
20412	2649	ENDORAL X-RAYS/BITE WINGS	Refunds are available for a maximum of 1 pre-treatment endoral and 1 post-treatment endoral together with the codes relevant to them up to a maximum of 6 endorals/bite wings per year (1 January - 31 December)
22014	2651	INTRAORAL PHOTO OR VIDEO FROM 17 YEARS OF AGE	Refunds are available for a maximum of 1 pre-treatment and 1 post-treatment photo together with the codes relevant to them up to a maximum of 6 photos per year (1 January - 31 December) regardless of age
23128	2663	DENTASCAN OR CONE BEAM VOLUMETRIC TOMOGRAPHY: 1 ARCH	OBLIGATORY: It is obligatory at the refund stage to submit the Panorex image on which the date carried out is shown
23134	2664	DENTASCAN OR CONE BEAM VOLUMETRIC TOMOGRAPHY: 2 ARCHES	OBLIGATORY: It is obligatory at the refund stage to submit the Panorex

			image on which the date carried out is shown
Pedodontics - Periodontology			
Periodontal surgery services cannot overlap on the same arches or hemiarches regardless of the age of the member/client. Codes 30313-2585 are not refundable in conjunction with code 2616 (sinus lift surgery) if the hemiarch involved is edentulous. Codes 30315-2588, “Root planing”, cannot overlap with or be equated with tartar removal or oral hygiene (services provided with specific codes and limitations) and cannot be refunded together with code 6137.			
30311	30311	GINGIVAL SURGERY PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - up to 16 years of age	Refundable once every 5 years (ref. invoice) for the same arch (regardless of age)
30312	30312	MUCOGINGIVAL OR FORNIX LOWERING SURGERY, PER ARCH (INCLUDING ANY TYPE OF FLAP - INCLUDING SUTURE) - up to 16 years of age	Refundable once every 5 years (ref. invoice) for the same arch (regardless of age)
30313	30313	BONE SURGERY (INCLUDING ANY TYPE OF ACCESS FLAP - INCLUDING SUTURE) COMPLETE TREATMENT PER HEMIARCH - UP TO 16 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same hemiarch (regardless of age)
30314	30314	GENGIVECTOMY AS A SINGLE SERVICE - PER HEMIARCH - UP TO 16 YEARS OF AGE	Refundable once every 5 years (ref. invoice) for the same hemiarch (regardless of age)
30315	30315	ROOT PLANING AND GINGIVAL CURETTAGE (REGARDLESS OF THE NUMBER OF HEMIARCHES TREATED) - UP TO 16 YEARS OF AGE	Refundable once every 2 years (ref. invoice) for the same hemiarch (regardless of age)
Pedodontics - Oral Surgery			
Post-extraction haemorrhage treatments, surgical dressings are included in the respective services/treatments. Codes 30317-2593 are already inclusive of the orthodontist's services for anchorage; if a claim is made concurrently to the orthodontic treatment, therefore, detailed pre-treatment documentation for codes 30317-2593 and documentation showing the entire orthodontic treatment must be submitted. Codes for extractions apply only to natural teeth (they cannot be equated with extraction/implant removal) in their entirety (extractions of fragments are not refundable). Code 30319 is refundable only for germ removal of a still forming permanent tooth. Code 30321 is limited to minor abscess surgery. FasiOpen reserves the right to request additional documentation and/or details and/or medical reports relating to operations relating to code 30321. General anaesthesia (including professional fees and the respective drugs/medicines) is only refundable for in-patient dental surgery if your Healthcare Plan provides for refunding of in-patient dental treatment. There is no refund for any type of anaesthesia other than general anaesthesia during hospitalisation (if your Health Plan recognises refunds for hospitalisation for dental services); for all other cases, costs relating to anaesthesia are included in the refund fees of the dental services themselves. Included within the individual services, where necessary, are sutures of any kind, materials and medicines.			
30316	30316	GENERAL - ONLY DURING HOSPITALISATION (UP TO 16 YEARS OF AGE - PER HOSPITALISATION)	Refundable once, only during hospitalisation (per hospitalisation) only for indirect provision services.
30317	30317	DISINCLUSION OF RETAINED TEETH PER TOOTH (INCLUDING ORTHODONTIC SERVICES FOR ANCHORAGE) - UP TO 20 YEARS OF AGE	Refundable once per tooth. OBLIGATORY: TREATMENT PLAN with pre-treatment X-ray showing the tooth to be disincluded
30318	30318	EXTRACTION OF A TOOTH OR A SIMPLE OR COMPLEX ROOT OF A DECIDUOUS TOOTH (INCLUDING ANY SUTURES AND SEDATION)	Refundable once per tooth
30319	30319	GERMECTOMY (INCLUDING ALL SURGICAL STAGES AND ACTIVITIES INCLUDING MUCOGINGIVAL FLAP AND/OR OSTEOTOMY AND/OR ODONTOTOMY - SUTURES AND SEDATION - EXCLUDING SEDATION WITH NITROUS OXIDE) UP	Refundable once per tooth location. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography -

		TO 16 YEARS OF AGE	Refund Stage post-treatment radiography
30320	30320	FRENULOTOMY OR FRENULECTOMY PER ARCH - UP TO 16 YEARS OF AGE	Refundable once per arch regardless of age
30321	30321	SMALL SURGICAL OPERATIONS ON ABCESSES - UP TO 16 YEARS OF AGE	Refundable once per case (regardless of the number). OBLIGATORY: Intraoral photo of treated abscess at the refund stage
Pedodontics - Conservative			
If covered by your Health Plan, only one filling per tooth is refundable every 3 years regardless of class, age, and whether deciduous/permanent. The following are included in the respective services/treatment: positioning of the dam; reattachment of fragment; chemical treatment for hypersensitivity; fillings, any type, together with code 2609, 30326 and/or root canal treatment (any code) and/or endodontic re-treatment (any number of roots - any code) of the same tooth regardless of age/type of tooth (deciduous/permanent). Fillings, of any class and/or type, are not refundable together with codes 2603, 2632 and 30323 required for the same tooth; likewise, no fillings (any class and code) are refundable in conjunction with codes 2591 “Apicoectomy”, 2613-30329 “Pulpotomy”, or 2623-30331 “Core reconstruction”. Codes 30326-2609 are refundable only on devitalized teeth (treated concurrently or previously), therefore any refund of codes 30326-2609 implies that the tooth has been treated (whether paid by the Fund or not). Codes 2609, 30326, 2603, 2632, 30323 and fillings of any class/code are not refundable with regard to teeth for which a “Post and core” has been paid for or rehabilitated. 2622 (regardless of the material used). Codes 2603, 2632, 30323 are not refundable with regard to the anterior group (canine to canine) and cannot be equated with prosthetic veneers and/or ¾ prosthetic crowns, whether permanent or temporary. Codes 30322-2602 and fillings, of any class/code cannot be equated with dental sealants. Codes 30322-2602 cannot be equated with the treatment of Apexification and Apexogenesis (which are not refundable).			
30322	30322	DIRECT-INDIRECT - DECIDUOUS OR PERMANENT - PULP CAPPING - PER TOOTH - UP TO 16 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age and regardless of whether deciduous or permanent)
30323	30323	INLAY PER DECIDUOUS/PERMANENT TOOTH - REGARDLESS OF MATERIAL/METHOD/TECHNIQUE - INLAY OR ONLAY OR OVERLAY INCLUDING BUILD-UP AND TEMPORARY - PER DECIDUOUS/PERMANENT TOOTH - DIRECT/INDIRECT REGARDLESS OF THE NUMBER OF SURFACES - UP TO 16 YEARS OF AGE	Refundable once every 5 years per tooth location regardless of material and age. OBLIGATORY: Certification of Compliance at refund stage issued by the dental technician's laboratory stating the ITCA number. If the product is made with CAD/CAM technique, also a copy of the batch of material used in its construction
30324	30324	FILLING OF ANY CAVITIES, CLASS 1 - 2 - 3 - 4 - 5 - ANY MATERIAL - PER PERMANENT TOOTH UP TO 16 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age, class or whether deciduous or permanent
30325	30325	FILLING OF DECIDUOUS TOOTH (ANY CLASS - ANY MATERIAL - REFUNDABLE ONCE EVERY 3 YEARS IN THE SAME TOOTH REGARDLESS OF WHETHER IT IS DECIDUOUS OR PERMANENT)	Refundable once every 3 years (ref. invoice) regardless of age, class or whether deciduous or permanent
30326	30326	TOOTH RECONSTRUCTION WITH SCREW OR POST ANCHORING OF DECIDUOUS OR PERMANENT DEVITALIZED TEETH (CONCURRENTLY OR PREVIOUSLY TREATED) PER TOOTH UP TO 16 YEARS OF AGE	Refundable once every 3 years (ref. invoice) regardless of age and regardless of whether deciduous or permanent)
Pedodontics - Endodontics			

The following services/treatments are included in the respective services/treatments: positioning of the dam; treatment of perforations with endodonto-parodontal communication; fillings of any type/code together with root canal treatment (any code) and/or endodontic re-treatment (any code) of the same tooth; pre-endodontic coronal reconstruction. Apexification treatments and endodontic first aid dressings are not refundable. Codes 30329-2613 are not refundable in conjunction with codes 30330-2614-2668-2669-. Codes 30330-2614-2668-2669 cannot overlap on the same tooth element and are not refundable in conjunction with root canal treatment (any code).			
30327	30327	COMPLETE ROOT CANAL TREATMENT OF DECIDUOUS TOOTH 1 CANAL (INCLUDING ANY TYPE OF FILLING) INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
30328	30328	COMPLETE ROOT CANAL TREATMENT OF MULTI-ROOT DECIDUOUS TOOTH - 2 OR MORE CANALS (REGARDLESS OF THE NUMBER OF CANALS) INCLUDING ANY TYPE OF FILLING AND INCLUDING PRE-ENDODONTIC CORONAL RECONSTRUCTION - PER TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
30329	30329	PULPOTOMY AND FILLING OF THE PULP CHAMBER OR PULPECTOMY AND TEMPORARY FILLING FOR ANY NUMBER OF CANALS - PER DECIDUOUS TOOTH - INCLUDING ENDORAL X-RAYS	Refundable once per tooth
30330	30330	ENDODONTIC RE-TREATMENT OF DECIDUOUS TOOTH REGARDLESS OF THE NUMBER OF CANALS (INCLUDING ANY TYPE OF FILLING OF THE ACCESS CAVITY, INCLUDING ANY REMOVAL OF INTRACANAL PINS) PER TOOTH INCLUDING ENDORAL X-RAYS	Refundable once per tooth, which cannot overlap with other root canal treatments or endodontic re-treatments
Pedodontics - Fixed prosthetics			
Any prosthetic service (regardless of age or type) is not refundable for the same tooth location (natural tooth or implant replacing the tooth itself) until 5 years have elapsed from the date of invoice for the service previously paid for regardless of the reasons for the need to reconstruct or replace the prosthesis. No other possibilities are available. Services/treatments include: any diagnostic wax-up; any milling/counter milling; provisional and/or permanent cementing of fixed prostheses. Permanent fixed prostheses (permanent crowns and inlays of any code) can be performed with CAD/CAM techniques directly by the dentist if the appropriate machinery is available; in this case, as specified by the Ministry of Health, the dentist is required to provide (in addition to obligatory requirements), specific written certification containing warnings, contraindications, materials used, the batch number of the block of material (CE/EU marked), traceability of materials and the type of machinery used to produce the item. Maryland Bridges are not refundable and cannot be equated with prosthetic crowns (any type/code) or inlays (any type/code). Prosthetic veneers and/or ¾ prosthetic crowns are not refundable and cannot be equated with codes 30332-2625-2671-2618-2619 (regardless of the technique used). Refunds for code 2622 preclude subsequent refunds for code 30323-30326-30331-2609-2603-2632 and fillings, of any class/code, and root canal treatments (for the latter unless the claim is made simultaneously) of any code regardless of the number of canals.			
30331	30331	RECONSTRUCTION OF CORE IN COMPOSITE MATERIAL, GIC, AMALGAM ONLY FOR PERMANENT NATURAL TEETH TO BE REHABILITATED WITH PROSTHETIC CROWNS (FIXED PROSTHESES DUE TO PATHOLOGY: AMELOGENESIS OR DENTINOGENESIS IMPERFECTA) - PER TOOTH FROM AGE 12 TO 16	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/ intraoral photo
30332	30332	PERMANENT PROSTHETIC CROWN (COMPLETE CROWN - CANNOT BE EQUATED WITH PROSTHETIC VENEERS) REGARDLESS OF MATERIAL USED (COMPLETE CROWN) - REGARDLESS OF METHOD/TECHNIQUE - FOR DURABLE RECONSTRUCTION OF COMPROMISED TOOTH AND/OR DUE TO PATHOLOGY: AMELOGENESIS OR DENTINOGENESIS IMPERFECTA - PER TOOTH - FROM AGE 12 TO 16	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo

30333	30333	PROVISIONAL PROSTHETIC CROWN (COMPLETE CROWN - CANNOT BE EQUATED WITH PROSTHETIC VENEERS) REGARDLESS OF MATERIAL USED - REGARDLESS OF METHOD/TECHNIQUE - PER TOOTH FROM AGE 6 TO 16	Refundable once every 5 years (ref. invoice) per tooth location regardless of material and age. OBLIGATORY: TREATMENT PLAN with pre-treatment radiography/intraoral photo - Refund Stage with post-treatment radiography/intraoral photo
Pedodontics - Gnathology			
The following items are not refundable: any recording of intermaxillary relations and studying of the case in an articulator; any recording with electronic or electromyographic equipment and studying of the case; repair of diagnostic plate or splint. Codes 30336 -2635 -2648 are not refundable in combination with each other and are also subject to time limits (cannot be equated with pre-surgical templates, orthodontic treatment, orthodontic retainers of any kind, Froggy Mouth and/or pacifier-bite and similar). Codes 30336 -2635 -2648 are not refundable in the same year during which orthodontic treatment is claimed or in the presence of 2 total prostheses in the 2 arches. Codes 30335-2634 cannot be equated with dental sealants (which are not refundable).			
30335	30335	PARTIAL OR TOTAL SELECTIVE GRINDING, MAXIMUM 1 SESSION (REGARDLESS OF ARCH) - UP TO 16 YEARS OF AGE	Refundable once a year (ref. invoice) regardless of age
30336	30336	BITE OR ORTHOTIC APPLIANCE - REGARDLESS OF ARCH - DIRECT OR INDIRECT SYSTEM - NOT REFUNDABLE IN ASSOCIATION WITH AND/OR IN THE SAME YEAR AS DENTAL TREATMENT (ANY TECHNIQUE AND/OR METHODOLOGY) OR RETAINER - UP TO 20 YEARS OF AGE	Refundable once every 2 years (ref. invoice) regardless of arch, method and age
Pedodontics - Orthodontics			
Orthodontic therapies are refundable for a maximum of 3 years, even if not consecutive, regardless of the number of arches undergoing treatment and in any case within the year (1 January - 31 December) in which the patient turns the maximum age specified for the service within his/her health plan. Please note that it is not possible to submit a refund claim for dental treatments with expenditure documentation that refers to multiple years of treatment. Included in the respective services/treatments are: orthodontic diagnostic examination (impressions and models, cephalometric analysis). The following are not refundable separately, i.e. they are included in the treatment: reconstruction of orthodontic appliances; repair of orthodontic appliances; orthodontic diagnostic set-up; checks throughout the period of treatment/care. Code 2589, “Interdental splinting” in the Periodontology sub-branch can only be used in the event of periodontal problems from age 25 upwards and cannot be used in support of orthodontic therapy or equated with an orthodontic retainer, for which there is a specific code. Orthodontic retainer code 30310 counts towards the 3-year maximum refund period for orthodontic care. Please note that, since an orthodontic retainer is fitted at the end of the treatment, any refund of code 30310 precludes subsequent refunds of items related to the orthodontic treatment itself (regardless of arch), even if not all years of the maximum refund period have been used.			
30307	30307	DENTAL THERAPY WITH FIXED APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, until the maximum age specified within the Health Plan. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment “bite/reverse

			bite" - Refund Phase per year of treatment - telecranium o photo of models in occlusion
30307	30307	DENTAL THERAPY WITH FIXED APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, until the maximum age specified within the Health Plan. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment "bite/reverse bite" - Refund Phase per year of treatment - telecranium o photo of models in occlusion
30308	30308	DENTAL THERAPY WITH MOBILE/FUNCTIONAL APPLIANCES PER ARCH PER YEAR, INCLUDING CEPHALOMETRIC ANALYSIS	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, until the maximum age specified within the Health Plan. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment "bite/reverse bite" - Refund Phase per year of treatment - telecranium o photo of models in occlusion
30309	30309	DENTAL THERAPY WITH INVISIBLE APPLIANCES (ANY TYPE/MATERIAL) PER ARCH - PER YEAR - INCLUDING CEPHALOMETRIC ANALYSIS	Refundable once a year (1 January - 31 December), for a maximum of 3 years, also not consecutive, until the maximum age specified within the Health Plan. Cannot overlap with other dental treatment items during the year. OBLIGATORY: TREATMENT PLAN PER YEAR OF TREATMENT with telecranium or photo of pre-treatment "bite/reverse bite" - Refund Phase per year of treatment - telecranium o photo of models in occlusion
30310	30310	DENTAL MAINTENANCE THERAPY WITH FIXED OR MOBILE RETAINER REGARDLESS OF THE NUMBER OF ARCHES	Refundable for a maximum 1 year (1 January - 31 December) in the context of a maximum of 3 years recognised for treatment, within the maximum limits set by the Health Plan. Cannot overlap with other dental treatment items during the year. OBLIGATORY: PRE TREATMENT Intraoral photo of the retainer in position - Refund Stage -

			Telecranium o Intraoral photo of the finished treatment (if finished) or Intraoral photo of the retainer in position (different from the pre-treatment one)
Pedodontics - Pedodontic Radiology			
X-rays beyond those described are not refundable. Complete endoral x-rays (16/21) are not refundable. If images are provided on media or digitally, these must show: name, surname, date, right-side and left-side references (or reference quadrant) both on the file within the media and on the image itself. For endoral x-rays and intraoral photos (regardless of code), refunds are available for a maximum of 6 images per year regardless of age. One pre-treatment image (endoral X-ray or intraoral photo) and one post-treatment image (endoral X-ray or intraoral photo) are refundable per code up to the maximum limit. Code 30306 is refundable only in association with code 30332, while code 2652 is refundable only in association with codes 30307-30308-30309-30310.			
30306	30306	INTRA-ORAL PHOTO OR VIDEO UP TO 16 YEARS OF AGE ONLY AS PRE AND POST TREATMENT FOR PEDODONTIC PROSTHETIC CODES	Refunds are available for a maximum of 1 pre-treatment and 1 post-treatment photo together with the codes relevant to them up to a maximum of 6 photos per year (1 January - 31 December) regardless of age. OBLIGATORY: TREATMENT PLAN - services must be claimed together with the codes that relate to them. Refund stage: submission of the requested images (must be requested together with the codes that relate to them also at the refund stage)
22022	2652	PHOTO OF REVERSE BITE AND/OR PHOTO OF MODELS IN OCCLUSION (ONLY IN RELATION TO CODES IN THE ORTHODONTICS SECTION REGARDLESS OF THE NUMBER OF ARCHES TREATED - REGARDLESS OF THE TYPE OF TREATMENT).	Refunds are available for 1 photo of the “bite/reverse bite” or pre-treatment models in occlusion per year and 1 post-treatment per year only together with Orthodontic Therapy up to a maximum of 6 photos per year. OBLIGATORY: TREATMENT PLAN - services must be claimed together with the codes that relate to them. Refund stage: submission of the requested images (must be requested together with the codes that relate to them also at the refund stage)

SECTION T - SPA TREATMENTS

Refunds for spa treatments are recognised only if these are expressly provided for by individual Health Plans and if they have been carried out at authorised establishments equipped for this purpose located in spa resorts. For simultaneous treatments with mud therapy or balneotherapy treatments and hydropinic or inhalation therapies, the higher fee only is applied as specified in the Guide. To obtain a refund for spa treatments a specific medical prescription must be sent certifying the need for the treatment itself and specifying the pathology currently existing (not the symptomatology).

Strictly excluded from refund are costs of accommodation and/or other secondary expenditure and/or anything else not explicitly stated. Please note that the fees specified by the individual Health Plans are inclusive of the fees of the persons providing the services and/or all equipment/instrumentation.

90076	2947	MUD AND BALNEOTHERAPY - PER DAY PER CLIENT	Refundable maximum 12 days a year (1 January - 31 December)
90084	2948	HYDROPINICS AND/OR INHALATIONS AND/OR IRRIGATIONS - PER DAY PER CLIENT	Refundable maximum 10 days a year (1 January - 31 December)

SECTION U - PUBLIC HEALTHCARE CHARGES

FasiOpen refunds Public Healthcare Charges within the limitations (all) of everything stated in the Covers/Areas of the individual health plans, if related to the services provided for by each health plan itself. Specifically, if a service used and paid for through Public Healthcare Charges is included in the Fund's area of activities but not included in the Covers/Areas of your health plan, then it will not be recognised as refundable.

9993	2949	PUBLIC HEALTHCARE CHARGES FOR SPECIALIST SERVICES	Refundable within the limitations specified in the individual healthcare plans and only if related to services included in your healthcare plan

SECTION V - SURGICAL PACKAGES

Refunds for package-based procedures/operations are available only if the operations are included in the Covers of the individual Health Plans. Packages are all-inclusive of: medical team and/or support staff (technicians/assistants, etc.), operating theatre/outpatient room/outpatient operating theatre (depending on the type of package), stay in the facility (where applicable), the necessary instruments/equipment to perform the procedures themselves and high-cost procedures (where applicable), materials, medicines, any prostheses (for procedures involving these), analyses and tests related to the procedure itself and performed intra-hospitalisation, initial post-surgery and intra-hospitalisation rehabilitation treatments where applicable (orthopaedic operations).

Please note that, for Health Plans with case-by-case refunds, package-based refunds for the services/procedures listed below fully replace the individual case-by-case service items/codes if these were previously shown in the Nomenclature and were therefore in your Health Plan (previous editions). Please note that, for Health Plans with case-by-case refunds, the value of the individual packages corresponds exactly to the sum of the maximum refunds set out in the previous editions of the Nomenclature (and therefore in the Health Plans). “Package-based” services provide for a single refund amount (for Health Plans with case-by-case refunds), regardless of whether they are through direct or indirect provision and regardless of the technique used to provide them. The amount for “package-based” services relates to the operation/procedure as a single phase, i.e. if an operation in which a package-based approach has been used is carried out during hospitalisation for another surgical operation, an additional specific “concurrent operation” code (relating to the procedure only) will be available within the Nomenclature and therefore within the Covers of the individual Health Plan (if that type of operation/procedure is included) stating a different amount for which, only in this case, the value for refund purposes will be 100%. For gastroenterology procedures (if included in the Health Plan), various packages have been made available that also cover several concurrent endoscopic procedures. With regard to this please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also calculated as diagnostic endoscopies. Please remember that for diagnostic/exploratory procedures carried out concurrently with surgical procedures with the same access route, only the surgical procedure is refundable since the diagnostic procedure is regarded as a preparatory one, i.e. the diagnostic procedure is not summed with the same surgical procedure. In the case of “packages” received by direct provision, the amount accepted by the healthcare facility in the signed affiliation is the maximum that can be invoiced for that specific procedure/surgical operation. Any further monies paid by the member/client must in all cases be duly shown on the invoice (and in the relevant telematic application used for direct provision services) and may be attributed to items expressly identified by the Fund as non-refundable - i.e. they cannot in any way regard competencies, materials, medicines, instruments, procedures etc. specified by FasiOpen as being included in the services themselves.

Hip

Surgery Packages for hip replacements have been differentiated by technique (Traditional Technique and Robotic Surgery). Surgery Packages for hip replacements do not mutually overlap and do not overlap in terms of technique. In calculating fees for the packages, 6 standard days of hospitalisation have been assumed for the traditional technique while 4 standard days have been assumed for RAS (Robotic Surgery) procedures. The difference in days of hospitalisation, to clarify further, is due to the less invasive nature of RAS (Robotic Surgery).

10094	10094	SURGERY PACKAGE (Traditional Technique) TOTAL HIP REPLACEMENT (ARTHROPROSTHESES: TOTAL HIP - COMPLETE TREATMENT). REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND IN-	Refundable once per body part (hip). Cannot overlap with other technique and/or hip surgery package

		PATIENT PHYSIOTHERAPY	
10095	10095	SURGERY PACKAGE (Traditional Technique) TOTAL HIP REPLACEMENT REVISION (ARTHROPROSTHESES: TOTAL HIP REVISION - COMPLETE TREATMENT) SURGERY FOR REMOVAL AND REPLACEMENT OR REPOSITIONING CARRIED OUT IN THE SAME HOSPITAL IN WHICH THE FIRST SURGERY WAS CARRIED OUT. REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND IN-PATIENT PHYSIOTHERAPY	Refundable once per body part (hip). Cannot overlap with other technique and/or hip surgery package
10099	10099	SURGERY PACKAGE (Traditional Technique) HIP PROSTHESIS REMOVAL AND REPOSITIONING CARRIED OUT SUBSEQUENTLY TO THE FIRST HOSPITALISATION (COMPLETE TREATMENT). REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND IN-PATIENT PHYSIOTHERAPY	
10109	10109	SURGERY PACKAGE (Robotic Surgery - RAS) TOTAL HIP REPLACEMENT (ARTHROPROSTHESIS: TOTAL HIP - COMPLETE TREATMENT). REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, Use of computer-assisted surgery equipment (any), HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND INPATIENT PHYSIOTHERAPY	Refundable once per body part (hip). Cannot overlap with other technique and/or hip surgery package
10110	10110	SURGERY PACKAGE (Robotic Surgery - RAS) TOTAL HIP REPLACEMENT REVISION (ARTHROPROSTHESIS: TOTAL HIP REVISION - COMPLETE TREATMENT) SURGERY FOR REMOVAL AND REPLACEMENT OR REPOSITIONING CARRIED OUT IN THE SAME HOSPITAL IN WHICH THE FIRST SURGERY WAS CARRIED OUT. REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, Use of computer-assisted surgery equipment (any), HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND INPATIENT PHYSIOTHERAPY	Refundable once per body part (hip). Cannot overlap with other technique and/or hip surgery package
10111	10111	SURGERY PACKAGE (Robotic Surgery - RAS) HIP PROSTHESIS REMOVAL AND REPOSITIONING CARRIED OUT SUBSEQUENTLY TO THE FIRST HOSPITALISATION (COMPLETE TREATMENT). REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, Use of computer-assisted surgery equipment (any), HOSPITAL STAY, MATERIALS, MEDICINES, JOINT PROSTHESIS, DIAGNOSTIC TESTS AND INPATIENT PHYSIOTHERAPY	
Cataract			
Cataract surgery is only refundable if included in your Health Plan Covers, within the limitations and conditions of your Health Plan. In this case too, the package is all-inclusive (excluding any type of hospitalisation, i.e. the surgery package is provided only as an outpatient service).			
10088	10088	CATARACT PACKAGE, REMOVAL AND IMPLANTATION OF ARTIFICIAL LENS IN ANTERIOR OR POSTERIOR CHAMBER (ANY TECHNIQUE - EYE). REFUND INCLUDES: MEDICAL TEAM, OPERATING THEATRE, TIME SPENT IN THE FACILITY, MATERIALS, MEDICINES, LENS PROSTHESIS	Refundable once per body part (eye)
Gastroenterology			
Packages for gastroenterological procedures are refundable within the limitations of the individual Health Plan Covers. Also for package-based services, for diagnostic/exploratory procedures carried out together with operative procedures with the same access route, only the operative procedure is deemed refundable, with the diagnostic procedure regarded as a preparatory act. Please note that procedures involving the removal (using any instrument) of polyps up to 3 mm in size are also deemed to be diagnostic procedures. The individual items in the packages cannot overlap with each other.			
10100	10100	DIAGNOSTIC ESOFAGOGASTRODUODENOSCOPY PACKAGE (including outpatient room, medical team, any histological examinations)	
10101	10101	DIAGNOSTIC PANCOLONSCOPY WITH FIBRE OPTICS PACKAGE (including outpatient room, medical team, any histological	

		examinations)	
10102	10102	ESOFAGOGASTRODUODENOSCOPY AND PANCOLONSCOPY - BOTH DIAGNOSTIC - PACKAGE (including outpatient room, medical team, any histological examinations)	
10103	10103	OPERATIVE ESOFAGOGASTRODUODENOSCOPY PACKAGE INCLUDING POLYPECTOMY, INSERTION OF PROSTHESES, REMOVAL OF EXTRANEOUS BODIES, ARGON LASER, ETC. (including outpatient operating theatre, medical team, any histological examinations)	
10104	10104	OPERATIVE PANCOLONSCOPY PACKAGE INCLUDING RECTAL-COLIC POLYPECTOMY, REMOVAL OF EXTRANEOUS BODIES, HAEMOSTASIS OF NON-VARICOSE LESIONS (including outpatient operating theatre, medical team, any histological examinations)	
10105	10105	ESOFAGOGASTRODUODENOSCOPY AND PANCOLONSCOPY - BOTH OPERATIVE - PACKAGE (including outpatient operating theatre, medical team, any histological examinations)	
10106	10106	OPERATIVE ESOFAGOGASTRODUODENOSCOPY AND DIAGNOSTIC PANCOLONSCOPY PACKAGE (including outpatient operating theatre, medical team, any histological examinations)	
10107	10107	OPERATIVE PANCOLONSCOPY AND DIAGNOSTIC ESOFAGOGASTRODUODENOSCOPY PACKAGE (including outpatient operating theatre, medical team, any histological examinations)	

SECTION Z - PREVENTION

Prevention of Oral Cavity Cancer

Refundable only as a direct-provision service if included in your Health Plan within Dentistry Cover. There is no excess payable by the member/client since the service is paid in full by the Fund.

24014	6261	PREVENTION OF ORAL CAVITY CANCER	Refundable once a year (ref. invoice) only as a direct-provision service from age 45 upwards

Medical PREVENTION

Refundable only if included in the Covers of your Health Plan.
One prevention package is refundable per year regardless of the type, with the proviso that the same package cannot be repeated/refunded before 2 years have elapsed from the invoice date of the previous claim according to the following example:
Cardiovascular Prevention for Men - invoice 01/02/2021 - this prevention package will be refundable again from 03/03/2023, but a different package may be claimed/refunded from 02/03/2022, for example the Thyroid Cancer Prevention package.
Details of the services included in the individual package are shown in the Prevention Cover of your Health Plan.

6142	6142	CARDIOVASCULAR PREVENTION FOR WOMEN	Available from age 45 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
6141	6141	CARDIOVASCULAR PREVENTION FOR MEN	Available from age 45 upwards. One prevention

			package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
67047	6273	THYROID CANCER PREVENTION	Available from age 45 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
67033	6253	OPHTHALMIC PREVENTION	Available from age 40 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
6140	6140	ONCOLOGICAL PREVENTION FOR WOMEN	Available from age 45 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
6139	6139	ONCOLOGICAL PREVENTION FOR MEN	Available from age 45 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
30209	6291	DISMETABOLIC SYNDROME PREVENTION PACKAGE - glycaemia, fractional (HDL and LDL) and total cholesterol, triglyceridemia, microalbuminuria, uricaemia	Available from age 50 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)
8009	8009	MELANOMA PREVENTION (Specialist dermatological consultation, Nerve Mapping, Epiluminescence, Delivery of examination images/photos)	Available from age 50 upwards. One prevention package is refundable per year (ref. invoice) regardless of the type of prevention, with the proviso that the same prevention package cannot be refunded before 2 years have elapsed (ref. invoice)

OTHER SERVICES/Transport by ambulance

This item is only available if included in a specific Cover within your Health Plan, to the extent provided for by this. FasiOpen recognises a contribution towards the cost of "Transport by Ambulance", limited to indirect provision services and exclusively within Italy.

Transportation by Ambulance is recognised as refundable only for serious pathologies in which clients/patients cannot be transported, with own means, from their home to the chosen healthcare facility for hospitalisation and vice versa. Hospitalisation means an overnight stay in a nursing home or hospital. Therefore, without prejudice to the fact that the only means of transport recognised as refundable is an ambulance, no transport is recognised for ongoing therapies such as (but not limited to) chemotherapy, dialysis, physiokinesis therapy, etc.

Please also note that the service recognised as refundable does not refer to emergency transport, but only to planned hospitalisations.

No contribution to the cost of transport is recognised as refundable for transfers from one nursing home or hospital to another nursing home or hospital.

To claim a refund you must, together with the form, attach the receipt/invoice issued by the (duly authorised) Ambulance Service that provided the transport showing the following information:

- the details of the person who provided the transport;
- the name of the person who used the transport (who must be registered with the Fund with his/her administrative status in order);
- the date of transport;
- the place of departure and arrival;

The specific medical certificate documenting the state of health of the client who used the transport must also be attached, to verify his/her effective inability to use another or his/her own means of transport.

7013	6134	TRANSPORTATION BY AMBULANCE	Limited to indirect provision services within Italy

SERVICES AVAILABLE ONLY BY INDIRECT PROVISION

In a way limited to specific Health Plans, within the limitations contained in these, the Fund grants a "Hospitalisation Allowance" if this has taken place as an indirect-provision service in the Italian National Health Service.

This allowance/daily allowance is granted only and exclusively to clients who have actually received care, regardless of age; i.e. only to those directly receiving the care (if they belong to an eligible household registered with the Fund at the beginning of hospitalisation, and if their administrative status is in order); i.e. no allowance/daily allowance and/or further allowance/daily allowance is granted to any family members who stay at the facility (even continuously) to assist the patient.

Payment of the allowance/daily allowance is granted only when no refund is claimed and/or has not been claimed from FasiOpen in relation to and/or ascribable to overnight hospitalisation for Surgery and/or services ascribable to the aforementioned hospitalisation (diagnostics, specialist consultations, therapies, pre- and post-surgery assessments, ambulance transport, etc.). The allowance/daily allowance items will not be recognised as refundable in cases of surgical hospitalisation that is not included among the operations specified in Cover 1 and/or Cover 1.2 (if provided for) in your Health Plan.

Requests for payment of an allowance/daily allowance (where provided for by your Health Plan) must be received no later than 3 months after the date of discharge. With regard to this please remember that you must, together with the refund claim, attach a complete and legible copy of the medical records relating to the Surgery carried out.

FasiOpen, in a way limited to the Health Plans that provide for it, will contribute towards the cost of lenses or spectacles fitted for the correction of visual disturbances or eye pathologies, upon presentation of a prescription issued by a physician specialising in ophthalmology, not later than 6 months from the date of purchase of the lenses themselves.

The refund request must be accompanied by fiscally valid expenditure documentation (with the buyer's data and detailed amounts for the individual items/services) and a certificate of conformity pursuant to EU regulations (European Regulation 2017/745 - former Directive 93/42/EEC).

Refunds for Lenses and Spectacles will not be refunded earlier than 12 months following the previous balance invoice, and only after a change in eyesight has been confirmed.

No refunds are available for frames, spectacles and/or contact lenses for cosmetic purposes, single-use (daily) contact lenses, accessory products for the care of lenses and/or spectacles, lenses and spectacles before expiry of the refund period, or if there has been no change in eyesight.

7003	999996	CHILDBIRTH HOSPITALISATION ALLOWANCE	Refundable to the maximum extent provided by individual health plans that include it
90000	999998	ALLOWANCE IN LIEU FOR HOSPITALISATIONS - UP TO 15 NIGHTS	Refundable to the maximum extent provided by individual health plans that include it
90001	999999	ALLOWANCE IN LIEU FOR HOSPITALISATIONS - FROM THE 16TH NIGHT UNTIL THE CEILING IS REACHED	Refundable to the maximum extent provided by

			individual health plans that include it
10004	10004	LENSES AND SPECTACLES	Refundable once a year (ref. invoice)

GENERAL GLOSSARY

DIRECT PROVISION CARE: the refund, by the Fund, directly to affiliated healthcare facilities (hereinafter "affiliated healthcare facilities"), of costs paid in advance by themselves on behalf of clients, within the maximum amounts and limits set out in the individual Health Plans. Direct provision services only occur when both the healthcare facility and the physician-surgeon-orthodontist (who, together with his/her team, has accepted the agreement through the healthcare facility itself) have entered into the agreement, without prejudice to the necessary requisites for the member to access the direct provision services.

INDIRECT PROVISION CARE: the refund, by FasiOpen, directly to the member, of costs incurred by him/her, within the limits of the maximum rates set out in the individual Health Plans at the time of invoicing the balance. Indirect provision care applies when services are provided at a healthcare facility that does not belong to the network recognised by FasiOpen or in cases in which, despite being an affiliated healthcare facility, it is not possible to carry out direct provision services (for example: problems with personal details/contributory status, services for which direct provision is not available, or cases in which the physician/surgeon has not entered into the affiliation).

CLIENT: person eligible for assistance from the Fund and registered with the Fund, according to the conditions set out in the Regulations, belonging to the family unit of a member who remains the sole effective holder of the relationship with the Fund.

CLINICAL MOLECULAR BIOLOGY: molecular biology studies and interprets biological phenomena at the molecular level, considering the structure, properties and reactions of the chemical molecules that make up living organisms. Clinical Molecular Biology is a disciplinary sector relating to laboratory medicine, which contains and indicates a set of tests to determine DNA, RNA, proteins or metabolites in order to detect the genotypes, mutations or biochemical variations that enable specific states of health to be identified.

PRIVATE NURSING HOME FOR ACUTE: Healthcare facility with beds for the medical care of acute illnesses and possessing due authorisation issued by the competent authorities.

ACCREDITED PRIVATE NURSING HOME FOR ACUTE: Healthcare facility with beds for the medical care of acute illnesses affiliated with the Italian National Health Service/Regional Health Service and possessing due authorisation issued by the competent authorities.

CONSULTATION: specialist consultation by a physician with a different specialisation to that of the treating physician during night-time or daytime stays, or with a different specialisation from that which made the hospitalisation necessary, in cases in which the treating physician considers it necessary and indispensable.

SPA TREATMENTS: therapies received at spa establishments in possession of due authorisation issued by the competent authorities.

DAY HOSPITAL (D.H.): method of providing services in which the patient remains at the healthcare facility with hospitalisation limited to daytime hours and without an overnight stay.

DAY SURGERY (D.S.): method of providing surgical operations or invasive diagnostic and/or therapeutic procedures (if provided for in the individual Health Plans/Covers), with hospitalisation limited to daytime hours.

HOSPITALISATION WITH OVERNIGHT STAY (O.S.): overnight stay in healthcare facilities authorised by the competent authorities to perform medical and surgical therapies.

REHABILITATION/PHYSIOTHERAPY DIARY: in the event of hospitalisation, a document included with the medical record in which the date, time and types of services received by the patient during hospitalisation are noted, including notes by the therapist; in the case of outpatient therapies, a document signed by the patient in which access occasions to the facility (dates) and the typed of services given are noted.

• ***PHYSICAL DEFECTS***: these are deviation from the normal morphological form of a body or parts of its organs due to acquired pathological or traumatic conditions.

DOMICILE: place of residence of the member/client, even if temporary.

EXCLUSIONS: list of services excluded from cost-sharing by the Fund. Please remember that, as well as the exclusions stated in the current Basic Nomenclature, anything not explicitly provided for in the Nomenclature itself and anything not explicitly included in the Covers of your chosen Health Plan must be regarded as non-refundable.

EXTRA-MOENIA (OR EXTRAMURARY): self-employed professional activity at private healthcare facilities by physicians-surgeons-orthodontists who are employees of the Italian National Health Service/Regional Health Service.

INVOICE ON ACCOUNT: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility for only a part of the final fee when the services have not been completely received by the client. In the context of the relationship with FasiOpen, an invoice on account must always be accompanied by and therefore sent together with a partial or final balance invoice (within 3 months from the date of issue of the latter, as indicated in the Regulations). A stand-alone invoice on account is not refundable by the Fund.

PARTIAL BALANCE INVOICE: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility for payment of that part of the services already received by the member/client, when other services are yet to be received. In the context of the relationship with FasiOpen, the partial balance invoice must be sent (together with any invoice on account if present) within 3 months from the date of issue. Please note that, although an invoice has “on account” in its description, it can be considered to be a “partial balance” if the exact correlation between the amount and the completed services can be identified.

BALANCE INVOICE: fiscal document issued by the physician-surgeon-orthodontist or the healthcare facility when the entire fee has been paid and the services to which the invoice refers have been received. In the context of the relationship with FasiOpen, the balance invoice must be sent according to the timescales and conditions set out in the Regulations.

PHYSIOKINESIS THERAPY: physical treatments/care prescribed by one's physician of choice and used in duly authorised outpatient healthcare facilities (also see “Rehabilitation”). Since these are “healthcare services” they are always exempt from VAT regardless of invoicing, which may be issued by physical persons, companies, cooperatives, non-profit organisations or other organizations. Physiokinesis therapy services are “healthcare services” performed by physicians-surgeons who are qualified in physiatrics or orthopaedics and traumatology, or by graduates in physiotherapy or with equivalent qualifications recognised by current regulations and the competent authorities. Please remember that the professional qualification of rehabilitation physiotherapist is not held, for example, by kinesiologists, aesthetic and/or sports masseurs, ISEF/IUSM graduates, shiatsu practitioners, chiropractic graduates, reflexologists, posturologists, naturopaths, or masseurs and head attendants of hydrotherapy/spa establishments etc.

INJURY: an event due to a chance, violent and external cause that produces objectively ascertainable harm.

OUTPATIENT SURGICAL OPERATION: surgical operation carried out without daytime hospitalisation (therefore excluding recognition of day surgery hospitalisation) at a physician's surgery or at the outpatient clinic of a healthcare facility.

SURGICAL OPERATION: a therapeutic action carried out with manual and/or instrumental operations at healthcare facilities authorised to perform surgical procedures at a day surgery or with overnight hospitalisation.

INTRA-MOENIA (OR INTRA-MURARY): self-employed professional activity at public or private non-accredited healthcare facilities by physicians-surgeons-orthodontists who are employees of the Italian National Health Service/Regional Health Service.

MEMBER: holder of FasiOpen membership.

ILLNESS: any verifiable and objective alteration to health not resulting from injury. Must be

proven in a specific medical certificate in which the “diagnosis” is shown.

MALFORMATIONS: means deviation from the normal morphological structure of a body or parts its organs due to congenital conditions.

MANU MEDICA: health services provided by graduates in medicine and surgery. Some physiokinesis therapy services, to be recognised by the Fund as refundable, must be performed by physicians with a specialist qualification in physiatry or orthopaedics and traumatology and not by personnel with a diploma or three-year degree in physiotherapy.

NUCLEAR MEDICINE: a medical speciality that uses radioisotopes to study any alterations in organ functionality for the diagnosis and/or treatment of various pathologies.

PHYSICIAN OF CHOICE OR TREATING PHYSICIAN: physician chosen by the member for his/her treatment and in possession of a specialist qualification duly recognised in Italy by the competent authorities.

MEDICAL SPECIALIST IN PUBLIC HEALTHCARE FACILITY: physician qualified in a speciality who performs his/her professional work as an employee of the Italian National Health Service/Regional Health Service at a public healthcare facility (university polyclinic, hospital, hospitalisation and treatment institute, local health authority, family consultant or other authorised public healthcare facility).

NOMENCLATURE: list of services included in the areas of activity of the Fund. The FasiOpen Nomenclature is arranged case by case. Services not included in the FasiOpen Nomenclature are not refundable by the Fund. Services included in the FasiOpen Nomenclature, on the other hand, are services for which the Fund provides for cost-sharing only if they are included in the Covers of a member's individual Health Plan to the extent and in the manner provided for by the individual Cover.

HOSPITAL: Healthcare facility with beds for the medical care of acute and/or chronic illnesses, duly authorised by the competent authorities. Hospitals can be either public or private.

SURGICAL PACKAGE: set of services concurrent to the performance of surgery for which a flat-rate refund is envisaged.

PREVENTION PACKAGES: set of non-divisible services and/or tests intended to prevent the appearance, spread and progression of illnesses and therefore the occurrence of damage, possibly irreversible, when the pathology is in progress, and for which a flat-rate refund is envisaged.

DIAGNOSTIC OUTPATIENT POLYCLINIC: Healthcare facility duly authorised by the competent authorities to perform outpatient diagnostic tests and/or specialist consultations and/or surgical operations and/or medical therapies.

UNIVERSITY POLYCLINIC: Authorised healthcare facility with beds for the medical care of acute and/or chronic illnesses, duly authorised by the competent authorities, at which teaching is also carried out. University Polyclinics can be either public or private.

SERVICES SUBJECT TO LIMITS: services included in the Fund's Nomenclature and Health Plans, for which FasiOpen has set administrative limits to their eligibility for refund. These limits may be time-based (e.g.: refundable once a year), quantitative (e.g.: a maximum of 10 services can be refunded), or related to age (e.g.: refundable from 0 to 3 years of age), gender (male or female), or part of the body (e.g. right eye, left leg).

HOSPITAL FEE FOR REHABILITATION: hospital fee recognised as refundable only for overnight hospitalizations.

REHABILITATION: therapies to re-educate body systems harmed by injuries and/or illness to restore their functionality for normal activities; can be provided as an outpatient service at healthcare facilities authorised for physiokinesis therapy and rehabilitation, or in particular cases at the patient's home (see also “Physiokinesis therapy”).

NEUROMOTORAL REHABILITATION FOR ACUTE AND CHRONIC NEURODEGENERATIVE PATHOLOGIES: therapies for the purpose, in the event of invalidating neurological damage, of

recovering functional motor or neuromotor capacities recently reduced and/or lost due to illness or trauma and/or chronic degenerative pathologies (cerebral stroke, Parkinson's disease, multiple sclerosis, etc.).

HOSPITALISATION: a stay in a place giving healthcare with overnight stay or daytime stay in a day hospital or day surgery, made necessary by injury or illness.

SAME SESSION/DURING THE SAME SESSION: period of time required to perform one or more medical procedures carried out during the same occasion of access to the Healthcare Facility/Outpatient Clinic.

TABLE OF FEES: presentation of the maximum amounts refundable by FasiOpen and of any limits to the recognition of services, by both direct and indirect provision, for each service provided for in the Health Plan with refund case by case (recognisable under the conditions set out in the Health Plan itself), in which each fee displayed signifies “up to €.....”.

OCCUPATIONAL THERAPY: therapies for the purposes of recuperating or maintaining the skills needed to carry out daily life among people affected by pre-existing cognitive, physical and psychic disabilities.

PUBLIC HEALTHCARE CHARGES: contribution paid by citizens to the cost of specialist consultations and diagnostic tests, therapies etc. performed at public healthcare facilities, or at private healthcare facilities accredited by the Italian National Health Service/Regional Health Service. Please note that Public Healthcare Charges are a different item of expenditure to the Fixed Fee introduced in the 2011 Budget and the Additional Fixed Prescription Fee Contribution. Citizens are exempt from paying these charges if they are within certain age or income groups or if they are suffering from certain illnesses.

GENETIC MEDICAL CONSULTATION (CLINICAL GENETICS): specialist consultation carried out by a physician specialised in medical genetics.

SPECIALIST OUTPATIENT CONSULTATION: consultation carried out by a physician in possession of a specialist qualification duly recognised in Italy by the competent authorities and registered with the Italian Board of Physicians, Surgeons and Orthodontists, to diagnose and/or prescribe therapies within the context of his/her specialisation.

SPECIALIST CONSULTATION DURING HOSPITALISATION: consultation carried out by the treating physician and/or his or her team in the course of medical or surgical therapy on behalf of a hospitalised client.

CONFINDUSTRIA

FEDERMANAGER

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