GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 1022 **16 November 2007**

NATIONAL HEALTH ACT, 2003
(ACT NO. 61 OF 2003)

DETERMINATION AND PUBLICATION OF THE REFERENCE PRICE LIST FOR 2008

The Director-General: Health has, in terms of regulation 10 of the Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of Reference Price List published under Notice No. R.681 of 23 July 2007, (Gazette No. 30110 of 23 July 2007), determined the Reference Price List for 2008 in the Schedule.

TD MSELEKU
DIRECTOR-GENERAL: HEALTH

NATIONAL HEALTH REFERENCE PRICE LIST

FOR

2008 SCHEDULES

MEDICAL SCIENTISTS

Medical Scientists 2008

NATIONAL REFERENCE PRICE LIST FOR MEDICAL SCIENTISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

01	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.03

ITEMS

Code	Description	Ver	Add	Medical Scientist : Genetic Counselling	
				RVU	Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00			
200	Genetic counselling. Duration: 1-10min.	05.03		0.500	31.60 (27.70)
201	Genetic counselling. Duration: 11-20min.	05.03		1.500	94.90 (83.20)
202	Genetic counselling. Duration: 21-30min.	05.03		2.500	158.20 (138.80)
203	Genetic counselling. Duration: 31-40min.	05.03		3.500	221.40 (194.20)
204	Genetic counselling. Duration: 41-50min.	05.03		4.500	284.70 (249.70)
205	Genetic counselling. Duration: 51-60min.	05.03		5.500	348.00 (305.30)
206	Genetic counselling. Duration: 61-70min.	05.03		6.500	411.20 (360.70)
207	Genetic counselling. Duration: 71-80min.	05.03		7.500	474.50 (416.20)
208	Genetic counselling. Duration: 81-90min.	05.03		8.500	537.80 (471.80)
Sample extraction					
300	DNA extraction - Blood	06.02		-	-
310	DNA extraction - Tissue (other than blood and including CVS and amniotic fluid)	06.02		-	-
320	DNA extraction - Tissue (paraffin blocks)	06.02		-	-
330	RNA extraction - Blood	06.02		-	-
340	RNA extraction - Tissue (other than blood and including CVS and amniotic fluid)	06.02		-	-
350	RNA extraction - Tissue (paraffin blocks)	06.02		-	-
PCR					
400	PCR-basic (up to four PCR primer sets)	06.02		-	-
410	PCR-multiplex (five or more primer sets)	06.02		-	-
420	PCR-realtime	06.02		-	-
430	PCR-reverse transcriptase	06.02		-	-
Detection Methods					
500	Diagnostic electrophoresis (agarose and polyacrylamide gel electrophoresis and capillary electrophoresis)	06.02		-	-
510	Restriction enzyme digestion (use multiples based on cost of enzyme)	06.02		-	-
520	Probe hybridisation assays	06.02		-	-
530	dHPLC	06.02		-	-
540	MLPA	06.02		-	-
Southern Blotting					
610	DNA probe labelling (including hybridisation and autoradiography)	06.02		-	-
600	Southern blot (digest, gel and blotting)	06.02		-	-

Code	Description	Ver	Add	Medical Scientist : Genetic Counselling	
				RVU	Fee
Other					
700	Protein truncation test	06.02		-	-
730	Interpretation and reporting	06.02		-	-
720	DNA sequencing	06.02		-	-
710	Maternal contamination test (prenatal testing)	06.02		-	-

Medical Scientists 2008

				36901					
	NATIONAL REFERENCE PRICE LIST FOR MEDICAL SCIENTISTS WITH EFFECT FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value		Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00							
	GENERAL RULES								
01	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2005.03							
	ITEMS								
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00							
200	Genetic counselling. Duration: 1-10min.	2005.03		370	0.500	1.0	R	31.60	
201	Genetic counselling. Duration: 11-20min.	2005.03		370	1.500	1.0	R	94.90	
202	Genetic counselling. Duration: 21-30min.	2005.03		370	2.500	1.0	R	158.20	
203	Genetic counselling. Duration: 31-40min.	2005.03		370	3.500	1.0	R	221.40	
204	Genetic counselling. Duration: 41-50min.	2005.03		370	4.500	1.0	R	284.70	
205	Genetic counselling. Duration: 51-60min.	2005.03		370	5.500	1.0	R	348.00	
206	Genetic counselling. Duration: 61-70min.	2005.03		370	6.500	1.0	R	411.20	
207	Genetic counselling. Duration: 71-80min.	2005.03		370	7.500	1.0	R	474.50	
208	Genetic counselling. Duration: 81-90min.	2005.03		370	8.500	1.0	R	537.80	
	Sample extraction								
300	DNA extraction - Blood	2006.02		370	-	1.0	R	-	

310	DNA extraction - Tissue (other than blood and including CVS and amniotic fluid)	2006.02		370	-	1.0	R	-	
320	DNA extraction - Tissue (paraffin blocks)	2006.02		370	-	1.0	R	-	
330	RNA extraction - Blood	2006.02		370	-	1.0	R	-	
340	RNA extraction - Tissue (other than blood and including CVS and amniotic fluid)	2006.02		370	-	1.0	R	-	
350	RNA extraction - Tissue (paraffin blocks)	2006.02		370	-	1.0	R	-	
	PCR								
400	PCR-basic (up to four PCR primer sets)	2006.02		370	-	1.0	R	-	
410	PCR-multiplex (five or more primer sets)	2006.02		370	-	1.0	R	-	
420	PCR-realtime	2006.02		370	-	1.0	R	-	
430	PCR-reverse transcriptase	2006.02		370	-	1.0	R	-	
	Detection Methods								
500	Diagnostic electrophoresis (agarose and polyacrylamide gel electrophoresis and capillary electrophoresis)	2006.02		370	-	1.0	R	-	
510	Restriction enzyme digestion (use multiples based on cost of enzyme)	2006.02		370	-	1.0	R	-	
520	Probe hybridisation assays	2006.02		370	-	1.0	R	-	
530	dHPLC	2006.02		370	-	1.0	R	-	
540	MLPA	2006.02		370	-	1.0	R	-	
	Southern Blotting								
610	DNA probe labelling (including hybridisation and autoradiography)	2006.02		370	-	1.0	R	-	
600	Southern blot (digest, gel and blotting)	2006.02		370	-	1.0	R	-	
	Other								
700	Protein truncation test	2006.02		370	-	1.0	R	-	
730	Interpretation and reporting	2006.02		370	-	1.0	R	-	
720	DNA sequencing	2006.02		370	-	1.0	R	-	
710	Maternal contamination test (prenatal testing)	2006.02		370	-	1.0	R	-	

Medical Scientists 2008

Code	Description
36901	Medical Scientist : Genetic Counselling

Medical Scientists 2008

Code	Description	RCF
370	Genetic Councellor	63.268

MEDICAL TECHNOLOGY

Medical Technology 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL LABORATORY TECHNOLOGISTS, WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
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VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

Preamble

It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules.

- Services must only be on referral.

General Rules

001	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered. NB: Every account shall contain the following particulars : The account or statement contemplated in section 59(1) of the Act must contain the following - (a) The surname and initials of the member; (b) the surname, first name and other initials, if any, of the patient; (c) the name of the scheme concerned; (d) the membership number of the member; (e) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; (f) the relevant diagnostic and such other item code numbers that relates to such relevant health service; (g) the date on which each relevant health service was rendered; (h) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of, the medicine;	04.00
002	No "shopping list" must be distributed to doctors and no group tests will be carried out.	04.00
003	No charge to be raised in respect of services such as sample handling and after hours services.	04.00
004	Interaction with patient for collecting of specimens shall be limited to those specimens that are physiologically expelled, such as sputum and urine and taking of venous and peripheral blood.	05.02
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

Haematology

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3705	Alkali resistant haemoglobin	04.00		4.500	30.40 (26.70)
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	04.00		3.650	24.60 (21.60)
3710	Antibody titration	04.00		7.200	48.60 (42.60)
3711	Arneth count	04.00		2.250	15.20 (13.30)
3712	Antibody identification	04.00		8.450	57.00 (50.00)
3713	Bleeding time (does not include the cost of the simplate device)	04.00		6.940	46.80 (41.10)
3714	Blood volume, dye method	04.00		7.200	48.60 (42.60)
3715	Buffy layer examination	04.00		19.900	134.20 (117.70)
3717	Bone marrow cytological examination only	04.00		19.900	134.20 (117.70)
3722	Capillary fragility: Hess	04.00		2.020	13.60 (11.90)
3723	Circulating anticoagulants	04.00		5.850	39.50 (34.60)
3724	Coagulation factor inhibitor assay	04.00		57.560	388.20 (340.50)
3726	Activated protein C resistance	04.00		26.000	175.40 (153.90)
3727	Coagulation time	04.00		3.160	21.30 (18.70)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3729	Cold agglutinins	04.00		3.600	24.30 (21.30)
3730	Protein S: Functional	04.00		37.500	252.90 (221.80)
3731	Compatibility for blood transfusion	04.00		3.600	24.30 (21.30)
3732	Cryoglobulin	04.00		3.600	24.30 (21.30)
3734	Protein C (chromogenic)	04.00		30.290	204.30 (179.20)
3735	Anti-thrombin III (chromogenic)	04.00		22.000	148.40 (130.20)
3736	Plasminogen (chromogenic)	04.00		61.650	415.80 (364.70)
3737	Lupus Russel Viper method	04.00		17.000	114.70 (100.60)
3738	Lupus Kaolin Exner method	04.00		25.000	168.60 (147.90)
3739	Erythrocyte count	04.00		2.250	15.20 (13.30)
3740	Factors V and VII: Qualitative	04.00		7.200	48.60 (42.60)
3741	Coagulation factor assay: Functional	04.00		9.450	63.70 (55.90)
3742	Coagulation factor assay: Immunological	04.00		4.500	30.40 (26.70)
3743	Erythrocyte sedimentation rate	04.00		3.000	20.20 (17.70)
3744	Fibrin stabilizing factor (urea test)	04.00		4.500	30.40 (26.70)
3746	Fibrin monomers	04.00		2.700	18.20 (16.00)
3751	Osmotic fragility (screen)	04.00		2.250	15.20 (13.30)
3752	Osmotic fragility test: Quantitative	04.00		10.000	67.50 (59.20)
3753	Osmotic fragility (before and after incubation)	04.00		18.000	121.40 (106.50)
3755	Full blood count (including items 3739, 3762, 3763, 3785, 3791)	04.00		10.500	70.80 (62.10)
3756	Full cross match	04.00		7.200	48.60 (42.60)
3757	Coagulation factors: Quantitative	04.00		32.200	217.20 (190.50)
3758	Factor VIII related antigen	04.00		60.460	407.80 (357.70)
3759	Coagulation factor correction study	04.00		11.720	79.10 (69.40)
3762	Haemoglobin estimation	04.00		1.800	12.10 (10.60)
3763	Contact activated product assay	04.00		16.200	109.30 (95.90)
3764	Grouping: A B and O antigens	04.00		3.600	24.30 (21.30)
3765	Grouping: Rh antigen	04.00		3.600	24.30 (21.30)
3767	Euglobulin Lysis time	04.00		25.580	172.50 (151.30)
3768	Haemoglobin A2 (column chromatography)	04.00		15.000	101.20 (88.80)
3769	Haemoglobin electrophoresis	04.00		26.820	180.90 (158.70)
3770	Haemoglobin-S (solubility test)	04.00		3.600	24.30 (21.30)
3771	Factor III-availability test	04.00		5.850	39.50 (34.60)
3772	Haptoglobin: Quantitative	04.00		9.450	63.70 (55.90)
3773	Ham's acidified serum test	04.00		8.000	54.00 (47.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3775	Heinz bodies	04.00		2.250	15.20 (13.30)
3776	Haemosiderin in urinary sediment	04.00		2.250	15.20 (13.30)
3781	Heparin tolerance	04.00		7.200	48.60 (42.60)
3783	Leucocyte differential count	04.00		6.200	41.80 (36.70)
3785	Leucocytes: Total count	04.00		1.800	12.10 (10.60)
3786	QBC malaria concentration and fluorescent staining	04.00		25.000	168.60 (147.90)
3787	LE-cells	04.00		8.300	56.00 (49.10)
3789	Neutrophil alkaline phosphatase	04.00		28.000	188.90 (165.70)
3791	Packed cell volume: Haematocrit	04.00		1.800	12.10 (10.60)
3792	Plasmodium falciparum: Monoclonal immunological identification	04.00		9.000	60.70 (53.20)
3793	Plasma haemoglobin	04.00		6.750	45.50 (39.90)
3795	Platelet aggregation per aggregant	04.00		12.140	81.90 (71.80)
3796	Platelet antibodies: Agglutination	04.00		5.400	36.40 (31.90)
3797	Platelet count	04.00		2.250	15.20 (13.30)
3799	Platelet adhesiveness	04.00		4.500	30.40 (26.70)
3801	Prothrombin consumption	04.00		5.850	39.50 (34.60)
3803	Prothrombin determination (two stages)	04.00		5.850	39.50 (34.60)
3805	Prothrombin index	04.00		6.000	40.50 (35.50)
3806	Therapeutic drug level: Dosage	04.00		4.500	30.40 (26.70)
3807	Recalcification time	04.00		2.250	15.20 (13.30)
3809	Reticulocyte count	04.00		3.000	20.20 (17.70)
3810	Schumm's test	04.00		3.600	24.30 (21.30)
3811	Sickling test	04.00		2.250	15.20 (13.30)
3814	Sucrose lysis test for PNH	04.00		3.600	24.30 (21.30)
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	04.00		21.100	142.30 (124.80)
3820	Thrombo - Elastogram	04.00		26.000	175.40 (153.90)
3825	Fibrinogen titre	04.00		3.600	24.30 (21.30)
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	04.00		8.000	54.00 (47.40)
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	04.00		16.000	107.90 (94.60)
3832	Red cell pyruvate kinase: Quantitative	04.00		16.000	107.90 (94.60)
3834	Red cell Rhesus phenotype	04.00		9.900	66.80 (58.60)
3835	Haemoglobin F in blood smear	04.00		5.850	39.50 (34.60)
3837	Partial thromboplastin time	04.00		5.850	39.50 (34.60)
3841	Thrombin time (screen)	04.00		7.160	48.30 (42.40)
3843	Thrombin time (serial)	04.00		7.650	51.60 (45.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3847	Haemoglobin H	04.00		2.250	15.20 (13.30)
3851	Fibrin degeneration products (diffusion plate)	04.00		10.350	69.80 (61.20)
3853	Fibrin degeneration products (latex slide)	04.00		4.500	30.40 (26.70)
3854	XDP (Dimer test or equivalent latex slide test)	04.00		8.500	57.30 (50.30)
3855	Haemagglutination inhibition	04.00		9.900	66.80 (58.60)
Microscopic and miscellaneous tests					
3863	Autogenous vaccine	04.00		12.600	85.00 (74.60)
3864	Entomological examination	04.00		20.700	139.60 (122.50)
3865	Parasites in blood smear	04.00		5.600	37.80 (33.20)
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	04.00		4.900	33.10 (29.00)
3868	Fungus identification	04.00		8.300	56.00 (49.10)
3869	Faeces (including parasites)	04.00		4.900	33.10 (29.00)
3875	Inclusion bodies	04.00		4.500	30.40 (26.70)
3878	Crystal identification polarized light microscopy	04.00		4.500	30.40 (26.70)
3879	Campylobacter in stool: Fastidious culture	04.00		9.900	66.80 (58.60)
3880	Antigen detection with polyclonal antibodies	04.00		4.500	30.40 (26.70)
3881	Mycobacteria	04.00		3.000	20.20 (17.70)
3882	Antigen detection with monoclonal antibodies	04.00		10.800	72.80 (63.90)
3883	Concentration techniques for parasites	04.00		3.000	20.20 (17.70)
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	04.00		6.300	42.50 (37.30)
3885	Cytochemical stain	04.00		5.450	36.80 (32.30)
Bacteriology					
3887	Antibiotic susceptibility test: Per organism	04.00		8.000	54.00 (47.40)
3888	Adhesive tape preparation	04.00		2.700	18.20 (16.00)
3889	Clostridium difficile toxin: Monoclonal immunological	04.00		12.400	83.60 (73.30)
3890	Antibiotic assay of tissues and fluids	04.00		13.900	93.80 (82.30)
3891	Blood culture: Aerobic	04.00		5.850	39.50 (34.60)
3892	Blood culture: Anaerobic	04.00		5.850	39.50 (34.60)
3893	Bacteriological culture: Miscellaneous	04.00		6.300	42.50 (37.30)
3894	Radiometric blood culture	04.00		10.800	72.80 (63.90)
3895	Bacteriological culture: Fastidious organisms	04.00		9.900	66.80 (58.60)
3896	In vivo culture: Bacteria	04.00		16.000	107.90 (94.60)
3897	In vivo culture: Virus	04.00		16.000	107.90 (94.60)
3898	Bacterial exotoxin production (in vitro assay)	04.00		4.500	30.40 (26.70)
3899	Bacterial exotoxin production (in vivo assay)	04.00		20.700	139.60 (122.50)
3901	Fungal culture	04.00		4.500	30.40 (26.70)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3962	Rebuck skin window	04.00		5.400	36.40 (31.90)
3963	Serum complement level: Each component	04.00		3.150	21.20 (18.60)
3967	Auto-antibody: Sensitized erythrocytes	04.00		4.500	30.40 (26.70)
3968	Herpes virus typing: Monoclonal immunological	04.00		20.690	139.60 (122.50)
3969	Western blot technique	04.00		74.000	499.10 (437.80)
3970	Epstein-Barr virus antibody titer	04.00		6.750	45.50 (39.90)
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	04.00		14.100	95.10 (83.40)
3933	IgE: Total: EMIT or ELISA	04.00		11.700	78.90 (69.20)
3934	Auto antibodies by labelled antibodies	04.00		16.000	107.90 (94.60)
3935	Sperm antibodies	04.00		16.000	107.90 (94.60)
3936	Virus neutralisation test: First antibody	04.00		75.000	505.90 (443.80)
3937	Virus neutralisation test: Each additional antibody	04.00		15.000	101.20 (88.80)
3938	Precipitation test per antigen	04.00		4.500	30.40 (26.70)
3939	Agglutination test per antigen	04.00		5.500	37.10 (32.50)
3940	Haemagglutination test: Per antigen	04.00		9.900	66.80 (58.60)
3941	Modified Coombs' test for brucellosis	04.00		4.500	30.40 (26.70)
3943	Antibody titer to bacterial exotoxin	04.00		3.600	24.30 (21.30)
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.400	83.60 (73.30)
3945	Complement fixation test	04.00		5.850	39.50 (34.60)
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	04.00		14.050	94.80 (83.20)
3947	C-reactive protein	04.00		10.840	73.10 (64.10)
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.950	87.30 (76.60)
3949	Qualitative Kahn, VDRL or other flocculation	04.00		2.250	15.20 (13.30)
3950	Neutrophil phagocytosis	04.00		25.200	170.00 (149.10)
3951	Quantitative Kahn, VDRL or other flocculation	04.00		3.600	24.30 (21.30)
3952	Neutrophil chemotaxis	04.00		67.950	458.30 (402.00)
3953	Tube agglutination test	04.00		4.150	28.00 (24.60)
3955	Paul Bunnell: Presumptive	04.00		2.250	15.20 (13.30)
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	04.00		8.500	57.30 (50.30)
3957	Paul Bunnell: Absorption	04.00		4.500	30.40 (26.70)
3971	Immuno-diffusion test: Per antigen	04.00		3.150	21.20 (18.60)
3972	Respiratory syncytial virus (ELISA technique)	04.00		35.000	236.10 (207.10)
3973	Immuno electrophoresis: Per immune serum	04.00		9.450	63.70 (55.90)
3974	Polymerase chain reaction	04.00		75.000	505.90 (443.80)
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	04.00		12.000	80.90 (71.00)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3902	Clostridium difficile (cytotoxicity neutralisation)	04.00		30.000	202.40 (177.50)
3903	Antibiotic level: Biological fluids	04.00		11.700	78.90 (69.20)
3904	Rotavirus latex slide test	04.00		5.620	37.90 (33.20)
3905	Identification of virus or rickettsia	04.00		20.700	139.60 (122.50)
3906	Identification: Chlamydia	04.00		16.000	107.90 (94.60)
3907	Culture for staphylococcus aureus	04.00		2.250	15.20 (13.30)
3908	Anaerobe culture: Comprehensive	04.00		9.900	66.80 (58.60)
3909	Anaerobe culture: Limited procedure	04.00		4.500	30.40 (26.70)
3911	Beta-lactamase assay	04.00		4.500	30.40 (26.70)
3914	Sterility control test: Biological method	04.00		4.500	30.40 (26.70)
3915	Mycobacterium culture	04.00		4.500	30.40 (26.70)
3916	Radiometric tuberculosis culture	04.00		10.800	72.80 (63.90)
3917	Mycoplasma culture: Limited	04.00		2.250	15.20 (13.30)
3918	Mycoplasma culture: Comprehensive	04.00		9.900	66.80 (58.60)
3919	Identification of mycobacterium	04.00		9.900	66.80 (58.60)
3920	Mycobacterium: Antibiotic sensitivity	04.00		9.900	66.80 (58.60)
3921	Antibiotic synergistic study	04.00		20.700	139.60 (122.50)
3922	Viable cell count	04.00		1.350	9.11 (7.99)
3923	Biochemical identification of bacterium: Abridged	04.00		3.150	21.20 (18.60)
3924	Biochemical identification of bacterium: Extended	04.00		12.500	84.30 (73.90)
3925	Serological identification of bacterium: Abridged	04.00		3.150	21.20 (18.60)
3926	Serological identification of bacterium: Extended	04.00		10.200	68.80 (60.40)
3927	Grouping for streptococci	04.00		7.300	49.20 (43.20)
3928	Antimicrobic substances	04.00		3.800	25.60 (22.50)
3929	Radiometric mycobacterium identification	04.00		14.000	94.40 (82.80)
3930	Radiometric mycobacterium antibiotic sensitivity	04.00		25.000	168.60 (147.90)
3931	Helicobacter: Monoclonal immunological	04.00		12.400	83.60 (73.30)
4650	Antibiotic MIC per organism per antibiotic	04.00		8.000	54.00 (47.40)
4651	Non-radiometric automated blood cultures	04.00		13.900	93.80 (82.30)
4652	Rapid automated bacterial identification per organism	04.00		15.000	101.20 (88.80)
4653	Rapid automated antibiotic susceptibility per organism	04.00		17.000	114.70 (100.60)
4654	Rapid automated MIC per organism per antibiotic	04.00		17.000	114.70 (100.60)
Serology					
3959	Rose Waaler agglutination test	04.00		4.500	30.40 (26.70)
3960	Gonococcal, listeria or echinococcus agglutination	04.00		9.500	64.10 (56.20)
3961	Slide agglutination test	04.00		2.630	17.70 (15.50)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3977	Counter immuno-electrophoresis	04.00		6.750	45.50 (39.90)
3978	Lymphocyte transformation	04.00		51.700	348.70 (305.90)
4601	Panel typing: Antibody detection: Class I	04.00		36.000	242.80 (213.00)
4602	Panel typing: Antibody detection: Class II	04.00		44.000	296.80 (260.40)
4603	HLA test for specific locus/antigen - serology	04.00		27.000	182.10 (159.70)
4604	HLA typing: Class I - serology	04.00		52.000	350.70 (307.60)
4605	HLA typing: Class II - serology	04.00		52.000	350.70 (307.60)
4606	HLA typing: Class I & II - serology	04.00		90.000	607.10 (532.50)
4607	Cross matching T-cells (per tray)	04.00		18.000	121.40 (106.50)
4608	Cross matching B-cells	04.00		38.000	256.30 (224.80)
4609	Cross matching T- & B-cells	04.00		48.000	323.80 (284.00)
Biochemical tests: Blood					
3991	Abnormal pigments: Qualitative	04.00		4.500	30.40 (26.70)
3993	Abnormal pigments: Quantitative	04.00		9.000	60.70 (53.20)
3995	Acid phosphate	04.00		5.180	34.90 (30.60)
3997	Acid phosphatase fractionation	04.00		1.800	12.10 (10.60)
3996	Amino acids Quantitative (Post derivatisation HPLC)	04.00		78.120	526.90 (462.20)
3999	Albumin	04.00		4.800	32.40 (28.40)
4000	Alcohol	04.00		12.400	83.60 (73.30)
4001	Alkaline phosphatase	04.00		5.180	34.90 (30.60)
4002	Alkaline phosphatase-iso-enzymes	04.00		11.700	78.90 (69.20)
4003	Ammonia: Enzymatic	04.00		7.710	52.00 (45.60)
4004	Ammonia: Monitor	04.00		4.500	30.40 (26.70)
4005	Alpha-1-antitrypsin: Total	04.00		7.200	48.60 (42.60)
4006	Amylase	04.00		5.180	34.90 (30.60)
4007	Arsenic in blood, hair or nails	04.00		36.250	244.50 (214.50)
4009	Bilirubin: Total	04.00		4.770	32.20 (28.20)
4010	Bilirubin: Conjugated	04.00		3.620	24.40 (21.40)
4014	Cadmium: Atomic absorption	04.00		18.120	122.20 (107.20)
4016	Calcium: Ionized	04.00		6.750	45.50 (39.90)
4017	Calcium: Spectrophotometric	04.00		3.620	24.40 (21.40)
4018	Calcium: Atomic absorption	04.00		7.250	48.90 (42.90)
4019	Carotene	04.00		2.250	15.20 (13.30)
4020	Carnitine (Total or free) in biological fluid: Each	04.00		11.690	78.80 (69.10)
4021	Carnitine (Total or free) in muscle: Each	04.00		23.380	157.70 (138.30)
4022	Acyl Carnitine	04.00		23.380	157.70 (138.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4023	Chloride	04.00		2.590	17.50 (15.40)
4026	LDL cholesterol (chemical determination)	04.00		6.900	46.50 (40.80)
4027	Cholesterol total	04.00		5.340	36.00 (31.60)
4028	HDL cholesterol	04.00		6.900	46.50 (40.80)
4029	Cholinesterase: Serum or erythrocyte: Each	04.00		7.480	50.50 (44.30)
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	04.00		9.000	60.70 (53.20)
4031	Total CO2	04.00		5.180	34.90 (30.60)
4032	Creatinine	04.00		3.620	24.40 (21.40)
4040	Homocysteine (random)	04.00		15.300	103.20 (90.50)
4041	Homocysteine (after Methionine load)	04.00		18.100	122.10 (107.10)
4042	D-Xylose absorption test: Two hours	04.00		13.150	88.70 (77.80)
4045	Fibrinogen: Quantitative	04.00		3.600	24.30 (21.30)
4047	Hollander test	04.00		24.750	166.90 (146.40)
4049	Glucose tolerance test (2 specimens)	04.00		8.970	60.50 (53.10)
4050	Glucose strip-test with photometric reading	04.00		1.800	12.10 (10.60)
4051	Galactose	04.00		11.250	75.90 (66.60)
4052	Glucose tolerance test (3 specimens)	04.00		13.170	88.80 (77.90)
4053	Glucose tolerance test (4 specimens)	04.00		17.370	117.20 (102.80)
4057	Glucose: Quantitative	04.00		3.620	24.40 (21.40)
4061	Glucose tolerance test (5 specimens)	04.00		21.560	145.40 (127.50)
4062	Galactose-1-phosphate uridyl transferase	04.00		16.000	107.90 (94.60)
4063	Fructosamine	04.00		7.200	48.60 (42.60)
4064	HbA1C	06.04		14.250	96.10 (84.30)
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.00		46.880	316.20 (277.40)
4067	Lithium: Flame ionisation	04.00		5.180	34.90 (30.60)
4068	Lithium: Atomic absorption	04.00		7.480	50.50 (44.30)
4071	Iron	04.00		6.750	45.50 (39.90)
4073	Iron-binding capacity	04.00		7.650	51.60 (45.30)
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	04.11		6.750	45.50 (39.90)
4079	Ketones in plasma: Qualitative	04.00		2.250	15.20 (13.30)
4081	Drug level-biological fluid: Quantitative	04.00		10.800	72.80 (63.90)
4083	Lysosomal enzyme assay	04.00		36.560	246.60 (216.30)
4085	Lipase	04.00		5.180	34.90 (30.60)
4091	Lipoprotein electrophoresis	04.00		9.000	60.70 (53.20)
4093	Osmolality: Serum or urine	04.00		6.750	45.50 (39.90)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4023	Chloride	04.00		2.590	17.50 (15.40)
4026	LDL cholesterol (chemical determination)	04.00		6.900	46.50 (40.80)
4027	Cholesterol total	04.00		5.340	36.00 (31.60)
4028	HDL cholesterol	04.00		6.900	46.50 (40.80)
4029	Cholinesterase: Serum or erythrocyte: Each	04.00		7.480	50.50 (44.30)
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	04.00		9.000	60.70 (53.20)
4031	Total CO2	04.00		5.180	34.90 (30.60)
4032	Creatinine	04.00		3.620	24.40 (21.40)
4040	Homocysteine (random)	04.00		15.300	103.20 (90.50)
4041	Homocysteine (after Methionine load)	04.00		18.100	122.10 (107.10)
4042	D-Xylose absorption test: Two hours	04.00		13.150	88.70 (77.80)
4045	Fibrinogen: Quantitative	04.00		3.600	24.30 (21.30)
4047	Hollander test	04.00		24.750	166.90 (146.40)
4049	Glucose tolerance test (2 specimens)	04.00		8.970	60.50 (53.10)
4050	Glucose strip-test with photometric reading	04.00		1.800	12.10 (10.60)
4051	Galactose	04.00		11.250	75.90 (66.60)
4052	Glucose tolerance test (3 specimens)	04.00		13.170	88.80 (77.90)
4053	Glucose tolerance test (4 specimens)	04.00		17.370	117.20 (102.80)
4057	Glucose: Quantitative	04.00		3.620	24.40 (21.40)
4061	Glucose tolerance test (5 specimens)	04.00		21.560	145.40 (127.50)
4062	Galactose-1-phosphate uridyl transferase	04.00		16.000	107.90 (94.60)
4063	Fructosamine	04.00		7.200	48.60 (42.60)
4064	HbA1C	06.04		14.250	96.10 (84.30)
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.00		46.880	316.20 (277.40)
4067	Lithium: Flame ionisation	04.00		5.180	34.90 (30.60)
4068	Lithium: Atomic absorption	04.00		7.480	50.50 (44.30)
4071	Iron	04.00		6.750	45.50 (39.90)
4073	Iron-binding capacity	04.00		7.650	51.60 (45.30)
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	04.11		6.750	45.50 (39.90)
4079	Ketones in plasma: Qualitative	04.00		2.250	15.20 (13.30)
4081	Drug level-biological fluid: Quantitative	04.00		10.800	72.80 (63.90)
4083	Lysosomal enzyme assay	04.00		36.560	246.60 (216.30)
4085	Lipase	04.00		5.180	34.90 (30.60)
4091	Lipoprotein electrophoresis	04.00		9.000	60.70 (53.20)
4093	Osmolality: Serum or urine	04.00		6.750	45.50 (39.90)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4094	Magnesium: Spectrophotometric	04.00		3.620	24.40 (21.40)
4095	Magnesium: Atomic absorption	04.00		7.250	48.90 (42.90)
4096	Mercury: Atomic absorption	04.00		18.120	122.20 (107.20)
4098	Copper: Atomic absorption	04.00		18.120	122.20 (107.20)
4105	Protein electrophoresis	04.00		9.000	60.70 (53.20)
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	04.00		20.000	134.90 (118.30)
4109	Phosphate	04.00		3.620	24.40 (21.40)
4111	Phospholipids	04.00		3.150	21.20 (18.60)
4113	Potassium	04.00		3.620	24.40 (21.40)
4114	Sodium	04.00		3.620	24.40 (21.40)
4117	Protein: Total	04.00		3.110	21.00 (18.40)
4121	pH, pCO2 or pO2: Each	04.00		6.750	45.50 (39.90)
4123	Pyruvic acid	04.00		4.500	30.40 (26.70)
4125	Salicylates	04.00		4.500	30.40 (26.70)
4126	Secretin-pancreozymin response	04.00		26.100	176.00 (154.40)
4127	Caeruloplasmin	04.00		4.500	30.40 (26.70)
4128	Phenylalanine: Quantitative	04.00		11.250	75.90 (66.60)
4129	Glutamate dehydrogenase (GDH)	04.00		5.400	36.40 (31.90)
4130	Aspartate aminotransferase (AST)	04.00		5.400	36.40 (31.90)
4131	Alanine aminotransferase (ALT)	04.00		5.400	36.40 (31.90)
4132	Creatine kinase (CK)	04.00		5.400	36.40 (31.90)
4133	Lactate dehidrogenase (LD)	04.00		5.400	36.40 (31.90)
4134	Gamma glutamyl transferase (GGT)	04.00		5.400	36.40 (31.90)
4135	Aldolase	04.00		5.400	36.40 (31.90)
4136	Angiotensin converting enzyme (ACE)	04.00		9.000	60.70 (53.20)
4137	Lactate dehydrogenase isoenzyme	04.00		10.800	72.80 (63.90)
4138	CK-MB: Immunoinhibition/precipitation	04.11		10.800	72.80 (63.90)
4139	Adenosine deaminase	04.00		5.400	36.40 (31.90)
4142	Red cell enzymes: Each	04.00		7.800	52.60 (46.10)
4143	Serum/plasma enzymes	04.00		5.400	36.40 (31.90)
4144	Transferrin	04.00		11.700	78.90 (69.20)
4146	Lead: Atomic absorption	04.00		15.000	101.20 (88.80)
4147	Triglyceride	04.00		7.930	53.50 (46.90)
4149	Red cell magnesium	04.00		11.700	78.90 (69.20)
4151	Urea	04.00		3.620	24.40 (21.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4152	CK-MB: Mass determination: Quantitative (Automated)	04.00		12.400	83.60 (73.30)
4153	CK-MB: Mass determination: Quantitative (Not automated)	04.00		17.470	117.80 (103.30)
4154	Myoglobin quantitative: Monoclonal immunological	04.00		12.400	83.60 (73.30)
4155	Uric acid	04.00		3.780	25.50 (22.40)
4157	Vitamin A-saturation test	04.00		15.300	103.20 (90.50)
4158	Vitamin E (tocopherol)	04.00		3.600	24.30 (21.30)
4159	Vitamin A	04.00		6.300	42.50 (37.30)
4160	Vitamin C (ascorbic acid)	04.00		2.250	15.20 (13.30)
4161	Troponin isoforms: Each	04.00		20.000	134.90 (118.30)
4163	Apoprotein AI: Turbidometric method	04.00		8.280	55.80 (48.90)
4165	Apoprotein AII: Turbidometric method	04.00		8.280	55.80 (48.90)
4167	Apoprotein B: Turbidometric method	04.00		8.280	55.80 (48.90)
4170	Lipoprotein (a)(Lp(a)) assay	04.00		12.420	83.80 (73.50)
4171	Sodium + potassium + chloride + CO2 + urea	04.00		15.840	106.80 (93.70)
4172	ELISA/EMIT technique	04.00		12.420	83.80 (73.50)
4181	Quantitative protein estimation: Mancini method	04.00		7.760	52.30 (45.90)
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	04.00		8.280	55.80 (48.90)
4183	Quantitative protein estimation: Labelled antibody	04.00		12.420	83.80 (73.50)
4185	Lactose	04.00		10.800	72.80 (63.90)
4187	Zinc: Atomic absorption	04.00		18.120	122.20 (107.20)
Biochemical tests: Urine					
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	04.00		1.500	10.10 (8.86)
4189	Abnormal pigments	04.00		4.500	30.40 (26.70)
4193	Alkapton test: Homogentisic acid	04.00		4.500	30.40 (26.70)
4194	Amino acids: Quantitative (Post derivatisation HPLC)	04.00		78.120	526.90 (462.20)
4195	Amino laevulinic acid	04.00		18.000	121.40 (106.50)
4197	Amylase	04.00		5.180	34.90 (30.60)
4198	Arsenic	04.00		18.120	122.20 (107.20)
4199	Ascorbic acid	04.00		2.250	15.20 (13.30)
4201	Bence-Jones protein	04.00		2.700	18.20 (16.00)
4203	Phenol	04.00		3.600	24.30 (21.30)
4204	Calcium: Atomic absorption	04.00		7.250	48.90 (42.90)
4205	Calcium: Spectrophotometric	04.00		3.620	24.40 (21.40)
4206	Calcium: Absorption and excretion studies	04.00		25.000	168.60 (147.90)
4209	Lead: Atomic absorption	04.00		15.000	101.20 (88.80)
4211	Bile pigments: Qualitative	04.00		2.250	15.20 (13.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4213	Protein: Quantitative	04.00		2.250	15.20 (13.30)
4216	Mucopolysaccharides: Qualitative	04.00		3.600	24.30 (21.30)
4217	Oxalate	04.00		9.380	63.30 (55.50)
4218	Glucose: Quantitative	04.00		2.250	15.20 (13.30)
4219	Steroids: Chromatography (each)	04.00		7.200	48.60 (42.60)
4221	Creatinine	04.00		3.620	24.40 (21.40)
4223	Creatinine clearance	04.00		7.650	51.60 (45.30)
4227	Electrophoresis: Qualitative	04.00		4.500	30.40 (26.70)
4229	Uric acid clearance	04.00		7.650	51.60 (45.30)
4237	5-Hydroxy-indole-acetic acid: Screen test	04.00		2.700	18.20 (16.00)
4239	5-Hydroxy-indole-acetic acid: Quantitative	04.00		6.750	45.50 (39.90)
4247	Ketones: Excluding dip-stick method	04.00		2.250	15.20 (13.30)
4248	Reducing substances	04.00		1.800	12.10 (10.60)
4251	Metanephrines: Column chromatography	04.00		22.050	148.70 (130.40)
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	04.00		27.000	182.10 (159.70)
4254	Nitrosonaphtol test for tyrosine	04.00		2.250	15.20 (13.30)
4263	pH: Excluding dip-stick method	04.00		0.900	6.07 (5.32)
4265	Thin layer chromatography: One way	04.00		6.750	45.50 (39.90)
4266	Thin layer chromatography: Two way	04.00		11.250	75.90 (66.60)
4267	Total organic matter screen: Infrared	04.00		31.250	210.80 (184.90)
4268	Organic acids: Quantitative: GCMS	04.00		109.380	737.80 (647.20)
4269	Phenylpyruvic acid: Ferric chloride	04.00		2.250	15.20 (13.30)
4271	Phosphate excretion index	04.00		22.050	148.70 (130.40)
4272	Porphobilinogen qualitative screen: Urine	04.00		5.000	33.70 (29.60)
4273	Porphobilinogen/ALA: Quantitative each	04.00		15.000	101.20 (88.80)
4283	Magnesium: Spectrophotometric	04.00		3.620	24.40 (21.40)
4284	Magnesium: Atomic absorption	04.00		7.250	48.90 (42.90)
4285	Identification of carbohydrate	04.00		7.650	51.60 (45.30)
4287	Identification of drug: Qualitative	04.00		4.500	30.40 (26.70)
4288	Identification of drug: Quantitative	04.00		10.800	72.80 (63.90)
4293	Urea clearance	04.00		5.400	36.40 (31.90)
4297	Copper: Spectrophotometric	04.00		3.620	24.40 (21.40)
4298	Copper: Atomic absorption	04.00		18.120	122.20 (107.20)
4300	Indican or indole: Qualitative	04.00		3.150	21.20 (18.60)
4301	Chloride	04.00		2.590	17.50 (15.40)
4307	Ammonium chloride loading test	04.00		22.050	148.70 (130.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4309	Urobilinogen: Quantitative	04.00		6.750	45.50 (39.90)
4313	Phosphates	04.00		3.620	24.40 (21.40)
4315	Potassium	04.00		3.620	24.40 (21.40)
4316	Sodium	04.00		3.620	24.40 (21.40)
4319	Urea	04.00		3.620	24.40 (21.40)
4321	Uric acid	04.00		3.620	24.40 (21.40)
4322	Fluoride	04.00		5.180	34.90 (30.60)
4323	Total protein and protein electrophoresis	04.00		11.250	75.90 (66.60)
4325	VMA: Quantitative	04.00		11.250	75.90 (66.60)
4326	Catecholamines (HPLC)	04.00		78.120	526.90 (462.20)
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.11		46.880	316.20 (277.40)
4335	Cystine: Quantitative	04.00		12.600	85.00 (74.60)
4336	Dinitrophenol hydrazine test: Ketoacids	04.00		2.250	15.20 (13.30)
4337	Hydroxyproline: Quantitative	04.00		18.900	127.50 (111.80)
Biochemical tests: Faeces					
4339	Chloride	04.00		2.590	17.50 (15.40)
4343	Fat: Qualitative	04.00		3.150	21.20 (18.60)
4345	Fat: Quantitative	04.00		22.050	148.70 (130.40)
4347	Ph	04.00		0.900	6.07 (5.32)
4351	Occult blood: Chemical test	04.00		2.250	15.20 (13.30)
4352	Occult blood: Monoclonal antibodies	04.00		10.000	67.50 (59.20)
4357	Potassium	04.00		3.620	24.40 (21.40)
4358	Sodium	04.00		3.620	24.40 (21.40)
4361	Stercobilin	04.00		2.250	15.20 (13.30)
4362	Elastase quantitative ELISA	04.00		47.000	317.00 (278.10)
4363	Stercobilinogen: Quantitative	04.00		6.750	45.50 (39.90)
4364	Chymotrypsin determination: Enzymatic	04.00		7.470	50.40 (44.20)
Biochemical tests: Miscellaneous					
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	04.00		5.000	33.70 (29.60)
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	04.00		20.000	134.90 (118.30)
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	04.00		20.000	134.90 (118.30)
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	04.00		30.000	202.40 (177.50)
4370	Drug level in biological fluid: Monoclonal immunological	04.00		12.400	83.60 (73.30)
4371	Amylase in exudate	04.00		5.180	34.90 (30.60)
4372	Fluoride in biological fluids and water	04.00		15.620	105.40 (92.50)
4373	Breast milk analysis	04.00		6.750	45.50 (39.90)
4374	Trace metals in biological fluid: Atomic absorption	04.00		18.130	122.30 (107.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4375	Calcium in fluid: Spectrophotometric	04.00		3.620	24.40 (21.40)
4376	Calcium in fluid: Atomic absorption	04.00		7.250	48.90 (42.90)
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	04.11		21.880	147.60 (129.50)
4380	Lecithin in amniotic fluid: L/S ratio	04.00		27.000	182.10 (159.70)
4382	Bilirubin in amniotic fluid: Spectrophotometric essay	04.00		9.450	63.70 (55.90)
4386	Oestrogen/Progesterone receptors: Fluorescent method	04.00		20.700	139.60 (122.50)
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique	04.00		230.000	1551.40 (1360.90)
4388	Gastric contents: Maximal stimulation test	04.00		27.000	182.10 (159.70)
4389	Gastric fluid: Total acid per specimen	04.00		2.250	15.20 (13.30)
4390	Foam test: Amniotic fluid	04.00		3.150	21.20 (18.60)
4391	Renal calculus: Chemistry	04.00		5.400	36.40 (31.90)
4392	Renal calculus: Crystallography	04.00		16.250	109.60 (96.10)
4393	Saliva: Potassium	04.00		3.620	24.40 (21.40)
4394	Saliva: Sodium	04.00		3.620	24.40 (21.40)
4395	Sweat: Sodium	04.00		3.620	24.40 (21.40)
4396	Sweat: Potassium	04.00		3.620	24.40 (21.40)
4397	Sweat: Chloride	04.00		2.590	17.50 (15.40)
4399	Sweat collection by iontophoresis (excluding collection material)	04.00		4.500	30.40 (26.70)
4400	Tryptophane loading test	04.00		22.050	148.70 (130.40)
Cerebrospinal fluid					
4401	Cell count	04.00		3.450	23.30 (20.40)
4407	Cell count, protein, glucose and chloride	04.00		7.650	51.60 (45.30)
4409	Chloride	04.00		2.590	17.50 (15.40)
4415	Potassium	04.00		3.620	24.40 (21.40)
4416	Sodium	04.00		3.620	24.40 (21.40)
4417	Protein: Qualitative	04.00		0.900	6.07 (5.32)
4419	Protein: Quantitative	04.00		3.110	21.00 (18.40)
4421	Glucose	04.00		3.620	24.40 (21.40)
4423	Urea	04.00		3.620	24.40 (21.40)
4425	Protein electrophoresis	04.00		12.600	85.00 (74.60)
RNA/DNA based tests and andrology					
RNA/DNA based tests and andrology: RNA/DNA based tests					
4430	Recombinant DNA technique	04.00		25.000	168.60 (147.90)
4431	Ribosomal RNA targeting for bacteriological identification	04.00		35.000	236.10 (207.10)
4432	Ribosomal RNA amplification for bacteriological identification	04.00		75.000	505.90 (443.80)
4433	Bacteriological DNA identification (LCR)	04.00		25.000	168.60 (147.90)
4434	Bacteriological DNA identification (PCR)	04.00		75.000	505.90 (443.80)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
RNA/DNA based tests and andrology: Andrology					
4435	Mixed antiglobulin reaction: Semen	04.00		6.600	44.50 (39.00)
4436	Friberg test: Semen	04.00		14.500	97.80 (85.80)
4437	Kremer test: Semen	04.00		3.600	24.30 (21.30)
4440	Semen analysis: Cell count	04.00		7.650	51.60 (45.30)
4441	Semen analysis: Cytology	04.00		7.200	48.60 (42.60)
4442	Semen analysis: Viability + motility - 6 hours	04.00		6.000	40.50 (35.50)
4443	Semen analysis: Supravital stain	04.00		5.440	36.70 (32.20)
4445	Seminal fluid: Alpha glucosidase	04.00		20.000	134.90 (118.30)
4446	Seminal fluid fructose	04.00		3.150	21.20 (18.60)
4447	Seminal fluid: Acid phosphatase	04.00		5.180	34.90 (30.60)
Immunology					
4448	HCG: Latex agglutination: Qualitative (side room)	04.00		4.000	27.00 (23.70)
4449	HCG: Latex agglutination: Semi-quantitative (side room)	04.00		9.310	62.80 (55.10)
4450	HCG: Monoclonal immunological: Qualitative	04.00		10.000	67.50 (59.20)
4451	HCG: Monoclonal immunological: Quantitative	04.00		12.400	83.60 (73.30)
4455	Anti IgE receptor antibody test (10 samples and dilution)	04.00		161.560	1089.70 (955.90)
4456	Eosinophil cationic protein	04.00		27.810	187.60 (164.60)
4457	Mast cell tryptase	04.00		96.870	653.40 (573.20)
4458	Micro-albuminuria: Radio-isotope method	04.00		12.420	83.80 (73.50)
4459	Acetyl choline receptor antibody	04.00		158.120	1066.50 (935.50)
4460	CA-199 tumour marker	04.00		20.000	134.90 (118.30)
4462	CA-125 tumour marker	04.00		20.000	134.90 (118.30)
4463	C6 complement functional essay	04.00		45.000	303.50 (266.20)
4464	House dust mite antigen ELIZA	04.00		20.310	137.00 (120.20)
4466	Beta-2-microglobulin	04.00		12.420	83.80 (73.50)
4468	CA-549	04.00		20.000	134.90 (118.30)
4469	Tumour markers: Monoclonal immunological (each)	04.00		20.000	134.90 (118.30)
4470	CA-195 tumour marker	04.00		20.000	134.90 (118.30)
4471	Carcino-embryonic antigen	04.00		20.000	134.90 (118.30)
4472	MCA antigen tumour marker	04.00		20.000	134.90 (118.30)
4476	Neopterin	04.00		20.000	134.90 (118.30)
4477	Neuron specific enolase	04.00		20.000	134.90 (118.30)
4479	Vitamin B12-absorption: Shilling test	04.00		11.700	78.90 (69.20)
4480	Serotonin	04.00		18.750	126.50 (111.00)
4482	Free thyroxine (FT4)	04.00		17.480	117.90 (103.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4485	Insulin	04.00		12.420	83.80 (73.50)
4490	Releasing hormone response	04.00		50.000	337.30 (295.90)
4491	Vitamin B12	04.00		12.420	83.80 (73.50)
4492	Vitamin D3: Calcitroil (RIA)	04.00		75.000	505.90 (443.80)
4493	Drug concentration: Quantitative	04.00		12.420	83.80 (73.50)
4494	Free hormone assay	04.00		17.480	117.90 (103.40)
4495	Growth hormone	04.00		12.420	83.80 (73.50)
4496	Hormone concentration: Quantitative	04.00		12.420	83.80 (73.50)
4497	Carbohydrate deficient transferrin	04.00		29.060	196.00 (171.90)
4499	Cortisol	04.00		12.420	83.80 (73.50)
4500	DHEA sulphate	04.00		12.420	83.80 (73.50)
4501	Testosterone	04.00		12.420	83.80 (73.50)
4502	Free testosterone	04.00		17.480	117.90 (103.40)
4503	Oestradiol	04.00		12.420	83.80 (73.50)
4505	Oestriol	04.00		10.800	72.80 (63.90)
4506	Multiple antigen specific IgE screening test for Atopy	04.00		37.260	251.30 (220.40)
4507	Thyrotropin (TSH)	04.00		19.600	132.20 (116.00)
4508	Combined antigen specific IgE	04.00		24.480	165.10 (144.80)
4509	Free tri-iodothyronine (FT3)	04.00		17.480	117.90 (103.40)
4512	Parathormone	04.00		17.080	115.20 (101.10)
4513	IgE: Total	04.00		12.420	83.80 (73.50)
4514	Antigen specific IgE	04.00		12.420	83.80 (73.50)
4515	Aldosterone	04.00		12.420	83.80 (73.50)
4516	Follitropin (FSH)	04.00		12.420	83.80 (73.50)
4517	Lutropin (LH)	04.00		12.420	83.80 (73.50)
4519	Prostate specific antigen	04.00		14.490	97.70 (85.70)
4520	17 Hydroxy progesterone	04.00		12.420	83.80 (73.50)
4521	Progesterone	04.00		12.420	83.80 (73.50)
4522	Alpha-feto protein	04.00		12.420	83.80 (73.50)
4523	ACTH	04.00		21.740	146.60 (128.60)
4526	Sex hormone binding globulin	04.00		12.420	83.80 (73.50)
4527	Gastrin	04.00		12.420	83.80 (73.50)
4528	Ferritin	04.00		12.420	83.80 (73.50)
4529	Anti-DNA antibodies	04.00		12.420	83.80 (73.50)
4530	Antiplatelet antibodies	04.00		15.300	103.20 (90.50)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4531	Hepatitis: Per antigen or antibody	04.00		14.490	97.70 (85.70)
4532	Transcobalamine	04.00		12.420	83.80 (73.50)
4533	Folic acid	04.00		12.420	83.80 (73.50)
4534	Prostatic acid phosphatase	04.00		12.420	83.80 (73.50)
4536	Erythrocyte folate	04.00		17.480	117.90 (103.40)
4537	Prolactin	04.00		12.420	83.80 (73.50)
4540	HCG: Quantitative as used for Down's screen	04.00		15.000	101.20 (88.80)
Clinical pathology: Miscellaneous					
4544	Attendance in theatre	04.00		27.000	182.10 (159.70)
Exfoliative cytology					
4561	Sputum, all body fluids and tumour aspirates: First unit	04.00		13.400	104.20 (91.40)
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	04.00		7.800	60.70 (53.20)
4564	Performance of fine-needle aspiration for cytology	04.00		15.000	116.70 (102.40)
4565	Examination of fine needle aspiration in theatre	04.00		90.000	700.10 (614.10)
4566	Vaginal or cervical smears, each	04.00		11.000	85.60 (75.10)
Human Genetics					
Cytogenitc					
4750	Cell culture: Lymphocytes, cord blood	04.00		15.000	103.60 (90.90)
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	04.00		45.000	310.80 (272.60)
4752	Cell culture: Chorionic villi	04.00		60.000	414.40 (363.50)
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	04.00		135.000	932.40 (817.90)
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	04.00		270.000	1864.90 (1635.90)
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	04.00		70.000	483.50 (424.10)
4760	FISH procedure, including cell culture	04.00		115.000	794.30 (696.80)
4761	FISH analysis per probe system	04.00		35.000	241.70 (212.00)
DNA-testing					
4763	Blood: DNA extraction	04.00		45.000	310.80 (272.60)
4764	Blood: Genotype per person: Southern blotting	04.00		89.000	614.70 (539.20)
4765	Blood: Genotype per person: PCR	04.00		60.000	414.40 (363.50)
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	04.00		90.000	621.60 (545.30)
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	04.00		188.000	1298.50 (1139.00)
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	04.00		120.000	828.80 (727.00)

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				37600				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL LABORATORY TECHNOLOGISTS, WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	Preamble							
	It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules.□ □ - Services must only be on referral.	2004.00						
	General Rules							
001	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered. NB: Every account shall contain the following particulars : The account or statement contemplated in section 59(1) of the Act must contain the following - (a)□The surname and initials of the member; (b)□the surname, first name and other initials, if any, of the patient; (c)□the name of the scheme concerned; (d)□the membership number of the member; (e)□the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; (f)□the relevant diagnostic and such other item code numbers that relates to such relevant health service; (g)□the date on which each relevant health service was rendered; (h)□the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of an	2004.00						
002	No "shopping list" must be distributed to doctors and no group tests will be carried out.	2004.00						
003	No charge to be raised in respect of services such as sample handling and after hours services.	2004.00						
004	Interaction with patient for collecting of specimens shall be limited to those specimens that are physiologically expelled, such as sputum and urine and taking of venous and peripheral blood.	2005.02						

005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00							
	Haematology								
3705	Alkali resistant haemoglobin	2004.00		350	4.500	1.0	R	30.40	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	2004.00		350	3.650	1.0	R	24.60	
3710	Antibody titration	2004.00		350	7.200	1.0	R	48.60	
3711	Ameth count	2004.00		350	2.250	1.0	R	15.20	
3712	Antibody identification	2004.00		350	8.450	1.0	R	57.00	
3713	Bleeding time (does not include the cost of the simplate device)	2004.00		350	6.940	1.0	R	46.80	
3714	Blood volume, dye method	2004.00		350	7.200	1.0	R	48.60	
3715	Buffy layer examination	2004.00		350	19.900	1.0	R	134.20	
3717	Bone marrow cytological examination only	2004.00		350	19.900	1.0	R	134.20	
3722	Capillary fragility: Hess	2004.00		350	2.020	1.0	R	13.60	
3723	Circulating anticoagulants	2004.00		350	5.850	1.0	R	39.50	
3724	Coagulation factor inhibitor assay	2004.00		350	57.560	1.0	R	388.20	
3726	Activated protein C resistance	2004.00		350	26.000	1.0	R	175.40	
3727	Coagulation time	2004.00		350	3.160	1.0	R	21.30	
3729	Cold agglutinins	2004.00		350	3.600	1.0	R	24.30	
3730	Protein S: Functional	2004.00		350	37.500	1.0	R	252.90	
3731	Compatibility for blood transfusion	2004.00		350	3.600	1.0	R	24.30	
3732	Cryoglobulin	2004.00		350	3.600	1.0	R	24.30	
3734	Protein C (chromogenic)	2004.00		350	30.290	1.0	R	204.30	
3735	Anti-thrombin III (chromogenic)	2004.00		350	22.000	1.0	R	148.40	
3736	Plasminogen (chromogenic)	2004.00		350	61.650	1.0	R	415.80	
3737	Lupus Russel Viper method	2004.00		350	17.000	1.0	R	114.70	
3738	Lupus Kaolin Exner method	2004.00		350	25.000	1.0	R	168.60	
3739	Erythrocyte count	2004.00		350	2.250	1.0	R	15.20	
3740	Factors V and VII: Qualitative	2004.00		350	7.200	1.0	R	48.60	
3741	Coagulation factor assay: Functional	2004.00		350	9.450	1.0	R	63.70	
3742	Coagulation factor assay: Immunological	2004.00		350	4.500	1.0	R	30.40	
3743	Erythrocyte sedimentation rate	2004.00		350	3.000	1.0	R	20.20	
3744	Fibrin stabilizing factor (urea test)	2004.00		350	4.500	1.0	R	30.40	
3746	Fibrin monomers	2004.00		350	2.700	1.0	R	18.20	
3751	Osmotic fragility (screen)	2004.00		350	2.250	1.0	R	15.20	
3752	Osmotic fragility test: Quantitative	2004.00		350	10.000	1.0	R	67.50	
3753	Osmotic fragility (before and after incubation)	2004.00		350	18.000	1.0	R	121.40	
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	2004.00		350	10.500	1.0	R	70.80	
3756	Full cross match	2004.00		350	7.200	1.0	R	48.60	
3757	Coagulation factors: Quantitative	2004.00		350	32.200	1.0	R	217.20	
3758	Factor VIII related antigen	2004.00		350	60.460	1.0	R	407.80	
3759	Coagulation factor correction study	2004.00		350	11.720	1.0	R	79.10	
3762	Haemoglobin estimation	2004.00		350	1.800	1.0	R	12.10	
3763	Contact activated product assay	2004.00		350	16.200	1.0	R	109.30	
3764	Grouping: A B and O antigens	2004.00		350	3.600	1.0	R	24.30	

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3765	Grouping: Rh antigen	2004.00		350	3.600	1.0	R	24.30	
3767	Euglobulin Lysis time	2004.00		350	25.580	1.0	R	172.50	
3768	Haemoglobin A2 (column chromatography)	2004.00		350	15.000	1.0	R	101.20	
3769	Haemoglobin electrophoresis	2004.00		350	26.820	1.0	R	180.90	
3770	Haemoglobin-S (solubility test)	2004.00		350	3.600	1.0	R	24.30	
3771	Factor III-availability test	2004.00		350	5.850	1.0	R	39.50	
3772	Haptoglobin: Quantitative	2004.00		350	9.450	1.0	R	63.70	
3773	Ham's acidified serum test	2004.00		350	8.000	1.0	R	54.00	
3775	Heinz bodies	2004.00		350	2.250	1.0	R	15.20	
3776	Haemosiderin in urinary sediment	2004.00		350	2.250	1.0	R	15.20	
3781	Heparin tolerance	2004.00		350	7.200	1.0	R	48.60	
3783	Leucocyte differential count	2004.00		350	6.200	1.0	R	41.80	
3785	Leucocytes: Total count	2004.00		350	1.800	1.0	R	12.10	
3786	QBC malaria concentration and fluorescent staining	2004.00		350	25.000	1.0	R	168.60	
3787	LE-cells	2004.00		350	8.300	1.0	R	56.00	
3789	Neutrophil alkaline phosphatase	2004.00		350	28.000	1.0	R	188.90	
3791	Packed cell volume: Haematocrit	2004.00		350	1.800	1.0	R	12.10	
3792	Plasmodium falciparum: Monoclonal immunological identification	2004.00		350	9.000	1.0	R	60.70	
3793	Plasma haemoglobin	2004.00		350	6.750	1.0	R	45.50	
3795	Platelet aggregation per aggregant	2004.00		350	12.140	1.0	R	81.90	
3796	Platelet antibodies: Agglutination	2004.00		350	5.400	1.0	R	36.40	
3797	Platelet count	2004.00		350	2.250	1.0	R	15.20	
3799	Platelet adhesiveness	2004.00		350	4.500	1.0	R	30.40	
3801	Prothrombin consumption	2004.00		350	5.850	1.0	R	39.50	
3803	Prothrombin determination (two stages)	2004.00		350	5.850	1.0	R	39.50	
3805	Prothrombin index	2004.00		350	6.000	1.0	R	40.50	
3806	Therapeutic drug level: Dosage	2004.00		350	4.500	1.0	R	30.40	
3807	Recalcification time	2004.00		350	2.250	1.0	R	15.20	
3809	Reticulocyte count	2004.00		350	3.000	1.0	R	20.20	
3810	Schumm's test	2004.00		350	3.600	1.0	R	24.30	
3811	Sickling test	2004.00		350	2.250	1.0	R	15.20	
3814	Sucrose lysis test for PNH	2004.00		350	3.600	1.0	R	24.30	
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	2004.00		350	21.100	1.0	R	142.30	
3820	Thrombo - Elastogram	2004.00		350	26.000	1.0	R	175.40	
3825	Fibrinogen titre	2004.00		350	3.600	1.0	R	24.30	
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	2004.00		350	8.000	1.0	R	54.00	
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	2004.00		350	16.000	1.0	R	107.90	
3832	Red cell pyruvate kinase: Quantitative	2004.00		350	16.000	1.0	R	107.90	
3834	Red cell Rhesus phenotype	2004.00		350	9.900	1.0	R	66.80	
3835	Haemoglobin F in blood smear	2004.00		350	5.850	1.0	R	39.50	
3837	Partial thromboplastin time	2004.00		350	5.850	1.0	R	39.50	
3841	Thrombin time (screen)	2004.00		350	7.160	1.0	R	48.30	
3843	Thrombin time (serial)	2004.00		350	7.650	1.0	R	51.60	
3847	Haemoglobin H	2004.00		350	2.250	1.0	R	15.20	
3851	Fibrin degeneration products (diffusion plate)	2004.00		350	10.350	1.0	R	69.80	

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3853	Fibrin degeneration products (latex slide)	2004.00		350	4.500	1.0	R	30.40	
3854	XDP (Dimer test or equivalent latex slide test)	2004.00		350	8.500	1.0	R	57.30	
3855	Haemagglutination inhibition	2004.00		350	9.900	1.0	R	66.80	
	Microscopic and miscellaneous tests								
3863	Autogenous vaccine	2004.00		350	12.600	1.0	R	85.00	
3864	Entomological examination	2004.00		350	20.700	1.0	R	139.60	
3865	Parasites in blood smear	2004.00		350	5.600	1.0	R	37.80	
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	2004.00		350	4.900	1.0	R	33.10	
3868	Fungus identification	2004.00		350	8.300	1.0	R	56.00	
3869	Faeces (including parasites)	2004.00		350	4.900	1.0	R	33.10	
3875	Inclusion bodies	2004.00		350	4.500	1.0	R	30.40	
3878	Crystal identification polarized light microscopy	2004.00		350	4.500	1.0	R	30.40	
3879	Campylobacter in stool: Fastidious culture	2004.00		350	9.900	1.0	R	66.80	
3880	Antigen detection with polyclonal antibodies	2004.00		350	4.500	1.0	R	30.40	
3881	Mycobacteria	2004.00		350	3.000	1.0	R	20.20	
3882	Antigen detection with monoclonal antibodies	2004.00		350	10.800	1.0	R	72.80	
3883	Concentration techniques for parasites	2004.00		350	3.000	1.0	R	20.20	
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	2004.00		350	6.300	1.0	R	42.50	
3885	Cytochemical stain	2004.00		350	5.450	1.0	R	36.80	
	Bacteriology								
3887	Antibiotic susceptibility test: Per organism	2004.00		350	8.000	1.0	R	54.00	
3888	Adhesive tape preparation	2004.00		350	2.700	1.0	R	18.20	
3889	Clostridium difficile toxin: Monoclonal immunological	2004.00		350	12.400	1.0	R	83.60	
3890	Antibiotic assay of tissues and fluids	2004.00		350	13.900	1.0	R	93.80	
3891	Blood culture: Aerobic	2004.00		350	5.850	1.0	R	39.50	
3892	Blood culture: Anaerobic	2004.00		350	5.850	1.0	R	39.50	
3893	Bacteriological culture: Miscellaneous	2004.00		350	6.300	1.0	R	42.50	
3894	Radiometric blood culture	2004.00		350	10.800	1.0	R	72.80	
3895	Bacteriological culture: Fastidious organisms	2004.00		350	9.900	1.0	R	66.80	
3896	In vivo culture: Bacteria	2004.00		350	16.000	1.0	R	107.90	
3897	In vivo culture: Virus	2004.00		350	16.000	1.0	R	107.90	
3898	Bacterial exotoxin production (in vitro assay)	2004.00		350	4.500	1.0	R	30.40	
3899	Bacterial exotoxin production (in vivo assay)	2004.00		350	20.700	1.0	R	139.60	
3901	Fungal culture	2004.00		350	4.500	1.0	R	30.40	
3902	Clostridium difficile (cytotoxicity neutralisation)	2004.00		350	30.000	1.0	R	202.40	
3903	Antibiotic level: Biological fluids	2004.00		350	11.700	1.0	R	78.90	
3904	Rotavirus latex slide test	2004.00		350	5.620	1.0	R	37.90	
3905	Identification of virus or rickettsia	2004.00		350	20.700	1.0	R	139.60	
3906	Identification: Chlamydia	2004.00		350	16.000	1.0	R	107.90	
3907	Culture for staphylococcus aureus	2004.00		350	2.250	1.0	R	15.20	
3908	Anaerobe culture: Comprehensive	2004.00		350	9.900	1.0	R	66.80	
3909	Anaerobe culture: Limited procedure	2004.00		350	4.500	1.0	R	30.40	
3911	Beta-lactamase assay	2004.00		350	4.500	1.0	R	30.40	
3914	Sterility control test: Biological method	2004.00		350	4.500	1.0	R	30.40	
3915	Mycobacterium culture	2004.00		350	4.500	1.0	R	30.40	

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3916	Radiometric tuberculosis culture	2004.00		350	10.800	1.0	R	72.80	
3917	Mycoplasma culture: Limited	2004.00		350	2.250	1.0	R	15.20	
3918	Mycoplasma culture: Comprehensive	2004.00		350	9.900	1.0	R	66.80	
3919	Identification of mycobacterium	2004.00		350	9.900	1.0	R	66.80	
3920	Mycobacterium: Antibiotic sensitivity	2004.00		350	9.900	1.0	R	66.80	
3921	Antibiotic synergistic study	2004.00		350	20.700	1.0	R	139.60	
3922	Viable cell count	2004.00		350	1.350	1.0	R	9.11	
3923	Biochemical identification of bacterium: Abridged	2004.00		350	3.150	1.0	R	21.20	
3924	Biochemical identification of bacterium: Extended	2004.00		350	12.500	1.0	R	84.30	
3925	Serological identification of bacterium: Abridged	2004.00		350	3.150	1.0	R	21.20	
3926	Serological identification of bacterium: Extended	2004.00		350	10.200	1.0	R	68.80	
3927	Grouping for streptococci	2004.00		350	7.300	1.0	R	49.20	
3928	Antimicrobic substances	2004.00		350	3.800	1.0	R	25.60	
3929	Radiometric mycobacterium identification	2004.00		350	14.000	1.0	R	94.40	
3930	Radiometric mycobacterium antibiotic sensitivity	2004.00		350	25.000	1.0	R	168.60	
3931	Helicobacter: Monoclonal immunological	2004.00		350	12.400	1.0	R	83.60	
4650	Antibiotic MIC per organism per antibiotic	2004.00		350	8.000	1.0	R	54.00	
4651	Non-radiometric automated blood cultures	2004.00		350	13.900	1.0	R	93.80	
4652	Rapid automated bacterial identification per organism	2004.00		350	15.000	1.0	R	101.20	
4653	Rapid automated antibiotic susceptibility per organism	2004.00		350	17.000	1.0	R	114.70	
4654	Rapid automated MIC per organism per antibiotic	2004.00		350	17.000	1.0	R	114.70	
	Serology								
3959	Rose Waaler agglutination test	2004.00		350	4.500	1.0	R	30.40	
3960	Gonococcal, listeria or echinococcus agglutination	2004.00		350	9.500	1.0	R	64.10	
3961	Slide agglutination test	2004.00		350	2.630	1.0	R	17.70	
3962	Rebuck skin window	2004.00		350	5.400	1.0	R	36.40	
3963	Serum complement level: Each component	2004.00		350	3.150	1.0	R	21.20	
3967	Auto-antibody: Sensitized erythrocytes	2004.00		350	4.500	1.0	R	30.40	
3968	Herpes virus typing: Monoclonal immunological	2004.00		350	20.690	1.0	R	139.60	
3969	Western blot technique	2004.00		350	74.000	1.0	R	499.10	
3970	Epstein-Barr virus antibody titer	2004.00		350	6.750	1.0	R	45.50	
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	2004.00		350	14.100	1.0	R	95.10	
3933	IgE: Total: EMIT or ELISA	2004.00		350	11.700	1.0	R	78.90	
3934	Auto antibodies by labelled antibodies	2004.00		350	16.000	1.0	R	107.90	
3935	Sperm antibodies	2004.00		350	16.000	1.0	R	107.90	
3936	Virus neutralisation test: First antibody	2004.00		350	75.000	1.0	R	505.90	
3937	Virus neutralisation test: Each additional antibody	2004.00		350	15.000	1.0	R	101.20	
3938	Precipitation test per antigen	2004.00		350	4.500	1.0	R	30.40	
3939	Agglutination test per antigen	2004.00		350	5.500	1.0	R	37.10	
3940	Haemagglutination test: Per antigen	2004.00		350	9.900	1.0	R	66.80	
3941	Modified Coombs' test for brucellosis	2004.00		350	4.500	1.0	R	30.40	
3943	Antibody titer to bacterial exotoxin	2004.00		350	3.600	1.0	R	24.30	
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	2004.00		350	12.400	1.0	R	83.60	
3945	Complement fixation test	2004.00		350	5.850	1.0	R	39.50	
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	2004.00		350	14.050	1.0	R	94.80	

3947	C-reactive protein	2004.00		350	10.840	1.0	R	73.10	
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	2004.00		350	12.950	1.0	R	87.30	
3949	Qualitative Kahn, VDRL or other flocculation	2004.00		350	2.250	1.0	R	15.20	
3950	Neutrophil phagocytosis	2004.00		350	25.200	1.0	R	170.00	
3951	Quantitative Kahn, VDRL or other flocculation	2004.00		350	3.600	1.0	R	24.30	
3952	Neutrophil chemotaxis	2004.00		350	67.950	1.0	R	458.30	
3953	Tube agglutination test	2004.00		350	4.150	1.0	R	28.00	
3955	Paul Bunnell: Presumptive	2004.00		350	2.250	1.0	R	15.20	
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	2004.00		350	8.500	1.0	R	57.30	
3957	Paul Bunnell: Absorption	2004.00		350	4.500	1.0	R	30.40	
3971	Immuno-diffusion test: Per antigen	2004.00		350	3.150	1.0	R	21.20	
3972	Respiratory syncytial virus (ELISA technique)	2004.00		350	35.000	1.0	R	236.10	
3973	Immuno electrophoresis: Per immune serum	2004.00		350	9.450	1.0	R	63.70	
3974	Polymerase chain reaction	2004.00		350	75.000	1.0	R	505.90	
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	2004.00		350	12.000	1.0	R	80.90	
3977	Counter immuno-electrophoresis	2004.00		350	6.750	1.0	R	45.50	
3978	Lymphocyte transformation	2004.00		350	51.700	1.0	R	348.70	
4601	Panel typing: Antibody detection: Class I	2004.00		350	36.000	1.0	R	242.80	
4602	Panel typing: Antibody detection: Class II	2004.00		350	44.000	1.0	R	296.80	
4603	HLA test for specific locus/antigen - serology	2004.00		350	27.000	1.0	R	182.10	
4604	HLA typing: Class I - serology	2004.00		350	52.000	1.0	R	350.70	
4605	HLA typing: Class II - serology	2004.00		350	52.000	1.0	R	350.70	
4606	HLA typing: Class I & II - serology	2004.00		350	90.000	1.0	R	607.10	
4607	Cross matching T-cells (per tray)	2004.00		350	18.000	1.0	R	121.40	
4608	Cross matching B-cells	2004.00		350	38.000	1.0	R	256.30	
4609	Cross matching T- & B-cells	2004.00		350	48.000	1.0	R	323.80	
	Biochemical tests: Blood								
3991	Abnormal pigments: Qualitative	2004.00		350	4.500	1.0	R	30.40	
3993	Abnormal pigments: Quantitative	2004.00		350	9.000	1.0	R	60.70	
3995	Acid phosphate	2004.00		350	5.180	1.0	R	34.90	
3997	Acid phosphatase fractionation	2004.00		350	1.800	1.0	R	12.10	
3998	Amino acids Quantitative (Post derivatisation HPLC)	2004.00		350	78.120	1.0	R	526.90	
3999	Albumin	2004.00		350	4.800	1.0	R	32.40	
4000	Alcohol	2004.00		350	12.400	1.0	R	83.60	
4001	Alkaline phosphatase	2004.00		350	5.180	1.0	R	34.90	
4002	Alkaline phosphatase-iso-enzymes	2004.00		350	11.700	1.0	R	78.90	
4003	Ammonia: Enzymatic	2004.00		350	7.710	1.0	R	52.00	
4004	Ammonia: Monitor	2004.00		350	4.500	1.0	R	30.40	
4005	Alpha-1-antitrypsin: Total	2004.00		350	7.200	1.0	R	48.60	
4006	Amylase	2004.00		350	5.180	1.0	R	34.90	
4007	Arsenic in blood, hair or nails	2004.00		350	36.250	1.0	R	244.50	
4009	Bilirubin: Total	2004.00		350	4.770	1.0	R	32.20	
4010	Bilirubin: Conjugated	2004.00		350	3.620	1.0	R	24.40	
4014	Cadmium: Atomic absorption	2004.00		350	18.120	1.0	R	122.20	
4016	Calcium: Ionized	2004.00		350	6.750	1.0	R	45.50	

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4017	Calcium: Spectrophotometric	2004.00	350	3.620	1.0	R	24.40	
4018	Calcium: Atomic absorption	2004.00	350	7.250	1.0	R	48.90	
4019	Carotene	2004.00	350	2.250	1.0	R	15.20	
4020	Carnitine (Total or free) in biological fluid: Each	2004.00	350	11.690	1.0	R	78.80	
4021	Carnitine (Total or free) in muscle: Each	2004.00	350	23.380	1.0	R	157.70	
4022	Acyl Carnitine	2004.00	350	23.380	1.0	R	157.70	
4023	Chloride	2004.00	350	2.590	1.0	R	17.50	
4026	LDL cholesterol (chemical determination)	2004.00	350	6.900	1.0	R	46.50	
4027	Cholesterol total	2004.00	350	5.340	1.0	R	36.00	
4028	HDL cholesterol	2004.00	350	6.900	1.0	R	46.50	
4029	Cholinesterase: Serum or erythrocyte: Each	2004.00	350	7.480	1.0	R	50.50	
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	2004.00	350	9.000	1.0	R	60.70	
4031	Total CO2	2004.00	350	5.180	1.0	R	34.90	
4032	Creatinine	2004.00	350	3.620	1.0	R	24.40	
4040	Homocysteine (random)	2004.00	350	15.300	1.0	R	103.20	
4041	Homocysteine (after Methionine load)	2004.00	350	18.100	1.0	R	122.10	
4042	D-Xylose absorption test: Two hours	2004.00	350	13.150	1.0	R	88.70	
4045	Fibrinogen: Quantitative	2004.00	350	3.600	1.0	R	24.30	
4047	Hollander test	2004.00	350	24.750	1.0	R	166.90	
4049	Glucose tolerance test (2 specimens)	2004.00	350	8.970	1.0	R	60.50	
4050	Glucose strip-test with photometric reading	2004.00	350	1.800	1.0	R	12.10	
4051	Galactose	2004.00	350	11.250	1.0	R	75.90	
4052	Glucose tolerance test (3 specimens)	2004.00	350	13.170	1.0	R	88.80	
4053	Glucose tolerance test (4 specimens)	2004.00	350	17.370	1.0	R	117.20	
4057	Glucose: Quantitative	2004.00	350	3.620	1.0	R	24.40	
4061	Glucose tolerance test (5 specimens)	2004.00	350	21.560	1.0	R	145.40	
4062	Galactose-1-phosphate uridyl transferase	2004.00	350	16.000	1.0	R	107.90	
4063	Fructosamine	2004.00	350	7.200	1.0	R	48.60	
4064	HbA1C	2006.04	350	14.250	1.0	R	96.10	
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	2004.00	350	46.880	1.0	R	316.20	
4067	Lithium: Flame ionisation	2004.00	350	5.180	1.0	R	34.90	
4068	Lithium: Atomic absorption	2004.00	350	7.480	1.0	R	50.50	
4071	Iron	2004.00	350	6.750	1.0	R	45.50	
4073	Iron-binding capacity	2004.00	350	7.650	1.0	R	51.60	
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	2004.11	350	6.750	1.0	R	45.50	
4079	Ketones in plasma: Qualitative	2004.00	350	2.250	1.0	R	15.20	
4081	Drug level-biological fluid: Quantitative	2004.00	350	10.800	1.0	R	72.80	
4083	Lysosomal enzyme assay	2004.00	350	36.560	1.0	R	246.60	
4085	Lipase	2004.00	350	5.180	1.0	R	34.90	
4091	Lipoprotein electrophoresis	2004.00	350	9.000	1.0	R	60.70	
4093	Osmolality: Serum or urine	2004.00	350	6.750	1.0	R	45.50	
4094	Magnesium: Spectrophotometric	2004.00	350	3.620	1.0	R	24.40	
4095	Magnesium: Atomic absorption	2004.00	350	7.250	1.0	R	48.90	
4096	Mercury: Atomic absorption	2004.00	350	18.120	1.0	R	122.20	
4098	Copper: Atomic absorption	2004.00	350	18.120	1.0	R	122.20	

4105	Protein electrophoresis	2004.00		350	9.000	1.0	R	60.70	
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	2004.00		350	20.000	1.0	R	134.90	
4109	Phosphate	2004.00		350	3.620	1.0	R	24.40	
4111	Phospholipids	2004.00		350	3.150	1.0	R	21.20	
4113	Potassium	2004.00		350	3.620	1.0	R	24.40	
4114	Sodium	2004.00		350	3.620	1.0	R	24.40	
4117	Protein: Total	2004.00		350	3.110	1.0	R	21.00	
4121	pH, pCO2 or pO2: Each	2004.00		350	6.750	1.0	R	45.50	
4123	Pyruvic acid	2004.00		350	4.500	1.0	R	30.40	
4125	Salicylates	2004.00		350	4.500	1.0	R	30.40	
4126	Secretin-pancreozymin response	2004.00		350	26.100	1.0	R	176.00	
4127	Caeruloplasmin	2004.00		350	4.500	1.0	R	30.40	
4128	Phenylalanine: Quantitative	2004.00		350	11.250	1.0	R	75.90	
4129	Glutamate dehydrogenase (GDH)	2004.00		350	5.400	1.0	R	36.40	
4130	Aspartate aminotransferase (AST)	2004.00		350	5.400	1.0	R	36.40	
4131	Alanine aminotransferase (ALT)	2004.00		350	5.400	1.0	R	36.40	
4132	Creatine kinase (CK)	2004.00		350	5.400	1.0	R	36.40	
4133	Lactate dehidrogenase (LD)	2004.00		350	5.400	1.0	R	36.40	
4134	Gamma glutamyl transferase (GGT)	2004.00		350	5.400	1.0	R	36.40	
4135	Aldolase	2004.00		350	5.400	1.0	R	36.40	
4136	Angiotensin converting enzyme (ACE)	2004.00		350	9.000	1.0	R	60.70	
4137	Lactate dehydrogenase isoenzyme	2004.00		350	10.800	1.0	R	72.80	
4138	CK-MB: Immunoinhibition/precipitation	2004.11		350	10.800	1.0	R	72.80	
4139	Adenosine deaminase	2004.00		350	5.400	1.0	R	36.40	
4142	Red cell enzymes: Each	2004.00		350	7.800	1.0	R	52.60	
4143	Serum/plasma enzymes	2004.00		350	5.400	1.0	R	36.40	
4144	Transferrin	2004.00		350	11.700	1.0	R	78.90	
4146	Lead: Atomic absorption	2004.00		350	15.000	1.0	R	101.20	
4147	Triglyceride	2004.00		350	7.930	1.0	R	53.50	
4149	Red cell magnesium	2004.00		350	11.700	1.0	R	78.90	
4151	Urea	2004.00		350	3.620	1.0	R	24.40	
4152	CK-MB: Mass determination: Quantitative (Automated)	2004.00		350	12.400	1.0	R	83.60	
4153	CK-MB: Mass determination: Quantitative (Not automated)	2004.00		350	17.470	1.0	R	117.80	
4154	Myoglobin quantitative: Monoclonal immunological	2004.00		350	12.400	1.0	R	83.60	
4155	Uric acid	2004.00		350	3.780	1.0	R	25.50	
4157	Vitamin A-saturation test	2004.00		350	15.300	1.0	R	103.20	
4158	Vitamin E (tocopherol)	2004.00		350	3.600	1.0	R	24.30	
4159	Vitamin A	2004.00		350	6.300	1.0	R	42.50	
4160	Vitamin C (ascorbic acid)	2004.00		350	2.250	1.0	R	15.20	
4161	Troponin isoforms: Each	2004.00		350	20.000	1.0	R	134.90	
4163	Apoprotein AI: Turbidometric method	2004.00		350	8.280	1.0	R	55.80	
4165	Apoprotein AII: Turbidometric method	2004.00		350	8.280	1.0	R	55.80	
4167	Apoprotein B: Turbidometric method	2004.00		350	8.280	1.0	R	55.80	
4170	Lipoprotein (a)(Lp(a)) assay	2004.00		350	12.420	1.0	R	83.80	
4171	Sodium + potassium + chloride + CO2 + urea	2004.00		350	15.840	1.0	R	106.80	

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4172	ELISA/EMIT technique	2004.00		350	12.420	1.0	R	83.80	
4181	Quantitative protein estimation: Mancini method	2004.00		350	7.760	1.0	R	52.30	
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	2004.00		350	8.280	1.0	R	55.80	
4183	Quantitative protein estimation: Labelled antibody	2004.00		350	12.420	1.0	R	83.80	
4185	Lactose	2004.00		350	10.800	1.0	R	72.80	
4187	Zinc: Atomic absorption	2004.00		350	18.120	1.0	R	122.20	
	Biochemical tests: Urine								
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	2004.00		350	1.500	1.0	R	10.10	
4189	Abnormal pigments	2004.00		350	4.500	1.0	R	30.40	
4193	Alkapton test: Homogentisic acid	2004.00		350	4.500	1.0	R	30.40	
4194	Amino acids: Quantitative (Post derivatisation HPLC)	2004.00		350	78.120	1.0	R	526.90	
4195	Amino laevulinic acid	2004.00		350	18.000	1.0	R	121.40	
4197	Amylase	2004.00		350	5.180	1.0	R	34.90	
4198	Arsenic	2004.00		350	18.120	1.0	R	122.20	
4199	Ascorbic acid	2004.00		350	2.250	1.0	R	15.20	
4201	Bence-Jones protein	2004.00		350	2.700	1.0	R	18.20	
4203	Phenol	2004.00		350	3.600	1.0	R	24.30	
4204	Calcium: Atomic absorption	2004.00		350	7.250	1.0	R	48.90	
4205	Calcium: Spectrophotometric	2004.00		350	3.620	1.0	R	24.40	
4206	Calcium: Absorption and excretion studies	2004.00		350	25.000	1.0	R	168.60	
4209	Lead: Atomic absorption	2004.00		350	15.000	1.0	R	101.20	
4211	Bile pigments: Qualitative	2004.00		350	2.250	1.0	R	15.20	
4213	Protein: Quantitative	2004.00		350	2.250	1.0	R	15.20	
4216	Mucopolysaccharides: Qualitative	2004.00		350	3.600	1.0	R	24.30	
4217	Oxalate	2004.00		350	9.380	1.0	R	63.30	
4218	Glucose: Quantitative	2004.00		350	2.250	1.0	R	15.20	
4219	Steroids: Chromatography (each)	2004.00		350	7.200	1.0	R	48.60	
4221	Creatinine	2004.00		350	3.620	1.0	R	24.40	
4223	Creatinine clearance	2004.00		350	7.650	1.0	R	51.60	
4227	Electrophoresis: Qualitative	2004.00		350	4.500	1.0	R	30.40	
4229	Uric acid clearance	2004.00		350	7.650	1.0	R	51.60	
4237	5-Hydroxy-indole-acetic acid: Screen test	2004.00		350	2.700	1.0	R	18.20	
4239	5-Hydroxy-indole-acetic acid: Quantitative	2004.00		350	6.750	1.0	R	45.50	
4247	Ketones: Excluding dip-stick method	2004.00		350	2.250	1.0	R	15.20	
4248	Reducing substances	2004.00		350	1.800	1.0	R	12.10	
4251	Metanephrines: Column chromatography	2004.00		350	22.050	1.0	R	148.70	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	2004.00		350	27.000	1.0	R	182.10	
4254	Nitrosonaphtol test for tyrosine	2004.00		350	2.250	1.0	R	15.20	
4263	pH: Excluding dip-stick method	2004.00		350	0.900	1.0	R	6.07	
4265	Thin layer chromatography: One way	2004.00		350	6.750	1.0	R	45.50	
4266	Thin layer chromatography: Two way	2004.00		350	11.250	1.0	R	75.90	
4267	Total organic matter screen: Infrared	2004.00		350	31.250	1.0	R	210.80	
4268	Organic acids: Quantitative: GCMS	2004.00		350	109.380	1.0	R	737.80	
4269	Phenylpyruvic acid: Ferric chloride	2004.00		350	2.250	1.0	R	15.20	
4271	Phosphate excretion index	2004.00		350	22.050	1.0	R	148.70	

4272	Porphobilinogen qualitative screen: Urine	2004.00		350	5.000	1.0	R	33.70	
4273	Porphobilinogen/ALA: Quantitative each	2004.00		350	15.000	1.0	R	101.20	
4283	Magnesium: Spectrophotometric	2004.00		350	3.620	1.0	R	24.40	
4284	Magnesium: Atomic absorption	2004.00		350	7.250	1.0	R	48.90	
4285	Identification of carbohydrate	2004.00		350	7.650	1.0	R	51.60	
4287	Identification of drug: Qualitative	2004.00		350	4.500	1.0	R	30.40	
4288	Identification of drug: Quantitative	2004.00		350	10.800	1.0	R	72.80	
4293	Urea clearance	2004.00		350	5.400	1.0	R	36.40	
4297	Copper: Spectrophotometric	2004.00		350	3.620	1.0	R	24.40	
4298	Copper: Atomic absorption	2004.00		350	18.120	1.0	R	122.20	
4300	Indican or Indole: Qualitative	2004.00		350	3.150	1.0	R	21.20	
4301	Chloride	2004.00		350	2.590	1.0	R	17.50	
4307	Ammonium chloride loading test	2004.00		350	22.050	1.0	R	148.70	
4309	Urobilinogen: Quantitative	2004.00		350	6.750	1.0	R	45.50	
4313	Phosphates	2004.00		350	3.620	1.0	R	24.40	
4315	Potassium	2004.00		350	3.620	1.0	R	24.40	
4316	Sodium	2004.00		350	3.620	1.0	R	24.40	
4319	Urea	2004.00		350	3.620	1.0	R	24.40	
4321	Uric acid	2004.00		350	3.620	1.0	R	24.40	
4322	Fluoride	2004.00		350	5.180	1.0	R	34.90	
4323	Total protein and protein electrophoresis	2004.00		350	11.250	1.0	R	75.90	
4325	VMA: Quantitative	2004.00		350	11.250	1.0	R	75.90	
4326	Catecholamines (HPLC)	2004.00		350	78.120	1.0	R	526.90	
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	2004.11		350	46.880	1.0	R	316.20	
4335	Cystine: Quantitative	2004.00		350	12.600	1.0	R	85.00	
4336	Dinitrophenol hydrazine test: Ketoacids	2004.00		350	2.250	1.0	R	15.20	
4337	Hydroxyproline: Quantitative	2004.00		350	18.900	1.0	R	127.50	
	Biochemical tests: Faeces								
4339	Chloride	2004.00		350	2.590	1.0	R	17.50	
4343	Fat: Qualitative	2004.00		350	3.150	1.0	R	21.20	
4345	Fat: Quantitative	2004.00		350	22.050	1.0	R	148.70	
4347	Ph	2004.00		350	0.900	1.0	R	6.07	
4351	Occult blood: Chemical test	2004.00		350	2.250	1.0	R	15.20	
4352	Occult blood: Monoclonal antibodies	2004.00		350	10.000	1.0	R	67.50	
4357	Potassium	2004.00		350	3.620	1.0	R	24.40	
4358	Sodium	2004.00		350	3.620	1.0	R	24.40	
4361	Stercobilin	2004.00		350	2.250	1.0	R	15.20	
4362	Elastase quantitative ELISA	2004.00		350	47.000	1.0	R	317.00	
4363	Stercobilinogen: Quantitative	2004.00		350	6.750	1.0	R	45.50	
4364	Chymotrypsin determination: Enzymatic	2004.00		350	7.470	1.0	R	50.40	
	Biochemical tests: Miscellaneous								
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	2004.00		350	5.000	1.0	R	33.70	
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	2004.00		350	20.000	1.0	R	134.90	
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	2004.00		350	20.000	1.0	R	134.90	
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	2004.00		350	30.000	1.0	R	202.40	

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4370	Drug level in biological fluid: Monoclonal immunological	2004.00		350	12.400	1.0	R	83.60	
4371	Amylase in exudate	2004.00		350	5.180	1.0	R	34.90	
4372	Fluoride in biological fluids and water	2004.00		350	15.620	1.0	R	105.40	
4373	Breast milk analysis	2004.00		350	6.750	1.0	R	45.50	
4374	Trace metals in biological fluid: Atomic absorption	2004.00		350	18.130	1.0	R	122.30	
4375	Calcium in fluid: Spectrophotometric	2004.00		350	3.620	1.0	R	24.40	
4376	Calcium in fluid: Atomic absorption	2004.00		350	7.250	1.0	R	48.90	
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	2004.11		350	21.880	1.0	R	147.60	
4380	Lecithin in amniotic fluid: L/S ratio	2004.00		350	27.000	1.0	R	182.10	
4382	Bilirubin in amniotic fluid: Spectrophotometric essay	2004.00		350	9.450	1.0	R	63.70	
4386	Oestrogen/Progesterone receptors: Fluorescent method	2004.00		350	20.700	1.0	R	139.60	
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique	2004.00		350	230.000	1.0	R	1 551.40	
4388	Gastric contents: Maximal stimulation test	2004.00		350	27.000	1.0	R	182.10	
4389	Gastric fluid: Total acid per specimen	2004.00		350	2.250	1.0	R	15.20	
4390	Foam test: Amniotic fluid	2004.00		350	3.150	1.0	R	21.20	
4391	Renal calculus: Chemistry	2004.00		350	5.400	1.0	R	36.40	
4392	Renal calculus: Crystallography	2004.00		350	16.250	1.0	R	109.60	
4393	Saliva: Potassium	2004.00		350	3.620	1.0	R	24.40	
4394	Saliva: Sodium	2004.00		350	3.620	1.0	R	24.40	
4395	Sweat: Sodium	2004.00		350	3.620	1.0	R	24.40	
4396	Sweat: Potassium	2004.00		350	3.620	1.0	R	24.40	
4397	Sweat: Chloride	2004.00		350	2.590	1.0	R	17.50	
4399	Sweat collection by Iontophoresis (excluding collection material)	2004.00		350	4.500	1.0	R	30.40	
4400	Tryptophane loading test	2004.00		350	22.050	1.0	R	148.70	
	Cerebrospinal fluid								
4401	Cell count	2004.00		350	3.450	1.0	R	23.30	
4407	Cell count, protein, glucose and chloride	2004.00		350	7.650	1.0	R	51.60	
4409	Chloride	2004.00		350	2.590	1.0	R	17.50	
4415	Potassium	2004.00		350	3.620	1.0	R	24.40	
4416	Sodium	2004.00		350	3.620	1.0	R	24.40	
4417	Protein: Qualitative	2004.00		350	0.900	1.0	R	6.07	
4419	Protein: Quantitative	2004.00		350	3.110	1.0	R	21.00	
4421	Glucose	2004.00		350	3.620	1.0	R	24.40	
4423	Urea	2004.00		350	3.620	1.0	R	24.40	
4425	Protein electrophoresis	2004.00		350	12.600	1.0	R	85.00	
	RNA/DNA based tests and andrology								
	RNA/DNA based tests and andrology: RNA/DNA based tests								
4430	Recombinant DNA technique	2004.00		350	25.000	1.0	R	168.60	
4431	Ribosomal RNA targeting for bacteriological identification	2004.00		350	35.000	1.0	R	236.10	
4432	Ribosomal RNA amplification for bacteriological identification	2004.00		350	75.000	1.0	R	505.90	
4433	Bacteriological DNA identification (LCR)	2004.00		350	25.000	1.0	R	168.60	
4434	Bacteriological DNA identification (PCR)	2004.00		350	75.000	1.0	R	505.90	
	RNA/DNA based tests and andrology: Andrology								
4435	Mixed antiglobulin reaction: Semen	2004.00		350	6.600	1.0	R	44.50	
4436	Friberg test: Semen	2004.00		350	14.500	1.0	R	97.80	

4437	Kremer test: Semen	2004.00		350	3.600	1.0	R	24.30	
4440	Semen analysis: Cell count	2004.00		350	7.650	1.0	R	51.60	
4441	Semen analysis: Cytology	2004.00		350	7.200	1.0	R	48.60	
4442	Semen analysis: Viability + motility - 6 hours	2004.00		350	6.000	1.0	R	40.50	
4443	Semen analysis: Supravital stain	2004.00		350	5.440	1.0	R	36.70	
4445	Seminal fluid: Alpha glucosidase	2004.00		350	20.000	1.0	R	134.90	
4446	Seminal fluid fructose	2004.00		350	3.150	1.0	R	21.20	
4447	Seminal fluid: Acid phosphatase	2004.00		350	5.180	1.0	R	34.90	
	Immunology								
4448	HCG: Latex agglutination: Qualitative (side room)	2004.00		350	4.000	1.0	R	27.00	
4449	HCG: Latex agglutination: Semi-quantitative (side room)	2004.00		350	9.310	1.0	R	62.80	
4450	HCG: Monoclonal immunological: Qualitative	2004.00		350	10.000	1.0	R	67.50	
4451	HCG: Monoclonal immunological: Quantitative	2004.00		350	12.400	1.0	R	83.60	
4455	Anti IgE receptor antibody test (10 samples and dilution)	2004.00		350	161.560	1.0	R	1 089.70	
4456	Eosinophil cationic protein	2004.00		350	27.810	1.0	R	187.60	
4457	Mast cell tryptase	2004.00		350	96.870	1.0	R	653.40	
4458	Micro-albuminuria: Radio-isotope method	2004.00		350	12.420	1.0	R	83.80	
4459	Acetyl choline receptor antibody	2004.00		350	158.120	1.0	R	1 066.50	
4460	CA-199 tumour marker	2004.00		350	20.000	1.0	R	134.90	
4462	CA-125 tumour marker	2004.00		350	20.000	1.0	R	134.90	
4463	C6 complement functional essay	2004.00		350	45.000	1.0	R	303.50	
4464	House dust mite antigen ELIZA	2004.00		350	20.310	1.0	R	137.00	
4466	Beta-2-microglobulin	2004.00		350	12.420	1.0	R	83.80	
4468	CA-549	2004.00		350	20.000	1.0	R	134.90	
4469	Tumour markers: Monoclonal immunological (each)	2004.00		350	20.000	1.0	R	134.90	
4470	CA-195 tumour marker	2004.00		350	20.000	1.0	R	134.90	
4471	Carcino-embryonic antigen	2004.00		350	20.000	1.0	R	134.90	
4472	MCA antigen tumour marker	2004.00		350	20.000	1.0	R	134.90	
4476	Neopterin	2004.00		350	20.000	1.0	R	134.90	
4477	Neuron specific enolase	2004.00		350	20.000	1.0	R	134.90	
4479	Vitamin B12-absorption: Shilling test	2004.00		350	11.700	1.0	R	78.90	
4480	Serotonin	2004.00		350	18.750	1.0	R	126.50	
4482	Free thyroxine (FT4)	2004.00		350	17.480	1.0	R	117.90	
4485	Insulin	2004.00		350	12.420	1.0	R	83.80	
4490	Releasing hormone response	2004.00		350	50.000	1.0	R	337.30	
4491	Vitamin B12	2004.00		350	12.420	1.0	R	83.80	
4492	Vitamin D3: Calcitroil (RIA)	2004.00		350	75.000	1.0	R	505.90	
4493	Drug concentration: Quantitative	2004.00		350	12.420	1.0	R	83.80	
4494	Free hormone assay	2004.00		350	17.480	1.0	R	117.90	
4495	Growth hormone	2004.00		350	12.420	1.0	R	83.80	
4496	Hormone concentration: Quantitative	2004.00		350	12.420	1.0	R	83.80	
4497	Carbohydrate deficient transferrin	2004.00		350	29.060	1.0	R	196.00	
4499	Cortisol	2004.00		350	12.420	1.0	R	83.80	
4500	DHEA sulphate	2004.00		350	12.420	1.0	R	83.80	
4501	Testosterone	2004.00		350	12.420	1.0	R	83.80	

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4502	Free testosterone	2004.00		350	17.480	1.0	R	117.90	
4503	Oestradiol	2004.00		350	12.420	1.0	R	83.80	
4505	Oestriol	2004.00		350	10.800	1.0	R	72.80	
4506	Multiple antigen specific IgE screening test for Atopy	2004.00		350	37.260	1.0	R	251.30	
4507	Thyrotropin (TSH)	2004.00		350	19.600	1.0	R	132.20	
4508	Combined antigen specific IgE	2004.00		350	24.480	1.0	R	165.10	
4509	Free tri-iodothyronine (FT3)	2004.00		350	17.480	1.0	R	117.90	
4512	Parathormone	2004.00		350	17.080	1.0	R	115.20	
4513	IgE: Total	2004.00		350	12.420	1.0	R	83.80	
4514	Antigen specific IgE	2004.00		350	12.420	1.0	R	83.80	
4515	Aldosterone	2004.00		350	12.420	1.0	R	83.80	
4516	Follitropin (FSH)	2004.00		350	12.420	1.0	R	83.80	
4517	Lutropin (LH)	2004.00		350	12.420	1.0	R	83.80	
4519	Prostate specific antigen	2004.00		350	14.490	1.0	R	97.70	
4520	17 Hydroxy progesterone	2004.00		350	12.420	1.0	R	83.80	
4521	Progesterone	2004.00		350	12.420	1.0	R	83.80	
4522	Alpha-feto protein	2004.00		350	12.420	1.0	R	83.80	
4523	ACTH	2004.00		350	21.740	1.0	R	146.60	
4526	Sex hormone binding globulin	2004.00		350	12.420	1.0	R	83.80	
4527	Gastrin	2004.00		350	12.420	1.0	R	83.80	
4528	Ferritin	2004.00		350	12.420	1.0	R	83.80	
4529	Anti-DNA antibodies	2004.00		350	12.420	1.0	R	83.80	
4530	Antiplatelet antibodies	2004.00		350	15.300	1.0	R	103.20	
4531	Hepatitis: Per antigen or antibody	2004.00		350	14.490	1.0	R	97.70	
4532	Transcobalamine	2004.00		350	12.420	1.0	R	83.80	
4533	Folic acid	2004.00		350	12.420	1.0	R	83.80	
4534	Prostatic acid phosphatase	2004.00		350	12.420	1.0	R	83.80	
4536	Erythrocyte folate	2004.00		350	17.480	1.0	R	117.90	
4537	Prolactin	2004.00		350	12.420	1.0	R	83.80	
4540	HCG: Quantitative as used for Down's screen	2004.00		350	15.000	1.0	R	101.20	
	Clinical pathology: Miscellaneous								
4544	Attendance in theatre	2004.00		350	27.000	1.0	R	182.10	
	Exfoliative cytology								
4561	Sputum, all body fluids and tumour aspirates: First unit	2004.00		351	13.400	1.0	R	104.20	
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	2004.00		351	7.800	1.0	R	60.70	
4564	Performance of fine-needle aspiration for cytology	2004.00		351	15.000	1.0	R	116.70	
4565	Examination of fine needle aspiration in theatre	2004.00		351	90.000	1.0	R	700.10	
4566	Vaginal or cervical smears, each	2004.00		351	11.000	1.0	R	85.60	
	Human Genetics								
	Cytogenitc								
4750	Cell culture: Lymphocytes, cord blood	2004.00		352	15.000	1.0	R	103.60	
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	2004.00		352	45.000	1.0	R	310.80	
4752	Cell culture: Chorionic villi	2004.00		352	60.000	1.0	R	414.40	
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	2004.00		352	135.000	1.0	R	932.40	

4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	2004.00		352	270.000	1.0	R 1 864.90	
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	2004.00		352	70.000	1.0	R 483.50	
4760	FISH procedure, including cell culture	2004.00		352	115.000	1.0	R 794.30	
4761	FISH analysis per probe system	2004.00		352	35.000	1.0	R 241.70	
	DNA-testing							
4763	Blood: DNA extraction	2004.00		352	45.000	1.0	R 310.80	
4764	Blood: Genotype per person: Southern blotting	2004.00		352	89.000	1.0	R 614.70	
4765	Blood: Genotype per person: PCR	2004.00		352	60.000	1.0	R 414.40	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	2004.00		352	90.000	1.0	R 621.60	
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	2004.00		352	188.000	1.0	R 1 298.50	
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	2004.00		352	120.000	1.0	R 828.80	

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Code	Description
37600	Medical Technology

Medical Technology 2008

Code	Description	RCF
350	Medical Technology - Clinical Pathology	6.745
351	Medical Technology - Cytology	7.779
352	Medical Technology - Genetics	6.907

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Mental Health Institutions 2008

				55500				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF MENTAL HEALTH CARE FACILITIES WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
C	All accounts submitted by mental health institutions shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	2004.00						
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	2004.00						
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00						
E.3.3	Mental Institutions refers to all institutions registered with the Department of Health in terms of the Mental Health Care Act 17 of 2002 having practice code numbers commencing with the digits 55.	2006.04						

Mental Health Institutions 2008

	Accommodation fees includes the services listed below: A.□The minimum services that are required are items 3, 5 and 6. B.□If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1□Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2□Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3□Notification of admission 4□Immediate notification of changes to: · length of stay · level of care · theatre procedures 5□Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6□Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. · Including coding of complications and co-morbidity. To be done as accurately as practically								
F		2004.00							
	SCHEDULE								
8	INSTITUTIONS REGISTERED IN TERMS OF THE MENTAL HEALTH ACT 1973 WITH A PRACTICE NUMBER COMMENCING WITH "55"								
004	General ward fee: with overnight stay	2004.00		470	10.000	1.0	R	838.60	
005	General ward fee: without overnight stay	2004.00		470	7.355	1.0	R	616.80	
006	General ward fee: under 5 hours stay	2004.00		470	3.808	1.0	R	319.40	
045	Ward and dispensary drugs. The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.	2005.03		470	-	1.0	R	-	
055	Electroconvulsive therapy (ECT) (No theatre fee chargeable)	2004.00		470	4.997	1.0	R	419.10	
231	Monitors	2006.04		470	1.463	1.0	R	122.70	Z

Mental Health Institutions 2008

273	To take out. Dispensed items including ampoules, over the counter and proprietary items issued to patients. All items must be shown on accounts. Dispensed items including ampoules, over the counter and proprietary items issued to patients. The same principles as in code 045 apply.	2004.00		470	-	1.0	R -		

Mental Health Institutions 2008

Code	Description
55500	Mental Health Institutions

Mental Health Institutions 2008

				55500				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF MENTAL HEALTH CARE FACILITIES WITH EFFECT FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00						
	GENERAL RULES							
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
C	All accounts submitted by mental health institutions shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	2004.00						
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	2004.00						
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00						
E.3.3	Mental Institutions refers to all institutions registered with the Department of Health in terms of the Mental Health Care Act 17 of 2002 having practice code numbers commencing with the digits 55.	2006.04						

	Accommodation fees includes the services listed below: A.□The minimum services that are required are items 3, 5 and 6. B.□If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1□Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2□Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3□Notification of admission 4□Immediate notification of changes to: · length of stay · level of care · theatre procedures 5□Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6□Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.								
F	· Including coding of complications and co-morbidity. To be done as accurately as practically	2004.00							
	SCHEDULE								
8	INSTITUTIONS REGISTERED IN TERMS OF THE MENTAL HEALTH ACT 1973 WITH A PRACTICE NUMBER COMMENCING WITH "55"								
004	General ward fee: with overnight stay	2004.00		470	10.000	1.0	R	838.60	
005	General ward fee: without overnight stay	2004.00		470	7.355	1.0	R	616.80	
006	General ward fee: under 5 hours stay	2004.00		470	3.808	1.0	R	319.40	
045	Ward and dispensary drugs. The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.	2005.03		470	-	1.0	R	-	
055	Electroconvulsive therapy (ECT) (No theatre fee chargeable)	2004.00		470	4.997	1.0	R	419.10	
231	Monitors	2006.04		470	1.463	1.0	R	122.70	Z

Mental Health Institutions 2008

273	To take out. Dispensed items including ampoules, over the counter and proprietary items issued to patients. All items must be shown on accounts. Dispensed items including ampoules, over the counter and proprietary items issued to patients. The same principles as in code 045 apply.	2004.00		470	-	1.0	R -		

Mental Health Institutions 2008

Code	Description
55500	Mental Health Institutions

Mental Health Institutions 2008

Code	Description	RCF
470	Mental Health Institutions	83.864

OPTOMETRISTS

Optometrists 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OPTOMETRISTS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individuel funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

RULES

MODIFIERS

ITEMS

Consultations:

Code	Description	Ver	Add	Optometry	
				RVU	Fee
11001	Optometric Examination (incl Tonometry)	06.02		30.000	195.90 (171.80)
11081	Optometric Examination & Visual Fields	06.02		35.000	228.60 (200.50)
11021	Optometric-Re-examination	06.02		20.000	130.60 (114.60)
11041	Consultation :15 min. without performing Optometric Exam.	06.02		15.000	98.00 (86.00)
Diagnostic Procedures:					
11303	Cycloplegic Refraction	06.02		15.000	98.00 (86.00)
11323	Preferential Looking (Infants < Two Years)	06.02		15.000	98.00 (86.00)
11346	Corneal Topography	06.02		20.000	130.60 (114.60)
11356	Gonioscopy	06.02		10.000	65.30 (57.30)
11366	Dilated Fundus Examination / BIO	06.02		10.000	65.30 (57.30)
11423	Visual Field	06.02		15.000	98.00 (86.00)
11443	Threshold Visual Fields	06.02		25.000	163.30 (143.20)
11246	Revaluation of Colour Vision	06.02		15.000	98.00 (86.00)
11265	Evaluation of Contrast Sensitivity	06.02		10.000	65.30 (57.30)
11283	Evaluation of Lacrimal System	06.02		10.000	65.30 (57.30)
11604	Photography of Anterior Segment	06.02		10.000	65.30 (57.30)
11624	Photography of Fundus	06.02		10.000	65.30 (57.30)
11644	Photographic Materials	06.02		-	-
Procedures done in isolation					
11141	Evaluation of Refractive Status	06.02		20.000	130.60 (114.60)
11161	Screening for Pathology	06.02		15.000	98.00 (86.00)
11183	Keratometry	06.02		10.000	65.30 (57.30)
11202	Tonometry (Non-contact)	06.02		10.000	65.30 (57.30)
11212	Tonometry (Aplanation)	06.02		10.000	65.30 (57.30)
11221	Screening of Colour Vision	06.02		5.000	32.70 (28.70)
11402	Screening of Visual Fields	06.02		10.000	65.30 (57.30)
12503	Assessment of CL Related Problems - Monocular	06.02		10.000	65.30 (57.30)
12523	Assessment of CL Related Problems - Binocular	06.02		15.000	98.00 (86.00)

Code	Description	Ver	Add	Optometry	
				RVU	Fee
12533	CL Instruction	06.02		15.000	98.00 (86.00)
Dispensing Fees					
11501	Dispensing Fee - Single Vision	06.02		5.000	32.70 (28.70)
11521	Dispensing Fee - Bifocals	06.02		10.000	65.30 (57.30)
11541	Dispensing Fee - Varifocals	06.02		10.000	65.30 (57.30)
11707	Night/Weekend/Public Holiday Visit	06.02		15.000	98.00 (86.00)
11729	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	06.02		-	-
11809	Screening School (per hour)	06.02		60.000	391.90 (343.80)
11829	Screening Industrial (per hour)	06.02		60.000	391.90 (343.80)
Contact Lens Procedures					
12012	Basic - per visit	06.02		30.000	195.90 (171.80)
12032	Complex - per visit	06.02		30.000	195.90 (171.80)
12052	Advanced - per visit	06.02		30.000	195.90 (171.80)
12072	CL Dispensing and/or Assessment	06.02		15.000	98.00 (86.00)
Binocular Vision/Orthoptics					
13003	Evaluation of Binocular Instability Simple Case	06.02		30.000	195.90 (171.80)
13023	Evaluation of Binocular Instability Complex Case	06.02		60.000	391.90 (343.80)
Visually Related Disorders					
13105	Evaluation of Visually Related Learning Disorders	06.02		90.000	587.80 (515.60)
13125	Evaluation of Eye Movements (e.g. Visigraph)	06.02		30.000	195.90 (171.80)
Colorimetry Codes					
13509	Screening - Rate of Reading Test	06.02		15.000	98.00 (86.00)
13529	Evaluation - Ortho-Didactical Reading Skills	06.02		45.000	293.90 (257.80)
13549	Evaluation - Intuitive Colorimetry	06.02		60.000	391.90 (343.80)
Visual Therapy/Orthoptics Training					
13403	Training Home Therapy Instruction	06.02		10.000	65.30 (57.30)
13423	Training Individual (per 15 minutes)	06.02		15.000	98.00 (86.00)
13445	Training Individual (per 30minutes)	06.02		30.000	195.90 (171.80)
13463	Training Group per Patient (per 15 minutes)	06.02		3.750	24.50 (21.50)
13489	Training Away from Practice	06.02		30.000	195.90 (171.80)
Low Vision Assessment & Training (per Half hour)					
16013	Simple LV Assessment	06.02		30.000	195.90 (171.80)
16033	Complex LV Assessment	06.02		30.000	195.90 (171.80)
16053	Advanced LV Assessment	06.02		30.000	195.90 (171.80)
16073	Simple LV Training	06.02		30.000	195.90 (171.80)
16093	Complex LV Training	06.02		30.000	195.90 (171.80)
16113	Advanced LV Training	06.02		30.000	195.90 (171.80)
Sports Vision - In Office Procedures					
14008	Screening Sports Vision Individual	06.02		20.000	130.60 (114.60)

Code	Description	Ver	Add	Optometry	
				RVU	Fee
14218	Evaluation Sports Vision Individual	06.02		45.000	293.90 (257.80)
14238	Training Sports Vision Individual (per 15 minutes)	06.02		15.000	98.00 (86.00)
	Group fees are per individual member of the group	06.02			
14268	Screening Sports Vision Group	06.02		3.750	24.50 (21.50)
14278	Evaluation Sports Vision Group	06.02		8.750	57.10 (50.10)
14288	Training Sports Vision Group (per 15 minutes)	06.02		3.750	24.50 (21.50)
Sports Vision - Procedures done in the Field					
14309	Screening Sports Vision Individual	06.02		30.000	195.90 (171.80)
14319	Evaluation Sports Vision Individual	06.02		60.000	391.90 (343.80)
14329	Training Sports Vision Individual (per 15 minutes)	06.02		15.000	98.00 (86.00)
	Group fees are per individual member of the group	06.02			
14369	Screening Sports Vision Group	06.02		6.250	40.80 (35.80)
14379	Evaluation Sports Vision Group	06.02		12.500	81.60 (71.60)
14389	Training Sports Vision Group (per 15 minutes)	06.02		3.750	24.50 (21.50)
Reports etc					
19001	Report at request of Medical Aid	06.02		15.000	98.00 (86.00)
19021	Report at Patient's request	06.02		25.000	163.30 (143.20)
19081	Confirming Med. Aid Benefit by tel. or fax (per 10 minutes)	06.02		5.000	32.70 (28.70)
Generic Lenses					
40501	Frames	06.02		-	-
70011	Single Vision lens (up to 6.00Sph)	06.02		2.374	176.90 (155.20)
70021	Special Vision High Powers	06.02		5.786	431.20 (378.20)
70712	Bifocal-Round/flat/top Seg 68*28 Seg	06.02		7.567	563.90 (494.60)
75012	Varifocal Distance to near	06.02		11.869	884.50 (775.90)
80011	Single Vision lens	06.02		2.374	176.90 (155.20)
80021	Special Vision High Powers	06.02		5.104	380.40 (333.70)
80812	Bifocal-Round/flat/top Seg 74*28 Seg	06.02		5.727	426.80 (374.40)
85012	Varifocal Distance to near	06.02		11.128	829.30 (727.50)
84000	Varifocal Intermediate to Near	06.05		11.128	829.30 (727.50)
99999	All other codes	06.02		-	-

Optometrists 2008

				37000					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OPTOMETRISTS EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF		Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2006.02							
	RULES								
	MODIFIERS								
	ITEMS								
	Consultations:								
11001	Optometric Examination (incl Tonometry)	2006.02		490	30.000	1.0	R	195.90	
11081	Optometric Examination & Visual Fields	2006.02		490	35.000	1.0	R	228.60	
11021	Optometric-Re-examination	2006.02		490	20.000	1.0	R	130.60	
11041	Consultation :15 min. without performing Optometric Exam.	2006.02		490	15.000	1.0	R	98.00	
	Diagnostic Procedures:								
11303	Cycloplegic Refraction	2006.02		490	15.000	1.0	R	98.00	
11323	Preferential Looking (Infants < Two Years)	2006.02		490	15.000	1.0	R	98.00	
11346	Corneal Topography	2006.02		490	20.000	1.0	R	130.60	
11356	Gonioscopy	2006.02		490	10.000	1.0	R	65.30	
11366	Dilated Fundus Examination / BIO	2006.02		490	10.000	1.0	R	65.30	
11423	Visual Field	2006.02		490	15.000	1.0	R	98.00	
11443	Threshold Visual Fields	2006.02		490	25.000	1.0	R	163.30	
11246	Revaluation of Colour Vision	2006.02		490	15.000	1.0	R	98.00	
11265	Evaluation of Contrast Sensitivity	2006.02		490	10.000	1.0	R	65.30	
11283	Evaluation of Lacrimal System	2006.02		490	10.000	1.0	R	65.30	
11604	Photography of Anterior Segment	2006.02		490	10.000	1.0	R	65.30	
11624	Photography of Fundus	2006.02		490	10.000	1.0	R	65.30	
11644	Photographic Materials	2006.02		490	-	1.0	R	-	
	Procedures done in isolation								
11141	Evaluation of Refractive Status	2006.02		490	20.000	1.0	R	130.60	
11161	Screening for Pathology	2006.02		490	15.000	1.0	R	98.00	
11183	Keratometry	2006.02		490	10.000	1.0	R	65.30	
11202	Tonometry (Non-contact)	2006.02		490	10.000	1.0	R	65.30	
11212	Tonometry (Aplanation)	2006.02		490	10.000	1.0	R	65.30	
11221	Screening of Colour Vision	2006.02		490	5.000	1.0	R	32.70	

Optometrists 2008

11402	Screening of Visual Fields	2006.02	490	10.000	1.0	R	65.30	
12503	Assessment of CL Related Problems - Monocular	2006.02	490	10.000	1.0	R	65.30	
12523	Assessment of CL Related Problems - Binocular	2006.02	490	15.000	1.0	R	98.00	
12533	CL Instruction	2006.02	490	15.000	1.0	R	98.00	
	Dispensing Fees							
11501	Dispensing Fee - Single Vision	2006.02	490	5.000	1.0	R	32.70	
11521	Dispensing Fee - Bifocals	2006.02	490	10.000	1.0	R	65.30	
11541	Dispensing Fee - Varifocals	2006.02	490	10.000	1.0	R	65.30	
11707	Night/Weekend/Public Holiday Visit	2006.02	490	15.000	1.0	R	98.00	
11729	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2006.02	490	-	1.0	R	-	
11809	Screening School (per hour)	2006.02	490	60.000	1.0	R	391.90	
11829	Screening Industrial (per hour)	2006.02	490	60.000	1.0	R	391.90	
	Contact Lens Procedures							
12012	Basic - per visit	2006.02	490	30.000	1.0	R	195.90	
12032	Complex - per visit	2006.02	490	30.000	1.0	R	195.90	
12052	Advanced - per visit	2006.02	490	30.000	1.0	R	195.90	
12072	CL Dispensing and/or Assessment	2006.02	490	15.000	1.0	R	98.00	
	Binocular Vision/Orthoptics							
13003	Evaluation of Binocular Instability Simple Case	2006.02	490	30.000	1.0	R	195.90	
13023	Evaluation of Binocular Instability Complex Case	2006.02	490	60.000	1.0	R	391.90	
	Visually Related Disorders							
13105	Evaluation of Visually Related Learning Disorders	2006.02	490	90.000	1.0	R	587.80	
13125	Evaluation of Eye Movements (e.g. Visigraph)	2006.02	490	30.000	1.0	R	195.90	
	Colorimetry Codes							
13509	Screening - Rate of Reading Test	2006.02	490	15.000	1.0	R	98.00	
13529	Evaluation - Ortho-Didactical Reading Skills	2006.02	490	45.000	1.0	R	293.90	
13549	Evaluation - Intuitive Colorimetry	2006.02	490	60.000	1.0	R	391.90	
	Visual Therapy/Orthoptics Training							
13403	Training Home Therapy Instruction	2006.02	490	10.000	1.0	R	65.30	
13423	Training Individual (per 15 minutes)	2006.02	490	15.000	1.0	R	98.00	
13445	Training Individual (per 30minutes)	2006.02	490	30.000	1.0	R	195.90	
13463	Training Group per Patient (per 15 minutes)	2006.02	490	3.750	1.0	R	24.50	
13489	Training Away from Practice	2006.02	490	30.000	1.0	R	195.90	
	Low Vision Assessment & Training (per Half hour)							
16013	Simple LV Assessment	2006.02	490	30.000	1.0	R	195.90	
16033	Complex LV Assessment	2006.02	490	30.000	1.0	R	195.90	
16053	Advanced LV Assessment	2006.02	490	30.000	1.0	R	195.90	
16073	Simple LV Training	2006.02	490	30.000	1.0	R	195.90	
16093	Complex LV Training	2006.02	490	30.000	1.0	R	195.90	
16113	Advanced LV Training	2006.02	490	30.000	1.0	R	195.90	
	Sports Vision - In Office Procedures							
14008	Screening Sports Vision Individual	2006.02	490	20.000	1.0	R	130.60	
14218	Evaluation Sports Vision Individual	2006.02	490	45.000	1.0	R	293.90	
14238	Training Sports Vision Individual (per 15 minutes)	2006.02	490	15.000	1.0	R	98.00	

Optometrists 2008

	Group fees are per individual member of the group	2006.02							
14268	Screening Sports Vision Group	2006.02		490	3.750	1.0	R	24.50	
14278	Evaluation Sports Vision Group	2006.02		490	8.750	1.0	R	57.10	
14288	Training Sports Vision Group (per 15 minutes)	2006.02		490	3.750	1.0	R	24.50	
	Sports Vision - Procedures done in the Field								
14309	Screening Sports Vision Individual	2006.02		490	30.000	1.0	R	195.90	
14319	Evaluation Sports Vision Individual	2006.02		490	60.000	1.0	R	391.90	
14329	Training Sports Vision Individual (per 15 minutes)	2006.02		490	15.000	1.0	R	98.00	
	Group fees are per individual member of the group	2006.02							
14369	Screening Sports Vision Group	2006.02		490	6.250	1.0	R	40.80	
14379	Evaluation Sports Vision Group	2006.02		490	12.500	1.0	R	81.60	
14389	Training Sports Vision Group (per 15 minutes)	2006.02		490	3.750	1.0	R	24.50	
	Reports etc								
19001	Report at request of Medical Aid	2006.02		490	15.000	1.0	R	98.00	
19021	Report at Patient's request	2006.02		490	25.000	1.0	R	163.30	
19081	Confirming Med. Aid Benefit by tel. or fax (per 10 minutes)	2006.02		490	5.000	1.0	R	32.70	
	Generic Lenses								
40501	Frames	2006.02		491	-	1.0	R	-	
70011	Single Vision lens (up to 6.00Sph)	2006.02		491	2.374	1.0	R	176.90	
70021	Special Vision High Powers	2006.02		491	5.786	1.0	R	431.20	
70712	Bifocal-Round/flat/top Seg 68*28 Seg	2006.02		491	7.567	1.0	R	563.90	
75012	Varifocal Distance to near	2006.02		491	11.869	1.0	R	884.50	
80011	Single Vision lens	2006.02		491	2.374	1.0	R	176.90	
80021	Special Vision High Powers	2006.02		491	5.104	1.0	R	380.40	
80812	Bifocal-Round/flat/top Seg 74*28 Seg	2006.02		491	5.727	1.0	R	426.80	
85012	Varifocal Distance to near	2006.02		491	11.128	1.0	R	829.30	
84000	Varifocal Intermediate to Near	2006.05		491	11.128	1.0	R	829.30	
99999	All other codes	2006.02		491	-	1.0	R	-	

Optometrists 2008

Code	Description
37000	Optometry

G07-094434—3

Optometrists 2008

Code	Description	RCF
490	Optometry	6.531
491	Optometry Goods	74.521

ORTHOPTIST

Orthoptists 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF ORTHOPTISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

ITEMS

Code	Description	Ver	Add	Orthoptists	
				RVU	Fee
001	Orthoptic consultation (Ocular motility assessment, comprehensive examination)	04.00		10.000	86.00 (75.40)
003	Orthoptic treatment (Ocular motility imbalance)	04.00		8.700	74.80 (65.60)
005	Orthoptic consultation (Hess chart)	04.00		11.100	95.50 (83.80)
007	Orthoptic visual fields charting or field of binocular single vision	04.00		21.700	186.70 (163.80)
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-

Orthoptists 2008

				37400				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF ORTHOPTISTS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	ITEMS							
001	Orthoptic consultation (Ocular motility assessment, comprehensive examination)	2004.00		330	10	1	86	
003	Orthoptic treatment (Ocular motility imbalance)	2004.00		330	8.7	1	74.8	
005	Orthoptic consultation (Hess chart)	2004.00		330	11.1	1	95.5	
007	Orthoptic visual fields charting or field of binocular single vision	2004.00		330	21.7	1	186.7	
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		330	0	0	0	

Orthoptists 2008

Code	Description
37400	Orthoptists

Orthoptists 2008

Code	Description	RCF
330	Orthoptists	8.602

OSTEOPATHY

Osteopathy 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OSTEOPATHS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

RULES

01	All accounts must be presented with the following information clearly stated: - name of osteopath - qualifications of the osteopath - BHF practice number - Postal address and telephone number - Date on which the service(s) were provided - Applicable item codes - The nature of the treatment - The surname and initials of the member - The first name of the patient - The name of the medical scheme - The membership number of the patient - The name and practice number of the referring practitioner	06.02
02	The fee of more than one procedure performed at the same consultation or visit, shall be the fee for the major procedure plus the fee in respect of each additional procedure, but under no circumstances will additional fees be charged for more than three additional procedures carried out in the treatment of any one condition.	06.02
03	After a series of 10 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.	06.02
04	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the correct NAPPI code is supplied on the account.	06.02

ITEMS

1. Consultation, Spinal or Joint Manipulation

Code	Description	Ver	Add
001	Initial consultation/manipulation (fee covering history, examination and treatment)	06.02	
	COIDS - Full case history, physical exam & use of diagnostic equipment, but excluding remedies, immobilisation, and manipulative procedure	06.02	
002	Subsequent manipulation/examination (fee covering subsequent examination and treatment / manipulation for the same condition)	06.02	
	COIDS - Subsequent consultation & examination not requiring treatment	06.02	
003	Consultation/examination where not treatment is required	06.02	
	COIDS - Spinal or extra-spinal joint manipulation ONLY.	06.02	

2. Modalities/Adjunctive Therapy

Soft Tissue Manipulation			
101	Massage	06.02	
103	Myofacial pain therapy	06.02	
Deep Heating Radiation			
111	Short wave diathermy	06.02	
113	Microwave diathermy	06.02	
Superficial Heating Therapy			
121	Hydrocollator/Ice pack - Hot or cold packs	06.02	
123	Infra-red	06.02	
125	Ultra-violet	06.02	
127	Parrafin bath/wax unit	06.02	
129	Whirlpool/Hubbard tank immersion	06.02	
131	Fluidotherapy	06.02	
133	Sitz bath	06.02	
Non-heating Modalities			
141	Galvanism/Faradic & Sine wave	06.02	
143	Low voltage galvanic iontophoresis	06.02	
145	Ultrasound	06.02	
147	Combined ultrasound & electric stimulation	06.02	
149	Inteferential	06.02	
151	Vacutron/Vasopneumatic devices	06.02	
153	Vacutron plus inteferential	06.02	

Code	Description	Ver	Add
155	Vibration therapy	06.02	
157	High voltage pulse direct current	06.02	
159	Electro-Stim 180	06.02	
161	TENS	06.02	
163	Micro current modalities	06.02	
165	Traction: Mechanical/Static, etc.	06.02	
167	Laser therapy	06.02	
Cold Applications			
171	Cryomatic/Cryotherapy	06.02	
173	Cold packs	06.02	
Therapeutic Exercise			
187	Proprioceptive neuromuscular facilitation	06.02	
189	Gait training	06.02	
191	Prosthetic fitting and training	06.02	
Immobilisation			
201	Hard and soft immobilisation	06.02	
203	Supportive strapping, bracing, splinting and taping	06.02	
205	Supportive devices	06.02	

Osteopathy 2008

Code	Description	Practice Type	2007
001	Initial consultation/manipulation (fee covering history, examination and treatment)	Osteopathy	0.000
002	Subsequent manipulation/examination (fee covering subsequent examination and treatment / manipulation for the same condition)	Osteopathy	0.000
003	Consultation/examination where not treatment is required	Osteopathy	0.000
101	Massage	Osteopathy	0.000
103	Myofacial pain therapy	Osteopathy	0.000
111	Short wave diathermy	Osteopathy	0.000
113	Microwave diathermy	Osteopathy	0.000
121	Hydrocollator/Ice pack - Hot or cold packs	Osteopathy	0.000
123	Infra-red	Osteopathy	0.000
125	Ultra-violet	Osteopathy	0.000
127	Parrafin bath/wax unit	Osteopathy	0.000
129	Whirlpool/Hubbard tank immersion	Osteopathy	0.000
131	Fluidotherapy	Osteopathy	0.000
133	Sitz bath	Osteopathy	0.000
141	Galvanism/Faradic & Sine wave	Osteopathy	0.000
143	Low voltage galvanic iontophoresis	Osteopathy	0.000
145	Ultrasound	Osteopathy	0.000
147	Combined ultrasound & electric stimulation	Osteopathy	0.000
149	Inteferential	Osteopathy	0.000
151	Vacutron/Vasopneumatic devices	Osteopathy	0.000
153	Vacutron plus inteferential	Osteopathy	0.000
155	Vibration therapy	Osteopathy	0.000
157	High voltage pulse direct current	Osteopathy	0.000
159	Electro-Stim 180	Osteopathy	0.000
161	TENS	Osteopathy	0.000
163	Micro current modalities	Osteopathy	0.000
165	Traction: Mechanical/Static, etc.	Osteopathy	0.000
167	Laser therapy	Osteopathy	0.000
171	Cryomatic/Cryotherapy	Osteopathy	0.000
173	Cold packs	Osteopathy	0.000
187	Proprioceptive neuromuscular facilitation	Osteopathy	0.000
189	Gait training	Osteopathy	0.000
191	Prosthetic fitting and training	Osteopathy	0.000
201	Hard and soft immobilisation	Osteopathy	0.000
203	Supportive strapping, bracing, splinting and taping	Osteopathy	0.000
205	Supportive devices	Osteopathy	0.000

	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OSTEOPATHS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2006.02		
	RULES			
01	All accounts must be presented with the following information clearly stated: - name of osteopath - qualifications of the osteopath - BHF practice number - Postal address and telephone number - Date on which the service(s) were provided - Applicable item codes - The nature of the treatment - The surname and initials of the member - The first name of the patient - The name of the medical scheme - The membership number of the patient - The name and practice number of the referring practitioner	2006.02		
02	The fee of more than one procedure performed at the same consultation or visit, shall be the fee for the major procedure plus the fee in respect of each additional procedure, but under no circumstances will additional fees be charged for more than three additional procedures carried out in the treatment of any one condition.	2006.02		
03	After a series of 10 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.	2006.02		
04	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the correct NAPPI code is supplied on the account.	2006.02		
	ITEMS			
1.	Consultation, Spinal or Joint Manipulation			
001	Initial consultation/manipulation (fee covering history, examination and treatment)	2006.02		

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Osteopathy 2008

	COIDS - Full case history, physical exam & use of diagnostic equipment, but excluding remedies, immobilisation, and manipulative procedure	2006.02		
002	Subsequent manipulation/examination (fee covering subsequent examination and treatment / manipulation for the same condition)	2006.02		
	COIDS - Subsequent consultation & examination not requiring treatment	2006.02		
003	Consultation/examination where not treatment is required	2006.02		
	COIDS - Spinal or extra-spinal joint manipulation ONLY.	2006.02		
2.	Modalities/Adjunctive Therapy			
	Soft Tissue Manipulation			
101	Massage	2006.02		
103	Myofacial pain therapy	2006.02		
	Deep Heating Radiation			
111	Short wave diathermy	2006.02		
113	Microwave diathermy	2006.02		
	Superficial Heating Therapy			
121	Hydrocollator/Ice pack - Hot or cold packs	2006.02		
123	Infra-red	2006.02		
125	Ultra-violet	2006.02		
127	Parrafin bath/wax unit	2006.02		
129	Whirlpool/Hubbard tank immersion	2006.02		
131	Fluidotherapy	2006.02		
133	Sitz bath	2006.02		
	Non-heating Modalities			
141	Galvanism/Faradic & Sine wave	2006.02		
143	Low voltage galvanic iontophoresis	2006.02		
145	Ultrasound	2006.02		
147	Combined ultrasound & electric stimulation	2006.02		

149	Inteferential	2006.02		
151	Vacutron/Vasopneumatic devices	2006.02		
153	Vacutron plus Inteferential	2006.02		
155	Vibration therapy	2006.02		
157	High voltage pulse direct current	2006.02		
159	Electro-Stim 180	2006.02		
161	TENS	2006.02		
163	Micro current modalities	2006.02		
165	Traction: Mechanical/Static, etc.	2006.02		
167	Laser therapy	2006.02		
	Cold Applications			
171	Cryomatic/Cryotherapy	2006.02		
173	Cold packs	2006.02		
	Therapeutic Exercise			
187	Proprioceptive neuromuscular facilitation	2006.02		
189	Gait training	2006.02		
191	Prosthetic fitting and training	2006.02		
	Immobilisation			
201	Hard and soft immobilisation	2006.02		
203	Supportive strapping, bracing, splinting and taping	2006.02		
205	Supportive devices	2006.02		

PHYSICAL REHABILITATION

Physical Rehabilitation Hospitals 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF REHABILITATION HOSPITALS WITH A PRACTICE NUMBER COMMENCING WITH "59" WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES		
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
B.1	Procedure for the classification of hospitals:	04.00
B.1.1	Inspections of sub-acute facilities, private hospitals, rehabilitation hospitals or sub-acute facilities having practice code numbers commencing with the digits 059 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	04.00
C	All accounts submitted by rehabilitation hospitals shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	04.00
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	04.00
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	04.00
F	Accommodation fees includes the services listed below: A. The minimum services that are required are items 3, 5 and 6. B. If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1 Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2 Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3 Notification of admission 4 Immediate notification of changes to: · length of stay · level of care · theatre procedures 5 Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6 Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. · Including coding of complications and co-morbidity. To be done as accurately as practically possible by the hospital. 7 Case management by means of standard documentation and liaison between scheme and hospital appointed case managers · Liaison means communication and sharing of information between case managers, but does not include active case management by the hospital.	04.00
SCHEDULE		
7	**GLOBAL FEE FOR REHABILITATION WITH A PRACTICE NUMBER COMMENCING WITH "59"**	
	The following rehabilitation categories will be treated in recognised and accredited rehabilitation hospitals: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replacements), Amputation (lower extremity), Cardiac, Pulmonary, Major multiple trauma. Other neurological or orthopaedic impairments will require specific letters of motivation.	04.00
	This section is only applicable to facilities registered as Physical Rehabilitation Hospitals and not Sub-acute facilities.	04.00

Rehabilitation					
Code	Description	Ver	Add	Physical Rehabilitation Hospitals	
				RVU	Fee

Code	Description	Ver	Add	Physical Rehabilitation Hospitals	
				RVU	Fee
100	Out patients, 3 hours per day (maximum 18 days)	04.00		10.000	409.90 (359.60)
101	Out patients, 6 hours per day (maximum 18 days)	04.00		21.103	865.00 (758.80)
105	General care (maximum 27 days)	04.00		42.013	1722.10 (1510.60)
107	High care (maximum 36 days)	04.00		49.522	2029.90 (1780.60)
109	Rehabilitation ICU (maximum 7 days)	04.00		89.005	3648.30 (3200.30)

Physical Rehabilitation Hospitals 2008

				65900				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF REHABILITATION HOSPITALS WITH A PRACTICE NUMBER COMMENCING WITH "59" WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
B.1	Procedure for the classification of hospitals:	2004.00						
B.1.1	Inspections of sub-acute facilities, private hospitals, rehabilitation hospitals or sub-acute facilities having practice code numbers commencing with the digits 059 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	2004.00						
C	All accounts submitted by rehabilitation hospitals shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	2004.00						
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	2004.00						
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00						

F	Accommodation fees includes the services listed below: A.□The minimum services that are required are items 3, 5 and 6. B.□If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1□Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2□Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3□Notification of admission 4□Immediate notification of changes to: · length of stay · level of care · theatre procedures 5□Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6□Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. · Including coding of complications and co-morbidity. To be done as accurately as practically	2004.00						
	SCHEDULE							
7	GLOBAL FEE FOR REHABILITATION WITH A PRACTICE NUMBER COMMENCING WITH							
	The following rehabilitation categories will be treated in recognised and accredited rehabilitation hospitals: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replacements), Amputation (lower extremity), Cardiac, Pulmonary, Major multiple trauma. Other neurological or orthopaedic impairments will require specific letters of motivation.	2004.00						
	This section is only applicable to facilities registered as Physical Rehabilitation Hospitals and not Sub-acute facilities.	2004.00						
	Rehabilitation							
100	Out patients, 3 hours per day (maximum 18 days)	2004.00		530	10.000	1.0	R 409.90	
101	Out patients, 6 hours per day (maximum 18 days)	2004.00		530	21.103	1.0	R 865.00	
105	General care (maximum 27 days)	2004.00		530	42.013	1.0	R 1 722.10	

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Physical Rehabilitation Hospitals 2008

107	High care (maximum 36 days)	2004.00		530	49.522	1.0	R 2 029.90	
109	Rehabilitation ICU (maximum 7 days)	2004.00		530	89.005	1.0	R 3 648.30	

Physical Rehabilitation Hospitals 2008

Code	Description
55900	Physical Rehabilitation Hospitals

Physical Rehabilitation Hospitals 2008

Code	Description	RCF
530	Physical Rehabilitation Hospitals	40.990

PHYSIOTHERAPY

Physiotherapy 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF PHYSIOTHERAPISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)

SCHEDULE

General rules governing the scale of benefits

001	Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged, but shall not be payable by medical schemes. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. Modifier 0001 to be quoted	04.00
002	In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee as may be agreed upon between the practitioner and the scheme may be charged	04.00
003	Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant rate will be applicable. Modifier 0003 must be quoted when this rule is applied	04.00
004	In the case of prolonged or costly treatment, the practitioner should first ascertain from the scheme concerned whether it will accept financial responsibility in respect of such treatment, since the member may be subject to maximum annual benefits	04.00
005	After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment	04.00
006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	04.00
007	Practitioners are reminded that a lower fee than that appearing in the scale of benefits shall be charged if the customary fee in the area is less than that charged. Reduced fees shall also be charged where the practitioner would have reduced his/her fee in private practice in particular cases. Prolonged treatment or exceptional cases should also receive special consideration in accordance with the usual medical practice	04.00
008	The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.	05.05
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.	04.00
011	Every physiotherapist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner (where applicable). · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The practice code number end name of practitioner · The nature and cost of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
012	NB: Rounding off does not apply to amounts occurring once the modifiers are used.	04.00

Code	Description	Ver	Add	Physiotherapy	
				RVU	Fee
013	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the AA-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable. Please note that although only some medical schemes accept responsibility for the payment of transport expenses, others do so in exceptional cases only.				04.00
014	Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.				04.00
016	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.				04.00
Modifiers					
0001	Appointment not kept				04.00
0003	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner				04.00
0006	Add 50% of the total fee for the treatment				04.00
0008	Only 50% of the fee for these additional procedures may be charged				04.00
0009	The full fee for the additional condition may be charged				04.00
0010	Only 50% of the fee for the second condition may be charged				04.00
0013	Travelling costs (being more than 16 kilometres in total) according to AA-rate. Please note that although only some medical schemes accept responsibility for the payment of transport expenses, others do so in exceptional cases only.				04.00
0014	Physiotherapy services rendered to an in-patient in a nursing home or hospital.				04.00
1	**RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY**				
Code	**Description**	**Ver**	**Add**	**Physiotherapy**	
				RVU	**Fee**
001	Infra-red, Radiant heat, Wax therapy Hot packs	04.00		5.000	26.70 (23.40)
005	Ultraviolet light	04.00		10.000	53.30 (46.80)
006	Laser beam	04.00		15.000	80.00 (70.20)
007	Cryotherapy	04.00		5.000	26.70 (23.40)
2	**LOW FREQUENCY CURRENTS**				
103	Galvanism, Diodynamic current, Tens.	04.00		10.000	53.30 (46.80)
105	Muscle and nerve stimulating currents.	04.00		12.000	64.00 (56.10)
107	Interferential Therapy.	04.00		10.000	53.30 (46.80)
3	**HIGH FREQUENCY CURRENTS**				
201	Shortwave diathermy.	04.00		5.000	26.70 (23.40)
203	Ultrasound.	04.00		10.000	53.30 (46.80)
205	Microwave.	04.00		5.000	26.70 (23.40)
4	**PHYSICAL MODALITIES**				
300	Vibration	04.00		10.000	53.30 (46.80)
301	Percussion	04.00		16.100	85.80 (75.30)
302	Massage	04.00		10.000	53.30 (46.80)
303	Myofacial release/soft tissue mobilisation, one or more body parts	04.00		20.090	107.10 (93.90)
304	Acupuncture	04.00		15.000	80.00 (70.20)
305	Re-education of movement/Exercises (excluding ante- and post-natal exercises)	04.00		10.000	53.30 (46.80)
307	Pre- and post-operative exercises and/or breathing exercises	04.00		10.000	53.30 (46.80)
308	Group exercises (excluding ante- and post-natal exercises - maximum of 10 in a group)	04.00		10.000	53.30 (46.80)
309	Isokinetic treatment.	04.00		10.000	53.30 (46.80)
310	Neural tissue mobilisation	04.00		20.000	106.60 (93.50)
313	Ante and post natal exercises/counselling	04.00		10.000	53.30 (46.80)
314	Lymph drainage	04.00		5.000	26.70 (23.40)
315	Postural drainage.	04.00		10.000	53.30 (46.80)

Code	Description	Ver	Add	Physiotherapy	
				RVU	Fee
317	Traction.	04.00		10.000	53.30 (46.80)
318	Upper respiratory nebulisation and/or lavage	04.00		10.000	53.30 (46.80)
319	Nebulisation	04.00		10.000	53.30 (46.80)
321	Intermittent positive pressure ventilation.	04.00		10.000	53.30 (46.80)
323	Suction: Level 1 (including sputum specimen taken by suction)	04.00		5.000	26.70 (23.40)
325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	04.00		20.090	107.10 (93.90)
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	04.00		5.000	26.70 (23.40)
328	Dry needling	04.00		15.000	80.00 (70.20)
5	**MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION**				
401	Spinal.	04.00		15.000	80.00 (70.20)
402	Pre meditated manipulation	04.00		10.000	53.30 (46.80)
405	All other joints.	04.00		15.000	80.00 (70.20)
407	Immobilisation (excluding materials). Rule 008 does not apply.	04.00		15.000	80.00 (70.20)
6	**REHABILITATION**				
501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	04.00		25.000	133.30 (116.90)
502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	04.00		25.000	133.30 (116.90)
503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min.	04.00		55.000	293.20 (257.20)
504	EMG Biofeedback treatment	04.00		15.000	80.00 (70.20)
505	Group rehabilitation. Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision, without individual attention for the whole treatment session, no charge may be levied by facility	05.05		12.000	64.00 (56.10)
506	Stress management	04.00		20.000	106.60 (93.50)
507	Respiratory Re-education and Training. Duration: 30min.	04.00		15.000	80.00 (70.20)
509	Rehabilitation. Each additional full 15 mins. Where the pathology requires the undivided attention of the physiotherapist. (Rule 0008 does not apply.) Can only be used with codes 501, 502, 507 or 503 to indicate the completion of an additional 15 minutes. A maximum of two instances of this code may be charged per session.	06.02		15.000	80.00 (70.20)
7	**EVALUATION**				
701	Evaluation/counselling at the first visit only (to be fully documented)	04.00		15.000	80.00 (70.20)
702	Complex evaluation/counselling at the first visit only (to be fully documented).	04.00		30.000	159.90 (140.30)
703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per episode of care.	04.00		15.000	80.00 (70.20)
704	Lung function: Peak flow (once per treatment).	04.00		5.000	26.70 (23.40)
705	Computerised/Electronic test for lung pathology	04.00		15.000	80.00 (70.20)
706	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required by the medical scheme.	05.03		15.000	80.00 (70.20)
707	Physical Performance test. Must be fully documented.	04.00		20.000	106.60 (93.50)
708	Interview, guidance or consultation with the patient or his family. To be used only once per episode of care.	05.02		15.000	80.00 (70.20)
801	Electrical test for diagnostic purposes (including IT curve and Isokinetic tests) for a specific medical condition	04.00		35.000	186.60 (163.70)
803	Effort test - multistage treadmill.	04.00		35.000	186.60 (163.70)
8	**VISITING CODES**				
901	Treatment at a nursing home : Relevant fee plus (to be charged only once per day and not with every hospital visit	04.00		10.000	53.30 (46.80)

Code	Description	Ver	Add	Physiotherapy	
				RVU	Fee
903	Domicilliary treatments : Relevant fee plus.	04.00		20.000	106.60 (93.50)
10	OTHER				
117	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	04.00		10.000	53.30 (46.80)
938	Bird or equivalent freestanding nebuliser excluding oxygen domicilliary per day.	04.00		10.000	53.30 (46.80)
939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	04.00		-	-
940	Cost of appliances: Items to be charged (exclusive of VAT) at net acquisition price plus- 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	04.00		-	-
941	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.	04.00			
	Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. By prior arrangement with the medical scheme.	05.03			

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				37200				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF PHYSIOTHERAPISTS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)							
	SCHEDULE							
	General rules governing the scale of benefits							
001	Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged, but shall not be payable by medical schemes. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. Modifier 0001 to be quoted	2004.00						
002	In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee as may be agreed upon between the practitioner and the scheme may be charged	2004.00						
003	Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant rate will be applicable. Modifier 0003 must be quoted when this rule is applied	2004.00						
004	In the case of prolonged or costly treatment, the practitioner should first ascertain from the scheme concerned whether it will accept financial responsibility in respect of such treatment, since the member may be subject to maximum annual benefits	2004.00						
005	After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment	2004.00						

006	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	2004.00						
007	Practitioners are reminded that a lower fee than that appearing in the scale of benefits shall be charged if the customary fee in the area is less than that charged. Reduced fees shall also be charged where the practitioner would have reduced his/her fee in private practice in particular cases. Prolonged treatment or exceptional casee should also receive special consideration in accordance with the usual medical practice	2004.00						
008	The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.	2005.05						
009	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.	2004.00						
010	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.	2004.00						

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011	Every physiotherapist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner (where applicable). · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The practice code number and name of practitioner · The nature and cost of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2004.00						
012	NB: Rounding off does not apply to amounts occurring once the modifiers are used.	2004.00						
013	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the AA-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable. Please note that although only some medical schemes accept responsibility for the payment of transport expenses, others do so in exceptional cases only.	2004.00						
014	Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.	2004.00						
016	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
	Modifiers							
0001	Appointment not kept	2004.00						
0003	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner	2004.00						
0006	Add 50% of the total fee for the treatment	2004.00						
0008	Only 50% of the fee for these additional procedures may be charged	2004.00						
0009	The full fee for the additional condition may be charged	2004.00						
0010	Only 50% of the fee for the second condition may be charged	2004.00						
0013	Travelling costs (being more than 16 kilometres in total) according to AA-rate. Please note that although only some medical schemes accept responsibility for the payment of transport expenses, others do so in exceptional cases only.	2004.00						

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0014	Physiotherapy services rendered to an in-patient in a nursing home or hospital.	2004.00							
1	RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY								
001	Infra-red, Radiant heat, Wax therapy Hot packs	2004.00		260	5.000	1.0	R	26.70	
005	Ultraviolet light	2004.00		260	10.000	1.0	R	53.30	
006	Laser beam	2004.00		260	15.000	1.0	R	80.00	
007	Cryotherapy	2004.00		260	5.000	1.0	R	26.70	
2	LOW FREQUENCY CURRENTS								
103	Galvanism, Diodynamic current, Tens.	2004.00		260	10.000	1.0	R	53.30	
105	Muscle and nerve stimulating currents.	2004.00		260	12.000	1.0	R	64.00	
107	Interferential Therapy.	2004.00		260	10.000	1.0	R	53.30	
3	HIGH FREQUENCY CURRENTS								
201	Shortwave diathermy.	2004.00		260	5.000	1.0	R	26.70	
203	Ultrasound.	2004.00		260	10.000	1.0	R	53.30	
205	Microwave.	2004.00		260	5.000	1.0	R	26.70	
4	PHYSICAL MODALITIES								
300	Vibration	2004.00		260	10.000	1.0	R	53.30	
301	Percussion	2004.00		260	16.100	1.0	R	85.80	
302	Massage	2004.00		260	10.000	1.0	R	53.30	
303	Myofacial release/soft tissue mobilisation, one or more body parts	2004.00		260	20.090	1.0	R	107.10	
304	Acupuncture	2004.00		260	15.000	1.0	R	80.00	
305	Re-education of movement/Exercises (excluding ante- and post-natal exercises)	2004.00		260	10.000	1.0	R	53.30	
307	Pre- and post-operative exercises and/or breathing exercises	2004.00		260	10.000	1.0	R	53.30	
308	Group exercises (excluding ante- and post-natal exercises - maximum of 10 in a group)	2004.00		260	10.000	1.0	R	53.30	
309	Isokinetic treatment.	2004.00		260	10.000	1.0	R	53.30	

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310	Neural tissue mobilisation	2004.00		260	20.000	1.0	R	106.60	
313	Ante and post natal exercises/counselling	2004.00		260	10.000	1.0	R	53.30	
314	Lymph drainage	2004.00		260	5.000	1.0	R	26.70	
315	Postural drainage.	2004.00		260	10.000	1.0	R	53.30	
317	Traction.	2004.00		260	10.000	1.0	R	53.30	
318	Upper respiratory nebulisation and/or lavage	2004.00		260	10.000	1.0	R	53.30	
319	Nebulisation	2004.00		260	10.000	1.0	R	53.30	
321	Intermittent positive pressure ventilation.	2004.00		260	10.000	1.0	R	53.30	
323	Suction: Level 1 (including sputum specimen taken by suction)	2004.00		260	5.000	1.0	R	26.70	
325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	2004.00		260	20.090	1.0	R	107.10	
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	2004.00		260	5.000	1.0	R	26.70	
328	Dry needling	2004.00		260	15.000	1.0	R	80.00	
5	MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION								
401	Spinal.	2004.00		260	15.000	1.0	R	80.00	
402	Pre meditated manipulation	2004.00		260	10.000	1.0	R	53.30	
405	All other joints.	2004.00		260	15.000	1.0	R	80.00	
407	Immobilisation (excluding materials). Rule 008 does not apply.	2004.00		260	15.000	1.0	R	80.00	
6	REHABILITATION								
501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	2004.00		260	25.000	1.0	R	133.30	
502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	2004.00		260	25.000	1.0	R	133.30	
503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min.	2004.00		260	55.000	1.0	R	293.20	
504	EMG Biofeedback treatment	2004.00		260	15.000	1.0	R	80.00	

505	Group rehabilitation. Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision, without individual attention for the whole treatment session, no charge may be levied by facility	2005.05		260	12.000	1.0	R	64.00	
506	Stress management	2004.00		260	20.000	1.0	R	106.60	
507	Respiratory Re-education and Training. Duration: 30min.	2004.00		260	15.000	1.0	R	80.00	
509	Rehabilitation. Each additional full 15 mins. Where the pathology requires the undivided attention of the physiotherapist. (Rule 0008 does not apply.) Can only be used with codes 501, 502, 507 or 503 to indicate the completion of an additional 15 minutes. A maximum of two instances of this code may be charged per session.	2006.02		260	15.000	1.0	R	80.00	
7	EVALUATION								
701	Evaluation/counselling at the first visit only (to be fully documented)	2004.00		260	15.000	1.0	R	80.00	
702	Complex evaluation/counselling at the first visit only (to be fully documented).	2004.00		260	30.000	1.0	R	159.90	
703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per episode of care.	2004.00		260	15.000	1.0	R	80.00	
704	Lung function: Peak flow (once per treatment).	2004.00		260	5.000	1.0	R	26.70	
705	Computerised/Electronic test for lung pathology	2004.00		260	15.000	1.0	R	80.00	
706	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required by the medical scheme.	2005.03		260	15.000	1.0	R	80.00	
707	Physical Performance test. Must be fully documented.	2004.00		260	20.000	1.0	R	106.60	
708	Interview, guidance or consultation with the patient or his family. To be used only once per episode of care.	2005.02		260	15.000	1.0	R	80.00	
801	Electrical test for diagnostic purposes (including IT curve and isokinetic tests) for a specific medical condition	2004.00		260	35.000	1.0	R	186.60	
803	Effort test - multistage treadmill.	2004.00		260	35.000	1.0	R	186.60	
8	VISITING CODES								
901	Treatment at a nursing home : Relevant fee plus (to be charged only once per day and not with every hospital visit	2004.00		260	10.000	1.0	R	53.30	
903	Domiciliary treatments : Relevant fee plus.	2004.00		260	20.000	1.0	R	106.60	
10	OTHER								
117	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		260	-	1.0	R	-	
937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	2004.00		260	10.000	1.0	R	53.30	
938	Bird or equivalent freestanding nebuliser excluding oxygen domiciliary per day.	2004.00		260	10.000	1.0	R	53.30	

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939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	2004.00		260	-	1.0	R -	
940	Cost of appliances: Items to be charged (exclusive of VAT) at net acquisition price plus- 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.	2004.00		260	-	0.0	R -	
941	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.	2004.00						
	Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. By prior arrangement with the medical scheme.	2005.03						

Physiotherapy 2008

Code	Description
37200	Physiotherapy

Physiotherapy 2008

Code	Description
37200	Physiotherapy

Physiotherapy 2008

Code	Description	RCF
260	Physiotherapists	5.331

Phytotherapy 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PHYTOTHERAPISTS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

RULES

ITEMS

Consultations

Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or preparation of medicines.

Code	Description	Ver	Add	Phytotherapy	
				RVU	Fee
130	Consultation (initial or follow up). Duration 1 - 15 mins	06.04		7.500	35.90 (31.50)
131	Consultation (initial or follow up). Duration 16 - 30 mins	06.04		22.500	107.60 (94.40)
132	Consultation (initial or follow up). Duration 31 - 45 mins	06.04		37.500	179.30 (157.30)
133	Consultation (initial or follow up). Duration 46 - 60 mins	06.04		52.500	251.00 (220.20)
134	Consultation, each additional full 15 mins, to a maximum of 60 mins	06.04		15.000	71.70 (62.90)

Preparation and Dispensing of Medicaments

Medicaments

	The amount charged in respect of proprietary medicines shall be at net acquisition price. In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	06.04

310	Tinctures, per 10 ml	06.02		2.700	2.99 (2.62)
320	Tea mixes, per 10g	06.02		1.000	1.11 (0.97)
330	Capsules/tablets, per capsule	06.02		3.400	3.76 (3.30)
340	Creams/Ointments, per 10ml	06.02		20.100	22.20 (19.50)
350	Syrups, per 10ml	06.02		2.800	3.10 (2.72)
360	Medicinal oils, per 10ml	06.02		1.300	1.44 (1.26)
390	Proprietary materials	06.02		-	-
395	Proprietary medicines	06.02		-	-

Phytotherapy 2008

				41300				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PHYTOTHERAPISTS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2006.02						
	RULES							
	ITEMS							
	Consultations							
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or preparation of medicines.	2006.04						
130	Consultation (initial or follow up). Duration 1 - 15 mins	2006.04		510	7.500	1.0	R 35.90	
131	Consultation (initial or follow up). Duration 16 - 30 mins	2006.04		510	22.500	1.0	R 107.60	
132	Consultation (initial or follow up). Duration 31 - 45 mins	2006.04		510	37.500	1.0	R 179.30	
133	Consultation (initial or follow up). Duration 46 - 60 mins	2006.04		510	52.500	1.0	R 251.00	
134	Consultation, each additional full 15 mins, to a maximum of 60 mins	2006.04		510	15.000	1.0	R 71.70	
	Preparation and Dispensing of Medicaments							
	Medicaments							
	The amount charged in respect of proprietary medicines shall be at net acquisition price.□ □ In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus -□ □ * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and□ □ * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	2006.04						
310	Tinctures, per 10 ml	2006.02		520	2.700	1.0	R 2.99	

Phytotherapy 2008

Code	Description
41300	Phytotherapy

Phytotherapy 2008

Code	Description	RCF
510	Phytotherapy	4.781
520	Phytotherapy materials	1.106

Phytotherapy 2008

320	Tea mixes, per 10g	2006.02		520	1.000	1.0	R	1.11	
330	Capsules/tablets, per capsule	2006.02		520	3.400	1.0	R	3.76	
340	Creams/Ointments, per 10ml	2006.02		520	20.100	1.0	R	22.20	
350	Syrups, per 10ml	2006.02		520	2.800	1.0	R	3.10	
360	Medicinal oils, per 10ml	2006.02		520	1.300	1.0	R	1.44	
390	Proprietary materials	2006.02		520	-	1.0	R	-	
395	Proprietary medicines	2006.02		520	-	1.0	R	-	

PODIATRY

Podiatry 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PODIATRISTS, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

General Rules		
A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; and . the name and practice number of the referring practitioner, if applicable.	05.03
B	The rate in respect of more than one procedure performed at the same consultation or visit, shall be the full rate for the major procedure plus half the rate in respect of each additional procedure carried out in the treatment of any one condition.	04.00
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
D	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	05.03
Modifiers		
0002	For procedures 021 to 031 carried out in a day clinic or unattached operating theatre unit, the rate shall be reduced to two-thirds.	04.00
0004	Consultation or treatment in a nursing facility/hospital	04.00
0006	Consultation or treatment at the patient's recidence	04.00
ITEMS		
	Modifier 0004 must be quoted for consultation or treatment rendered in a nursing home or hospital.	04.00
	Modifier 0006 must be quoted for consultations or treatment rendered at the patient's residence.	04.00

CONSULTATIONS.

Code	Description	Ver	Add	Podiatry RVU	Podiatry Fee
301	Consultation (initial or follow up) 5-10 minutes	06.04		7.500	60.70 (53.20)
302	Consultation (initial or follow up) 11-20 minutes	06.03		15.000	121.50 (106.60)
303	Consultation (initial or follow up) 21-30 minutes	06.03		25.000	202.50 (177.60)
304	Consultation (initial or follow up) 31-45 minutes	06.03		37.500	303.70 (266.40)
006	More than one patient seen at a residence (See note below).	06.02		8.500	62.20 (54.60)
	NOTE : This code is a blanket code for home visits away from the practitioners rooms where more than one but up to and including six patients are treated. The code may be used again if seven to twelve patients are seen.	06.02			
101	Appointments not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
INJECTIONS.					
009	Administration of injection, per administration	04.00		1.300	9.52 (8.35)
ROUTINE TREATMENTS.					
010	General podiatric care up to 15 minutes including the following: Trim nails, Debride and cut dystrophic nails; one to five, Evacuation of sub-ungual haematoma, Paring or cutting of benign hyperkeratotic lesion; single lesion, Drain paronychia; one nail and Nail spike removal; single	04.00		3.900	28.50 (25.00)

Code	Description	Ver	Add	Podiatry	
				RVU	Fee
011	General podiatric care (30 minutes) including the following: Debride and cut dystrophic nails: six or more, Nail spike removal; two to four, Paring or cutting of benign hyperkeratotic lesion; two to four lesions, Paring or cutting of benign hyperkeratotic lesion; more than four lesions, Reduction of heel fissures, Enucleation of interdigital corns; more than two	04.00		7.800	57.10 (50.10)
012	Extended care for chronic disease management or ulcer management (applicable to diabetes, arthritis and peripheral vascular diseases)	04.00		7.400	54.20 (47.50)
013	General podiatric care more than 30 minutes (a combination of items 010 and 011)	04.00		11.800	86.40 (75.80)
VERRUCA TREATMENTS.					
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation				04.00
014	Verruca Pedis (Chemotherapy first lesion) (consultation and treatment).	04.00		5.900	43.20 (37.90)
015	Subsequent lesion.	04.00		2.900	21.20 (18.60)
016	Cryotherapy first lesion (consultation and treatment).	04.00		7.800	57.10 (50.10)
017	Subsequent lesion.	04.00		3.900	28.50 (25.00)
018	Diathermy first lesion (consultation and treatment).	04.00		6.900	50.50 (44.30)
019	Subsequent lesion.	04.00		3.500	25.60 (22.50)
Nail Surgery.					
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation				04.00
021	Nail wedge resection with matrix phenolisation : one nail - one side (including consultation).	04.00		19.600	143.50 (125.90)
022	Two nails - one side.	04.00		25.500	186.70 (163.80)
024	Two nails - both sides.	04.00		36.400	266.40 (233.70)
023	One nail - two sides (including consultation).	04.00		25.500	186.70 (163.80)
025	Avulsion with matrix phenolisation (including consultation).	04.00		19.600	143.50 (125.90)
031	Avulsion without matrix phenolisation (including consultation).	04.00		12.800	93.70 (82.20)
Other.					
040	Infection control, per patient	04.00		1.200	8.78 (7.70)
041	Remedial therapy.	04.00		4.900	35.90 (31.50)
042	Sterile pack.	06.03		5.900	43.20 (37.90)
044	Suturing (includes consultation).	04.00		7.800	57.10 (50.10)
046	Incision Biopsy.	04.00		5.900	43.20 (37.90)
047	Removal of foreign body.	04.00		8.900	65.10 (57.10)
048	Suturing / Wound closure material : Cost of material plus 10%	06.03		-	-
146	Excision biopsy.	04.00		8.900	65.10 (57.10)
201	Sterile Surgical Blades (maximum of 2 per patient)	06.03		1.000	7.32 (6.42)
203	Wound dressing material (maximum of 2 per patient)	06.03		2.000	14.60 (12.80)
205	Plaster of Paris bandage roll (maximum of 2 per patient). At net acquisition price.	06.03		-	-
207	Moulded Orthotic material fee	06.03		11.800	86.40 (75.80)
209	Simple insole material fee	06.03		5.900	43.20 (37.90)
211	Local anaesthetic medication per ampoule (maximum of 5 per patient)	06.03		2.000	14.60 (12.80)
213	Injection medication fee (other than local anaesthetic). At net acquisition price.	06.03		-	-
	Items 215, 217 or 219 may be used for corrective or supportive strapping or padding placed into footwear. The area of the foot must be specified.	04.00			
215	Padding and strapping : Digital, per foot	04.00		2.800	20.50 (18.00)
217	Padding and strapping: Metatarsal, per foot	04.00		3.500	25.60 (22.50)

Code	Description	Ver	Add	Podiatry	
				RVU	Fee
219	Padding and strapping: Heel, per foot	04.00		3.500	25.60 (22.50)
Appliances and Orthotics					
	(By arrangement with the scheme concerned).				04.00
043	Biomechanical examination.	04.00		15.700	114.90 (100.80)
051	Neutral impression Plaster of Paris casting	04.00		8.500	62.20 (54.60)
052	Orthotic repair.	04.00		12.800	93.70 (82.20)
053	Temporary orthotic or corrective component.	04.00		12.800	93.70 (82.20)
054	Prescription covering and soft tissue supplements.	04.00		8.900	65.10 (57.10)
055	Silicone devices: Digital	04.00		5.400	39.50 (34.60)
056	Computerised gait analysis	06.02		19.600	143.50 (125.90)
057	Template measurement.	04.00		2.900	21.20 (18.60)
058	Immobilisation casting	06.04		10.600	77.60 (68.10)
059	Simple insole - one foot.	04.00		11.100	81.30 (71.30)
061	Simple insoles - both feet.	04.00		20.100	147.10 (129.00)
060	Silicone devices: metatarsal	04.00		10.700	78.30 (68.70)
064	Silicone devices: heel	04.00		15.900	116.40 (102.10)
	The rates for items 063 and 065 include the cost of instrinsic and extrinsic posting adjustments	04.00			
063	Prescription orthotic : one foot.	04.00		19.100	139.80 (122.60)
065	Prescription orthotics : both feet.	04.00		38.300	280.40 (246.00)
067	Preformed moulded insoles: Adult, both feet	04.00		22.100	161.80 (141.90)
069	Preformed moulded insoles: Adult, one foot	04.00		11.000	80.50 (70.60)
071	Preformed moulded insoles: Child, both feet	04.00		17.000	124.40 (109.10)
073	Preformed moulded insoles: Child, one foot	04.00		8.500	62.20 (54.60)

Code	Description	Ver	Add	Podiatry	
				RVU	Fee
CONSUMABLE LIST					
	STERILISING ITEMS Cold Sterilant e.g. Cidex, Steri 101, Etc. Ultraviolet Tubes (Replacements) Autoclave Bags WASTE DISPOSAL Sharps Container Medical Waste Bin REGULARLY USED ITEMS Disposable Hand Towels e.g. Kimdri Disinfecting Handwash e.g. Hibiscrub Linen Savers Cotton Wool Gloves: Non-Sterile Sterile Gauze: Non-Sterile Sterile Tube Gauze (Various Sizes) Padding e.g. Semi Compressed Felt Strapping e.g. Hapla, Zopla Disinfecting Hand Gel e.g. Steri 601 Surface Disinfectant e.g. Steri 201 Tongue Depressors Applicator Sticks Friars Balsam Silver Nitrate? Hibitane Concentrate Phenol Silicone & Activator for Devices Monochloracetic Acid Salacylic Acid in Lanolin Dental Needles Xylotox Se Plain Solution for Injection Emergency Drugs e.g. Adrenaline/Epipen Penrose Drains / Tournicot Hydrogen Peroxide 70% Alcohol Hibicol Acetone Sterile Blades (Various Sizes) Moores Discs Sterile Dressing Trays Sutures Single Use Sterile Syringes				04.00

Podiatry 2008

				36800				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PODIATRISTS, EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	General Rules							
A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; and . the name and practice number of the referring practitioner, if applicable.	2005.03						
B	The rate in respect of more than one procedure performed at the same consultation or visit, shall be the full rate for the major procedure plus half the rate in respect of each additional procedure carried out in the treatment of any one condition.	2004.00						
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						

D	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	2005.03						
	Modifiers							
0002	For procedures 021 to 031 carried out in a day clinic or unattached operating theatre unit, the rate shall be reduced to two-thirds.	2004.00						
0004	Consultation or treatment in a nursing facility/hospital	2004.00						
0006	Consultation or treatment at the patient's residence	2004.00						
	ITEMS							
	Modifier 0004 must be quoted for consultation or treatment rendered in a nursing home or hospital.	2004.00						
	Modifier 0006 must be quoted for consultations or treatment rendered at the patient's residence.	2004.00						
	CONSULTATIONS.							
301	Consultation (initial or follow up) 5-10 minutes	2006.04		274	7.5	1	60.7	
302	Consultation (initial or follow up) 11-20 minutes	2006.03		274	15	1	121.5	
303	Consultation (initial or follow up) 21-30 minutes	2006.03		274	25	1	202.5	
304	Consultation (initial or follow up) 31-45 minutes	2006.03		274	37.5	1	303.7	
006	More than one patient seen at a residence (See note below).	2006.02		270	8.5	1	62.2	
	NOTE : This code is a blanket code for home visits away from the practitioners rooms where more than one but up to and including six patients are treated. The code may be used again if seven to twelve patients are seen.	2006.02						
101	Appointments not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		270	0	0	0	
	INJECTIONS.							
009	Administration of injection, per administration	2004.00		270	1.3	1	9.52	
	ROUTINE TREATMENTS.							

Podiatry 2008

010	General podiatric care up to 15 minutes including the following: Trim nails, Debride and cut dystrophic nails; one to five, Evacuation of sub-ungual haematoma, Paring or cutting of benign hyperkeratotic lesion; single lesion, Drain paronychia; one nail and Nail spike removal; single	2004.00		270	3.9	1	28.5	
011	General podiatric care (30 minutes) including the following: Debride and cut dystrophic nails: six or more, Nail spike removal; two to four, Paring or cutting of benign hyperkeratotic lesion; two to four lesions, Paring or cutting of benign hyperkeratotic lesion; more than four lesions, Reduction of heel fissures, Enucleation of interdigital corns; more than two	2004.00		270	7.8	1	57.1	
012	Extended care for chronic disease management or ulcer management (applicable to diabetes, arthritis and peripheral vascular diseases)	2004.00		270	7.4	1	54.2	
013	General podiatric care more than 30 minutes (a combination of items 010 and 011)	2004.00		270	11.8	1	86.4	
	VERRUCA TREATMENTS.							
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation	2004.00						
014	Verruca Pedis (Chemotherapy first lesion) (consultation and treatment).	2004.00		270	5.9	1	43.2	
015	Subsequent lesion.	2004.00		270	2.9	1	21.2	
016	Cryotherapy first lesion (consultation and treatment).	2004.00		270	7.8	1	57.1	
017	Subsequent lesion.	2004.00		270	3.9	1	28.5	
018	Diathermy first lesion (consultation and treatment).	2004.00		270	6.9	1	50.5	
019	Subsequent lesion.	2004.00		270	3.5	1	25.6	
	Nail Surgery.							
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation	2004.00						
021	Nail wedge resection with matrix phenolisation : one nail - one side (including consultation).	2004.00		270	19.6	1	143.5	
022	Two nails - one side.	2004.00		270	25.5	1	186.7	
024	Two nails - both sides.	2004.00		270	36.4	1	266.4	
023	One nail - two sides (including consultation).	2004.00		270	25.5	1	186.7	
025	Avulsion with matrix phenolisation (including consultation).	2004.00		270	19.6	1	143.5	
031	Avulsion without matrix phenolisation (including consultation).	2004.00		270	12.8	1	93.7	
	Other.							

Podiatry 2008

040	Infection control, per patient	2004.00		270	1.2	1	8.78	
041	Remedial therapy.	2004.00		270	4.9	1	35.9	
042	Sterile pack.	2006.03		270	5.9	1	43.2	
044	Suturing (includes consultation).	2004.00		270	7.8	1	57.1	
046	Incision Biopsy.	2004.00		270	5.9	1	43.2	
047	Removal of foreign body.	2004.00		270	8.9	1	65.1	
048	Suturing / Wound closure material : Cost of material plus 10%	2006.03		270	0	0	0	
146	Excision biopsy.	2004.00		270	8.9	1	65.1	
201	Sterile Surgical Blades (maximum of 2 per patient)	2006.03		270	1	1	7.32	
203	Wound dressing material (maximum of 2 per patient)	2006.03		270	2	1	14.6	
205	Plaster of Paris bandage roll (maximum of 2 per patient). At net acquisition price.	2006.03		270	0	0	0	
207	Moulded Orthotic material fee	2006.03		270	11.8	1	86.4	
209	Simple insole material fee	2006.03		270	5.9	1	43.2	
211	Local anaesthetic medication per ampoule (maximum of 5 per patient)	2006.03		270	2	1	14.6	
213	Injection medication fee (other than local anaesthetic). At net acquisition price.	2006.03		270	0	0	0	
	Items 215, 217 or 219 may be used for corrective or supportive strapping or padding placed into footwear. The area of the foot must be specified.	2004.00						
215	Padding and strapping : Digital, per foot	2004.00		270	2.8	1	20.5	
217	Padding and strapping: Metatarsal, per foot	2004.00		270	3.5	1	25.6	
219	Padding and strapping: Heel, per foot	2004.00		270	3.5	1	25.6	
	Appliances and Orthotics							
	(By arrangement with the scheme concerned).	2004.00						
043	Biomechanical examination.	2004.00		270	15.7	1	114.9	
051	Neutral impression Plaster of Paris casting	2004.00		270	8.5	1	62.2	

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052	Orthotic repair.	2004.00		270	12.8	1	93.7	
053	Temporary orthotic or corrective component.	2004.00		270	12.8	1	93.7	
054	Prescription covering and soft tissue supplements.	2004.00		270	8.9	1	65.1	
055	Silicone devices: Digital	2004.00		270	5.4	1	39.5	
056	Computerised gait analysis	2006.02		270	19.6	1	143.5	
057	Template measurement.	2004.00		270	2.9	1	21.2	
058	Immobilisation casting	2006.04		270	10.6	1	77.6	
059	Simple insole - one foot.	2004.00		270	11.1	1	81.3	
061	Simple insoles - both feet.	2004.00		270	20.1	1	147.1	
060	Silicone devices: metatarsal	2004.00		270	10.7	1	78.3	
064	Silicone devices: heel	2004.00		270	15.9	1	116.4	
	The rates for items 063 and 065 include the cost of instrinsic and extrinsic posting adjustments	2004.00						
063	Prescription orthotic : one foot.	2004.00		270	19.1	1	139.8	
065	Prescription orthotics : both feet.	2004.00		270	38.3	1	280.4	
067	Preformed moulded insoles: Adult, both feet	2004.00		270	22.1	1	161.8	
069	Preformed moulded insoles: Adult, one foot	2004.00		270	11	1	80.5	
071	Preformed moulded insoles: Child, both feet	2004.00		270	17	1	124.4	
073	Preformed moulded insoles: Child, one foot	2004.00		270	8.5	1	62.2	
	CONSUMABLE LIST							

	STERILISING ITEMS□	2004.0						
	Cold Sterilant e.g. Cidex, Steri 101, Etc.□	0						
	Ultraviolet Tubes (Replacements)□							
	Autoclave Bags□							
	□							
	WASTE DISPOSAL□							
	Sharps Container□							
	Medical Waste Bin□							
	□							
	REGULARLY USED ITEMS□							
	Disposable Hand Towels e.g. Kimdri□							
	Disinfecting Handwash e.g. Hibiscrub□							
	Linen Savers□							
	Cotton Wool□							
	Gloves:□Non-Sterile□							
	□□Sterile□							
	Gauze:□Non-Sterile□							
	□□Sterile□							
	Tube Gauze (Various Sizes)□							
	Padding e.g. Semi Compressed Felt□							
	Strapping e.g. Hapla, Zopla□							
	Disinfecting Hand Gel e.g. Steri 601□							
	Surface Disinfectant e.g. Steri 201□							
	Tongue Depressors□							
	Applicator Sticks□							
	Friars Balsam□							
	Silver Nitrate?□							
	Hibitane Concentrate□							
	Phenol□							
	Silicone & Activator for Devices□							
	Monochloracetic Acid□							
	Salacylic Acid in Lanolin□							
	Dental Needles□							
	Xylotox Se Plain Solution for Injection□							
	Emergency Drugs e.g. Adrenaline/Epipen□							
	Penrose Drains / Tournicot□							

Podiatry 2008

Code	Description
36800	Podiatry

Podiatry 2008

Code	Description	RCF
270	Podiatry	7.320
274	Podiatry - Time-based	8.098

PRIVATE HOSPITALS

Private Hospitals 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE HOSPITALS (PRACTICE NUMBERS "57" OR "58") AND UNATTACHED OPERATING THEATRE UNITS/DAY CLINICS (PRACTICE NUMBER "77") WITH EFFECT FROM 1 JANUARY 2008		
The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well. In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.		
GENERAL RULES		
SCHEDULE		
B	The charges relating to each type of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.	04.00
C	The charges indicated in Section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.	04.00
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
E.1	Procedure for the classification of hospitals:	04.00
E.1.1	Inspections private hospitals or unattached operating theatre units/day clinics having practice code numbers commencing with the digits 057, 058 or 077 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	04.00
E.3.2	The provisions referred to in E.1.1 shall apply mutatis mutandis to all approved specialised intensive care units, specialised theatres, catheterisation laboratories and trauma unit.	04.00
F.1	Procedures to consider applications by institutions to be classified as unattached operating theatre units having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units with 76 practice numbers.	04.00
F.1.1	Inspections of new unattached theatre operating units and units having practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units having practice numbers commencing with the digits 77 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	04.00
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	04.00
H	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the hospital/unattached operating theatre unit concerned.	04.00
I	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	04.00

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
1	**ACCOMMODATION**								
Ward fees									
	Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts. In the case of hospitals, the day admission fee (code 007) shall be charged in respect of all patients admitted as day patients and discharged before 23h00 on the same date. The following will be applicable to items 001 to 005, 015, 020, 200, 201, 202 and 215 to 218: On the day of admission: If accommodation is less than 12 hours from time of admission : half the daily rate If accommodation is more than 12 hours from time of admission: full daily rate Two half day fees would be applicable when a patient is transferred internally between any ward and any specialised unit. On day of discharge: If accommodation is less than 12 hours: half the daily rate If accommodation is more than 12 hours: full daily rate The items listed as non-recoverable in Annuxure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.								04.00
1.1	**General Wards**								
Code	**Description**	**Ver**	**Add**	**Private Hospitals ('A' - Status)**		**Private Hospitals ('B' - Status)**		**Approved U O T U / Day clinics**	
				RVU	Fee	RVU	Fee	RVU	Fee
001	Surgical cases: per day.	04.00		36.063	1003.80 (880.50)	36.063	1003.80 (880.50)	-	-
002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	04.00		37.888	1054.70 (925.20)	37.888	1054.70 (925.20)	-	-
003	Psychiatric general ward fee, per day	04.00		29.854	831.00 (728.90)	29.854	831.00 (728.90)	-	-
004	Medical and neurological cases: per day.	04.00		36.063	1003.80 (880.50)	36.063	1003.80 (880.50)	-	-
005	Paediatric cases (under 14 years of age)	04.00		44.513	1239.10 (1086.90)	44.513	1239.10 (1086.90)	-	-
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day	04.00							
007	Day admission (irrespective of type of ward patient is admitted to, i.e. general, neurosurgical or paediatric) which includes all patients discharged by 23h00 on date of admission	04.00		23.079	642.40 (563.50)	23.079	642.40 (563.50)	19.725	549.10 (481.70)
014	Overnight fee - Medical practitioner to pre-authorise all overnight admissions	04.00		-	-	-	-	8.692	242.00 (212.30)
019	Out-patients facility fee for ambulatory admission - chargeable for patients admitted for local anaesthetic procedures - No ward fees applicable. Note: Each account should be accompanied by a report from the practitioner indicating the nature of the complication. Definition: Item 019 may only be used in conjunction with item 071 for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335	04.00		10.679	297.30 (260.80)	10.679	297.30 (260.80)	10.679	297.30 (260.80)
022	Out-patient wound care facility	04.00		5.263	146.50 (128.50)	5.263	146.50 (128.50)	5.263	146.50 (128.50)

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
Maternity									
	1. The maternity fees are a fixed per diem fee and replace all other charges: INCLUDING: Charges such as multiple births (nursery fee for 2nd baby excluded); After-hour deliveries (including caesareans); Labour ward or other ward fees, nursery fees; Incubators; Phototherapy; Theatre and equipment fees; and Surgical items (see list under point 8). But EXCLUDE Sections 5.1 to 5.3; Sections 5.7 to 5.8 (Gases); and 1. The costs of special treatment of newly born infants, e.g. circumcision certified as necessary by the attending practitioner, which shall be dealt with in accordance with the National Reference Price List for private hospitals and the rules of the relevant scheme pertaining to such dependants. 2. If an epidural anaesthetic is given for either a vaginal delivery or a caesarean section, an additional fee (item 011) may be charged. This comprises of an epidural pack, all consumables used, as well as nursing time. 3. An uncomplicated stay in a nursery for routine observation is included in the maternity fee, as well as phototherapy and routine high care observation after delivery for the new born baby. 4. A neonate requiring specialised treatment in a ward, high care or ICU shall be considered to be a patient in its own right and, for that reason, the National Reference Price List shall be applied to such neonate and an account may be rendered on a fee for service basis. In such cases, the fixed fee per day remains applicable until the mother is discharged, but the amount of item 015, per day must be deducted from the fixed fee (comprising the nursery fee component). 5. If the mother is admitted into high care or ICU, the full account is rendered on a fee for service basis, as this is clearly not an uncomplicated delivery. The codes for the nursery fee (item 015) and the delivery room (item 016) must be used to cover these specific services. 6. The first day fee includes the cost of admitting the mother, `prepping' and `staging' etc, admission into the delivery room, the delivery and post natal period up until midnight. This includes any cost incurred during the early stages of an uncomplicated delivery, even if prolonged labour occurs. The second day is calculated as starting from midnight following the birth of the neonate on the day of the delivery. If however, the mother needs admission for stabilisation or treatment of a medical condition such as diabetes, pre-eclampsia or urinary tract infection, such an admission falls outside the scope of the maternity fixed fee. An account will then be rendered on a fee for service basis, until such time that the baby is delivered. If delivery itself is uncomplicated, then the first day (fixed) fee will be chargeable on the date of delivery, and second and subsequent days until the mother is discharged. If however, the mother is admitted to ICU or high care the full account must be rendered on a fee for service basis. If the baby needs admission - see (4). 7. Admission for suppression of premature labour is not an uncomplicated delivery, and an account must be rendered on a fee for service basis. 8. The following list of surgicals (maternity basket) are included in the per diem fee. THEATRE SURGICALS FOR NORMAL VAGINAL DELIVERIES								04.00

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	THEATRE CHARGES 1 X Amnihook 1 X Continue Flo 1 X Cord Clamp 3 X Gloves Surgical St 8 X Gloves Sterile 4 X I D Bands 0.5 X Jaques Catheter 1 X Jelco IV 1 X KY Jelly Sachet 20 X Maternity Pad 5 X Preptic Swabs 1 X Spiral Electrode 1 X Spinocan 1 X Suction Catheter St 1 X Swabbing Tray 1 X Tegaderm 1626 1 X Vaginal Plug 2 X Water for Irrigation 1 X Stockinette 2 X Silicone Tubing 1 X Add a Line SUTURES 0.25 X Suture W734 0.25 X Suture W758 0.25 X Suture W727 0.25 X Suture W734 0.25 X Suture W758 0.25 X Suture W770 0.25 X Suture W759 0.25 X Suture W441 SYRINGES 1 X Syringe 1ml 1 X Syringe 20ml 3 X Syringe 2ml 2 X Syringe 5ml DRESSINGS 2 X Cotton Wool Balls L/s								
	THEATRE SURGICALS FOR CAESARS WITH GENERAL ANAESTHETIC THEATRE CHARGES 1 X Amnihook 1 X Airway 1 X Sterile Tray 2 X Continue Flo 1 X Cord Clamp 1 X Diathermy Plate Dispo 1 X ET Tube 3 X Electrodes Red Dot 1 X Foley catheter								

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	8 X Gloves Surgical St								
	5 X Gloves Sterile								
	4 X I D Bands								
	1 X Jelco IV								
	2 X KY Jelly Sachet								
	20 X Maternity Pad								
	10 X Preptic Swabs								
	1 X Sheet _								
	1 X Spiral Electrode								
	1 X Spinocan								
	1 X Suction Catheter St								
	1 X Swabbing Tray								
	1.2 X Tegaderm 1626								
	1 X Urine Drn Bag								
	1 X Vent Pump Set								
	1 X Yankuer Suction								
	6 X Water for irrigation								
	1 X Stockinette								
	2 X Silicone Tubing								
	2 X Opticlude								
	1 X Add a Line								
	SUTURES								
	0.06 X Suture W441								
	0.30 X Suture 8623G								
	0.11 Suture W791								
	0.30 X Suture W9999								
	2.20 X Suture W493								
	0.17 X Suture W795								
	0.17 X Suture W797								
	0.30 X Suture W439								
	0.17 X Suture W434								
	0.17 X Suture W445								
	1 X Suture W728								
	1 X Suture V518G								
	1 X Suture V486G								
	0.20 X Suture V523G								
	0.30 X Suture V523G								
	SYRINGES								
	1 X Syringe 1ml								
	1 X Syringe 20ml								
	1 X Syringe 10ml								
	8 X Syringe 2ml								
	2 X Syringe 5ml								
	DRAIN								
	1 X Corrugated Drain								
	DRESSINGS								
	15 X Abominal Swabs								
	3 X Cotton Wool Balls L/s								
	5 X Gauze Sterile Xray								
	1 X Telfa Dressing								

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	1 X Steripad 1 X Tegaderm 1627 5 X Paint Balls								
Natural births									
009	First day (Day of confinement).	04.00		174.458	4856.20 (4259.80)	174.458	4856.20 (4259.80)	-	-
010	Subsequent day(s).Per day	04.00		60.096	1672.80 (1467.40)	60.096	1672.80 (1467.40)	-	-
017	Subsequent day(s) excluding nursery fee.	04.00		43.717	1216.90 (1067.50)	43.717	1216.90 (1067.50)	-	-
Caesarean									
012	First day (Day of confinement).	04.00		270.992	7543.30 (6616.90)	270.992	7543.30 (6616.90)	-	-
013	Subsequent day(s). Per day	04.00		59.583	1658.60 (1454.90)	59.583	1658.60 (1454.90)	-	-
	Note: The following fees (items 015 and 016) are included in the above per diem fees, and may only be charged on a fee for service account	04.00							
015	Nursery fee.	04.00		16.925	471.10 (413.20)	16.925	471.10 (413.20)	-	-
016	Delivery room. This item is not applicable for deliveries by registered midwifes in private practice.	05.03		72.746	2025.00 (1776.30)	72.746	2025.00 (1776.30)	-	-
018	Subsequent day(s) excluding nursery fee	04.00		42.963	1195.90 (1049.00)	42.963	1195.90 (1049.00)	-	-
Epidural fee									
011	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	04.00		26.500	737.70 (647.10)	26.500	737.70 (647.10)	-	-
Birthing Unit									
	The birthing unit fee may only be charged by an approved maternity unit in a hospital. It includes preparation, labour room, recovery ward fee for mother and baby and the maternity basket. The only additional charge that may be levied is for pharmaceuticals. This fee may not be charged for together with the per diem fees for maternity and is not applicable to medical practitioners or other professions.								05.03
030	Global fee for a Birthing Unit (Accredited or Approved by BHF). This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient is discharged within 12 hours from birth.	05.03		109.004	3034.20 (2661.60)	109.004	3034.20 (2661.60)	-	-
031	Global fee for a Birthing Unit (Accredited or Approved by BHF) This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient stay exceed 12 hours and is discharged within 24 hours from birth.	05.03		169.100	4707.10 (4129.00)	169.100	4707.10 (4129.00)	-	-
032	Additional Birthing Unit fee chargeable for every additional 12 hours of patient stay beyond the 24 hours contemplated in code 031	05.03		30.026	835.80 (733.20)	30.026	835.80 (733.20)	-	-
1.2	**Private Wards**								
020	Private ward Hospitals shall obtain a certificate motivating for the necessity for accommodation in a private ward, including reversed barrier nursing, from the attendant practitioner, and such certificate shall be forwarded to the relevant scheme for pre-authorisation. General ward fees are applicable to isolation.	04.00		46.608	1297.40 (1138.10)	46.608	1297.40 (1138.10)	-	-
021	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	04.00		-	-	-	-	-	-

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
1.3	**Special Care Units**								
	Specialised units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), Neonatal Intensive Care Unit (NICU), High Care (HC), Neonatal High Care (NHC), A & B.								04.00
	Hospitals shall obtain a certificate stating the reason for accommodation in any specialised or other intensive care unit or in high care ward including neonatal intensive care and high care from the attending practitioner, and such certificate showing the date and time of admission and discharge from the unit shall be forwarded to the relevant medical scheme for pre-authorisation. No charge may be levied to medical schemes for special or private nursing. Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF.								04.00
200	Specialised ICU (As approved by BHF according to General Rule E.1.1) Per day	04.00		195.088	5430.50 (4763.60)	195.088	5430.50 (4763.60)	-	-
	(Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. Item 201 will apply if no pre-authorisation is obtained. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neuro-surgery cases involving surgery on the brain and spinal cord).	04.00							
201	Intensive Care Unit: Per day.	04.00		148.479	4133.10 (3625.50)	148.479	4133.10 (3625.50)	-	-
202	Neonatal Intensive Care Unit: Per day.	04.00		184.863	5145.80 (4513.90)	184.863	5145.80 (4513.90)	-	-
	(The charges referred to under items 200, 201 and 202 include the use of all equipment except: Bennett MA, Servo and Bear ventilators or equivalent apparatus plus the cost of oxygen)	04.00							
215	High Care Ward, Per day.	04.00		95.108	2647.40 (2322.30)	95.108	2647.40 (2322.30)	-	-
216	Neonatal High Care Ward 'A' (Intensive nursing and monitoring)	04.00		103.308	2875.70 (2522.50)	103.308	2875.70 (2522.50)	-	-
217	Neonatal High Care Ward 'B' (Standard nursing and monitoring)	04.00		67.538	1880.00 (1649.10)	67.538	1880.00 (1649.10)	-	-
218	Neonatal ward fee (Pre-discharge - This fee may not be charged for routine post-natal nursery care).	04.00		44.513	1239.10 (1086.90)	44.513	1239.10 (1086.90)	-	-
	Note: Once the baby has been stabilised and no longer requires ICU care but is not ready to be returned to the general nursery, no additional equipment charges, eg phototherapy may be charged. All admissions to units/wards referred to under 201 to 202 shall be confirmed with the relevant scheme for each 72 hours and 215 to 218 shall be confirmed weekly with the relevant scheme.	04.00							
2	**EMERGENCY UNIT**								
2.1	**Emergency Unit Fee**								
105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by BHF	04.00		45.858	1276.50 (1119.70)	45.858	1276.50 (1119.70)	-	-
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	04.00		-	-	-	-	-	-
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	04.00		10.533	293.20 (257.20)	10.533	293.20 (257.20)	10.533	293.20 (257.20)
	Note: The procedure room fee (071) cannot be charged in addition to 302	04.00							
2.2	**THEATRE FEES**								
061	Excimer Laser Theatre fee, per minute	04.00		0.650	18.10 (15.90)	0.650	18.10 (15.90)	0.650	18.10 (15.90)

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	The items listed as non-recoverable in Annuxure B shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.	04.00							
Minor Theatre, regardless of type of theatre available, the incident is procedure driven and not facility driven									
	A facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and short or no general anaesthetic, are carried out. No Sophisticated monitoring is required but resuscitation equipment (trolley) must be available in the procedure room. Conscious sedation by arrangement with scheme.								04.00
Time in minor theatre									
071	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	04.00		0.500	13.90 (12.20)	0.500	13.90 (12.20)	0.429	11.90 (10.40)
	The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows	04.00							
2.3	**Major theatre**								
	In addition to the theatre charge calculated as above, a surcharge (modifier 0002 and/or 0003) shall be allowed in cases where specialised theatres referred to in General Rule E.1.1 are utilised for the performance of any of the undermentioned procedures, whether carried out individually or in combination with each other, this surcharge shall be deemed to cover the equipment in the criteria. Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF								04.00
0002	Modifier 0002: Orthopaedic, Neurosurgical and Vascular: · Joint replacements (only hip, knee, shoulder ankle or elbow) · Femoral popliteal bypasses · Carotid endarterectomies · Aortic Aneurysm repair and arterial grafts · Neurosurgery (Surgery on the brain and spinal cord only, excludes neurolysis)	04.00		48.309	1344.73 (1179.59)	48.309	1344.73 (1179.59)	-	-
0003	Modifier 0003: Cardiac surgery Cardio-thoracic and Cardio-vascular surgery · All open heart surgery, with or without the insertion of a prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment (except item 513), no additional fees may be charged NOTE: The above surcharge will also be applicable to approved provincial hospitals	04.00		110.688	3081.11 (2702.73)	110.688	3081.11 (2702.73)	-	-
Time in Theatre									
081	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	04.00		1.554	43.30 (38.00)	1.554	43.30 (38.00)	1.329	37.00 (32.50)
	The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows	04.00							
Specialised Theatre Modifiers									
3	**PROCEDURAL FEES**								
	The fees quoted for items 052, 053 and 055 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533, 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: Ward fees may however be chargeable together with items 053 and 055.								05.03
3.1	**Procedures**								
052	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	04.00		14.342	399.20 (350.20)	14.342	399.20 (350.20)	14.342	399.20 (350.20)
053	Angiograms.	04.00		14.342	399.20 (350.20)	14.342	399.20 (350.20)	-	-
055	Electroconvulsive therapy (ECT)	04.00		14.342	399.20 (350.20)	14.342	399.20 (350.20)	14.342	399.20 (350.20)

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Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
3.2	**Catheterisation laboratory procedures**								
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information if required by the medical scheme.								05.03
	The fees quoted for items 054, 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533 and 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: ward fees may however be chargeable together with items 054, 055, 056, 070 and 073.								05.03
054	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1 NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.	04.00		51.446	1432.10 (1256.20)	51.446	1432.10 (1256.20)	-	-
056	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		96.929	2698.10 (2366.80)	96.929	2698.10 (2366.80)	-	-
070	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1. NB: EPS for cardiac ablations - items 529 must be charged additionally.	04.00		251.804	7009.20 (6148.40)	251.804	7009.20 (6148.40)	-	-
073	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	04.00		186.233	5184.00 (4547.40)	186.233	5184.00 (4547.40)	-	-
075	Catheterisation laboratory film price (once per procedure)	04.00		5.546	154.40 (135.40)	5.546	154.40 (135.40)	-	-
3.3	**Radiation Oncology**								
Simulation - Fixed custom made									
902	Simple - Simulation of a single area with either a single port or parallel opposed ports. Simple or no blocking or use of custom/home made simulation	04.00		15.263	424.90 (372.70)	15.263	424.90 (372.70)	-	-
903	Intermediate - Simulation of three or more converging ports, two separate treatment areas or multiple blocks.	04.00		23.283	648.10 (568.50)	23.283	648.10 (568.50)	-	-
904	Complex - Simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocks, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast	04.00		30.525	849.70 (745.40)	30.525	849.70 (745.40)	-	-
905	Computerised Tomographic.	04.00		30.525	849.70 (745.40)	30.525	849.70 (745.40)	-	-
Treatment Planning									
906	Manual.	04.00		-	-	-	-	-	-
907	Simple - Planning requiring single treatment area of interest in a single port or simple parallel opposed ports with simple or no blocking	04.00		14.383	400.40 (351.20)	14.383	400.40 (351.20)	-	-
908	Computerised (intermediate) - Planning requiring three or more ports, two separate treatment areas, multiple blocks or special time dose constraints	04.00		21.942	610.80 (535.80)	21.942	610.80 (535.80)	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
909	Computerised (complex) - Planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations or a combination of therapeutic modalities	04.00		28.742	800.10 (701.80)	28.742	800.10 (701.80)	-	-
Technical Aids									
910	Control films (As per radiology film price list).	04.00		-	-	-	-	-	-
911	Dosimetric procedures.	04.00		0.838	23.30 (20.40)	0.838	23.30 (20.40)	-	-
912	Artefacts: Simple - design and construction (simple block or bolus)	04.00		2.096	58.30 (51.10)	2.096	58.30 (51.10)	-	-
913	Artefacts: intermediate - design and construction (multiple blocks, stents, bite blocks, special bolus).	04.00		5.704	158.80 (139.30)	5.704	158.80 (139.30)	-	-
914	Artefacts: complex (specify) - design and construction (irregular blocks, special shields, compensators, wedges, molds or casts)	04.00		11.404	317.40 (278.40)	11.404	317.40 (278.40)	-	-
Linear accelerator treatment									
915	Photon treatment, single field.	04.00		22.288	620.40 (544.20)	22.288	620.40 (544.20)	-	-
916	Photon treatment, multiple fields	04.00		32.100	893.50 (783.80)	32.100	893.50 (783.80)	-	-
917	Electron treatment.	04.00		22.288	620.40 (544.20)	22.288	620.40 (544.20)	-	-
919	Brachytherapy - global fee per patient.	04.00		169.388	4715.10 (4136.10)	169.388	4715.10 (4136.10)	-	-
3.4	**Stereotactic radiosurgery**								
	Included in item 430 Stereotactic frames and attachments Linear Accelerator Specialised graphic planning, hardware and software Simulator and dark rooms 10 dental films Stereotactic masks All disposables 4 to 20 Graphic transparencies (including 1 week of planning) 2 trained radiographers Fixation and immobilisation Nuclear Specialist Medical Physicist Duration 1 - 4 hours 2 treatment radiographers Excluded from fee Other medical practitioners CT & MRI								04.00
399	Linear Accelerator radiosurgery - Global Fee	04.00		3682.963	102519.00 (89928.90)	3682.963	102519.00 (89928.90)	-	-
	Item 399 is an all- inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all the professional providers of service involved in the treatment rendered under this item.	04.00							
430	Global fee for stereotactic radiosurgery	04.00		2520.600	70163.40 (61546.80)	2520.600	70163.40 (61546.80)	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
4	**STANDARD CHARGES FOR EQUIPMENT**								
220	Ballistic Lithotripsy/Lithoclast: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	04.00		18.700	520.50 (456.60)	18.700	520.50 (456.60)	18.700	520.50 (456.60)
221	Ballistic Lithotripsy/Lithoclast: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	04.00		12.454	346.70 (304.10)	12.454	346.70 (304.10)	12.454	346.70 (304.10)
222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	04.00		124.638	3469.40 (3043.30)	124.638	3469.40 (3043.30)	124.638	3469.40 (3043.30)
223	Laser Lithotripsy: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	04.00		83.021	2311.00 (2027.20)	83.021	2311.00 (2027.20)	83.021	2311.00 (2027.20)
224	Stone basket (reusable) for the removal of kidney-, bladder- or gallstones: Per case	04.00		50.263	1399.10 (1227.30)	50.263	1399.10 (1227.30)	50.263	1399.10 (1227.30)
225	Stereotactic equipment for use in neuro-surgical procedures, when used in conjunction with x-rays, MRI scans or CAT scans: Per case	04.00		48.033	1337.00 (1172.80)	48.033	1337.00 (1172.80)	-	-
226	Continuous Passive Exerciser: Per day.	04.00		3.808	106.00 (93.00)	3.808	106.00 (93.00)	3.808	106.00 (93.00)
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	04.00		10.604	295.20 (258.90)	10.604	295.20 (258.90)	10.604	295.20 (258.90)
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	04.00		5.242	145.90 (128.00)	5.242	145.90 (128.00)	5.242	145.90 (128.00)
230	Patient-controlled analgesia pump, being a programmable reusable analgesia infusion system, providing patient control and/or continuous analgesia modes with mechanisms to limit self administration per time period and with lockout interval. Applicable only to administration of analgesics: Per day	04.00		4.021	111.90 (98.20)	4.021	111.90 (98.20)	4.021	111.90 (98.20)
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward Chargeable in the following instances: - Major joint replacement - Open, upper abdominal surgery - Severe burns - Paediatrics in special cases on motivation - Thoracotomies (motivation by practitioner) - Intractable pain associated with malignancy	04.00							
231	Cardiac monitors - In private, general and high care wards only - not to be charged for routine ECG's: Per day or part thereof	04.00		4.371	121.70 (106.80)	4.371	121.70 (106.80)	-	-
232	Bird or equivalent free standing nebuliser (excluding oxygen): Per day	04.00		3.129	87.10 (76.40)	3.129	87.10 (76.40)	3.129	87.10 (76.40)
233	Croupettes (excluding oxygen): Per day or part thereof	04.00		0.896	24.90 (21.80)	0.896	24.90 (21.80)	-	-
234	Incubators (excluding oxygen) (not chargeable together with items 215 to 218: Per day or part thereof	04.00		1.675	46.60 (40.90)	1.675	46.60 (40.90)	-	-
235	Oxygen tents (excluding oxygen): Per day or part thereof	04.00		1.458	40.60 (35.60)	1.458	40.60 (35.60)	-	-
236	Mechanical ventilator or equivalent (only in ICU and high care ward where no ICU is available) (excluding oxygen): Per day or part thereof	04.00		13.963	388.70 (341.00)	13.963	388.70 (341.00)	-	-
237	CUSA (plus CUSA pack as per section 5).	04.00		67.804	1887.40 (1655.60)	67.804	1887.40 (1655.60)	-	-
238	Lasers - Argon or Hollum (ophthalmic).	04.00		21.004	584.70 (512.90)	21.004	584.70 (512.90)	21.004	584.70 (512.90)
239	Lasers - CO2 (surgical).	04.00		27.138	755.40 (662.60)	27.138	755.40 (662.60)	27.138	755.40 (662.60)
241	Lasers - Candella (Rates by arrangement with the scheme concerned)	04.00		-	-	-	-	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
242	Occutomes.	04.00		8.933	248.70 (218.20)	8.933	248.70 (218.20)	8.933	248.70 (218.20)
243	Lasers - YAG (ophthalmic).	04.00		23.683	659.20 (578.20)	23.683	659.20 (578.20)	23.683	659.20 (578.20)
244	Lasers - YAG (surgical).	04.00		29.492	820.90 (720.10)	29.492	820.90 (720.10)	29.492	820.90 (720.10)
245	First Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment for one or more stones in same kidney which are eliminated in one treatment.	04.00		272.863	7595.40 (6662.60)	272.863	7595.40 (6662.60)	272.863	7595.40 (6662.60)
246	Second Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	04.00		181.733	5058.70 (4437.50)	181.733	5058.70 (4437.50)	181.733	5058.70 (4437.50)
	Note: The fees in respect of items 220 to 223, 245 to 246 and 339 to 341 are inclusive of all equipment and components but exclusive of theatre fees and items chargeable under Section 5. The C-arm (item 249) and screening table (item 251) are not chargeable with these equipment fees.	04.00							
249	C Arm (not chargeable when Modifiers 0002, 0003 or item 251 applies).	04.00		8.817	245.40 (215.30)	8.817	245.40 (215.30)	8.817	245.40 (215.30)
250	Ultrasonic imaging equipment.	04.00		14.738	410.20 (359.80)	14.738	410.20 (359.80)	14.738	410.20 (359.80)
	(Limited to real-time imaging equipment for transrectal applications with needle-biopsy capability or Doppler ultrasound for vascular anatomy and haemo-dynamics) Note: This can be used for infertility treatment	04.00							
251	Screening table - fixed base urology table (including all radiographic equipment) (See item 249) Note: May not be used in conjunction with items 220 to 223, 245 to 246 and 339 to 341.	04.00		19.883	553.50 (485.50)	19.883	553.50 (485.50)	19.883	553.50 (485.50)
252	Gastroscope (fibre optic/flexible only).	04.00		11.617	323.40 (283.70)	11.617	323.40 (283.70)	11.617	323.40 (283.70)
253	Colonoscope (fibre optic/flexible only)	04.00		12.992	361.60 (317.20)	12.992	361.60 (317.20)	12.992	361.60 (317.20)
254	Duodenoscope (fibre optic/flexible only).	04.00		12.308	342.60 (300.50)	12.308	342.60 (300.50)	12.308	342.60 (300.50)
255	Sigmoidoscope (fibre optic).	04.00		9.979	277.80 (243.70)	9.979	277.80 (243.70)	9.979	277.80 (243.70)
256	Bronchoscope (flexible/fibre optic, adults).	04.00		8.200	228.30 (200.30)	8.200	228.30 (200.30)	8.200	228.30 (200.30)
257	Laryngoscope (fibre optic/flexible excluding intubation)	04.00		4.788	133.30 (116.90)	4.788	133.30 (116.90)	4.788	133.30 (116.90)
258	Sinoscope (rigid only)	04.00		5.463	152.10 (133.40)	5.463	152.10 (133.40)	5.463	152.10 (133.40)
259	Oesophagoscope (rigid only)	04.00		2.725	75.90 (66.60)	2.725	75.90 (66.60)	2.725	75.90 (66.60)
261	Hysteroscope	04.00		3.429	95.40 (83.70)	3.429	95.40 (83.70)	3.429	95.40 (83.70)
262	Colposcope (Not chargeable when item 239 applies)	04.00		4.788	133.30 (116.90)	4.788	133.30 (116.90)	4.788	133.30 (116.90)
263	Cysto Urethroscope	04.00		4.108	114.40 (100.40)	4.108	114.40 (100.40)	4.108	114.40 (100.40)

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				RVU	Fee	RVU	Fee	RVU	Fee
264	Arthroscope (including basic reusable instruments and equipment)	04.00		11.200	311.80 (273.50)	11.200	311.80 (273.50)	11.200	311.80 (273.50)
	Note: The basic reusable instruments and equipment (which would always include the equivalent to the items named) are included in the fee of item 264 (see list below) : - Telescope, light source, cable - Monitor - Electrosurgical instrument - High frequency cord - Obturator - Camera - Focussing camera coupler - Control console, footswitch - Probe, scissors, (hooked, parrot beak), grasper, forceps (punch basket, duckbill), camelback handle, powered arthroplasty system, handpiece.	04.00							
294	Transcranial Doppler	04.00		24.417	679.70 (596.20)	24.417	679.70 (596.20)	-	-
295	Ultrasonic Cutting and Coagulating Devices (See section 5.3.3)	04.00		6.721	187.10 (164.10)	6.721	187.10 (164.10)	6.721	187.10 (164.10)
335	Excimer laser: Hire fee per eye	04.00		74.092	2062.40 (1809.10)	74.092	2062.40 (1809.10)	74.092	2062.40 (1809.10)
337	Microkeratome used with an excimer laser, per operation.	04.00		13.608	378.80 (332.30)	13.608	378.80 (332.30)	13.608	378.80 (332.30)
339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are elliminated in one treatment	04.00		8.279	230.50 (202.20)	8.279	230.50 (202.20)	8.279	230.50 (202.20)
341	Ballistic lithotripsy magnetic: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	04.00		5.525	153.80 (134.90)	5.525	153.80 (134.90)	5.525	153.80 (134.90)
343	Sigmoidoscope (rigid, adults)	04.00		2.050	57.10 (50.10)	2.050	57.10 (50.10)	2.050	57.10 (50.10)
345	Sigmoidoscope (rigid, paediatrics)	04.00		1.658	46.20 (40.50)	1.658	46.20 (40.50)	1.658	46.20 (40.50)
347	Bronchoscope (flexible/fibre optic, paediatrics)	04.00		8.200	228.30 (200.30)	8.200	228.30 (200.30)	8.200	228.30 (200.30)
	Note: For codes 252-256 and 343-347, reusable biopsy and polyp forceps are included in the fee.	04.00							
348	Bronchoscope (rigid, adults)	04.00		3.283	91.40 (80.20)	3.283	91.40 (80.20)	3.283	91.40 (80.20)
349	Bronchoscope (rigid, paediatrics)	04.00		4.788	133.30 (116.90)	4.788	133.30 (116.90)	4.788	133.30 (116.90)
360	Category 1 - Laparoscopy and thoracoscopy, per case. See Annexure A	04.00		26.825	746.70 (655.00)	26.825	746.70 (655.00)	26.825	746.70 (655.00)
364	Category 2 - Interventional Laparoscopic and Thorascopic procedures, per case. See Annexure A	04.00		31.867	887.00 (778.10)	31.867	887.00 (778.10)	31.867	887.00 (778.10)
507	Argon Beamer (See section 5.3.2)	04.00		2.721	75.70 (66.40)	2.721	75.70 (66.40)	2.721	75.70 (66.40)
	Note: The Argon Beamer will not apply where a standard electosurgery unit is used. It can only be used with surgery on internal organs and in neurosurgery.	04.00							
509	Endometrial Resection (Radio frequency)	04.00		16.425	457.20 (401.10)	16.425	457.20 (401.10)	16.425	457.20 (401.10)
511	Colour Doppler (external)	04.00		49.167	1368.60 (1200.50)	49.167	1368.60 (1200.50)	49.167	1368.60 (1200.50)

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				RVU	Fee	RVU	Fee	RVU	Fee
513	Transoesphageal Colour Doppler. (May be charged together with Modifier 0003)	04.00		59.325	1651.40 (1448.60)	59.325	1651.40 (1448.60)	59.325	1651.40 (1448.60)
515	Cardiorhythm Ablater. (May be charged in addition to the catheterisation Laboratory).	04.00		32.313	899.50 (789.00)	32.313	899.50 (789.00)	32.313	899.50 (789.00)
517	Phaco emulsifier	04.00		17.400	484.30 (424.80)	17.400	484.30 (424.80)	17.400	484.30 (424.80)
519	Uretho Reno Fibroscope, per case	04.00		14.663	408.20 (358.10)	14.663	408.20 (358.10)	14.663	408.20 (358.10)
521	OAS Frameless Stereotaxy	04.00		172.908	4813.10 (4222.00)	172.908	4813.10 (4222.00)	-	-
523	OPD Tacography (Includes paper)	04.00		2.800	77.90 (68.30)	2.800	77.90 (68.30)	-	-
525	RFG3C Lesion Generator (Rhizotomy)	04.00		55.979	1558.20 (1366.80)	55.979	1558.20 (1366.80)	-	-
527	Swift Lase Kit (Tonsillectomy)	04.00		10.908	303.60 (266.30)	10.908	303.60 (266.30)	-	-
529	Bard Apparatus 1. For EPS studies the analogue monoplane unit (item 054) must be charged additionally. 2. EPS studies for cardiac ablations - the digital bi-plane unit (item 070) must be charged additionally.	04.00		41.879	1165.70 (1022.50)	41.879	1165.70 (1022.50)	-	-
531	Densitometer	04.00		25.817	718.60 (630.40)	25.817	718.60 (630.40)	-	-
533	Civus (Cardiac Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	04.00		70.117	1951.80 (1712.10)	70.117	1951.80 (1712.10)	-	-
535	Ivus (Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	04.00		154.017	4287.20 (3760.70)	154.017	4287.20 (3760.70)	-	-
537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery.	04.00		0.646	18.00 (15.80)	0.646	18.00 (15.80)	-	-
	Disposable cover is non-chargeable. This item may not be charged together with any disposable monitoring style gel pads or when techniques other than electrosurgery are used. (e.g. not to be charged with the ultrasonic cutting and coagulating device or equivalent).	04.00							
	Equipment fees for automated, stereotactic, digital imaged surgical breast biopsy (UNDER REVIEW)								04.00
	Note: For the purpose of a 6 month trial cost analysis, the manufacturer of the ABBI equipment recommends that the total breast biopsy procedure, inclusive of all fees, disposables and professional charges should not exceed the current conventional open excisional procedures. The recommendation is to cap the amount at R12634.50 per procedure unless otherwise motivated for. Core needle and vacuum assisted core needle would therefore be capped at R 5053.80 and fine needle at R 3790.40. The disposables for the ABBI are included in the equipment fee.								05.03
540	Stereotactic guided digital imaged breast biopsy procedure	04.00		282.729	7870.00 (6903.50)	282.729	7870.00 (6903.50)	-	-
541	Stereotactic guided digital imaged cover needle biopsy	04.00		166.321	4629.70 (4061.10)	166.321	4629.70 (4061.10)	-	-
542	Stereotactic guided digital imaged vacuum assisted core needle biopsy.	04.00		166.321	4629.70 (4061.10)	166.321	4629.70 (4061.10)	-	-
543	Stereotactic guided digital imaged fine needle aspiration	04.00		116.471	3242.10 (2843.90)	116.471	3242.10 (2843.90)	-	-
544	Mammotome Stereotactic Driver - vacuum assisted core needle biopsy. (UNDER REVIEW)	04.00		-	-	-	-	-	-
545	Mammotome Hand Held ultrasound vacuum assisted vacuum core needle biopsy. (UNDER REVIEW)	04.00		-	-	-	-	-	-

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Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
550	Equipment fee for dynamic (non-frame based - StealthStation) stereotactic image guided referencing surgery and treatment planning used in conjunction with CT or MRI imaging in pre-authorised cranial, spinal cord and ENT procedures, per procedure	04.00		180.775	5032.10 (4414.10)	180.775	5032.10 (4414.10)	-	-
560	Low pressure hyperbaric oxygen treatment protocol. (By arrangement) Only for Prescribed Minimum Benefits Code 277S: Anaerobic infections - life threatening (when no state facility is available)	04.00		-	-	-	-	-	-
562	Standard pressure hyperbaric oxygen treatment protocol. (By arrangement).	04.00		-	-	-	-	-	-
564	US Navy TT5 treatment protocol. (By arrangement)	04.00		-	-	-	-	-	-
566	US Navy TT6 treatment protocol. (By arrangement)	04.00		-	-	-	-	-	-
568	US Navy TT6 extended treatment protocol. (By arrangement).	04.00		-	-	-	-	-	-
570	Comes 30 treatment protocol. (By arrangement).	04.00		-	-	-	-	-	-
572	US Navy Table 6A treatment protocol. (By arrangement)	04.00		-	-	-	-	-	-
574	Pressure relieving mattress hire fee, per day	04.00		-	-	-	-	-	-
576	Infrared Coagulator: per use	04.00		-	-	-	-	-	-
578	Prostatic hyperthemia and thermotherapy: per case	04.00		256.325	7135.10 (6258.90)	256.325	7135.10 (6258.90)	-	-
580	Sequential compression device, per case	04.00		-	-	-	-	-	-
582	Selector ultrasonic aspirator	04.00		-	-	-	-	-	-
584	Cryosurgery acuprobe	04.00		-	-	-	-	-	-
594	Motility machine	04.00		-	-	-	-	-	-
596	Ph recorder	04.00		-	-	-	-	-	-
606	Epilepsy monitoring system	04.00		-	-	-	-	-	-
608	Lynx ultrasound scanner	04.00		-	-	-	-	-	-
610	Intra-operative multi-frequency probe	04.00		-	-	-	-	-	-
612	Flexible laparoscopic probe	04.00		-	-	-	-	-	-
5	**STANDARD DRUG, MATERIAL, CONSUMABLE AND DISPOSABLE CHARGES**								
	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.								04.00
5.1	**STANDARD DRUG CHARGES**								
	(Only substances controlled by the Medicines and Related Substances Control Act, Act 101 of 1965, as amended/Medicine Control Council)								04.00
5.1.1	**Inpatients and day patients: Dispensed items including ampoules, over the counter and proprietary items issued to inpatients, day patients and TTO's**								
	Not to be charged for consumable, disposable and surgical items								04.00
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor). All items which patients take home as TTO's must be shown on accounts.								04.00
272	Pharmacy	04.00							
273	To take out	04.00							
278	Ward stock	04.00		-	-	-	-	-	-
282	Theatre	04.00		-	-	-	-	-	-
5.1.2	**Emergency Room: Dispensed items including ampoules, over the counter and proprietary items and TTO's issued to patients treated in the emergency room (Items 301 and 302) when not admitted to a ward.**								
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor). All items which patients take home as TTO's must be shown on accounts.								04.00

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	Not to be charged for consumable, disposable and surgical items								04.00
407	Pharmacy	04.00		-	-	-	-	-	-
411	Theatre	04.00		-	-	-	-	-	-
413	To take out	04.00		-	-	-	-	-	-
5.2	**Consumable, disposable, and surgical items used in ward, theatre or emergency room**								
	When used in ward or theatre Net acquisition price inclusive of VAT (unless the facility is not a registered VAT vendor). Items to be fully specified								04.00
	See consumable and disposable list.								04.00
266	Large disposable sterile trays - per tray (excluding theatre)	04.00							
267	Sterile disposable swabbing and ENT trays - per tray (excluding theatre)	04.00							
269	Soluble bags for barrier nursing only, limited to 2 per patient, per day	04.00							
415	Emergency room	04.00		-	-	-	-	-	-
417	Pharmacy	04.00		-	-	-	-	-	-
419	Ward stock	04.00		-	-	-	-	-	-
421	Theatre	04.00		-	-	-	-	-	-
5.3	**Fractional charges**								
	Net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor) to be charged per case at the fractional rates indicated below.								04.00
	Note: Fractional charges can only apply to reusable and limited life reusable/resposable products.								04.00
5.3.1	**Drills, burrs, cutters, blades**								
280	Neuro/Craniotomy	04.00		-	33.33%	-	33.33%	-	33.33%
432	Arthroscopy	04.00		-	20.00%	-	20.00%	-	20.00%
433	Orthopaedic	04.00		-	33.33%	-	33.33%	-	33.33%
437	Mastoidectomy and major ear surgery	04.00		-	33.33%	-	33.33%	-	33.33%
439	Maxillo- Facial drills and burrs (not applicable to oral surgery, eg wisdom teeth)	04.00		-	33.33%	-	33.33%	-	33.33%
5.3.2	**Surgical laser fibre optic leads, hand pieces and probes, scalpels, argon beamer instruments (Limited life re-usable components)**								
	Hospitals/unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name, and schemes shall have the right to call for such invoices from the institution concerned								04.00
281	Vascular surgery	04.00		-	100%	-	100%	-	100%
443	General surgery	04.00		-	12.5%	-	12.5%	-	12.5%
445	Gynaecology	04.00		-	12.5%	-	12.5%	-	12.5%
447	Ophthalmic	04.00		-	12.5%	-	12.5%	-	12.5%
449	Urology	04.00		-	12.5%	-	12.5%	-	12.5%
451	ENT	04.00		-	12.5%	-	12.5%	-	12.5%
453	Orthopaedic	04.00		-	12.5%	-	12.5%	-	12.5%
5.3.3	**Ultrasonic Cutting and Coagulating Devices (Limited life re-usable)**								
General surgery, Gynaecology, Cardio-Vascular and Urology									
455	Handpiece and Cable Assembly (one unit)	04.00		-	1%	-	1%	-	1%
456	Coagulating Shear (Laparoscopic/open)	04.00		-	33.33%	-	33.33%	-	33.33%
458	Coagulating Shear - Single use (Laparoscopic/open) Refer to Section 5.2	04.00		-	-	-	-	-	-
457	Blades (sharp hook, dissecting hook, ball)	04.00		-	12.5%	-	12.5%	-	12.5%

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				RVU	Fee	RVU	Fee	RVU	Fee
459	Blades - Single use (sharp hook, dissecting hook, ball) Refer to 5.2	04.00		-	-	-	-	-	-
5.3.4	**Warm air blankets**								
429	Warm air blanket may be charged in the following cases and limited to 1 per stay - Infants - Elderly patients over 65, - Patients exposed for a long period of time in theatre longer than 2 hours - Post traumatic hypothermia - one per stay - Cardio-thoracic hypothermic patients in recovery and ICU - one per stay	04.00		-	100%	-	100%	-	100%
5.3.5	**Diathermy pencils, laryngeal masks and fluoroshield gloves**								
431	Diathermy pencils	04.00		-	33.33%	-	33.33%	-	33.33%
435	Laryngeal masks	04.00		-	2.5%	-	2.5%	-	2.5%
441	Fluoroshield gloves (1 pair per procedure)	04.00		-	33.33%	-	33.33%	-	33.33%
5.7	**Gases**								
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified								04.00
Oxygen and Nitrous Oxide									
	For both gases together, per minute								04.00
283	PWV area	04.00		0.110	3.06 (2.68)	0.110	3.06 (2.68)	0.110	3.06 (2.68)
701	Cape Town	04.00		0.151	4.20 (3.68)	0.151	4.20 (3.68)	0.151	4.20 (3.68)
702	Port Elizabeth	04.00		0.134	3.73 (3.27)	0.134	3.73 (3.27)	0.134	3.73 (3.27)
703	East London	04.00		0.149	4.15 (3.64)	0.149	4.15 (3.64)	0.149	4.15 (3.64)
704	Durban	04.00		0.138	3.84 (3.37)	0.138	3.84 (3.37)	0.138	3.84 (3.37)
705	Other areas	04.00		0.123	3.42 (3.00)	0.123	3.42 (3.00)	0.123	3.42 (3.00)
Oxygen, ward use									
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex								04.00
284	PWV area	04.00		0.162	4.51 (3.96)	0.162	4.51 (3.96)	0.162	4.51 (3.96)
710	Cape Town	04.00		0.268	7.46 (6.54)	0.268	7.46 (6.54)	0.268	7.46 (6.54)
711	Port Elizabeth	04.00		0.258	7.18 (6.30)	0.258	7.18 (6.30)	0.258	7.18 (6.30)
712	East London	04.00		0.248	6.90 (6.05)	0.248	6.90 (6.05)	0.248	6.90 (6.05)
713	Durban	04.00		0.210	5.85 (5.13)	0.210	5.85 (5.13)	0.210	5.85 (5.13)
714	Other areas	04.00		0.200	5.57 (4.89)	0.200	5.57 (4.89)	0.200	5.57 (4.89)
Oxygen, recovery room or emergency room									
	Flat rate for oxygen per case								04.00
720	PWV area	04.00		0.322	8.96 (7.86)	0.322	8.96 (7.86)	0.322	8.96 (7.86)
721	Cape Town	04.00		0.533	14.80 (13.00)	0.533	14.80 (13.00)	0.533	14.80 (13.00)
722	Port Elizabeth	04.00		0.513	14.30 (12.50)	0.513	14.30 (12.50)	0.513	14.30 (12.50)
723	East London	04.00		0.492	13.70 (12.00)	0.492	13.70 (12.00)	0.492	13.70 (12.00)
724	Durban	04.00		0.421	11.70 (10.30)	0.421	11.70 (10.30)	0.421	11.70 (10.30)
725	Other areas	04.00		0.398	11.10 (9.74)	0.398	11.10 (9.74)	0.398	11.10 (9.74)
Oxygen in Theatre									
	Fee for oxygen per minute in the operating theatre when no other gas administered								04.00

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				RVU	Fee	RVU	Fee	RVU	Fee
730	PWV area	04.00		0.010	0.28 (0.25)	0.010	0.28 (0.25)	0.010	0.28 (0.25)
731	Cape Town	04.00		0.018	0.50 (0.44)	0.018	0.50 (0.44)	0.018	0.50 (0.44)
732	Port Elizabeth	04.00		0.017	0.47 (0.41)	0.017	0.47 (0.41)	0.017	0.47 (0.41)
733	East London	04.00		0.017	0.47 (0.41)	0.017	0.47 (0.41)	0.017	0.47 (0.41)
734	Durban	04.00		0.013	0.36 (0.32)	0.013	0.36 (0.32)	0.013	0.36 (0.32)
735	Other areas	04.00		0.013	0.36 (0.32)	0.013	0.36 (0.32)	0.013	0.36 (0.32)
Carbon Dioxide									
291	Per minute	04.00		0.020	0.56 (0.49)	0.020	0.56 (0.49)	0.020	0.56 (0.49)
Laser Mix									
292	Per minute	04.00		0.387	10.80 (9.47)	0.387	10.80 (9.47)	0.387	10.80 (9.47)
Entonox									
293	Per 30 minutes	04.00		3.675	102.30 (89.70)	3.675	102.30 (89.70)	3.675	102.30 (89.70)
5.8	**Inhalation anaesthetics**								
	All prices will be expressed per millilitre and will be based on the Single Exit Price (SEP)								08.00
285	Halothane (Halothane): per ml	08.00		-	-	-	-	-	-
752	Ethrane (Enflurane): per ml	08.00		-	-	-	-	-	-
753	Forane (Isoflurane): per ml	08.00		-	-	-	-	-	-
754	Isofor (Isoflurane): per ml	08.00		-	-	-	-	-	-
755	Ultane (Sevoflurane): per ml	08.00		-	-	-	-	-	-
756	Suprane (Desflurane), per ml	08.00		-	-	-	-	-	-
757	Aerrane (Isoflurane): per ml	08.00		-	-	-	-	-	-
758	Alyrane (Enflurane): per ml	08.00		-	-	-	-	-	-
759	Fluothane (Halothane), per ml	08.00		-	-	-	-	-	-
5.9	**Prostheses (Surgically implanted)**								
286	A prosthesis shall mean a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral and necessary part of the device so implanted, and shall be charged as a single unit. Pins, rods, screws, plates or similar items, when used independently of a prosthesis and for the purpose of furthering any healing process, shall be chargeable. Hospitals/unattached operating theatre units shall show the name and reference number of each item. The manufacturer's name, and suppliers invoices should be attached to the account and the components should be specified on the account. Net acquisition price on suppliers invoice, inclusive of VAT (unless the facility is not a registered VAT vendor), by prior arrangement with scheme.	04.00		-	-	-	-	-	-
5.10	**Medical artificial items (non-prostheses)**								
287	According to agreement with schemes concerned. (Examples of items included hereunder shall be wheelchairs, crutches and excretion bags). Copies of invoices shall be supplied to schemes.	04.00		-	-	-	-	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
5.14	**Blood charges**								
288	Emergency non-crossmatched blood ex hospital (i.e. on stand-by) - Number of units and nature of emergency to be specified and copy of invoice included. This item is only chargeable when a private hospital supplies O-negative whole blood to a patient in an emergency situation. A motivation stating the reason for administering the O-negative blood must accompany the account and no mark-up is permitted on this item.	04.00		-	-	-	-		
289	Routine blood charges, when incurred in respect of blood or related products procured from a recognised blood bank for transfusion purposes, may be charged at R 14.70 per collection, plus R 3.09 per kilometre travelled. This fee is applicable to all modes for collecting blood including hospital ambulances	05.03		-	-	-	-	-	-
297	Emergency blood collection. Claims for this item code must be supported by documentary evidence of the patient's condition	06.00		19.388	539.70 (473.40)	19.388	539.70 (473.40)	-	-
5.15	**Incise drapes**								
298	Incise drapes (See Annexure B)	04.00		-	-	-	-	-	-
299	Ophthalmic drapes. (See Annexure B)	04.00		-	-	-	-	-	-
300	Non-incise drapes (isolation, fluid-collection and combination)	04.00		-	-	-	-	-	-
	Chargeable in the following procedures: Hip, knee, shoulder and elbow joint replacements Open heart and cardiac bypass surgery Vascular surgery (excluding catheterisation laboratory procedures) Neuro-surgery (Brain and spinal cord) Arthroscopy of hip, shoulder, knee or elbow joints Spinal surgery	04.00							
	Note: The name, item number and cost must be shown.								04.00
5.16	**Disposable Patient Controlled Analgesia Pump**								
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward Chargeable in the following instances: - Major joint replacement - Open, upper abdominal surgery - Severe burns - Paediatrics in special cases on motivation - Thoracotomies (motivation by practitioner) - Intractable pain associated with malignancy								04.00
6	**NON STANDARD ITEMS/SERVICES**								
	Such items are not covered by the National Reference Price List and schemes reserve the right to decide individually how these items/services will be dealt with								04.00
290	Items/services e.g. telephone calls/hire, television hire, boarding, extra meals, dry cleaning of clothing, extra nursing in ward etc. The nature of each service shall be specified	04.00		-	-	-	-	-	-
Procedures : Open heart, cardiac by-pass surgery and all organ transplants									
121	Benefits to be pre-authorised with the scheme concerned	04.00		-	-	-	-	-	-

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
ANNEXURES									
	ENDOSCOPIC (laparoscopic & thoracoscopic) GENERIC LIST								04.00

Category 1 Procedures **Laparoscopy and Thoracoscopy, per case**	Category 2 Procedures **Interventional laparoscopy, Thoracic and Urological procedures, per case**
Standard Charges • 360 Laparoscopic Equipment Fee, per case - Telescope - Light Guide Cable - Camera - Monitor - Hi –frequency Cord • **Includes** laparoscopic instrumentation, per case. All equivalents included - Scissors - Graspers (clamp, clinch, babcock) - Dissectors - Electro surgical Instrument - Suction irrigation shafts	**Standard Charges:** • 364 Laparoscopic Equipment Fee, per case - Telescope - Light Guide Cable - Camera - Monitor - Hi –frequency Cord • INCLUDES Laparoscopic Instrumentation, per case. All equivalents included - Endoscopic needle holder and knot pusher - Scissors - Graspers (clamp, clinch, babcock) - Dissectors - Retractors - Suction irrigation shaft - Electro surgical Instrument
Recoverable Disposable Products " single-use" allowed • Insuflation Needle • Trocars	**Recoverable Disposable Products "single –use" allowed** • Insuflation Needle • Trocars • Ligating Clip Appliers • Ultrasonic or electro surgical cutting and coagulation accessories (instrumentation and accessories) • **Endoscopic Staplers/Cutters**
NOTE: • Category 1 procedures are predominantly diagnostic and the listed re-usable instruments are considered relevant and appropriate for category 1 procedures	• Should a diagnostic procedure move to a 'therapeutic intervention , then the procedure would become a category 2 procedure
Part Chargeable Products: • Ultrasonic Handpiece and Cable = 1%	

Notes: Refer to detailed Endoscopic Disposable Product list.
Procedure to be applied per CPT code – list attached.

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics		
				RVU	Fee	RVU	Fee	RVU	Fee	
	Comments 1. Optical, blunt, Hasson cannula, trocar – may substitute the primary port trocar and eliminate the use of verres needles. 2. Harmonic scalpel shears and and blades – not to be charged together with disposable electrosurgical probes, argon beam coagulator, clip appliers, bipolar forceps and Tripolar forceps. 3. Harmonic scalpel shears and blades – not to be used for laparoscopic cholecystectomy and sterilisation 4. Tripolar forceps – not to be used together with electrosurgical probes, harmonic scalpel, clip appliers 5. Autosuture Endostitch – to be motivated and 1 suture assistant per procedure allowed. 6. Specimen retrieval bags – to motivate use (used when specimen needs to be captured and removed to avoid site contamination); procedure related – histology report required.									
	APPENDIX A LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES CATEGORY 1 (CPT4 2000 code numbers included where possible) Diagnostic laparoscopy (49320) Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670) Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771) Hysteroscopy diagnostic (58555) Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C (58558) THORACOSCOPY, DIAGNOSTIC THORACOSCOPY, DIAGNOSTIC with biopsy THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy CATEGORY 2 Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673) Laparoscopy, surgical; with fimbrioplasty (58672) Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface, any method (58662) Laparoscopy, surgical; with lysis of adhesions (changed 1998 to salpigolysis, ovariolysis) (58660) Laparoscopy, surgical; with removal leiomyomata (58551) Laparoscopy surgical; withenterolysis (freeing intestinal adhesion) (44200) Laparoscopy, surgical; with retropritoneal node sampling (biopsy) (38570) Laparoscopy,surgical, abdomen, peritoneum, omentum; with drainage lymphocele to peritoneal cavity (49323) Laparoscopy, surgical; appendectomy (44970) Laparoscopy, surgical, abdomen, peritoneum and omentum; with biopsy (49321) Laparoscopy, surgical, abdominal, peritoneum and omentum; with aspiration of cavity or cyst (e.g. ovarian cyst) single or multiple (49322) Laparoscopy, surgical; with removal of adnexal structures (partial or total oopherectomy and/or salpingectomy) (58661) Laparoscopy, surgical; orchiopexy for intra-abdominal testis (54692) Laparoscopy, surgical; ligation spermatic veins for varicocele (55550) Laparoscopy, surgical; ablation of renal cysts (50541) Laparoscopy, surgical; urethral suspension for stress incontinence (51990) Laparoscopy, surgical; sling operation for stress incontinence (51992) Hysteroscopy with lysis intra-uterine adhesions (58559) Hysteroscopy with removal impacted foreign body (58562) Hysteroscopy with removal leiomyomata \ (58561)									04.00

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				RVU	Fee	RVU	Fee	RVU	Fee
	Hysteroscopy with endometrial ablation \ (58563)								
	Laparoscopic treatment of ectopic pregnancy, without salpingectomy and/or oopherectomy (59150)								
	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oopherectomy (59151)								
	Laparoscopy, surgical; with vaginal hysterectomy. (Lap assisted vag. Hyst) (58550)								
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy (38571)								
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) (38572)								
	Laparoscopy with adrenalectomy (60650)								
	Laparoscopy, surgical; pyeloplasty (50544)								
	Laparoscopy, surgical; nephrectomy (50540)								
	Laparoscopy, surgical; donor nephrectomy (50547)								
	Laparoscopically assisted nephroureterectomy (50548)								
	Laparoscopy, surgical, ureterolithotomy 50945)								
	Laparoscopy, surgical; transection of Vagus nerve, truncal (43651)								
	Laparoscopy, surgical; transection of Vagus nerves, selective or highly selective (43652)								
	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy (47560)								
	Laparoscopy, surgical; with guided transhepatic cholangiography, with biopsy (47561)								
	Laparoscopy, surgical; cholecystoenterostomy (47570)								
	Laparoscopy, surgical; cholecystectomy with cholangiography (47563)								
	Laparoscopy, surgical; cholecystectomy with explor, common bile duct (47564)								
	Laparoscopy, surgical; splenectomy (38120)								
	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g. Stamm procedure) (43653)								
	Laparoscopy, surgical; jejunostomy (44201)								
	Laparoscopy, surgical; intestinal resection, with anastomosis (44202)								
	Laparoscopy, surgical; oesophagogastric fundoplasty eg Nissen, Toupet procedures) (43280)								
	Unlisted laparoscopic procedure, uterus(58578)								
	Unlisted hysteroscopy procedure, uterus (58579)								
	Unlisted laparoscopic procedure, oviduct, ovary (58679)								
	Unlisted laparoscopic spleen procedure (38129)								
	Unlisted laparoscopic lymphatic procedure (38589)								
	Unlisted laparoscopic oesophagus procedure (43289)								
	Unlisted laparoscopic stomach procedure (43659)								
	Unlisted laparoscopic intestinal procedure (except rectum) (44209)								
	Unlisted laparoscopic appendix procedure (44979)								
	Unlisted laparoscopic biliary tract procedure (47579)								
	Unlisted laparoscopy procedure, abdomen, peritoneum & omentum (49329)								
	Unlisted laparoscopic hernia procedure (49659)								
	Unlisted laparoscopic renal procedure (50549)								
	Unlisted laparoscopic procedure, testis (54699)								
	Unlisted laparoscopic procedure, spermatic cord (55559)								
	Unlisted laparoscopic procedure, maternity care and delivery (59898)								
	Unlisted laparoscopic endocrine procedure (80659)								
	THORACOSCOPY, SURGICAL								
	THORACOSCOPY, SURGICAL pleurodesis								
	THORACOSCOPY, SURGICAL partial pulmonary decortication								
	THORACOSCOPY, SURGICAL total pulm. Decortication								
	THORACOSCOPY, SURGICAL removal interpleural foreign body								
	THORACOSCOPY, SURGICAL control traum. Haemorrhage								
	THORACOSCOPY, SURGICAL exc./plication bullae								
	THORACOSCOPY, SURGICAL parietal pleurectomy								

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Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics		
				RVU	Fee	RVU	Fee	RVU	Fee	
	THORACOSCOPY, SURGICAL wedge resection THORACOSCOPY, SURGICAL removal clot/foreign body from pericardial space THORACOSCOPY, SURGICAL creation pericardial window THORACOSCOPY, SURGICAL total pericardectomy THORACOSCOPY, SURGICAL exc pericard. Cyst, tumor, mass THORACOSCOPY, SURGICAL exc mediastinal cyst, tumor, mass THORACOSCOPY, SURGICAL lobectomy, total or segmental THORACOSCOPY, SURGICAL with sympathectomy THORACOSCOPY, SURGICAL with esophagomyotomy New codes for Category 2 CPT42000 CPT4 2001 Laparoscopy, surgical; radical nephrectomy 50545 Laparoscopy, surgical; nephrectomy including partial ureterectomy 50546 Laparoscopy, surgical; nephrectomy with total ureterectomy 50548 Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement 50948 Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement 50948 Unlisted laparoscopic procedure, ureter 50949									
	APPENDIX B PRINCIPLES The following principles are applicable: 1. At all times best clinical practice must be adhered too. 2. Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only. Photocopies of all documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documentation at the hospital/sameday surgical facilities concerned. The Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Sub-Acute Facilities, Private Hospitals and Sameday Surgery Facilities will be reviewed half-yearly. 3. The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows: ¢ Items included in the per minute theatre fee. ¢ Items included in the per day ward or unit fee. ¢ Items are charged to the patient's account where reimbursement is not granted by a medical scheme. 4. Any agreed difference on the basic interpretation of the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities list will be made in accordance with the approval of the duly appointed representatives of the individual contractor, medical aid, MCO and representatives of private hospitals. Such approval shall be ratified in writing and circulated to all parties concerned. Where the hospital uses an excessively priced product, a review process should be conducted, and appropriate price adjustment made. 5. Disposable items are single use only and must never be reused. ¢ Single use items will be charged at 100%. ¢ Hospitals will sign an ethical undertaking that single use items will only be used once. If a hospital does not conform it may be reported to the group head office. If an acceptable explanation is not supplied within 14 days, payment on that account may be withheld. 6. Limited life re-usable products are products intended for multiple use and endorsed as such by the manufacturers. Such products will be charged according to the "Fractional" charges as detailed and are under continual review. The item will be considered life re-usable (limited multiple use) if it can re re-used less than 100 times (endorsed as such by the manufacturer).									04.00

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee

7. Where a hospital uses an excessively priced product, a review process with the parties as listed under 3 above should be conducted, and appropriate price adjustment made.

8. TTO's will be issued and charged according to the rules of the scheme.

9. All prescribed items will be recoverable according to the rules of the scheme.

Key Indicators

The different key indicators in the Recommended Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities List are as follows:

All prescribed items dispensed in wards or theatre are fully recoverable according to scheme's rules.

Key	Description
THR	Theatre consumable and disposable items
WRD	Ward consumable and disposable items
NR	Item is non-recoverable
C	Item is chargeable under certain circumstance
R	Item is recoverable
P	Item is recoverable from patient
F	Fractional (re-usable) and is charged out on a pro-rata basis (as per 5.5.1-5.5.4).
N/A	Not used/not applicable

Disposable Means the manufacturer states one time use only.
S/U(Single use) Item =Payable 100%

Medical Prescribed Meals See List

Practice Code References to the NRPL-HS includes 57/58, 76 and 77

	PRODUCT	THR	WRD	COMMENT
1.	Accessories for AV impulse, Flowtron DVT and similar (Impads,	C	C	Subject to scheme rules and authorisation criteria;
2.	Adapters disposable	C	C	
3.	Adapters re-usable	NR	NR	
4.	Adhesive/non-adhesive bandages and rolls (Elastoplast, Micropore,	C	C	Fractional use is non-chargeable;
5.	Aerochamber	NR	NR	Chargeable as TTO
6.	Alcohol Swabs (Preptic, Webcol and similar)	NR	NR	Chargeable as TTO on prescription;
7.	Alcohol/Spirits	NR	NR	

Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	7.	Alcohol/Spirits	NR	NR						
	8.	Amalgam Caplets and all dental composites	NR	N/A						
	9.	Anaesthetic accessories (circuits, masks, trays);	NR	N/A	Blue and Green gauze chargeable separately					
	10.	Antipeol Ointment	NR	C	When prescribed by a doctor as a full unit or part of mixture.					
	11.	Antiseptic solutions (Hibiscrub, Betadine and similar);	NR	C	Chargeable for use in Burns and Haemorrhoidectomy. On prescriptions for therapeutic reasons only. Non-chargeable when used by staff or for prepping of skin.					
	12.	Aortic/Vascular Punch - disposable	R	N/A						
	13.	Aortic/Vascular Punch - re-usable	NR	NR						
	14.	Aqueous Cream - other uses	NR	C	Chargeable when used as a therapeutic agent, as part of the mixture and prescribed by a doctor.					
	15.	Aqueous Cream - used as body lotion	NR	NR						
	16.	Arm Immobiliser (Sling and similar)	NR	C	Subject to Scheme rules when procedure related					
	17.	Artificial Tears and eye lubricants (Duratears, Cleargel, Tears plus natural and similar)	NR	C	For long term sedated ventilated patients. (Only when full tube is used.) Prescribed by a doctor.					
	18.	Arthrowand (Disposable instrument): (a) Arthrowand (b) Spinal Arthrowand (c) Plansmowand/Entecwand	C	NR	Chargeable if used in the following Procedures Arthroscopy – Knee, Shoulder, Ankle Acromioplasty Sinovectomy – Wrist Lateral Release – Knee, Wrist Acromioclavicular release Decompresion of Shoulder "Frozen" Shoulder Meniscectomy ACL reconstruction PCL reconstruction *Arthrowand can be used together with Dyonic Blades or Burrs for different requirements per procedure eg. Tissue and Bone.* Spinal and Revision surgery Lumbar discectomy Cervical discectomy Spinal tumour removal Intra-cranial tumour removal Pliff-cage procedure Lumbar Revision surgery Lumbar instrumentation and fusion Cervical cage infusion Percutaneous Lumbar disc coblation Tonsilotomy Soft Palate Channelling Tonsilectomy Nasal passage channeling					
	19.	Baby Food	NR	NR						
	20.	Baby Packs	NR	NR						
	21.	Baby Toiletries	NR	NR						

Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	22.	Bacterial/Viral Breathing Filters and Humidifier Moisture Breathing Filters	C	C	One per theatre case. One per 24 hours ventilation in Specialised Units					
	23.	Beaver blades in Myringotomy	NR	NR						
	24.	Bentley Connectors- disposable	C	C	To be specified if not a part of a pack.					
	25.	Bentley Connectors- re-useable	NR	NR						
	26.	Biocide	NR	NR						
	27.	Biopsy Forceps – disposable	R	N/A						
	28.	Bipolar Forceps (disposable);	NR	NR	Excluding endoscopic surgery;					
	29.	Blades (arthroscopic)-Disposable	R	N/A	Guideline maximum of 3 blades/burrs for an appropriate shoulder procedure or 2 for an appropriate knee procedure. The use of more to be motivated.					
	30.	Blades (arthroscopic)-Limited life reusable	F	N/A	Part chargeable as per section 5.3.1;					
	31.	Blades (ENT)-Disposable	R	N/A	Maximum 2 per procedure;					
	32.	Blades (surgical knives, scalpel) – Disposable	R	R						
	33.	Blades Saw – Limited life reusable	F	NA	As per section 5.3.1;					
	34.	Blades Saw -Disposable	R	N/A						
	35.	Blades-Limited life reusable	F	N/A	Part chargeable as per section 5.3.1;					
	36.	Blankets: Warm Air, disposable	C	C	Chargeable 100% when complying to the criteria as per section 5.3.4 1 per stay					
	37.	Blood pressure cuffs-Disposable (Cuffable cuffs, Disposa-Cuff and similar);	C	C	Neonates only; One per stay;					
	38.	Blood pressure machine (Baumanometer, Dinamapp and similar)	NR	NR						
	39.	Breast Pads	N/A	NR						
	40.	Breast Pump	N/A	NR						
	41.	Breathing/ventilator circuits and disposable accessories (tubing, catheter mounts, connectors and similar)- Reusable	NR	NR						
	42.	Breathing/ventilator circuits and disposable accessories (tubing, catheter mounts, connectors and similar)-Disposable	NR	NR						
	43.	Bulb Syringes - disposable	R	C	One per patient per stay. Bladder irrigation only in wards.					
	44.	Bulb Syringes - glass	NR	NR						
	45.	Burrs – Disposable	R	N/A						
	46.	Burrs - Limited life reusable	F	N/A	Fractional as per BHF Schedule 5.3.1;					
	47.	Burrs (Dental surgery)-reusable and disposable	NR	NR	Included in the Dental Practitioners Fee					
	48.	Burrs (ENT surgery)-disposable	R	N/A						
	49.	Capnograph Set – disposable	NR	NR						
	50.	Cardiac Monitors	NR	C	Equipment fee chargeable in High Care and Wards when a patient is monitored. Item 231. Non-Chargeable in ICU.					
	51.	Cardiotocography paper	NR	NR						

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Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	52.	Catheters (Jacques, Nelaton and similar)- Reusable	NR	NR						
	53.	Cetavlon	NR	NR						
	54.	Chlorhexidine Solution	NR	NR						
	55.	Chlorine Antiseptics (Biocide and similar)	NR	NR						
	56.	Chloromycetin Applicaps	R	C	Two per day in ICU for unconscious or sedated ventilated patients on prescription.					
	57.	Cidex	NR	NR						
	58.	Clip Removers	NR	NR	Included in Practitioners fee for post-operative care for four weeks					
	59.	Collection Charges - Pathology	NR	NR						
	60.	Connectors - disposable	C	C	To be specified if not a part of pack. (e.g. Bentley or Cobe)					
	61.	Connectors - re-usable	NR	NR						
	62.	Cosmetic products (body lotions, powders, creams, oils and shampoos);	N/A	NR						
	63.	Cutters – Disposable	R	N/A	*Single Use*					
	64.	Cutters (bone)-Limited life re useable	F	N/A	Fractional chargeable as per BHF Schedule 5.3.1;					
	65.	Cytology Brushes – Disposable	C	N/A	Fully recoverable if supplied by hospital.					
	66.	Daylee Towels	NR	NR						
	67.	Depilatory Creams	NR	NR						
	68.	Dettol	NR	NR						
	69.	Diagnostic Strips – Blood	N/A	C	Diabetic patients -account to state Diabetic. Chargeable in Pancreatitis not Substance abuse related Patients receiving hyperalimentation Patients in ICU/HC /NICU/ NHC units					
	70.	Diagnostic Strips – Blood & Urine (Routine Testing)	NR	NR						
	71.	Diathermy Equipment	NR	NR						
	72.	Diathermy electrosurgical instruments (pencil, handles)- disposable	R	N/A						
	73.	Diathermy electrosurgical instruments (pencils, handles)-Limited life reusable	F	N/A	Part charge as per section 5.3.5;					
	74.	Diathermy Plates – disposable	R	N/A	Chargeable to a maximum of R79.50 each;					
	75.	Disinfectants	NR	NR						
	76.	Disposable cables and cords	NR	NR						
	77.	Disposable Humidifiers (Aquapak, Respiflo, Sterimist or equivalent);	N/A	C	One per 24 hours or part thereof with administration of oxygen.					
	78.	Douch Bottles - Disposable	NR	C	Gynaecology Non chargeable for prepping					
	79.	Douche Cans – Reusable	NR	NR						
	80.	Drills – Disposable	R	N/A						
	81.	Drills (Dental Surgery)-Disposable	NR	NR	Included in the Dental Practitioner fee					
	82.	Drills –Limited life reusable	F	N/A	Part chargeable as per section 5.3.1;					
	83.	Drops (Eye/Ear/Nose)- fractional use	C	NR	Fractional use is non-chargeable; Only Eye drops are chargeable in theatre;					

Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	84.	EABS	NR	NR						
	85.	ECG – Electrodes	R	R						
	86.	ECG – Equipment	NR	NR						
	87.	ECG – Paper	NR	R						
	88.	Electrode Tip Cleaner (Scrape Eeze, Friction Pads and similar)- Disposable	NR	NR						
	89.	Endoscopic – disposables	C	N/A	See Endoscopic Procedure List – attached.					
	90.	Endotracheal Introducers	NR	NR						
	91.	Epidural Fee	C	C	Only applicable for Maternity					
	92.	Epidural Kit/Set	C	N/A	Epidural Kit chargeable in all cases except Maternity. Not to be charged when fee is charged.					
	93.	Ether	NR	NR						
	94.	Eusol	NR	C	For septic wound dressing					
	95.	External Fixators	R	N/A	Pre-Authorised by scheme. Benefit to be confirmed by scheme.					
	96.	Eye patches (opticlude and similar) in theatre	NR		Eye pads are included in theatre basket;					
	97.	Face Masks	NR	C	For reverse barrier nursing only (Head covers and overshoes non-chargeable);					
	98.	Films, Video Prints, Compact Discs – disposables (Endoscopic Procedures)	NR	NR						
	99.	Films, Video Prints, Compact Discs, Thermal Paper	C	NR	Refer section 3.3 - item 075 one fee per procedure					
	100.	Fluoroshield Gloves	F	N/A	As per section 5.3.5 item 441					
	101.	Foley's Temp Catheter	C	N/A	On motivation Maximum of R500 Cardiac only					
	102.	Formalin in Saline	NR	NR						
	103.	Fosenema / Len-o-lax	N/A	R	When prescribed.					
	104.	Glass Syringes	NR	NR						
	105.	Gloves - Sterile (Examination)	N/A	C	For minor sterile procedures in the ward e.g. suction, catheterisation. Non-chargeable with tray					
	106.	Gloves – Non-Sterile	NR	C	Chargeable only for reverse barrier nursing, motivation required.					
	107.	Gloves – Sterile (Surgical)	R	C	Chargeable for incisional procedures, e.g. CVP lines and major wound dressing (burns). Not chargeable with tray					
	108.	Glucometer	N/A	N/A	TTO only if authorised by scheme. Otherwise for patient's private account.					

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Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
109.	Gowns in theatre (barrier SABS approved with breathable and fluid impermeable polymer membrane)-Limited life reusable	C	N/A	Chargeable for specific procedures only Hip, knee, shoulder and elbow joint replacements Open heart and cardiac bypass surgery Vascular Surgery Neuro-Surgery (Brain and spinal cord) Arthroscopy of hip, shoulder, knee or elbow joints Spinal surgery Recommended price R80.00 per gown For surgical team only (max 4).					
110.	Gowns in theatre (barrier SABS approved)-Disposable	C	N/A	Chargeable for specific procedures only Hip, knee, shoulder and elbow joint replacements Open heart and cardiac bypass surgery Vascular Surgery Neuro-Surgery (Brain and spinal cord) Arthroscopy of hip, shoulder, knee or elbow joints Spinal surgery For surgical team only (max 4). Maximum price R135.00 per gown (To be revised with price changes.)					
111.	Gowns in theatre with hoods and shields (Charnley and similar having breathable and fluid impermeable polymer membrane for single use according to recommendations by the supplier, as approved by SABS)- Disposable	R	N/A	Chargeable with modifiers 0002 and 0003 up to R520 per set to a maximum of 3 sets;					
112.	Gowns in theatre with hoods and shields (Charnley and similar Reusable Barrier Gowns having breathable and fluid impermeable polymer membrane for multiple use according to recommendations by the supplier, as approved by SABS)- Limited life reusable	R	N/A	Chargeable with modifiers 0002 and 0003 up to R135 per set to a maximum of 3 sets;					
113.	Gowns in ward (barrier SABS approved)- Disposable	N/A	C	Chargeable for reverse barrier nursing and severe burns – motivation to accompany account.					
114.	Harmonic Scalpel, or equivalent - disposable components	R	N/A	Refer to endoscopic list;					
115.	Harmonic Scalpel, or equivalent components – reusable.	F	N/A	Chargeable as per section 5.3.3;					
116.	Head covers (bonnets, caps and similar)	NR	NR						
117.	Head Strap for CPAP	N/A	C	Chargeable when diagnosis- related, e.g. Burns/infectious diseases.					
118.	Heart/Lung Machine	NR	NR						
119.	Heath reflective pads (Critter covers, Neospot and similar);	N/A	C	One daily in Neonatal Specialised Units;					
120.	Heel Hugger-infant	NR	NR	As per scheme arrangement;					
121.	Hibitane Obstetric Cream	N/A	R	Registered ethical product.					
122.	Hibitane Solution - sachets	NR	NR						
123.	Humidifying Chamber (Fisher&Paykel and similar)-Disposable	N/A	C	Adults and neonates – one per LOS in specialised units;					

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
124.	Hydrogen Peroxide	NR	NR						
125.	I.V. Support	C	C	Neonates and Paediatrics < 6 years only - One per LOS per limb and when disorientated in Theatre More to be motivated					
126.	Ice Pack/Cold Pack - disposable	N/A	C	Appropriate procedures only. Payable according to scheme rules;					
127.	Incontinence Products - Draw Sheet	NR	NR						
128.	Incontinence Products - Linen Savers	NR	C	Chargeable to scheme for incontinent patients only. Procedure related e.g. Haemorrhoidectomy or to replace the dressing. Subject to medical scheme rules.					
129.	Incontinence Products - Pads (e.g. sanitary)	C	C	Procedure related e.g. Haemorrhoidectomies, etc., or to replace the dressing; Gynaecological Procedures (D&C) Others to be charged to patient's private account. Subject to medical scheme rules.					
130.	Incontinence Products - Diapers/ Nappies	NR	C	Paediatric or Geriatrics : Gastro only Others to be charged to patient's private account.					
131.	Incontinence Products – Pads e.g. Besure/Molicare	N/A	P						
132.	Jellies and Creams (Terracortril, KY and similar)- fractional use	NR	NR						
133.	K Y Jelly – Sachets	R	R	Procedure related					
134.	Lancets, Autolets, Softclix	NR	C	For Diabetic patient's -account to state Diabetic. For hyperalimentation Chargeable in Pancreatitis not substance abuse related In ICU /NICU /HC /NHC A&B Units					
135.	Laryngeal Masks	F	N/A	2.5% As per section 5.3.5 – item 435					
136.	Laser Components - disposable	R	N/A						
137.	Laser Components - re-usable	F	N/A	Part chargeable as per section 5.3.2					
138.	Laundry Bags - Soluble	NR	C	Chargeable for Barrier nursing (septic cases only) 2 Bags per day per patient as per item 269					
139.	Ligasure Electrode – Disposable	NR	N/A	Preauthorisation required;					
140.	Limb Holder (restrainer) – Disposable	N/A	C	1 per limb per patient per stay on motivation.					
141.	Loan Set Fee	NR	NR						
142.	Marking Pen – sterile (Codman Marker and similar)	C	NR	Procedure related: Craniotomy, Neuro & Spinal. Skin flaps Keratotomy					
143.	Maternity Per Diem Fee	C	N/A	Includes surgical items listed in BHF Schedule Ethical products are chargeable					
144.	Meal Supplements	NR	NR	On motivation					
145.	Meals, Baby Foods, Milk Substitutes	NR	NR						
146.	Medically prescribed meals	N/A	C	By arrangement based on diagnosis Refer to attached Medically Prescribed Meals list					
147.	Medicine Glasses, Spoons and Syringes	NR	C	Syringe chargeable for tube feeding and medicine dosing in Neonatal Specialised Units One syringe per day.					
148.	Mentor Cable - disposable	NR	NR						

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
149.	Mentor Cable - re-usable	NR	NR						
150.	Mercurochrome & Methiolate	NR	NR						
151.	Micro Retractor	NR	NR						
152.	Milk Substitutes	NR	NR						
153.	Milton	NR	NR						
154.	Mixing Systems for Cement	C	N/A	Chargeable as part of Prosthesis, to be included in prosthesis invoice, which accompanies account. Note: Cement containing Antibiotic to be charged separately					
155.	Mother & Baby Pack	NR	NR						
156.	Nasal Cannula – disposable	N/A	C	One per stay if oxygen is administered.					
157.	Nebulising Mask - disposable	N/A	C	One per stay if patient is nebulised.					
158.	Nebulising Mask - Trachea	N/A	C	One per stay if patient is nebulised.					
159.	Neuro Sucker – disposable	C	N/A	Neuro cases only					
160.	Nursing Services	NR	NR						
161.	Operating Instruments - reusable	NR	NR						
162.	Overshoes	NR	NR						
163.	Oximeter	NR	NR						
164.	Oxisensor – disposable	NR	C	One per stay for neonates in specialised units; Not paying if equipment not suitable/ compatible. Not to be charged with Oxitip;					
165.	Oxitip	NR	C	One per stay for neonates in specialised units; Not to be charged with Oxisensor;					
166.	Oxygen Analysers, Hoods, Attachments – disposable	C	C						
167.	Oxygen Analysers, Hoods, Attachments – re-usable	NR	NR						
168.	Oxygen Mask + tubing– disposable	C	C	In recovery if oxygen is administered post operatively. One per patient per stay;					
169.	Pacing Wire and Cables – disposable	C	N/A	Must be procedure related. Maximum 1 cable and 2 wires, excess to be motivated. Subject to medical scheme rules.					
170.	Packing Fee	NR	NR						
171.	PCA Pump – reusable	NR	C	As per item 230 One per patient per day, maximum 48 hours. Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward Chargeable in the following instances: Major joint replacement Open, upper abdominal surgery Severe burns Paediatrics in special cases on motivation Thoracotomies (motivation by practitioner) Intractable pain associated with malignancy					

Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	172.	PCA Pumps – disposable	C	C	As per section 5.16 One per patient per 48 hours. Chargeable in theatre if patient goes directly into ward. Not to be charged in Specialised units, ICU and High Care units Chargeable in the following instances: Major joint replacement Open, upper abdominal surgery Severe burns Paediatrics in special cases on motivation Thoracotomies (motivation by practitioner) Intractable pain associated with malignancy				
	173.	Peak Flow Meter	NR	NR						
	174.	Peak Flow Meter – disposable Mouth Piece	N/A	R						
	175.	Peep Valve and/or CPAP mask – disposable	N/A	C	Max of one CPAP mask per patient per stay Max of two valves per patient per stay More to be motivated					
	176.	Plastic Bags	NR	NR						
	177.	Pour Bottle – Saline	C	C	Chargeable when procedure related, e.g. for wound irrigation. Excessive usage to be motivated. Not to be charged with pour bottle water					
	178.	Pour Bottle – Water	C	C	Not to be charged with pour bottle saline Only chargeable for patient related conditions: flushing of wounds, under water drains and bladder irrigation in theatre and wards *Ventilated Patients 1 litre per 24 hours*					
	179.	Preparation Items (Shaving Trays, Razor, Scrub Brush)	NR	NR						
	180.	Pressure Monitoring Kit - disposable	R	R						
	181.	Pressure relieving mattress (Nimbus and similar)	NR	NR						
	182.	Pressure relieving products (Novogel, Reston foam and similar)	N/A	C	Subject to scheme rules;					
	183.	Probe Covers	N/A	C	One daily in Neonatal Specialised Units					
	184.	Prosthesis	C	N/A	Pre-authorised and benefit to be confirmed by scheme. Supplier's invoice to accompany account. Refer section 5.9 (change)					
	185.	Razors	NR	NR						
	186.	Re-breathing bags (ambubag and equivalents)	NR	NR						
	187.	Receptal Liners & Shut Off Valves	NR	C	Chargeable in ICU, Specialized units and High Care for patients with severe respiratory complications					
	188.	Recovery Room	NR	NR						
	189.	Safety Pins	NR	NR						
	190.	Sampling Lines (Datex and similar)	NR	NR						
	191.	Savlon & Savlodil	NR	NR						

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Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
192.	Servo Ventilator (equipment)	N/A	C	Chargeable only in ICU and High Care where applicable.					
193.	Sheepskin	NR	NR						
194.	Skin Prep Solutions	NR	NR						
195.	Space blanket	R	R	Not to be charged with a warm air blanket					
196.	Spatulas, Tongue Depressors	NR	NR						
197.	Specimen Containers	NR	NR						
198.	Spigots	NR	NR						
199.	Spirometer (Incentive and similar)-Dispoasble	NR	NR	Chargeable as TTO					
200.	Spray Top Bottles	NR	NR						
201.	Sprays (Opsite, Disidine)- fractional use	NR	NR						
202.	Sputum Cups	NR	NR						
203.	Sterilising of Instruments or Materials	NR	NR						
204.	Sterilising Solutions, Gases and Tablets	NR	NR						
205.	Steripeel & Equivalents	NR	NR						
206.	Sternal support products (Heart Hugger and similar)	NR	NR	As per scheme arrangement;					
207.	Stethoscopes	NR	NR						
208.	Stitch Cutter	NR	NR						
209.	Stone Baskets – Disposable	R	N/A	1 basket only to a max of R2496 May not be used together item 224 in tariff schedule					
210.	Stone Baskets – re-useable	NR		Re-usable chargeable as per item 224 in tariff schedule					
211.	Suction Nozzle – disposable	R	R						
212.	Swivel Connector – disposable	NR	NR	Part of Ventilator Circuit					
213.	Swivel Connector – re-usable	NR	NR						
214.	Tantol Cleanser / Lotion	N/A	P						
215.	Taps & Reamers	NR	N/A						
216.	Temperature Probe Covers	C	C	One daily in Neonatal Specialised units Not to be charged together with disposable probe.					
217.	Theatre Drapes - Incise	R	N/A	As per section 5.15					
218.	Theatre Drapes - Ophthalmic	R	N/A	As per section 5.15					
219.	Theatre Drapes- Equipment (Microscope, camera, drill sleeve, Mayo and similar)	NR	N/A	Included in the Tariff					
220.	Theatre Drapes– Patient Isolation (Non-woven, paper, plastic, polyethylene based)-Disposable	C	N/A	Chargeable when used in the following Procedures: Hip, knee, shoulder and elbow joint replacements. Open heart and cardiac bypass surgery. Vascular Surgery (Excluding Catheterisation Laboratory procedures) Neuro-Surgery (Brain and Spinal cord) Arthroscopy of hip, shoulder, knee or elbow joints Spinal surgery					
221.	Theatre Drapes-Instrument holders (1018 and similar)	C	N/A	Cranial Procedures only;					
222.	Thermometer- Reusable	NR	NR						

Code		Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
	223.	Thermometers/Temperature Probes (Oesophageal or Rectal)-Disposable	C	C	Chargeable in Cardio-Thoracic cases (one rectal and one oesophageal) or theatre cases longer than 3 hours at anaesthetist's discretion One per patient per every 3 weeks in Neonatal Specialised Units Probe Covers one per day					
	224.	Thoraguide Kit (for underwater drainage)	R	C	Chargeable in I.C.U and Emergency Room					
	225.	Toiletries (face cloths, toothbrush, soaps and similar)	NR	NR						
	226.	Topical Anaesthetics (Remicaine and similar)	C	C	When full tube used per patient. Procedure related (Male catheterisation in ward, Haemorrhoidectomy, TUR)					
	227.	Topical anaesthetics (Remicaine, Xylocaine , Anethaine and similar)-fractional use	NR	NR						
	228.	Transducers – disposable	R	R						
	229.	Trays – sterile	NR	C	Tray and contents not to be charged together If price exceeds max. then contents must be charged Disposable contents only chargeable Ready made packs – list of contents and price to be supplied. Small trays, swabbing, ENT – R9.00 Large trays – dressing, cath, multipack – R15.60					
	230.	Tubing – reusable	NR	NR						
	231.	Tubing –disposable	C	C	Maximum R31 payable on tubing per stay unless patient returns to Theatre then an additional R31 may be charged per additional visit					
	232.	Ung Emulsificans	NR	C	When used in treatment on prescription.					
	233.	Vascular sealing devices (Angioseal, Vasoseal, Perclose, The Closer, and similar);	NR	NR						
	234.	Vaseline	NR	NR						
	235.	Ventilators (Servo, Bennett) - equipment	N/A	C	Chargeable only in ICU and High Care where applicable.					
	236.	Water Bottle – Pour			Refer Pour Bottles					
	237.	Wipes (unisolve, baby and similar)	NR	NR						
	238.	X ray swabs in the ward (abdominal swabs and similar);	R	C	Chargeable in the ward for: Severe septic cases (laparotomy, burns and similar); Unsutured chests in Cardio- thoracic ICU. Subject to case management.					
	239.	Xylocaine Spray	NR	NR						
	240.	Yankauer Suction – Plain Yankauer Suction with Control	C	C	Disposable max. 2 per case. (One of each) In ward for resuscitation and trauma only					
	241.	Zinc & Castor Oil Cream	N/A	N/A						
	APPENDIX C Infectious Diseases CONDITION									04.00

Code	Description	Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
				RVU	Fee	RVU	Fee	RVU	Fee
	Acute Flaccid Paralysis Anthrax Chicken Pox Diptheria Haemophyllis influenza Haemorrhagic fevers of Africa: ¢ Crimean-Congo Ebola ¢ Lassa ¢ Marburg ¢ Rift Valley ¢ Dengue Herpes Zoster HIV/AIDS Legionnaires Disease Measles: ¢ Rubeola ¢ Rubella Meningococcal infections Multi-drug Resistant Bacteria: ¢ MRSA ¢ VRE ¢ MRSE Poliomyelitis Pyrexia unknown origin Rabies Small Pox Tuberculosis Pulmonary Typhus Fever Viral Hepatitis Whooping Cough (Pertussis) Note: The above is a general list and the clinical appropriate use of items for specific conditions is subject to Case Management.								
	APPENDIX D Medically Prescribed Meals:								04.00

ORAL SUPPLEMENTS	Standard	Ensure
(oral and tube feeds)		Fortisip
		Fortimel
		Fresubin Original drink (Vanilla)
		Nutren And Nutren Jnr (Gluten -free)
	Standard & Fibre	Ensure with Fibre
		Nutren with Fibre
	Isotonic	Fresubin Original
	Isotonic &Fibre	Fresubin Original Fibre
		Jevity

Code	Description		Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
					RVU	Fee	RVU	Fee	RVU	Fee
		Jevity								
		Osmolite								
	Low Residue	Modulen N								
		Osmolite HN								
		Peptamen & Peptamen Jnr								
	High Energy, High Protein & Fibre	Fresubin Energy Fibre drink (Lemon, Banana, Chocolate & Capuchino)								
	High Energy & High Protein	Fresubin Energy drink								
		(Strawberry & Vanilla)								
TUBE FEEDS	Semi-Elemental	Alitraq								
		Peptamen & Peptamen Jnr RTH								
		Peptisorb								
		Survimed OPD (Liquid)								
		Vital								
	Standard	Nutren RTH								
		Nutrison								
		Nutrison Energy								
		Nutrison Paediatric								
	High Energy & High Protein	Fresubin 750 MCT(HP Energy)								
	Semi-Elemental High Protein & High Fibre	Perative,								
		Nutren Fibre RTH								
DISEASE SPECIFIC	Maximum Glucose Tolerance	Fresubin Diabetes								
		Glucerna								
		Nutren Diabetes								
	Pulmonary Insufficiency	Pulmocare								
		Supportan								
	Renal Failure	Suplena								
	HIV/Aids	Advera								
		Survimed OPD								
		Supportan								
	Cancer Patients	Supportan drink (Milk Coffee),								

Code	Description			Ver	Add	Private Hospitals ('A' - Status)		Private Hospitals ('B' - Status)		Approved U O T U / Day clinics	
						RVU	Fee	RVU	Fee	RVU	Fee
			Stresson Multi Fibre,								
			Peptisorb								
	MODULAR	Protein	Promod								
			Protifar								
		MCT Oil	MCT Oil								
			Fresubin 750MCT(HP Energy)								
		Glutamine	Glutapack-10								
			Dipeptiven 50ml & 100ml								
		Food thickener	Thick & Easy								
		Carbohydrate	Fantomalt								
			Polycose								
	Note: Or generic equivalents. All tubes feeds subject to Case Management										

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				55700					55800					577		
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE HOSPITALS (PRACTICE NUMBERS "57" OR "58") AND UNATTACHED OPERATING THEATRE UNITS/DAY CLINICS (PRACTICE NUMBER "77") WITH EFFECT FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag	CF	Units	BF
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00														
	GENERAL RULES																
	SCHEDULE																
B	The charges relating to each type of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.	2004.00															
C	The charges indicated in Section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.	2004.00															
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00															
E.1	Procedure for the classification of hospitals:	2004.00															
E.1.1	Inspections private hospitals or unattached operating theatre units/day clinics having practice code numbers commencing with the digits 057, 058 or 077 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	2004.00															
E.3.2	The provisions referred to in E.1.1 shall apply mutatis mutandis to all approved specialised intensive care units, specialised theatres, catheterisation laboratories and trauma unit.	2004.00															
F.1	Procedures to consider applications by institutions to be classified as unattached operating theatre units having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units with 76 practice numbers.	2004.00															
F.1.1	Inspections of new unattached theatre operating units and units having practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units having practice numbers commencing with the digits 77 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	2004.00															
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	2004.00															

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H	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the hospital/unattached operating theatre unit concerned.	2004.00																
I	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00																
1	ACCOMMODATION																	
	Ward fees																	
	Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts.□ □ In the case of hospitals, the day admission fee (code 007) shall be charged in respect of all patients admitted as day patients and discharged before 23h00 on the same date.□ □ The following will be applicable to items 001 to 005, 015, 020, 200, 201, 202 and 215 to 218:□ □ On the day of admission:□ If accommodation is less than 12 hours from time of admission : half the daily rate□ If accommodation is more than 12 hours from time of admission: full daily rate□ □ Two half day fees would be applicable when a patient is transferred internally between any ward and any specialised unit.□ □ On day of discharge:□ If accommodation is less than 12 hours: half the daily rate□ If accommodation is more than 12 hours: full daily rate□ □ The items listed as non-recoverable in Annuxure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.	2004.00																
1.1	General Wards																	
001	Surgical cases: per day.	2004.00		320	36.063	1.0	R 1 003.80		320	36.063	1.0	R 1 003.80		320	-	0.0		
002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	2004.00		320	37.888	1.0	R 1 054.70		320	37.888	1.0	R 1 054.70		320	-	0.0		
003	Psychiatric general ward fee, per day	2004.00		320	29.854	1.0	R 831.00		320	29.854	1.0	R 831.00		320	-	0.0		
004	Medical and neurological cases: per day.	2004.00		320	36.063	1.0	R 1 003.80		320	36.063	1.0	R 1 003.80		320	-	0.0		
005	Paediatric cases (under 14 years of age)	2004.00		320	44.513	1.0	R 1 239.10		320	44.513	1.0	R 1 239.10		320	-	0.0		
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day	2004.00																
007	Day admission (irrespective of type of ward patient is admitted to, i.e. general, neurosurgical or paediatric) which includes all patients discharged by 23h00 on date of admission	2004.00		320	23.079	1.0	R 642.40		320	23.079	1.0	R 642.40		320	19.725	1.0		
014	Overnight fee - Medical practitioner to pre-authorise all overnight admissions	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	8.692	1.0		

019	Out-patients facility fee for ambulatory admission - chargeable for patients admitted for local anaesthetic procedures - No ward fees applicable. Note: Each account should be accompanied by a report from the practitioner indicating the nature of the complication. Definition: Item 019 may only be used in conjunction with item 071 for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335	2004.00		320	10.679	1.0	R 297.30		320	10.679	1.0	R 297.30		320	10.679	1.0
022	Out-patient wound care facility	2004.00		320	5.263	1.0	R 146.50		320	5.263	1.0	R 146.50		320	5.263	1.0
	Maternity															
	1. The maternity fees are a fixed per diem fee and replace all other charges: □ INCLUDING:□ □ Charges such as multiple births (nursery fee for 2nd baby excluded);□ After-hour deliveries (including caesareans);□ Labour ward or other ward fees, nursery fees;□ Incubators;□ Phototherapy;□ Theatre and equipment fees; and □ Surgical items (see list under point 8). □ □ But EXCLUDE□ Sections 5.1 to 5.3;□ Sections 5.7 to 5.8 (Gases); and□ □ 1. The costs of special treatment of newly born infants, e.g. circumcision certified as necessary by the attending practitioner, which shall be dealt with in accordance with the National Reference Price List for private hospitals and the rules of the relevant scheme pertaining to such dependants.□ □ 2.□If an epidural anaesthetic is given for either a vaginal delivery or a caesarean section, an additional fee (item 011) may be charged. This comprises of an epidural pack, all consumables used, as well as nursing time.□ □ 3.□An uncomplicated stay in a nursery for routine observation is included in the maternity fee, as well as phototherapy and routine high care observation after delivery for the new born baby.□	2004.00														
	Natural births															
009	First day (Day of confinement).	2004.00		320	174.458	1.0	R 4 856.20		320	174.458	1.0	R 4 856.20		320	-	0.0
010	Subsequent day(s).Per day	2004.00		320	60.096	1.0	R 1 672.80		320	60.096	1.0	R 1 672.80		320	-	0.0
017	Subsequent day(s) excluding nursery fee.	2004.00		320	43.717	1.0	R 1 216.90		320	43.717	1.0	R 1 216.90		320	-	0.0
	Caesarean															
012	First day (Day of confinement).	2004.00		320	270.992	1.0	R 7 543.30		320	270.992	1.0	R 7 543.30		320	-	0.0
013	Subsequent day(s). Per day	2004.00		320	59.583	1.0	R 1 658.60		320	59.583	1.0	R 1 658.60		320	-	0.0
	Note: The following fees (items 015 and 016) are included in the above per diem fees, and may only be charged on a fee for service account	2004.00														
015	Nursery fee.	2004.00		320	16.925	1.0	R 471.10		320	16.925	1.0	R 471.10		320	-	0.0

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016	Delivery room. This item is not applicable for deliveries by registered midwifes in private practice.	2005.03		320	72.746	1.0	R 2 025.00		320	72.746	1.0	R 2 025.00		320	-	0.0
018	Subsequent day(s) excluding nursery fee	2004.00		320	42.963	1.0	R 1 195.90		320	42.963	1.0	R 1 195.90		320	-	0.0
	Epidural fee															
011	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	2004.00		320	26.500	1.0	R 737.70		320	26.500	1.0	R 737.70		320	-	0.0
	Birthing Unit															
	The birthing unit fee may only be charged by an approved maternity unit in a hospital. It includes preparation, labour room, recovery ward fee for mother and baby and the maternity basket. The only additional charge that may be levied is for pharmaceuticals.□ □ This fee may not be charged for together with the per diem fees for maternity and is not applicable to medical practitioners or other professions.	2005.03														
030	Global fee for a Birthing Unit (Accredited or Approved by BHF). This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient is discharged within 12 hours from birth.	2005.03		320	109.004	1.0	R 3 034.20		320	109.004	1.0	R 3 034.20		320	-	0.0
031	Global fee for a Birthing Unit (Accredited or Approved by BHF) This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient stay exceed 12 hours and is discharged within 24 hours from birth.	2005.03		320	169.100	1.0	R 4 707.10		320	169.100	1.0	R 4 707.10		320	-	1.0
032	Additional Birthing Unit fee chargeable for every additional 12 hours of patient stay beyond the 24 hours contemplated in code 031	2005.03		320	30.026	1.0	R 835.80		320	30.026	1.0	R 835.80		320	-	1.0
1.2	Private Wards															
020	Private ward Hospitals shall obtain a certificate motivating for the necessity for accommodation in a private ward, including reversed barrier nursing, from the attendant practitioner, and such certificate shall be forwarded to the relevant scheme for pre-authorisation. General ward fees are applicable to isolation.	2004.00		320	46.608	1.0	R 1 297.40		320	46.608	1.0	R 1 297.40		320	-	0.0
021	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
1.3	Special Care Units															
	Specialised units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), Neonatal Intensive Care Unit (NICU), High Care (HC), Neonatal High Care (NHC), A & B.	2004.00														
	Hospitals shall obtain a certificate stating the reason for accommodation in any specialised or other intensive care unit or in high care ward including neonatal intensive care and high care from the attending practitioner, and such certificate showing the date and time of admission and discharge from the unit shall be forwarded to the relevant medical scheme for pre-authorisation.□ □ No charge may be levied to medical schemes for special or private nursing.□ □ Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF.	2004.00														

200	Specialised ICU (As approved by BHF according to General Rule E.1.1) Per day	2004.00	320	195.088	1.0	R 5 430.50	320	195.088	1.0	R 5 430.50	320	-	0.0
	(Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. Item 201 will apply if no pre-authorisation is obtained. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neuro-surgery cases involving surgery on the brain and spinal cord).	2004.00											
201	Intensive Care Unit: Per day.	2004.00	320	148.479	1.0	R 4 133.10	320	148.479	1.0	R 4 133.10	320	-	0.0
202	Neonatal Intensive Care Unit: Per day.	2004.00	320	184.863	1.0	R 5 145.80	320	184.863	1.0	R 5 145.80	320	-	0.0
	(The charges referred to under items 200, 201 and 202 include the use of all equipment except: Bennett MA, Servo and Bear ventilators or equivalent apparatus plus the cost of oxygen)	2004.00											
215	High Care Ward, Per day.	2004.00	320	95.108	1.0	R 2 647.40	320	95.108	1.0	R 2 647.40	320	-	0.0
216	Neonatal High Care Ward `A' (Intensive nursing and monitoring)	2004.00	320	103.308	1.0	R 2 875.70	320	103.308	1.0	R 2 875.70	320	-	0.0
217	Neonatal High Care Ward `B' (Standard nursing and monitoring)	2004.00	320	67.538	1.0	R 1 880.00	320	67.538	1.0	R 1 880.00	320	-	0.0
218	Neonatal ward fee (Pre-discharge - This fee may not be charged for routine post-natal nursery care).	2004.00	320	44.513	1.0	R 1 239.10	320	44.513	1.0	R 1 239.10	320	-	0.0
	Note: Once the baby has been stabilised and no longer requires ICU care but is not ready to be returned to the general nursery, no additional equipment charges, eg phototherapy may be charged.□ □ All admissions to units/wards referred to under 201 to 202 shall be confirmed with the relevant scheme for each 72 hours and 215 to 218 shall be confirmed weekly with the relevant scheme.	2004.00											
2	EMERGENCY UNIT												
2.1	Emergency Unit Fee												
105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by BHF	2004.00	320	45.858	1.0	R 1 276.50	320	45.858	1.0	R 1 276.50	320	-	0.0
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	2004.00	320	-	0.0	R -	320	-	0.0	R -	320	-	0.0
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	2004.00	320	10.533	1.0	R 293.20	320	10.533	1.0	R 293.20	320	10.533	1.0
	Note: The procedure room fee (071) cannot be charged in addition to 302	2004.00											
2.2	THEATRE FEES												
061	Excimer Laser Theatre fee, per minute	2004.00	320	0.650	1.0	R 18.10	320	0.650	1.0	R 18.10	320	0.650	1.0
	The items listed as non-recoverable in Annuxure B shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.	2004.00											
	Minor Theatre, regardless of type of theatre available, the incident is procedure driven and not facility driven												
	A facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and short or no general anaesthetic, are carried out. No Sophisticated monitoring is required but resuscitation equipment (trolley) must be available in the procedure room. Conscious sedation by arrangement with scheme.	2004.00											
	Time in minor theatre												
071	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	2004.00	320	0.500	1.0	R 13.90	320	0.500	1.0	R 13.90	320	0.429	1.0

	The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows	2004.00															
2.3	Major theatre																
	In addition to the theatre charge calculated as above, a surcharge (modifier 0002 and/or 0003) shall be allowed in cases where specialised theatres referred to in General Rule E.1.1 are utilised for the performance of any of the undermentioned procedures, whether carried out individually or in combination with each other, this surcharge shall be deemed to cover the equipment in the criteria.□ □ Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF	2004.00															
0002	Modifier 0002: Orthopaedic, Neurosurgical and Vascular: · Joint replacements (only hip, knee, shoulder ankle or elbow) · Femoral popliteal bypasses · Carotid endarterectomies · Aortic Aneurysm repair and arterial grafts · Neurosurgery (Surgery on the brain and spinal cord only, excludes neurolysis)	2004.00		320	48.309	1.0	R 1 344.73		320	48.309	1.0	R 1 344.73		320	-	0.0
0003	Modifier 0003: Cardiac surgery Cardio-thoracic and Cardio-vascular surgery · All open heart surgery, with or without the insertion of a prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment (except item 513), no additional fees may be charged NOTE: The above surcharge will also be applicable to approved provincial hospitals	2004.00		320	110.688	1.0	R 3 081.11		320	110.688	1.0	R 3 081.11		320	-	0.0
	Time in Theatre																
081	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	2004.00		320	1.554	1.0	R 43.30		320	1.554	1.0	R 43.30		320	1.329	1.0
	The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows	2004.00															
	Specialised Theatre Modifiers																
3	PROCEDURAL FEES																
	The fees quoted for items 052, 053 and 055 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533, 535 and any items chargeable in terms of Section 4 and 5 hereof.□ □ NOTE: Ward fees may however be chargeable together with items 053 and 055.	2005.03															
3.1	Procedures																
052	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	2004.00		320	14.342	1.0	R 399.20		320	14.342	1.0	R 399.20		320	14.342	1.0
053	Angiograms.	2004.00		320	14.342	1.0	R 399.20		320	14.342	1.0	R 399.20		320	-	0.0
055	Electroconvulsive therapy (ECT)	2004.00		320	14.342	1.0	R 399.20		320	14.342	1.0	R 399.20		320	14.342	1.0
3.2	Catheterisation laboratory procedures																
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information if required by the medical scheme.	2005.03															

	The fees quoted for items 054, 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533 and 535 and any items chargeable in terms of Section 4 and 5 hereof.□ □ NOTE: ward fees may however be chargeable together with items 054, 055, 056, 070 and 073.	2005.03														
054	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1 NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.	2004.00		320	51.446	1.0	R 1 432.10		320	51.446	1.0	R 1 432.10		320	-	0.0
056	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	2004.00		320	96.929	1.0	R 2 698.10		320	96.929	1.0	R 2 698.10		320	-	0.0
070	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1. NB: EPS for cardiac ablations - items 529 must be charged additionally.	2004.00		320	251.804	1.0	R 7 009.20		320	251.804	1.0	R 7 009.20		320	-	0.0
073	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital equipped to perform the relevant surgery, as approved by the committee established in terms of General Rule E.1.1	2004.00		320	186.233	1.0	R 5 184.00		320	186.233	1.0	R 5 184.00		320	-	0.0
075	Catheterisation laboratory film price (once per procedure)	2004.00		320	5.546	1.0	R 154.40		320	5.546	1.0	R 154.40		320	-	0.0
3.3	Radiation Oncology															
	Simulation - Fixed custom made															
902	Simple - Simulation of a single area with either a single port or parallel opposed ports. Simple or no blocking or use of custom/home made simulation	2004.00		320	15.263	1.0	R 424.90		320	15.263	1.0	R 424.90		320	-	0.0
903	Intermediate - Simulation of three or more converging ports, two separate treatment areas or multiple blocks.	2004.00		320	23.283	1.0	R 648.10		320	23.283	1.0	R 648.10		320	-	0.0
904	Complex - Simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocks, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast	2004.00		320	30.525	1.0	R 849.70		320	30.525	1.0	R 849.70		320	-	0.0
905	Computerised Tomographic.	2004.00		320	30.525	1.0	R 849.70		320	30.525	1.0	R 849.70		320	-	0.0
	Treatment Planning															
906	Manual.	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
907	Simple - Planning requiring single treatment area of interest in a single port or simple parallel opposed ports with simple or no blocking	2004.00		320	14.383	1.0	R 400.40		320	14.383	1.0	R 400.40		320	-	0.0

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908	Computerised (intermediate) - Planning requiring three or more ports, two separate treatment areas, multiple blocks or special time dose constraints	2004.00		320	21.942	1.0	R 610.80		320	21.942	1.0	R 610.80		320	-	0.0
909	Computerised (complex) - Planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations or a combination of therapeutic modalities	2004.00		320	28.742	1.0	R 800.10		320	28.742	1.0	R 800.10		320	-	0.0
	Technical Aids																
910	Control films (As per radiology film price list).	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
911	Dosimetric procedures.	2004.00		320	0.838	1.0	R 23.30		320	0.838	1.0	R 23.30		320	-	0.0
912	Artefacts: Simple - design and construction (simple block or bolus)	2004.00		320	2.096	1.0	R 58.30		320	2.096	1.0	R 58.30		320	-	0.0
913	Artefacts: Intermediate - design and construction (multiple blocks, stents, bite blocks, special bolus).	2004.00		320	5.704	1.0	R 158.80		320	5.704	1.0	R 158.80		320	-	0.0
914	Artefacts: complex (specify) - design and construction (irregular blocks, special shields, compensators, wedges, molds or casts)	2004.00		320	11.404	1.0	R 317.40		320	11.404	1.0	R 317.40		320	-	0.0
	Linear accelerator treatment																
915	Photon treatment, single field.	2004.00		320	22.288	1.0	R 620.40		320	22.288	1.0	R 620.40		320	-	0.0
916	Photon treatment, multiple fields	2004.00		320	32.100	1.0	R 893.50		320	32.100	1.0	R 893.50		320	-	0.0
917	Electron treatment.	2004.00		320	22.288	1.0	R 620.40		320	22.288	1.0	R 620.40		320	-	0.0
919	Brachytherapy - global fee per patient.	2004.00		320	169.388	1.0	R 4 715.10		320	169.388	1.0	R 4 715.10		320	-	0.0
3.4	Stereotactic radiosurgery																
	Included in item 430 □ Stereotactic frames and attachments□ Linear Accelerator□ Specialised graphic planning, hardware and software□ Simulator and dark rooms□ 10 dental films□ Stereotactic masks□ All disposables□ 4 to 20 Graphic transparencies (including 1 week of planning)□ 2 trained radiographers□ Fixation and immobilisation□ Nuclear Specialist Medical Physicist□ Duration 1 - 4 hours□ 2 treatment radiographers□ Excluded from fee□ Other medical practitioners□ CT & MRI	2004.00															
399	Linear Accelerator radiosurgery - Global Fee	2004.00		320	#######	1.0	##########		320	#######	1.0	##########		320	-	0.0
	Item 399 is an all- inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all the professional providers of service involved in the treatment rendered under this item.	2004.00															
430	Global fee for stereotactic radiosurgery	2004.00		320	#######	1.0	R 70 163.40		320	#######	1.0	R 70 163.40		320	-	0.0
4	STANDARD CHARGES FOR EQUIPMENT																

220	Ballistic Lithotripsy/Lithoclast: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	2004.00		320	18.700	1.0	R 520.50		320	18.700	1.0	R 520.50		320	18.700	1.0
221	Ballistic Lithotripsy/Lithoclast: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	2004.00		320	12.454	1.0	R 346.70		320	12.454	1.0	R 346.70		320	12.454	1.0
222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	2004.00		320	124.638	1.0	R 3 469.40		320	124.638	1.0	R 3 469.40		320	124.638	1.0
223	Laser Lithotripsy: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	2004.00		320	83.021	1.0	R 2 311.00		320	83.021	1.0	R 2 311.00		320	83.021	1.0
224	Stone basket (reusable) for the removal of kidney-, bladder- or gallstones: Per case	2004.00		320	50.263	1.0	R 1 399.10		320	50.263	1.0	R 1 399.10		320	50.263	1.0
225	Stereotactic equipment for use in neuro-surgical procedures, when used in conjunction with x-rays, MRI scans or CAT scans: Per case	2004.00		320	48.033	1.0	R 1 337.00		320	48.033	1.0	R 1 337.00		320	-	0.0
226	Continuous Passive Exerciser: Per day.	2004.00		320	3.808	1.0	R 106.00		320	3.808	1.0	R 106.00		320	3.808	1.0
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	2004.00		320	10.604	1.0	R 295.20		320	10.604	1.0	R 295.20		320	10.604	1.0
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	2004.00		320	5.242	1.0	R 145.90		320	5.242	1.0	R 145.90		320	5.242	1.0
230	Patient-controlled analgesia pump, being a programmable reusable analgesia infusion system, providing patient control and/or continuous analgesia modes with mechanisms to limit self administration per time period and with lockout interval. Applicable only to administration of analgesics: Per day	2004.00		320	4.021	1.0	R 111.90		320	4.021	1.0	R 111.90		320	4.021	1.0
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward□ Chargeable in the following instances:□ - Major joint replacement□ - Open, upper abdominal surgery□ - Severe burns□ - Paediatrics in special cases on motivation□ - Thoracotomies (motivation by practitioner)□ - Intractable pain associated with malignancy	2004.00														
231	Cardiac monitors - in private, general and high care wards only - not to be charged for routine ECG's: Per day or part thereof	2004.00		320	4.371	1.0	R 121.70		320	4.371	1.0	R 121.70		320	-	0.0
232	Bird or equivalent free standing nebuliser (excluding oxygen): Per day	2004.00		320	3.129	1.0	R 87.10		320	3.129	1.0	R 87.10		320	3.129	1.0
233	Croupettes (excluding oxygen): Per day or part thereof	2004.00		320	0.896	1.0	R 24.90		320	0.896	1.0	R 24.90		320	-	0.0
234	Incubators (excluding oxygen) (not chargeable together with items 215 to 218: Per day or part thereof	2004.00		320	1.675	1.0	R 46.60		320	1.675	1.0	R 46.60		320	-	0.0
235	Oxygen tents (excluding oxygen): Per day or part thereof	2004.00		320	1.458	1.0	R 40.60		320	1.458	1.0	R 40.60		320	-	0.0
236	Mechanical ventilator or equivalent (only in ICU and high care ward where no ICU is available) (excluding oxygen): Per day or part thereof	2004.00		320	13.963	1.0	R 388.70		320	13.963	1.0	R 388.70		320	-	0.0
237	CUSA (plus CUSA pack as per section 5).	2004.00		320	67.804	1.0	R 1 887.40		320	67.804	1.0	R 1 887.40		320	-	0.0
238	Lasers - Argon or Holium (ophthalmic).	2004.00		320	21.004	1.0	R 584.70		320	21.004	1.0	R 584.70		320	21.004	1.0
239	Lasers - CO2 (surgical).	2004.00		320	27.138	1.0	R 755.40		320	27.138	1.0	R 755.40		320	27.138	1.0

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241	Lasers - Candella (Rates by arrangement with the scheme concerned)	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
242	Occutomes.	2004.00		320	8.933	1.0	R	248.70		320	8.933	1.0	R	248.70		320	8.933	1.0
243	Lasers - YAG (ophthalmic).	2004.00		320	23.683	1.0	R	659.20		320	23.683	1.0	R	659.20		320	23.683	1.0
244	Lasers - YAG (surgical).	2004.00		320	29.492	1.0	R	820.90		320	29.492	1.0	R	820.90		320	29.492	1.0
245	First Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment for one or more stones in same kidney which are eliminated in one treatment.	2004.00		320	272.863	1.0	R	7 595.40		320	272.863	1.0	R	7 595.40		320	272.863	1.0
246	Second Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	2004.00		320	181.733	1.0	R	5 058.70		320	181.733	1.0	R	5 058.70		320	181.733	1.0
	Note: The fees in respect of items 220 to 223, 245 to 246 and 339 to 341 are inclusive of all equipment and components but exclusive of theatre fees and items chargeable under Section 5.□ □ The C-arm (item 249) and screening table (item 251) are not chargeable with these equipment fees.	2004.00																
249	C Arm (not chargeable when Modifiers 0002, 0003 or item 251 applies).	2004.00		320	8.817	1.0	R	245.40		320	8.817	1.0	R	245.40		320	8.817	1.0
250	Ultrasonic imaging equipment.	2004.00		320	14.738	1.0	R	410.20		320	14.738	1.0	R	410.20		320	14.738	1.0
	(Limited to real-time imaging equipment for transrectal applications with needle-biopsy capability or Doppler ultrasound for vascular anatomy and haemo-dynamics)□ □ Note: This can be used for infertility treatment	2004.00																
251	Screening table - fixed base urology table (including all radiographic equipment) (See item 249) Note: May not be used in conjunction with items 220 to 223, 245 to 246 and 339 to 341.	2004.00		320	19.883	1.0	R	553.50		320	19.883	1.0	R	553.50		320	19.883	1.0
252	Gastroscope (fibre optic/flexible only).	2004.00		320	11.617	1.0	R	323.40		320	11.617	1.0	R	323.40		320	11.617	1.0
253	Colonoscope (fibre optic/flexible only)	2004.00		320	12.992	1.0	R	361.60		320	12.992	1.0	R	361.60		320	12.992	1.0
254	Duodenoscope (fibre optic/flexible only).	2004.00		320	12.308	1.0	R	342.60		320	12.308	1.0	R	342.60		320	12.308	1.0
255	Sigmoidoscope (fibre optic).	2004.00		320	9.979	1.0	R	277.80		320	9.979	1.0	R	277.80		320	9.979	1.0
256	Bronchoscope (flexible/fibre optic, adults).	2004.00		320	8.200	1.0	R	228.30		320	8.200	1.0	R	228.30		320	8.200	1.0
257	Laryngoscope (fibre optic/flexible excluding intubation)	2004.00		320	4.788	1.0	R	133.30		320	4.788	1.0	R	133.30		320	4.788	1.0
258	Sinoscope (rigid only)	2004.00		320	5.463	1.0	R	152.10		320	5.463	1.0	R	152.10		320	5.463	1.0
259	Oesophagoscope (rigid only)	2004.00		320	2.725	1.0	R	75.90		320	2.725	1.0	R	75.90		320	2.725	1.0
261	Hysteroscope	2004.00		320	3.429	1.0	R	95.40		320	3.429	1.0	R	95.40		320	3.429	1.0
262	Colposcope (Not chargeable when item 239 applies)	2004.00		320	4.788	1.0	R	133.30		320	4.788	1.0	R	133.30		320	4.788	1.0
263	Cysto Urethroscope	2004.00		320	4.108	1.0	R	114.40		320	4.108	1.0	R	114.40		320	4.108	1.0
264	Arthroscope (including basic reusable instruments and equipment)	2004.00		320	11.200	1.0	R	311.80		320	11.200	1.0	R	311.80		320	11.200	1.0

	Note: The basic reusable instruments and equipment (which would always include the equivalent to the items named) are included in the fee of item 264 (see list below) :□ □ - Telescope, light source, cable□ - Monitor□ - Electrosurgical instrument□ - High frequency cord□ - Obturator□ - Camera□ - Focussing camera coupler□ - Control console, footswitch□ - Probe, scissors, (hooked, parrot beak), grasper, forceps (punch basket, duckbill), camelback handle, powered arthroplasty system, handpiece.	2004.00																
294	Transcranial Doppler	2004.00		320	24.417	1.0	R	679.70		320	24.417	1.0	R	679.70		320	-	0.0
295	Ultrasonic Cutting and Coagulating Devices (See section 5.3.3)	2004.00		320	6.721	1.0	R	187.10		320	6.721	1.0	R	187.10		320	6.721	1.0
335	Excimer laser: Hire fee per eye	2004.00		320	74.092	1.0	R	2 062.40		320	74.092	1.0	R	2 062.40		320	74.092	1.0
337	Microkeratome used with an excimer laser, per operation.	2004.00		320	13.608	1.0	R	378.80		320	13.608	1.0	R	378.80		320	13.608	1.0
339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	2004.00		320	8.279	1.0	R	230.50		320	8.279	1.0	R	230.50		320	8.279	1.0
341	Ballistic lithotripsy magnetic: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	2004.00		320	5.525	1.0	R	153.80		320	5.525	1.0	R	153.80		320	5.525	1.0
343	Sigmoidoscope (rigid, adults)	2004.00		320	2.050	1.0	R	57.10		320	2.050	1.0	R	57.10		320	2.050	1.0
345	Sigmoidoscope (rigid, paediatrics)	2004.00		320	1.658	1.0	R	46.20		320	1.658	1.0	R	46.20		320	1.658	1.0
347	Bronchoscope (flexible/fibre optic, paediatrics)	2004.00		320	8.200	1.0	R	228.30		320	8.200	1.0	R	228.30		320	8.200	1.0
	Note: For codes 252-256 and 343-347, reusable biopsy and polyp forceps are included in the fee.	2004.00																
348	Bronchoscope (rigid, adults)	2004.00		320	3.283	1.0	R	91.40		320	3.283	1.0	R	91.40		320	3.283	1.0
349	Bronchoscope (rigid, paediatrics)	2004.00		320	4.788	1.0	R	133.30		320	4.788	1.0	R	133.30		320	4.788	1.0
360	Category 1 - Laparoscopy and thoracoscopy, per case. See Annexure A	2004.00		320	26.825	1.0	R	746.70		320	26.825	1.0	R	746.70		320	26.825	1.0
364	Category 2 - Interventional Laparoscopic and Thorascopic procedures, per case. See Annexure A	2004.00		320	31.867	1.0	R	887.00		320	31.867	1.0	R	887.00		320	31.867	1.0
507	Argon Beamer (See section 5.3.2)	2004.00		320	2.721	1.0	R	75.70		320	2.721	1.0	R	75.70		320	2.721	1.0
	Note: The Argon Beamer will not apply where a standard electosurgery unit is used. It can only be used with surgery on internal organs and in neurosurgery.	2004.00																
509	Endometrial Resection (Radio frequency)	2004.00		320	16.425	1.0	R	457.20		320	16.425	1.0	R	457.20		320	16.425	1.0
511	Colour Doppler (external)	2004.00		320	49.167	1.0	R	1 368.60		320	49.167	1.0	R	1 368.60		320	49.167	1.0
513	Transoesphageal Colour Doppler. (May be charged together with Modifier 0003)	2004.00		320	59.325	1.0	R	1 651.40		320	59.325	1.0	R	1 651.40		320	59.325	1.0
515	Cardiorhythm Ablater. (May be charged in addition to the catheterisation Laboratory).	2004.00		320	32.313	1.0	R	899.50		320	32.313	1.0	R	899.50		320	32.313	1.0
517	Phaco emulsifier	2004.00		320	17.400	1.0	R	484.30		320	17.400	1.0	R	484.30		320	17.400	1.0
519	Uretho Reno Fibroscope, per case	2004.00		320	14.663	1.0	R	408.20		320	14.663	1.0	R	408.20		320	14.663	1.0
521	OAS Frameless Stereotaxy	2004.00		320	172.908	1.0	R	4 813.10		320	172.908	1.0	R	4 813.10		320	-	0.0
523	OPD Tacography (Includes paper)	2004.00		320	2.800	1.0	R	77.90		320	2.800	1.0	R	77.90		320	-	0.0
525	RFG3C Lesion Generator (Rhizotomy)	2004.00		320	55.979	1.0	R	1 558.20		320	55.979	1.0	R	1 558.20		320	-	0.0
527	Swift Lase Kit (Tonsillectomy)	2004.00		320	10.908	1.0	R	303.60		320	10.908	1.0	R	303.60		320	-	0.0

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529	Bard Apparatus 1. For EPS studies the analogue monoplane unit (item 054) must be charged additionally. 2. EPS studies for cardiac ablations - the digital bi-plane unit (item 070) must be charged additionally.	2004.00		320	41.879	1.0	R 1 165.70		320	41.879	1.0	R 1 165.70		320	-	0.0
531	Densitometer	2004.00		320	25.817	1.0	R 718.60		320	25.817	1.0	R 718.60		320	-	0.0
533	Civus (Cardiac Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	2004.00		320	70.117	1.0	R 1 951.80		320	70.117	1.0	R 1 951.80		320	-	0.0
535	Ivus (Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	2004.00		320	154.017	1.0	R 4 287.20		320	154.017	1.0	R 4 287.20		320	-	0.0
537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery.	2004.00		320	0.646	1.0	R 18.00		320	0.646	1.0	R 18.00		320	-	0.0
	Disposable cover is non-chargeable. This item may not be charged together with any disposable monitoring style gel pads or when techniques other than electrosurgery are used. (e.g. not to be charged with the ultrasonic cutting and coagulating device or equivalent).	2004.00														
	Equipment fees for automated, stereotactic, digital imaged surgical breast biopsy (UNDER REVIEW)	2004.00														
	Note: For the purpose of a 6 month trial cost analysis, the manufacturer of the ABBI equipment recommends that the total breast biopsy procedure, inclusive of all fees, disposables and professional charges should not exceed the current conventional open excisional procedures. The recommendation is to cap the amount at R12634.50 per procedure unless otherwise motivated for. Core needle and vacuum assisted core needle would therefore be capped at R 5053.80 and fine needle at R 3790.40. The disposables for the ABBI are included in the equipment fee.	2005.03														
540	Stereotactic guided digital imaged breast biopsy procedure	2004.00		320	282.729	1.0	R 7 870.00		320	282.729	1.0	R 7 870.00		320	-	0.0
541	Stereotactic guided digital imaged cover needle biopsy	2004.00		320	166.321	1.0	R 4 629.70		320	166.321	1.0	R 4 629.70		320	-	0.0
542	Stereotactic guided digital imaged vacuum assisted core needle biopsy.	2004.00		320	166.321	1.0	R 4 629.70		320	166.321	1.0	R 4 629.70		320	-	0.0
543	Stereotactic guided digital imaged fine needle aspiration	2004.00		320	116.471	1.0	R 3 242.10		320	116.471	1.0	R 3 242.10		320	-	0.0
544	Mammotome Stereotactic Driver - vacuum assisted core needle biopsy. (UNDER REVIEW)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
545	Mammotome Hand Held ultrasound vacuum assisted vacuum core needle biopsy. (UNDER REVIEW)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
550	Equipment fee for dynamic (non-frame based - StealthStation) stereotactic image guided referencing surgery and treatment planning used in conjunction with CT or MRI imaging in pre-authorised cranial, spinal cord and ENT procedures, per procedure	2004.00		320	180.775	1.0	R 5 032.10		320	180.775	1.0	R 5 032.10		320	-	0.0
560	Low pressure hyperbaric oxygen treatment protocol. (By arrangement) Only for Prescribed Minimum Benefits Code 277S: Anaerobic infections - life threatening (when no state facility is available)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
562	Standard pressure hyperbaric oxygen treatment protocol. (By arrangement).	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
564	US Navy TT5 treatment protocol. (By arrangement)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
566	US Navy TT6 treatment protocol. (By arrangement)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
568	US Navy TT6 extended treatment protocol. (By arrangement).	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
570	Comes 30 treatment protocol. (By arrangement).	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
572	US Navy Table 6A treatment protocol. (By arrangement)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
574	Pressure relieving mattress hire fee, per day	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
576	Infrared Coagulator: per use	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0

578	Prostatic hyperthermia and thermotherapy: per case	2004.00		320	256.325	1.0	R	7 135.10		320	256.325	1.0	R	7 135.10		320	-	0.0
580	Sequential compression device, per case	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
582	Selector ultrasonic aspirator	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
584	Cryosurgery acuprobe	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
594	Motility machine	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
596	Ph recorder	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
606	Epilepsy monitoring system	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
608	Lynx ultrasound scanner	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
610	Intra-operative multi-frequency probe	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
612	Flexible laparoscopic probe	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5	STANDARD DRUG, MATERIAL, CONSUMABLE AND DISPOSABLE CHARGES																	
	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00																
5.1	STANDARD DRUG CHARGES																	
	(Only substances controlled by the Medicines and Related Substances Control Act, Act 101 of 1965, as amended/Medicine Control Council)	2004.00																
5.1.1	Inpatients and day patients: Dispensed items including ampoules, over the counter and proprietary items issued to inpatients, day patients and TTO's																	
	Not to be charged for consumable, disposable and surgical items	2004.00																
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor).□ □ All items which patients take home as TTO's must be shown on accounts.	2004.00																
272	Pharmacy	2004.00																
273	To take out	2004.00																
278	Ward stock	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
282	Theatre	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5.1.2	Emergency Room: Dispensed items including ampoules, over the counter and proprietary items and TTO's issued to patients treated in the emergency room (items 301 and 302) when not admitted to a ward.																	
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor).□ □ All items which patients take home as TTO's must be shown on accounts.	2004.00																
	Not to be charged for consumable, disposable and surgical items	2004.00																
407	Pharmacy	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
411	Theatre	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
413	To take out	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5.2	Consumable, disposable, and surgical items used in ward, theatre or emergency room																	
	When used in ward or theatre □ Net acquisition price inclusive of VAT (unless the facility is not a registered VAT vendor). Items to be fully specified	2004.00																
	See consumable and disposable list.	2004.00																

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266	Large disposable sterile trays - per tray (excluding theatre)	2004.00																
267	Sterile disposable swabbing and ENT trays - per tray (excluding theatre)	2004.00																
269	Soluble bags for barrier nursing only, limited to 2 per patient, per day	2004.00																
415	Emergency room	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
417	Pharmacy	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
419	Ward stock	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
421	Theatre	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5.3	Fractional charges																	
	Net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor) to be charged per case at the fractional rates indicated below.	2004.00																
	Note: Fractional charges can only apply to reusable and limited life reusable/resposable products.	2004.00																
5.3.1	Drills, burrs, cutters, blades																	
280	Neuro/Craniotomy	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
432	Arthroscopy	2004.00		320	-	0.0	R	-	20.0	320	-	0.0	R	-	20.0	320	-	0.0
433	Orthopaedic	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
437	Mastoidectomy and major ear surgery	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
439	Maxillo- Facial drills and burrs (not applicable to oral surgery, eg wisdom teeth)	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
5.3.2	Surgical laser fibre optic leads, hand pieces and probes, scalpels, argon beamer instruments (Limited life re-usable components)																	
	Hospitals/unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name, and schemes shall have the right to call for such invoices from the institution concerned	2004.00																
281	Vascular surgery	2004.00		320	-	0.0	R	-	100	320	-	0.0	R	-	100	320	-	0.0
443	General surgery	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
445	Gynaecology	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
447	Ophthalmic	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
449	Urology	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
451	ENT	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
453	Orthopaedic	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
5.3.3	Ultrasonic Cutting and Coagulating Devices (Limited life re-usable)																	
	General surgery, Gynaecology, Cardio-Vascular and Urology																	
455	Handpiece and Cable Assembly (one unit)	2004.00		320	-	0.0	R	-	1%	320	-	0.0	R	-	1%	320	-	0.0
456	Coagulating Shear (Laparoscopic/open)	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
458	Coagulating Shear - Single use (Laparoscopic/open) Refer to Section 5.2	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
457	Blades (sharp hook, dissecting hook, ball)	2004.00		320	-	0.0	R	-	12.5	320	-	0.0	R	-	12.5	320	-	0.0
459	Blades - Single use (sharp hook, dissecting hook, ball) Refer to 5.2	2004.00		320	-	0.0	R	-	-	320	-	0.0	R	-	-	320	-	0.0
5.3.4	Warm air blankets																	
429	Warm air blanket may be charged in the following cases and limited to 1 per stay - Infants - Elderly patients over 65, - Patients exposed for a long period of time in theatre longer than 2 hours - Post traumatic hypothermia - one per stay - Cardio-thoracic hypothermic patients in recovery and ICU - one per stay	2004.00		320	-	0.0	R	-	100	320	-	0.0	R	-	100	320	-	0.0

5.3.5	Diathermy pencils, laryngeal masks and fluoroshield gloves																
431	Diathermy pencils	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
435	Laryngeal masks	2004.00		320	-	0.0	R	-	2.5%	320	-	0.0	R	-	2.5%	320	-	0.0
441	Fluoroshield gloves (1 pair per procedure)	2004.00		320	-	0.0	R	-	33.3	320	-	0.0	R	-	33.3	320	-	0.0
5.7	Gases																	
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified	2004.00																
	Oxygen and Nitrous Oxide																	
	For both gases together, per minute	2004.00																
283	PWV area	2004.00		320	0.110	1.0	R	3.06		320	0.110	1.0	R	3.06		320	0.110	1.0
701	Cape Town	2004.00		320	0.151	1.0	R	4.20		320	0.151	1.0	R	4.20		320	0.151	1.0
702	Port Elizabeth	2004.00		320	0.134	1.0	R	3.73		320	0.134	1.0	R	3.73		320	0.134	1.0
703	East London	2004.00		320	0.149	1.0	R	4.15		320	0.149	1.0	R	4.15		320	0.149	1.0
704	Durban	2004.00		320	0.138	1.0	R	3.84		320	0.138	1.0	R	3.84		320	0.138	1.0
705	Other areas	2004.00		320	0.123	1.0	R	3.42		320	0.123	1.0	R	3.42		320	0.123	1.0
	Oxygen, ward use																	
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex	2004.00																
284	PWV area	2004.00		320	0.162	1.0	R	4.51		320	0.162	1.0	R	4.51		320	0.162	1.0
710	Cape Town	2004.00		320	0.268	1.0	R	7.46		320	0.268	1.0	R	7.46		320	0.268	1.0
711	Port Elizabeth	2004.00		320	0.258	1.0	R	7.18		320	0.258	1.0	R	7.18		320	0.258	1.0
712	East London	2004.00		320	0.248	1.0	R	6.90		320	0.248	1.0	R	6.90		320	0.248	1.0
713	Durban	2004.00		320	0.210	1.0	R	5.85		320	0.210	1.0	R	5.85		320	0.210	1.0
714	Other areas	2004.00		320	0.200	1.0	R	5.57		320	0.200	1.0	R	5.57		320	0.200	1.0
	Oxygen, recovery room or emergency room																	
	Flat rate for oxygen per case	2004.00																
720	PWV area	2004.00		320	0.322	1.0	R	8.96		320	0.322	1.0	R	8.96		320	0.322	1.0
721	Cape Town	2004.00		320	0.533	1.0	R	14.80		320	0.533	1.0	R	14.80		320	0.533	1.0
722	Port Elizabeth	2004.00		320	0.513	1.0	R	14.30		320	0.513	1.0	R	14.30		320	0.513	1.0
723	East London	2004.00		320	0.492	1.0	R	13.70		320	0.492	1.0	R	13.70		320	0.492	1.0
724	Durban	2004.00		320	0.421	1.0	R	11.70		320	0.421	1.0	R	11.70		320	0.421	1.0
725	Other areas	2004.00		320	0.398	1.0	R	11.10		320	0.398	1.0	R	11.10		320	0.398	1.0
	Oxygen in Theatre																	
	Fee for oxygen per minute in the operating theatre when no other gas administered	2004.00																
730	PWV area	2004.00		320	0.010	1.0	R	0.28		320	0.010	1.0	R	0.28		320	0.010	1.0
731	Cape Town	2004.00		320	0.018	1.0	R	0.50		320	0.018	1.0	R	0.50		320	0.018	1.0
732	Port Elizabeth	2004.00		320	0.017	1.0	R	0.47		320	0.017	1.0	R	0.47		320	0.017	1.0
733	East London	2004.00		320	0.017	1.0	R	0.47		320	0.017	1.0	R	0.47		320	0.017	1.0
734	Durban	2004.00		320	0.013	1.0	R	0.36		320	0.013	1.0	R	0.36		320	0.013	1.0
735	Other areas	2004.00		320	0.013	1.0	R	0.36		320	0.013	1.0	R	0.36		320	0.013	1.0
	Carbon Dioxide																	
291	Per minute	2004.00		320	0.020	1.0	R	0.56		320	0.020	1.0	R	0.56		320	0.020	1.0
	Laser Mix																	
292	Per minute	2004.00		320	0.387	1.0	R	10.80		320	0.387	1.0	R	10.80		320	0.387	1.0
	Entonox																	
293	Per 30 minutes	2004.00		320	3.675	1.0	R	102.30		320	3.675	1.0	R	102.30		320	3.675	1.0

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5.8	Inhalation anaesthetics																
	All prices will be expressed per millilitre and will be based on the Single Exit Price (SEP)	2008.00															
285	Halothane (Halothane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
752	Ethrane (Enflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
753	Forane (Isoflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
754	Isofor (Isoflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
755	Ultane (Sevoflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
756	Suprane (Desflurane), per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
757	Aerrane (Isoflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
758	Alyrane (Enflurane): per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
759	Fluothane (Halothane), per ml	2008.00		320	-	1.0	R	-		320	-	1.0	R	-		320	-	1.0
5.9	Prostheses (Surgically implanted)																
286	A prosthesis shall mean a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral and necessary part of the device so implanted, and shall be charged as a single unit. Pins, rods, screws, plates or similar items, when used independently of a prosthesis and for the purpose of furthering any healing process, shall be chargeable. Hospitals/unattached operating theatre units shall show the name and reference number of each item. The manufacturer's name, and suppliers invoices should be attached to the account and the components should be specified on the account. Net acquisition price on suppliers invoice, inclusive of VAT (unless the facility is not a registered VAT vendor), by prior arrangement with scheme.	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5.10	Medical artificial items (non-prostheses)																
287	According to agreement with schemes concerned. (Examples of items included hereunder shall be wheelchairs, crutches and excretion bags). Copies of invoices shall be supplied to schemes.	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
5.14	Blood charges																
288	Emergency non-crossmatched blood ex hospital (i.e. on stand-by) - Number of units and nature of emergency to be specified and copy of invoice included. This item is only chargeable when a private hospital supplies O-negative whole blood to a patient in an emergency situation. A motivation stating the reason for administering the O-negative blood must accompany the account and no mark-up is permitted on this item.	2004.00		320	-	0.0	R	-		320	-	0.0	R	-				
289	Routine blood charges, when incurred in respect of blood or related products procured from a recognised blood bank for transfusion purposes, may be charged at R 14.70 per collection, plus R 3.09 per kilometre travelled. This fee is applicable to all modes for collecting blood including hospital ambulances	2005.03		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
297	Emergency blood collection. Claims for this item code must be supported by documentary evidence of the patient's condition	2006.00		320	19.388	1.0	R	539.70		320	19.388	1.0	R	539.70		320	-	0.0
5.15	Incise drapes																
298	Incise drapes (See Annexure B)	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0
299	Ophthalmic drapes. (See Annexure B)	2004.00		320	-	0.0	R	-		320	-	0.0	R	-		320	-	0.0

300	Non-incise drapes (isolation, fluid-collection and combination)	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
	Chargeable in the following procedures: Hip, knee, shoulder and elbow joint replacements□ Open heart and cardiac bypass surgery□ Vascular surgery (excluding catheterisation laboratory procedures)□ Neuro-surgery (Brain and spinal cord)□ Arthroscopy of hip, shoulder, knee or elbow joints□ Spinal surgery□	2004.00														
	Note: The name, item number and cost must be shown.	2004.00														
5.16	Disposable Patient Controlled Analgesia Pump															
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward□ □ Chargeable in the following instances:□ - Major joint replacement□ - Open, upper abdominal surgery□ - Severe burns□ - Paediatrics in special cases on motivation□ - Thoracotomies (motivation by practitioner)□ - Intractable pain associated with malignancy□	2004.00														
6	NON STANDARD ITEMS/SERVICES															
	Such items are not covered by the National Reference Price List and schemes reserve the right to decide individually how these items/services will be dealt with	2004.00														
290	Items/services e.g. telephone calls/hire, television hire, boarding, extra meals, dry cleaning of clothing, extra nursing in ward etc. The nature of each service shall be specified	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
	Procedures : Open heart, cardiac by-pass surgery and all organ transplants															
121	Benefits to be pre-authorised with the scheme concerned	2004.00		320	-	0.0	R -		320	-	0.0	R -		320	-	0.0
	ANNEXURES															

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	ENDOSCOPIC (laparoscopic & thoracoscopic) GENERIC LIST□ <<Insert object table here>>□ Notes: Refer to detailed Endoscopic Disposable Product list.□ Procedure to be applied per CPT code – list attached.□ □ Comments□ 1. Optical, blunt, Hasson cannula, trocar – may substitute the primary port trocar and eliminate the use of verres needles.□ 2. Harmonic scalpel shears and and blades – not to be charged together with disposable electrosurgical probes, argon beam coagulator, clip appliers, bipolar forceps and Tripolar forceps.□ 3. Harmonic scalpel shears and blades – not to be used for laparoscopic cholecystectomy and sterilisation□ 4. Tripolar forceps – not to be used together with electrosurgical probes, harmonic scalpel, clip appliers□ 5. Autosuture Endostitch – to be motivated and 1 suture assistant per procedure allowed.□ 6. Specimen retrieval bags – to motivate use (used when specimen needs to be captured and removed to avoid site contamination); procedure related – histology report required.	2004.00															
	APPENDIX A □ LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES□□ □ CATEGORY 1□(CPT4 2000 code numbers included where possible)□ □□ Diagnostic laparoscopy (49320)□ Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670)□ Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771)□ Hysteroscopy diagnostic (58555)□ Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C (58558)□ □ THORACOSCOPY, DIAGNOSTIC □□ THORACOSCOPY, DIAGNOSTIC with biopsy □□ THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy□□ THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy□□ THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy□□ THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy□□ THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy□□ □□ CATEGORY 2 □□ □□ Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673)□ Laparoscopy, surgical; with fimbrioplasty (58672)□ Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface,	2004.00															

	APPENDIX B □ PRINCIPLES□ □ The following principles are applicable:□ □ 1. □At all times best clinical practice must be adhered too.□ □ 2. □Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only. Photocopies of all documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documentation at the hospital/sameday surgical facilities concerned. The Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Sub-Acute Facilities, Private Hospitals and Sameday Surgery Facilities will be reviewed half-yearly.□ . □ 3. □The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows:□ □ ¢□Items included in the per minute theatre fee.□ ¢□Items included in the per day ward or unit fee.□	2004.00														

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	□																
	□																
	Infectious Diseases□																
	□																
	CONDITION□																
	□																
	Acute Flaccid Paralysis□																
	Anthrax□																
	Chicken Pox□																
	Diptheria□																
	Haemophyllis influenza□																
	Haemorrhagic fevers of Africa:□																
	¢□Crimean-Congo Ebola□																
	¢□Lassa□																
	¢□Marburg□																
	¢□Rift Valley□																
	¢□Dengue□																
	Herpes Zoster□																
	HIV/AIDS□																
	Legionnaires Disease□																
	Measles:□																
	¢□Rubeola□																
	¢□Rubella□																
	Meningococcal infections□																
	Multi-drug Resistant Bacteria:□																
	¢□MRSA□																
	¢□VRE□																
	¢□MRSE□																
	Poliomyelitis□																
	Pyrexia unknown origin□																
	Rabies□																
	Small Pox□																
	Tuberculosis Pulmonary□																
	Typhus Fever□																
	Viral Hepatitis□																
	Whooping Cough (Pertussis)□	2004.00															
	APPENDIX D																
	□																
	Medically Prescribed Meals:	2004.00															

Private Hospitals 2008

Code	Description
55700	Private Hospitals ('A' - Status)
55800	Private Hospitals ('B' - Status)
57700	Approved U O T U / Day clinics

Private Hospitals 2008

Code	Description	RCF
320	Private Hospitals	27.836

PSYCHOLOGY

Psychology 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOLOGISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

B	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency psychological procedure, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	04.00
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
D	Every account shall contain the following particulars: a) The surname and initials of the member; b) The surname, first name and other initials, if any, of the patient; c) The name of the scheme concerned;. d) The membership number of the member; e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f) The date on which each relevant health service was rendered; g) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.03
E	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.03
F	With the exception of compilation of reports as per Rule E, time charged in terms of the codes in this schedule only includes time spent in direct interaction with the patient.	05.05

MODIFIERS

	Modifier governing the section Psychological Services	04.00
0003	Emergency treatments - Relevant fee plus 50%	04.00
0004	Psychology services rendered to an in-patient in a nursing home or hospital.	04.00

CONSULTATIVE AND THERAPEUTIC SERVICES

Code	Description	Ver	Add	Psychology RVU	Psychology Fee
007	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	05.02			
200	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	05.04		0.500	45.60 (40.00)
201	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	05.04		1.500	136.90 (120.10)
202	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	05.04		2.500	228.10 (200.10)
203	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	05.04		3.500	319.40 (280.20)
204	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	05.04		4.500	410.60 (360.20)
205	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	05.04		5.500	501.90 (440.30)
206	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	05.04		6.500	593.20 (520.40)
207	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	05.04		7.500	684.40 (600.40)
208	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	05.04		8.500	775.70 (680.40)

Code	Description	Ver	Add	Psychology	
				RVU	Fee
209	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 91-100min.	05.04		9.500	866.90 (760.40)
210	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 101-110min.	05.04		10.500	958.20 (840.50)
211	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 111-120min.	05.04		11.500	1049.40 (920.50)
	This code would be used in addition to code 211.	06.02			
290	Extended assessment, consultation, counselling and/or therapy (individual or family) - per full 15 minutes in excess of 120 minutes	05.05	+	0.750	68.40 (60.00)
GROUP SERVICES					
300	Psychology group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	05.03		0.100	9.13 (8.01)
301	Psychology group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	05.03		0.300	27.40 (24.00)
302	Psychology group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	05.03		0.500	45.60 (40.00)
303	Psychology group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	05.03		0.700	63.90 (56.10)
304	Psychology group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	05.03		0.900	82.10 (72.00)
305	Psychology group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	05.03		1.100	100.40 (88.10)
306	Psychology group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	05.03		1.300	118.60 (104.00)
307	Psychology group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	05.03		1.500	136.90 (120.10)
308	Psychology group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	05.03		1.700	155.10 (136.10)
309	Psychology group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	05.03		1.900	173.40 (152.10)
310	Psychology group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	05.03		2.100	191.60 (168.10)
311	Psychology group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	05.03		2.300	209.90 (184.10)

Psychology 2008

				39600				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOLOGISTS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00						
	GENERAL RULES							
B	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency psychological procedure, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	2004.00						
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						

D	Every account shall contain the following particulars: a) The surname and initials of the member; b) The surname, first name and other initials, if any, of the patient; c) The name of the scheme concerned;. d) The membership number of the member; e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f) The date on which each relevant health service was rendered; g) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2005.03							
E	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	2005.03							
F	With the exception of compilation of reports as per Rule E, time charged in terms of the codes in this schedule only includes time spent in direct interaction with the patient.	2005.05							
	MODIFIERS								
	Modifier governing the section Psychological Services	2004.00							
0003	Emergency treatments - Relevant fee plus 50%	2004.00							
0004	Psychology services rendered to an in-patient in a nursing home or hospital.	2004.00							
	CONSULTATIVE AND THERAPEUTIC SERVICES								
007	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2005.02							
200	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	2005.04		280	0.500	1.0	R	45.60	
201	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	2005.04		280	1.500	1.0	R	136.90	
202	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	2005.04		280	2.500	1.0	R	228.10	
203	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	2005.04		280	3.500	1.0	R	319.40	
204	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	2005.04		280	4.500	1.0	R	410.60	
205	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	2005.04		280	5.500	1.0	R	501.90	
206	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	2005.04		280	6.500	1.0	R	593.20	
207	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	2005.04		280	7.500	1.0	R	684.40	
208	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	2005.04		280	8.500	1.0	R	775.70	

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Psychology 2008

209	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 91-100min.	2005.04		280	9.500	1.0	R	866.90	
210	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 101-110min.	2005.04		280	10.500	1.0	R	958.20	
211	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 111-120min.	2005.04		280	11.500	1.0	R	1 049.40	
	This code would be used in addition to code 211.	2006.02							
290	Extended assessment, consultation, counselling and/or therapy (individual or family) - per full 15 minutes in excess of 120 minutes	2005.05	+	280	0.750	1.0	R	68.40	
	GROUP SERVICES								
300	Psychology group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	2005.03		280	0.100	1.0	R	9.13	
301	Psychology group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	2005.03		280	0.300	1.0	R	27.40	
302	Psychology group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	2005.03		280	0.500	1.0	R	45.60	
303	Psychology group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	2005.03		280	0.700	1.0	R	63.90	
304	Psychology group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	2005.03		280	0.900	1.0	R	82.10	
305	Psychology group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	2005.03		280	1.100	1.0	R	100.40	
306	Psychology group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	2005.03		280	1.300	1.0	R	118.60	
307	Psychology group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	2005.03		280	1.500	1.0	R	136.90	
308	Psychology group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	2005.03		280	1.700	1.0	R	155.10	
309	Psychology group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	2005.03		280	1.900	1.0	R	173.40	
310	Psychology group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2005.03		280	2.100	1.0	R	191.60	
311	Psychology group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2005.03		280	2.300	1.0	R	209.90	

Psychology 2008

Code	Description
38600	Psychology

Psychology 2008

Code	Description	RCF
280	Psychologists	91.254

PSYCHOMETRY & REGISTERED COUNCELLORS

Psychometry & Registered Counsellors 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOMETRISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

A	Every account shall contain the following particulars: a) The surname and initials of the member; b) The surname, first name and other initials, if any, of the patient; c) The name of the scheme concerned;. d) The membership number of the member; e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f) The date on which each relevant health service was rendered; g) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.04
B	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.04

PSYCHOMETRIC SERVICES

Code	Description	Ver	Add	Registered Counsellors		Psychometry	
				RVU	Fee	RVU	Fee
007	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	05.04					
200	Psychometric testing. Duration: 1-10min.	05.04				0.500	22.80 (20.00)
201	Psychometric testing. Duration: 11-20min.	05.04				1.500	68.40 (60.00)
202	Psychometric testing. Duration: 21-30min.	05.04				2.500	114.10 (100.10)
203	Psychometric testing. Duration: 31-40min.	05.04				3.500	159.70 (140.10)
204	Psychometric testing. Duration: 41-50min.	05.04				4.500	205.30 (180.10)
205	Psychometric testing. Duration: 51-60min.	05.04				5.500	251.00 (220.20)
206	Psychometric testing. Duration: 61-70min.	05.04				6.500	296.60 (260.20)
207	Psychometric testing. Duration: 71-80min.	05.04				7.500	342.20 (300.20)
208	Psychometric testing. Duration: 81-90min.	05.04				8.500	387.80 (340.20)
209	Psychometric testing. Duration: 91-100min.	05.04				9.500	433.50 (380.30)
210	Psychometric testing. Duration: 101-110min.	05.04				10.500	479.10 (420.30)
211	Psychometric testing. Duration: 111-120min.	05.04				11.500	524.70 (460.30)
290	Psychometric testing - per full 15 minutes in excess of 120 minutes.	06.05	+			0.750	34.20 (30.00)
SERVICES RENDERED BY REGISTERED COUNSELLORS							
300	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	06.06		0.500	22.80 (20.00)		
301	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	06.06		1.500	68.40 (60.00)		
302	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	06.06		2.500	114.10 (100.10)		
303	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	06.06		3.500	159.70 (140.10)		
304	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	06.06		4.500	205.30 (180.10)		

Code	Description	Ver	Add	Registered Counsellors		Psychometry	
				RVU	Fee	RVU	Fee
305	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	06.06		5.500	251.00 (220.20)		
306	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	06.06		6.500	296.60 (260.20)		
307	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	06.06		7.500	342.20 (300.20)		
308	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	06.06		8.500	387.80 (340.20)		
400	Group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	06.06		0.100	4.56 (4.00)		
401	Group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	06.06		0.300	13.70 (12.00)		
402	Group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	06.06		0.500	22.80 (20.00)		
403	Group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	06.06		0.700	31.90 (28.00)		
404	Group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	06.06		0.900	41.10 (36.10)		
405	Group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	06.06		1.100	50.20 (44.00)		
406	Group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	06.06		1.300	59.30 (52.00)		
407	Group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	06.06		1.500	68.40 (60.00)		
408	Group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	06.06		1.700	77.60 (68.10)		
409	Group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	06.06		1.900	86.70 (76.10)		
410	Group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	06.06		2.100	95.80 (84.00)		
411	Group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	06.06		2.300	104.90 (92.00)		
490	Extended group consultation, counselling and/or therapy - per patient per full 15 minutes in excess of 120 minutes	06.06		0.150	6.84 (6.00)		

Psychometry Registered Counsellors 2008

				38100					38500				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOMETRISTS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2005.04											
	GENERAL RULES												
A	Every account shall contain the following particulars: a) The surname and initials of the member; b) The surname, first name and other initials, if any, of the patient; c) The name of the scheme concerned;. d) The membership number of the member; e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f) The date on which each relevant health service was rendered; g) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2005.04											
B	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	2005.04											
	PSYCHOMETRIC SERVICES												
007	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2005.04											
200	Psychometric testing. Duration: 1-10min.	2005.04							285	0.500	1.0	R 22.80	
201	Psychometric testing. Duration: 11-20min.	2005.04							285	1.500	1.0	R 68.40	
202	Psychometric testing. Duration: 21-30min.	2005.04							285	2.500	1.0	R 114.10	
203	Psychometric testing. Duration: 31-40min.	2005.04							285	3.500	1.0	R 159.70	
204	Psychometric testing. Duration: 41-50min.	2005.04							285	4.500	1.0	R 205.30	
205	Psychometric testing. Duration: 51-60min.	2005.04							285	5.500	1.0	R 251.00	
206	Psychometric testing. Duration: 61-70min.	2005.04							285	6.500	1.0	R 296.60	
207	Psychometric testing. Duration: 71-80min.	2005.04							285	7.500	1.0	R 342.20	

Psychometry Registered Counsellors 2008

208	Psychometric testing. Duration: 81-90min.	2005.04							285	8.500	1.0	R	387.80			
209	Psychometric testing. Duration: 91-100min.	2005.04							285	9.500	1.0	R	433.50			
210	Psychometric testing. Duration: 101-110min.	2005.04							285	10.500	1.0	R	479.10			
211	Psychometric testing. Duration: 111-120min.	2005.04							285	11.500	1.0	R	524.70			
290	Psychometric testing - per full 15 minutes in excess of 120 minutes.	2006.05	+						285	0.750	1.0	R	34.20			
	SERVICES RENDERED BY REGISTERED COUNSELLORS															
300	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	2006.06		285	0.500	1.0	R	22.80								
301	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	2006.06		285	1.500	1.0	R	68.40								
302	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	2006.06		285	2.500	1.0	R	114.10								
303	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	2006.06		285	3.500	1.0	R	159.70								
304	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	2006.06		285	4.500	1.0	R	205.30								
305	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	2006.06		285	5.500	1.0	R	251.00								
306	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	2006.06		285	6.500	1.0	R	296.60								
307	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	2006.06		285	7.500	1.0	R	342.20								
308	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	2006.06		285	8.500	1.0	R	387.80								
400	Group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	2006.06		285	0.100	1.0	R	4.56								
401	Group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	2006.06		285	0.300	1.0	R	13.70								
402	Group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	2006.06		285	0.500	1.0	R	22.80								
403	Group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	2006.06		285	0.700	1.0	R	31.90								
404	Group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	2006.06		285	0.900	1.0	R	41.10								
405	Group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	2006.06		285	1.100	1.0	R	50.20								
406	Group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	2006.06		285	1.300	1.0	R	59.30								
407	Group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	2006.06		285	1.500	1.0	R	68.40								
408	Group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	2006.06		285	1.700	1.0	R	77.60								
409	Group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	2006.06		285	1.900	1.0	R	86.70								
410	Group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2006.06		285	2.100	1.0	R	95.80								
411	Group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2006.06		285	2.300	1.0	R	104.90								
490	Extended group consultation, counselling and/or therapy - per patient per full 15 minutes in excess of 120 minutes	2006.06		285	0.150	1.0	R	6.84								

Psychometry Registered Counsellors 2008

Code	Description
38100	Registered Counsellors
38500	Psychometry

Psychometry Registered Counsellors 2008

Code	Description	RCF
285	Psychometrists	45.628

RADIOGRAPHY

Radiography 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY RADIOGRAPHERS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

DIAGNOSTIC PROCEDURES

Note : Items 015, 029, 031, 033, 037, 065, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 115, 117, 119, 121, 129, 131, 133, 135, 137, 139, 141, 149, 167, 171 and 173 should be only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number. Schemes should not pay the radiographer if she/he is supervised by a radiologist.

GENERAL RULES

1000	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

MODIFIERS

0001	The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. Individual medical schemes may require a motivation to accompany the claim.	06.02		12.490	35.20 (30.88)
0021	Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.				04.00
0080	Multiple examinations: Full fees				04.00
0081	Repeat examinations: No reduction				04.00
0084	Films should be charged under code 300.				06.02

1 SKELETON

1.1 LIMBS

Code	Description	Ver	Add	Radiography RVU	Radiography Fee
001	Finger, toe	04.00		12.300	34.70 (30.40)
003	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	04.00		16.200	45.70 (40.10)
005	Smith-Petersen or equivalent control, in theatre	04.00		134.600	379.30 (332.70)
007	Stress studies, e.g. joint	04.00		16.200	45.70 (40.10)
009	Length studies per right and left pair of long bones	04.00		16.200	45.70 (40.10)
011	Skeletal survey under 5 years	04.00		48.500	136.70 (119.90)
013	Skeletal survey over 5 years	04.00		52.300	147.40 (129.30)
015	Arthrography per joint	04.00		39.500	111.30 (97.60)

1.2 SPINAL COLUMN

017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	04.00		24.600	69.30 (60.80)
021	Stress studies	04.00		10.000	28.20 (24.70)
025	Scoliosis studies	04.00		39.300	110.70 (97.10)
027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	04.00		17.000	47.90 (42.00)

MYELOGRAPHY

029	Lumbar	04.00		43.100	121.50 (106.60)
031	Thoracic	04.00		40.100	113.00 (99.10)
033	Cervical	04.00		59.400	167.40 (146.80)
035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	04.00		-	-
037	Discography	04.00		31.500	88.80 (77.90)

1.3 SKULL

039	Skull studies	04.00		32.300	91.00 (79.80)

Code	Description	Ver	Add	Radiography	
				RVU	Fee
041	Paranasal sinuses	04.00		17.000	47.90 (42.00)
043	Facial bones and/or orbits	04.00		34.900	98.30 (86.20)
045	Mandible	04.00		26.000	73.30 (64.30)
047	Nasal bone	04.00		16.200	45.70 (40.10)
049	Mastoid: Bilateral	04.00		50.000	140.90 (123.60)
TEETH					
051	One quadrant	04.00		7.700	21.70 (19.00)
053	Two quadrants	04.00		8.500	24.00 (21.10)
055	Full mouth	04.00		10.800	30.40 (26.70)
057	Rotation tomography of the teeth and jaws	04.00		14.600	41.10 (36.10)
059	Temporo-mandibular joints: Per side	04.00		19.200	54.10 (47.50)
061	Tomography: Per side	04.00		30.500	85.90 (75.40)
063	Localisation of foreign body in the eye	04.00		30.700	86.50 (75.90)
065	Ventriculography	04.00		37.400	105.40 (92.50)
067	Post-nasal studies: Lateral neck	04.00		10.000	28.20 (24.70)
069	Maxillo-facial cephalometry	04.00		26.900	75.80 (66.50)
071	Dacryocystography	04.00		24.200	68.20 (59.80)
2	**ALIMENTARY TRACT**				
073	Sialography (plus 80% for each additional gland)	04.00		24.600	69.30 (60.80)
075	Pharynx and oesophagus	04.00		22.800	64.30 (56.40)
077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	04.00		31.500	88.80 (77.90)
079	Small bowel meal (control film of abdomen included, except when part of item 081)	04.00		27.700	78.10 (68.50)
081	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	04.00		47.200	133.00 (116.70)
083	Barium enema (control film of abdomen included)	04.00		50.900	143.40 (125.80)
085	Biliary tract: ERCP (choledogram and/or pancreatography screening included)	04.00		47.000	132.40 (116.10)
087	Gastric/oesophageal/duodenal intubation control	04.00		20.800	58.60 (51.40)
089	Hypotonic duodenography (077 included)	04.00		57.300	161.50 (141.70)
3	**BILIARY TRACT**				
091	Oral cholecystography	04.00		47.800	134.70 (118.20)
093	Intravenous	04.00		58.600	165.10 (144.80)
095	Operative: First series	04.00		58.100	163.70 (143.60)
097	Subsequent series	04.00		24.000	67.60 (59.30)
099	Post-operative: T-tube	04.00		20.100	56.60 (49.60)
101	Trans-hepatic, percutaneous	04.00		34.600	97.50 (85.50)
103	Tomography of biliary tract: Add	04.00		21.500	60.60 (53.20)
CHEST					
105	Larynx (tomography included)	04.00		42.400	119.50 (104.80)

Code	Description	Ver	Add	Radiography	
				RVU	Fee
107	Chest (item 167 included)	04.00		19.200	54.10 (47.50)
109	Chest and cardiac studies (item 167 included)	04.00		23.100	65.10 (57.10)
111	Ribs	04.00		19.200	54.10 (47.50)
113	Stemum or sterno-clavicular joints	04.00		24.600	69.30 (60.80)
BRONCHOGRAPHY					
115	Unilateral	04.00		33.500	94.40 (82.80)
117	Bilateral	04.00		56.500	159.20 (139.60)
119	Pleurography	04.00		15.700	44.20 (38.80)
121	Laryngography	04.00		15.700	44.20 (38.80)
123	Thoracic inlet	04.00		15.700	44.20 (38.80)
5	**ABDOMEN**				
125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	04.00		17.000	47.90 (42.00)
127	Acute abdomen or equivalent studies	04.00		30.700	86.50 (75.90)
6	**URINARY TRACT**				
129	Control film included and bladder views before and after micturition	04.00		67.000	188.80 (165.60)
133	Waterload test: Add	04.00		20.100	56.60 (49.60)
135	Cystography only or urethrography only (retrograde)	04.00		37.600	106.00 (93.00)
CYSTO-URETHROGRAPHY					
137	Retrograde	04.00		33.100	93.30 (81.80)
139	Retrograde-prograde pyelography	04.00		42.400	119.50 (104.80)
141	Aspiration renal cyst	04.00		17.000	47.90 (42.00)
143	Tomography of renal tract: Add	04.00		19.200	54.10 (47.50)
7	**GYNAECOLOGY AND OBSTETRICS**				
145	Pregnancy	04.00		19.200	54.10 (47.50)
147	Pelvimetry	04.00		35.500	100.00 (87.70)
149	Hysterosalpingography	04.00		32.000	90.20 (79.10)
8	**TOMOGRAPHY AND CINEMATOGRAPHY**				
151	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension, fees shall be charged for the additional investigation at 50% of the rate with a maximum of two additional investigations	04.00		-	-
153	Tomography (multi-dimensional in motion): Add 150%	04.00		-	-
9	**COMPUTED TOMOGRAPHY**				
155	Head, single examination, full series	04.00		262.700	740.30 (649.40)
157	Head, repeat examination at the same visit, after contrast, full series	04.00		90.200	254.20 (223.00)
159	Chest	04.00		303.700	855.80 (750.70)
161	Abdomen (including base of chest and/or pelvis)	04.00		353.000	994.80 (872.60)
163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	04.00		82.100	231.40 (203.00)
165	Limbs and other limited examinations	04.00		82.100	231.40 (203.00)
MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS					
0089	The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations, and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%	04.00			

Code	Description	Ver	Add	Radiography	
				RVU	Fee
10	**MISCELLANEOUS**				
167	Fluoroscopy: Per half hour: Add (not applicable to items 107 and 109)	04.00		21.400	60.30 (52.90)
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	04.00		29.600	83.40 (73.20)
171	Sinography	04.00		44.300	124.80 (109.50)
173	Bone densitometry	05.03		80.900	228.00 (200.00)
175	Mammography: Unilateral or bilateral	04.00		58.100	163.70 (143.60)
177	Repeat mammography, unilateral or bilateral for localisation of tumour	04.00		58.100	163.70 (143.60)
179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed	04.00		17.600	49.60 (43.50)
181	Setting of sterile trays	04.00		3.000	8.45 (7.41)
	Films are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	06.02			
300	X-Ray films	06.02			
ATTENDANCE IN CATHETERISATION LABORATORY					
	Use codes 191 to 193 to charge for radiographer input where that is not included in cath lab facility fee				04.00
191	Preparation in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures.	04.00		43.000	121.20 (106.30)
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	04.00		43.000	121.20 (106.30)
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
194	Right heart investigation of valve and venous system of the right heart	04.00		43.000	121.20 (106.30)
195	PTCA per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
196	Left heart investigation of valve of the left heart and ventrical	04.00		43.100	121.50 (106.60)
197	Stent procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
201	Temporary pacemaker procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
203	Permanent pacemaker procedure in catheterisation laboratory per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
205	Intra-aortic balloon pump procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
207	Electro-physiological studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
209	Bleomycine and other studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
211	Intra vascular ultrasound per 30 minutes of part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
213	Rotablator/Laser procedures per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	121.20 (106.30)
RULES					
Z	No fee to be subject to more than one reduction				04.00
11	**PORTABLE UNIT EXAMINATIONS**				
185	Where portable x-ray unit is used in the hospital or theatre: Add	04.00		19.400	54.70 (48.00)
187	Theatre investigations with fixed installation : Add	04.00		8.300	23.40 (20.50)

Radiography 2008

				33900					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY RADIOGRAPHERS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**		**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00							
	DIAGNOSTIC PROCEDURES								
	Note : Items 015, 029, 031, 033, 037, 065, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 115, 117, 119, 121, 129, 131, 133, 135, 137, 139, 141, 149, 167, 171 and 173 should be only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number. Schemes should not pay the radiographer if she/he is supervised by a radiologist.	2004.00							
	GENERAL RULES								
1000	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00							
	MODIFIERS								
0001	The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. Individual medical schemes may require a motivation to accompany the claim.	2006.02		290	12.490	1.0	R	35.20	
0021	Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.	2004.00							
0080	Multiple examinations: Full fees	2004.00							
0081	Repeat examinations: No reduction	2004.00							
0084	Films should be charged under code 300.	2006.02							
1	SKELETON								
1.1	LIMBS								
001	Finger, toe	2004.00		290	12.300	1.0	R	34.70	
003	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	2004.00		290	16.200	1.0	R	45.70	
005	Smith-Petersen or equivalent control, in theatre	2004.00		290	134.600	1.0	R	379.30	
007	Stress studies, e.g. joint	2004.00		290	16.200	1.0	R	45.70	
009	Length studies per right and left pair of long bones	2004.00		290	16.200	1.0	R	45.70	
011	Skeletal survey under 5 years	2004.00		290	48.500	1.0	R	136.70	
013	Skeletal survey over 5 years	2004.00		290	52.300	1.0	R	147.40	
015	Arthrography per joint	2004.00		290	39.500	1.0	R	111.30	

Radiography 2008

1.2	SPINAL COLUMN								
017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	2004.00		290	24.600	1.0	R	69.30	
021	Stress studies	2004.00		290	10.000	1.0	R	28.20	
025	Scoliosis studies	2004.00		290	39.300	1.0	R	110.70	
027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	2004.00		290	17.000	1.0	R	47.90	
	MYELOGRAPHY								
029	Lumbar	2004.00		290	43.100	1.0	R	121.50	
031	Thoracic	2004.00		290	40.100	1.0	R	113.00	
033	Cervical	2004.00		290	59.400	1.0	R	167.40	
035	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	2004.00		290	-	0.0	R	-	
037	Discography	2004.00		290	31.500	1.0	R	88.80	
1.3	SKULL								
039	Skull studies	2004.00		290	32.300	1.0	R	91.00	
041	Paranasal sinuses	2004.00		290	17.000	1.0	R	47.90	
043	Facial bones and/or orbits	2004.00		290	34.900	1.0	R	98.30	
045	Mandible	2004.00		290	26.000	1.0	R	73.30	
047	Nasal bone	2004.00		290	16.200	1.0	R	45.70	
049	Mastoid: Bilateral	2004.00		290	50.000	1.0	R	140.90	
	TEETH								
051	One quadrant	2004.00		290	7.700	1.0	R	21.70	
053	Two quadrants	2004.00		290	8.500	1.0	R	24.00	
055	Full mouth	2004.00		290	10.800	1.0	R	30.40	
057	Rotation tomography of the teeth and jaws	2004.00		290	14.600	1.0	R	41.10	
059	Temporo-mandibular joints: Per side	2004.00		290	19.200	1.0	R	54.10	
061	Tomography: Per side	2004.00		290	30.500	1.0	R	85.90	
063	Localisation of foreign body in the eye	2004.00		290	30.700	1.0	R	86.50	
065	Ventriculography	2004.00		290	37.400	1.0	R	105.40	
067	Post-nasal studies: Lateral neck	2004.00		290	10.000	1.0	R	28.20	
069	Maxillo-facial cephalometry	2004.00		290	26.900	1.0	R	75.80	
071	Dacryocystography	2004.00		290	24.200	1.0	R	68.20	
2	ALIMENTARY TRACT								
073	Sialography (plus 80% for each additional gland)	2004.00		290	24.600	1.0	R	69.30	
075	Pharynx and oesophagus	2004.00		290	22.800	1.0	R	64.30	
077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	2004.00		290	31.500	1.0	R	88.80	
079	Small bowel meal (control film of abdomen included, except when part of item 081)	2004.00		290	27.700	1.0	R	78.10	
081	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	2004.00		290	47.200	1.0	R	133.00	
083	Barium enema (control film of abdomen included)	2004.00		290	50.900	1.0	R	143.40	
085	Biliary tract: ERCP (choledogram and/or pancreatography screening included)	2004.00		290	47.000	1.0	R	132.40	
087	Gastric/oesophageal/duodenal intubation control	2004.00		290	20.800	1.0	R	58.60	
089	Hypotonic duodenography (077 included)	2004.00		290	57.300	1.0	R	161.50	
3	BILIARY TRACT								
091	Oral cholecystography	2004.00		290	47.800	1.0	R	134.70	

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093	Intravenous	2004.00		290	58.600	1.0	R	165.10	
095	Operative: First series	2004.00		290	58.100	1.0	R	163.70	
097	Subsequent series	2004.00		290	24.000	1.0	R	67.60	
099	Post-operative: T-tube	2004.00		290	20.100	1.0	R	56.60	
101	Trans-hepatic, percutaneous	2004.00		290	34.600	1.0	R	97.50	
103	Tomography of biliary tract: Add	2004.00		290	21.500	1.0	R	60.60	
	CHEST								
105	Larynx (tomography included)	2004.00		290	42.400	1.0	R	119.50	
107	Chest (item 167 included)	2004.00		290	19.200	1.0	R	54.10	
109	Chest and cardiac studies (item 167 included)	2004.00		290	23.100	1.0	R	65.10	
111	Ribs	2004.00		290	19.200	1.0	R	54.10	
113	Sternum or sterno-clavicular joints	2004.00		290	24.600	1.0	R	69.30	
	BRONCHOGRAPHY								
115	Unilateral	2004.00		290	33.500	1.0	R	94.40	
117	Bilateral	2004.00		290	56.500	1.0	R	159.20	
119	Pleurography	2004.00		290	15.700	1.0	R	44.20	
121	Laryngography	2004.00		290	15.700	1.0	R	44.20	
123	Thoracic inlet	2004.00		290	15.700	1.0	R	44.20	
5	ABDOMEN								
125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	2004.00		290	17.000	1.0	R	47.90	
127	Acute abdomen or equivalent studies	2004.00		290	30.700	1.0	R	86.50	
6	URINARY TRACT								
129	Control film included and bladder views before and after micturition	2004.00		290	67.000	1.0	R	188.80	
133	Waterload test: Add	2004.00		290	20.100	1.0	R	56.60	
135	Cystography only or urethrography only (retrograde)	2004.00		290	37.600	1.0	R	106.00	
	CYSTO-URETHROGRAPHY								
137	Retrograde	2004.00		290	33.100	1.0	R	93.30	
139	Retrograde-prograde pyelography	2004.00		290	42.400	1.0	R	119.50	
141	Aspiration renal cyst	2004.00		290	17.000	1.0	R	47.90	
143	Tomography of renal tract: Add	2004.00		290	19.200	1.0	R	54.10	
7	GYNAECOLOGY AND OBSTETRICS								
145	Pregnancy	2004.00		290	19.200	1.0	R	54.10	
147	Pelvimetry	2004.00		290	35.500	1.0	R	100.00	
149	Hysterosalpingography	2004.00		290	32.000	1.0	R	90.20	
8	TOMOGRAPHY AND CINEMATOGRAPHY								
151	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension, fees shall be charged for the additional investigation at 50% of the rate with a maximum of two additional investigations	2004.00		290	-	0.0	R	-	
153	Tomography (multi-dimensional in motion): Add 150%	2004.00		290	-	0.0	R	-	
9	COMPUTED TOMOGRAPHY								
155	Head, single examination, full series	2004.00		290	262.700	1.0	R	740.30	
157	Head, repeat examination at the same visit, after contrast, full series	2004.00		290	90.200	1.0	R	254.20	
159	Chest	2004.00		290	303.700	1.0	R	855.80	
161	Abdomen (including base of chest and/or pelvis)	2004.00		290	353.000	1.0	R	994.80	

163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	2004.00		290	82.100	1.0	R	231.40	
165	Limbs and other limited examinations	2004.00		290	82.100	1.0	R	231.40	
	MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS								
0089	The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations, and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%	2004.00							
10	MISCELLANEOUS								
167	Fluoroscopy: Per half hour: Add (not applicable to items 107 and 109)	2004.00		290	21.400	1.0	R	60.30	
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	2004.00		290	29.600	1.0	R	83.40	
171	Sinography	2004.00		290	44.300	1.0	R	124.80	
173	Bone densitometry	2005.03		290	80.900	1.0	R	228.00	
175	Mammography: Unilateral or bilateral	2004.00		290	58.100	1.0	R	163.70	
177	Repeat mammography, unilateral or bilateral for localisation of tumour	2004.00		290	58.100	1.0	R	163.70	
179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed	2004.00		290	17.600	1.0	R	49.60	
181	Setting of sterile trays	2004.00		290	3.000	1.0	R	8.45	
	Films are to be charged (exclusive of VAT) at net acquisition price plus -□ □ * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and□ □ * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.□	2006.02							
300	X-Ray films	2006.02							
	ATTENDANCE IN CATHETERISATION LABORATORY								
	Use codes 191 to 193 to charge for radiographer input where that is not included in cath lab facility fee	2004.00							
191	Preparation in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures.	2004.00		290	43.000	1.0	R	121.20	
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	2004.00		290	43.000	1.0	R	121.20	
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
194	Right heart investigation of valve and venous system of the right heart	2004.00		290	43.000	1.0	R	121.20	
195	PTCA per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
196	Left heart investigation of valve of the left heart and ventrical	2004.00		290	43.100	1.0	R	121.50	
197	Stent procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
201	Temporary pacemaker procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	

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203	Permanent pacemaker procedure in catheterisation laboratory per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
205	Intra-aortic balloon pump procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
207	Electro-physiological studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
209	Bleomycine and other studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
211	Intra vascular ultrasound per 30 minutes of part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
213	Rotablator/Laser procedures per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		290	43.000	1.0	R	121.20	
	RULES								
Z	No fee to be subject to more than one reduction	2004.00							
11	PORTABLE UNIT EXAMINATIONS								
185	Where portable x-ray unit is used in the hospital or theatre: Add	2004.00		290	19.400	1.0	R	54.70	
187	Theatre Investigations with fixed installation : Add	2004.00		290	8.300	1.0	R	23.40	

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Code	Description
33900	Radiography

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Code	Description	RCF
290	Radiographers	2.818

RADIOLOGY

Radiology 2008

NATIONAL REFERENCE PRICE LIST FOR RADIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

This schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025"). "025" practices may only charge the codes with a 3rd digit of 9. "038" practices may charge all codes except codes with a 3rd digit of 9. Practitioners registered as both radiologists and nuclear physicians may charge all codes.

This schedule must be used in conjunction with the Radiological Society of S A Guidelines.

Code Structure Framework

a. The tariff code consists of 5 digits

i. 1st digit indicates the main anatomical region or procedural category.
- 0 = General (non specific)
- 1 = Head
- 2 = Neck
- 3 = Thorax
- 4 = Abdomen and Pelvis (soft tissue)
- 5 = Spine, Pelvis and Hips
- 6 = Upper limbs
- 7 = Lower limbs
- 8 = Interventional
- 9 = Soft tissue regions (nuclear medicine)
- eg "Head" = 1xxxx

ii. 2nd digit indicates the sub region within a main region or category eg.
- "Head / Skull and Brain" = 10xxx

iii. 3rd digit indicates modality
- 1 = General (Black and White) x-rays
- 2 = Ultrasound
- 3 = Computed Tomography
- 4 = Magnetic Resonance Imaging
- 5 = Angiography
- 6 = Interventional radiology
- 9 = Nuclear Medicine (Isotopes)

eg:
"Head / Skull and Brain / General x-ray" = 101xx

iv. 4th and 5th digits are specific to a procedure / examination, eg
"Head / Skull and Brain / General / X-ray of the skull" = 10100.

Guidelines for use of coding structure

- The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.
- Some codes may have multiple applications and their use is described in notes associated with each code
- Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA.
- The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs)
- Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.

Consumables

- Contrast Medium
  - Prior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up.
  - After the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up.
- Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90.
- All other consumables are to be billed at net acquisition price, until the implementation of Act 90. Thereafter Act 90 regulations apply.
- The cost of film is included in the comprehensive procedure codes and is not billed for separately.
- Appropriate codes must be provided for consumables.

General Comments on Procedural Codes

- All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115.
- Setting of sterile tray is included in all appropriate procedure codes.
- Where introduction of contrast is necessary eg. sialography, arthrography, angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes.
- The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study.
- CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies).
- Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures.

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies							
General Codes							
Modifiers							
00091	Radiology and nuclear medicine services rendered to hospital inpatients						04.00
00092	Radiology and nuclear medicine services rendered to outpatients						04.00
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used						04.00
Equipment / Diagnostic							
Code	**Description**	**Ver**	**Add**	**Nuclear Medicine**		**Radiology**	
				RVU	**Fee**	**RVU**	**Fee**
00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).	05.04				-	-
	Appropriate code to be provided. See separate codes for contrast and isotopes	04.00					
00110	X-ray skeletal survey under five years	04.00				6.260	419.90 (368.30)
00115	X-ray skeletal survey over five years	04.00				10.400	697.50 (611.80)
00120	X-ray sinogram any region	04.00				10.890	730.40 (640.70)
00130	X-ray with mobile unit in other facility	04.00				1.900	127.40 (111.80)
	To be added to applicable procedure codes eg 30100.	04.00					
00135	X-ray control view in theatre any region	04.00				5.260	352.80 (309.50)
00140	X-ray fluoroscopy any region	04.00				2.260	151.60 (133.00)
	May only be added to the examination when fluoroscopy is not included in the standard procedure code. May not be added to: • any angiography, venography, lymphangiography or interventional codes. • any contrasted fluoroscopy examination.	04.00					
00145	X-ray fluoroscopy guidance for biopsy, any region	04.00				5.300	355.50 (311.80)
	Add to the procedure eg. 80600, 80605, 80610.	04.00					
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour	04.00				2.420	162.30 (142.40)
	Only to be used if equipment is owned by the radiologist.	04.00					
00155	X-ray C-arm fluoroscopy in theatre per half hour (procedure only)	04.00				2.300	154.30 (135.40)
00160	X-ray fixed theatre installation (equipment fee only)	04.00				2.260	151.60 (133.00)
	Only to be used if equipment is owned by the radiologist.	04.00					
00190	X-ray examination contrast material	04.00				-	-
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	04.00					
00210	Ultrasound with mobile unit in other facility	04.00				1.840	123.40 (108.20)
	Add to the relevant ultrasound examination codes eg 10200.	04.00					
00220	Ultrasound intra-operative study	04.00				7.320	491.00 (430.70)
	Covers all regions studied. Single code per operative procedure.	04.00					
00230	Ultrasound guidance	04.00				12.100	811.50 (711.80)
	Comprehensive ultrasound code including regional study and guidance. Guided procedure code to be added eg. 80600, 80605, 80610.	04.00					
00240	Ultrasound guidance for tissue ablation	04.00				11.240	753.90 (661.30)
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure code to be added if performed by a radiologist. 80620 or 80630.	04.00					
00250	Ultrasound limited Doppler study any region	05.03				6.500	436.00 (382.50)
	Stand alone code may not be added to any other code.	05.03					
00290	Ultrasound examination contrast material	04.00				-	-

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	04.00					
00310	CT planning study for radiotherapy	04.00				21.370	1433.30 (1257.30)
00591	Radiology prosthetic device	06.02					
	To be used once per planning session for any region	04.00					
00320	CT guidance (separate procedure)	04.00				16.920	1134.80 (995.40)
	Comprehensive CT code including regional study and guidance. Guided procedure code to be added eg 80600, 80605, and 80610.	04.00					
00330	CT guidance, with diagnostic procedure	04.00				8.460	567.40 (497.70)
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.	04.00					
00340	CT guidance and monitoring for tissue ablation	04.00				21.150	1418.50 (1244.30)
	May only be used once per procedure for a region. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. If performed by radiologist, add procedural code 80620, or 80630.	04.00					
00390	CT examination contrast material	04.00				-	-
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	04.00					
00410	MR study of the whole body for metastases screening	04.00				70.400	4721.70 (4141.80)
00420	MR Spectroscopy any region	04.00				28.900	1938.30 (1700.30)
	May be added to the regional study, once only.	04.00					
00430	MR guidance for needle replacement	04.00				42.560	2854.50 (2503.90)
	Comprehensive MRI code including region studied and guidance. Guided procedure code to be added eg 80600, 80605, 80610.	04.00					
00440	MR low field strength imaging of peripheral joint any region	04.00				12.000	804.80 (706.00)
00450	MR planning study for radiotherapy or surgical procedure	04.00				38.000	2548.70 (2235.70)
00455	MR planning study for radiotherapy or surgical procedure, with contrast	04.00				47.000	3152.30 (2765.20)
00490	MR examination contrast material	04.00				-	-
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	04.00					
00510	Analogue monoplane screening table	04.00				41.010	2750.50 (2412.70)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00520	Analogue monoplane table with DSA attachment	04.00				47.500	3185.80 (2794.60)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00530	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.	04.00				47.500	3185.80 (2794.60)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00540	Digital monoplane screening table	04.00				79.920	5360.20 (4701.90)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00550	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.	04.00				93.030	6239.50 (5473.20)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00560	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment.	04.00				125.000	8383.80 (7354.20)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00590	Angiography and interventional examination contrast material	04.00				-	-
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	04.00					
00900	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton	04.00		34.920	2342.10 (2054.50)		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT	04.00		48.330	3241.50 (2843.40)		
00906	Nuclear Medicine study - Venous thrombosis regional	04.00		21.540	1444.70 (1267.30)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
00909	Nuclear Medicine study - Tumour whole body	04.00		34.150	2290.40 (2009.10)		
00912	Nuclear Medicine study - Tumour whole body multiple studies	04.00		47.560	3189.80 (2798.10)		
00915	Nuclear Medicine study - Tumour whole body and SPECT	04.00		47.560	3189.80 (2798.10)		
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT	04.00		60.980	4089.90 (3587.60)		
00921	Nuclear Medicine study – Infection whole body	04.00		31.450	2109.40 (1850.40)		
00924	Nuclear Medicine study – infection whole body with SPECT	04.00		44.860	3008.80 (2639.30)		
00927	Nuclear Medicine study – infection whole body multiple studies	04.00		44.860	3008.80 (2639.30)		
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies	04.00		58.270	3908.20 (3428.20)		
00933	Nuclear Medicine study - Bone marrow imaging limited area	04.00		24.100	1616.40 (1417.90)		
00936	Nuclear Medicine study - Bone marrow imaging whole body	04.00		37.510	2515.80 (2206.80)		
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies	04.00		37.510	2515.80 (2206.80)		
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies	04.00		50.920	3415.20 (2995.80)		
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic	04.00		24.100	1616.40 (1417.90)		
00960	Nuclear Medicine therapy – Hyperthyroidism	04.00		11.990	804.20 (705.40)		
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases	04.00		6.470	433.90 (380.60)		
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy	04.00		6.470	433.90 (380.60)		
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy	04.00		6.470	433.90 (380.60)		
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate	04.00		6.470	433.90 (380.60)		
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy	04.00		6.470	433.90 (380.60)		
00990	Nuclear Medicine Isotope	04.00		-	-		
	Identification code for the use of isotope with a procedure. Appropriate codes to be supplied.	04.00					
00991	Nuclear Medicine Substrate	04.00		-	-		
Call and assistance							
	• Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. • Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. • Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. • Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. • Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.						05.05
01010	Emergency call out fee, first case	04.00				3.000	201.20 (176.50)
01020	Emergency call out fee, subsequent cases same trip	04.00				2.000	134.10 (117.60)
01030	Radiologist assistance in theatre, per half hour	04.00				6.000	402.40 (353.00)
01040	Radiographer attendance in theatre, per half hour	04.00				1.600	107.30 (94.10)
01050	Written report on study done elsewhere, short	04.00				1.500	100.60 (88.20)
01055	Written report on study done elsewhere, extensive	04.00				4.200	281.70 (247.10)
01060	Written report for medico legal purposes, per hour	04.00				9.720	651.90 (571.80)
01070	Consultation for pre-assessment of interventional procedure	04.00				4.860	326.00 (286.00)
01100	X-ray procedure after hours, per procedure	04.00				2.000	-

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
01200	Ultrasound procedure after hours, per procedure	04.00				4.000	-
01300	CT procedure after hours, per procedure	04.00				10.000	-
01400	MR procedure after hours, per procedure	04.00				14.000	-
01500	Angiography procedure after hours, per procedure	04.00				20.000	-
01600	Interventional procedure after hours, per procedure	04.00				26.000	-
01970	Consultation for nuclear medicine study	04.00		2.200	147.60 (129.50)		
Monitoring							
	• ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.						04.00
02010	ECG/pulse Oximeter monitoring	04.00				2.000	134.10 (117.60)
Head							
Skull and Brain							
	Codes 10100 (skull) and 10110 (tomography) may be combined.						04.00
10100	X-ray of the skull	04.00				3.860	258.90 (227.10)
10110	X-ray tomography of the skull	04.00				4.300	288.40 (253.00)
10120	X-ray shuntogram for VP shunt	04.00				15.360	1030.20 (903.70)
10200	Ultrasound of the brain – Neonatal	04.00				7.380	495.00 (434.20)
10210	Ultrasound of the brain including doppler	04.00				13.220	886.70 (777.80)
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	04.00				15.040	1008.70 (884.80)
10300	CT Brain uncontrasted	04.00				22.650	1519.10 (1332.50)
10310	CT Brain with contrast only	04.00				33.280	2232.10 (1958.00)
10320	CT Brain pre and post contrast	04.00				40.480	2715.00 (2381.60)
10325	CT brain pre and post contrast for perfusion studies	05.03				49.100	3293.10 (2888.70)
	Stand alone code may not be added to any other CT studies of the brain, except for code 10330	05.03					
10330	CT angiography of the brain	04.00				77.580	5203.30 (4564.30)
10335	CT of the brain pre and post contrast with angiography	04.00				97.910	6566.80 (5760.40)
10340	CT brain for cranio-stenosis including 3D	04.00				34.160	2291.10 (2009.70)
10350	CT Brain stereotactic localisation	04.00				19.360	1298.50 (1139.00)
10360	CT base of skull coronal high resolution study for CSF leak	05.03				34.900	2340.70 (2053.20)
10400	MR of the brain, limited study	04.00				43.560	2921.60 (2562.80)
10410	MR of the brain uncontrasted	04.00				63.800	4279.10 (3753.60)
10420	MR of the brain with contrast	04.00				75.940	5093.30 (4467.80)
10430	MR of the brain pre and post contrast	04.00				104.040	6978.00 (6121.10)
10440	MR of the brain pre and post contrast, for perfusion studies	04.00				107.440	7206.00 (6321.10)
10450	MR of the brain plus angiography	04.00				92.200	6183.90 (5424.50)
10460	MR of the brain pre and post contrast plus angiography	04.00				121.230	8130.90 (7132.40)
10470	MR angiography of the brain uncontrasted	04.00				58.500	3923.60 (3441.80)
10480	MR angiography of the brain contrasted	04.00				74.020	4964.50 (4354.80)
10485	MR of the brain, with diffusion studies	04.00				79.000	5298.50 (4647.80)
10490	MR of the brain, pre and post contrast, with diffusion studies,	04.00				110.640	7420.60 (6509.30)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
10492	MR study of the brain plus angiography plus diffusion, uncontrasted	04.00				95.000	6371.70 (5589.20)
10495	MR of the brain pre and post contrast plus angiography and diffusion	04.00				125.440	8413.30 (7380.10)
10500	Arteriography of intracranial vessels: 1 - 2 vessels	04.00				48.600	3259.60 (2859.30)
10510	Arteriography of intracranial vessels: 3 - 4 vessels	04.00				82.330	5521.90 (4843.80)
10520	Arteriography of extra-cranial (non-cervical) vessels	04.00				48.440	3248.90 (2849.90)
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels	04.00				118.090	7920.30 (6947.60)
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography	04.00				97.570	6544.00 (5740.40)
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography	04.00				37.290	2501.00 (2193.90)
10560	Venography of dural sinuses	04.00				52.230	3503.10 (3072.90)
10900	Nuclear Medicine study – Bone regional, static	04.00		21.500	1442.00 (1264.90)		
10905	Nuclear Medicine study – Bone regional, static, with flow	04.00		27.530	1846.40 (1619.60)		
10910	Nuclear Medicine study – Bone regional, static with SPECT	04.00		34.920	2342.10 (2054.50)		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT	04.00		40.940	2745.80 (2408.60)		
10920	Nuclear Medicine study – Brain, planar, complete, static	04.00		16.920	1134.80 (995.40)		
10925	Nuclear Medicine study – Brain complete static with vascular flow	04.00		22.950	1539.30 (1350.30)		
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT	04.00		30.330	2034.20 (1784.40)		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT	04.00		36.360	2438.70 (2139.20)		
10940	Nuclear Medicine study - CSF flow imaging cisternography	04.00		21.600	1448.70 (1270.80)		
10945	Nuclear Medicine study – Ventriculography	04.00		13.410	899.40 (788.90)		
10950	Nuclear Medicine study - Shunt evaluation static, planar	04.00		13.410	899.40 (788.90)		
10955	Nuclear Medicine study - CFS leakage detection and localisation	04.00		13.410	899.40 (788.90)		
10960	Nuclear medicine study - CSF SPECT	04.00		13.410	899.40 (788.90)		
Facial bones and nasal bones							
	Codes 11100 (facial bones) and 11110 (tomography) may be combined						04.00
11100	X-ray of the facial bones	04.00				3.930	263.60 (231.20)
11110	X-ray tomography of the facial bones	04.00				4.300	288.40 (253.00)
11120	X-ray of the nasal bones	04.00				2.390	160.30 (140.60)
11300	CT of the facial bones	04.00				20.960	1405.80 (1233.20)
11310	CT of the facial bones with 3D reconstructions	04.00				30.400	2038.90 (1788.50)
11320	CT of the facial bones/soft tissue, pre and post contrast	04.00				41.260	2767.30 (2427.50)
11400	MR of the facial soft tissue	04.00				62.400	4185.20 (3671.20)
11410	MR of the facial soft tissue pre and post contrast	04.00				100.600	6747.20 (5918.60)
11420	MR of the facial soft tissue plus angiography, with contrast	04.00				110.300	7397.80 (6489.30)
11430	MR angiography of the facial soft tissue	04.00				74.020	4964.50 (4354.80)
Orbits, lacrimal glands and tear ducts							
	Code 12130 (tomography) may be added to 12100 or 12110 or 12120 (orbits) or 12140 (dacrocystography).						04.00
12100	X-ray orbits less than three views	04.00				3.560	238.80 (209.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
12110	X-ray of the orbits, three or more views, including foramina	04.00				5.300	355.50 (311.80)
12120	X-ray of the orbits for foreign body	04.00				3.560	238.80 (209.50)
12130	X-ray tomography of the orbits	04.00				4.300	288.40 (253.00)
12140	X-ray dacrocystography	04.00				11.200	751.20 (658.90)
12200	Ultrasound of the orbit/eye	04.00				5.130	344.10 (301.80)
12210	Ultrasound of the orbit/eye including doppler	04.00				10.970	735.80 (645.40)
12300	CT of the orbits single plane	04.00				15.700	1053.00 (923.70)
12310	CT of the orbits, more than one plane	04.00				20.590	1381.00 (1211.40)
12320	CT of the orbits pre and post contrast single plane	04.00				36.030	2416.50 (2119.70)
12330	CT of the orbits pre and post contrast multiple planes	04.00				39.700	2662.70 (2335.70)
12400	MR of the orbits	04.00				62.460	4189.20 (3674.70)
12410	MR of the orbitae, pre and post contrast	04.00				100.640	6749.90 (5921.00)
12900	Nuclear Medicine study – Dacrocystography	04.00		20.770	1393.00 (1221.90)		
Paranasal sinuses							
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).						04.00
13100	X-ray of the paranasal sinuses, single view	04.00				2.740	183.80 (161.20)
13110	X-ray of the paranasal sinuses, two or more views	04.00				3.660	245.50 (215.40)
13120	X-ray tomography of the paranasal sinuses	04.00				4.300	288.40 (253.00)
13130	X-ray of the naso-pharyngeal soft tissue	04.00				2.740	183.80 (161.20)
13300	CT of the paranasal sinuses single plane, limited study	04.00				7.200	482.90 (423.60)
13310	CT of the paranasal sinuses, two planes, limited study	04.00				12.400	831.70 (729.60)
13320	CT of the paranasal sinuses, any plane, complete study	04.00				15.420	1034.20 (907.20)
13330	CT of the paranasal sinuses, more than one plane, complete study	04.00				20.770	1393.00 (1221.90)
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast	04.00				34.740	2330.00 (2043.90)
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast	04.00				41.010	2750.50 (2412.70)
13400	MR of the paranasal sinuses	04.00				60.270	4042.30 (3545.90)
13410	MR of the paranasal sinuses, pre and post contrast	04.00				96.590	6478.30 (5682.70)
Mandible, teeth and maxilla							
	Code 14110 (orthopantomogram) may be combined with 14100 (mandible) if two separate studies are performed. Code 14110 (orthopantomogram) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14160 (tomography) may be combined with 14130 or 14140 or 14150 (teeth). Code 14160 (tomography) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14330 and 14340 (Dental implants) may be combined if mandible and maxilla are examined at the same visit.						04.00
14100	X-ray of the mandible	04.00				3.660	245.50 (215.40)
14110	X-ray orthopantomogram of the jaws and teeth	04.00				4.060	272.30 (238.90)
14120	X-ray maxillofacial cephalometry	04.00				2.770	185.80 (163.00)
14130	X-ray of the teeth single quadrant	04.00				2.000	134.10 (117.60)
14140	X-ray of the teeth more than one quadrant	04.00				2.530	169.70 (148.90)
14150	X-ray of the teeth full mouth	04.00				3.620	242.80 (213.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
14160	X-ray tomography of the teeth per side	04.00				3.230	216.60 (190.00)
14300	CT of the mandible	04.00				22.280	1494.30 (1310.80)
14310	CT of the mandible, pre and post contrast	04.00				41.260	2767.30 (2427.50)
14320	CT mandible with 3D reconstructions	04.00				30.400	2038.90 (1788.50)
14330	CT for dental implants in the mandible	04.00				27.450	1841.10 (1615.00)
14340	CT for dental implants in the maxilla	04.00				27.450	1841.10 (1615.00)
14400	MR of the mandible/maxilla	04.00				63.800	4279.10 (3753.60)
14410	MR of the mandible/maxilla, pre and post contrast	04.00				98.640	6615.80 (5803.30)
TM Joints							
	Code 15100 (TM joint) and 15120 (tomography) may be combined. Code 15110 (TM joint) and 15130 (tomography) may be combined. Code 15140 (arthrography) and 15120 (tomography) may be combined. Code 15150 (arthrography) and 15130 (tomography)may be combined. Codes 15320 (CT arthrogram) and 15420 (MR arthrogram) include introduction of contrast (00140 may not be added).						04.00
15100	X-ray tempero-mandibular joint, left	04.00				3.560	238.80 (209.50)
15110	X-ray tempero-mandibular joint, right	04.00				3.560	238.80 (209.50)
15120	X-ray tomography tempero-mandibular joint, left	04.00				4.300	288.40 (253.00)
15130	X-ray tomography tempero-mandibular joint, right	04.00				4.300	288.40 (253.00)
15140	X-ray arthrography of the tempero-mandibular joint, left	04.00				15.410	1033.50 (906.60)
15150	X-ray arthrography of the tempero-mandibular joint, right	04.00				15.410	1033.50 (906.60)
15200	Ultrasound tempero-mandibular joints, one or both sides	04.00				6.560	440.00 (386.00)
15300	CT of the tempero-mandibular joints	04.00				25.380	1702.20 (1493.20)
15310	CT of the tempero-mandibular joints plus 3D reconstructions	04.00				34.500	2313.90 (2029.70)
15320	CT arthrogram of the tempero-mandibular joints	04.00				35.960	2411.80 (2115.60)
15400	MR of the tempero-mandibular joints	04.00				63.800	4279.10 (3753.60)
15410	MR of the tempero-mandibular joints, pre and post contrast	04.00				100.840	6763.30 (5932.70)
15420	MR arthrogram of the tempero-mandibular joints	04.00				74.710	5010.80 (4395.40)
Mastoids and internal auditory canal							
	Code 16100 (mastoids) and 16120 (tomography) may be combined. Code 16110 (mastoids bilat) and 16130 (tomography) may be combined Code 16140 (IAM's) and 16150 (tomography) may be combined.						04.00
16100	X-ray of the mastoids, unilateral	04.00				3.590	240.80 (211.20)
16110	X-ray of the mastoids, bilateral	04.00				7.180	481.60 (422.50)
16120	X-ray tomography of the petro-temporal bone, unilateral	04.00				4.300	288.40 (253.00)
16130	X-ray tomography of the petro-temporal bone, bilateral	04.00				8.600	576.80 (506.00)
16140	X-ray internal auditory canal, bilateral	04.00				5.230	350.80 (307.70)
16150	X-ray tomography of the internal auditory canal, bilateral	04.00				4.300	288.40 (253.00)
16300	CT of the mastoids	04.00				12.600	845.10 (741.30)
16310	CT of the internal auditory canal	04.00				21.470	1440.00 (1263.20)
16320	CT of the internal auditory canal, pre and post contrast	04.00				34.200	2293.80 (2012.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
16330	CT of the ear structures, limited study	04.00				13.400	898.70 (788.30)
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes	04.00				43.350	2907.50 (2550.40)
16400	MR of the internal auditory canals, limited study	04.00				43.560	2921.60 (2562.80)
16410	MR of the internal auditory canals, pre and post contrast, limited study	04.00				68.930	4623.10 (4055.40)
16420	MR of the internal auditory canals, pre and post contrast, complete study	04.00				102.640	6884.10 (6038.70)
16430	MR of the ear structures	04.00				64.400	4319.30 (3788.90)
16440	MR of the ear structures, pre and post contrast	04.00				102.640	6884.10 (6038.70)
Sella turcica							
	Code 17100 (sella) and 17110 (tomography) may be combined.						04.00
17100	X-ray of the sella turcica	04.00				3.080	206.60 (181.20)
17110	X-ray tomography of the sella turcica	04.00				4.300	288.40 (253.00)
17300	CT of the sella turcica/hypophysis	04.00				17.450	1170.40 (1026.70)
17310	CT of the sella turcica/hypophysis, pre and post contrast	04.00				42.260	2834.40 (2486.30)
17400	MR of the hypophysis	04.00				43.560	2921.60 (2562.80)
17410	MR of the hypophysis, pre and post contrast	04.00				74.030	4965.20 (4355.40)
Salivary glands and floor of the mouth							
	Code 18100 (calculus) and 18110 (open mouth) may be combined. Codes 18120 (sialography) and 18320 (CT sialography) include introduction of contrast and fluoroscopy (00140 may not be added).						04.00
18100	X-ray of the salivary glands and ducts for calculus	04.00				2.840	190.50 (167.10)
18110	X-ray of the salivary ducts, open mouth for calculus	04.00				1.900	127.40 (111.80)
18120	X-ray sialography, per gland	04.00				14.080	944.30 (828.30)
18200	Ultrasound of the salivary glands/floor of the mouth	04.00				6.560	440.00 (386.00)
18300	CT of the salivary glands, uncontrasted	04.00				12.600	845.10 (741.30)
18310	CT of the salivary glands/floor of the mouth, pre and post contrast	04.00				42.100	2823.60 (2476.80)
18320	CT sialography	04.00				26.280	1762.60 (1546.10)
18400	MR of the salivary glands/floor of the mouth	04.00				63.200	4238.80 (3718.20)
18410	MR of the salivary glands/floor of the mouth, pre and post contrast	04.00				100.840	6763.30 (5932.70)
18900	Nuclear Medicine study - Salivary gland imaging	04.00		20.770	1393.00 (1221.90)		
Soft Tissue							
19900	Nuclear Medicine study - Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		
19905	Nuclear Medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
19910	Nuclear Medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
19915	Nuclear Medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3189.80 (2798.10)		
19920	Nuclear medicine study - Infection localisation planar, static	04.00		18.040	1209.90 (1061.30)		
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2109.40 (1850.40)		
19930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2109.40 (1850.40)		
19935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3008.80 (2639.30)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Neck							
	Code 20120 (laryngography) includes fluoroscopy (00140 may not be added). Code 20130 (speech) includes tomography and cinematography (00140 may not be added). Code 20450 (MR Angiography) may be combined with 10410 (MR brain).						04.00
20100	X-ray of soft tissue of the neck	04.00				2.740	183.80 (161.20)
20110	X-ray of the larynx including tomography	04.00				9.390	629.80 (552.50)
20120	X-ray laryngography	04.00				8.280	555.30 (487.10)
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording	04.00				8.300	556.70 (488.30)
20200	Ultrasound of the thyroid	04.00				6.560	440.00 (386.00)
20210	Ultrasound of soft tissue of the neck	04.00				6.560	440.00 (386.00)
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler	04.00				15.000	1006.10 (882.60)
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler	04.00				21.840	1464.80 (1284.90)
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler	05.03				10.800	724.40 (635.40)
20300	CT of the soft tissues of the neck	04.00				18.250	1224.00 (1073.70)
20310	CT of the soft tissues of the neck, with contrast	04.00				38.150	2558.70 (2244.50)
20320	CT of the soft tissues of the neck, pre and post contrast	04.00				43.810	2938.30 (2577.50)
20330	CT angiography of the extracranial vessels in the neck	04.00				79.360	5322.70 (4669.00)
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain	04.00				107.600	7210.00 (6324.60)
20350	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain plus a pre and post contrast study of the brain	04.00				124.430	8345.50 (7320.60)
20400	Mr of the soft tissue of the neck	04.00				63.600	4265.70 (3741.80)
20410	MR of the soft tissue of the neck, pre and post contrast	04.00				102.040	6843.60 (6003.30)
20420	MR of the soft tissue of the neck and uncontrasted angiography	04.00				92.600	6210.70 (5448.00)
20430	MR angiography of the extracranial vessels in the neck, without contrast	04.00				59.600	3997.40 (3506.50)
20440	MR angiography of the extracranial vessels in the neck, with contrast	04.00				74.020	4964.50 (4354.60)
20450	MR angiography of the extra and intracranial vessels with contrast	04.00				116.050	7783.50 (6827.60)
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast	05.05				135.170	9065.90 (7952.50)
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast	04.00				156.060	10466.30 (9181.00)
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels	04.00				44.430	2979.90 (2613.90)
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels	04.00				50.730	3402.50 (2984.60)
20520	Arteriography of cervical vessels: carotid and vertebral	04.00				77.580	5206.60 (4567.20)
20530	Arteriography of aortic arch and cervical vessels	04.00				91.970	6168.40 (5410.90)
20540	Arteriography of aortic arch, cervical and intracranial vessels	04.00				108.870	7301.90 (6405.20)
20550	Venography of jugular and vertebral veins	04.00				48.950	3283.10 (2879.90)
Thyroid (Nuclear Medicine)							
21900	Nuclear Medicine study - Thyroid, single uptake	04.00		9.680	649.20 (569.60)		
21910	Nuclear medicine study - Thyroid, multiple uptake	04.00		14.690	985.30 (864.50)		
21920	Nuclear medicine study - Thyroid imaging with uptake	04.00		17.720	1188.50 (1042.50)		
21930	Nuclear medicine study - Thyroid imaging	04.00		12.720	853.16 (748.30)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
21940	Nuclear medicine study - Thyroid imaging with vascular flow	04.00		18.740	1256.90 (1102.50)		
21950	Nuclear medicine study - Thyroid suppression/stimulation	04.00		12.720	853.10 (748.30)		
Parathyroid (Nuclear Medicine)							
22900	Nuclear Medicine study - Parathyroid, planar, static	04.00		16.520	1108.00 (971.90)		
22910	Nuclear medicine study - Parathyroid, planar, static, multiple	04.00		28.910	1939.00 (1700.90)		
22920	Nuclear medicine study - Parathyroid, planar, static with subtraction technique	04.00		21.880	1467.50 (1287.30)		
22930	Nuclear medicine study - Parathyroid SPECT	04.00		13.410	899.40 (788.90)		
Soft Tissue							
29900	Nuclear Medicine study - Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		
29905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
29910	Nuclear medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
29915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3189.80 (2798.10)		
29920	Nuclear medicine study - Tumour localisation planar, static	04.00		18.040	1209.90 (1061.30)		
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2109.40 (1850.40)		
29930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2109.40 (1850.40)		
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3008.80 (2639.30)		
29940	Nuclear medicine study - Regional lymph node mapping, static, planar	04.00		24.100	1616.40 (1417.90)		
29945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	04.00		36.490	2447.40 (2146.80)		
29950	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		12.390	831.00 (728.90)		
Thorax							
Chest wall, pleura, lungs and mediastinum							
	Code 30140 (tomography) may be combined with 30100 or 30110 (chest) or 30150 or 30155 (ribs) or 30160 (thoracic inlet). Codes 30170 (Sterno-clavicular) and 30175 (tomography) may be combined. Code 30180 (sternum) and 30185 (tomography) may be combined. Code 30340 (CT limited high resolution) may be combined with 30310 or 30320 or 30330 (CT chest). Motivation may be required. Code 30350 (high resolution) is a stand alone study. Code 30360, (CT chest for pulmonary embolism) is a complete examination and includes the preceding uncontrasted CT scan of the chest, and may not be combined with 40330 or 40333 (CT abdomen and pelvis). Code 30370 (CT pulmonary embolism plus CT venography) may not be combined with 70230 (Doppler).						04.00
30100	X-ray of the chest, single view	04.00				3.040	203.90 (178.90)
30110	X-ray of the chest two views, PA and lateral	04.00				3.840	257.50 (225.90)
30120	X-ray of the chest complete with additional views	04.00				4.240	284.40 (249.50)
30130	X-ray of the chest complete including fluoroscopy	04.00				4.480	300.50 (263.60)
30140	X-ray tomography of the chest	04.00				4.300	288.40 (253.00)
30150	X-ray of the ribs	04.00				4.790	321.30 (281.80)
30155	X-ray of the chest and ribs	04.00				6.420	430.60 (377.70)
30160	X-ray of the thoracic inlet	04.00				2.560	171.70 (150.60)
30170	X-ray of the sterno-clavicular joints	04.00				4.210	282.40 (247.70)
30175	X-ray tomography of the sterno-clavicular joint	04.00				4.300	288.40 (253.00)
30180	X-ray of the sternum	04.00				4.210	282.40 (247.70)
30185	X-ray tomography of the sternum	04.00				4.300	288.40 (253.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
30200	Ultrasound of the chest wall, any region	04.00				6.560	440.00 (386.00)
30210	Ultrasound of the pleural space	04.00				6.560	440.00 (386.00)
30220	Ultrasound of the mediastinal structures	04.00				6.560	440.00 (386.00)
30300	CT of the chest, limited study	04.00				9.500	637.20 (558.90)
30310	CT of the chest uncontrasted	04.00				26.600	1784.10 (1565.00)
30320	CT of the chest contrasted	04.00				42.430	2845.80 (2496.30)
30330	CT of the chest, pre and post contrast	04.00				45.700	3065.10 (2688.70)
30340	CT of the chest, limited high resolution study	04.00				11.200	751.20 (658.90)
30350	CT of the chest, complete high resolution study	04.00				24.010	1610.40 (1412.60)
30355	CT of the chest, complete high resolution study with additonal prone and expiratory studies	05.03				33.300	2233.40 (1959.10)
30360	CT of the chest for pulmonary embolism	04.00				57.120	3831.00 (3360.50)
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	04.00				80.280	5384.40 (4723.20)
30400	MR of the chest	04.00				63.600	4265.70 (3741.80)
30410	MR of the chest with uncontrasted angiography	04.00				92.600	6210.70 (5448.00)
30420	MR of the chest, pre and post contrast	04.00				102.040	6843.80 (6003.30)
30900	Nuclear Medicine study - Lung perfusion	04.00		21.540	1444.70 (1267.30)		
30910	Nuclear Medicine study - Lung ventilation, aerosol	04.00		21.500	1442.00 (1264.90)		
30920	Nuclear Medicine study - Lung perfusion and ventilation	04.00		42.030	2819.00 (2472.80)		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas	04.00		14.170	950.40 (833.70)		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas	04.00		34.690	2326.70 (2041.00)		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic	05.03		26.510	1778.00 (1559.60)		
30960	Nuclear medine study - alveolar permeability	05.03		26.510	1778.00 (1559.60)		
	Stand alone code. Not to be combined with 30910.	05.03					
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation	05.03		6.020	403.80 (354.20)		
	Stand alone code. Not to be combined with 30920.	05.03					
Oesophagus							
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).						04.00
31100	X-ray barium swallow	04.00				6.600	442.70 (388.30)
31105	Xray 3 phase dynamic contrasted swallow	05.03				12.600	845.10 (741.30)
31110	X-ray barium swallow, double contrast	04.00				7.920	531.20 (466.00)
31120	X-ray barium swallow with cinematogrephy	04.00				10.070	675.40 (592.50)
Aorta and large vessels							
	Codes 32210 and 32220 (Ivus) may be combined						04.00
32200	Ultrasound intravascular arterial or venous assessment for intervention, once per complete procedure	04.00				4.200	281.70 (247.10)
32210	Ultrasound intravascular (IVUS) first vessel	04.00				8.440	566.10 (496.60)
32220	Ultrasound intravascular (IVUS) subsequent vessels	04.00				5.300	355.50 (311.80)
32300	CT angiography of the aorta and branches	04.00				79.080	5303.90 (4652.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
32305	CT angiography of the thoracic and abdominal aorta and branches	05.03				105.500	7075.90 (6206.90)
32310	CT angiography of the pulmonary vasculature	04.00				79.080	5303.90 (4652.50)
32400	MR angiography of the aorta and branches	04.00				78.500	5265.00 (4618.40)
32410	MR angiography of the pulmonary vasculature	04.00				105.270	7060.50 (6193.40)
32500	Arteriography of thoracic aorta	04.00				28.260	1895.40 (1662.60)
32510	Arteriography of bronchial intercostal vessels alone	04.00				50.150	3363.60 (2950.50)
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels	04.00				67.430	4522.50 (3967.10)
32530	Arteriography of pulmonary vessels	04.00				63.270	4243.50 (3722.40)
32540	Arteriography of heart chambers, coronary arteries	04.00				44.270	2969.20 (2604.60)
32550	Venography of thoracic vena cava	04.00				28.380	1903.40 (1669.60)
32560	Venography of vena cava, azygos system	04.00				56.310	3776.70 (3312.90)
32570	Venography patency of A-port or other central line	04.00				19.640	1317.30 (1155.50)
Heart							
	Codes 33300 (CT anatomy / function) and 33310 (CT Angiography) may be done as stand alone studies or as additive studies if both are performed at the same time.	04.00					
33205	Ultrasound study of the heart for foetal or paediatric cases including doppler	04.00				12.300	825.00 (723.70)
	Code 33205 is a stand alone study and may not be added to 33200 or 33210. This code is intended for paediatric and foetal cases only	04.00					
33200	Ultrasound study of the heart, including Doppler	04.00				8.200	550.00 (482.50)
33210	Ultrasound study of the heart trans-oesophageal	04.00				10.520	705.60 (618.90)
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel	04.00				5.200	348.80 (306.00)
33300	CT anatomical/functional study of the heart	04.00				34.610	2321.30 (2036.20)
33310	CT angiography of heart vessels	04.00				81.280	5451.40 (4781.90)
33400	MR of the heart, anatomical study	04.00				62.200	4171.80 (3659.50)
33410	MR of the heart, anatomical and functional study	04.00				69.000	4627.80 (4059.50)
33420	MR of the heart, pre and post contrast	04.00				103.040	6910.90 (6062.20)
33430	MR angiography of the heart vessels	04.00				70.710	4742.50 (4160.10)
33440	MR of the heart, anatomical, functional and coronary angiography	04.00				106.840	7165.80 (6285.80)
33900	Nuclear Medicine study - Cardiac shunt detection	04.00		21.500	1442.00 (1264.90)		
33905	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion single study	04.00		26.510	1778.00 (1559.60)		
33910	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion multiple studies	04.00		34.920	2342.10 (2054.50)		
33915	Nuclear Medicine study - Cardiac blood pool imaging, gated SPECT	04.00		13.410	899.40 (788.90)		
33920	Nuclear medicine study - Cardiac blood pool imaging, first pass technique	04.00		26.510	1778.00 (1559.60)		
33925	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi) planar, non gated	04.00		16.520	1108.00 (971.90)		
33930	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi) planar, non gated	04.00		16.520	1108.00 (971.90)		
33935	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (non gated)	04.00		16.520	1108.00 (971.90)		
33940	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT non gated	04.00		16.520	1108.00 (971.90)		
33945	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (gated)	04.00		28.910	1939.00 (1700.90)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
33950	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT (gated)	04.00		28.910	1939.00 (1700.90)		
33955	Nuclear medicine study - Plus wall movement and ejection fraction, SPECT	04.00		6.020	403.80 (354.20)		
33960	Nuclear medicine study - Cardiac hot spot imaging (infarction) planar	04.00		21.500	1442.00 (1264.90)		
33965	Nuclear medicine study - Cardiac hot spot imaging (infarction) SPECT	04.00		13.410	899.40 (788.90)		
33970	Nuclear Medicine study - Multi stage treadmill ECG test	04.00		6.660	446.70 (391.80)		
Mamma							
	Codes 34110 (localization), 34120 (stereo-tactic localization) and 34130 (stereo-tactic biopsy) may not be combined. Code 34130 (stereo-tactic biopsy). Add procedural code 80610 (cutting needle) or 34150 (mammotome) Code 34205 (U/S FNA) includes the procedural code (may not be combined with 34150).						04.00
34100	X-ray mammography including ultrasound	04.00				10.440	700.20 (614.20)
34101	X-Ray mammography unilateral, including ultrasound	06.04				8.352	560.20 (491.40)
	Code 34100 may not be combined with 34205 when these two procedures are done in the same sitting. Code 34100 includes ultrasound. In this situation use code 80605 (fine needle aspiration) with 34100	04.00					
34105	X-ray mammography galactography	04.00				9.400	630.50 (553.10)
	Once off fee per visit. May be added to 34100	04.00					
34110	X-ray mammography study for localisation	04.00				7.240	485.60 (426.00)
34120	X-ray stereotactic mammography – localisation	04.00				10.400	697.50 (611.80)
34130	X-ray stereotactic mammography – biopsy	04.00				11.600	778.00 (682.50)
34140	X-ray of biopsy specimen of the mamma	04.00				2.740	183.80 (161.20)
34150	X-ray Mammotome hand held biopsy apparatus	04.00				9.800	657.30 (576.60)
34200	Ultrasound study of the breast	04.00				7.900	529.90 (464.80)
34205	Ultrasound guided aspiration FNA/localisation of the breast	04.00				12.100	811.50 (711.80)
34300	Computer assisted diagnosis for mammography	04.00				1.400	93.90 (82.40)
34400	MR study of the breast	04.00				62.600	4198.60 (3683.00)
34410	MR study of the breast pre and post contrast	04.00				100.840	6763.30 (5932.70)
Soft Tissue							
39900	Nuclear medicine study - Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		
39905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
39910	Nuclear medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
39915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3189.80 (2798.10)		
39920	Nuclear medicine study - Infection localisation planar, static	04.00		18.040	1209.90 (1061.30)		
39925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2109.40 (1850.40)		
39930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2109.40 (1850.40)		
39935	Nuclear medicine study - Infection localisation planar, static, multiple studies, SPECT	04.00		44.860	3008.80 (2639.30)		
39940	Nuclear medicine study - Regional lymph node mapping, static, planar	04.00		24.100	1616.40 (1417.90)		
39945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	04.00		36.490	2447.40 (2146.80)		
39950	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		12.390	831.00 (728.90)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Abdomen and Pelvis							
Abdomen/stomach/bowel							
	Code 40120 (tomography) may be combined with 40100 or 40105 or 40110 (abdomen). Codes 40140 to 40190 (barium studies) include fluoroscopy (00140 may not be added). Code 40190 (intussusception) is a stand alone code and may not be combined with 40160 or 40165 (barium enema), (00140 may not be added).	04.00					
40100	X-ray of the abdomen	04.00				3.320	222.70 (195.40)
40105	X-ray of the abdomen supine and erect, or decubitus	04.00				5.360	359.50 (315.40)
40110	X-ray of the abdomen multiple views including chest	04.00				8.100	543.30 (476.60)
40120	X-ray tomography of the abdomen	04.00				4.300	288.40 (253.00)
40140	X-ray barium meal single contrast	04.00				8.870	594.90 (521.80)
40143	X-ray barium meal double contrast	04.00				11.990	804.20 (705.40)
40147	X-ray barium meal double contrast with follow through	04.00				15.800	1059.70 (929.60)
40150	X-ray small bowel enteroclysis (meal)	04.00				25.450	1706.90 (1497.30)
	Code 40150 excludes duodenal intubation and 40175 (Duodenal intubation) may be added.	06.02					
40153	X-ray small bowel meal follow through single contrast	04.00				19.550	1311.20 (1150.20)
40157	X-ray small bowel meal with pneumocolon	04.00				25.630	1719.00 (1507.90)
40160	X-ray large bowel enema single contrast	04.00				12.970	869.90 (763.10)
40165	X-ray large bowel enema double contrast	04.00				19.630	1316.60 (1154.90)
40170	X-ray guided gastro oesophageal intubation	04.00				1.600	107.30 (94.10)
40175	X-ray guided duodenal intubation	04.00				2.800	187.80 (164.70)
40180	X-ray defaecogram	04.00				12.970	869.90 (763.10)
40190	X-ray guided reduction of intussusception	04.00				16.270	1091.20 (957.20)
40200	Ultrasound study of the abdominal wall	04.00				5.540	371.60 (326.00)
40210	Ultrasound study of the whole abdomen including the pelvis	04.00				8.240	552.70 (484.80)
40300	CT study of the abdomen	04.00				26.410	1771.30 (1553.80)
40310	CT study of the abdomen with contrast	04.00				44.820	3006.10 (2636.90)
40313	CT study of the abdomen pre and post contrast	04.00				52.990	3554.00 (3117.50)
40320	CT of the pelvis	04.00				26.130	1752.50 (1537.30)
40323	CT of the pelvis with contrast	04.00				47.480	3184.50 (2793.40)
40327	CT of the pelvis pre and post contrast	04.00				53.870	3613.10 (3169.40)
40330	CT of the abdomen and pelvis	04.00				38.500	2582.20 (2265.10)
40333	CT of the abdomen and pelvis with contrast	04.00				62.170	4169.70 (3657.60)
40337	CT of the abdomen and pelvis pre and post contrast	04.00				67.430	4522.50 (3967.10)
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast	04.00				74.110	4970.60 (4360.20)
40345	CT of the chest, abdomen and pelvis without contrast	04.00				70.120	4702.90 (4125.40)
40350	CT of the chest, abdomen and pelvis with contrast	04.00				88.350	5925.60 (5197.90)
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast	04.00				93.050	6240.90 (5474.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
40360	CT of the base of skull to symphysis pubis with contrast	04.00				102.730	6890.10 (6043.90)
40365	CT colonoscopy	04.00				34.780	2332.70 (2046.20)
	Stand alone study, may not be added to any code between 40300 and 40360	04.00					
40400	MR of the abdomen	04.00				64.580	4331.40 (3799.50)
40410	MR of the abdomen pre and post contrast	04.00				100.840	6763.30 (5932.70)
40420	MR of the pelvis, soft tissue	04.00				64.580	4331.40 (3799.50)
40430	MR of the pelvis, soft tissue, pre and post contrast	04.00				102.040	6843.80 (6003.30)
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying	04.00		21.500	1442.00 (1264.90)		
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies	04.00		34.920	2342.10 (2054.50)		
40910	Nuclear Medicine study - Gastro intestinal protein loss	04.00		21.500	1442.00 (1264.90)		
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies	04.00		34.920	2342.10 (2054.50)		
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic	04.00		21.500	1442.00 (1264.90)		
40925	Nuclear medicine study – Acute GIT bleed multiple studies	04.00		34.920	2342.10 (2054.50)		
40930	Nuclear medicine study - Meckel's localisation	04.00		20.770	1393.00 (1221.90)		
40935	Nuclear medicine study - Gastric mucosa imaging	04.00		20.770	1393.00 (1221.90)		
40940	Nuclear medicine study - colonic transit multiple studies	05.03		44.860	3008.80 (2639.30)		
	Stand alone code	05.03					
Liver, spleen, gall bladder and pancreas							
	Code 41110, 41120 and 41130 (cholangiography) include fluoroscopy (00140 may not be added).						04.00
41100	X-ray ERCP including screening	04.00				18.900	1267.60 (1111.90)
41105	X-ray ERCP reporting on images done in theatre	04.00				2.400	161.00 (141.20)
41110	X-ray cholangiography intra-operative	04.00				8.450	566.70 (497.10)
41120	X-ray T-tube cholangiography post operative	04.00				14.050	942.30 (826.60)
41130	X-ray transhepatic percutaneous cholangiography	04.00				32.340	2169.00 (1902.60)
41200	Ultrasound study of the upper abdomen	04.00				7.000	469.50 (411.80)
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis	04.00				9.800	657.30 (576.60)
	Code 41210 is a stand alone study and may not be added to 40200, 40210, 41200 or 42200	04.00					
41300	CT of the abdomen triphasic study – liver	04.00				54.900	3682.10 (3229.90)
41400	MR study of the liver/pancreas	04.00				64.780	4344.80 (3811.20)
41410	MR study of the liver/pancreas pre and post contrast	04.00				100.840	6763.30 (5932.70)
41420	MRCP	04.00				49.200	3299.80 (2894.60)
41430	MR study of the abdomen with MRCP	04.00				92.980	6236.20 (5470.40)
41440	MR study of the abdomen pre and post contrast with MRCP	04.00				133.600	8960.60 (7860.20)
41900	Nuclear Medicine study - Liver and spleen, planar views only	04.00		21.500	1442.00 (1264.90)		
41905	Nuclear Medicine study - Liver and spleen, with flow study	04.00		27.530	1846.40 (1619.60)		
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT	04.00		34.920	2342.10 (2054.50)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT	04.00		40.940	2745.80 (2408.60)		
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic	04.00		21.500	1442.00 (1264.90)		
41925	Nuclear Medicine study – hepatobiliary tract including flow	04.00		26.510	1778.00 (1559.60)		
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies	04.00		34.920	2342.10 (2054.50)		
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies	04.00		39.920	2677.40 (2348.60)		
41940	Nuclear medicine study - Gall bladder ejection fraction	04.00		6.020	403.80 (354.20)		
41945	Nuclear medicine study – Biliary gastric reflux study	04.00		20.770	1393.00 (1221.90)		
Renal tract							
42100	X-ray tomography of the renal tract	04.00				4.300	288.40 (253.00)
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP). Codes 42115 (IVP), 42120 (cystography), 42130 (urethography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).	04.00					
42110	X-ray excretory urogram including tomography	04.00				24.860	1667.40 (1462.60)
42115	X-ray excretory urogram including tomography with micturating study	04.00				32.860	2203.90 (1933.20)
42120	X-ray cystography	04.00				15.050	1009.40 (885.40)
42130	X-ray urethrography	04.00				15.370	1030.90 (904.30)
42140	X-ray micturating cysto-urethrography	04.00				19.300	1294.50 (1135.50)
42150	X-ray retrograde/prograde pyelography	04.00				12.530	840.40 (737.20)
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre	04.00				2.410	161.60 (141.80)
42160	X-ray prograde pyelogram – percutaneous	04.00				32.670	2191.20 (1922.10)
42200	Ultrasound study of the renal tract including bladder	04.00				7.420	497.70 (436.60)
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney	04.00				3.800	254.90 (223.60)
	Code 42205 is a stand alone study and may not be added to 42200	04.00					
42210	Ultrasound study of the renal arteries including Doppler	05.03				10.600	710.90 (623.60)
42300	CT of the renal tract for a stone	04.00				25.150	1686.80 (1479.60)
42400	MR of the renal tract for obstruction	04.00				47.000	3152.30 (2765.20)
42410	MR of the kidneys without contrast	04.00				64.580	4331.40 (3799.50)
42420	MR of the kidneys pre and post contrast	04.00				102.240	6857.20 (6015.10)
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)	04.00		21.940	1471.50 (1290.80)		
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow	04.00		27.960	1875.30 (1645.00)		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT	04.00		35.350	2370.90 (2079.70)		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT	04.00		41.370	2774.70 (2433.90)		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow	04.00		26.510	1778.00 (1559.60)		
42930	Nuclear Medicine study – Renovascular study, baseline	04.00		26.510	1778.00 (1559.60)		
42940	Nuclear Medicine study – Renovascular study, with intervention	04.00		26.510	1778.00 (1559.60)		
42950	Nuclear medicine study - indirect voiding cystogram	05.05		6.020	403.80 (354.20)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Reproductive system							
	Codes 43120 and 43130 (hystero-salpingography) include fluoroscopy (00140 may not be added). Codes 43230 (U/S ova aspiration) and 43240 (amniocentesis) are complete procedure codes.						04.00
	Codes 43230 (U/S ova aspiration) and 43240 (amniocentesis) are complete procedures and may not be combined with 00230 (ultrasound guidance) or 80605 (fine needle aspiration). Code 43240 may be combined with 43260 (second trimester), 43270 (third trimester) and 43273 (third trimester follow up)						04.00
43100	X-ray pelvimetry single	04.00				4.000	268.30 (235.40)
43110	X-ray pelvimetry multiple views	04.00				5.800	389.00 (341.20)
43120	X-ray hystero-salpingography	04.00				10.030	672.70 (590.10)
43130	X-ray hystero-salpingography with introduction of contrast	04.00				13.530	907.50 (796.10)
43200	Ultrasound study of the pelvis transabdominal	04.00				5.700	382.30 (335.40)
43205	Ultrasound study of the female pelvis transvaginal	04.00				7.210	483.60 (424.20)
43210	Ultrasound study of the prostate transrectal	04.00				7.380	495.00 (434.20)
43215	Ultrasound transrectal prostate volume for brachytherapy	04.00				10.400	697.50 (611.80)
43220	Ultrasound study of the testes	04.00				7.380	495.00 (434.20)
43225	Ultrasound study for male impotence including doppler and injection of vaso contrictor	04.00				15.000	1006.10 (882.50)
	Code 43225 is a stand alone study and may not be added to 43200, 43210, 43220 or 44200	04.00					
43230	Ultrasound guided transvaginal aspiration for ova	04.00				13.500	905.40 (794.20)
43240	Ultrasound guided amniocenthesis	04.00				5.840	391.70 (343.60)
43250	Ultrasound study of the pregnant uterus, first trimester	04.00				4.200	281.70 (247.10)
43260	Ultrasound study of the pregnant uterus, second trimester	04.00				6.360	426.60 (374.20)
43270	Ultrasound study of the pregnant uterus, third trimester, first visit	04.00				6.360	426.60 (374.20)
43273	Ultrasound study of the pregnant uterus, third trimester, follow-up visit	04.00				4.200	281.70 (247.10)
43277	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit	04.00				8.170	548.00 (480.70)
43280	Ultrasound doppler of the umbilical cord for resistive index	04.00				3.800	254.90 (223.60)
	Code 43280 is a stand alone study and may not be added to the following codes: 43250, 43260, 43270, 43273 or 43277	04.00					
43300	CT pelvimetry – Topogram	04.00				6.580	441.30 (387.10)
43400	MR study of pelvic reproductive organs - limited study	04.00				47.600	3192.50 (2800.40)
43405	MR study for pelvimetry	04.00				20.000	1341.40 (1176.70)
43410	MR study of pelvic reproductive organs - complete – uncontrasted	04.00				64.580	4331.40 (3799.50)
43420	MR study of pelvic reproductive organs - complete – pre and post contrast	04.00				102.240	6857.20 (6015.10)
43950	Nuclear medicine study - Radio pharmaceutical voiding cystogram	04.00		21.500	1442.00 (1264.90)		
43960	Nuclear medicine study - Testicular imaging	04.00		26.510	1778.00 (1559.60)		
43970	Nuclear medicine study - hystero-salpingography	05.03		26.510	1778.00 (1559.60)		
Aorta and vessels							
	Code 44400 (MR Angiography) may be combined with 40400 (MR abdomen).						04.00
44200	Ultrasound study of abdominal aorta and branches including doppler	04.00				18.320	1228.70 (1077.80)
44205	Ultrasound study of the IVC and pelvic veins including Doppler	05.03				14.000	939.00 (823.70)
	This is a stand alone code and may not be added to 44200.	05.03					

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
44300	CT angiography of abdominal aorta and branches	04.00				76.720	5145.60 (4513.70)
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen	04.00				94.320	6326.00 (5549.10)
44310	CT angiography of the pelvis	04.00				78.640	5274.40 (4626.70)
44320	CT angiography of the abdominal aorta and pelvis	04.00				89.540	6005.40 (5267.90)
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis	04.00				119.150	7991.40 (7010.00)
44330	CT portogram	04.00				74.400	4990.00 (4377.20)
44400	MR angiography of abdominal aorta and branches	04.00				76.640	5140.20 (4508.90)
44500	Arteriography of abdominal aorta alone	04.00				28.120	1886.00 (1654.40)
44503	Arteriography of aorta plus coeliac, mesenteric branches	04.00				75.630	5072.50 (4449.60)
44505	Arteriography of aorta plus renal, adrenal branches	04.00				63.010	4226.10 (3707.10)
44507	Arteriography of aorta plus non-visceral branches	04.00				60.790	4077.20 (3576.50)
44510	Arteriography of coeliac, mesenteric vessels alone	04.00				64.350	4316.00 (3786.00)
44515	Arteriography of renal, adrenal vessels alone	04.00				49.490	3319.30 (2911.70)
44517	Arteriography of non-visceral abdominal vessels alone	04.00				54.910	3682.80 (3230.50)
44520	Arteriography of internal and external iliac vessels alone	04.00				56.720	3804.20 (3337.00)
44525	Venography of internal and external iliac veins alone	04.00				62.110	4165.70 (3654.10)
44530	Corpora cavernosography	04.00				25.060	1680.80 (1474.40)
44535	Vasography, vesciculography	04.00				29.190	1957.80 (1717.40)
44540	Venography of inferior vena cava	04.00				26.120	1751.90 (1536.80)
44543	Venography of hepatic veins alone	04.00				53.770	3606.40 (3163.50)
44545	Venography of inferior vena cava and hepatic veins	04.00				68.910	4621.80 (4054.20)
44550	Venography of lumbar azygos system alone	04.00				43.890	2943.70 (2582.20)
44555	Venography of inferior vena cava and lumbar azygos veins	04.00				65.460	4390.40 (3851.20)
44560	Venography of renal, adrenal veins alone	04.00				43.990	2950.40 (2588.10)
44565	Venography of inferior vena cava and renal/adrenal veins	04.00				68.390	4586.90 (4023.60)
44570	Venography of spermatic, ovarian veins alone	04.00				40.390	2709.00 (2376.30)
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins	04.00				73.990	4962.50 (4353.10)
44580	Venography indirect splenoportogram	04.00				48.670	3264.30 (2863.40)
44583	Venography direct splenoportogram	04.00				31.590	2118.70 (1858.50)
44587	Venography transhepatic portogram	04.00				66.750	4476.90 (3927.10)
Soft Tissue							
49900	Nuclear Medicine study – Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		
49905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
49910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
49915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3189.80 (2798.10)		
49920	Nuclear medicine study – Infection localisation planar, static	04.00		18.040	1209.90 (1061.30)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies	04.00		31.450	2109.40 (1850.40)		
49940	Nuclear medicine study – Infection localisation planar, static and SPECT	04.00		31.450	2109.40 (1850.40)		
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3008.80 (2639.30)		
49960	Nuclear medicine study – Regional lymph node mapping dynamic	04.00		5.010	336.00 (294.70)		
49965	Nuclear medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1616.40 (1417.90)		
49970	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	04.00		37.510	2515.80 (2206.80)		
49975	Nuclear medicine study – Regional lymph node mapping SPECT	04.00		13.410	899.40 (788.90)		
49980	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		13.410	899.40 (788.90)		
Spine, Pelvis and Hips							
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventianla myelography codes viz. 51160, 52150, 53160						04.00
General							
	Code 50130 (Lumbar puncture) and 50140 (cisternal puncture) include fluoroscopy and introduction of contrast (00140 may not be added).						04.00
50100	X-ray of the spine scoliosis view AP only	04.00				7.000	469.50 (411.80)
50105	X-ray of the spine scoliosis view AP and lateral	04.00				12.000	804.80 (706.00)
50110	X-ray of the spine scoliosis view AP and lateral including stress views	04.00				18.540	1243.50 (1090.80)
50120	X-ray bone densitometry	04.00				11.520	772.60 (677.70)
50130	X-ray guided lumbar puncture	04.00				4.800	321.90 (282.40)
50140	X-ray guided cisternal puncture cisternogram	04.00				22.980	1541.30 (1352.00)
50300	CT quantitive bone mineral density	04.00				11.830	793.40 (696.00)
50500	Arteriogram of the spinal column and cord, all vessels	04.00				127.230	8533.30 (7485.40)
50510	Venography of the spinal, paraspinal veins	04.00				58.450	3920.20 (3438.80)
Cervical							
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51140 (tomography) may be combined with 51110 or 51120 (spine). Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51300 (CT) limited - limited to a single cervical vertebral body. Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 51320 (CT) complete study - an extensive study of the cervical spine. Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).						04.00
51100	X-ray f the cervical spine, stress views only	04.00				4.140	277.70 (243.60)
51110	X-ray of the cervical spine, one or two views	04.00				3.010	201.90 (177.10)
51120	X-ray of the cervical spine, more than two views	04.00				4.280	287.10 (251.80)
51130	X-ray of the cervical spine, more than two views including stress views	04.00				7.580	508.40 (446.00)
51140	X-ray Tomography cervical spine	04.00				4.300	288.40 (253.00)
51160	X-ray myelography of the cervical spine	04.00				27.460	1841.70 (1615.50)
51170	X-ray discography cervical spine per level	04.00				25.170	1688.20 (1480.90)
51300	CT of the cervical spine limited study	04.00				9.500	637.20 (558.90)
51310	CT of the cervical spine – regional study	04.00				13.910	932.90 (818.30)
51320	CT of the cervical spine – complete study	04.00				37.130	2490.30 (2184.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
51330	CT of the cervical spine pre and post contrast	04.00				58.850	3947.10 (3462.40)
51340	CT myelography of the cervical spine	04.00				47.190	3165.00 (2776.30)
51350	CT myelography of the cervical spine following myelogram	04.00				21.690	1454.70 (1276.10)
51400	MR of the cervical spine, limited study	04.00				44.400	2977.90 (2612.20)
51410	MR of the cervical spine and cranio-cervical junction	04.00				64.820	4347.50 (3813.60)
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	04.00				102.140	6850.50 (6009.20)
51900	Nuclear Medicine study – Bone regional cervical	04.00		21.500	1442.00 (1264.90)		
51910	Nuclear Medicine study – Bone tomography regional cervical	04.00		13.410	899.40 (788.90)		
51920	Nuclear Medicine study – with flow	04.00		6.020	403.80 (354.20)		
Thoracic							
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine). Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52300 (CT) limited study – limited to a single thoracic vertebral body. Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. Code 52310 (CT) complete study - an extensive study of the thoracic spine. Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).						04.00
52100	X-ray of the thoracic spine, one or two views	04.00				3.210	215.30 (188.90)
52110	X-ray of the thoracic spine, more than two views	04.00				4.000	268.30 (235.40)
52120	X-ray tomography thoracic spine	04.00				4.300	288.40 (253.00)
52140	X-ray of the thoracic spine, more that two views including stress views	04.00				6.640	445.30 (390.60)
52150	X-ray myelography of the thoracic spine	04.00				18.620	1248.80 (1095.40)
52300	CT of the thoracic spine limited study	04.00				9.500	637.20 (558.90)
52305	CT of the thoracic spine – regional study	04.00				13.910	932.90 (818.30)
52310	CT of the thoracic spine complete study	04.00				35.780	2399.80 (2105.10)
52320	CT of the thoracic spine pre and post contrast	04.00				58.850	3947.10 (3462.40)
52330	CT myelography of the thoracic spine	04.00				48.090	3225.40 (2829.30)
52340	CT myelography of the thoracic spine following myelogram	04.00				20.370	1366.20 (1198.40)
52400	MR of the thoracic spine, limited study	04.00				46.600	3125.50 (2741.70)
52410	MR of the thoracic spine	04.00				64.340	4315.30 (3785.40)
52420	MR of the thoracic spine pre and post contrast	04.00				101.420	6802.20 (5966.80)
52900	Nuclear Medicine study – Bone regional dorsal	04.00		21.500	1442.00 (1264.90)		
52910	Nuclear Medicine study – Bone tomography regional dorsal	04.00		13.410	899.40 (788.90)		
52920	Nuclear Medicine study – with flow	04.00		6.020	403.80 (354.20)		
Lumbar							
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53140 (tomography) may be combined with 53110 or 53120 (spine). Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 53300 (CT) limited study – limited to a single lumbar vertebral body. Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 53320 (CT) complete study - an extensive study of the lumbar spine. Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).						04.00

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
53100	X-ray of the lumbar spine – stress study only	04.00				4.140	277.70 (243.60)
53110	X-ray of the lumbar spine, one or two views	04.00				3.560	238.80 (209.50)
53120	X-ray of the lumbar spine, more than two views	04.00				4.460	299.10 (262.40)
53130	X-ray of the lumbar spine, more that two views including stress views	04.00				7.520	504.40 (442.50)
53140	X-ray tomography lumbar spine	04.00				4.300	288.40 (253.00)
53160	X-ray myelography of the lumbar spine	04.00				23.940	1605.70 (1408.50)
53170	X-ray discography lumbar spine per level	04.00				25.170	1688.20 (1480.90)
53300	CT of the lumbar spine limited study	04.00				9.500	637.20 (558.90)
53310	CT of the lumbar spine – regional study	04.00				13.910	932.90 (818.30)
53320	Ct of the lumbar spine complete study	04.00				37.640	2524.50 (2214.50)
53330	CT of the lumbar spine pre and post contrast	04.00				58.850	3947.10 (3462.40)
53340	CT myelography of the lumbar spine	04.00				49.110	3293.80 (2889.30)
53350	CT myelography of the lumbar spine following myelogram	04.00				23.460	1573.50 (1380.30)
53400	MR of the lumbar spine, limited study	04.00				46.200	3098.60 (2718.10)
53410	MR of the lumbar spine	04.00				64.320	4313.90 (3784.10)
53420	MR of the lumbar spine pre and post contrast	04.00				103.290	6927.70 (6076.90)
53900	Nuclear medicine study – Bone regional lumbar	04.00		21.500	1442.00 (1264.90)		
53910	Nuclear medicine study – Bone tomography regional lumbar	04.00		13.410	899.40 (788.90)		
53920	Nuclear medicine study – with flow	04.00		6.020	403.80 (354.20)		
Sacrum							
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints). Code 54300 (CT) limited study - limited to single sacral vertebral body. Code 54310 (CT) complete study - an extensive study of the sacral spine.						04.00
54100	X-ray of the sacrum and coccyx	04.00				3.580	240.10 (210.60)
54110	X-ray of the sacro-iliac joints	04.00				4.100	275.00 (241.20)
54120	X-ray tomography – sacrum and/or coccyx	04.00				4.300	288.40 (253.00)
54300	CT of the sacrum – limited study	04.00				7.600	509.70 (447.10)
54310	CT of the sacrum – complete study – uncontrasted	04.00				25.610	1717.70 (1506.80)
54320	CT of the sacrum with contrast	04.00				46.930	3147.60 (2761.10)
54330	CT of the sacrum pre and post contrast	04.00				52.970	3552.70 (3116.40)
54400	MR of the sacrum	04.00				65.000	4359.60 (3824.20)
54410	MR of the sacrum pre and post contrast	04.00				101.040	6776.80 (5944.60)
Pelvis							
	Codes 55110 (tomography) and 55100 (pelvis) may be combined. Code 55300 (CT) limited study – limited to a small region of interest of the pelvis eg. ascetabular roof or pubic ramus.						04.00
55100	X-ray of the pelvis	04.00				3.660	245.50 (215.40)
55110	X-ray tomography – pelvis	04.00				4.300	288.40 (253.00)
55300	CT of the bony pelvis limited	04.00				9.500	637.20 (558.90)
55310	CT of the bony pelvis complete uncontrasted	04.00				25.610	1717.70 (1506.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
55320	CT of the bony pelvis complete 3D recon	04.00				37.470	2513.10 (2204.50)
55330	CT of the bony pelvis with contrast	04.00				46.930	3147.60 (2761.10)
55340	CT of the bony pelvis – pre and post contrast	04.00				52.970	3552.70 (3116.40)
55400	MR of the bony pelvis	04.00				65.000	4359.60 (3824.20)
55410	MR of the bony pelvis pre and post contrast	04.00				102.240	6857.20 (6015.10)
55900	Nuclear medicine study – Bone regional pelvis	04.00		21.500	1442.00 (1264.90)		
55910	Nuclear medicine study – Bone tomography regional pelvis	04.00		13.410	899.40 (788.90)		
55920	Nuclear medicine study – with flow	04.00		6.020	403.80 (354.20)		
Hips							
	Code 56130 (tomography) may be combined with 56100 or 56110 or 56120 (hip). Code 56140 (stress) may be combined with 56100 or 56110 or 56120 (hip). Code 56150 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 56160 (introduction of contrast into hip joint) to be used with 56310 (CT hip) and 56410 (MR hip) and includes fluoroscopy. The combination of 56150 and 56310 and 56410 is not supported except in exceptional circumstances with motivation. Code 56300 (CT) study limited to small region of interest eg part of femur head.						04.00
56100	X-ray of the left hip	04.00				3.180	213.30 (187.10)
56110	X-ray of the right hip	04.00				3.180	213.30 (187.10)
56120	X-ray pelvis and hips	04.00				6.020	403.80 (354.20)
56130	X-ray tomography – hip	04.00				4.300	288.40 (253.00)
56140	X-ray of the hip/s – stress study	04.00				4.380	293.80 (257.70)
56150	X-ray arthrography of the hip joint including introduction contrast	04.00				15.750	1056.40 (926.70)
56160	X-ray guidance and introduction of contrast into hip joint only	04.00				7.410	497.00 (436.00)
56200	Ultrasound of the hip joints	04.00				6.500	436.00 (382.50)
56300	CT of hip – limited	04.00				9.500	637.20 (558.90)
56310	CT of hip – complete	05.05				27.370	1835.70 (1610.30)
56320	CT of hip – complete with 3D recon	04.00				39.780	2668.00 (2340.40)
56330	CT of hip with contrast	04.00				43.260	2901.40 (2545.10)
56340	CT of hip pre and post contrast	04.00				47.880	3211.30 (2816.90)
56400	MR of the hip joint/s, limited study	04.00				44.900	3011.40 (2641.60)
56410	MR of the hip joint/s	04.00				64.100	4299.20 (3771.20)
56420	MR of the hip joint/s, pre and post contrast	04.00				101.640	6817.00 (5979.80)
56900	Nuclear medicine study – Bone regional pelvis	04.00		21.500	1442.00 (1264.90)		
56910	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
56920	Nuclear medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Upper limbs							
General							
	Code 60100 (stress only) is a stand alone study and may not be combined with other codes. Code 60110 (tomography) may be combined with any one of the defined regional x-ray studies of the upper limb. Motivation may be required for more than one regional tomographic study per visit. Code 60200 (U/S) may only be used once per visit. Code 60300 (CT) limited study – limited to a small region of interest eg. part of humeral head. Code 60400 (MR limited) may only be used once per visit.						04.00
60100	X-ray upper limbs - any region - stress studies only	04.00				4.520	303.20 (266.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
60110	X-ray upper limbs - any region – tomography	04.00				4.300	288.40 (253.00)
60200	Ultrasound upper limb – soft tissue - any region	04.00				7.380	495.00 (434.20)
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler	04.00				13.640	914.80 (802.50)
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler	04.00				13.640	914.80 (802.50)
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis	04.00				12.540	841.10 (737.80)
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler	04.00				17.260	1157.60 (1015.40)
60300	CT of the upper limbs limited study	04.00				9.500	637.20 (558.90)
60310	CT angiography of the upper limb	04.00				78.280	5250.20 (4605.40)
60400	MR of the upper limbs limited study, any region	04.00				44.800	3004.70 (2635.70)
60410	MR angiography of the upper limb	04.00				74.660	5007.40 (4392.50)
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral	04.00				45.670	3063.10 (2686.90)
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral	04.00				82.670	5544.70 (4863.80)
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral	04.00				56.750	3806.20 (3338.80)
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral	04.00				88.110	5909.50 (5183.80)
60540	Venography, antegrade of upper limb veins, unilateral	04.00				26.120	1751.90 (1536.80)
60550	Venography, antegrade of upper limb veins, bilateral	04.00				49.430	3315.30 (2908.20)
60560	Venography, retrograde of upper limb veins, unilateral	04.00				31.010	2079.80 (1824.40)
60570	Venography, retrograde of upper limb veins, bilateral	04.00				54.810	3676.10 (3224.60)
60580	Venography, shuntogram, dialysis access shunt	04.00				23.790	1595.60 (1399.60)
60900	Nuclear medicine study – Venogram upper limb	04.00		37.120	2489.60 (2183.90)		
Shoulder							
	Code 61160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 61170 (introduction of contrast into the shoulder joint) may be combined with 61300 and 61305 (CT), or 61400 and 61405 (MR). The combination of 61160 (arthrography) and 61300 and 61305 (CT) or 61400 and 61405 (MR) is not supported except in exceptional circumstances with motivation.						04.00
61100	X-ray of the left clavicle	04.00				3.040	203.90 (178.90)
61105	X-ray of the right clavicle	04.00				3.040	203.90 (178.90)
61110	X-ray of the left scapula	04.00				3.040	203.90 (178.90)
61115	X-ray of the right scapula	04.00				3.040	203.90 (178.90)
61120	X-ray of the left acromio-clavicular joint	04.00				3.140	210.60 (184.70)
61125	X-ray of the right acromio-clavicular joint	04.00				3.140	210.60 (184.70)
61128	X-ray of acromio-clavicular joints plus stress studies bilateral	04.00				7.680	515.10 (451.80)
61130	X-ray of the left shoulder	04.00				3.480	233.40 (204.70)
61135	X-ray of the right shoulder	04.00				3.480	233.40 (204.70)
61140	X-ray of the left shoulder plus subacromial impingement views	04.00				5.920	397.10 (348.30)
61145	X-ray of the right shoulder plus subacromial impingement views	04.00				5.920	397.10 (348.30)
61150	X-ray of the left subacromial impingement views only	04.00				3.240	217.30 (190.60)
61155	X-ray of the right subacromial impingement views only	04.00				3.240	217.30 (190.60)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
61160	X-ray arthrography shoulder joint including introduction of contrast	04.00				15.630	1061.70 (931.30)
61170	X-ray guidance and introduction of contrast into shoulder joint only	04.00				7.410	497.00 (436.00)
61200	Ultrasound of the left shoulder joint	04.00				6.500	436.00 (382.50)
61210	Ultrasound of the right shoulder joint	04.00				6.500	436.00 (382.50)
61300	CT of the left shoulder joint – uncontrasted	04.00				24.360	1633.80 (1433.20)
61305	CT of the right shoulder joint – uncontrasted	04.00				24.360	1633.80 (1433.20)
61310	CT of the left shoulder – complete with 3D recon	04.00				37.660	2525.90 (2215.70)
61315	CT of the right shoulder – complete with 3D recon	04.00				37.660	2525.90 (2215.70)
61320	CT of the left shoulder joint - pre and post contrast	04.00				48.630	3261.60 (2861.10)
61325	CT of the right shoulder joint - pre and post contrast	04.00				48.630	3261.60 (2861.10)
61400	MR of the left shoulder	04.00				64.640	4335.40 (3803.00)
61405	MR of the right shoulder	04.00				64.640	4335.40 (3803.00)
61410	MR of the left shoulder pre and post contrast	04.00				101.040	6776.80 (5944.60)
61415	MR of the right shoulder pre and post contrast	04.00				101.040	6776.80 (5944.60)
Humerus							
62100	X-ray of the left humerus	04.00				2.940	197.20 (173.00)
62105	X-ray of the right humerus	04.00				2.940	197.20 (173.00)
62300	CT of the left upper arm	04.00				24.360	1633.80 (1433.20)
62305	CT of the right upper arm	04.00				24.360	1633.80 (1433.20)
62310	CT of the left upper arm contrasted	04.00				39.970	2680.80 (2351.60)
62315	CT of the right upper arm contrasted	04.00				39.970	2680.80 (2351.60)
62320	CT of the left upper arm pre and post contrast	04.00				48.580	3258.30 (2858.20)
62325	CT of the right upper arm pre and post contrast	04.00				48.580	3258.30 (2858.20)
62400	MR of the left upper arm	04.00				64.200	4305.90 (3777.10)
62405	MR of the right upper arm	04.00				64.200	4305.90 (3777.10)
62410	MR of the left upper arm pre and post contrast	04.00				102.040	6843.80 (6003.30)
62415	MR of the right upper arm pre and post contrast	04.00				102.040	6843.80 (6003.30)
62900	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
62905	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
62910	Nuclear medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Elbow							
	Code 63120 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 63130 (introduction of contrast) may be combined with 63300 and 63305 (CT) or 63400 and 63405 (MR). The combination of 63120 (arthrography) and 63300 and 63305 or 63400 and 63405 (MR) is not supported except in exceptional circumstances with motivation.	04.00					
63100	X-ray of the left elbow	04.00				3.140	210.60 (184.70)
63105	X-ray of the right elbow	04.00				3.140	210.60 (184.70)
63110	X-ray of the left elbow with stress	04.00				4.340	291.10 (255.40)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
63115	X-ray of the right elbow with stress	04.00				4.340	291.10 (255.40)
63120	X-ray arthrography elbow joint including introduction of contrast	04.00				15.890	1065.70 (934.80)
63130	X-ray guidance and introduction of contrast into elbow joint only	04.00				7.410	497.00 (436.00)
63200	Ultrasound of the left elbow joint	04.00				6.500	436.00 (382.50)
63205	Ultrasound of the right elbow joint	04.00				6.500	436.00 (382.50)
63300	CT of the left elbow	04.00				24.360	1633.80 (1433.20)
63305	CT of the right elbow	04.00				24.360	1633.80 (1433.20)
63310	CT of the left elbow – complete with 3D recon	04.00				37.660	2525.90 (2215.70)
63315	CT of the right elbow – complete with 3D recon	04.00				37.660	2525.90 (2215.70)
63320	CT of the left elbow contrasted	04.00				39.970	2680.80 (2351.60)
63325	CT of the right elbow contrasted	04.00				39.970	2680.80 (2351.60)
63330	CT of the left elbow pre and post contrast	04.00				48.630	3261.60 (2861.10)
63335	CT of the right elbow pre and post contrast	04.00				48.630	3261.60 (2861.10)
63400	MR of the left elbow	04.00				64.640	4335.40 (3803.00)
63405	MR of the right elbow	04.00				64.640	4335.40 (3803.00)
63410	MR of the left elbow pre and post contrast	04.00				101.040	6776.80 (5944.60)
63415	MR of the right elbow pre and post contrast	04.00				101.040	6776.80 (5944.60)
63905	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
63910	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
63915	Nuclear medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Forearm							
64100	X-ray of the left forearm	04.00				2.940	197.20 (173.00)
64105	X-ray of the right forearm	04.00				2.940	197.20 (173.00)
64110	X-ray peripheral bone densitometry	04.00				1.960	131.50 (115.40)
64300	CT of the left forearm	04.00				24.360	1633.80 (1433.20)
64305	CT of the right forearm	04.00				24.360	1633.80 (1433.20)
64310	CT of the left forearm contrasted	04.00				39.970	2680.80 (2351.60)
64315	CT of the right forearm contrasted	04.00				39.970	2680.80 (2351.60)
64320	CT of the left forearm pre and post contrast	04.00				48.580	3258.30 (2858.20)
64325	CT of the right forearm pre and post contrast	04.00				48.580	3258.30 (2858.20)
64400	MR of the left forearm	04.00				64.200	4305.90 (3777.10)
64405	MR of the right forearm	04.00				64.200	4305.90 (3777.10)
64410	MR of the left forearm pre and post contrast	04.00				98.040	6575.50 (5768.00)
64415	MR of the right forearm pre and post contrast	04.00				98.040	6575.50 (5768.00)
64900	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
64905	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
64910	Nuclear medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Hand and Wrist							
	Code 65120 (finger) may not be combined with 65100 or 65105 (hands). Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done. Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added). Code 65170 (contrast) may be combined with 65300 and 65305 (CT) or 65400 and 65405 (MR). The combination of 65160 (arthrography) and 65300 and 65305 or 65400 and 65405 is not supported except in exceptional circumstances with motivation.	04.00					
65100	X-ray of the left hand	04.00				3.080	206.60 (181.20)
65105	X-ray of the right hand	04.00				3.080	206.60 (181.20)
65110	X-ray of the left hand – bone age	04.00				3.080	206.60 (181.20)
65120	X-ray of a finger	04.00				2.670	179.10 (157.10)
65130	X-ray of the left wrist	04.00				3.180	213.30 (187.10)
65135	X-ray of the right wrist	04.00				3.180	213.30 (187.10)
65140	X-ray of the left scaphoid	04.00				3.300	221.30 (194.10)
65145	X-ray of the right scaphoid	04.00				3.300	221.30 (194.10)
65150	X-ray of the left wrist, scaphoid and stress views	04.00				7.560	507.00 (444.70)
65155	X-ray of the right wrist, scaphoid and stress views	04.00				7.560	507.00 (444.70)
65160	X-ray arthrography wrist joint including introduction of contrast	04.00				15.930	1068.40 (937.20)
65170	X-ray guidance and introduction of contrast into wrist joint only	04.00				7.410	497.00 (436.00)
65200	Ultrasound of the left wrist	04.00				6.500	436.00 (382.50)
65210	Ultrasound of the right wrist	04.00				6.500	436.00 (382.50)
65300	CT of the left wrist and hand	04.00				24.360	1633.80 (1433.20)
65305	CT of the right wrist and hand	04.00				24.360	1633.80 (1433.20)
65310	CT of the left wrist and hand - complete with 3D recon	04.00				37.660	2525.90 (2215.70)
65315	CT of the right wrist and hand - complete with 3D recon	04.00				37.660	2525.90 (2215.70)
65320	CT of the left wrist and hand contrasted	04.00				39.970	2680.80 (2351.60)
65325	CT of the right wrist and hand contrasted	04.00				39.970	2680.80 (2351.60)
65330	CT of the left wrist and hand pre and post contrast	04.00				48.630	3261.60 (2861.10)
65335	CT of the right wrist and hand pre and post contrast	04.00				48.630	3261.60 (2861.10)
65400	MR of the left wrist and hand	04.00				64.640	4335.40 (3803.00)
65405	MR of the right wrist and hand	04.00				64.640	4335.40 (3803.00)
65410	MR of the left wrist and hand pre and post contrast	04.00				101.040	6776.80 (5944.60)
65415	MR of the right wrist and hand pre and post contrast	04.00				101.040	6776.80 (5944.60)
65900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
65905	Nuclear Medicine study – bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
65910	Nuclear Medicine study – bone tomography regional	04.00		13.410	899.40 (788.90)		
Soft Tissue							
69900	Nuclear medicine study – Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3189.80 (2798.10)		
69920	Nuclear medicine study – Infection localisation planar, static	04.00		18.040	1209.90 (1061.30)		
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies	04.00		31.450	2109.40 (1850.40)		
69930	Nuclear medicine study – Infection localisation planar, static and SPECT	04.00		31.450	2109.40 (1850.40)		
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3008.80 (2639.30)		
69940	Nuclear medicine study – Regional lymph node mapping dynamic	04.00		6.020	403.80 (354.20)		
69945	Nuclear medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1616.40 (1417.90)		
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	04.00		37.510	2515.80 (2206.80)		
69955	Nuclear medicine study – Regional lymph node mapping SPECT	04.00		13.410	899.40 (788.90)		
69960	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		13.410	899.40 (788.90)		
Lower Limbs							
General							
	Code 70100 (stress) is a stand alone study and may not be combined with other codes. Code 70110 (tomography) may be combined with any one of the defined regional x-ray studies of the lower limb. Motivation may be required for more than one regional tomographic study per visit. Code 70200 (U/S) may only be billed once per visit. Code 70300 ((CT) limited study – limited to a small region of interest eg part of condyle of the knee. Codes 70310 and 70320 (CT angiography) may not be combined. Code 70400 (MR limited) may only be used once per visit. Code 70410 and 70420 (MR angiography) may not be combined.	04.00					
70100	X-ray lower limbs - any region- stress studies only	04.00				4.520	303.20 (266.00)
70110	X-ray lower limbs - any region-tomography	04.00				4.300	288.40 (253.00)
70120	X-ray of the lower limbs full length study	04.00				6.460	433.30 (380.10)
70200	Ultrasound lower limb – soft tissue - any region	04.00				7.380	495.00 (434.20)
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler	04.00				13.640	914.80 (802.50)
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler	04.00				13.640	914.80 (802.50)
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis	04.00				13.640	914.80 (802.50)
70240	Ultrasound peripheral venous system lower limbs including pulse and colour doppler in erect and supine position including all compression and reflux manoeuvres, deep and superficial systems bilaterally	04.00				19.660	1318.60 (1156.70)
70300	CT of the lower limbs limited study	04.00				9.500	637.20 (558.90)
70310	CT angiography of the lower limb	04.00				79.430	5327.40 (4673.20)
70320	CT angiography abdominal aorta and outflow lower limbs	04.00				98.340	6595.70 (5785.70)
70400	MR of the lower limbs limited study	04.00				46.400	3112.00 (2729.80)
70410	MR angiography of the lower limb	04.00				76.660	5141.60 (4510.20)
70420	MR angiography of the abdominal aorta and lower limbs	04.00				118.860	7971.90 (6992.90)
70500	Angiography of pelvic and lower limb arteries unilateral	04.00				40.590	2722.40 (2388.10)
70505	Angiography of pelvic and lower limb arteries bilateral	04.00				75.920	5092.00 (4466.70)
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral	04.00				61.230	4106.70 (3602.40)
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral	04.00				85.660	5745.20 (5039.60)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
70520	Angiography translumbar aorta with full peripheral study	04.00				45.680	3063.80 (2687.50)
70530	Venography, antegrade of lower limb veins, unilateral	04.00				25.460	1707.60 (1497.90)
70535	Venography, antegrade of lower limb veins, bilateral	04.00				49.430	3315.30 (2908.20)
70540	Venography, retrograde of lower limb veins, unilateral	04.00				31.170	2090.60 (1833.90)
70545	Venography, retrograde of lower limb veins, bilateral	04.00				56.790	3808.90 (3341.10)
70560	Lymphangiography, lower limb, unilateral	04.00				51.040	3423.30 (3002.90)
70565	Lymphangiography, lower limb, bilateral	04.00				83.970	5631.90 (4940.30)
70900	Nuclear medicine study – Venogram lower limb	04.00		37.120	2489.60 (2183.90)		
Femur							
71100	X-ray of the left femur	04.00				2.940	197.20 (173.00)
71105	X-ray of the right femur	04.00				2.940	197.20 (173.00)
71300	CT of the left femur	04.00				24.520	1644.60 (1442.60)
71305	CT of the right femur	04.00				24.520	1644.60 (1442.60)
71310	CT of the left upper leg contrasted	04.00				41.830	2805.50 (2461.00)
71315	CT of the right upper leg contrasted	04.00				41.830	2805.50 (2461.00)
71320	CT of the left upper leg pre and post contrast	04.00				49.710	3334.00 (2924.60)
71325	CT of the right upper leg pre and post contrast	04.00				49.710	3334.00 (2924.60)
71400	MR of the left upper leg	04.00				64.800	4346.10 (3812.40)
71405	MR of the right upper leg	04.00				64.800	4346.10 (3812.40)
71410	MR of the left upper leg pre and post contrast	04.00				102.040	6843.80 (6003.30)
71415	MR of the right upper leg pre and post contrast	04.00				102.040	6843.80 (6003.30)
71900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
71905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
71910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Knee							
	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.						04.00
72100	X-ray of the left knee one or two views	04.00				2.770	185.80 (163.00)
72105	X-ray of the right knee one or two views	04.00				2.770	185.80 (163.00)
72110	X-ray of the left knee, more than two views	04.00				3.320	222.70 (195.40)
72115	X-ray of the right knee, more than two views	04.00				3.320	222.70 (195.40)
72120	X-ray of the left knee including patella	04.00				4.620	309.90 (271.80)
72125	X-ray of the right knee including patella	04.00				4.620	309.90 (271.80)
72130	X-ray of the left knee with stress views	04.00				5.820	390.30 (342.40)
72135	X-ray of the right knee with stress views	04.00				5.820	390.30 (342.40)
72140	X-ray of left patella	04.00				2.770	185.80 (163.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
72145	X-ray of right patella	04.00				2.770	185.80 (163.00)
72150	X-ray both knees standing – single view	04.00				2.800	187.80 (164.70)
72160	X-ray arthrography knee joint including introduction of contrast	04.00				15.810	1060.40 (930.20)
72170	X-ray guidance and introduction of contrast into knee joint only	04.00				7.410	497.00 (436.00)
72200	Ultrasound of the left knee joint	04.00				6.500	436.00 (382.50)
72205	Ultrasound of the right knee joint	04.00				6.500	436.00 (382.50)
72300	CT of the left knee	04.00				24.520	1644.60 (1442.60)
72305	CT of the right knee	04.00				24.520	1644.60 (1442.60)
72310	CT of the left knee complete study with 3D reconstructions	04.00				35.930	2409.80 (2113.90)
72315	CT of the right knee complete study with 3D reconstructions	04.00				35.930	2409.80 (2113.90)
72320	CT of the left knee contrasted	04.00				41.830	2805.50 (2461.00)
72325	CT of the right knee contrasted	04.00				41.830	2805.50 (2461.00)
72330	CT of the left knee pre and post contrast	04.00				49.760	3337.40 (2927.50)
72335	CT of the right knee pre and post contrast	04.00				49.760	3337.40 (2927.50)
72400	MR of the left knee	04.00				64.100	4299.20 (3771.20)
72405	MR of the right knee	04.00				64.100	4299.20 (3771.20)
72410	MR of the left knee pre and post contrast	04.00				100.840	6763.30 (5932.70)
72415	MR of the right knee pre and post contrast	04.00				100.840	6763.30 (5932.70)
72900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
72905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
72910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Lower Leg							
73100	X-ray of the left lower leg	04.00				2.940	197.20 (173.00)
73105	X-ray of the right lower leg	04.00				2.940	197.20 (173.00)
73300	CT of the left lower leg	04.00				24.520	1644.60 (1442.60)
73305	CT of the right lower leg	04.00				24.520	1644.60 (1442.60)
73310	CT of the left lower leg contrasted	04.00				41.830	2805.50 (2461.00)
73315	CT of the right lower leg contrasted	04.00				41.830	2805.50 (2461.00)
73320	CT of the left lower leg pre and post contrast	04.00				49.710	3334.00 (2924.60)
73325	CT of the right lower leg pre and post contrast	04.00				49.710	3334.00 (2924.60)
73400	MR of the left lower leg	04.00				64.200	4305.90 (3777.10)
73405	MR of the right lower leg	04.00				64.200	4305.90 (3777.10)
73410	MR of the left lower leg pre end post contrast	04.00				102.040	6843.80 (6003.30)
73415	MR of the right lower leg pre and post contrast	04.00				102.040	6843.80 (6003.30)
73900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
73905	Nuclear Medicine study – bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
73910	Nuclear Medicine study – bone tomography regional	04.00		13.410	899.40 (788.90)		
Ankle and Foot							
	Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and 74405 (MR) are not supported except in exceptional circumstances with motivation.						04.00
74100	X-ray of the left ankle	04.00				3.320	222.70 (195.40)
74105	X-ray of the right ankle	04.00				3.320	222.70 (195.40)
74110	X-ray of the left ankle with stress views	04.00				4.520	303.20 (266.00)
74115	X-ray of the right ankle with stress views	04.00				4.520	303.20 (266.00)
74120	X-ray of the left foot	04.00				2.800	187.80 (164.70)
74125	X-ray of the right foot	04.00				2.800	187.80 (164.70)
74130	X-ray of the left calcaneus	04.00				2.740	183.80 (161.20)
74135	X-ray of the right calcaneus	04.00				2.740	183.80 (161.20)
74140	X-ray of both feet – standing – single view	04.00				2.800	187.80 (164.70)
74145	X-ray of a toe	04.00				2.670	179.10 (157.10)
74150	X-ray of the sesamoid bones one or both sides	04.00				2.800	187.80 (164.70)
74160	X-ray arthrography ankle joint including introduction of contrast	04.00				15.910	1067.10 (936.10)
74170	X-ray guidance and introduction of contrast into ankle joint	04.00				7.410	497.00 (436.00)
74210	Ultrasound of the left ankle	04.00				6.500	436.00 (382.50)
74215	Ultrasound of the right ankle	04.00				6.500	436.00 (382.50)
74220	Ultrasound of the left foot	04.00				6.500	436.00 (382.50)
74225	Ultrasound of the right foot	04.00				6.500	436.00 (382.50)
74290	Ultrasound bone densitometry	04.00				2.040	136.80 (120.00)
74300	CT of the left ankle/foot	04.00				24.520	1644.60 (1442.60)
74305	CT of the right ankle/foot	04.00				24.520	1644.60 (1442.60)
74310	CT of the left ankle/foot – complete with 3D recon	04.00				37.810	2535.90 (2224.50)
74315	CT of the right ankle/foot – complete with 3D recon	04.00				37.810	2535.90 (2224.50)
74320	CT of the left ankle/foot contrasted	04.00				41.830	2805.50 (2461.00)
74325	CT of the right ankle/foot contrasted	04.00				41.830	2805.50 (2461.00)
74330	CT of the left ankle/foot pre and post contrast	04.00				49.710	3334.00 (2924.60)
74335	CT of the right ankle/foot pre and post contrast	04.00				49.710	3334.00 (2924.60)
74400	MR of the left ankle	04.00				64.100	4299.20 (3771.20)
74405	MR of the right ankle	04.00				64.100	4299.20 (3771.20)
74410	MR of the left ankle pre and post contrast	04.00				100.640	6749.90 (5921.00)
74415	MR of the right ankle pre and post contrast	04.00				100.640	6749.90 (5921.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
74420	MR of the left foot	04.00				64.200	4305.90 (3777.10)
74425	MR of the right foot	04.00				64.200	4305.90 (3777.10)
74430	MR of the left foot pre and post contrast	04.00				102.040	6843.80 (6003.30)
74435	MR of the right foot pre and post contrast	04.00				102.040	6843.80 (6003.30)
74900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1442.00 (1264.90)		
74905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	1846.40 (1619.60)		
74910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	899.40 (788.90)		
Soft Tissue							
79900	Nuclear Medicine study – Tumour localisation planar, static	04.00		20.740	1391.00 (1220.20)		
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2358.90 (2069.20)		
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2290.40 (2009.10)		
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	04.00		47.560	3189.80 (2798.10)		
79920	Nuclear Medicine study – Infection localisation planar, static	04.00		18.430	1236.10 (1084.30)		
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	04.00		31.840	2135.50 (1873.20)		
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	04.00		31.840	2135.50 (1873.20)		
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		45.250	3034.90 (2662.20)		
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	04.00		6.020	403.80 (354.20)		
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1616.40 (1417.90)		
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	04.00		37.510	2515.80 (2206.80)		
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	04.00		13.410	899.40 (788.90)		
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	04.00		13.410	899.40 (788.90)		
Intervention							
General							
	Codes 80600, 80605, 80610, 80620, 80630, 81660, 81680, 82600, 84660, 85640, 85645, 86610, 86615, 86620, 86630, (aspiration / biopsy / ablations etc) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be combined with these codes. If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00510, 00520, 00530, 00540, 00550, 00560), it may not be billed for separately. Codes 80640, 80645, 87682, 87683 include fluoroscopy. Machine fees may not be added. All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.						05.03
80600	Percutaneous abscess, cyst drainage, any region	04.00				9.370	628.40 (551.20)
80605	Fine needle aspiration biopsy, any region	04.00				4.220	283.00 (248.20)
80610	Cutting needle, trochar biopsy, any region	04.00				6.360	426.60 (374.20)
80620	Tumour/cyst ablation chemical	04.00				25.370	1701.60 (1492.60)
80630	Tumour ablation radio frequency, per lesion	05.03				21.210	1422.60 (1247.90)
80640	Insertion of CVP line in radiology suite	04.00				8.990	603.00 (528.90)
80645	Peripheral central venous line insertion	05.03				12.120	812.90 (713.10)
80650	Infiltration of a peripheral joint, any region	05.03				6.400	429.20 (376.50)
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.	05.03					

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Neuro intervention							
81600	Intracranial aneurysm occlusion, direct	04.00				214.520	14387.90 (12621.00)
81605	Intracranial arteriovenous shunt occlusion	04.00				254.820	17090.80 (14991.90)
81610	Dural sinus arteriovenous shunt occlusion	04.00				264.330	17728.60 (15551.40)
81615	Extracranial arteriovenous shunt occlusion	04.00				157.280	10548.80 (9253.30)
81620	Extracranial arterial embolisation (head and neck)	04.00				163.120	10940.50 (9596.90)
81625	Caroticocavernous fistula occlusion	04.00				192.290	12896.90 (11313.10)
81630	Intracranial angioplasty for stenosis, vasospasm	04.00				126.920	8512.50 (7467.10)
81632	Intracranial stent placement (including PTA)	05.03				133.720	8968.60 (7867.20)
81635	Temporary balloon occlusion test	04.00				83.420	5595.00 (4907.90)
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.	05.03					
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)	04.00				178.180	11950.50 (10482.90)
81645	Intracranial aneurysm occlusion with balloon remodelling	04.00				216.350	14510.60 (12728.60)
81650	Intracranial aneurysm occlusion with stent assistance	04.00				230.450	15456.30 (13558.20)
81655	Intracranial thrombolysis, catheter directed	04.00				58.940	3953.10 (3467.60)
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650	05.03					
81660	Nerve block, head and neck, per level	05.03				7.660	513.80 (450.70)
81665	Neurolysis, head and neck, per level	05.03				20.140	1350.80 (1184.90)
81670	Nerve block, head and neck, radio frequency, per level	05.03				19.040	1277.00 (1120.20)
81680	Nerve block, coeliac plexus or other regions, per level	05.03				9.280	622.40 (546.00)
Thorax							
82600	Chest drain insertion	04.00				8.820	591.60 (518.90)
82605	Trachial, bronchial stent insertion	04.00				30.360	2036.20 (1786.10)
Gastrointestinal							
83600	Oesophageal stent insertion	04.00				31.220	2093.90 (1836.80)
83605	GIT balloon dilation	04.00				24.360	1633.80 (1433.20)
83610	GIT stent insertion (non-oesophageal)	04.00				32.020	2147.60 (1883.90)
83615	Percutaneous gastrostomy, jejunostomy	04.00				25.360	1700.90 (1492.00)
Hepatobiliary							
84600	Percutaneous biliary drainage, external	04.00				33.980	2279.00 (1999.10)
84605	Percutaneous external/internal biliary drainage	04.00				37.210	2495.70 (2189.20)
84610	Permanent biliary stent insertion	04.00				51.220	3435.30 (3013.40)
84615	Drainage tube replacement	04.00				20.220	1356.20 (1189.60)
84620	Percutaneous bile duct stone or foreign object removal	04.00				49.980	3352.20 (2940.50)
84625	Percutaneous gall bladder drainage	04.00				29.580	1983.90 (1740.30)
84630	Percutaneous gallstone removal, including drainage	04.00				69.250	4644.60 (4074.20)
84635	Transjugular liver biopsy	04.00				24.930	1672.10 (1466.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
84640	Transjugular intrahepatic Portosystemic shunt	04.00				119.470	8012.90 (7028.90)
84645	Transhepatic Portogram including venous sampling, pressure studies	04.00				81.890	5492.40 (4817.90)
84650	Transhepatic Portogram with embolisation of varices	04.00				100.810	6761.30 (5931.00)
84655	Percutaneous hepatic tumour ablation	04.00				15.680	1051.70 (922.50)
84660	Percutaneous hepatic abscess, cyst drainage	04.00				13.200	885.30 (776.60)
84665	Hepatic chemoembolisation	04.00				59.440	3986.60 (3497.00)
84670	Hepatic arterial infusion catheter placement	04.00				60.300	4044.30 (3547.60)
Urogenital							
85600	Percutaneous nephrostomy, external drainage	04.00				29.970	2010.10 (1763.20)
85605	Percutaneous double J stent insertion including access	04.00				40.820	2737.80 (2401.60)
85610	Percutaneous renal stone, foreign body removal including access	04.00				66.790	4479.60 (3929.50)
85615	Percutaneous nephrostomy tract establishment	04.00				29.270	1963.10 (1722.00)
85620	Change of nephrostomy tube	04.00				15.900	1066.40 (935.40)
85625	Percutaneous cystostomy	04.00				16.520	1108.00 (971.90)
85630	Urethral balloon dilatation	04.00				14.240	955.10 (837.80)
85635	Urethral stent insertion	04.00				31.220	2093.90 (1836.80)
85640	Renal cyst ablation	04.00				11.920	799.50 (701.30)
85645	Renal abscess, cyst drainage	04.00				15.160	1016.80 (891.90)
85655	Fallopian tube recanalisation	04.00				45.060	3022.20 (2651.10)
Spinal							
86600	Spinal vascular malformation embolisation	04.00				275.160	18455.00 (16188.60)
86605	Vertebroplasty per level	04.00				22.300	1495.70 (1312.00)
86610	Facet joint block per level, uni- or bilateral	05.03				9.540	639.80 (561.20)
	Code 86610 may only be billed once per level, and not per left and right side per level	04.00					
86615	Spinal nerve block per level, uni- or bilateral	05.03				8.160	547.30 (480.10)
86620	Epidural block	04.00				9.420	631.80 (554.20)
86625	Chemonucleolysis, including discogram	04.00				18.320	1228.70 (1077.80)
86630	Spinal nerve ablation per level	04.00				11.600	778.00 (682.50)
Vascular							
	Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedure, 87650 (thrombolysis). If a balloon angioplasty and / or stent placement is performed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multiple balloon dilatations or stent placements at one defined site will only attract one procedure code.						04.00
87600	Percutaneous transluminal angioplasty: aorta, IVC	04.00				56.560	3793.50 (3327.60)
87601	Percutaneous transluminal angioplasty: iliac	04.00				55.760	3739.80 (3280.50)
87602	Percutaneous transluminal angioplasty: femoropopliteal	04.00				60.160	4034.90 (3539.40)
87603	Percutaneous transluminal angioplasty: subpopliteal	04.00				73.340	4918.90 (4314.80)
87604	Percutaneous transluminal angioplasty: brachiocephalic	04.00				67.120	4501.70 (3948.90)
87605	Percutaneous transluminal angioplasty: subclavian, axillary	04.00				60.160	4034.90 (3539.40)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
87606	Percutaneous transluminal angioplasty: extracranial carotid	04.00				71.620	4803.60 (4213.70)
87607	Percutaneous transluminal angioplasty: extracranial vertebral	04.00				73.300	4916.20 (4312.50)
87608	Percutaneous transluminal angioplasty: renal	04.00				87.690	5881.40 (5159.10)
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	04.00				87.690	5881.40 (5159.10)
87620	Aorta stent-graft placement	04.00				120.750	8098.70 (7104.10)
87621	Stent insertion (including PTA): aorta, IVC	04.00				73.870	4954.50 (4346.10)
87622	Stent insertion (including PTA): iliac	04.00				76.370	5122.10 (4493.10)
87623	Stent insertion (including PTA): femoropopliteal	04.00				77.970	5229.40 (4587.20)
87624	Stent insertion (including PTA): subpopliteal	04.00				84.550	5670.80 (4974.40)
87625	Stent insertion (including PTA): brachiocephalic	04.00				98.470	6604.40 (5793.30)
87626	Stent insertion (including PTA): subclavian, axillary	04.00				86.690	5814.30 (5100.30)
87627	Stent insertion (including PTA): extracranial carotid	04.00				106.990	7175.80 (6294.60)
87628	Stent insertion (including PTA): extracranial vertebral	04.00				100.550	6743.90 (5915.70)
87629	Stent insertion (including PTA): renal	04.00				98.590	6612.40 (5800.40)
87630	Stent insertion (including PTA): coeliac, mesenteric	04.00				98.590	6612.40 (5800.40)
87631	Stent-graft placement: iliac	04.00				76.370	5122.10 (4493.10)
87632	Stent-graft placement: femoropopliteal	04.00				77.970	5229.40 (4587.20)
87633	Stent-graft placement: brachiocephalic	04.00				98.470	6604.40 (5793.30)
87634	Stent-graft placement: subclavian, axillary	04.00				82.770	5551.40 (4869.60)
87635	Stent-graft placement: extracranial carotid	04.00				120.430	8077.20 (7085.30)
87636	Stent-graft placement: extracranial vertebral	04.00				114.730	7694.90 (6749.90)
87637	Stent-graft placement: renal	04.00				98.590	6612.40 (5800.40)
87638	Stent-graft placement: coeliac, mesenteric	04.00				98.590	6612.40 (5800.40)
87650	Thrombolysis in angiography suite, per 24 hours	04.00				45.820	3073.10 (2695.70)
	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional codes 10520, 20500, 20510, 20520, 20530, 20540,32500,32530,44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87638.	05.03					
87651	Aspiration, rheolytic thrombectomy	04.00				77.670	5209.30 (4569.60)
87652	Atherectomy, per vessel	04.00				91.890	6163.10 (5406.20)
87653	Percutaneous tunnelled / subcutaneous arterial or venous central or other line insertion	05.03				28.150	1888.00 (1656.10)
87654	Thrombolysis follow-up	04.00				23.570	1580.80 (1386.70)
87655	Percutaneous sclerotherapy, vascular malformation	04.00				21.100	1415.20 (1241.40)
87660	Embolisation, mesenteric	04.00				100.430	6735.80 (5908.60)
87661	Embolisation, renal	04.00				99.360	6664.10 (5845.70)
87662	Embolisation, bronchial, intercostal	04.00				108.340	7266.40 (6374.00)
87663	Embolisation, pulmonary arteriovenous shunt	04.00				103.220	6923.00 (6072.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
87664	Embolisation, abdominal, other vessels	04.00				101.440	6803.60 (5968.10)
87665	Embolisation, thoracic, other vessels	04.00				97.600	6546.00 (5742.10)
87666	Embolisation, upper limb	04.00				90.920	6098.00 (5349.10)
87667	Embolisation, lower limb	04.00				92.140	6179.80 (5420.90)
87668	Embolisation, pelvis, non-uterine	04.00				117.120	7855.20 (6890.50)
87669	Embolisation, uterus	04.00				113.880	7637.90 (6699.90)
87670	Embolisation, spermatic, ovaria veins	04.00				85.820	5755.90 (5049.00)
87680	Inferior vena cava filter placement	04.00				61.840	4147.60 (3638.20)
87681	Intravascular foreign body removal	04.00				85.030	5703.00 (5002.60)
87682	Revision of access port (tunnelled or implantable)	05.03				14.120	947.00 (830.70)
87683	Removal of access port (tunnelled or implantable)	05.04				11.120	745.80 (654.20)
87690	Superior petrosal venous sampling	04.00				73.010	4896.80 (4295.40)
87691	Pancreatic stimulation test	04.00				89.790	6022.20 (5282.60)
87692	Transportal venous sampling	04.00				76.950	5161.00 (4527.20)
87693	Adrenal venous sampling	04.00				55.010	3689.50 (3236.40)
87694	Parathyroid venous sampling	04.00				86.660	5812.30 (5098.50)
87695	Renal venous sampling	04.00				55.010	3689.50 (3236.40)

ANNEXURE A

	Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL For use in conjuction with codes: 00190 X-ray examination contrast material 00290 Ultrasound examination contrast material 00390 CT examination contrast material 00490 MR examination contrast material 00590 Angiography and interventional examination contrast material Note to Funders: The following contrast items may be grouped into various categories e.g. Ionic, non-ionic, and several items may be appropriate for use within a category. Funders may either reimburse as per identified item or may choose to apply a reference price within a category. For detail of methodology refer to Annexure B.	04.00

ANNEXURE B

Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL — 04.00

Supplier	Product Name	Product Size	NAPPI	Full Product Description	(Exc VAT)	Inc VAT
Tyco	Conray 280	10 x 50 ml	715808028	Tyco - Conray 280 - 10 x 50 ml	175.53	200.11
Tyco	Conray 325	10 x 50 ml	715824015	Tyco - Conray 325 - 10 x 50 ml	184.96	210.85
Tyco	Optiray 300	10 x 30 ml	807087009	Tyco - Optiray 300 - 10 x 30 ml	143.08	163.11
Tyco	Optiray 300	10 x 50 ml	804975019	Tyco - Optiray 300 - 10 x 50 ml	211.75	241.40
Tyco	Optiray 300	10 x 100 ml	807117005	Tyco - Optiray 300 - 10 x 100 ml	395.91	451.33
Tyco	Optiray 300 prefills	10 x 50 ml	857475002	Tyco - Optiray 300 prefills - 10 x 50 ml	231.91	264.38
Tyco	Optiray 300 H/Pressure	10 x 100 ml	857483005	Tyco - Optiray 300 H/Pressure - 10 x 100 ml	473.24	539.49
Tyco	Optiray 300 H/Pressure	10 x 125 ml	857491008	Tyco - Optiray 300 H/Pressure - 10 x 125 ml	573.55	653.84
Tyco	Optiray 320	10 x 50 ml	807133019	Tyco - Optiray 320 - 10 x 50 ml	213.36	243.23
Tyco	Optiray 320	10 x 100 ml	807141038	Tyco - Optiray 320 - 10 x 100 ml	385.46	439.42
Tyco	Optiray 350	10 x 50 ml	815721013	Tyco - Optiray 350 - 10 x 50 ml	225.54	257.11
Tyco	Optiray 350	10 x 100 ml	804967008	Tyco - Optiray 350 - 10 x 100 ml	478.46	545.45
Tyco	Optiray 350 prefills	10 x 50 ml	857505009	Tyco - Optiray 350 prefills - 10 x 50 ml	235.48	268.45

Code	Description				Ver	Add	Nuclear Medicine		Radiology	
							RVU	Fee	RVU	Fee
Tyco	Optiray 350 H/Pressure	10 x 125 ml	857513001	Tyco - Optiray 350 H/Pressure - 10 x 125 ml			589.62	672.17		
Pharmaplan	Joparniron 200	10 x 10 ml	734624018	Pharmaplan - Joparniron 200 - 10 x 10 ml			83.94	95.69		
Pharmaplan	Joparniron 300	10 x 10 ml	734675003	Pharmaplan - Joparniron 300 - 10 x 10 ml			97.10	110.70		
Pharmaplan	Joparniron 300	10 x 20 ml	810126001	Pharmaplan - Joparniron 300 - 10 x 20 ml			157.05	179.04		
Pharmaplan	Joparniron 300	10 x 50 ml	734632002	Pharmaplan - Joparniron 300 - 10 x 50 ml			209.51	238.84		
Pharmaplan	Joparniron 300	10 x 100 ml	734659008	Pharmaplan - Joparniron 300 - 10 x 100 ml			386.06	440.10		
Pharmaplan	Joparniron 370	10 x 50 ml	734640005	Pharmaplan - Joparniron 370 - 10 x 50 ml			227.30	259.12		
Pharmaplan	Joparniron 370	10 x 100 ml	734667019	Pharmaplan - Joparniron 370 - 10 x 100 ml			411.67	469.30		
Pharmaplan	Imeron 250	10 x 50 ml	886425006	Pharmaplan - Imeron 250 - 10 x 50 ml			190.49	217.15		
Pharmaplan	Imeron 300	10 x 50 ml	886441005	Pharmaplan - Imeron 300 - 10 x 50 ml			215.01	245.12		
Pharmaplan	Imeron 300	10 x 100ml	886448005	Pharmaplan - Imeron 300 - 10 x 100ml			397.83	453.52		
Pharmaplan	Imeron 300	10 x 200ml	886456001	Pharmaplan - Imeron 300 - 10 x 200ml			753.28	858.74		
Pharmaplan	Imeron 350	10 x 50 ml	886464004	Pharmaplan - Imeron 350 - 10 x 50 ml			227.16	258.96		
Pharmaplan	Imeron 350	10 x 100ml	886472007	Pharmaplan - Imeron 350 - 10 x 100ml			414.30	472.31		
Pharmaplan	Imeron 350	10 x 200ml	886479007	Pharmaplan - Imeron 350 - 10 x 200ml			800.36	912.41		
Pharmaplan	Imeron 400	10 x 50 ml	886480003	Pharmaplan - Imeron 400 - 10 x 50 ml			237.75	271.04		
Pharmaplan	Imeron 400	10 x 100ml	886487003	Pharmaplan - Imeron 400 - 10 x 100ml			449.24	512.13		
Pharmaplan	Imeron 400	10 x 200ml	886495008	Pharmaplan - Imeron 400 - 10 x 200ml			853.33	972.79		
Axim	Hexabrix 320	10 x 50 ml	730777006	Axim - Hexabrix 320 - 10 x 50 ml			385.20	439.13		
Axim	Hexabrix 320	10 x 100 ml	730785009	Axim - Hexabrix 320 - 10 x 100 ml			749.00	853.86		
Axim	Hexabrix 320	1 x 200 ml	856940003	Axim - Hexabrix 320 - 1 x 200 ml			1 423.10	1 622.33		
Axim	Dotarem	10 x 10 ml	857033026	Axim - Dotarem - 10 x 10 ml			242.03	275.92		
Axim	Dotarem	10 x 15 ml	857041010	Axim - Dotarem - 10 x 15 ml			364.01	414.98		
Axim	Dotarem	10 x 20 ml	857068016	Axim - Dotarem - 10 x 20 ml			484.07	551.84		
Axim	Xenetix 300	10 x 50 ml	856959014	Axim - Xenetix 300 - 10 x 50 ml			207.15	236.15		
Axim	Xenetix 300	10 x 100 ml	856967017	Axim - Xenetix 300 - 10 x 100 ml			391.71	446.54		
Axim	Xenetix 300	1 x 200 ml	856975001	Axim - Xenetix 300 - 1 x 200 ml			758.93	865.18		
Axim	Xenetix 300	1 x 500 ml	856983004	Axim - Xenetix 300 - 1 x 500 ml			1 865.31	2 126.45		
Axim	Xenetix 350	10 x 50 ml	857017012	Axim - Xenetix 350 - 10 x 50 ml			225.98	257.62		
Axim	Xenetix 350	10 x 100 ml	856991015	Axim - Xenetix 350 - 10 x 100 ml			409.60	466.94		
Axim	Xenetix 350	1 x 200 ml	857009001	Axim - Xenetix 350 - 1 x 200 ml			847.44	966.08		
Axim	Xenetix 350	1 x 500 ml	857025007	Axim - Xenetix 350 - 1 x 500 ml			2 118.60	2 415.20		
Schering	Ultravist 300	10 x 20 ml	820482005	Schering - Ultravist 300 - 10 x 20 ml			166.92	190.29		
Schering	Ultravist 300	10 x 50 ml	810584018	Schering - Ultravist 300 - 10 x 50 ml			209.04	238.30		
Schering	Ultravist 300	10 x 75 ml	818151013	Schering - Ultravist 300 - 10 x 75 ml			291.90	332.76		
Schering	Ultravist 300	10 x 100 ml	810592029	Schering - Ultravist 300 - 10 x 100 ml			386.06	440.10		
Schering	Ultravist 370	10 x 50 ml	810606038	Schering - Ultravist 370 - 10 x 50 ml			225.98	257.62		
Schering	Ultravist 370	10 x 100 ml	810614049	Schering - Ultravist 370 - 10 x 100 ml			407.24	464.26		
Schering	Ultravist 370	10 x 200 ml	894656007	Schering - Ultravist 370 - 10 x 200 ml			733.04	835.66		
Schering	Isovist 240	10 x 10 ml	854131019	Schering - Isovist 240 - 10 x 10 ml			104.00	118.56		
Schering	Magnevist PF 10 ml	5 x 10 ml	839159005	Schering - Magnevist PF 10 ml - 5 x 10 ml			227.91	259.82		
Schering	Magnevist PF 15 ml	5 x 15 ml	839167008	Schering - Magnevist PF 15 ml - 5 x 15 ml			340.26	387.90		
Schering	Magnevist PF, 20 ml	5 x 20 ml	839175019	Schering - Magnevist PF, 20 ml - 5 x 20 ml			449.40	512.32		
Schering	Magnevist 20 ml	10 x 20 ml	839140002	Schering - Magnevist 20 ml - 10 x 20 ml			390.02	444.62		
Schering	Gadovist 7.5ml	1 7.5ml	700229001	Schering - Gadovist 7.5ml - 1 7.5ml			436.56	497.68		
Schering	Urografin 30%	1 x 250 ml	774170018	Schering - Urografin 30% - 1 x 250 ml			333.84	380.58		
Schering	Urografin 60%	10 x 20 ml	774154004	Schering - Urografin 60% - 10 x 20 ml			66.88	76.24		
Schering	Urografin 60%	10 x 100 ml	774189002	Schering - Urografin 60% - 10 x 100 ml			282.48	322.03		
Schering	Urografin 76%	10 x 20 ml	774162007	Schering - Urografin 76% - 10 x 20 ml			87.10	99.29		

Code	Description				Ver	Add	Nuclear Medicine		Radiology	
							RVU	Fee	RVU	Fee
	Schering	Gastrografin	1 x 100 ml	728314002	Schering - Gastrografin - 1 x 100 ml		296.39		337.88	
	Amersham	Omnipaque 240 mg	15ml	862630002	Amersham - Omnipaque 240 mg - 15ml		128.40		146.38	
	Amersham	Omnipaque 300 mg	20 ml	807001007	Amersham - Omnipaque 300 mg - 20 ml		156.49		178.40	
	Amersham	Omnipaque 300 mg	50 ml	807028002	Amersham - Omnipaque 300 mg - 50 ml		207.15		236.15	
	Amersham	Omnipaque 300 mg	100 ml	804568006	Amersham - Omnipaque 300 mg - 100 ml		376.64		429.37	
	Amersham	Omnipaque 300mg Plastic	200ml	700701001	Amersham - Omnipaque 300mg Plastic - 200ml		828.61		944.61	
	Amersham	Omnipaque 300mg Plastic	500ml	700702001	Amersham - Omnipaque 300mg Plastic - 500ml		2 047.98		2 334.70	
	Amersham	Omnipaque 350 mg	50 ml	807036005	Amersham - Omnipaque 350 mg - 50 ml		216.57		246.89	
	Amersham	Omnipaque 350 mg	100 ml	807044008	Amersham - Omnipaque 350 mg - 100 ml		395.47		450.84	
	Amersham	Omnipaque 350mg Plastic	200ml	700704001	Amersham - Omnipaque 350mg Plastic - 200ml		880.40		1 003.65	
	Amersham	Omnipaque 350mg Plastic	500ml	700705001	Amersham - Omnipaque 350mg Plastic - 500ml		2 189.22		2 495.71	
	Amersham	Omniscan	10 ml	701301006	Amersham - Omniscan - 10 ml		192.60		219.56	
	Amersham	Omniscan	20 ml	701302003	Amersham - Omniscan - 20 ml		385.20		439.13	
	Amersham	Omniscan Prefilled 10ml	10 ml	701298003	Amersham - Omniscan Prefilled 10ml - 10 ml		269.64		307.39	
	Amersham	Omniscan Prefilled 15ml	15 ml	701305003	Amersham - Omniscan Prefilled 15ml - 15 ml		404.46		461.08	
	Amersham	Omniscan Prefilled 20ml	20 ml	701300019	Amersham - Omniscan Prefilled 20ml - 20 ml		539.28		614.78	
	Amersham	Visipaque 320 mg	20 ml	862649005	Amersham - Visipaque 320 mg - 20 ml		108.28		123.44	
	Amersham	Visipaque 320 mg	50 ml	847534006	Amersham - Visipaque 320 mg - 50 ml		235.40		268.36	
	Amersham	Visipaque 320 mg	100 ml	847542009	Amersham - Visipaque 320 mg - 100 ml		433.14		493.78	
	Amersham	Visipaque 320 mg	200 ml	862657008	Amersham - Visipaque 320 mg - 200 ml		838.02		955.35	
	Pharmaplan	MultiHance 10ml	10 ml	702975011	Pharmaplan – MultiHance 10ml		474.50		540.93	
	Pharmaplan	MultiHance 15ml	15 ml	702976011	Pharmaplan – MultiHance 15ml		709.93		809.32	
	Pharmaplan	MultiHance 20ml	20 ml	702979011	Pharmaplan – MultiHance 20ml		945.35		1 077.70	

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Contrast Index Price Range - 2004 contrast prices 04.00

Product Type	Iodine Concentration	Vial Size ml	Avg	Range	NAPPI CODES OF PRODUCTS IN THE CATEGORY							
Ionic												
	280 - 325 mg	50	205.48	200.11 - 210.85	715808028	715824015						
	30%	250	380.58		774170018							
	60%	20	76.24		774154004							
	60%	100	322.03		774189002							
	70%	20	99.29		774162007							
	Gastrografin	100	337.88		728314002							
Ionic Low Osmolality												
	320mg	50	439.13		730777006							
	320mg	100	853.86		730785009							
	320mg	200	1622.33		856940003							
Non Ionic												
	250mg	50	217.15		886425006							
	300mg	75	332.76		818151013							
	300 - 320mg	20	182.57	178.4 - 190.29	810126001	820482005	807001007					
	300 - 320mg	30	163.11		807087009							
	300 - 320mg	50	242.95	236.15 - 264.38	804975019	807133019	734632002	886441005	856959014	810584018	807028002	857475002
	300 - 320mg	100	442.91	429.37 - 453.52	807117005	807141038	734659008	886448005	856967017	810592029	804568006	
	300 - 320mg	200	889.51	858.74 - 944.61	886456001	856975001	700701001					
	300 - 320mg	500	2230.58	2126.45 - 2334.7	856983004	700702001						
	350 - 370mg	50	257.97	246.89 - 268.45	815721013	857505009	734640005	886464004	857017012	810606038	807036005	
	350 - 370mg	100	478.18	450.84 - 545.45	804967008	734667019	886472007	856991015	810614049	807044008		
	350 - 370mg	200	929.45	835.66 - 1003.65	886479007	857009001	894656007	700704001				
	350 - 370mg	500	2455.46	2415.2 - 2495.71	857025007	700705001						
	400mg	50	271.04		886480003							
	400mg	100	512.13		886487003							
	400mg	200	972.79		886495006							

Code	Description				Ver	Add	Nuclear Medicine		Radiology				
							RVU	Fee	RVU	Fee			
Non Ionic High Pressure syringes													
	300mg	100	539.49		857483005								
	300mg	125	653.84		857491008								
	350mg	125	672.17		857513001								
Non Ionic Iso osmolality													
	320mg	20	123.44		862649005								
	320mg	50	268.36		847534006								
	320mg	100	493.78		847542009								
	320mg	200	123.44		862657008								
Myelography													
	200 - 240mg	10	107.13	95.69 - 118.56	734624018	854131019							
	200 - 240mg	15	146.38		862630002								
	300mg	10	110.70		734675003								
	300mg	20	178.72	178.4 - 179.04	810126001	807001007							
Gadolinium (MRI)													
	standard	10	265.67	219.56 - 307.39	857033026	839159005	701301006	701298003					
	standard	15	421.32	387.9 - 461.08	857041010	839167008	701305003						
	standard	20	512.54	439.13 - 614.78	857068016	839175019	839140002	701302003	701300019				
	high	7.5	497.68		700229001								

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ANNEXURE C

Recommended Isotope and Kit Prices for Nuclear Medicine for 2004 by the Association of Nuclear Medicine Physicians
For use in conjuction with codes:

00990 Nuclear Medicine Isotope
00991 Nuclear Medicine Substrate

04.00

Supplier	Product Name	Nappi code	Product size	PRICE (excl. VAT)	PRICE (incl. VAT)
			(Patient dosage)		
Amersham	Tc-99m GENERATOR(10gBq)	888478/004	0-30mCi	319.00	363.66
Amersham	CHROMIUM-51	889025/002	1mCi	1787.50	2037.75
Amersham	CHROMIUM-51	889033/005	1mCi	1787.50	2037.75
Amersham	CHROMIUM-51	889041/001	5mCi	2161.50	2464.11
Amersham	GALLIUM-67	889064/007	5mCi	2585.00	2946.90
Amersham	GALLIUM-67	889056/004	10mCi	3080.00	3511.20
Amersham	INDIUM-111	889080/006	2mCi	4636.50	5285.61
Amersham	INDIUM-111	889087/006	1mCi	2002.00	2282.28
Amersham	IODINE-131	886665/002	1110kBq	69.85	79.63
Amersham	IODINE-131	886673/005	1850kBq	88.00	100.32
Amersham	IODINE-131	886681/001	7400kBq	119.90	136.69
Amersham	IODINE-131	886688/001	18500kBq	123.20	140.45
Amersham	IODINE-131	886696/004	1 x 9250kBq	On Request	
Amersham	IODINE-131 BENZYLGUANIDIN	886707/004	18.5Bq37MBq	On Request	
Amersham	IODINE-131 BENZYLGUANIDIN	886715/007	37MBq	2354.00	2683.56
Amersham	IODINE-131 BENZYLGUANIDIN	886723/003	185MBq	2354.00	2683.56
Amersham	IODINE-131 BENZYLGUANIDIN	886731/006	3700MBq	On Request	
Amersham	IODINE-131 BENZYLGUANIDIN	886738/006	5550MBq	On Request	
Amersham	IODINE-131 BENZYLGUANIDIN	886746/002	7400MBq1850MBq	9460.00	10784.40
Amersham	IODINE-131 BENZYLGUANIDIN	886754/005	1850MBq	On Request	
Amersham	IODINE-131	886700/004	37MBq	2904.00	3310.56
Amersham	SODIUM IODIDE	888633/004	37MBq	605.00	689.70
Amersham	SODIUM IODIDE	888641/007	74MBq	610.50	695.97
Amersham	SODIUM IODIDE	888648/007	110MBq	621.50	708.51
Amersham	SODIUM IODIDE	888656/003	111MBq	621.50	708.51
Amersham	SODIUM IODIDE	888664/006	129.5MBq	621.50	708.51
Amersham	SODIUM IODIDE	888672/002	150MBq	704.00	802.56
Amersham	SODIUM IODIDE	888679/002	185MBq	704.00	802.56
Amersham	SODIUM IODIDE	888680/005	200MBq	704.00	802.56
Amersham	SODIUM IODIDE	888687/005	222MBq	704.00	802.56
Amersham	SODIUM IODIDE	888695/001	225MBq	704.00	802.56
Amersham	SODIUM IODIDE	888706/001	250MBq	704.00	802.56
Amersham	SODIUM IODIDE	888714/004	259MBq	704.00	802.56
Amersham	SODIUM IODIDE	888722/007	260MBq	704.00	802.56
Amersham	SODIUM IODIDE	888729/007	275MBq	704.00	802.56
Amersham	SODIUM IODIDE	888730/003	277.5MBq	704.00	802.56
Amersham	SODIUM IODIDE	888737/003	296MBq	704.00	802.56
Amersham	SODIUM IODIDE	888745/006	300MBq	704.00	802.56
Amersham	SODIUM IODIDE	888753/002	330MBq	704.00	802.56
Amersham	SODIUM IODIDE	888761/005	350MBq	704.00	802.56
Amersham	SODIUM IODIDE	888768/005	370MBq	704.00	802.56
Amersham	SODIUM IODIDE	888776/001	400MBq	726.00	827.64

Code	Description				Ver	Add	Nuclear Medicine		Radiology	
							RVU	Fee	RVU	Fee
	Amersham	SODIUM IODIDE	888784/004	410MBq			726.00	827.64		
	Amersham	SODIUM IODIDE	888792/007	445MBq			737.00	840.18		
	Amersham	SODIUM IODIDE	888799/007	450MBq			748.00	852.72		
	Amersham	SODIUM IODIDE	888803/007	480MBq			770.00	877.80		
	Amersham	SODIUM IODIDE	888811/003	500MBq			786.50	896.61		
	Amersham	SODIUM IODIDE	888818/003	520MBq			825.00	940.50		
	Amersham	SODIUM IODIDE	888834/002	555MBq			836.00	953.04		
	Amersham	SODIUM IODIDE	888842/005	590MBq			858.00	978.12		
	Amersham	SODIUM IODIDE	888849/005	630MBq			913.00	1040.82		
	Amersham	SODIUM IODIDE	888850/001	665MBq			935.00	1065.90		
	Amersham	SODIUM IODIDE	888857/001	700MBq			1001.00	1141.14		
	Amersham	SODIUM IODIDE	888865/004	740MBq			1023.00	1166.22		
	Amersham	SODIUM IODIDE	888873/007	925MBq			1155.00	1316.70		
	Amersham	SODIUM IODIDE	888881/003	1110MBq			1210.00	1379.40		
	Amersham	SODIUM IODIDE	888888/003	1480Mbq			1265.00	1442.10		
	Amersham	SODIUM IODIDE	888896/006	1850MBq			1303.50	1485.99		
	Amersham	SODIUM IODIDE	888900/006	2220MBq			1391.50	1586.31		
	Amersham	SODIUM IODIDE	888907/006	2405MBq			1430.00	1630.20		
	Amersham	SODIUM IODIDE	888915/002	2590MBq			1468.50	1674.09		
	Amersham	SODIUM IODIDE	888923/005	2960MBq			1837.00	2094.18		
	Amersham	SODIUM IODIDE	888931/001	3000MBq			1870.00	2131.80		
	Amersham	SODIUM IODIDE	888938/001	3700MBq			2040.50	2326.17		
	Amersham	SODIUM IODIDE	888946/004	4440MBq			2062.50	2351.25		
	Amersham	SODIUM IODIDE	888954/007	4625MBq			2299.00	2620.86		
	Amersham	SODIUM IODIDE	888962/003	5550MBq			2414.50	2752.53		
	Amersham	SODIUM IODIDE	888969/003	5920MBq			2695.00	3072.30		
	Amersham	SODIUM IODIDE	888970/006	6000MBq			2783.00	3172.00		
	Amersham	SODIUM IODIDE	888977/006	7400MBq			2838.00	3235.32		
	Amersham	SODIUM IODIDE	888985/002	9250MBq			3036.00	3461.04		
	Amersham	SODIUM IODIDE	888993/005	11100MBq			3503.50	3993.99		
	Amersham	IRON-59	889095/002	250uCi (9.25MBq)			1716.00	1956.24		
	Amersham	PHOSPHOROUS-32	889130/004	5mCi			2552.00	2909.28		
	Amersham	PHOSPHOROUS-32	889129/001	10mCi			2882.00	3285.48		
	Amersham	STRONTIUM-89	889137/004	4mCi (4mm)			16170.00	18433.80		
	Amersham	HEPATATE	889079/003	1vial			143.00	163.02		
	Amersham	NANOCOLL	889114/005	1vial			418.00	476.52		
	Amersham	PYROPHOPHATE	888617/005	1vial			108.90	124.15		
	Amersham	TIN COLLOID	889002/003	1vial			108.90	124.15		
	Amersham	DTPA COMPLEX	886657/006	1vial			108.90	124.15		
	Amersham	RBC	888625/002	1vial			108.90	124.15		
	Amersham	DISIDA	886650/006	1vial			108.90	124.15		
	Amersham	MDP	887100/005	1vial			108.90	124.15		
	Amersham	PULMOTEK	888610/005	1vial			113.30	129.16		
	Amersham	CERETEC(brain)	889010/006	1vial			1630.75	1859.06		
	Amersham	MYOVIEW	702508/001	1vial			1760.00	2006.40		
	Amersham	THALLIUM	889145/007	2mCi			962.50	1097.25		
	Amersham	THALLIUM	889153/003	3mCi			1485.00	1892.90		
	Amersham	THALLIUM	889161/006	5mCi			2530.00	2884.20		
	Amersham	XENON-133	889176/002	50mCi			3091.00	3523.74		

Code	Description				Ver	Add	Nuclear Medicine		Radiology	
							RVU	Fee	RVU	Fee
	Amersham	XENON-133	889168/006	100mCi			3311.00	3774.54		
	Amersham	YTTRIUM-90	889184/005	10mCi			2706.00	3084.84		
	Amersham	YTTRIUM-90	889192/001	25mCi			3520.00	4012.80		
	Amersham	DMSA (KIDNEY AGENT)	894028/006	1vial			143.00	163.02		
	Amersham	RADIO STRAND	412227/001	1STRAND (10 SEED:)			4141.50	4721.31		
	Amersham	ONCOSEED	412233/001	EACH			374.00	426.36		
	Amersham	ONCOSEED	412234/001	EACH			770.00	877.80		
	Amersham	ONCOSEED	412235/001	EACH			374.00	426.36		
	SYNCOR	CARDIOLITE	702904/003	1vial			1570.00	1789.80		
	NECSA	I-123 MIBG	703072/006	1 capsule			1310.43	1493.89		
	Amersham	MAG3	827649/882	1-10mCi			789.00	899.46		

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				12500					13800				
	NATIONAL REFERENCE PRICE LIST FOR RADIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00											
	This schedule is for the exclusive use of registered specialist radiology practices (Pr No "036") and nuclear medicine practices (Pr No "025"). "025" practices may only charge the codes with a 3rd digit of 9. "036" practices may charge all codes except codes with a 3rd digit of 9. Practitioners registered as both radiologists and nuclear physicians may charge all codes.	2006.06											
	This schedule must be used in conjunction with the Radiological Society of S A Guidelines.	2004.00											
	Code Structure Framework												

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	a.□The tariff code consists of 5 digits□ i.□1st digit indicates the main anatomical region or procedural category.□ •□0 = General (non specific)□ •□1 = Head□ •□2 = Neck□ •□3 = Thorax□ •□4 = Abdomen and Pelvis (soft tissue)□ •□5 = Spine, Pelvis and Hips□ •□6 = Upper limbs□ •□7 = Lower limbs□ •□8 = Interventional□ •□9 = Soft tissue regions (nuclear medicine)□ •□eg "Head" = 1xxxx□ □ ii.□2nd digit indicates the sub region within a main region or category eg.□ •□"Head / Skull and Brain" = 10xxx□ □ iii.□3rd digit indicates modality□ •□1 = General (Black and White) x-rays□ •□2 = Ultrasound□ •□3 = Computed Tomography□ •□4 = Magnetic Resonance Imaging□ •□5 = Angiography □ •□6 = Interventional radiology□ •□9 = Nuclear Medicine (Isotopes)□ eg: □ "Head / Skull and Brain / General x-ray" = 101xx□ □ iv.□4th and 5th digits are specific to a procedure / examination, eg□ "Head / Skull and Brain / General / X-ray of the skull" = 10100.	2004.00												
	Guidelines for use of coding structure													
	•□The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.□ •□Some codes may have multiple applications and their use is described in notes associated with each code□ •□Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA. □ •□The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs) □ •□Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.	2004.00												
	Consumables													

	•□Contrast Medium□ o□Prior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up.□ o□After the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up.□ •□Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90. □ •□All other consumables are to be billed at net acquisition price, until the implementation of Act 90. Thereafter Act 90 regulations apply. □ •□The cost of film is included in the comprehensive procedure codes and is not billed for separately.□ •□Appropriate codes must be provided for consumables.	2004.0 0												
	General Comments on Procedural Codes													
	•□All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115.□ •□Setting of sterile tray is included in all appropriate procedure codes. □ •□Where introduction of contrast is necessary eg. sialography, arthrography, angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes. □ •□The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study. □ •□CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies). □ •□Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures.	2004.0 0												
	Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies	2004.0 0												
	General Codes													
	Modifiers													
00091	Radiology and nuclear medicine services rendered to hospital inpatients	2004.0 0												
00092	Radiology and nuclear medicine services rendered to outpatients	2004.0 0												
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used	2004.0 0												
	Equipment / Diagnostic													
00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).	2005.0 4							410	-	1.0	R -		
	Appropriate code to be provided. See separate codes for contrast and isotopes	2004.0 0												

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00110	X-ray skeletal survey under five years	2004.00							410	6.260	1.0	R	419.90	
00115	X-ray skeletal survey over five years	2004.00							410	10.400	1.0	R	697.50	
00120	X-ray sinogram any region	2004.00							410	10.890	1.0	R	730.40	
00130	X-ray with mobile unit in other facility	2004.00							410	1.900	1.0	R	127.40	
	To be added to applicable procedure codes eg 30100.	2004.00												
00135	X-ray control view in theatre any region	2004.00							410	5.260	1.0	R	352.80	
00140	X-ray fluoroscopy any region	2004.00							410	2.260	1.0	R	151.60	
	May only be added to the examination when fluoroscopy is not included in the standard procedure code. May not be added to:□ • any angiography, venography, lymphangiography or interventional codes.□ • any contrasted fluoroscopy examination.	2004.00												
00145	X-ray fluoroscopy guidance for biopsy, any region	2004.00							410	5.300	1.0	R	355.50	
	Add to the procedure eg. 80600, 80605, 80610.	2004.00												
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour	2004.00							410	2.420	1.0	R	162.30	
	Only to be used if equipment is owned by the radiologist.	2004.00												
00155	X-ray C-arm fluoroscopy in theatre per half hour (procedure only)	2004.00							410	2.300	1.0	R	154.30	
00160	X-ray fixed theatre installation (equipment fee only)	2004.00							410	2.260	1.0	R	151.60	
	Only to be used if equipment is owned by the radiologist.	2004.00												
00190	X-ray examination contrast material	2004.00							410	-	1.0	R	-	
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	2004.00												
00210	Ultrasound with mobile unit in other facility	2004.00							410	1.840	1.0	R	123.40	
	Add to the relevant ultrasound examination codes eg 10200.	2004.00												
00220	Ultrasound intra-operative study	2004.00							410	7.320	1.0	R	491.00	
	Covers all regions studied. Single code per operative procedure.	2004.00												

00230	Ultrasound guidance	2004.00							410	12.100	1.0	R	811.50		
	Comprehensive ultrasound code including regional study and guidance. Guided procedure code to be added eg. 80600, 80605, 80610.	2004.00													
00240	Ultrasound guidance for tissue ablation	2004.00							410	11.240	1.0	R	753.90		
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure code to be added if performed by a radiologist. 80620 or 80630.	2004.00													
00250	Ultrasound limited Doppler study any region	2005.03							410	6.500	1.0	R	436.00	Z	
	Stand alone code may not be added to any other code.	2005.03													
00290	Ultrasound examination contrast material	2004.00							410	-	1.0	R	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	2004.00													
00310	CT planning study for radiotherapy	2004.00							410	21.370	1.0	R	1 433.30		
00591	Radiology prosthetic device	2006.02													
	To be used once per planning session for any region	2004.00													
00320	CT guidance (separate procedure)	2004.00							410	16.920	1.0	R	1 134.80		
	Comprehensive CT code including regional study and guidance. Guided procedure code to be added eg 80600, 80605, and 80610.	2004.00													
00330	CT guidance, with diagnostic procedure	2004.00							410	8.460	1.0	R	567.40		
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.	2004.00													
00340	CT guidance and monitoring for tissue ablation	2004.00							410	21.150	1.0	R	1 418.50		
	May only be used once per procedure for a region. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. If performed by radiologist, add procedural code 80620, or 80630.	2004.00													
00390	CT examination contrast material	2004.00							410	-	1.0	R	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	2004.00													
00410	MR study of the whole body for metastases screening	2004.00							410	70.400	1.0	R	4 721.70		
00420	MR Spectroscopy any region	2004.00							410	28.900	1.0	R	1 938.30		

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	May be added to the regional study, once only.	2004.00												
00430	MR guidance for needle replacement	2004.00							410	42.560	1.0	R	2 854.50	
	Comprehensive MRI code including region studied and guidance. Guided procedure code to be added eg 80600, 80605, 80610.	2004.00												
00440	MR low field strength imaging of peripheral joint any region	2004.00							410	12.000	1.0	R	804.80	
00450	MR planning study for radiotherapy or surgical procedure	2004.00							410	38.000	1.0	R	2 548.70	
00455	MR planning study for radiotherapy or surgical procedure, with contrast	2004.00							410	47.000	1.0	R	3 152.30	
00490	MR examination contrast material	2004.00							410	-	1.0	R	-	
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	2004.00												
00510	Analogue monoplane screening table	2004.00							410	41.010	1.0	R	2 750.50	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00520	Analogue monoplane table with DSA attachment	2004.00							410	47.500	1.0	R	3 185.80	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00530	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.	2004.00							410	47.500	1.0	R	3 185.80	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00540	Digital monoplane screening table	2004.00							410	79.920	1.0	R	5 360.20	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00550	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.	2004.00							410	93.030	1.0	R	6 239.50	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00560	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment.	2004.00							410	125.000	1.0	R	8 383.80	
	A machine code may be added once per complete procedure / patient visit.	2004.00												
00590	Angiography and interventional examination contrast material	2004.00							410	-	1.0	R	-	
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	2004.00												

00900	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton	2004.00		410	34.920	1.0	R	2 342.10						
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT	2004.00		410	48.330	1.0	R	3 241.50						
00906	Nuclear Medicine study - Venous thrombosis regional	2004.00		410	21.540	1.0	R	1 444.70						
00909	Nuclear Medicine study - Tumour whole body	2004.00		410	34.150	1.0	R	2 290.40						
00912	Nuclear Medicine study - Tumour whole body multiple studies	2004.00		410	47.560	1.0	R	3 189.80						
00915	Nuclear Medicine study - Tumour whole body and SPECT	2004.00		410	47.560	1.0	R	3 189.80						
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT	2004.00		410	60.980	1.0	R	4 089.90						
00921	Nuclear Medicine study – Infection whole body	2004.00		410	31.450	1.0	R	2 109.40						
00924	Nuclear Medicine study – infection whole body with SPECT	2004.00		410	44.860	1.0	R	3 008.80						
00927	Nuclear Medicine study – Infection whole body multiple studies	2004.00		410	44.860	1.0	R	3 008.80						
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies	2004.00		410	58.270	1.0	R	3 908.20						
00933	Nuclear Medicine study - Bone marrow imaging limited area	2004.00		410	24.100	1.0	R	1 616.40						
00936	Nuclear Medicine study - Bone marrow imaging whole body	2004.00		410	37.510	1.0	R	2 515.80						
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies	2004.00		410	37.510	1.0	R	2 515.80						
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies	2004.00		410	50.920	1.0	R	3 415.20						
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic	2004.00		410	24.100	1.0	R	1 616.40						
00960	Nuclear Medicine therapy – Hyperthyroidism	2004.00		410	11.990	1.0	R	804.20						
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases	2004.00		410	6.470	1.0	R	433.90						
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy	2004.00		410	6.470	1.0	R	433.90						
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy	2004.00		410	6.470	1.0	R	433.90						
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate	2004.00		410	6.470	1.0	R	433.90						
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy	2004.00		410	6.470	1.0	R	433.90						

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00990	Nuclear Medicine Isotope	2004.00		410	-	1.0	R	-								
	Identification code for the use of isotope with a procedure. Appropriate codes to be supplied.	2004.00														
00991	Nuclear Medicine Substrate	2004.00		410	-	1.0	R	-								
	Call and assistance															
	•□Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. □ •□Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours.□ •□Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure.□ •□Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. □ •□Second opinion consultations only to be used if a written report is provided as indicated in codes	2005.05														
01010	Emergency call out fee, first case	2004.00							410	3.000	1.0	R	201.20			
01020	Emergency call out fee, subsequent cases same trip	2004.00							410	2.000	1.0	R	134.10			
01030	Radiologist assistance in theatre, per half hour	2004.00							410	6.000	1.0	R	402.40			
01040	Radiographer attendance in theatre, per half hour	2004.00							410	1.600	1.0	R	107.30			
01050	Written report on study done elsewhere, short	2004.00							410	1.500	1.0	R	100.60			
01055	Written report on study done elsewhere, extensive	2004.00							410	4.200	1.0	R	281.70			
01060	Written report for medico legal purposes, per hour	2004.00							410	9.720	1.0	R	651.90			
01070	Consultation for pre-assessment of interventional procedure	2004.00							410	4.860	1.0	R	326.00			
01100	X-ray procedure after hours, per procedure	2004.00							410	2.000	0.0	R	-			
01200	Ultrasound procedure after hours, per procedure	2004.00							410	4.000	0.0	R	-			
01300	CT procedure after hours, per procedure	2004.00							410	10.000	0.0	R	-			
01400	MR procedure after hours, per procedure	2004.00							410	14.000	0.0	R	-			

01500	Angiography procedure after hours, per procedure	2004.0 0							410	20.000	0.0	R	-	
01600	Interventional procedure after hours, per procedure	2004.0 0							410	26.000	0.0	R	-	
01970	Consultation for nuclear medicine study	2004.0 0		410	2.200	1.0	R	147.60						
	Monitoring													
	•□ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.	2004.0 0												
02010	ECG/pulse Oximeter monitoring	2004.0 0							410	2.000	1.0	R	134.10	
	Head													
	Skull and Brain													
	Codes 10100 (skull) and 10110 (tomography) may be combined.	2004.0 0												
10100	X-ray of the skull	2004.0 0							410	3.860	1.0	R	258.90	
10110	X-ray tomography of the skull	2004.0 0							410	4.300	1.0	R	288.40	
10120	X-ray shuntogram for VP shunt	2004.0 0							410	15.360	1.0	R	1 030.20	
10200	Ultrasound of the brain – Neonatal	2004.0 0							410	7.380	1.0	R	495.00	
10210	Ultrasound of the brain including doppler	2004.0 0							410	13.220	1.0	R	886.70	
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	2004.0 0							410	15.040	1.0	R	1 008.70	
10300	CT Brain uncontrasted	2004.0 0							410	22.650	1.0	R	1 519.10	
10310	CT Brain with contrast only	2004.0 0							410	33.280	1.0	R	2 232.10	
10320	CT Brain pre and post contrast	2004.0 0							410	40.480	1.0	R	2 715.00	
10325	CT brain pre and post contrast for perfusion studies	2005.0 3							410	49.100	1.0	R	3 293.10	Z
	Stand alone code may not be added to any other CT studies of the brain, except for code 10330	2005.0 3												
10330	CT angiography of the brain	2004.0 0							410	77.580	1.0	R	5 203.30	
10335	CT of the brain pre and post contrast with angiography	2004.0 0							410	97.910	1.0	R	6 566.80	
10340	CT brain for cranio-stenosis including 3D	2004.0 0							410	34.160	1.0	R	2 291.10	
10350	CT Brain stereotactic localisation	2004.0 0							410	19.360	1.0	R	1 298.50	

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10360	CT base of skull coronal high resolution study for CSF leak	2005.03							410	34.900	1.0	R	2 340.70	Z
10400	MR of the brain, limited study	2004.00							410	43.560	1.0	R	2 921.60	
10410	MR of the brain uncontrasted	2004.00							410	63.800	1.0	R	4 279.10	
10420	MR of the brain with contrast	2004.00							410	75.940	1.0	R	5 093.30	
10430	MR of the brain pre and post contrast	2004.00							410	104.040	1.0	R	6 978.00	
10440	MR of the brain pre and post contrast, for perfusion studies	2004.00							410	107.440	1.0	R	7 206.00	
10450	MR of the brain plus angiography	2004.00							410	92.200	1.0	R	6 183.90	
10460	MR of the brain pre and post contrast plus angiography	2004.00							410	121.230	1.0	R	8 130.90	
10470	MR angiography of the brain uncontrasted	2004.00							410	58.500	1.0	R	3 923.60	
10480	MR angiography of the brain contrasted	2004.00							410	74.020	1.0	R	4 964.50	
10485	MR of the brain, with diffusion studies	2004.00							410	79.000	1.0	R	5 298.50	
10490	MR of the brain, pre and post contrast, with diffusion studies,	2004.00							410	110.640	1.0	R	7 420.60	
10492	MR study of the brain plus angiography plus diffusion, uncontrasted	2004.00							410	95.000	1.0	R	6 371.70	
10495	MR of the brain pre and post contrast plus angiography and diffusion	2004.00							410	125.440	1.0	R	8 413.30	
10500	Arteriography of intracranial vessels: 1 - 2 vessels	2004.00							410	48.600	1.0	R	3 259.60	
10510	Arteriography of intracranial vessels: 3 - 4 vessels	2004.00							410	82.330	1.0	R	5 521.90	
10520	Arteriography of extra-cranial (non-cervical) vessels	2004.00							410	48.440	1.0	R	3 248.90	
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels	2004.00							410	118.090	1.0	R	7 920.30	
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography	2004.00							410	97.570	1.0	R	6 544.00	
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography	2004.00							410	37.290	1.0	R	2 501.00	
10560	Venography of dural sinuses	2004.00							410	52.230	1.0	R	3 503.10	
10900	Nuclear Medicine study – Bone regional, static	2004.00		410	21.500	1.0	R	1 442.00						

10905	Nuclear Medicine study – Bone regional, static, with flow	2004.00		410	27.530	1.0	R	1 846.40							
10910	Nuclear Medicine study – Bone regional, static with SPECT	2004.00		410	34.920	1.0	R	2 342.10							
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT	2004.00		410	40.940	1.0	R	2 745.80							
10920	Nuclear Medicine study – Brain, planar, complete, static	2004.00		410	16.920	1.0	R	1 134.80							
10925	Nuclear Medicine study – Brain complete static with vascular flow	2004.00		410	22.950	1.0	R	1 539.30							
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT	2004.00		410	30.330	1.0	R	2 034.20							
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT	2004.00		410	36.360	1.0	R	2 438.70							
10940	Nuclear Medicine study - CSF flow imaging cisternography	2004.00		410	21.600	1.0	R	1 448.70							
10945	Nuclear Medicine study – Ventriculography	2004.00		410	13.410	1.0	R	899.40							
10950	Nuclear Medicine study - Shunt evaluation static, planar	2004.00		410	13.410	1.0	R	899.40							
10955	Nuclear Medicine study - CFS leakage detection and localisation	2004.00		410	13.410	1.0	R	899.40							
10960	Nuclear medicine study - CSF SPECT	2004.00		410	13.410	1.0	R	899.40							
	Facial bones and nasal bones														
	Codes 11100 (facial bones) and 11110 (tomography) may be combined	2004.00													
11100	X-ray of the facial bones	2004.00								410	3.930	1.0	R	263.60	
11110	X-ray tomography of the facial bones	2004.00								410	4.300	1.0	R	288.40	
11120	X-ray of the nasal bones	2004.00								410	2.390	1.0	R	160.30	
11300	CT of the facial bones	2004.00								410	20.960	1.0	R	1 405.80	
11310	CT of the facial bones with 3D reconstructions	2004.00								410	30.400	1.0	R	2 038.90	
11320	CT of the facial bones/soft tissue, pre and post contrast	2004.00								410	41.260	1.0	R	2 767.30	
11400	MR of the facial soft tissue	2004.00								410	62.400	1.0	R	4 185.20	
11410	MR of the facial soft tissue pre and post contrast	2004.00								410	100.600	1.0	R	6 747.20	
11420	MR of the facial soft tissue plus angiography, with contrast	2004.00								410	110.300	1.0	R	7 397.80	

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11430	MR angiography of the facial soft tissue	2004.00							410	74.020	1.0	R	4 964.50	
	Orbits, lacrimal glands and tear ducts													
	Code 12130 (tomography) may be added to 12100 or 12110 or 12120 (orbits) or 12140 (dacrocystography).	2004.00												
12100	X-ray orbits less than three views	2004.00							410	3.560	1.0	R	238.80	
12110	X-ray of the orbits, three or more views, including foramina	2004.00							410	5.300	1.0	R	355.50	
12120	X-ray of the orbits for foreign body	2004.00							410	3.560	1.0	R	238.80	
12130	X-ray tomography of the orbits	2004.00							410	4.300	1.0	R	288.40	
12140	X-ray dacrocystography	2004.00							410	11.200	1.0	R	751.20	
12200	Ultrasound of the orbit/eye	2004.00							410	5.130	1.0	R	344.10	
12210	Ultrasound of the orbit/eye including doppler	2004.00							410	10.970	1.0	R	735.80	
12300	CT of the orbits single plane	2004.00							410	15.700	1.0	R	1 053.00	
12310	CT of the orbits, more than one plane	2004.00							410	20.590	1.0	R	1 381.00	
12320	CT of the orbits pre and post contrast single plane	2004.00							410	36.030	1.0	R	2 416.50	
12330	CT of the orbits pre and post contrast multiple planes	2004.00							410	39.700	1.0	R	2 662.70	
12400	MR of the orbits	2004.00							410	62.460	1.0	R	4 189.20	
12410	MR of the orbitae, pre and post contrast	2004.00							410	100.640	1.0	R	6 749.90	
12900	Nuclear Medicine study – Dacrocystography	2004.00		410	20.770	1.0	R	1 393.00						
	Paranasal sinuses													
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).	2004.00												
13100	X-ray of the paranasal sinuses, single view	2004.00							410	2.740	1.0	R	183.80	
13110	X-ray of the paranasal sinuses, two or more views	2004.00							410	3.660	1.0	R	245.50	
13120	X-ray tomography of the paranasal sinuses	2004.00							410	4.300	1.0	R	288.40	
13130	X-ray of the naso-pharyngeal soft tissue	2004.00							410	2.740	1.0	R	183.80	

13300	CT of the paranasal sinuses single plane, limited study	2004.00							410	7.200	1.0	R	482.90		
13310	CT of the paranasal sinuses, two planes, limited study	2004.00							410	12.400	1.0	R	831.70		
13320	CT of the paranasal sinuses, any plane, complete study	2004.00							410	15.420	1.0	R	1 034.20		
13330	CT of the paranasal sinuses, more than one plane, complete study	2004.00							410	20.770	1.0	R	1 393.00		
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast	2004.00							410	34.740	1.0	R	2 330.00		
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast	2004.00							410	41.010	1.0	R	2 750.50		
13400	MR of the paranasal sinuses	2004.00							410	60.270	1.0	R	4 042.30		
13410	MR of the paranasal sinuses, pre and post contrast	2004.00							410	96.590	1.0	R	6 478.30		
	Mandible, teeth and maxilla														
	Code 14110 (orthopantomogram) may be combined with 14100 (mandible) if two separate studies are performed.□ Code 14110 (orthopantomogram) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed.□ Code 14160 (tomography) may be combined with 14130 or 14140 or 14150 (teeth).□ Code 14160 (tomography) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed.□ Code 14330 and 14340 (Dental implants) may be combined if mandible and maxilla are examined at the same visit.	2004.00													
14100	X-ray of the mandible	2004.00							410	3.660	1.0	R	245.50		
14110	X-ray orthopantomogram of the jaws and teeth	2004.00							410	4.060	1.0	R	272.30		
14120	X-ray maxillofacial cephalometry	2004.00							410	2.770	1.0	R	185.80		
14130	X-ray of the teeth single quadrant	2004.00							410	2.000	1.0	R	134.10		
14140	X-ray of the teeth more than one quadrant	2004.00							410	2.530	1.0	R	169.70		
14150	X-ray of the teeth full mouth	2004.00							410	3.620	1.0	R	242.80		
14160	X-ray tomography of the teeth per side	2004.00							410	3.230	1.0	R	216.60		
14300	CT of the mandible	2004.00							410	22.280	1.0	R	1 494.30		
14310	CT of the mandible, pre and post contrast	2004.00							410	41.260	1.0	R	2 767.30		

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14320	CT mandible with 3D reconstructions	2004.00							410	30.400	1.0	R	2 038.90		
14330	CT for dental implants in the mandible	2004.00							410	27.450	1.0	R	1 841.10		
14340	CT for dental implants in the maxilla	2004.00							410	27.450	1.0	R	1 841.10		
14400	MR of the mandible/maxilla	2004.00							410	63.800	1.0	R	4 279.10		
14410	MR of the mandible/maxilla, pre and post contrast	2004.00							410	98.640	1.0	R	6 615.80		
	TM Joints														
	Code 15100 (TM joint) and 15120 (tomography) may be combined. □ Code 15110 (TM joint) and 15130 (tomography) may be combined. □ Code 15140 (arthrography) and 15120 (tomography) may be combined.□ Code 15150 (arthrography) and 15130 (tomography)may be combined.□ Codes 15320 (CT arthrogram) and 15420 (MR arthrogram) include introduction of contrast (00140 may not be added).	2004.00													
15100	X-ray tempero-mandibular joint, left	2004.00							410	3.560	1.0	R	238.80		
15110	X-ray tempero-mandibular joint, right	2004.00							410	3.560	1.0	R	238.80		
15120	X-ray tomography tempero-mandibular joint, left	2004.00							410	4.300	1.0	R	288.40		
15130	X-ray tomography tempero-mandibular joint, right	2004.00							410	4.300	1.0	R	288.40		
15140	X-ray arthrography of the tempero-mandibular joint, left	2004.00							410	15.410	1.0	R	1 033.50		
15150	X-ray arthrography of the tempero-mandibular joint, right	2004.00							410	15.410	1.0	R	1 033.50		
15200	Ultrasound tempero-mandibular joints, one or both sides	2004.00							410	6.560	1.0	R	440.00		
15300	CT of the tempero-mandibular joints	2004.00							410	25.380	1.0	R	1 702.20		
15310	CT of the tempero-mandibular joints plus 3D reconstructions	2004.00							410	34.500	1.0	R	2 313.90		
15320	CT arthrogram of the tempero-mandibular joints	2004.00							410	35.960	1.0	R	2 411.80		
15400	MR of the tempero-mandibular joints	2004.00							410	63.800	1.0	R	4 279.10		
15410	MR of the tempero-mandibular joints, pre and post contrast	2004.00							410	100.840	1.0	R	6 763.30		
15420	MR arthrogram of the tempero-mandibular joints	2004.00							410	74.710	1.0	R	5 010.80		
	Mastoids and internal auditory canal														

	Code 16100 (mastoids) and 16120 (tomography) may be combined.□ Code 16110 (mastoids bilat) and 16130 (tomography) may be combined□ Code 16140 (IAM's) and 16150 (tomography) may be combined.	2004.0 0														
16100	X-ray of the mastoids, unilateral	2004.0 0								410	3.590	1.0	R	240.80		
16110	X-ray of the mastoids, bilateral	2004.0 0								410	7.180	1.0	R	481.60		
16120	X-ray tomography of the petro-temporal bone, unilateral	2004.0 0								410	4.300	1.0	R	288.40		
16130	X-ray tomography of the petro-temporal bone, bilateral	2004.0 0								410	8.600	1.0	R	576.80		
16140	X-ray internal auditory canal, bilateral	2004.0 0								410	5.230	1.0	R	350.80		
16150	X-ray tomography of the internal auditory canal, bilateral	2004.0 0								410	4.300	1.0	R	288.40		
16300	CT of the mastoids	2004.0 0								410	12.600	1.0	R	845.10		
16310	CT of the internal auditory canal	2004.0 0								410	21.470	1.0	R	1 440.00		
16320	CT of the internal auditory canal, pre and post contrast	2004.0 0								410	34.200	1.0	R	2 293.80		
16330	CT of the ear structures, limited study	2004.0 0								410	13.400	1.0	R	898.70		
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes	2004.0 0								410	43.350	1.0	R	2 907.50		
16400	MR of the internal auditory canals, limited study	2004.0 0								410	43.560	1.0	R	2 921.60		
16410	MR of the internal auditory canals, pre and post contrast, limited study	2004.0 0								410	68.930	1.0	R	4 623.10		
16420	MR of the internal auditory canals, pre and post contrast, complete study	2004.0 0								410	102.640	1.0	R	6 884.10		
16430	MR of the ear structures	2004.0 0								410	64.400	1.0	R	4 319.30		
16440	MR of the ear structures, pre and post contrast	2004.0 0								410	102.640	1.0	R	6 884.10		
	Sella turcica															
	Code 17100 (sella) and 17110 (tomography) may be combined.	2004.0 0														
17100	X-ray of the sella turcica	2004.0 0								410	3.080	1.0	R	206.60		
17110	X-ray tomography of the sella turcica	2004.0 0								410	4.300	1.0	R	288.40		
17300	CT of the sella turcica/hypophysis	2004.0 0								410	17.450	1.0	R	1 170.40		

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17310	CT of the sella turcica/hypophysis, pre and post contrast	2004.00								410	42.260	1.0	R	2 834.40		
17400	MR of the hypophysis	2004.00								410	43.560	1.0	R	2 921.60		
17410	MR of the hypophysis, pre and post contrast	2004.00								410	74.030	1.0	R	4 965.20		
	Salivary glands and floor of the mouth															
	Code 18100 (calculus) and 18110 (open mouth) may be combined. □ Codes 18120 (sialography) and 18320 (CT sialography) include introduction of contrast and fluoroscopy (00140 may not be added).	2004.00														
18100	X-ray of the salivary glands and ducts for calculus	2004.00								410	2.840	1.0	R	190.50		
18110	X-ray of the salivary ducts, open mouth for calculus	2004.00								410	1.900	1.0	R	127.40		
18120	X-ray sialography, per gland	2004.00								410	14.080	1.0	R	944.30		
18200	Ultrasound of the salivary glands/floor of the mouth	2004.00								410	6.560	1.0	R	440.00		
18300	CT of the salivary glands, uncontrasted	2004.00								410	12.600	1.0	R	845.10		
18310	CT of the salivary glands/floor of the mouth, pre and post contrast	2004.00								410	42.100	1.0	R	2 823.60		
18320	CT sialography	2004.00								410	26.280	1.0	R	1 762.60		
18400	MR of the salivary glands/floor of the mouth	2004.00								410	63.200	1.0	R	4 238.80		
18410	MR of the salivary glands/floor of the mouth, pre and post contrast	2004.00								410	100.840	1.0	R	6 763.30		
18900	Nuclear Medicine study - Salivary gland imaging	2004.00		410	20.770	1.0	R	1 393.00								
	Soft Tissue															
19900	Nuclear Medicine study - Tumour localisation planar, static	2004.00		410	20.740	1.0	R	1 391.00								
19905	Nuclear Medicine study - Tumour localisation planar, static, multiple studies	2004.00		410	35.170	1.0	R	2 358.90								
19910	Nuclear Medicine study - Tumour localisation planar, static and SPECT	2004.00		410	34.150	1.0	R	2 290.40								
19915	Nuclear Medicine study - Tumour localisation planar, static, multiple studies and SPECT	2004.00		410	47.560	1.0	R	3 189.80								
19920	Nuclear medicine study - Infection localisation planar, static	2004.00		410	18.040	1.0	R	1 209.90								
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies	2004.00		410	31.450	1.0	R	2 109.40								
19930	Nuclear medicine study - Infection localisation planar, static and SPECT	2004.00		410	31.450	1.0	R	2 109.40								

19935	Nuclear medicine study - infection localisation planar, static, multiple studies and SPECT	2004.00		410	44.860	1.0	R 3 008.80								
	Neck														
	Code 20120 (laryngography) includes fluoroscopy (00140 may not be added).□ Code 20130 (speech) includes tomography and cinematography (00140 may not be added).□ Code 20450 (MR Angiography) may be combined with 10410 (MR brain).	2004.00													
20100	X-ray of soft tissue of the neck	2004.00							410	2.740	1.0	R	183.80		
20110	X-ray of the larynx including tomography	2004.00							410	9.390	1.0	R	629.80		
20120	X-ray laryngography	2004.00							410	8.280	1.0	R	555.30		
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording	2004.00							410	8.300	1.0	R	556.70		
20200	Ultrasound of the thyroid	2004.00							410	6.560	1.0	R	440.00		
20210	Ultrasound of soft tissue of the neck	2004.00							410	6.560	1.0	R	440.00		
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler	2004.00							410	15.000	1.0	R	1 006.10		
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler	2004.00							410	21.840	1.0	R	1 464.80		
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler	2005.03							410	10.800	1.0	R	724.40	Z	
20300	CT of the soft tissues of the neck	2004.00							410	18.250	1.0	R	1 224.00		
20310	CT of the soft tissues of the neck, with contrast	2004.00							410	38.150	1.0	R	2 558.70		
20320	CT of the soft tissues of the neck, pre and post contrast	2004.00							410	43.810	1.0	R	2 938.30		
20330	CT angiography of the extracranial vessels in the neck	2004.00							410	79.360	1.0	R	5 322.70		
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain	2004.00							410	107.500	1.0	R	7 210.00		
20350	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain plus a pre and post contrast study of the brain	2004.00							410	124.430	1.0	R	8 345.50		
20400	Mr of the soft tissue of the neck	2004.00							410	63.600	1.0	R	4 265.70		
20410	MR of the soft tissue of the neck, pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
20420	MR of the soft tissue of the neck and uncontrasted angiography	2004.00							410	92.600	1.0	R	6 210.70		
20430	MR angiography of the extracranial vessels in the neck, without contrast	2004.00							410	59.600	1.0	R	3 997.40		

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20440	MR angiography of the extracranial vessels in the neck, with contrast	2004.00							410	74.020	1.0	R	4 964.50		
20450	MR angiography of the extra and intracranial vessels with contrast	2004.00							410	116.050	1.0	R	7 783.50		
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast	2005.05							410	135.170	1.0	R	9 065.90		
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast	2004.00							410	156.050	1.0	R	10 466.30		
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels	2004.00							410	44.430	1.0	R	2 979.90		
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels	2004.00							410	50.730	1.0	R	3 402.50		
20520	Arteriography of cervical vessels: carotid and vertebral	2004.00							410	77.630	1.0	R	5 206.60		
20530	Arteriography of aortic arch and cervical vessels	2004.00							410	91.970	1.0	R	6 168.40		
20540	Arteriography of aortic arch, cervical and intracranial vessels	2004.00							410	108.870	1.0	R	7 301.90		
20550	Venography of jugular and vertebral veins	2004.00							410	48.950	1.0	R	3 283.10		
	Thyroid (Nuclear Medicine)														
21900	Nuclear Medicine study - Thyroid, single uptake	2004.00		410	9.680	1.0	R	649.20							
21910	Nuclear medicine study - Thyroid, multiple uptake	2004.00		410	14.690	1.0	R	985.30							
21920	Nuclear medicine study - Thyroid imaging with uptake	2004.00		410	17.720	1.0	R	1 188.50							
21930	Nuclear medicine study - Thyroid imaging	2004.00		410	12.720	1.0	R	853.10							
21940	Nuclear medicine study - Thyroid imaging with vascular flow	2004.00		410	18.740	1.0	R	1 256.90							
21950	Nuclear medicine study - Thyroid suppression/stimulation	2004.00		410	12.720	1.0	R	853.10							
	Parathyroid (Nuclear Medicine)														
22900	Nuclear Medicine study - Parathyroid, planar, static	2004.00		410	16.520	1.0	R	1 108.00							
22910	Nuclear medicine study - Parathyroid, planar, static, multiple	2004.00		410	28.910	1.0	R	1 939.00							
22920	Nuclear medicine study - Parathyroid, planar, static with subtraction technique	2004.00		410	21.880	1.0	R	1 467.50							
22930	Nuclear medicine study - Parathyroid SPECT	2004.00		410	13.410	1.0	R	899.40							
	Soft Tissue														
29900	Nuclear Medicine study - Tumour localisation planar, static	2004.00		410	20.740	1.0	R	1 391.00							

29905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	2004.00		410	35.170	1.0	R	2 358.90							
29910	Nuclear medicine study - Tumour localisation planar, static and SPECT	2004.00		410	34.150	1.0	R	2 290.40							
29915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	2004.00		410	47.560	1.0	R	3 189.80							
29920	Nuclear medicine study - Tumour localisation planar, static	2004.00		410	18.040	1.0	R	1 209.90							
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies	2004.00		410	31.450	1.0	R	2 109.40							
29930	Nuclear medicine study - Infection localisation planar, static and SPECT	2004.00		410	31.450	1.0	R	2 109.40							
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	2004.00		410	44.860	1.0	R	3 008.80							
29940	Nuclear medicine study - Regional lymph node mapping, static, planar	2004.00		410	24.100	1.0	R	1 616.40							
29945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	2004.00		410	36.490	1.0	R	2 447.40							
29950	Nuclear medicine study – Lymph node localisation with gamma probe	2004.00		410	12.390	1.0	R	831.00							
	Thorax														
	Chest wall, pleura, lungs and mediastinum														
	Code 30140 (tomography) may be combined with 30100 or 30110 (chest) or 30150 or 30155 (ribs) or 30160 (thoracic inlet).□ Codes 30170 (Sterno-clavicular) and 30175 (tomography) may be combined. □ Code 30180 (sternum) and 30185 (tomography) may be combined. □ Code 30340 (CT limited high resolution) may be combined with 30310 or 30320 or 30330 (CT chest). Motivation may be required.□ Code 30350 (high resolution) is a stand alone study.□ Code 30360, (CT chest for pulmonary embolism) is a complete examination and includes the preceding uncontrasted CT scan of the chest, and may not be combined with 40330 or 40333 (CT abdomen and pelvis).□ Code 30370 (CT pulmonary embolism plus CT venography) may not be combined with 70230 (Doppler).	2004.00													
30100	X-ray of the chest, single view	2004.00							410	3.040	1.0	R	203.90		
30110	X-ray of the chest two views, PA and lateral	2004.00							410	3.840	1.0	R	257.50		
30120	X-ray of the chest complete with additional views	2004.00							410	4.240	1.0	R	284.40		
30130	X-ray of the chest complete including fluoroscopy	2004.00							410	4.480	1.0	R	300.50		
30140	X-ray tomography of the chest	2004.00							410	4.300	1.0	R	288.40		

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30150	X-ray of the ribs	2004.00							410	4.790	1.0	R	321.30		
30155	X-ray of the chest and ribs	2004.00							410	6.420	1.0	R	430.60		
30160	X-ray of the thoracic inlet	2004.00							410	2.560	1.0	R	171.70		
30170	X-ray of the sterno-clavicular joints	2004.00							410	4.210	1.0	R	282.40		
30175	X-ray tomography of the sterno-clavicular joint	2004.00							410	4.300	1.0	R	288.40		
30180	X-ray of the sternum	2004.00							410	4.210	1.0	R	282.40		
30185	X-ray tomography of the sternum	2004.00							410	4.300	1.0	R	288.40		
30200	Ultrasound of the chest wall, any region	2004.00							410	6.560	1.0	R	440.00		
30210	Ultrasound of the pleural space	2004.00							410	6.560	1.0	R	440.00		
30220	Ultrasound of the mediastinal structures	2004.00							410	6.560	1.0	R	440.00		
30300	CT of the chest, limited study	2004.00							410	9.500	1.0	R	637.20		
30310	CT of the chest uncontrasted	2004.00							410	26.600	1.0	R	1 784.10		
30320	CT of the chest contrasted	2004.00							410	42.430	1.0	R	2 845.80		
30330	CT of the chest, pre and post contrast	2004.00							410	45.700	1.0	R	3 065.10		
30340	CT of the chest, limited high resolution study	2004.00							410	11.200	1.0	R	751.20		
30350	CT of the chest, complete high resolution study	2004.00							410	24.010	1.0	R	1 610.40		
30355	CT of the chest, complete high resolution study with additonal prone and expiratory studies	2005.03							410	33.300	1.0	R	2 233.40	Z	
30360	CT of the chest for pulmonary embolism	2004.00							410	57.120	1.0	R	3 831.00		
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	2004.00							410	80.280	1.0	R	5 384.40		
30400	MR of the chest	2004.00							410	63.600	1.0	R	4 265.70		
30410	MR of the chest with uncontrasted angiography	2004.00							410	92.600	1.0	R	6 210.70		
30420	MR of the chest, pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		

30900	Nuclear Medicine study - Lung perfusion	2004.00		410	21.540	1.0	R	1 444.70							
30910	Nuclear Medicine study - Lung ventilation, aerosol	2004.00		410	21.500	1.0	R	1 442.00							
30920	Nuclear Medicine study - Lung perfusion and ventilation	2004.00		410	42.030	1.0	R	2 819.00							
30930	Nuclear Medicine study - Lung ventilation using radio-active gas	2004.00		410	14.170	1.0	R	950.40							
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas	2004.00		410	34.690	1.0	R	2 326.70							
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic	2005.03		410	26.510	1.0	R	1 778.00	Z						
30960	Nuclear medine study - alveolar permeability	2005.03		410	26.510	1.0	R	1 778.00	Z						
	Stand alone code. Not to be combined with 30910.	2005.03													
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation	2005.03		410	6.020	1.0	R	403.80	Z						
	Stand alone code. Not to be combined with 30920.	2005.03													
	Oesophagus														
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).	2004.00													
31100	X-ray barium swallow	2004.00								410	6.600	1.0	R	442.70	
31105	Xray 3 phase dynamic contrasted swallow	2005.03								410	12.600	1.0	R	845.10	Z
31110	X-ray barium swallow, double contrast	2004.00								410	7.920	1.0	R	531.20	
31120	X-ray barium swallow with cinematography	2004.00								410	10.070	1.0	R	675.40	
	Aorta and large vessels														
	Codes 32210 and 32220 (Ivus) may be combined	2004.00													
32200	Ultrasound intravascular arterial or venous assessment for intervention, once per complete procedure	2004.00								410	4.200	1.0	R	281.70	
32210	Ultrasound intravascular (IVUS) first vessel	2004.00								410	8.440	1.0	R	566.10	
32220	Ultrasound intravascular (IVUS) subsequent vessels	2004.00								410	5.300	1.0	R	355.50	
32300	CT angiography of the aorta and branches	2004.00								410	79.080	1.0	R	5 303.90	
32305	CT angiography of the thoracic and abdominal aorta and branches	2005.03								410	105.500	1.0	R	7 075.90	Z

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32310	CT angiography of the pulmonary vasculature	2004.0 0							410	79.080	1.0	R	5 303.90	
32400	MR angiography of the aorta and branches	2004.0 0							410	78.500	1.0	R	5 265.00	
32410	MR angiography of the pulmonary vasculature	2004.0 0							410	105.270	1.0	R	7 060.50	
32500	Arteriography of thoracic aorta	2004.0 0							410	28.260	1.0	R	1 895.40	
32510	Arteriography of bronchial intercostal vessels alone	2004.0 0							410	50.150	1.0	R	3 363.60	
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels	2004.0 0							410	67.430	1.0	R	4 522.50	
32530	Arteriography of pulmonary vessels	2004.0 0							410	63.270	1.0	R	4 243.50	
32540	Arteriography of heart chambers, coronary arteries	2004.0 0							410	44.270	1.0	R	2 969.20	
32550	Venography of thoracic vena cava	2004.0 0							410	28.380	1.0	R	1 903.40	
32560	Venography of vena cava, azygos system	2004.0 0							410	56.310	1.0	R	3 776.70	
32570	Venography patency of A-port or other central line	2004.0 0							410	19.640	1.0	R	1 317.30	
	Heart													
	Codes 33300 (CT anatomy / function) and 33310 (CT Angiography) may be done as stand alone studies or as additive studies if both are performed at the same time.	2004.0 0												
33205	Ultrasound study of the heart for foetal or paediatric cases including doppler	2004.0 0							410	12.300	1.0	R	825.00	
	Code 33205 is a stand alone study and may not be added to 33200 or 33210. This code is intended for paediatric and foetal cases only	2004.0 0												
33200	Ultrasound study of the heart, including Doppler	2004.0 0							410	8.200	1.0	R	550.00	
33210	Ultrasound study of the heart trans-oesophageal	2004.0 0							410	10.520	1.0	R	705.60	
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel	2004.0 0							410	5.200	1.0	R	348.80	
33300	CT anatomical/functional study of the heart	2004.0 0							410	34.610	1.0	R	2 321.30	
33310	CT angiography of heart vessels	2004.0 0							410	81.280	1.0	R	5 451.40	
33400	MR of the heart, anatomical study	2004.0 0							410	62.200	1.0	R	4 171.80	
33410	MR of the heart, anatomical and functional study	2004.0 0							410	69.000	1.0	R	4 627.80	
33420	MR of the heart, pre and post contrast	2004.0 0							410	103.040	1.0	R	6 910.90	

33430	MR angiography of the heart vessels	2004.00							410	70.710	1.0	R	4 742.50	
33440	MR of the heart, anatomical, functional and coronary angiography	2004.00							410	106.840	1.0	R	7 165.80	
33900	Nuclear Medicine study - Cardiac shunt detection	2004.00		410	21.500	1.0	R	1 442.00						
33905	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion single study	2004.00		410	26.510	1.0	R	1 778.00						
33910	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion multiple studies	2004.00		410	34.920	1.0	R	2 342.10						
33915	Nuclear Medicine study - Cardiac blood pool imaging, gated SPECT	2004.00		410	13.410	1.0	R	899.40						
33920	Nuclear medicine study - Cardiac blood pool imaging, first pass technique	2004.00		410	26.510	1.0	R	1 778.00						
33925	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi) planar, non gated	2004.00		410	16.520	1.0	R	1 108.00						
33930	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi) planar, non gated	2004.00		410	16.520	1.0	R	1 108.00						
33935	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (non gated)	2004.00		410	16.520	1.0	R	1 108.00						
33940	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT non gated	2004.00		410	16.520	1.0	R	1 108.00						
33945	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (gated)	2004.00		410	28.910	1.0	R	1 939.00						
33950	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT (gated)	2004.00		410	28.910	1.0	R	1 939.00						
33955	Nuclear medicine study - Plus wall movement and ejection fraction, SPECT	2004.00		410	6.020	1.0	R	403.60						
33960	Nuclear medicine study - Cardiac hot spot imaging (infarction) planar	2004.00		410	21.500	1.0	R	1 442.00						
33965	Nuclear medicine study - Cardiac hot spot imaging (infarction) SPECT	2004.00		410	13.410	1.0	R	899.40						
33970	Nuclear Medicine study - Multi stage treadmill ECG test	2004.00		410	6.660	1.0	R	446.70						
	Mamma													
	Codes 34110 (localization), 34120 (stereo-tactic localization) and 34130 (stereo-tactic biopsy) may not be combined.□ Code 34130 (stereo-tactic biopsy). Add procedural code 80610 (cutting needle) or 34150 (mammotome)□ Code 34205 (U/S FNA) includes the procedural code (may not be combined with 34150).	2004.00												
34100	X-ray mammography including ultrasound	2004.00							410	10.440	1.0	R	700.20	
34101	X-Ray mammography unilateral, including ultrasound	2006.04							410	8.352	1.0	R	560.20	

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	Code 34100 may not be combined with 34205 when these two procedures are done in the same sitting. Code 34100 includes ultrasound. In this situation use code 80605 (fine needle aspiration) with 34100	2004.00													
34105	X-ray mammography galactography	2004.00							410	9.400	1.0	R	630.50		
	Once off fee per visit. May be added to 34100	2004.00													
34110	X-ray mammography study for localisation	2004.00							410	7.240	1.0	R	485.60		
34120	X-ray stereotactic mammography – localisation	2004.00							410	10.400	1.0	R	697.50		
34130	X-ray stereotactic mammography – biopsy	2004.00							410	11.600	1.0	R	778.00		
34140	X-ray of biopsy specimen of the mamma	2004.00							410	2.740	1.0	R	183.80		
34150	X-ray Mammotome hand held biopsy apparatus	2004.00							410	9.800	1.0	R	657.30		
34200	Ultrasound study of the breast	2004.00							410	7.900	1.0	R	529.90		
34205	Ultrasound guided aspiration FNA/localisation of the breast	2004.00							410	12.100	1.0	R	811.50		
34300	Computer assisted diagnosis for mammography	2004.00							410	1.400	1.0	R	93.90		
34400	MR study of the breast	2004.00							410	62.600	1.0	R	4 198.60		
34410	MR study of the breast pre and post contrast	2004.00							410	100.840	1.0	R	6 763.30		
	Soft Tissue														
39900	Nuclear medicine study - Tumour localisation planar, static	2004.00		410	20.740	1.0	R	1 391.00							
39905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	2004.00		410	35.170	1.0	R	2 358.90							
39910	Nuclear medicine study - Tumour localisation planar, static and SPECT	2004.00		410	34.150	1.0	R	2 290.40							
39915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	2004.00		410	47.560	1.0	R	3 189.80							
39920	Nuclear medicine study - Infection localisation planar, static	2004.00		410	18.040	1.0	R	1 209.90							
39925	Nuclear medicine study - Infection localisation planar, static, multiple studies	2004.00		410	31.450	1.0	R	2 109.40							
39930	Nuclear medicine study - Infection localisation planar, static and SPECT	2004.00		410	31.450	1.0	R	2 109.40							
39935	Nuclear medicine study - Infection localisation planar, static, multiple studies, SPECT	2004.00		410	44.860	1.0	R	3 008.80							

39940	Nuclear medicine study - Regional lymph node mapping, static, planar	2004.00		410	24.100	1.0	R	1 616.40							
39945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	2004.00		410	36.490	1.0	R	2 447.40							
39950	Nuclear medicine study – Lymph node localisation with gamma probe	2004.00		410	12.390	1.0	R	831.00							
	Abdomen and Pelvis														
	Abdomen/stomach/bowel														
	Code 40120 (tomography) may be combined with 40100 or 40105 or 40110 (abdomen).□ Codes 40140 to 40190 (barium studies) include fluoroscopy (00140 may not be added). □ Code 40190 (intussusception) is a stand alone code and may not be combined with 40160 or 40165 (barium enema), (00140 may not be added).	2004.00													
40100	X-ray of the abdomen	2004.00							410	3.320	1.0	R	222.70		
40105	X-ray of the abdomen supine and erect, or decubitus	2004.00							410	5.360	1.0	R	359.50		
40110	X-ray of the abdomen multiple views including chest	2004.00							410	8.100	1.0	R	543.30		
40120	X-ray tomography of the abdomen	2004.00							410	4.300	1.0	R	288.40		
40140	X-ray barium meal single contrast	2004.00							410	8.870	1.0	R	594.90		
40143	X-ray barium meal double contrast	2004.00							410	11.990	1.0	R	804.20		
40147	X-ray barium meal double contrast with follow through	2004.00							410	15.800	1.0	R	1 059.70		
40150	X-ray small bowel enteroclysis (meal)	2004.00							410	25.450	1.0	R	1 706.90		
	Code 40150 excludes duodenal intubation and 40175 (Duodenal intubation) may be added.	2006.02													
40153	X-ray small bowel meal follow through single contrast	2004.00							410	19.550	1.0	R	1 311.20		
40157	X-ray small bowel meal with pneumocolon	2004.00							410	25.630	1.0	R	1 719.00		
40160	X-ray large bowel enema single contrast	2004.00							410	12.970	1.0	R	869.90		
40165	X-ray large bowel enema double contrast	2004.00							410	19.630	1.0	R	1 316.60		
40170	X-ray guided gastro oesophageal intubation	2004.00							410	1.600	1.0	R	107.30		
40175	X-ray guided duodenal intubation	2004.00							410	2.800	1.0	R	187.80		
40180	X-ray defaecogram	2004.00							410	12.970	1.0	R	869.90		

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40190	X-ray guided reduction of intussusception	2004.00								410	16.270	1.0	R	1 091.20		
40200	Ultrasound study of the abdominal wall	2004.00								410	5.540	1.0	R	371.60		
40210	Ultrasound study of the whole abdomen including the pelvis	2004.00								410	8.240	1.0	R	552.70		
40300	CT study of the abdomen	2004.00								410	26.410	1.0	R	1 771.30		
40310	CT study of the abdomen with contrast	2004.00								410	44.820	1.0	R	3 006.10		
40313	CT study of the abdomen pre and post contrast	2004.00								410	52.990	1.0	R	3 554.00		
40320	CT of the pelvis	2004.00								410	26.130	1.0	R	1 752.50		
40323	CT of the pelvis with contrast	2004.00								410	47.480	1.0	R	3 184.50		
40327	CT of the pelvis pre and post contrast	2004.00								410	53.870	1.0	R	3 613.10		
40330	CT of the abdomen and pelvis	2004.00								410	38.500	1.0	R	2 582.20		
40333	CT of the abdomen and pelvis with contrast	2004.00								410	62.170	1.0	R	4 169.70		
40337	CT of the abdomen and pelvis pre and post contrast	2004.00								410	67.430	1.0	R	4 522.50		
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast	2004.00								410	74.110	1.0	R	4 970.60		
40345	CT of the chest, abdomen and pelvis without contrast	2004.00								410	70.120	1.0	R	4 702.90		
40350	CT of the chest, abdomen and pelvis with contrast	2004.00								410	88.350	1.0	R	5 925.60		
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast	2004.00								410	93.050	1.0	R	6 240.90		
40360	CT of the base of skull to symphysis pubis with contrast	2004.00								410	102.730	1.0	R	6 890.10		
40365	CT colonoscopy	2004.00								410	34.780	1.0	R	2 332.70		
	Stand alone study, may not be added to any code between 40300 and 40360	2004.00														
40400	MR of the abdomen	2004.00								410	64.580	1.0	R	4 331.40		
40410	MR of the abdomen pre and post contrast	2004.00								410	100.840	1.0	R	6 763.30		
40420	MR of the pelvis, soft tissue	2004.00								410	64.580	1.0	R	4 331.40		

40430	MR of the pelvis, soft tissue, pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying	2004.00		410	21.500	1.0	R	1 442.00							
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies	2004.00		410	34.920	1.0	R	2 342.10							
40910	Nuclear Medicine study - Gastro intestinal protein loss	2004.00		410	21.500	1.0	R	1 442.00							
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies	2004.00		410	34.920	1.0	R	2 342.10							
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic	2004.00		410	21.500	1.0	R	1 442.00							
40925	Nuclear medicine study – Acute GIT bleed multiple studies	2004.00		410	34.920	1.0	R	2 342.10							
40930	Nuclear medicine study - Meckel's localisation	2004.00		410	20.770	1.0	R	1 393.00							
40935	Nuclear medicine study - Gastric mucosa imaging	2004.00		410	20.770	1.0	R	1 393.00							
40940	Nuclear medicine study - colonic transit multiple studies	2005.03		410	44.860	1.0	R	3 008.80	Z						
	Stand alone code	2005.03													
	Liver, spleen, gall bladder and pancreas														
	Code 41110, 41120 and 41130 (cholangiography) include fluoroscopy (00140 may not be added).	2004.00													
41100	X-ray ERCP including screening	2004.00							410	18.900	1.0	R	1 267.60		
41105	X-ray ERCP reporting on images done in theatre	2004.00							410	2.400	1.0	R	161.00		
41110	X-ray cholangiography intra-operative	2004.00							410	8.450	1.0	R	566.70		
41120	X-ray T-tube cholangiography post operative	2004.00							410	14.050	1.0	R	942.30		
41130	X-ray transhepatic percutaneous cholangiography	2004.00							410	32.340	1.0	R	2 169.00		
41200	Ultrasound study of the upper abdomen	2004.00							410	7.000	1.0	R	469.50		
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis	2004.00							410	9.800	1.0	R	657.30		
	Code 41210 is a stand alone study and may not be added to 40200, 40210, 41200 or 42200	2004.00													
41300	CT of the abdomen triphasic study – liver	2004.00							410	54.900	1.0	R	3 682.10		
41400	MR study of the liver/pancreas	2004.00							410	64.760	1.0	R	4 344.80		

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41410	MR study of the liver/pancreas pre and post contrast	2004.00							410	100.840	1.0	R	6 763.30		
41420	MRCP	2004.00							410	49.200	1.0	R	3 299.80		
41430	MR study of the abdomen with MRCP	2004.00							410	92.980	1.0	R	6 236.20		
41440	MR study of the abdomen pre and post contrast with MRCP	2004.00							410	133.600	1.0	R	8 960.60		
41900	Nuclear Medicine study - Liver and spleen, planar views only	2004.00		410	21.500	1.0	R	1 442.00							
41905	Nuclear Medicine study - Liver and spleen, with flow study	2004.00		410	27.530	1.0	R	1 846.40							
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT	2004.00		410	34.920	1.0	R	2 342.10							
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT	2004.00		410	40.940	1.0	R	2 745.80							
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic	2004.00		410	21.500	1.0	R	1 442.00							
41925	Nuclear Medicine study – hepatobiliary tract including flow	2004.00		410	26.510	1.0	R	1 778.00							
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies	2004.00		410	34.920	1.0	R	2 342.10							
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies	2004.00		410	39.920	1.0	R	2 677.40							
41940	Nuclear medicine study - Gall bladder ejection fraction	2004.00		410	6.020	1.0	R	403.80							
41945	Nuclear medicine study – Biliary gastric reflux study	2004.00		410	20.770	1.0	R	1 393.00							
	Renal tract														
42100	X-ray tomography of the renal tract	2004.00							410	4.300	1.0	R	288.40		
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP).□ Codes 42115 (IVP), 42120 (cystography), 42130 (urethography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).	2004.00													
42110	X-ray excretory urogram including tomography	2004.00							410	24.860	1.0	R	1 667.40		
42115	X-ray excretory urogram including tomography with micturating study	2004.00							410	32.860	1.0	R	2 203.90		
42120	X-ray cystography	2004.00							410	15.050	1.0	R	1 009.40		
42130	X-ray urethrography	2004.00							410	15.370	1.0	R	1 030.90		
42140	X-ray micturating cysto-urethrography	2004.00							410	19.300	1.0	R	1 294.50		

42150	X-ray retrograde/prograde pyelography	2004.00							410	12.530	1.0	R	840.40		
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre	2004.00							410	2.410	1.0	R	161.60		
42160	X-ray prograde pyelogram – percutaneous	2004.00							410	32.670	1.0	R	2 191.20		
42200	Ultrasound study of the renal tract including bladder	2004.00							410	7.420	1.0	R	497.70		
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney	2004.00							410	3.800	1.0	R	254.90		
	Code 42205 is a stand alone study and may not be added to 42200	2004.00													
42210	Ultrasound study of the renal arteries including Doppler	2005.03							410	10.600	1.0	R	710.90	Z	
42300	CT of the renal tract for a stone	2004.00							410	25.150	1.0	R	1 686.80		
42400	MR of the renal tract for obstruction	2004.00							410	47.000	1.0	R	3 152.30		
42410	MR of the kidneys without contrast	2004.00							410	64.580	1.0	R	4 331.40		
42420	MR of the kidneys pre and post contrast	2004.00							410	102.240	1.0	R	6 857.20		
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)	2004.00		410	21.940	1.0	R	1 471.50							
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow	2004.00		410	27.960	1.0	R	1 875.30							
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT	2004.00		410	35.350	1.0	R	2 370.90							
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT	2004.00		410	41.370	1.0	R	2 774.70							
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow	2004.00		410	26.510	1.0	R	1 778.00							
42930	Nuclear Medicine study – Renovascular study, baseline	2004.00		410	26.510	1.0	R	1 778.00							
42940	Nuclear Medicine study – Renovascular study, with intervention	2004.00		410	26.510	1.0	R	1 778.00							
42950	Nuclear medicine study - indirect voiding cystogram	2005.05		410	6.020	1.0	R	403.80	Z						
	Reproductive system														
	Codes 43120 and 43130 (hystero-salpingography) include fluoroscopy (00140 may not be added).□ Codes 43230 (U/S ova aspiration) and 43240 (amniocentesis) are complete procedure codes.	2004.00													

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	Codes 43230 (U/S ova aspiration) and 43240 (amniocentesis) are complete procedures and may not be combined with 00230 (ultrasound guidance) or 80605 (fine needle aspiration). Code 43240 may be combined with 43260 (second trimester), 43270 (third trimester) and 43273 (third trimester follow up)	2004.00													
43100	X-ray pelvimetry single	2004.00							410	4.000	1.0	R	268.30		
43110	X-ray pelvimetry multiple views	2004.00							410	5.800	1.0	R	389.00		
43120	X-ray hystero-salpingography	2004.00							410	10.030	1.0	R	672.70		
43130	X-ray hystero-salpingography with introduction of contrast	2004.00							410	13.530	1.0	R	907.50		
43200	Ultrasound study of the pelvis transabdominal	2004.00							410	5.700	1.0	R	382.30		
43205	Ultrasound study of the female pelvis transvaginal	2004.00							410	7.210	1.0	R	483.60		
43210	Ultrasound study of the prostate transrectal	2004.00							410	7.380	1.0	R	495.00		
43215	Ultrasound transrectal prostate volume for brachytherapy	2004.00							410	10.400	1.0	R	697.50		
43220	Ultrasound study of the testes	2004.00							410	7.380	1.0	R	495.00		
43225	Ultrasound study for male impotence including doppler and injection of vaso contrictor	2004.00							410	15.000	1.0	R	1 006.10		
	Code 43225 is a stand alone study and may not be added to 43200, 43210, 43220 or 44200	2004.00													
43230	Ultrasound guided transvaginal aspiration for ova	2004.00							410	13.500	1.0	R	905.40		
43240	Ultrasound guided amniocenthesis	2004.00							410	5.840	1.0	R	391.70		
43250	Ultrasound study of the pregnant uterus, first trimester	2004.00							410	4.200	1.0	R	281.70		
43260	Ultrasound study of the pregnant uterus, second trimester	2004.00							410	6.360	1.0	R	426.60		
43270	Ultrasound study of the pregnant uterus, third trimester, first visit	2004.00							410	6.360	1.0	R	426.60		
43273	Ultrasound study of the pregnant uterus, third trimester, follow-up visit	2004.00							410	4.200	1.0	R	281.70		
43277	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit	2004.00							410	8.170	1.0	R	548.00		
43280	Ultrasound doppler of the umbilical cord for resistive index	2004.00							410	3.800	1.0	R	254.90		
	Code 43280 is a stand alone study and may not be added to the following codes: 43250, 43260, 43270, 43273 or 43277	2004.00													

43300	CT pelvimetry – Topogram	2004.00								410	6.580	1.0	R	441.30		
43400	MR study of pelvic reproductive organs - limited study	2004.00								410	47.600	1.0	R	3 192.50		
43405	MR study for pelvimetry	2004.00								410	20.000	1.0	R	1 341.40		
43410	MR study of pelvic reproductive organs - complete – uncontrasted	2004.00								410	64.580	1.0	R	4 331.40		
43420	MR study of pelvic reproductive organs - complete – pre and post contrast	2004.00								410	102.240	1.0	R	6 857.20		
43950	Nuclear medicine study - Radio pharmaceutical voiding cystogram	2004.00		410	21.500	1.0	R	1 442.00								
43960	Nuclear medicine study - Testicular imaging	2004.00		410	26.510	1.0	R	1 778.00								
43970	Nuclear medicine study - hystero-salpingography	2005.03		410	26.510	1.0	R	1 778.00	Z							
	Aorta and vessels															
	Code 44400 (MR Angiography) may be combined with 40400 (MR abdomen).	2004.00														
44200	Ultrasound study of abdominal aorta and branches including doppler	2004.00								410	18.320	1.0	R	1 228.70		
44205	Ultrasound study of the IVC and pelvic veins including Doppler	2005.03								410	14.000	1.0	R	939.00	Z	
	This is a stand alone code and may not be added to 44200.	2005.03														
44300	CT angiography of abdominal aorta and branches	2004.00								410	76.720	1.0	R	5 145.60		
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen	2004.00								410	94.320	1.0	R	6 326.00		
44310	CT angiography of the pelvis	2004.00								410	78.640	1.0	R	5 274.40		
44320	CT angiography of the abdominal aorta and pelvis	2004.00								410	89.540	1.0	R	6 005.40		
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis	2004.00								410	119.150	1.0	R	7 991.40		
44330	CT portogram	2004.00								410	74.400	1.0	R	4 990.00		
44400	MR angiography of abdominal aorta and branches	2004.00								410	76.640	1.0	R	5 140.20		
44500	Arteriography of abdominal aorta alone	2004.00								410	28.120	1.0	R	1 886.00		
44503	Arteriography of aorta plus coeliac, mesenteric branches	2004.00								410	75.630	1.0	R	5 072.50		
44505	Arteriography of aorta plus renal, adrenal branches	2004.00								410	63.010	1.0	R	4 226.10		

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44507	Arteriography of aorta plus non-visceral branches	2004.00								410	60.790	1.0	R	4 077.20		
44510	Arteriography of coeliac, mesenteric vessels alone	2004.00								410	64.350	1.0	R	4 316.00		
44515	Arteriography of renal, adrenal vessels alone	2004.00								410	49.490	1.0	R	3 319.30		
44517	Arteriography of non-visceral abdominal vessels alone	2004.00								410	54.910	1.0	R	3 682.80		
44520	Arteriography of internal and external iliac vessels alone	2004.00								410	56.720	1.0	R	3 804.20		
44525	Venography of internal and external iliac veins alone	2004.00								410	62.110	1.0	R	4 165.70		
44530	Corpora cavernosography	2004.00								410	25.060	1.0	R	1 680.80		
44535	Vasography, vesiculography	2004.00								410	29.190	1.0	R	1 957.80		
44540	Venography of inferior vena cava	2004.00								410	26.120	1.0	R	1 751.90		
44543	Venography of hepatic veins alone	2004.00								410	53.770	1.0	R	3 606.40		
44545	Venography of inferior vena cava and hepatic veins	2004.00								410	68.910	1.0	R	4 621.80		
44550	Venography of lumbar azygos system alone	2004.00								410	43.890	1.0	R	2 943.70		
44555	Venography of inferior vena cava and lumbar azygos veins	2004.00								410	65.460	1.0	R	4 390.40		
44560	Venography of renal, adrenal veins alone	2004.00								410	43.990	1.0	R	2 950.40		
44565	Venography of inferior vena cava and renal/adrenal veins	2004.00								410	68.390	1.0	R	4 586.90		
44570	Venography of spermatic, ovarian veins alone	2004.00								410	40.390	1.0	R	2 709.00		
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins	2004.00								410	73.990	1.0	R	4 962.50		
44580	Venography indirect splenoportogram	2004.00								410	48.670	1.0	R	3 264.30		
44583	Venography direct splenoportogram	2004.00								410	31.590	1.0	R	2 118.70		
44587	Venography transhepatic portogram	2004.00								410	66.750	1.0	R	4 476.90		
	Soft Tissue															
49900	Nuclear Medicine study – Tumour localisation planar, static	2004.00		410	20.740	1.0	R	1 391.00								
49905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	2004.00		410	35.170	1.0	R	2 358.90								

49910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	2004.00		410	34.150	1.0	R	2 290.40							
49915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	2004.00		410	47.560	1.0	R	3 189.80							
49920	Nuclear medicine study – Infection localisation planar, static	2004.00		410	18.040	1.0	R	1 209.90							
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies	2004.00		410	31.450	1.0	R	2 109.40							
49940	Nuclear medicine study – Infection localisation planar, static and SPECT	2004.00		410	31.450	1.0	R	2 109.40							
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	2004.00		410	44.860	1.0	R	3 008.80							
49960	Nuclear medicine study – Regional lymph node mapping dynamic	2004.00		410	5.010	1.0	R	336.00							
49965	Nuclear medicine study – Regional lymph node mapping, static, planar	2004.00		410	24.100	1.0	R	1 616.40							
49970	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	2004.00		410	37.510	1.0	R	2 515.80							
49975	Nuclear medicine study – Regional lymph node mapping SPECT	2004.00		410	13.410	1.0	R	899.40							
49980	Nuclear medicine study – Lymph node localisation with gamma probe	2004.00		410	13.410	1.0	R	899.40							
	Spine, Pelvis and Hips														
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventianla myelography codes viz. 51160, 52150, 53160	2004.00													
	General														
	Code 50130 (Lumbar puncture) and 50140 (cisternal puncture) include fluoroscopy and introduction of contrast (00140 may not be added).	2004.00													
50100	X-ray of the spine scoliosis view AP only	2004.00							410	7.000	1.0	R	469.50		
50105	X-ray of the spine scoliosis view AP and lateral	2004.00							410	12.000	1.0	R	804.80		
50110	X-ray of the spine scoliosis view AP and lateral including stress views	2004.00							410	18.540	1.0	R	1 243.50		
50120	X-ray bone densitometry	2004.00							410	11.520	1.0	R	772.60		
50130	X-ray guided lumbar puncture	2004.00							410	4.800	1.0	R	321.90		
50140	X-ray guided cisternal puncture cisternogram	2004.00							410	22.980	1.0	R	1 541.30		
50300	CT quantitive bone mineral density	2004.00							410	11.830	1.0	R	793.40		
50500	Arteriogram of the spinal column and cord, all vessels	2004.00							410	127.230	1.0	R	8 533.30		

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50510	Venography of the spinal, paraspinal veins	2004.00							410	58.450	1.0	R 3 920.20		
	Cervical													
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography).□ Code 51140 (tomography) may be combined with 51110 or 51120 (spine).□ Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added).□ Code 51300 (CT) limited - limited to a single cervical vertebral body.□ Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces.□ Code 51320 (CT) complete study - an extensive study of the cervical spine.□ Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).	2004.00													
51100	X-ray f the cervical spine, stress views only	2004.00							410	4.140	1.0	R 277.70		
51110	X-ray of the cervical spine, one or two views	2004.00							410	3.010	1.0	R 201.90		
51120	X-ray of the cervical spine, more than two views	2004.00							410	4.280	1.0	R 287.10		
51130	X-ray of the cervical spine, more than two views including stress views	2004.00							410	7.580	1.0	R 508.40		
51140	X-ray Tomography cervical spine	2004.00							410	4.300	1.0	R 288.40		
51160	X-ray myelography of the cervical spine	2004.00							410	27.460	1.0	R 1 841.70		
51170	X-ray discography cervical spine per level	2004.00							410	25.170	1.0	R 1 688.20		
51300	CT of the cervical spine limited study	2004.00							410	9.500	1.0	R 637.20		
51310	CT of the cervical spine – regional study	2004.00							410	13.910	1.0	R 932.90		
51320	CT of the cervical spine – complete study	2004.00							410	37.130	1.0	R 2 490.30		
51330	CT of the cervical spine pre and post contrast	2004.00							410	58.850	1.0	R 3 947.10		
51340	CT myelography of the cervical spine	2004.00							410	47.190	1.0	R 3 165.00		
51350	CT myelography of the cervical spine following myelogram	2004.00							410	21.690	1.0	R 1 454.70		
51400	MR of the cervical spine, limited study	2004.00							410	44.400	1.0	R 2 977.90		
51410	MR of the cervical spine and cranio-cervical junction	2004.00							410	64.820	1.0	R 4 347.50		
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	2004.00							410	102.140	1.0	R 6 850.50		

51900	Nuclear Medicine study – Bone regional cervical	2004.00		410	21.500	1.0	R	1 442.00							
51910	Nuclear Medicine study – Bone tomography regional cervical	2004.00		410	13.410	1.0	R	899.40							
51920	Nuclear Medicine study – with flow	2004.00		410	6.020	1.0	R	403.80							
	Thoracic														
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine).□ Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added).□ Code 52300 (CT) limited study – limited to a single thoracic vertebral body. □ Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. □ Code 52310 (CT) complete study - an extensive study of the thoracic spine.□ Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	2004.00													
52100	X-ray of the thoracic spine, one or two views	2004.00								410	3.210	1.0	R	215.30	
52110	X-ray of the thoracic spine, more than two views	2004.00								410	4.000	1.0	R	268.30	
52120	X-ray tomography thoracic spine	2004.00								410	4.300	1.0	R	288.40	
52140	X-ray of the thoracic spine, more that two views including stress views	2004.00								410	6.640	1.0	R	445.30	
52150	X-ray myelography of the thoracic spine	2004.00								410	18.620	1.0	R	1 248.80	
52300	CT of the thoracic spine limited study	2004.00								410	9.500	1.0	R	637.20	
52305	CT of the thoracic spine – regional study	2004.00								410	13.910	1.0	R	932.90	
52310	CT of the thoracic spine complete study	2004.00								410	35.780	1.0	R	2 399.80	
52320	CT of the thoracic spine pre and post contrast	2004.00								410	58.850	1.0	R	3 947.10	
52330	CT myelography of the thoracic spine	2004.00								410	48.090	1.0	R	3 225.40	
52340	CT myelography of the thoracic spine following myelogram	2004.00								410	20.370	1.0	R	1 366.20	
52400	MR of the thoracic spine, limited study	2004.00								410	46.600	1.0	R	3 125.50	
52410	MR of the thoracic spine	2004.00								410	64.340	1.0	R	4 315.30	
52420	MR of the thoracic spine pre and post contrast	2004.00								410	101.420	1.0	R	6 802.20	
52900	Nuclear Medicine study – Bone regional dorsal	2004.00		410	21.500	1.0	R	1 442.00							

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52910	Nuclear Medicine study – Bone tomography regional dorsal	2004.00		410	13.410	1.0	R 899.40							
52920	Nuclear Medicine study – with flow	2004.00		410	6.020	1.0	R 403.80							
	Lumbar													
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography).□ Code 53140 (tomography) may be combined with 53110 or 53120 (spine).□ Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added).□ Code 53300 (CT) limited study – limited to a single lumbar vertebral body.□ Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces.□ Code 53320 (CT) complete study - an extensive study of the lumbar spine.□ Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	2004.00												
53100	X-ray of the lumbar spine – stress study only	2004.00							410	4.140	1.0	R 277.70		
53110	X-ray of the lumbar spine, one or two views	2004.00							410	3.560	1.0	R 238.80		
53120	X-ray of the lumbar spine, more than two views	2004.00							410	4.460	1.0	R 299.10		
53130	X-ray of the lumbar spine, more that two views including stress views	2004.00							410	7.520	1.0	R 504.40		
53140	X-ray tomography lumbar spine	2004.00							410	4.300	1.0	R 288.40		
53160	X-ray myelography of the lumbar spine	2004.00							410	23.940	1.0	R 1 605.70		
53170	X-ray discography lumbar spine per level	2004.00							410	25.170	1.0	R 1 688.20		
53300	CT of the lumbar spine limited study	2004.00							410	9.500	1.0	R 637.20		
53310	CT of the lumbar spine – regional study	2004.00							410	13.910	1.0	R 932.90		
53320	Ct of the lumbar spine complete study	2004.00							410	37.640	1.0	R 2 524.50		
53330	CT of the lumbar spine pre and post contrast	2004.00							410	58.850	1.0	R 3 947.10		
53340	CT myelography of the lumbar spine	2004.00							410	49.110	1.0	R 3 293.80		
53350	CT myelography of the lumbar spine following myelogram	2004.00							410	23.460	1.0	R 1 573.50		
53400	MR of the lumbar spine, limited study	2004.00							410	46.200	1.0	R 3 098.60		
53410	MR of the lumbar spine	2004.00							410	64.320	1.0	R 4 313.90		

53420	MR of the lumbar spine pre and post contrast	2004.00							410	103.290	1.0	R	6 927.70	
53900	Nuclear medicine study – Bone regional lumbar	2004.00		410	21.500	1.0	R	1 442.00						
53910	Nuclear medicine study – Bone tomography regional lumbar	2004.00		410	13.410	1.0	R	899.40						
53920	Nuclear medicine study – with flow	2004.00		410	6.020	1.0	R	403.80						
	Sacrum													
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints).□ Code 54300 (CT) limited study - limited to single sacral vertebral body. □ Code 54310 (CT) complete study - an extensive study of the sacral spine.	2004.00												
54100	X-ray of the sacrum and coccyx	2004.00							410	3.580	1.0	R	240.10	
54110	X-ray of the sacro-iliac joints	2004.00							410	4.100	1.0	R	275.00	
54120	X-ray tomography – sacrum and/or coccyx	2004.00							410	4.300	1.0	R	288.40	
54300	CT of the sacrum – limited study	2004.00							410	7.600	1.0	R	509.70	
54310	CT of the sacrum – complete study – uncontrasted	2004.00							410	25.610	1.0	R	1 717.70	
54320	CT of the sacrum with contrast	2004.00							410	46.930	1.0	R	3 147.60	
54330	CT of the sacrum pre and post contrast	2004.00							410	52.970	1.0	R	3 552.70	
54400	MR of the sacrum	2004.00							410	65.000	1.0	R	4 359.60	
54410	MR of the sacrum pre and post contrast	2004.00							410	101.040	1.0	R	6 776.80	
	Pelvis													
	Codes 55110 (tomography) and 55100 (pelvis) may be combined.□ Code 55300 (CT) limited study – limited to a small region of interest of the pelvis eg. ascetabular roof or pubic ramus.	2004.00												
55100	X-ray of the pelvis	2004.00							410	3.660	1.0	R	245.50	
55110	X-ray tomography – pelvis	2004.00							410	4.300	1.0	R	288.40	
55300	CT of the bony pelvis limited	2004.00							410	9.500	1.0	R	637.20	
55310	CT of the bony pelvis complete uncontrasted	2004.00							410	25.610	1.0	R	1 717.70	
55320	CT of the bony pelvis complete 3D recon	2004.00							410	37.470	1.0	R	2 513.10	

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55330	CT of the bony pelvis with contrast	2004.00								410	46.930	1.0	R	3 147.60		
55340	CT of the bony pelvis – pre and post contrast	2004.00								410	52.970	1.0	R	3 552.70		
55400	MR of the bony pelvis	2004.00								410	65.000	1.0	R	4 359.60		
55410	MR of the bony pelvis pre and post contrast	2004.00								410	102.240	1.0	R	6 857.20		
55900	Nuclear medicine study – Bone regional pelvis	2004.00		410	21.500	1.0	R	1 442.00								
55910	Nuclear medicine study – Bone tomography regional pelvis	2004.00		410	13.410	1.0	R	899.40								
55920	Nuclear medicine study – with flow	2004.00		410	6.020	1.0	R	403.80								
	Hips															
	Code 56130 (tomography) may be combined with 56100 or 56110 or 56120 (hip).□ Code 56140 (stress) may be combined with 56100 or 56110 or 56120 (hip). □ Code 56150 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). □ Code 56160 (introduction of contrast into hip joint) to be used with 56310 (CT hip) and 56410 (MR hip) and includes fluoroscopy. The combination of 56150 and 56310 and 56410 is not supported except in exceptional circumstances with motivation. □ Code 56300 (CT) study limited to small region of interest eg part of femur head.	2004.00														
56100	X-ray of the left hip	2004.00								410	3.180	1.0	R	213.30		
56110	X-ray of the right hip	2004.00								410	3.180	1.0	R	213.30		
56120	X-ray pelvis and hips	2004.00								410	6.020	1.0	R	403.80		
56130	X-ray tomography – hip	2004.00								410	4.300	1.0	R	288.40		
56140	X-ray of the hip/s – stress study	2004.00								410	4.380	1.0	R	293.80		
56150	X-ray arthrography of the hip joint including introduction contrast	2004.00								410	15.750	1.0	R	1 056.40		
56160	X-ray guidance and introduction of contrast into hip joint only	2004.00								410	7.410	1.0	R	497.00		
56200	Ultrasound of the hip joints	2004.00								410	6.500	1.0	R	436.00		
56300	CT of hip – limited	2004.00								410	9.500	1.0	R	637.20		
56310	CT of hip – complete	2005.05								410	27.370	1.0	R	1 835.70		
56320	CT of hip – complete with 3D recon	2004.00								410	39.780	1.0	R	2 668.00		

56330	CT of hip with contrast	2004.00							410	43.260	1.0	R	2 901.40	
56340	CT of hip pre and post contrast	2004.00							410	47.880	1.0	R	3 211.30	
56400	MR of the hip joint/s, limited study	2004.00							410	44.900	1.0	R	3 011.40	
56410	MR of the hip joint/s	2004.00							410	64.100	1.0	R	4 299.20	
56420	MR of the hip joint/s, pre and post contrast	2004.00							410	101.640	1.0	R	6 817.00	
56900	Nuclear medicine study -- Bone regional pelvis	2004.00		410	21.500	1.0	R	1 442.00						
56910	Nuclear medicine study – Bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40						
56920	Nuclear medicine study – Bone tomography regional	2004.00		410	13.410	1.0	R	899.40						
	Upper limbs													
	General													
	Code 60100 (stress only) is a stand alone study and may not be combined with other codes.□ Code 60110 (tomography) may be combined with any one of the defined regional x-ray studies of the upper limb. Motivation may be required for more than one regional tomographic study per visit.□ Code 60200 (U/S) may only be used once per visit.□ Code 60300 (CT) limited study – limited to a small region of interest eg. part of humeral head. □ Code 60400 (MR limited) may only be used once per visit.	2004.00												
60100	X-ray upper limbs - any region - stress studies only	2004.00							410	4.520	1.0	R	303.20	
60110	X-ray upper limbs - any region – tomography	2004.00							410	4.300	1.0	R	288.40	
60200	Ultrasound upper limb – soft tissue - any region	2004.00							410	7.380	1.0	R	495.00	
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler	2004.00							410	13.640	1.0	R	914.80	
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler	2004.00							410	13.640	1.0	R	914.80	
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis	2004.00							410	12.540	1.0	R	841.10	
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler	2004.00							410	17.260	1.0	R	1 157.60	
60300	CT of the upper limbs limited study	2004.00							410	9.500	1.0	R	637.20	
60310	CT angiography of the upper limb	2004.00							410	78.280	1.0	R	5 250.20	
60400	MR of the upper limbs limited study, any region	2004.00							410	44.800	1.0	R	3 004.70	

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60410	MR angiography of the upper limb	2004.00							410	74.660	1.0	R	5 007.40	
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral	2004.00							410	45.670	1.0	R	3 063.10	
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral	2004.00							410	82.670	1.0	R	5 544.70	
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral	2004.00							410	56.750	1.0	R	3 806.20	
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral	2004.00							410	88.110	1.0	R	5 909.50	
60540	Venography, antegrade of upper limb veins, unilateral	2004.00							410	26.120	1.0	R	1 751.90	
60550	Venography, antegrade of upper limb veins, bilateral	2004.00							410	49.430	1.0	R	3 315.30	
60560	Venography, retrograde of upper limb veins, unilateral	2004.00							410	31.010	1.0	R	2 079.80	
60570	Venography, retrograde of upper limb veins, bilateral	2004.00							410	54.810	1.0	R	3 676.10	
60580	Venography, shuntogram, dialysis access shunt	2004.00							410	23.790	1.0	R	1 595.60	
60900	Nuclear medicine study – Venogram upper limb	2004.00		410	37.120	1.0	R	2 489.60						
	Shoulder													
	Code 61160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added).□ Code 61170 (introduction of contrast into the shoulder joint) may be combined with 61300 and 61305 (CT), or 61400 and 61405 (MR). The combination of 61160 (arthrography) and 61300 and 61305 (CT) or 61400 and 61405 (MR) is not supported except in exceptional circumstances with motivation.	2004.00												
61100	X-ray of the left clavicle	2004.00							410	3.040	1.0	R	203.90	
61105	X-ray of the right clavicle	2004.00							410	3.040	1.0	R	203.90	
61110	X-ray of the left scapula	2004.00							410	3.040	1.0	R	203.90	
61115	X-ray of the right scapula	2004.00							410	3.040	1.0	R	203.90	
61120	X-ray of the left acromio-clavicular joint	2004.00							410	3.140	1.0	R	210.60	
61125	X-ray of the right acromio-clavicular joint	2004.00							410	3.140	1.0	R	210.60	
61128	X-ray of acromio-clavicular joints plus stress studies bilateral	2004.00							410	7.680	1.0	R	515.10	
61130	X-ray of the left shoulder	2004.00							410	3.480	1.0	R	233.40	

61135	X-ray of the right shoulder	2004.0 0							410	3.480	1.0	R	233.40	
61140	X-ray of the left shoulder plus subacromial impingement views	2004.0 0							410	5.920	1.0	R	397.10	
61145	X-ray of the right shoulder plus subacromial impingement views	2004.0 0							410	5.920	1.0	R	397.10	
61150	X-ray of the left subacromial impingement views only	2004.0 0							410	3.240	1.0	R	217.30	
61155	X-ray of the right subacromial impingement views only	2004.0 0							410	3.240	1.0	R	217.30	
61160	X-ray arthrography shoulder joint including introduction of contrast	2004.0 0							410	15.830	1.0	R	1 061.70	
61170	X-ray guidance and introduction of contrast into shoulder joint only	2004.0 0							410	7.410	1.0	R	497.00	
61200	Ultrasound of the left shoulder joint	2004.0 0							410	6.500	1.0	R	436.00	
61210	Ultrasound of the right shoulder joint	2004.0 0							410	6.500	1.0	R	436.00	
61300	CT of the left shoulder joint – uncontrasted	2004.0 0							410	24.360	1.0	R	1 633.80	
61305	CT of the right shoulder joint – uncontrasted	2004.0 0							410	24.360	1.0	R	1 633.80	
61310	CT of the left shoulder – complete with 3D recon	2004.0 0							410	37.660	1.0	R	2 525.90	
61315	CT of the right shoulder – complete with 3D recon	2004.0 0							410	37.660	1.0	R	2 525.90	
61320	CT of the left shoulder joint - pre and post contrast	2004.0 0							410	48.630	1.0	R	3 261.60	
61325	CT of the right shoulder joint - pre and post contrast	2004.0 0							410	48.630	1.0	R	3 261.60	
61400	MR of the left shoulder	2004.0 0							410	64.640	1.0	R	4 335.40	
61405	MR of the right shoulder	2004.0 0							410	64.640	1.0	R	4 335.40	
61410	MR of the left shoulder pre and post contrast	2004.0 0							410	101.040	1.0	R	6 776.80	
61415	MR of the right shoulder pre and post contrast	2004.0 0							410	101.040	1.0	R	6 776.80	
	Humerus													
62100	X-ray of the left humerus	2004.0 0							410	2.940	1.0	R	197.20	
62105	X-ray of the right humerus	2004.0 0							410	2.940	1.0	R	197.20	
62300	CT of the left upper arm	2004.0 0							410	24.360	1.0	R	1 633.80	

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62305	CT of the right upper arm	2004.00							410	24.360	1.0	R	1 633.80		
62310	CT of the left upper arm contrasted	2004.00							410	39.970	1.0	R	2 680.80		
62315	CT of the right upper arm contrasted	2004.00							410	39.970	1.0	R	2 680.80		
62320	CT of the left upper arm pre and post contrast	2004.00							410	48.580	1.0	R	3 258.30		
62325	CT of the right upper arm pre and post contrast	2004.00							410	48.580	1.0	R	3 258.30		
62400	MR of the left upper arm	2004.00							410	64.200	1.0	R	4 305.90		
62405	MR of the right upper arm	2004.00							410	64.200	1.0	R	4 305.90		
62410	MR of the left upper arm pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
62415	MR of the right upper arm pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
62900	Nuclear medicine study – Bone limited/regional static	2004.00		410	21.500	1.0	R	1 442.00							
62905	Nuclear medicine study – Bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40							
62910	Nuclear medicine study – Bone tomography regional	2004.00		410	13.410	1.0	R	899.40							
	Elbow														
	Code 63120 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added).□ Code 63130 (introduction of contrast) may be combined with 63300 and 63305 (CT) or 63400 and 63405 (MR). The combination of 63120 (arthrography) and 63300 and 63305 or 63400 and 63405 (MR) is not supported except in exceptional circumstances with motivation.	2004.00													
63100	X-ray of the left elbow	2004.00							410	3.140	1.0	R	210.60		
63105	X-ray of the right elbow	2004.00							410	3.140	1.0	R	210.60		
63110	X-ray of the left elbow with stress	2004.00							410	4.340	1.0	R	291.10		
63115	X-ray of the right elbow with stress	2004.00							410	4.340	1.0	R	291.10		
63120	X-ray arthrography elbow joint including introduction of contrast	2004.00							410	15.890	1.0	R	1 065.70		
63130	X-ray guidance and introduction of contrast into elbow joint only	2004.00							410	7.410	1.0	R	497.00		
63200	Ultrasound of the left elbow joint	2004.00							410	6.500	1.0	R	436.00		

63205	Ultrasound of the right elbow joint	2004.00							410	6.500	1.0	R	436.00	
63300	CT of the left elbow	2004.00							410	24.360	1.0	R	1 633.80	
63305	CT of the right elbow	2004.00							410	24.360	1.0	R	1 633.80	
63310	CT of the left elbow – complete with 3D recon	2004.00							410	37.660	1.0	R	2 525.90	
63315	CT of the right elbow – complete with 3D recon	2004.00							410	37.660	1.0	R	2 525.90	
63320	CT of the left elbow contrasted	2004.00							410	39.970	1.0	R	2 680.80	
63325	CT of the right elbow contrasted	2004.00							410	39.970	1.0	R	2 680.80	
63330	CT of the left elbow pre and post contrast	2004.00							410	48.630	1.0	R	3 261.60	
63335	CT of the right elbow pre and post contrast	2004.00							410	48.630	1.0	R	3 261.60	
63400	MR of the left elbow	2004.00							410	64.640	1.0	R	4 335.40	
63405	MR of the right elbow	2004.00							410	64.640	1.0	R	4 335.40	
63410	MR of the left elbow pre and post contrast	2004.00							410	101.040	1.0	R	6 776.80	
63415	MR of the right elbow pre and post contrast	2004.00							410	101.040	1.0	R	6 776.80	
63905	Nuclear medicine study – Bone limited/regional static	2004.00		410	21.500	1.0	R	1 442.00						
63910	Nuclear medicine study – Bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40						
63915	Nuclear medicine study – Bone tomography regional	2004.00		410	13.410	1.0	R	899.40						
	Forearm													
64100	X-ray of the left forearm	2004.00							410	2.940	1.0	R	197.20	
64105	X-ray of the right forearm	2004.00							410	2.940	1.0	R	197.20	
64110	X-ray peripheral bone densitometry	2004.00							410	1.960	1.0	R	131.50	
64300	CT of the left forearm	2004.00							410	24.360	1.0	R	1 633.80	
64305	CT of the right forearm	2004.00							410	24.360	1.0	R	1 633.80	
64310	CT of the left forearm contrasted	2004.00							410	39.970	1.0	R	2 680.80	

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64315	CT of the right forearm contrasted	2004.0 0							410	39.970	1.0	R	2 680.80		
64320	CT of the left forearm pre and post contrast	2004.0 0							410	48.580	1.0	R	3 258.30		
64325	CT of the right forearm pre and post contrast	2004.0 0							410	48.580	1.0	R	3 258.30		
64400	MR of the left forearm	2004.0 0							410	64.200	1.0	R	4 305.90		
64405	MR of the right forearm	2004.0 0							410	64.200	1.0	R	4 305.90		
64410	MR of the left forearm pre and post contrast	2004.0 0							410	98.040	1.0	R	6 575.50		
64415	MR of the right forearm pre and post contrast	2004.0 0							410	98.040	1.0	R	6 575.50		
64900	Nuclear medicine study – Bone limited/regional static	2004.0 0		410	21.500	1.0	R	1 442.00							
64905	Nuclear medicine study – Bone limited static plus flow	2004.0 0		410	27.530	1.0	R	1 846.40							
64910	Nuclear medicine study – Bone tomography regional	2004.0 0		410	13.410	1.0	R	899.40							
	Hand and Wrist														
	Code 65120 (finger) may not be combined with 65100 or 65105 (hands).□ Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done.□ Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added). □ Code 65170 (contrast) may be combined with 65300 and 65305 (CT) or 65400 and 65405 (MR). The combination of 65160 (arthrography) and 65300 and 65305 or 65400 and 65405 is not supported except in exceptional circumstances with motivation.	2004.0 0													
65100	X-ray of the left hand	2004.0 0							410	3.080	1.0	R	206.60		
65105	X-ray of the right hand	2004.0 0							410	3.080	1.0	R	206.60		
65110	X-ray of the left hand – bone age	2004.0 0							410	3.080	1.0	R	206.60		
65120	X-ray of a finger	2004.0 0							410	2.670	1.0	R	179.10		
65130	X-ray of the left wrist	2004.0 0							410	3.180	1.0	R	213.30		
65135	X-ray of the right wrist	2004.0 0							410	3.180	1.0	R	213.30		
65140	X-ray of the left scaphoid	2004.0 0							410	3.300	1.0	R	221.30		
65145	X-ray of the right scaphoid	2004.0 0							410	3.300	1.0	R	221.30		

65150	X-ray of the left wrist, scaphoid and stress views	2004.0 0							410	7.560	1.0	R	507.00		
65155	X-ray of the right wrist, scaphoid and stress views	2004.0 0							410	7.560	1.0	R	507.00		
65160	X-ray arthrography wrist joint including introduction of contrast	2004.0 0							410	15.930	1.0	R	1 068.40		
65170	X-ray guidance and introduction of contrast into wrist joint only	2004.0 0							410	7.410	1.0	R	497.00		
65200	Ultrasound of the left wrist	2004.0 0							410	6.500	1.0	R	436.00		
65210	Ultrasound of the right wrist	2004.0 0							410	6.500	1.0	R	436.00		
65300	CT of the left wrist and hand	2004.0 0							410	24.360	1.0	R	1 633.80		
65305	CT of the right wrist and hand	2004.0 0							410	24.360	1.0	R	1 633.80		
65310	CT of the left wrist and hand - complete with 3D recon	2004.0 0							410	37.660	1.0	R	2 525.90		
65315	CT of the right wrist and hand - complete with 3D recon	2004.0 0							410	37.660	1.0	R	2 525.90		
65320	CT of the left wrist and hand contrasted	2004.0 0							410	39.970	1.0	R	2 680.80		
65325	CT of the right wrist and hand contrasted	2004.0 0							410	39.970	1.0	R	2 680.80		
65330	CT of the left wrist and hand pre and post contrast	2004.0 0							410	48.630	1.0	R	3 261.60		
65335	CT of the right wrist and hand pre and post contrast	2004.0 0							410	48.630	1.0	R	3 261.60		
65400	MR of the left wrist and hand	2004.0 0							410	64.640	1.0	R	4 335.40		
65405	MR of the right wrist and hand	2004.0 0							410	64.640	1.0	R	4 335.40		
65410	MR of the left wrist and hand pre and post contrast	2004.0 0							410	101.040	1.0	R	6 776.80		
65415	MR of the right wrist and hand pre and post contrast	2004.0 0							410	101.040	1.0	R	6 776.80		
65900	Nuclear Medicine study – bone limited/regional static	2004.0 0		410	21.500	1.0	R	1 442.00							
65905	Nuclear Medicine study – bone limited static plus flow	2004.0 0		410	27.530	1.0	R	1 846.40							
65910	Nuclear Medicine study – bone tomography regional	2004.0 0		410	13.410	1.0	R	899.40							
	Soft Tissue														
69900	Nuclear medicine study – Tumour localisation planar, static	2004.0 0		410	20.740	1.0	R	1 391.00							

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69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies	2004.00		410	35.170	1.0	R	2 358.90							
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT	2004.00		410	34.150	1.0	R	2 290.40							
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	2004.00		410	47.560	1.0	R	3 189.80							
69920	Nuclear medicine study – Infection localisation planar, static	2004.00		410	18.040	1.0	R	1 209.90							
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies	2004.00		410	31.450	1.0	R	2 109.40							
69930	Nuclear medicine study – Infection localisation planar, static and SPECT	2004.00		410	31.450	1.0	R	2 109.40							
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	2004.00		410	44.860	1.0	R	3 008.80							
69940	Nuclear medicine study – Regional lymph node mapping dynamic	2004.00		410	6.020	1.0	R	403.60							
69945	Nuclear medicine study – Regional lymph node mapping, static, planar	2004.00		410	24.100	1.0	R	1 616.40							
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	2004.00		410	37.510	1.0	R	2 515.80							
69955	Nuclear medicine study – Regional lymph node mapping SPECT	2004.00		410	13.410	1.0	R	899.40							
69960	Nuclear medicine study – Lymph node localisation with gamma probe	2004.00		410	13.410	1.0	R	899.40							
	Lower Limbs														
	General														
	Code 70100 (stress) is a stand alone study and may not be combined with other codes.□ Code 70110 (tomography) may be combined with any one of the defined regional x-ray studies of the lower limb. Motivation may be required for more than one regional tomographic study per visit.□ Code 70200 (U/S) may only be billed once per visit.□ Code 70300 ((CT) limited study – limited to a small region of interest eg part of condyle of the knee.□ Codes 70310 and 70320 (CT angiography) may not be combined. □ Code 70400 (MR limited) may only be used once per visit.□ Code 70410 and 70420 (MR angiography) may not be combined.	2004.00													
70100	X-ray lower limbs - any region- stress studies only	2004.00							410	4.520	1.0	R	303.20		
70110	X-ray lower limbs - any region-tomography	2004.00							410	4.300	1.0	R	288.40		
70120	X-ray of the lower limbs full length study	2004.00							410	6.460	1.0	R	433.30		
70200	Ultrasound lower limb – soft tissue - any region	2004.00							410	7.380	1.0	R	495.00		

70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler	2004.00							410	13.640	1.0	R	914.80		
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler	2004.00							410	13.640	1.0	R	914.80		
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis	2004.00							410	13.640	1.0	R	914.80		
70240	Ultrasound peripheral venous system lower limbs including pulse and colour doppler in erect and supine position including all compression and reflux manoeuvres, deep and superficial systems bilaterally	2004.00							410	19.660	1.0	R	1 318.60		
70300	CT of the lower limbs limited study	2004.00							410	9.500	1.0	R	637.20		
70310	CT angiography of the lower limb	2004.00							410	79.430	1.0	R	5 327.40		
70320	CT angiography abdominal aorta and outflow lower limbs	2004.00							410	98.340	1.0	R	6 595.70		
70400	MR of the lower limbs limited study	2004.00							410	46.400	1.0	R	3 112.00		
70410	MR angiography of the lower limb	2004.00							410	76.660	1.0	R	5 141.60		
70420	MR angiography of the abdominal aorta and lower limbs	2004.00							410	118.860	1.0	R	7 971.90		
70500	Angiography of pelvic and lower limb arteries unilateral	2004.00							410	40.590	1.0	R	2 722.40		
70505	Angiography of pelvic and lower limb arteries bilateral	2004.00							410	75.920	1.0	R	5 092.00		
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral	2004.00							410	61.230	1.0	R	4 106.70		
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral	2004.00							410	85.660	1.0	R	5 745.20		
70520	Angiography translumbar aorta with full peripheral study	2004.00							410	45.680	1.0	R	3 063.80		
70530	Venography, antegrade of lower limb veins, unilateral	2004.00							410	25.460	1.0	R	1 707.60		
70535	Venography, antegrade of lower limb veins, bilateral	2004.00							410	49.430	1.0	R	3 315.30		
70540	Venography, retrograde of lower limb veins, unilateral	2004.00							410	31.170	1.0	R	2 090.60		
70545	Venography, retrograde of lower limb veins, bilateral	2004.00							410	56.790	1.0	R	3 808.90		
70560	Lymphangiography, lower limb, unilateral	2004.00							410	51.040	1.0	R	3 423.30		
70565	Lymphangiography, lower limb, bilateral	2004.00							410	83.970	1.0	R	5 631.90		
70900	Nuclear medicine study – Venogram lower limb	2004.00		410	37.120	1.0	R	2 489.60							

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	Femur														
71100	X-ray of the left femur	2004.00							410	2.940	1.0	R	197.20		
71105	X-ray of the right femur	2004.00							410	2.940	1.0	R	197.20		
71300	CT of the left femur	2004.00							410	24.520	1.0	R	1 644.60		
71305	CT of the right femur	2004.00							410	24.520	1.0	R	1 644.60		
71310	CT of the left upper leg contrasted	2004.00							410	41.830	1.0	R	2 805.50		
71315	CT of the right upper leg contrasted	2004.00							410	41.830	1.0	R	2 805.50		
71320	CT of the left upper leg pre and post contrast	2004.00							410	49.710	1.0	R	3 334.00		
71325	CT of the right upper leg pre and post contrast	2004.00							410	49.710	1.0	R	3 334.00		
71400	MR of the left upper leg	2004.00							410	64.800	1.0	R	4 346.10		
71405	MR of the right upper leg	2004.00							410	64.800	1.0	R	4 346.10		
71410	MR of the left upper leg pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
71415	MR of the right upper leg pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
71900	Nuclear Medicine study -- bone limited/regional static	2004.00		410	21.500	1.0	R	1 442.00							
71905	Nuclear Medicine study – Bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40							
71910	Nuclear Medicine study – Bone tomography regional	2004.00		410	13.410	1.0	R	899.40							
	Knee														
	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views)□ Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). □ Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.	2004.00													
72100	X-ray of the left knee one or two views	2004.00							410	2.770	1.0	R	185.80		
72105	X-ray of the right knee one or two views	2004.00							410	2.770	1.0	R	185.80		
72110	X-ray of the left knee, more than two views	2004.00							410	3.320	1.0	R	222.70		

72115	X-ray of the right knee, more than two views	2004.00							410	3.320	1.0	R	222.70	
72120	X-ray of the left knee including patella	2004.00							410	4.620	1.0	R	309.90	
72125	X-ray of the right knee including patella	2004.00							410	4.620	1.0	R	309.90	
72130	X-ray of the left knee with stress views	2004.00							410	5.820	1.0	R	390.30	
72135	X-ray of the right knee with stress views	2004.00							410	5.820	1.0	R	390.30	
72140	X-ray of left patella	2004.00							410	2.770	1.0	R	185.80	
72145	X-ray of right patella	2004.00							410	2.770	1.0	R	185.80	
72150	X-ray both knees standing – single view	2004.00							410	2.800	1.0	R	187.80	
72160	X-ray arthrography knee joint including introduction of contrast	2004.00							410	15.810	1.0	R	1 060.40	
72170	X-ray guidance and introduction of contrast into knee joint only	2004.00							410	7.410	1.0	R	497.00	
72200	Ultrasound of the left knee joint	2004.00							410	6.500	1.0	R	436.00	
72205	Ultrasound of the right knee joint	2004.00							410	6.500	1.0	R	436.00	
72300	CT of the left knee	2004.00							410	24.520	1.0	R	1 644.60	
72305	CT of the right knee	2004.00							410	24.520	1.0	R	1 644.60	
72310	CT of the left knee complete study with 3D reconstructions	2004.00							410	35.930	1.0	R	2 409.80	
72315	CT of the right knee complete study with 3D reconstructions	2004.00							410	35.930	1.0	R	2 409.80	
72320	CT of the left knee contrasted	2004.00							410	41.830	1.0	R	2 805.50	
72325	CT of the right knee contrasted	2004.00							410	41.830	1.0	R	2 805.50	
72330	CT of the left knee pre and post contrast	2004.00							410	49.760	1.0	R	3 337.40	
72335	CT of the right knee pre and post contrast	2004.00							410	49.760	1.0	R	3 337.40	
72400	MR of the left knee	2004.00							410	64.100	1.0	R	4 299.20	
72405	MR of the right knee	2004.00							410	64.100	1.0	R	4 299.20	

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72410	MR of the left knee pre and post contrast	2004.00							410	100.840	1.0	R	6 763.30		
72415	MR of the right knee pre and post contrast	2004.00							410	100.840	1.0	R	6 763.30		
72900	Nuclear Medicine study – Bone limited/regional static	2004.00		410	21.500	1.0	R	1 442.00							
72905	Nuclear Medicine study – Bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40							
72910	Nuclear Medicine study – Bone tomography regional	2004.00		410	13.410	1.0	R	899.40							
	Lower Leg														
73100	X-ray of the left lower leg	2004.00							410	2.940	1.0	R	197.20		
73105	X-ray of the right lower leg	2004.00							410	2.940	1.0	R	197.20		
73300	CT of the left lower leg	2004.00							410	24.520	1.0	R	1 644.60		
73305	CT of the right lower leg	2004.00							410	24.520	1.0	R	1 644.60		
73310	CT of the left lower leg contrasted	2004.00							410	41.830	1.0	R	2 805.50		
73315	CT of the right lower leg contrasted	2004.00							410	41.830	1.0	R	2 805.50		
73320	CT of the left lower leg pre and post contrast	2004.00							410	49.710	1.0	R	3 334.00		
73325	CT of the right lower leg pre and post contrast	2004.00							410	49.710	1.0	R	3 334.00		
73400	MR of the left lower leg	2004.00							410	64.200	1.0	R	4 305.90		
73405	MR of the right lower leg	2004.00							410	64.200	1.0	R	4 305.90		
73410	MR of the left lower leg pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
73415	MR of the right lower leg pre and post contrast	2004.00							410	102.040	1.0	R	6 843.80		
73900	Nuclear Medicine study – bone limited/regional static	2004.00		410	21.500	1.0	R	1 442.00							
73905	Nuclear Medicine study – bone limited static plus flow	2004.00		410	27.530	1.0	R	1 846.40							
73910	Nuclear Medicine study – bone tomography regional	2004.00		410	13.410	1.0	R	899.40							
	Ankle and Foot														

	Code 74145 (toe) may not be combined with 74120 or 74125 (foot).□ Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. □ Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. □ Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added).□ Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and 74405 (MR) are not supported except in exceptional circumstances with motivation.	2004.00													
74100	X-ray of the left ankle	2004.00							410	3.320	1.0	R	222.70		
74105	X-ray of the right ankle	2004.00							410	3.320	1.0	R	222.70		
74110	X-ray of the left ankle with stress views	2004.00							410	4.520	1.0	R	303.20		
74115	X-ray of the right ankle with stress views	2004.00							410	4.520	1.0	R	303.20		
74120	X-ray of the left foot	2004.00							410	2.800	1.0	R	187.80		
74125	X-ray of the right foot	2004.00							410	2.800	1.0	R	187.80		
74130	X-ray of the left calcaneus	2004.00							410	2.740	1.0	R	183.80		
74135	X-ray of the right calcaneus	2004.00							410	2.740	1.0	R	183.80		
74140	X-ray of both feet -- standing -- single view	2004.00							410	2.800	1.0	R	187.80		
74145	X-ray of a toe	2004.00							410	2.670	1.0	R	179.10		
74150	X-ray of the sesamoid bones one or both sides	2004.00							410	2.800	1.0	R	187.80		
74160	X-ray arthrography ankle joint including introduction of contrast	2004.00							410	15.910	1.0	R	1 067.10		
74170	X-ray guidance and introduction of contrast into ankle joint	2004.00							410	7.410	1.0	R	497.00		
74210	Ultrasound of the left ankle	2004.00							410	6.500	1.0	R	436.00		
74215	Ultrasound of the right ankle	2004.00							410	6.500	1.0	R	436.00		
74220	Ultrasound of the left foot	2004.00							410	6.500	1.0	R	436.00		
74225	Ultrasound of the right foot	2004.00							410	6.500	1.0	R	436.00		
74290	Ultrasound bone densitometry	2004.00							410	2.040	1.0	R	136.80		

74300	CT of the left ankle/foot	2004.0 0								410	24.520	1.0	R	1 644.60		
74305	CT of the right ankle/foot	2004.0 0								410	24.520	1.0	R	1 644.60		
74310	CT of the left ankle/foot – complete with 3D recon	2004.0 0								410	37.810	1.0	R	2 535.90		
74315	CT of the right ankle/foot – complete with 3D recon	2004.0 0								410	37.810	1.0	R	2 535.90		
74320	CT of the left ankle/foot contrasted	2004.0 0								410	41.830	1.0	R	2 805.50		
74325	CT of the right ankle/foot contrasted	2004.0 0								410	41.830	1.0	R	2 805.50		
74330	CT of the left ankle/foot pre and post contrast	2004.0 0								410	49.710	1.0	R	3 334.00		
74335	CT of the right ankle/foot pre and post contrast	2004.0 0								410	49.710	1.0	R	3 334.00		
74400	MR of the left ankle	2004.0 0								410	64.100	1.0	R	4 299.20		
74405	MR of the right ankle	2004.0 0								410	64.100	1.0	R	4 299.20		
74410	MR of the left ankle pre and post contrast	2004.0 0								410	100.640	1.0	R	6 749.90		
74415	MR of the right ankle pre and post contrast	2004.0 0								410	100.640	1.0	R	6 749.90		
74420	MR of the left foot	2004.0 0								410	64.200	1.0	R	4 305.90		
74425	MR of the right foot	2004.0 0								410	64.200	1.0	R	4 305.90		
74430	MR of the left foot pre and post contrast	2004.0 0								410	102.040	1.0	R	6 843.80		
74435	MR of the right foot pre and post contrast	2004.0 0								410	102.040	1.0	R	6 843.80		
74900	Nuclear Medicine study – Bone limited/regional static	2004.0 0		410	21.500	1.0	R	1 442.00								
74905	Nuclear Medicine study – Bone limited static plus flow	2004.0 0		410	27.530	1.0	R	1 846.40								
74910	Nuclear Medicine study – Bone tomography regional	2004.0 0		410	13.410	1.0	R	899.40								
	Soft Tissue															
79900	Nuclear Medicine study – Tumour localisation planar, static	2004.0 0		410	20.740	1.0	R	1 391.00								
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	2004.0 0		410	35.170	1.0	R	2 358.90								
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	2004.0 0		410	34.150	1.0	R	2 290.40								

79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	2004.00		410	47.560	1.0	R	3 189.80							
79920	Nuclear Medicine study – Infection localisation planar, static	2004.00		410	18.430	1.0	R	1 236.10							
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	2004.00		410	31.840	1.0	R	2 135.50							
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	2004.00		410	31.840	1.0	R	2 135.50							
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	2004.00		410	45.250	1.0	R	3 034.90							
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	2004.00		410	6.020	1.0	R	403.80							
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	2004.00		410	24.100	1.0	R	1 616.40							
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	2004.00		410	37.510	1.0	R	2 515.80							
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	2004.00		410	13.410	1.0	R	899.40							
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	2004.00		410	13.410	1.0	R	899.40							
	Intervention														
	General														
	Codes 80600, 80605, 80610, 80620, 80630, 81660, 81680, 82600, 84660, 85640, 85645, 86610, 86615, 86620, 86630, (aspiration / biopsy / ablations etc) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be combined with these codes.□ If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00510, 00520, 00530, 00540, 00550, 00560), it may not be billed for separately. □ Codes 80640, 80645, 87682, 87683 include fluoroscopy. Machine fees may not be added. □ All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.	2005.03													
80600	Percutaneous abscess, cyst drainage, any region	2004.00							410	9.370	1.0	R	628.40		
80605	Fine needle aspiration biopsy, any region	2004.00							410	4.220	1.0	R	283.00		
80610	Cutting needle, trochar biopsy, any region	2004.00							410	6.360	1.0	R	426.60		
80620	Tumour/cyst ablation chemical	2004.00							410	25.370	1.0	R	1 701.60		
80630	Tumour ablation radio frequency, per lesion	2005.03							410	21.210	1.0	R	1 422.60		
80640	Insertion of CVP line in radiology suite	2004.00							410	8.990	1.0	R	603.00		

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80645	Peripheral central venous line insertion	2005.03							410	12.120	1.0	R 812.90	Z
80650	Infiltration of a peripheral joint, any region	2005.03							410	6.400	1.0	R 429.20	Z
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.	2005.03											
	Neuro intervention												
81600	Intracranial aneurysm occlusion, direct	2004.00							410	214.520	1.0	R 14 387.90	
81605	Intracranial arteriovenous shunt occlusion	2004.00							410	254.820	1.0	R 17 090.80	
81610	Dural sinus arteriovenous shunt occlusion	2004.00							410	264.330	1.0	R 17 728.60	
81615	Extracranial arteriovenous shunt occlusion	2004.00							410	157.280	1.0	R 10 548.80	
81620	Extracranial arterial embolisation (head and neck)	2004.00							410	163.120	1.0	R 10 940.50	
81625	Caroticocavernous fistula occlusion	2004.00							410	192.290	1.0	R 12 896.90	
81630	Intracranial angioplasty for stenosis, vasospasm	2004.00							410	126.920	1.0	R 8 512.50	
81632	Intracranial stent placement (including PTA)	2005.03							410	133.720	1.0	R 8 968.60	Z
81635	Temporary balloon occlusion test	2004.00							410	83.420	1.0	R 5 595.00	
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.	2005.03											
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)	2004.00							410	178.180	1.0	R 11 950.50	
81645	Intracranial aneurysm occlusion with balloon remodelling	2004.00							410	216.350	1.0	R 14 510.60	
81650	Intracranial aneurysm occlusion with stent assistance	2004.00							410	230.450	1.0	R 15 456.30	
81655	Intracranial thrombolysis, catheter directed	2004.00							410	58.940	1.0	R 3 953.10	
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650	2005.03											
81660	Nerve block, head and neck, per level	2005.03							410	7.660	1.0	R 513.80	
81665	Neurolysis, head and neck, per level	2005.03							410	20.140	1.0	R 1 350.80	
81670	Nerve block, head and neck, radio frequency, per level	2005.03							410	19.040	1.0	R 1 277.00	

81680	Nerve block, coeliac plexus or other regions, per level	2005.03							410	9.280	1.0	R	622.40		
	Thorax														
82600	Chest drain insertion	2004.00							410	8.820	1.0	R	591.60		
82605	Trachial, bronchial stent insertion	2004.00							410	30.360	1.0	R	2 036.20		
	Gastrointestinal														
83600	Oesophageal stent insertion	2004.00							410	31.220	1.0	R	2 093.90		
83605	GIT balloon dilation	2004.00							410	24.360	1.0	R	1 633.80		
83610	GIT stent insertion (non-oesophageal)	2004.00							410	32.020	1.0	R	2 147.60		
83615	Percutaneous gastrostomy, jejunostomy	2004.00							410	25.360	1.0	R	1 700.90		
	Hepatobiliary														
84600	Percutaneous biliary drainage, external	2004.00							410	33.980	1.0	R	2 279.00		
84605	Percutaneous external/internal biliary drainage	2004.00							410	37.210	1.0	R	2 495.70		
84610	Permanent biliary stent insertion	2004.00							410	51.220	1.0	R	3 435.30		
84615	Drainage tube replacement	2004.00							410	20.220	1.0	R	1 356.20		
84620	Percutaneous bile duct stone or foreign object removal	2004.00							410	49.980	1.0	R	3 352.20		
84625	Percutaneous gall bladder drainage	2004.00							410	29.580	1.0	R	1 983.90		
84630	Percutaneous gallstone removal, including drainage	2004.00							410	69.250	1.0	R	4 644.60		
84635	Transjugular liver biopsy	2004.00							410	24.930	1.0	R	1 672.10		
84640	Transjugular intrahepatic Portosystemic shunt	2004.00							410	119.470	1.0	R	8 012.90		
84645	Transhepatic Portogram including venous sampling, pressure studies	2004.00							410	81.890	1.0	R	5 492.40		
84650	Transhepatic Portogram with embolisation of varices	2004.00							410	100.810	1.0	R	6 761.30		
84655	Percutaneous hepatic tumour ablation	2004.00							410	15.680	1.0	R	1 051.70		
84660	Percutaneous hepatic abscess, cyst drainage	2004.00							410	13.200	1.0	R	885.30		
84665	Hepatic chemoembolisation	2004.00							410	59.440	1.0	R	3 986.60		

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84670	Hepatic arterial infusion catheter placement	2004.0 0							410	60.300	1.0	R	4 044.30	
	Urogenital													
85600	Percutaneous nephrostomy, external drainage	2004.0 0							410	29.970	1.0	R	2 010.10	
85605	Percutaneous double J stent insertion including access	2004.0 0							410	40.820	1.0	R	2 737.80	
85610	Percutaneous renal stone, foreign body removal including access	2004.0 0							410	66.790	1.0	R	4 479.60	
85615	Percutaneous nephrostomy tract establishment	2004.0 0							410	29.270	1.0	R	1 963.10	
85620	Change of nephrostomy tube	2004.0 0							410	15.900	1.0	R	1 066.40	
85625	Percutaneous cystostomy	2004.0 0							410	16.520	1.0	R	1 108.00	
85630	Urethral balloon dilatation	2004.0 0							410	14.240	1.0	R	955.10	
85635	Urethral stent insertion	2004.0 0							410	31.220	1.0	R	2 093.90	
85640	Renal cyst ablation	2004.0 0							410	11.920	1.0	R	799.50	
85645	Renal abscess, cyst drainage	2004.0 0							410	15.160	1.0	R	1 016.80	
85655	Fallopian tube recanalisation	2004.0 0							410	45.060	1.0	R	3 022.20	
	Spinal													
86600	Spinal vascular malformation embolisation	2004.0 0							410	275.160	1.0	R	18 455.00	
86605	Vertebroplasty per level	2004.0 0							410	22.300	1.0	R	1 495.70	
86610	Facet joint block per level, uni- or bilateral	2005.0 3							410	9.540	1.0	R	639.80	
	Code 86610 may only be billed once per level, and not per left and right side per level	2004.0 0												
86615	Spinal nerve block per level, uni- or bilateral	2005.0 3							410	8.160	1.0	R	547.30	
86620	Epidural block	2004.0 0							410	9.420	1.0	R	631.80	
86625	Chemonucleolysis, including discogram	2004.0 0							410	18.320	1.0	R	1 228.70	
86630	Spinal nerve ablation per level	2004.0 0							410	11.600	1.0	R	778.00	
	Vascular													

	Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedure, 87650 (thrombolysis). □ If a balloon angioplasty and / or stent placement is performed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multiple balloon dilatations or stent placements at one defined site will only attract one procedure code.	2004.00													
87600	Percutaneous transluminal angioplasty: aorta, IVC	2004.00							410	56.560	1.0	R	3 793.50		
87601	Percutaneous transluminal angioplasty: iliac	2004.00							410	55.760	1.0	R	3 739.80		
87602	Percutaneous transluminal angioplasty: femoropopliteal	2004.00							410	60.160	1.0	R	4 034.90		
87603	Percutaneous transluminal angioplasty: subpopliteal	2004.00							410	73.340	1.0	R	4 918.90		
87604	Percutaneous transluminal angioplasty: brachiocephalic	2004.00							410	67.120	1.0	R	4 501.70		
87605	Percutaneous transluminal angioplasty: subclavian, axillary	2004.00							410	60.160	1.0	R	4 034.90		
87606	Percutaneous transluminal angioplasty: extracranial carotid	2004.00							410	71.620	1.0	R	4 803.60		
87607	Percutaneous transluminal angioplasty: extracranial vertebral	2004.00							410	73.300	1.0	R	4 916.20		
87608	Percutaneous transluminal angioplasty: renal	2004.00							410	87.690	1.0	R	5 881.40		
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	2004.00							410	87.690	1.0	R	5 881.40		
87620	Aorta stent-graft placement	2004.00							410	120.750	1.0	R	8 098.70		
87621	Stent insertion (including PTA): aorta, IVC	2004.00							410	73.870	1.0	R	4 954.50		
87622	Stent insertion (including PTA): iliac	2004.00							410	76.370	1.0	R	5 122.10		
87623	Stent insertion (including PTA): femoropopliteal	2004.00							410	77.970	1.0	R	5 229.40		
87624	Stent insertion (including PTA): subpopliteal	2004.00							410	84.550	1.0	R	5 670.80		
87625	Stent insertion (including PTA): brachiocephalic	2004.00							410	98.470	1.0	R	6 604.40		
87626	Stent insertion (including PTA): subclavian, axillary	2004.00							410	86.690	1.0	R	5 814.30		
87627	Stent insertion (including PTA): extracranial carotid	2004.00							410	106.990	1.0	R	7 175.80		
87628	Stent insertion (including PTA): extracranial vertebral	2004.00							410	100.550	1.0	R	6 743.90		
87629	Stent insertion (including PTA): renal	2004.00							410	98.590	1.0	R	6 612.40		

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87630	Stent insertion (including PTA): coeliac, mesenteric	2004.00							410	98.590	1.0	R	6 612.40		
87631	Stent-graft placement: iliac	2004.00							410	76.370	1.0	R	5 122.10		
87632	Stent-graft placement: femoropopliteal	2004.00							410	77.970	1.0	R	5 229.40		
87633	Stent-graft placement: brachiocephalic	2004.00							410	98.470	1.0	R	6 604.40		
87634	Stent-graft placement: subclavian, axillary	2004.00							410	82.770	1.0	R	5 551.40		
87635	Stent-graft placement: extracranial carotid	2004.00							410	120.430	1.0	R	8 077.20		
87636	Stent-graft placement: extracranial vertebral	2004.00							410	114.730	1.0	R	7 694.90		
87637	Stent-graft placement: renal	2004.00							410	98.590	1.0	R	6 612.40		
87638	Stent-graft placement: coeliac, mesenteric	2004.00							410	98.590	1.0	R	6 612.40		
87650	Thrombolysis in angiography suite, per 24 hours	2004.00							410	45.820	1.0	R	3 073.10		
	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional codes 10520, 20500, 20510, 20520, 20530, 20540,32500,32530,44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87638.	2005.03													
87651	Aspiration, rheolytic thrombectomy	2004.00							410	77.670	1.0	R	5 209.30		
87652	Atherectomy, per vessel	2004.00							410	91.890	1.0	R	6 163.10		
87653	Percutaneous tunnelled / subcutaneous arterial or venous central or other line insertion	2005.03							410	28.150	1.0	R	1 888.00		
87654	Thrombolysis follow-up	2004.00							410	23.570	1.0	R	1 580.80		
87655	Percutaneous sclerotherapy, vascular malformation	2004.00							410	21.100	1.0	R	1 415.20		
87660	Embolisation, mesenteric	2004.00							410	100.430	1.0	R	6 735.80		
87661	Embolisation, renal	2004.00							410	99.360	1.0	R	6 664.10		
87662	Embolisation, bronchial, intercostal	2004.00							410	108.340	1.0	R	7 266.40		
87663	Embolisation, pulmonary arteriovenous shunt	2004.00							410	103.220	1.0	R	6 923.00		
87664	Embolisation, abdominal, other vessels	2004.00							410	101.440	1.0	R	6 803.60		

87665	Embolisation, thoracic, other vessels	2004.00							410	97.600	1.0	R	6 546.00		
87666	Embolisation, upper limb	2004.00							410	90.920	1.0	R	6 098.00		
87667	Embolisation, lower limb	2004.00							410	92.140	1.0	R	6 179.80		
87668	Embolisation, pelvis, non-uterine	2004.00							410	117.120	1.0	R	7 855.20		
87669	Embolisation, uterus	2004.00							410	113.880	1.0	R	7 637.90		
87670	Embolisation, spermatic, ovaria veins	2004.00							410	85.820	1.0	R	5 755.90		
87680	Inferior vena cava filter placement	2004.00							410	61.840	1.0	R	4 147.60		
87681	Intravascular foreign body removal	2004.00							410	85.030	1.0	R	5 703.00		
87682	Revision of access port (tunnelled or implantable)	2005.03							410	14.120	1.0	R	947.00	Z	
87683	Removal of access port (tunnelled or implantable)	2005.04							410	11.120	1.0	R	745.80	Z	
87690	Superior petrosal venous sampling	2004.00							410	73.010	1.0	R	4 896.80		
87691	Pancreatic stimulation test	2004.00							410	89.790	1.0	R	6 022.20		
87692	Transportal venous sampling	2004.00							410	76.950	1.0	R	5 161.00		
87693	Adrenal venous sampling	2004.00							410	55.010	1.0	R	3 689.50		
87694	Parathyroid venous sampling	2004.00							410	86.660	1.0	R	5 812.30		
87695	Renal venous sampling	2004.00							410	55.010	1.0	R	3 689.50		
	ANNEXURE A														

Radiology 2008

	Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL□ For use in conjuction with codes:□ □ 00190 X-ray examination contrast material□ 00290 Ultrasound examination contrast material□ 00390 CT examination contrast material□ 00490 MR examination contrast material□ 00590 Angiography and interventional examination contrast material□ □ Note to Funders:□ The following contrast items may be grouped into various categories e.g. Ionic, non-Ionic, and several items may be appropriate for use within a category. Funders may either reimburse as per identified item or may choose to apply a reference price within a category. For detail of methodology refer to Annexure B.	2004.00												
	ANNEXURE B													
	Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL	2004.00												
	Contrast Index Price Range - 2004 contrast prices	2004.00												
	ANNEXURE C													
	Recommended Isotope and Kit Prices for Nuclear Medicine for 2004 by the Association of Nuclear Medicine Physicians□ For use in conjuction with codes:□ □ 00990 Nuclear Medicine Isotope□ 00991 Nuclear Medicine Substrate□ □ <<Insert object table here>>	2004.00												

Radiology 2008

Code	Description
12500	Nuclear Medicine
13600	Radiology

Radiology 2008

Code	Description	RCF
410	Radiology	67.070

REGISTERED NURSES IN PRIVATE PRACTICE & NURSING AGENCIES

Registered Nurses In Private Practice and Nursing Agencies 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

A	GENERAL INFORMATION

The "RegN" column (Practice Type 48800) of this schedule is a reference price list for registered nurses and midwives only (not enrolled nurses) in private practice, and may only be charged by the registered nurse performing the procedure, and whose practice number is reflected on the account.

The "NAgen" column (Practice Type 48000) of this schedule is a reference price list for registered accredited nursing agencies and accredited home health care organizations only (not nurses in private practice), i.e. if employed at a nursing agency or home health care organization the private nurse practitioner may not submit claims on his / her practice number.

A registered nurse or midwife is a nurse or midwife registered with the South African Nursing Council in terms of the Nursing Act 50 of 1978 (as amended).

1. Agency refers to:

a) An accredited business registered / licensed with the S A Nursing Council carrying out the business of providing Registered and supervised Enrolled Nursing services, as well as surgicals and equipment.

b) The agency should also be registered with a representative professional governing body.

2. Home health care organisations refers to:

a) An accredited business that provides registered and supervised Enrolled Nursing services, as well as surgicals and equipment for home care.

b) The accredited home care organisation should also be registered with a representative professional governing body.

All accounts must be presented with the following information clearly stated:
i. Name of nurse practitioner, agency or home health care organization (whichever is applicable);
ii. Pre-authorisation code, when applicable
iii. Qualifications of the nurse practitioner
iv. BHF practice number
v. Section 22A permit number (if applicable)
vi. Postal address and telephone number
vii. Dates on which services were provided
viii. The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.
ix. Surname and initials of the member
x. First name of the patient
xi. Name of the scheme
xii. Membership number of the member
xiii. Where the account is a photocopy of the original, certification by way or rubber-stamp and signature of the nurse, or in the case of "80" practice numbers, the appropriate representative agent
xiv. A statement of whether the account is in accordance with the National Health Reference Price List
xv. Where the after care is taken over by the nurse practitioner, a letter of referral from the doctor with the diagnosis and treatment should be attached.

B	GENERAL RULES	
01	CONSULTATION, COUNSELING, PLANNING AND/OR ASSESSMENT: Consultation, counseling and / or assessment (codes 001 and 002 below) encompasses consultation, history taking, patient examination and assessment, observation, treatment planning, after care treatment planning, discharge planning and/or counseling. If a consultation and one or more procedures are performed in the visit, both a consultation code and the relevant procedure code(s) may be charged but the time spent on the procedure shall not be included in the consultation period for purposes of determining the consultation fee. A consultation may not be charged where the sole purpose of the visit was to perform a procedure.	04.00
02	EMERGENCY VISITS Bona-fide, justifiable emergency nursing services rendered to a patient, at any time, may attract an additional fee as specified in item 014. These specifically relate to home visits for procedures which become necessary outside those which have been pre-arranged, such as but not exclusively, blocked urinary catheters, IV therapy which tissues or wound(s) which are draining excessively and require additional dressing. These should be accompanied by a written motivation. NOTE THAT THIS FEE IS ONLY APPLICABLE TO REGISTERED NURSES IN PRIVATE PRACTICE, AND NOT TO NURSING AGENCIES.	04.00

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
021	SUNDAYS AND PUBLIC HOLIDAYS When codes 036, 037 or 038 are charged for services rendered on a Sunday, the fee in respect of these codes shall be inflated by 50%. Modifier 0007 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. When codes 036, 037 or 038 are charged for services rendered on a public holiday, the fee in respect of these codes shall be inflated by 100%. Modifier 0001 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. NOTE THAT THIS FEE IS ONLY APPLICABLE TO NURSING AGENCIES AND NOT TO REGISTERED NURSES IN PRIVATE PRACTICE.				05.03		
03	PROCEDURES If a composite fee or general hourly rate is charged, no additional fee for procedures may be charged. The fee in respect of more than one procedure performed at the same time shall be the fee in respect of the major procedure plus 50% of the fee of each subsidiary or additional procedure. Modifier 0002 to be quoted.				04.00		
04	FEES The rate that may be charged in respect of rendering a service not listed in this benefit schedule shall be based on the rate in respect of a comparable service. Modifier 0003 to be quoted with the description of service rendered and the applicable item number used.				04.00		
05	COST OF MEDICINES AND MATERIALS The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Item 301 is to be quoted except for stomal products where item 205 is to be quoted.				04.00		
051	MEDICINES Scheduled medicines may not be supplied by an institution. Intramascular/Intravenous injection and OPAT may only be administered by a registered nurse.				05.03		
06	EQUIPMENT (HIRE AND SALES) Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied. To be billed in terms of item 302. Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. By prior arrangement with the medical scheme. For equipment that is sold to a member, the net acquisition cost of the equipment may be charged (item 303). This should be on a separate invoice attached to the account as the cost of these items are refunded to the member and not paid to the supplier.				04.00		
07	MIDWIFERY The global fee is to be charged where the midwife and any assistants attend to the entire four stages of delivery. Item 399 or 403 to be quoted. No additional service fee may be levied, but pharmaceuticals may be charged under item 301. Where intravenous infusions (including blood or blood cellular products) are administered as part of the after treatment after confinement, no extra fees will be charged as this is included in the global maternity fees. Should the attending midwife prefer to ask a medical practitioner to perform intravenous infusion, then the midwife (and not the patient) is responsible for remunerating such practitioner for the infusions. When a registered midwife treats a patient in the antenatal period and after starting the confinement requests a doctor to take over the case, the registered midwife shall calculate the fee for work done up to the handover of the case. Should a midwife be required to hand over the case to a medical practitioner due to complications during a home delivery and she is required to assist, item 410 may be used. Where the confinement has not started and the midwife requests a doctor to take over the case, the fee for the visits during early labour shall be charged as item 406. This may not be combined with item 400. Antenatal/postnatal exercise or education classes are generally not covered by the schemes and payment is the responsibility of the member.				05.03		
08	TRAVEL FEE Please note that generally schemes do not accept the responsibility for transport expenses, as they are deemed to be included in the fee.				04.00		
09	WELL BABY CLINICS Where vaccines are issued free by the state, no charge may be levied for the product. Vaccines may only be purchased, stored and dispensed by nurses with a Section 22A (15) permit. Emergency equipment must be available in the clinic.				05.06		
10	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.				04.00		
MODIFIERS							
0001	Public holidays, add 100%. Nursing agencies only.				05.03		
0002	Only 50% of the fee in respect of subsidiary/additional procedures may be charged.				04.00		
0003	The fee that may be charged in respect of the rendering of a service not listed in this recommended benefit schedule, shall be based on the fee in respect of a fee for a comparable service. Motivation must be attached.				04.00		
0007	Sundays add 50%. Nursing agencies only.				05.03		

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
ITEMS							
CONSULTATIONS (the Pathology/Diagnosis must be stated)							
Code	**Description**	**Ver**	**Add**	**Nursing Agencies/Home Care Services**		**Registered Nurses**	
				RVU	**Fee**	**RVU**	**Fee**
001	Individual consultation, counseling, planning and/or assessment. 30 - 45 minutes.	06.03		10.300	77.50 (68.00)	37.500	175.40 (153.90)
002	Individual consultation, counseling, planning and/or assessment. 46+ minutes.	06.03		14.200	106.90 (93.80)	52.500	245.50 (215.40)
014	For emergency consultation/visit, all hours - See General Rule 2.	04.00				7.700	58.00 (50.90)
SPECIMENS.							
020	This must form part of a consultation when a consultation is charged. Where a consultation was not performed and the nurse visited or attended to the patient with the sole purpose of obtaining a specimen, and dispatching to a laboratory or using own machine to test – please state specimen type and, where applicable, machine and test performed.	04.00		4.600	34.60 (30.40)	4.600	34.60 (30.40)
OBSERVATIONS. (Temperature, Pulse Respiration and B.P.)							
025	Where a consultation was not performed and the nurse attended to the patient with the sole purpose of doing an observation.	04.00		4.600	34.60 (30.40)	4.600	34.60 (30.40)
ADMINISTRATION OF MEDICATION.							
030	Where a consultation was not performed and the nurse attended to or visited the patient with the sole purpose of administering intramuscular or intravenous medication. The route of administration of medication to be stated, as well as the name of the medication. Oral, rectal, vaginal medication excluded as well as the application of topical medicine.	04.00		4.600	34.60 (30.40)	4.600	34.60 (30.40)
452	Immunisation	04.00				3.000	22.60 (19.80)
OPAT (Antibiotics, Chemotherapy, Blood Products and Dehydration)							
035	All inclusive global fee for the setting up of an IV line and administration of intravenous therapy by a registered nurse.	05.02		24.300	183.00 (160.50)	24.300	183.00 (160.50)
036	When a SRN returns to add medication to an existing IV infusion	05.02		12.200	91.90 (80.60)	12.200	91.90 (80.60)
COMPOSITE FEES							
	Note : These fees may only be charged by members of an accredited home healthcare organisation for services rendered at patient's home. (Care givers are not included in the fee). This includes all post hospitalisation/nursing care during a 24 hour period or part thereof. Motivation by a medical practitioner required. Single procedures/visits are not to be charged as a composite fee.						05.03
032	Low intensity care (Presenting problem(s) that are of low severity. The patient is stable, recovering or improving).	05.02		42.700	321.50 (282.00)		
033	Medium intensity care (Presenting problem(s) that are of moderate severity. The patient is responding inadequately to therapy or has developed a minor complication).	05.02		61.700	464.50 (407.50)		
034	High intensity care (this item presenting problem(s) that are of high complexity. The patient is unstable or has developed a significant new problem). By arrangement with scheme.	05.02		-	-		
	The above fees includes : all nursing intervention in a 24 hour period; all visits of a supervisory nature; non-recoverable items e.g. disinfectants, soaps, towellets, hibitane, aprons, fractions of strapping etc.; all travelling costs; all administrative costs; delivery/courier costs where these are necessary but excludes : any drugs and surgicals required; equipment sale or hire; auxiliary services by paraprofessionals, e.g. OT's and physiotherapists.	05.03					
	Note : Item 035 should not represent more than 4% of all claims received.						05.03
RECOMMENDED HOURLY RATES FOR REGISTERED NURSING AGENCIES							
039	Enrolled nursing assistant, per hour	05.02		3.700	27.90 (24.50)		
037	Enrolled nurse, per hour	05.03		5.100	38.40 (33.70)		
038	Registered nurse, per hour	05.03		6.460	48.60 (42.60)		

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
	1. The fee for 24 hour daily care may not exceed R 420.00 per day (or R 630.00 on a Sunday or R 840.00 on a public holiday) and no other procedure may be charged. 2. In the case of litigation, the registered nurse will be co-responsible for the practice of the enrolled nurse. 3. All services to be re-negotiated with the scheme every 7 days or such lesser period as stipulated in pre-authorisation.	05.03					
CARE OF WOUNDS (The pathology must be stated).							
040	Treatment of simple wounds/burns requiring dressing only.	04.00		8.800	66.30 (58.20)	8.800	66.30 (58.20)
041	Treatment of extensive wounds/burns requiring extensive nursing management eg irrigation, etc.	04.00		12.400	93.40 (81.90)	12.400	93.40 (81.90)
042	Treatment of moderate wounds/Burns eg drains or fistulas and inserting of sutures	04.00		11.000	82.80 (72.60)	11.000	82.80 (72.60)
045	Laser treatment for wound healing where prescribed by medical practitioner	04.00		7.670	57.70 (50.60)	7.670	57.70 (50.60)
RESPIRATORY SYSTEM.							
050	Nebulization/Inhalation.	04.00		3.800	28.60 (25.10)	3.800	28.60 (25.10)
051	Tracheostomy care.	04.00		7.900	59.50 (52.20)	7.900	59.50 (52.20)
052	Peak flow measurement.	04.00		3.100	23.30 (20.40)	3.100	23.30 (20.40)
	For ICU trained nurses registered with SANC as such and nurses working in the occupational health setting but not for a company. (Item 053)	04.00					
053	Flow volume test: inspiration/expiration using ELF/similar machine.	04.00				13.100	98.60 (86.50)
CARDIO-VASCULAR SYSTEM.							
	Only for ICU trained nurses registered as such with SANC. A medical practitioner must be available in the event of a resuscitation being required. (Items 062 and 063).	04.00					
060	Cardiopulmonary resuscitation.	04.00				23.000	173.20 (151.90)
061	Performing ECG only.	04.00				4.600	34.60 (30.40)
062	Effort test - bicycle.	04.00				16.900	127.20 (111.60)
063	Effort test - multistage treadmill.	04.00				38.400	289.10 (253.60)
MUSCULOSKELETAL SYSTEM.							
070	Application or removal splints and prosthesis.	04.00		3.900	29.40 (25.80)	3.900	29.40 (25.80)
071	Application or removal of traction	04.00		7.700	58.00 (50.90)	7.700	58.00 (50.90)
072	Application of skin traction	04.00		7.700	58.00 (50.90)	7.700	58.00 (50.90)
GASTRO INTESTINAL SYSTEM.							
080	Nasogastric tube insertion, feeding and removal.	04.00		9.200	69.30 (60.80)	9.200	69.30 (60.80)
082	Enema administration	04.00		4.800	36.10 (31.70)	4.800	36.10 (31.70)
083	Aspiration of stomach/gastric lavage.	04.00				6.900	52.00 (45.60)
084	Faecal impaction/manual removal.	04.00		8.700	65.50 (57.50)	8.700	65.50 (57.50)
URINARY SYSTEM.							
090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying.	04.00		9.500	71.50 (62.70)	9.500	71.50 (62.70)
091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal.	04.00		5.800	43.70 (38.30)	5.800	43.70 (38.30)
093	Incontinence management (30 minutes) This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and teaching.	04.00		9.500	71.50 (62.70)	9.500	71.50 (62.70)
GENERAL CARE.							
100	This includes all aspects of elementary nursing care performed at a patient's home which may include : Bath/ bedbath, getting patient out of bed, making of bed, hairwash, mouth hygiene, nail care, shave, put patient back to bed, pressure area care, per visit. (irrespective of time spent)	04.00		16.100	121.20 (106.30)	16.100	121.20 (106.30)

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
STOMALTHERAPY NURSING.							
	Applicable to stomal therapy trained registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.						05.02
	Please Note: Items 200, 201, 202, 204, 205, 079 and 081 may not be used in conjunction with items 230, 234, 238 and 250						04.00
079	Stomal irrigation - 60 minutes. May not be used in conjunction with the global fees.	04.00		4.800	36.10 (31.70)	4.800	36.10 (31.70)
	Colonic lavage - may be performed by all nurse practitioners but only when prescribed by a medical practitioner, and the written prescription is attached.	04.00					
081	Colonic lavage	04.00		4.800	36.10 (31.70)	4.800	36.10 (31.70)
200	Simple stoma - a well constructed, sited stoma which is easy to pouch. Very little or no peristomal skin excoriation.	04.00		8.800	66.30 (58.20)	8.800	66.30 (58.20)
201	Complex stoma - a poorly constructed, non-sited stoma requiring convexity or build up. Difficult to pouch. Severe peristomal skin excoriation.	04.00		12.400	93.40 (81.90)	12.400	93.40 (81.90)
202	Moderate stoma - a fairly well constructed, sited stoma which may require straight forward convexity or build up. Mild to moderate peristomal skin excoriation.	04.00		11.000	82.80 (72.60)	11.000	82.80 (72.60)
205	Stoma products charged in accordance with rule 05.	04.00		-	-	-	-
230	Global fee - Simple Stoma - Permanent: Includes the following: 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		124.900	940.40 (824.90)	124.900	940.40 (824.90)
234	Global fee - Moderate Stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		137.200	1033.00 (906.10)	137.200	1033.00 (906.10)
238	Global fee: Complex stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	04.00		159.900	1203.90 (1056.10)	159.900	1203.90 (1056.10)
250	Clinic visits after 6 months per half hour plus one procedure - eg irrigation, enema, etc. - plus material	04.00		10.000	75.30 (66.10)	10.000	75.30 (66.10)
EQUIPMENT							
	Applicable only to registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.						05.02
302	Equipment hire per day, charged according to rule 06.	04.00					
303	Equipment sold to a member should be net acquisition cost. This should be on a separate invoice attached to the account as the cost of these items are refunded to the member, and not paid to the supplier.	05.03		-	-	-	-
MIDWIFERY							
Global Obstetric Fees							
	This is charged where the midwife managed the entire four stages of delivery.						04.00
399	Global midwife delivery fee in hospital / birthing unit. Includes all care from the time of admission of the patient in labour until discharge from hospital.	04.00				210.900	1587.90 (1392.90)
403	Global obstetric fee – home birth. (to be charged if the entire confinement is completed at home). Includes all care from commencement of labour until 1 hour after delivery.	04.00				275.500	2074.20 (1819.50)
407	Global fee for childbirth education. By arrangement with scheme/patient.	04.00				-	-
Where the global fee is not applicable, the following will apply:							
400	First Stage Monitoring	04.00				73.800	555.60 (487.40)

Code	Description	Ver	Add	Nursing Agencies/Home Care Services		Registered Nurses	
				RVU	Fee	RVU	Fee
401	Second and Third stage labour. Vaginal delivery including episiotomy/tear and repair and general obstetric care.	04.00				90.200	679.10 (595.70)
402	Fourth Stage.	04.00				12.300	92.60 (81.20)
405	Phototherapy, per day	04.00				15.400	115.90 (101.70)
406	Visit to patient during first stage labour (may not be charged in conjunction with item 400)	04.00				10.000	75.30 (66.10)
410	Assisting at delivery (if a medical practitioner is requested to take over delivery due to complications during a home delivery)	04.00				27.600	207.80 (182.30)
420	Ante natal visits (excluding ante-natal exercises), per visit	04.00				7.700	58.00 (50.90)
421	Post natal visits (excluding post- natal exercises), per visit	04.00				11.500	86.60 (76.00)
425	Ante-natal or post-natal exercise classes, per patient	06.03				6.200	46.70 (41.00)
For advanced midwives registered with SANC only:							
404	Cardiotocography	04.00				10.000	75.30 (66.10)
WELL BABY CLINICS							
	Emergency equipment must be available in the baby clinic						04.00
450	Consultation	04.00				4.800	36.10 (31.70)
454	Supply of Vaccine (only for nurses with Section 22A (15) Permit)	05.06				-	-
PSYCHIATRIC NURSING THERAPY							
	Psychiatric Nursing Therapy may only be performed by a nurse with a psychiatric nursing qualification registered as such with the SANC						05.02
500	Individual interview/assessment. Adult, child, school, employer - per hour.	04.00				21.600	162.60 (142.60)
501	Individual therapy. (irrespective of time)	04.00				30.700	231.10 (202.70)
502	Family/marital/group per patient - specify number.	04.00				6.200	46.70 (41.00)
503	Play therapy/Home stimulation programme.	04.00				16.900	127.20 (111.60)
504	Co-therapist.	04.00				16.900	127.20 (111.60)
RENAL DIALYSIS							
092	Peritoneal dialysis per day	04.00		16.900	127.20 (111.60)	16.900	127.20 (111.60)
608	Home dialysis training in centre per 30 minutes	04.00		16.000	120.50 (105.70)	16.000	120.50 (105.70)
610	Home dialysis training or follow up at patient's home per 30 minutes (to maximum of 24 hours)	04.00		28.200	212.30 (186.20)	28.200	212.30 (186.20)
612	Home dialysis 1. Preparation of extra corporeal equipment 2. Preparation of needling patient's fistula and attaching patients to Haemodialysis machine or using subclavian catheter/permanent catheter/femerol catheter 3. Observation of patient whilst on dialysis 4. Monitoring Haemodialysis machine readings 5. Doing necessary nursing procedures to patient as required e.g. catheter site/wounds/mouth care, nursing care in general/helping to feed/prepare light meal/tea etc for patient whilst on dialysis 6. Termination of procedures e.g. giving blood back to patient and disposable of extra corporeal lines etc 7. Port dialysis observation of patient 8. Cleaning and sterilisation of dialysis machine and Reverse Osmosis machine	04.00		64.000	481.90 (422.70)	64.000	481.90 (422.70)
MEDICINES AND MATERIALS							
301	Consumables used, and charged according to rule 05	05.03		-	-	-	-

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				48000					48800				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES, EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00											
A	GENERAL INFORMATION												
	The "RegN" column (Practice Type 48800) of this schedule is a reference price list for registered nurses and midwives only (not enrolled nurses) in private practice, and may only be charged by the registered nurse performing the procedure, and whose practice number is reflected on the account. □ □ The "NAgen" column (Practice Type 48000) of this schedule is a reference price list for registered accredited nursing agencies and accredited home health care organizations only (not nurses in private practice), i.e. if employed at a nursing agency or home health care organization the private nurse practitioner may not submit claims on his / her practice number.□ □ A registered nurse or midwife is a nurse or midwife registered with the South African Nursing Council in terms of the Nursing Act 50 of 1978 (as amended).□ □ 1. Agency refers to:□ □ a) An accredited business registered / licensed with the S A Nursing Council carrying out the business of providing Registered and supervised Enrolled Nursing services, as well as surgicals and equipment.□	2004.00											
B	GENERAL RULES												

01	CONSULTATION, COUNSELING, PLANNING AND/OR ASSESSMENT: Consultation, counseling and / or assessment (codes 001 and 002 below) encompasses consultation, history taking, patient examination and assessment, observation, treatment planning, after care treatment planning, discharge planning and/or counseling. If a consultation and one or more procedures are performed in the visit, both a consultation code and the relevant procedure code(s) may be charged but the time spent on the procedure shall not be included in the consultation period for purposes of determining the consultation fee. A consultation may not be charged where the sole purpose of the visit was to perform a procedure.	2004.00											
02	EMERGENCY VISITS Bona-fide, justifiable emergency nursing services rendered to a patient, at any time, may attract an additional fee as specified in item 014. These specifically relate to home visits for procedures which become necessary outside those which have been pre-arranged, such as but not exclusively, blocked urinary catheters, IV therapy which tissues or wound(s) which are draining excessively and require additional dressing. These should be accompanied by a written motivation. NOTE THAT THIS FEE IS ONLY APPLICABLE TO REGISTERED NURSES IN PRIVATE PRACTICE, AND NOT TO NURSING AGENCIES.	2004.00											
021	SUNDAYS AND PUBLIC HOLIDAYS When codes 036, 037 or 038 are charged for services rendered on a Sunday, the fee in respect of these codes shall be inflated by 50%. Modifier 0007 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. When codes 036, 037 or 038 are charged for services rendered on a public holiday, the fee in respect of these codes shall be inflated by 100%. Modifier 0001 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. NOTE THAT THIS FEE IS ONLY APPLICABLE TO NURSING AGENCIES AND NOT TO REGISTERED NURSES IN PRIVATE PRACTICE.	2005.03											
03	PROCEDURES If a composite fee or general hourly rate is charged, no additional fee for procedures may be charged. The fee in respect of more than one procedure performed at the same time shall be the fee in respect of the major procedure plus 50% of the fee of each subsidiary or additional procedure. Modifier 0002 to be quoted.	2004.00											

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04	FEES The rate that may be charged in respect of rendering a service not listed in this benefit schedule shall be based on the rate in respect of a comparable service. Modifier 0003 to be quoted with the description of service rendered and the applicable item number used.	2004.00											
05	COST OF MEDICINES AND MATERIALS The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Item 301 is to be quoted except for stomal products where item 205 is to be quoted.	2004.00											
051	MEDICINES Scheduled medicines may not be supplied by an institution. Intramascular/intravenous injection and OPAT may only be administered by a registered nurse.	2005.03											
06	EQUIPMENT (HIRE AND SALES) Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied. To be billed in terms of item 302. Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. By prior arrangement with the medical scheme. For equipment that is sold to a member, the net acquisition cost of the equipment may be charged (item 303). This should be on a separate invoice attached to the account as the cost of these items are refunded to the member and not paid to the supplier.	2004.00											

07	MIDWIFERY The global fee is to be charged where the midwife and any assistants attend to the entire four stages of delivery. Item 399 or 403 to be quoted. No additional service fee may be levied, but pharmaceuticals may be charged under item 301. Where intravenous infusions (including blood or blood cellular products) are administered as part of the after treatment after confinement, no extra fees will be charged as this is included in the global maternity fees. Should the attending midwife prefer to ask a medical practitioner to perform intravenous infusion, then the midwife (and not the patient) is responsible for remunerating such practitioner for the infusions. When a registered midwife treats a patient in the antenatal period and after starting the confinement requests a doctor to take over the case, the registered midwife shall calculate the fee for work done up to the handover of the case. Should a midwife be required to hand over the case to a medical practitioner due to complications during a home delivery and she is required to assist, item 410 may be used.	2005.03												
08	TRAVEL FEE Please note that generally schemes do not accept the responsibility for transport expenses, as they are deemed to be included in the fee.	2004.00												
09	WELL BABY CLINICS Where vaccines are issued free by the state, no charge may be levied for the product. Vaccines may only be purchased, stored and dispensed by nurses with a Section 22A (15) permit. Emergency equipment must be available in the clinic.	2005.06												
10	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00												
	MODIFIERS													
0001	Public holidays, add 100%. Nursing agencies only.	2005.03												
0002	Only 50% of the fee in respect of subsidiary/additional procedures may be charged.	2004.00												
0003	The fee that may be charged in respect of the rendering of a service not listed in this recommended benefit schedule, shall be based on the fee in respect of a fee for a comparable service. Motivation must be attached.	2004.00												
0007	Sundays add 50%. Nursing agencies only.	2005.03												
	ITEMS													
	CONSULTATIONS (the Pathology/Diagnosis must be stated)													
001	Individual consultation, counseling, planning and/or assessment. 30 - 45 minutes.	2006.03		360	10.300	1.0	R	77.50		241	37.500	1.0	R	175.40
002	Individual consultation, counseling, planning and/or assessment. 46+ minutes.	2006.03		360	14.200	1.0	R	106.90		241	52.500	1.0	R	245.50
014	For emergency consultation/visit, all hours - See General Rule 2.	2004.00								240	7.700	1.0	R	58.00
	SPECIMENS.													

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020	This must form part of a consultation when a consultation is charged. Where a consultation was not performed and the nurse visited or attended to the patient with the sole purpose of obtaining a specimen, and dispatching to a laboratory or using own machine to test – please state specimen type and, where applicable, machine and test performed.	2004.00		360	4.600	1.0	R	34.60		240	4.600	1.0	R	34.60	
	OBSERVATIONS. (Temperature, Pulse Respiration and B.P.)														
025	Where a consultation was not performed and the nurse attended to the patient with the sole purpose of doing an observation.	2004.00		360	4.600	1.0	R	34.60		240	4.600	1.0	R	34.60	
	ADMINISTRATION OF MEDICATION.														
030	Where a consultation was not performed and the nurse attended to or visited the patient with the sole purpose of administering intramuscular or intravenous medication. The route of administration of medication to be stated, as well as the name of the medication. Oral, rectal, vaginal medication excluded as well as the application of topical medicine.	2004.00		360	4.600	1.0	R	34.60		240	4.600	1.0	R	34.60	
452	Immunisation	2004.00								240	3.000	1.0	R	22.60	
	OPAT (Antibiotics, Chemotherapy, Blood Products and Dehydration)														
035	All inclusive global fee for the setting up of an IV line and administration of intravenous therapy by a registered nurse.	2005.02		360	24.300	1.0	R	183.00		240	24.300	1.0	R	183.00	
036	When a SRN returns to add medication to an existing IV infusion	2005.02		360	12.200	1.0	R	91.90		240	12.200	1.0	R	91.90	
	COMPOSITE FEES														
	Note : These fees may only be charged by members of an accredited home healthcare organisation for services rendered at patient's home. (Care givers are not included in the fee).□ □ This includes all post hospitalisation/nursing care during a 24 hour period or part thereof. Motivation by a medical practitioner required. Single procedures/visits are not to be charged as a composite fee.	2005.03													
032	Low intensity care (Presenting problem(s) that are of low severity. The patient is stable, recovering or improving).	2005.02		360	42.700	1.0	R	321.50							
033	Medium intensity care (Presenting problem(s) that are of moderate severity. The patient is responding inadequately to therapy or has developed a minor complication).	2005.02		360	61.700	1.0	R	464.50							
034	High intensity care (this item presenting problem(s) that are of high complexity. The patient is unstable or has developed a significant new problem). By arrangement with scheme.	2005.02		360	-	0.0	R	-							
	The above fees includes : all nursing intervention in a 24 hour period; all visits of a supervisory nature; non-recoverable items e.g. disinfectants, soaps, towellets, hibitane, aprons, fractions of strapping etc.; all travelling costs; all administrative costs; delivery/courier costs where these are necessary□ but excludes : any drugs and surgicals required; equipment sale or hire; auxiliary services by paraprofessionals, e.g. OT's and physiotherapists.	2005.03													
	Note : Item 035 should not represent more than 4% of all claims received.	2005.03													
	RECOMMENDED HOURLY RATES FOR REGISTERED NURSING AGENCIES														
039	Enrolled nursing assistant, per hour	2005.02		360	3.700	1.0	R	27.90							

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037	Enrolled nurse, per hour	2005.03		360	5.100	1.0	R	38.40								
038	Registered nurse, per hour	2005.03		360	6.460	1.0	R	48.60								
	1. The fee for 24 hour daily care may not exceed R 420.00 per day (or R 630.00 on a Sunday or R 840.00 on a public holiday) and no other procedure may be charged.□ □ 2. In the case of litigation, the registered nurse will be co-responsible for the practice of the enrolled nurse.□ □ 3. All services to be re-negotiated with the scheme every 7 days or such lesser period as stipulated in pre-authorisation.	2005.03														
	CARE OF WOUNDS (The pathology must be stated).															
040	Treatment of simple wounds/burns requiring dressing only.	2004.00		360	8.800	1.0	R	66.30		240	8.800	1.0	R	66.30		
041	Treatment of extensive wounds/burns requiring extensive nursing management eg irrigation, etc.	2004.00		360	12.400	1.0	R	93.40		240	12.400	1.0	R	93.40		
042	Treatment of moderate wounds/Burns eg drains or fistulas and inserting of sutures	2004.00		360	11.000	1.0	R	82.80		240	11.000	1.0	R	82.80		
045	Laser treatment for wound healing where prescribed by medical practitioner	2004.00		360	7.670	1.0	R	57.70		240	7.670	1.0	R	57.70		
	RESPIRATORY SYSTEM.															
050	Nebulization/Inhalation.	2004.00		360	3.800	1.0	R	28.60		240	3.800	1.0	R	28.60		
051	Tracheostomy care.	2004.00		360	7.900	1.0	R	59.50		240	7.900	1.0	R	59.50		
052	Peak flow measurement.	2004.00		360	3.100	1.0	R	23.30		240	3.100	1.0	R	23.30		
	For ICU trained nurses registered with SANC as such and nurses working in the occupational health setting but not for a company. (Item 053)	2004.00														
053	Flow volume test: inspiration/expiration using ELF/similar machine.	2004.00								240	13.100	1.0	R	98.60		
	CARDIO-VASCULAR SYSTEM.															
	Only for ICU trained nurses registered as such with SANC. A medical practitioner must be available in the event of a resuscitation being required. (Items 062 and 063).	2004.00														
060	Cardiopulmonary resuscitation.	2004.00								240	23.000	1.0	R	173.20		
061	Performing ECG only.	2004.00								240	4.600	1.0	R	34.60		
062	Effort test - bicycle.	2004.00								240	16.900	1.0	R	127.20		
063	Effort test - multistage treadmill.	2004.00								240	38.400	1.0	R	289.10		
	MUSCULOSKELETAL SYSTEM.															

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070	Application or removal splints and prosthesis.	2004.00		360	3.900	1.0	R	29.40		240	3.900	1.0	R	29.40		
071	Application or removal of traction	2004.00		360	7.700	1.0	R	58.00		240	7.700	1.0	R	58.00		
072	Application of skin traction	2004.00		360	7.700	1.0	R	58.00		240	7.700	1.0	R	58.00		
	GASTRO INTESTINAL SYSTEM.															
080	Nasogastric tube insertion, feeding and removal.	2004.00		360	9.200	1.0	R	69.30		240	9.200	1.0	R	69.30		
082	Enema administration	2004.00		360	4.800	1.0	R	36.10		240	4.800	1.0	R	36.10		
083	Aspiration of stomach/gastric lavage.	2004.00								240	6.900	1.0	R	52.00		
084	Faecal impaction/manual removal.	2004.00		360	8.700	1.0	R	65.50		240	8.700	1.0	R	65.50		
	URINARY SYSTEM.															
090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying.	2004.00		360	9.500	1.0	R	71.50		240	9.500	1.0	R	71.50		
091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal.	2004.00		360	5.800	1.0	R	43.70		240	5.800	1.0	R	43.70		
093	Incontinence management (30 minutes) This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and teaching.	2004.00		360	9.500	1.0	R	71.50		240	9.500	1.0	R	71.50		
	GENERAL CARE.															
100	This includes all aspects of elementary nursing care performed at a patient's home which may include : Bath/ bedbath, getting patient out of bed, making of bed, hairwash, mouth hygiene, nail care, shave, put patient back to bed, pressure area care, per visit. (irrespective of time spent)	2004.00		360	16.100	1.0	R	121.20		240	16.100	1.0	R	121.20		
	STOMALTHERAPY NURSING.															
	Applicable to stomal therapy trained registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.	2005.02														
	Please Note: Items 200, 201, 202, 204, 205, 079 and 081 may not be used in conjunction with items 230, 234, 238 and 250	2004.00														
079	Stomal irrigation - 60 minutes. May not be used in conjunction with the global fees.	2004.00		360	4.800	1.0	R	36.10		240	4.800	1.0	R	36.10		
	Colonic lavage - may be performed by all nurse practitioners but only when prescribed by a medical practitioner, and the written prescription is attached.	2004.00														
081	Colonic lavage	2004.00		360	4.800	1.0	R	36.10		240	4.800	1.0	R	36.10		
200	Simple stoma - a well constructed, sited stoma which is easy to pouch. Very little or no peristomal skin excoriation.	2004.00		360	8.800	1.0	R	66.30		240	8.800	1.0	R	66.30		
201	Complex stoma - a poorly constructed, non-sited stoma requiring convexity or build up. Difficult to pouch. Severe peristomal skin excoriation.	2004.00		360	12.400	1.0	R	93.40		240	12.400	1.0	R	93.40		
202	Moderate stoma - a fairly well constructed, sited stoma which may require straight forward convexity or build up. Mild to moderate peristomal skin excoriation.	2004.00		360	11.000	1.0	R	82.80		240	11.000	1.0	R	82.80		

205	Stoma products charged in accordance with rule 05.	2004.00		360	-	0.0	R	-		240	-	0.0	R	-	
230	Global fee - Simple Stoma - Permanent: Includes the following: 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	2004.00		360	124.900	1.0	R	940.40		240	124.900	1.0	R	940.40	
234	Global fee - Moderate Stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	2004.00		360	137.200	1.0	R	1 033.00		240	137.200	1.0	R	1 033.00	
238	Global fee: Complex stoma - Permanent (Includes the following): 1 X Pre-op consultation: includes history, stomal siting, counselling 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)	2004.00		360	159.900	1.0	R	1 203.90		240	159.900	1.0	R	1 203.90	
250	Clinic visits after 6 months per half hour plus one procedure - eg irrigation, enema, etc. - plus material	2004.00		360	10.000	1.0	R	75.30		240	10.000	1.0	R	75.30	
	EQUIPMENT														
	Applicable only to registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.	2005.02													
302	Equipment hire per day, charged according to rule 06.	2004.00													
303	Equipment sold to a member should be net acquisition cost. This should be on a separate invoice attached to the account as the cost of these items are refunded to the member, and not paid to the supplier.	2005.03		360	-	0.0	R	-		240	-	0.0	R	-	
	MIDWIFERY														
	Global Obstetric Fees														
	This is charged where the midwife managed the entire four stages of delivery.	2004.00													
399	Global midwife delivery fee in hospital / birthing unit. Includes all care from the time of admission of the patient in labour until discharge from hospital.	2004.00								240	210.900	1.0	R	1 587.90	
403	Global obstetric fee – home birth. (to be charged if the entire confinement is completed at home). Includes all care from commencement of labour until 1 hour after delivery.	2004.00								240	275.500	1.0	R	2 074.20	

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407	Global fee for childbirth education. By arrangement with scheme/patient.	2004.00							240	-	0.0	R	-	
	Where the global fee is not applicable, the following will apply:													
400	First Stage Monitoring	2004.00							240	73.800	1.0	R	555.60	
401	Second and Third stage labour. Vaginal delivery including episiotomy/tear and repair and general obstetric care.	2004.00							240	90.200	1.0	R	679.10	
402	Fourth Stage.	2004.00							240	12.300	1.0	R	92.60	
405	Phototherapy, per day	2004.00							240	15.400	1.0	R	115.90	
406	Visit to patient during first stage labour (may not be charged in conjunction with item 400)	2004.00							240	10.000	1.0	R	75.30	
410	Assisting at delivery (if a medical practitioner is requested to take over delivery due to complications during a home delivery)	2004.00							240	27.600	1.0	R	207.80	
420	Ante natal visits (excluding ante-natal exercises), per visit	2004.00							240	7.700	1.0	R	58.00	
421	Post natal visits (excluding post- natal exercises), per visit	2004.00							240	11.500	1.0	R	86.60	
425	Ante-natal or post-natal exercise classes, per patient	2006.03							240	6.200	1.0	R	46.70	
	For advanced midwives registered with SANC only:													
404	Cardiotocography	2004.00							240	10.000	1.0	R	75.30	
	WELL BABY CLINICS													
	Emergency equipment must be available in the baby clinic	2004.00												
450	Consultation	2004.00							240	4.800	1.0	R	36.10	
454	Supply of Vaccine (only for nurses with Section 22A (15) Permit)	2005.06							240	-	0.0	R	-	
	PSYCHIATRIC NURSING THERAPY													
	Psychiatric Nursing Therapy may only be performed by a nurse with a psychiatric nursing qualification registered as such with the SANC	2005.02												
500	Individual interview/assessment. Adult, child, school, employer - per hour.	2004.00							240	21.600	1.0	R	162.60	
501	Individual therapy. (irrespective of time)	2004.00							240	30.700	1.0	R	231.10	
502	Family/marital/group per patient - specify number.	2004.00							240	6.200	1.0	R	46.70	
503	Play therapy/Home stimulation programme.	2004.00							240	16.900	1.0	R	127.20	
504	Co-therapist.	2004.00							240	16.900	1.0	R	127.20	
	RENAL DIALYSIS													

Registered Nurses In Private Practice and Nursing Agencies 2008

092	Peritoneal dialysis per day	2004.00		360	16.900	1.0	R	127.20		240	16.900	1.0	R	127.20		
608	Home dialysis training in centre per 30 minutes	2004.00		360	16.000	1.0	R	120.50		240	16.000	1.0	R	120.50		
610	Home dialysis training or follow up at patient's home per 30 minutes (to maximum of 24 hours)	2004.00		360	28.200	1.0	R	212.30		240	28.200	1.0	R	212.30		
612	Home dialysis 1. Preparation of extra corporeal equipment 2. Preparation of needling patient's fistula and attaching patients to Haemodialysis machine or using subclavian catheter/permanent catheter/femerol catheter 3. Observation of patient whilst on dialysis 4. Monitoring Haemodialysis machine readings 5. Doing necessary nursing procedures to patient as required e.g. catheter site/wounds/mouth care, nursing care in general/helping to feed/prepare light meal/tea etc for patient whilst on dialysis 6. Termination of procedures e.g. giving blood back to patient and disposable of extra corporeal lines etc 7. Port dialysis observation of patient 8. Cleaning and sterilisation of dialysis machine and Reverse Osmosis machine	2004.00		360	64.000	1.0	R	481.90		240	64.000	1.0	R	481.90		
	MEDICINES AND MATERIALS															
301	Consumables used, and charged according to rule 05	2005.03		360	-	0.0	R	-		240	-	0.0	R	-		

Registered Nurses In Private Practice and Nursing Agencies 2008

Code	Description
48000	Nursing Agencies/Home Care Services
48800	Registered Nurses

Registered Nurses In Private Practice and Nursing Agencies 2008

Code	Description	RCF
240	Registered Nurses	7.529
241	Registered Nurses (time based)	4.677
360	Nursing Agencies	7.529

SOCIAL WORKERS

Social Workers 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SOCIAL WORKERS, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

005	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars: a) The surname and initials of the member; b) The surname, first name and other initials, if any, of the patient; c) The name of the scheme concerned;. d) The membership number of the member; e) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f) the relevant diagnostic and such other item code numbers that relates to such relevant health service; g) The date on which each relevant health service was rendered; h) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
006	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
007	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency social work service, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	04.00
008	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.03

Modifiers

0003	Add 50% of the total fee for the treatment	04.00
0021	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	04.00
0022	Services rendered at patients residence: Quote modifier 0022 on all accounts for services performed at the patients residence.	04.00

ITEMS

Code	Description	Ver	Add	Social Workers RVU	Social Workers Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
200	Social worker consultation, counselling and/or therapy. Duration: 1-10min.	05.03		0.500	24.20 (21.20)
201	Social worker consultation, counselling and/or therapy. Duration: 11-20min.	05.03		1.500	72.50 (63.60)
202	Social worker consultation, counselling and/or therapy. Duration: 21-30min.	05.03		2.500	120.80 (106.00)
203	Social worker consultation, counselling and/or therapy. Duration: 31-40min.	05.03		3.500	169.20 (148.40)
204	Social worker consultation, counselling and/or therapy. Duration: 41-50min.	05.03		4.500	217.50 (190.80)
205	Social worker consultation, counselling and/or therapy. Duration: 51-60min.	05.03		5.500	265.80 (233.20)
206	Social worker consultation, counselling and/or therapy. Duration: 61-70min.	05.03		6.500	314.10 (275.50)
207	Social worker consultation, counselling and/or therapy. Duration: 71-80min.	05.03		7.500	362.50 (318.00)
208	Social worker consultation, counselling and/or therapy. Duration: 81-90min.	05.03		8.500	410.80 (360.40)
209	Social worker consultation, counselling and/or therapy. Duration: 91-100min.	05.03		9.500	459.10 (402.70)

Code	Description	Ver	Add	Social Workers	
				RVU	Fee
210	Social worker consultation, counselling and/or therapy. Duration: 101-110min.	05.03		10.500	507.50 (445.20)
211	Social worker consultation, counselling and/or therapy. Duration: 111-120min.	05.03		11.500	555.80 (487.50)
Group consultation, counselling or therapy					
	Group consultation, counselling and/or therapy items are chargeable to a maximum of 12 patients.				05.03
300	Social worker group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	05.03		0.100	4.83 (4.24)
301	Social worker group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	05.03		0.300	14.50 (12.70)
302	Social worker group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	05.03		0.500	24.20 (21.20)
303	Social worker group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	05.03		0.700	33.80 (29.60)
304	Social worker group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	05.03		0.900	43.50 (38.20)
305	Social worker group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	05.03		1.100	53.20 (46.70)
306	Social worker group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	05.03		1.300	62.80 (55.10)
307	Social worker group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	05.03		1.500	72.50 (63.60)
308	Social worker group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	05.03		1.700	82.20 (72.10)
309	Social worker group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	05.03		1.900	91.80 (80.50)
310	Social worker group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	05.03		2.100	101.50 (89.00)
311	Social worker group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	05.03		2.300	111.20 (97.50)

Social Workers 2008

				48900				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SOCIAL WORKERS, EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
005	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars: a)□The surname and initials of the member; b)□The surname, first name and other initials, if any, of the patient; c)□The name of the scheme concerned;. d)□The membership number of the member; e)□The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; f)□the relevant diagnostic and such other item code numbers that relates to such relevant health service; g)□The date on which each relevant health service was rendered; h)□The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2004.00						
006	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						

007	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency social work service, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.	2004.00							
008	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	2005.03							
	Modifiers								
0003	Add 50% of the total fee for the treatment	2004.00							
0021	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	2004.00							
0022	Services rendered at patients residence: Quote modifier 0022 on all accounts for services performed at the patients residence.	2004.00							
	ITEMS								
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		300	-	0.0	R	-	
200	Social worker consultation, counselling and/or therapy. Duration: 1-10min.	2005.03		300	0.500	1.0	R	24.20	
201	Social worker consultation, counselling and/or therapy. Duration: 11-20min.	2005.03		300	1.500	1.0	R	72.50	
202	Social worker consultation, counselling and/or therapy. Duration: 21-30min.	2005.03		300	2.500	1.0	R	120.80	
203	Social worker consultation, counselling and/or therapy. Duration: 31-40min.	2005.03		300	3.500	1.0	R	169.20	
204	Social worker consultation, counselling and/or therapy. Duration: 41-50min.	2005.03		300	4.500	1.0	R	217.50	
205	Social worker consultation, counselling and/or therapy. Duration: 51-60min.	2005.03		300	5.500	1.0	R	265.80	
206	Social worker consultation, counselling and/or therapy. Duration: 61-70min.	2005.03		300	6.500	1.0	R	314.10	
207	Social worker consultation, counselling and/or therapy. Duration: 71-80min.	2005.03		300	7.500	1.0	R	362.50	

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208	Social worker consultation, counselling and/or therapy. Duration: 81-90min.	2005.03		300	8.500	1.0	R	410.80	
209	Social worker consultation, counselling and/or therapy. Duration: 91-100min.	2005.03		300	9.500	1.0	R	459.10	
210	Social worker consultation, counselling and/or therapy. Duration: 101-110min.	2005.03		300	10.500	1.0	R	507.50	
211	Social worker consultation, counselling and/or therapy. Duration: 111-120min.	2005.03		300	11.500	1.0	R	555.80	
	Group consultation, counselling or therapy								
	Group consultation, counselling and/or therapy items are chargeable to a maximum of 12 patients.	2005.03							
300	Social worker group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	2005.03		300	0.100	1.0	R	4.83	
301	Social worker group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	2005.03		300	0.300	1.0	R	14.50	
302	Social worker group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	2005.03		300	0.500	1.0	R	24.20	
303	Social worker group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	2005.03		300	0.700	1.0	R	33.80	
304	Social worker group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	2005.03		300	0.900	1.0	R	43.50	
305	Social worker group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	2005.03		300	1.100	1.0	R	53.20	
306	Social worker group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	2005.03		300	1.300	1.0	R	62.80	
307	Social worker group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	2005.03		300	1.500	1.0	R	72.50	
308	Social worker group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	2005.03		300	1.700	1.0	R	82.20	
309	Social worker group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	2005.03		300	1.900	1.0	R	91.80	
310	Social worker group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2005.03		300	2.100	1.0	R	101.50	
311	Social worker group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2005.03		300	2.300	1.0	R	111.20	

Social Workers 2008

Code	Description
48900	Social Workers

Social Workers 2008

Code	Description	RCF
300	Social Workers	48.330

SPEECH THERAPISTS & AUDIOLOGISTS

Speech Therapists and Audiologists 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SPEECH THERAPISTS AND AUDIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

General Rules

A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; and . the name and practice number of the referring practitioner, if applicable.	04.00
B	The rate in respect of more than one evaluation under item 029 shall be the full rate for the first evaluation plus half the rate in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	04.00
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
E	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Use item 300 for this purpose.	05.03

ITEMS

1. Assessment, Consultation & Treatment

The time used to conduct any diagnostic or treatment procedure claimed in addition to the codes in this section, can not be considered in determining the duration of the assessment, consultation or treatment claimed — 05.03

1.1 Consultations

1.1.1 Audiology Consultations

Code	Description	Ver	Add	Speech Therapy / Audiology RVU	Fee
1010	Audiology consultation. Duration 1 - 15 mins	06.02		7.500	42.10 (36.90)
1011	Audiology consultation. Duration 16 - 30 mins	06.02		22.500	126.40 (110.90)
1012	Audiology consultation. Duration 31 - 45 mins	06.02		37.500	210.70 (184.80)
1013	Audiology consultation. Duration 46 - 60 mins	06.02		52.500	295.00 (258.80)
1015	Prolonged audiology consultation, each additional full 15 mins, to a maximum of 60 mins	06.02		15.000	84.30 (73.90)

1.1.2 Speech Therapy Consultations

1020	Speech therapy consultation. Duretion 1 - 15 mins	06.02		7.500	42.10 (36.90)
1021	Speech therapy consultation. Duration 16 - 30 mins	06.02		22.500	126.40 (110.90)
1022	Speech therapy consultation. Duration 31 - 45 mins	06.02		37.500	210.70 (184.80)
1023	Speech therapy consultation. Duration 46 - 60 mins	06.02		52.500	295.00 (258.80)

1.2 Assessment & Treatment

1.2.1 Speech Therapy Assessment & Treatment

1050	Speech therapy assessment and treatment. Duration 1 - 15 mins	06.02		7.500	42.10 (36.90)

Code	Description	Ver	Add	Speech Therapy / Audiology	
				RVU	Fee
1051	Speech therapy assessment and treatment. Duration 16 - 30 mins	06.02		22.500	126.40 (110.90)
1052	Speech therapy assessment and treatment. Duration 31 - 45 mins	06.02		37.500	210.70 (184.80)
1053	Speech therapy assessment and treatment. Duration 46 - 60 mins	06.02		52.500	295.00 (258.80)
2.	**Speech, Voice and Language Disorder**				
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy)	06.02		15.000	84.30 (73.90)
	Note: Professional Group Consultations - no fee to be charged.	04.00			
0009	Preparation of a home programme	06.02		15.000	84.30 (73.90)
	Note: This category is to prepare the home programme prior to consultation with patient or care giver	04.00			
0020	Report writing	06.02		30.000	168.60 (147.90)
0107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	06.02		-	-
3.	**Audiology.**				
A.	**Peripheral Hearing Evaluation**				
1100	Pure Tone Audiogram (Air conduction) (3273)	06.02		15.000	95.00 (83.30)
1105	Pure Tone Audiogram (Bone conduction) (3274)	06.02		12.000	76.00 (66.70)
1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277)	06.02		15.000	95.00 (83.30)
1115	Speech audiogram screening	06.02		5.000	31.70 (27.80)
1120	Visual reinforcement audiometry and/or combined play audiometry employed in a sound field environment to assess peripheral hearing	06.02		40.000	258.90 (227.10)
1125	Tinnitus Evaluation	06.02		15.000	95.00 (83.30)
B.	**Middle Ear Function Evaluation**				
1200	Immittance Measurements (Impedance / Tympanometry)	06.02		8.000	47.90 (42.00)
1205	Immittance Measurements - Impedance / Stapedial reflex (3276): Limited reflex spectrum (eg : 1-2 frequencies)	06.02		4.000	24.00 (21.10)
1210	Immittance Measurements - Impedance / Stapedial reflex (3276): Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies)	06.02		12.000	71.90 (63.10)
1215	Immittance Measurements - Impedance / High Frequency Tympanometry (for peadiatric population)	06.02		8.000	47.90 (42.00)
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral	06.02		12.000	71.90 (63.10)
1225	Rinné & Weber tests	06.02		4.000	25.30 (22.20)
C.	**Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology**				
1300	Tone Decay (for retro cochlear pathology)	06.02		8.000	50.70 (44.50)
1305	Reflex decay (for retro cochlear pathology)	06.02		8.000	47.90 (42.00)
1310	SISI (for cochlear pathology)	06.02		5.000	31.70 (27.80)
1315	Air conduction MCL (Most comfortable levels) & UCL (Uncomfortable levels) - for cochlear pathology and/or for purposes of selection of hearing aid technology or hearing aid programming	06.02		8.000	50.70 (44.50)
1320	Speech conduction MCL & UCL (for cochlear pathology)	06.02		4.000	25.30 (22.20)
1325	Test for functional hearing loss	06.02		10.000	63.40 (55.60)
1330	Stenger test (for functional hearing loss)	06.02		10.000	63.40 (55.60)
1335	Fistula test - (for peri-lymph fluid leakage)	06.05		15.000	95.00 (83.30)

Code	Description	Ver	Add	Speech Therapy / Audiology	
				RVU	Fee
D.	**Auditory Processing (AP) and Central Auditory Processing Tests (CAP)**				
	Only tests appropriate to the recommendations of the HPCSA Taskforce on CAPD should be administered i.e. low-linguistically loaded tests are tests of choice. No more than two tests from each category below can be administered. Repeat item 1400 for each test done. Deviations from this billing guideline requires motivation. PRELIMINARY TEST BATTERY Scan-C Scan-A PSI DIFFERENTIAL DIAGNOSIS BETWEEN CAPD AND ADHD Selective Auditory Attention Test Auditory Continuous Performance Test TESTS OF MONAURAL LOW REDUNDANCY Low Pass Filtered Speech - Ivey Low Pass Filtered Speech - NU-6 Lists 500Hz, 750Hz And 1000Hz Time Compressed Speech/Time Compressed Speech with Reverberation SPEECH IN NOISE TESTS SPIN SSI-ICM BKB-SIN SIN QuickSIN DICHOTIC SPEECH TESTS Dichotic Digits Test Dichotic Consonant Vowel SSI-CCM Staggered Spondaic Word Test Competing Sentences Test Dichotic Rhyme Test Dichotic Sentence Identification Test TEMPORAL PROCESSING TESTS Random Gap Detection Test TEMPORAL PATTERNING TESTS Frequency Pattern (Pitch Pattern) Sequence Test Duration Pattern Sequence Test BINAURAL INTERACTION TESTS Masking Level Difference for Speech Binaural Fusion Test (Ivey, NU-6 or CVC Fusion)				06.05
1400	Central Auditory Processing Disorders test, test to be specified.	06.05		13.000	84.10 (73.80)
E.	**Electro-Physiological Examinations/Auditory Evoked Potentials (AEP)**				
1500	Diagnostic Neurological short latency ABR (Auditory Brainstem Response) Bilateral; single decibel (2692)	06.02		60.000	388.30 (340.60)
1505	AABR - Bilateral (Automated Auditory Brainstem Response). Cannot be charged with 1510	06.02		30.000	179.60 (157.50)
1510	Screening ABR - Bilateral (Auditory Brainstem Response) . Cannot be charged with 1505	06.02		20.000	119.80 (105.10)
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli	06.02		60.000	388.30 (340.60)
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli	06.02		80.000	517.80 (454.20)
	Combinations of items 1531 to 1534 cannot be billed together.	06.02			
1531	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at: 1 frequency	06.02		30.000	194.20 (170.40)
1532	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	06.02		60.000	388.30 (340.60)
1533	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	06.02		90.000	582.50 (511.00)
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	06.02		120.000	776.60 (681.20)
	Combinations of items 1541 to 1544 cannot be billed together.	06.02			
1541	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2696) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 1 frequency	06.05		25.000	161.80 (141.90)
1542	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	06.05		50.000	323.60 (283.90)
1543	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	06.05		75.000	485.40 (425.80)
1544	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses(2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	06.05		100.000	647.20 (567.70)
	Combinations of items 1551 to 1554 cannot be billed together.	06.02			

Code	Description	Ver	Add	Speech Therapy / Audiology	
				RVU	Fee
1551	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 1 frequency	06.02		30.000	194.20 (170.40)
1552	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 2 frequencies	06.02		40.000	258.90 (227.10)
1553	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 3 frequencies	06.02		60.000	388.30 (340.60)
1554	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 4 frequencies	06.02		80.000	517.80 (454.20)
1560	P300 Cognitive AEP (Auditory Evoked Potential) or MMN (Mismatch Negativity)	06.02		35.000	226.50 (198.70)
1565	Electrocochleography: unilateral (2699). Cannot be charged with item 1570.	06.02		45.000	291.20 (255.40)
1570	Electrocochleography: bilateral (2700). Cannot be charged with item 1565.	06.02		90.000	582.50 (511.00)
1575	Cochlear nerve function test - intra-operative monitoring - per 30min	06.02		30.000	194.20 (170.40)
1580	OAE (Oto-acoustic emissions) - limited frequencies (transient or distortion product) for hearing screening of neonatal and pediatric population.	06.02		15.000	86.40 (75.80)
1581	OAE (Oto-acoustic emissions) - comprehensive diagnostic evaluation	06.02		30.000	179.60 (157.50)
F.	**Balance/Vestibular Examinations and Treatment**				
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253). Cannot use with item 1605.	06.02		55.000	356.00 (312.30)
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG). Cannot use with item 1600.	06.02		55.000	374.70 (328.70)
1610	Eye Visualization – spontaneous and positional nystagmus – monocular	06.02		35.000	201.60 (176.80)
1615	Eye Visualization – spontaneous and positional nystagmus – binocular	06.02		35.000	209.60 (183.90)
1620	Oculo-motor/central tests using electro-nystagmography (ENG). Cannot be used with item 1625.	06.02		25.000	170.30 (149.40)
1625	Oculo-motor/central tests using video-nystagmography (VNG). Cannot be used with item 1620.	06.02		25.000	170.30 (149.40)
1630	DVA (Dynamic Visual Acuity) test using Video-nystagmography (VNG)	06.02		10.000	68.10 (59.70)
1635	Caloric test using ENG electro-nystagmography (3255). Cannot be used with item 1640.	06.02		50.000	340.60 (298.80)
1640	Caloric test using VNG electro-nystagmography (3255). Cannot be used with item 1635.	06.02		50.000	340.60 (298.80)
1645	Posturography	06.02		25.000	170.30 (149.40)
1650	Rotational Chair test	06.02		15.000	89.80 (78.80)
1655	Otolith repositioning/canalith maneuvre	06.02		25.000	140.50 (123.20)
1660	Vestibular rehabilitation (neuromuscular) re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception	06.02		25.000	140.50 (123.20)
G.	**Cochlear Implant Tests**				
1700	Cochlear Implants: Pre-implant round window promontory testing. In cases where speech tests were not possible because of very limited speech and language acquisition (e.g. prelingually deaf adults)	06.02		45.000	269.50 (236.40)
1710	Cochlear Implants : Electrode mapping : per 15min (max 120min)	06.02		15.000	102.20 (89.60)
1720	Cochlear Implants : Implant test : Four test modes : intra- or post-operatively	06.02		5.000	31.70 (27.80)
1725	Cochlear Implants : Neural Response Telemetry : intra-operatively (during cochlear implant surgery)	06.02		20.000	136.20 (119.50)
1730	Cochlear Implants : Neural Response Telemetry : post-operatively (after cochlear implant surgery)	06.02		55.000	348.40 (305.60)
1735	Cochlear Implants : Electrical Stapedius Reflex Thresholds : intra-operatively only	06.02		13.000	88.60 (77.70)
1740	Cochlear Implants : Comprehensive speech perception testing, pre- and post-cochlear implant, per 15min (max 45min)	06.02		15.000	97.10 (85.20)
H.	**Hearing Amplification / Hearing Aids**				
1800	Hearing aid evaluation - per ear	06.02		15.000	86.40 (75.80)
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading)	06.02		13.000	84.10 (73.80)
1810	Insertion gain measurement, per ear	06.02		10.000	59.90 (52.50)

Code	Description	Ver	Add	Speech Therapy / Audiology	
				RVU	Fee
1815	Re-programming of hearing aid, per ear	06.02		10.000	57.60 (50.50)
1820	Technical adjustment of hearing aid/device, per ear.	06.02		6.000	34.60 (30.40)
1825	Repairs to hearing aids	06.02		-	-
1830	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme).	06.02		-	-
I.	**Occupational Health / Industrial Hearing Assessment**				
1900	Pure Tone Audiogram (Air conduction). (3237)	06.02		-	-
1905	Pure Tone Audiogram (Bone conduction) (3274)	06.02		-	-
1910	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels (3277)	06.02		-	-
1915	Speech audiogram screening	06.02		-	-
1920	Immittance Measurements (Impedance) (Tympanometry)	06.02		-	-
1925	Immittance Measurements (Impedance) (Stapedial reflex) (3276)	06.02		-	-
4.	**Material**				
0300	Medication	06.02		-	-
0301	Material	06.02		-	-

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				38200				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SPEECH THERAPISTS AND AUDIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00						
	General Rules							
A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; and . the name and practice number of the referring practitioner, if applicable.	2004.00						
B	The rate in respect of more than one evaluation under item 029 shall be the full rate for the first evaluation plus half the rate in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	2004.00						
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						

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	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.								
E	Use item 300 for this purpose.	2005.03							
	ITEMS								
1.	Assessment, Consultation & Treatment								
	The time used to conduct any diagnostic or treatment procedure claimed in addition to the codes in this section, can not be considered in determining the duration of the assessment, consultation or treatment claimed	2005.03							
1.1	Consultations								
1.1.1	Audiology Consultations								
1010	Audiology consultation. Duration 1 - 15 mins	2006.02		310	7.500	1.0	R	42.10	
1011	Audiology consultation. Duration 16 - 30 mins	2006.02		310	22.500	1.0	R	126.40	
1012	Audiology consultation. Duration 31 - 45 mins	2006.02		310	37.500	1.0	R	210.70	
1013	Audiology consultation. Duration 46 - 60 mins	2006.02		310	52.500	1.0	R	295.00	
1015	Prolonged audiology consultation, each additional full 15 mins, to a maximum of 60 mins	2006.02		310	15.000	1.0	R	84.30	
1.1.2	Speech Therapy Consultations								
1020	Speech therapy consultation. Duration 1 - 15 mins	2006.02		310	7.500	1.0	R	42.10	
1021	Speech therapy consultation. Duration 16 - 30 mins	2006.02		310	22.500	1.0	R	126.40	
1022	Speech therapy consultation. Duration 31 - 45 mins	2006.02		310	37.500	1.0	R	210.70	
1023	Speech therapy consultation. Duration 46 - 60 mins	2006.02		310	52.500	1.0	R	295.00	
1.2	Assessment & Treatment								
1.2.1	Speech Therapy Assessment & Treatment								
1050	Speech therapy assessment and treatment. Duration 1 - 15 mins	2006.02		310	7.500	1.0	R	42.10	
1051	Speech therapy assessment and treatment. Duration 16 - 30 mins	2006.02		310	22.500	1.0	R	126.40	
1052	Speech therapy assessment and treatment. Duration 31 - 45 mins	2006.02		310	37.500	1.0	R	210.70	
1053	Speech therapy assessment and treatment. Duration 46 - 60 mins	2006.02		310	52.500	1.0	R	295.00	
2.	Speech, Voice and Language Disorder								
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy)	2006.02		310	15.000	1.0	R	84.30	
	Note: Professional Group Consultations - no fee to be charged.	2004.00							
0009	Preparation of a home programme	2006.02		310	15.000	1.0	R	84.30	
	Note: This category is to prepare the home programme prior to consultation with patient or care giver	2004.00							
0020	Report writing	2006.02		310	30.000	1.0	R	168.60	
0107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2006.02		310	-	1.0	R	-	
3.	Audiology.								
A.	Peripheral Hearing Evaluation								
1100	Pure Tone Audiogram (Air conduction) (3273)	2006.02		313	15.000	1.0	R	95.00	
1105	Pure Tone Audiogram (Bone conduction) (3274)	2006.02		313	12.000	1.0	R	76.00	

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1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277)	2006.02		313	15.000	1.0	R	95.00	
1115	Speech audiogram screening	2006.02		313	5.000	1.0	R	31.70	
1120	Visual reinforcement audiometry and/or combined play audiometry employed in a sound field environment to assess peripheral hearing	2006.02		314	40.000	1.0	R	258.90	
1125	Tinnitus Evaluation	2006.02		313	15.000	1.0	R	95.00	
B.	Middle Ear Function Evaluation								
1200	Immittance Measurements (Impedance / Tympanometry)	2006.02		312	8.000	1.0	R	47.90	
1205	Immittance Measurements - Impedance / Stapedial reflex (3276): Limited reflex spectrum (eg : 1-2 frequencies)	2006.02		312	4.000	1.0	R	24.00	
1210	Immittance Measurements - Impedance / Stapedial reflex (3276): Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies)	2006.02		312	12.000	1.0	R	71.90	
1215	Immittance Measurements - Impedance / High Frequency Tympanometry (for peadiatric population)	2006.02		312	8.000	1.0	R	47.90	
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral	2006.02		312	12.000	1.0	R	71.90	
1225	Rinné & Weber tests	2006.02		313	4.000	1.0	R	25.30	
C.	Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology								
1300	Tone Decay (for retro cochlear pathology)	2006.02		313	8.000	1.0	R	50.70	
1305	Reflex decay (for retro cochlear pathology)	2006.02		312	8.000	1.0	R	47.90	
1310	SISI (for cochlear pathology)	2006.02		313	5.000	1.0	R	31.70	
1315	Air conduction MCL (Most comfortable levels) & UCL (Uncomfortable levels) - for cochlear pathology and/or for purposes of selection of hearing aid technology or hearing aid programming	2006.02		313	8.000	1.0	R	50.70	
1320	Speech conduction MCL & UCL (for cochlear pathology)	2006.02		313	4.000	1.0	R	25.30	
1325	Test for functional hearing loss	2006.02		313	10.000	1.0	R	63.40	
1330	Stenger test (for functional hearing loss)	2006.02		313	10.000	1.0	R	63.40	
1335	Fistula test - (for peri-lymph fluid leakage)	2006.05		313	15.000	1.0	R	95.00	
D.	Auditory Processing (AP) and Central Auditory Processing Tests (CAP)								

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	Only tests appropriate to the recommendations of the HPCSA Taskforce on CAPD should be administered i.e. low-linguistically loaded tests are tests of choice. No more than two tests from each category below can be administered. Repeat item 1400 for each test done. Deviations from this billing guideline requires motivation.□ □ PRELIMINARY TEST BATTERY □ Scan-C□ Scan-A□ PSI□ DIFFERENTIAL DIAGNOSIS BETWEEN CAPD AND ADHD □ Selective Auditory Attention Test □ Auditory Continuous Performance Test□ TESTS OF MONAURAL LOW REDUNDANCY □ Low Pass Filtered Speech - Ivey□ Low Pass Filtered Speech - NU-6 Lists 500Hz, 750Hz And 1000Hz□ Time Compressed Speech/Time Compressed Speech with Reverberation□ SPEECH IN NOISE TESTS □ SPIN□ SSI-ICM□ BKB-SIN□ SIN□ QuickSIN□ DICHOTIC SPEECH TESTS□ Dichotic Digits Test□ Dichotic Consonant Vowel□ SSI-CCM□ Staggered Spondaic Word Test□ Competing Sentences Test□ Dichotic Rhyme Test□ Dichotic Sentence Identification Test□ TEMPORAL PROCESSING TESTS □	2006.05							
1400	Central Auditory Processing Disorders test, test to be specified.	2006.05		314	13.000	1.0	R	84.10	
E.	Electro-Physiological Examinations/Auditory Evoked Potentials (AEP)								
1500	Diagnostic Neurological short latency ABR (Auditory Brainstem Response) Bilateral; single decibel (2692)	2006.02		314	60.000	1.0	R	388.30	
1505	AABR - Bilateral (Automated Auditory Brainstem Response). Cannot be charged with 1510	2006.02		312	30.000	1.0	R	179.60	
1510	Screening ABR - Bilateral (Auditory Brainstem Response) . Cannot be charged with 1505	2006.02		312	20.000	1.0	R	119.80	
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli	2006.02		314	60.000	1.0	R	388.30	
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli	2006.02		314	80.000	1.0	R	517.80	
	Combinations of items 1531 to 1534 cannot be billed together.	2006.02							
1531	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at: 1 frequency	2006.02		314	30.000	1.0	R	194.20	

1532	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	2006.02		314	60.000	1.0	R	388.30	
1533	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	2006.02		314	90.000	1.0	R	582.50	
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	2006.02		314	120.000	1.0	R	776.60	
	Combinations of items 1541 to 1544 cannot be billed together.	2006.02							
1541	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 1 frequency	2006.05		314	25.000	1.0	R	161.80	
1542	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	2006.05		314	50.000	1.0	R	323.60	
1543	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	2006.05		314	75.000	1.0	R	485.40	
1544	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses(2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	2006.05		314	100.000	1.0	R	647.20	
	Combinations of items 1551 to 1554 cannot be billed together.	2006.02							
1551	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 1 frequency	2006.02		314	30.000	1.0	R	194.20	
1552	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 2 frequencies	2006.02		314	40.000	1.0	R	258.90	
1553	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 3 frequencies	2006.02		314	60.000	1.0	R	388.30	
1554	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 4 frequencies	2006.02		314	80.000	1.0	R	517.80	
1560	P300 Cognitive AEP (Auditory Evoked Potential) or MMN (Mismatch Negativity)	2006.02		314	35.000	1.0	R	226.50	
1565	Electrocochleography: unilateral (2699). Cannot be charged with item 1570.	2006.02		314	45.000	1.0	R	291.20	
1570	Electrocochleography: bilateral (2700). Cannot be charged with item 1565.	2006.02		314	90.000	1.0	R	582.50	
1575	Cochlear nerve function test - intra-operative monitoring - per 30min	2006.02		314	30.000	1.0	R	194.20	
1580	OAE (Oto-acoustic emissions) - limited frequencies (transient or distortion product) for hearing screening of neonatal and pediatric population.	2006.02		311	15.000	1.0	R	86.40	
1581	OAE (Oto-acoustic emissions) - comprehensive diagnostic evaluation	2006.02		312	30.000	1.0	R	179.60	
F.	Balance/Vestibular Examinations and Treatment								
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253). Cannot use with item 1605.	2006.02		314	55.000	1.0	R	356.00	
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG). Cannot use with item 1600.	2006.02		315	55.000	1.0	R	374.70	
1610	Eye Visualization – spontaneous and positional nystagmus – monocular	2006.02		311	35.000	1.0	R	201.60	
1615	Eye Visualization – spontaneous and positional nystagmus – binocular	2006.02		312	35.000	1.0	R	209.60	
1620	Oculo-motor/central tests using electro-nystagmography (ENG). Cannot be used with item 1625.	2006.02		315	25.000	1.0	R	170.30	
1625	Oculo-motor/central tests using video-nystagmography (VNG). Cannot be used with item 1620.	2006.02		315	25.000	1.0	R	170.30	
1630	DVA (Dynamic Visual Acuity) test using Video-nystagmography (VNG)	2006.02		315	10.000	1.0	R	68.10	
1635	Caloric test using ENG electro-nystagmography (3255). Cannot be used with item 1640.	2006.02		315	50.000	1.0	R	340.60	
1640	Caloric test using VNG electro-nystagmography (3255). Cannot be used with item 1635.	2006.02		315	50.000	1.0	R	340.60	

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1645	Posturography	2006.02		315	25.000	1.0	R	170.30	
1650	Rotational Chair test	2006.02		312	15.000	1.0	R	89.80	
1655	Otolith repositioning/canalith maneuvre	2006.02		310	25.000	1.0	R	140.50	
1660	Vestibular rehabilitation (neuromuscular) re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception	2006.02		310	25.000	1.0	R	140.50	
G.	Cochlear Implant Tests								
1700	Cochlear Implants: Pre-implant round window promontory testing. In cases where speech tests were not possible because of very limited speech and language acquisition (e.g. prelingually deaf adults)	2006.02		312	45.000	1.0	R	269.50	
1710	Cochlear Implants : Electrode mapping : per 15min (max 120min)	2006.02		315	15.000	1.0	R	102.20	
1720	Cochlear Implants : Implant test : Four test modes : intra- or post-operatively	2006.02		313	5.000	1.0	R	31.70	
1725	Cochlear Implants : Neural Response Telemetry : Intra-operatively (during cochlear implant surgery)	2006.02		315	20.000	1.0	R	136.20	
1730	Cochlear Implants : Neural Response Telemetry : post-operatively (after cochlear implant surgery)	2006.02		313	55.000	1.0	R	348.40	
1735	Cochlear Implants : Electrical Stapedius Reflex Thresholds : intra-operatively only	2006.02		315	13.000	1.0	R	88.60	
1740	Cochlear Implants : Comprehensive speech perception testing, pre- and post-cochlear implant, per 15min (max 45min)	2006.02		314	15.000	1.0	R	97.10	
H.	Hearing Amplification / Hearing Aids								
1800	Hearing aid evaluation - per ear	2006.02		311	15.000	1.0	R	86.40	
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading)	2006.02		314	13.000	1.0	R	84.10	
1810	Insertion gain measurement, per ear	2006.02		312	10.000	1.0	R	59.90	
1815	Re-programming of hearing aid, per ear	2006.02		311	10.000	1.0	R	57.60	
1820	Technical adjustment of hearing aid/device, per ear.	2006.02		311	6.000	1.0	R	34.60	
1825	Repairs to hearing aids	2006.02		310	-	1.0	R	-	
1830	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme).	2006.02		310	-	1.0	R	-	
I.	Occupational Health / Industrial Hearing Assessment								
1900	Pure Tone Audiogram (Air conduction). (3237)	2006.02		310	-	1.0	R	-	
1905	Pure Tone Audiogram (Bone conduction) (3274)	2006.02		310	-	1.0	R	-	
1910	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels (3277)	2006.02		310	-	1.0	R	-	
1915	Speech audiogram screening	2006.02		310	-	1.0	R	-	
1920	Immittance Measurements (Impedance) (Tympanometry)	2006.02		310	-	1.0	R	-	
1925	Immittance Measurements (Impedance) (Stapedial reflex) (3276)	2006.02		310	-	1.0	R	-	
4.	Material								
0300	Medication	2006.02		310	-	1.0	R	-	
0301	Material	2006.02		310	-	1.0	R	-	

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Code	Description
38200	Speech Therapy / Audiology

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Code	Description	RCF
310	Speech Therapists	5.619
311	Speech Therapists Level 1 Equipment	5.760
312	Speech Therapists Level 2 Equipment	5.988
313	Speech Therapists Level 3 Equipment	6.335
314	Speech Therapists Level 4 Equipment	6.472
315	Speech Therapists Level 5 Equipment	6.812

SUB ACUTE FACILITIES

Sub Acute Facilities 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE SUB ACCUTE FACILITIES WITH A "049" PRACTICE NUMBER, WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

B	The charges are indicated in the relevant column opposite the item codes.	04.00
C	Procedure for the classification of private sub-acute facilities: i) Inspections of private sub-acute facilities having practice code numbers commencing with the digits "049" will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF. ii) The provisions referred to in D.1.1 shall apply mutatis mutandis to all private sub-acute facilities such as post-natal units, rehabilitation units and psychiatric units.	04.00
D	All accounts submitted by private sub-acute facilities shall comply with all of the requirements of Chapter 2, Regulation 5, promulgated in terms of the Medical Schemes Act, Act No. 131 of 1998. Such accounts shall also reflect the practice code number and name of the attending practitioner.	04.00
E	All accounts containing items, which are subject to a discount in terms of the rates shall indicate such items individually and shall show separately the gross amount of the discount.	04.00

SCHEDULE

1 ACCOMMODATION

Ward Fees

Private sub-acute facilities shall indicate the exact time of admission and discharge on all accounts. 04.00

Patients admitted as day patients shall be charged half daily rate if discharged before 23h00 on the same date:

The following will be applicable to items 001, 010, 013, 015, 017, 105 and 020
On the day of admission:
If accommodation is less than 12 hours from time of admission: half the daily rate.
If accommodation is more than 12 hours from time of admission: full daily rate.
On day of discharge:
If accommodation is less than 12 hours: half the daily rate.
If accommodation is more than 12 hours: full daily rate.

Two half-day fees would be applicable when a patient is transferred internally between any ward and any sub-acute unit.

1.1 General Wards

Code	Description	Ver	Add	Sub-Acute Facilities RVU	Sub-Acute Facilities Fee
001	Ward fee, per day	04.00		10.000	752.20 (659.80)

1.2 Rehabilitation units

The following high function rehabilitation impairment categories will be treated in recognised and accredited specialised rehabilitation units of private sub-acute facilities: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replacements), Amputation (lower extremity), Cardiac, Pulmonary, Major multiple trauma. Other neurological or orthopaedic impairments will require specific letters of motivation. 04.00

101	General ward/facility fee: under 5 hours stay	04.00		2.227	167.50 (146.90)
105	General care (ward/supporting facilities and equipment)	04.00		10.286	773.70 (678.70)
	Note: The maxima may be modified in individual cases on specific motivation from the doctor-in-charge.	04.00			

1.3 Psychiatric Rehabilitation Unit

The following psychiatric categories will be treated in recognised and accredited specialised psychiatric units of private sub-acute facilities: Depression, Bipolar mood disorder, Anxiety disorder, Organic mood disorder, Dementia, Psychological behavioural disorder, Schizophrenia, Mental retardation, Eating disorder, Nonorganic sleep disorder, Sexual disfunction (not by organic disorder) and Mental behaviour disorder (ass pueperium), will require specific letters of motivation. Inclusive of all specialised psychiatric equipment, monitors, etc. 04.00

003	Ward fee: with overnight stay (specific motivation from the doctor-in-charge) (ward/supporting facilities and equipment)	04.00		10.430	784.60 (688.20)
005	General ward fee: under 5 hours stay	04.00		2.266	170.50 (149.60)
007	General ward fee: without overnight stay	04.00		5.392	405.60 (355.80)

Code	Description	Ver	Add	Sub-Acute Facilities	
				RVU	Fee
2	**STANDARD MATERIAL CHARGES**				
2.1	**Ward stock**				
	The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.				05.03
419	Ward stock	04.00		-	-
2.2	**Gases**				
	Oxygen, ward use Fee for oxygen, per quarter hour of part thereof.				04.00
284	PWV area	04.00		1.000	4.50 (3.95)
710	Cape Town	04.00		1.659	7.47 (6.55)
711	Port Elizabeth	04.00		1.592	7.16 (6.28)
712	East London	04.00		1.532	6.89 (6.04)
713	Durban	04.00		1.296	5.83 (5.11)
714	Other areas	04.00		1.234	5.55 (4.87)

Sub Acute Facilities 2008

				54900				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE SUB ACCUTE FACILITIES WITH A "049" PRACTICE NUMBER, WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
B	The charges are indicated in the relevant column opposite the item codes.	2004.00						
C	Procedure for the classification of private sub-acute facilities: i)□Inspections of private sub-acute facilities having practice code numbers commencing with the digits "049" will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF. □ ii)□The provisions referred to in D.1.1 shall apply mutatis mutandis to all private sub-acute facilities such as post-natal units, rehabilitation units and psychiatric units.	2004.00						
D	All accounts submitted by private sub-acute facilities shall comply with all of the requirements of Chapter 2, Regulation 5, promulgated in terms of the Medical Schemes Act, Act No. 131 of 1998. Such accounts shall also reflect the practice code number and name of the attending practitioner.	2004.00						
E	All accounts containing items, which are subject to a discount in terms of the rates shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00						
	SCHEDULE							
1	ACCOMMODATION							
	Ward Fees							

Sub Acute Facilities 2008

	Private sub-acute facilities shall indicate the exact time of admission and discharge on all accounts.□ □ Patients admitted as day patients shall be charged half daily rate if discharged before 23h00 on the same date:□ □ The following will be applicable to items 001, 010, 013, 015, 017, 105 and 020 □ On the day of admission:□ If accommodation is less than 12 hours from time of admission: half the daily rate.□ If accommodation is more than 12 hours from time of admission: full daily rate.□ On day of discharge:□ If accommodation is less than 12 hours: half the daily rate.□ If accommodation is more than 12 hours: full daily rate.□ □ Two half-day fees would be applicable when a patient is transferred internally between any ward and any sub-acute unit.□	2004.00							
1.1	General Wards								
001	Ward fee, per day	2004.00		480	10.000	1.0	R	752.20	
1.2	Rehabilitation units								
	The following high function rehabilitation impairment categories will be treated in recognised and accredited specialised rehabilitation units of private sub-acute facilities: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replacements), Amputation (lower extremity), Cardiac, Pulmonary, Major multiple trauma. Other neurological or orthopaedic impairments will require specific letters of motivation.	2004.00							
101	General ward/facility fee: under 5 hours stay	2004.00		480	2.227	1.0	R	167.50	
105	General care (ward/supporting facilities and equipment)	2004.00		480	10.286	1.0	R	773.70	
	Note: The maxima may be modified in individual cases on specific motivation from the doctor-in-charge.	2004.00							
1.3	Psychiatric Rehabilitation Unit								
	The following psychiatric categories will be treated in recognised and accredited specialised psychiatric units of private sub-acute facilities: Depression, Bipolar mood disorder, Anxiety disorder, Organic mood disorder, Dementia, Psychological behavioural disorder, Schizophrenia, Mental retardation, Eating disorder, Nonorganic sleep disorder, Sexual disfunction (not by organic disorder) and Mental behaviour disorder (ass pueperium), will require specific letters of motivation. Inclusive of all specialised psychiatric equipment, monitors, etc.	2004.00							
003	Ward fee: with overnight stay (specific motivation from the doctor-in-charge) (ward/supporting facilities and equipment)	2004.00		480	10.430	1.0	R	784.60	
005	General ward fee: under 5 hours stay	2004.00		480	2.266	1.0	R	170.50	
007	General ward fee: without overnight stay	2004.00		480	5.392	1.0	R	405.60	
2	STANDARD MATERIAL CHARGES								
2.1	Ward stock								

Sub Acute Facilities 2008

	The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).□ □ In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.	2005.03							
419	Ward stock	2004.00		440	-	0.0	R	-	
2.2	Gases								
	Oxygen, ward use□ Fee for oxygen, per quarter hour of part thereof.	2004.00							
284	PWV area	2004.00		440	1.000	1.0	R	4.50	
710	Cape Town	2004.00		440	1.659	1.0	R	7.47	
711	Port Elizabeth	2004.00		440	1.592	1.0	R	7.16	
712	East London	2004.00		440	1.532	1.0	R	6.89	
713	Durban	2004.00		440	1.296	1.0	R	5.83	
714	Other areas	2004.00		440	1.234	1.0	R	5.55	

Sub Acute Facilities 2008

Code	Description
54900	Sub-Acute Facilities

Sub Acute Facilities 2008

Code	Description	RCF
440	Sub-acute Facilities	4.500
480	Sub-acute facilities	75.221

TISSUE TRANSPORTATION

Tissue Transportation 2008

NATIONAL REFERENCE PRICE LIST FOR TISSUE TRANSPORTATION, EFFECTIVE FROM 1 JANUARY 2008			
The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.			
GENERAL RULES			
001	Items in the section on blood transportation are only chargeable by providers with a "003" practice number (Accredited Blood and Blood Product Couriers)	06.00	
1	**BLOOD TRANSPORTATION**		
Code	**Description**	**Ver**	**Add**
700	Routine compat collection: Collection of patient's blood compat by courier from hospital / clinic, other than as an emergency. Compat to be delivered to blood bank for cross match.	06.00	
710	Routine blood / blood product collection: Collection and delivery of cross-matched blood/blood produce by courier from blood bank, other than as an emergency. Blood/blood product to be taken to hospital/clinic for patient.	06.00	
720	Emergency blood / blood product collection: Collection of blood/blood product (without a full cross-match) where the driver has to wait for the blood/blood product and deliver it to the hospital (i.e. ROUND TRIP).	06.00	
	Medical scheme may require verification of emergency and determine the nature of such required verification. May not be billed with 700, 710 or 730.	06.00	
730	Emergency blood / blood product collection following change of status of request: Collection of blood/blood product (with or without a full cross-match) where, after the original request was delivered to the blood bank by the courier as a routine request, the status of the request was subsequently changed by the hospital or clinic to an emergency necessitating a non-routine collection by the courier. Blood/blood product to be taken to hospital/clinic for patient.	06.00	
	Medical scheme may require verification of change of status and determine the nature of such required verification. Typically billed with 700. May not be billed with 710.	06.00	
740	Long distance: Additional per km fee for collections further than 50km. This fee applies only to those kilometres in excess of 50 km. Supporting documentation required, illustrating distance traveled.	06.00	

Tissue Transportation 2008

Code	Description	Practice Type	2007	2008
700	Routine compat collection: Collection of patient's blood compat by courier from hospital / clinic, other than as an emergency. Compat to be delivered to blood bank for cross match.	Accredited Blood and Blood Product Couriers	0.000	
710	Routine blood / blood product collection: Collection and delivery of cross-matched blood/blood produce by courier from blood bank, other than as an emergency. Blood/blood product to be taken to hospital/clinic for patient.	Accredited Blood and Blood Product Couriers	0.000	
720	Emergency blood / blood product collection: Collection of blood/blood product (without a full cross-match) where the driver has to wait for the blood/blood product and deliver it to the hospital (i.e. ROUND TRIP).	Accredited Blood and Blood Product Couriers	0.000	
730	Emergency blood / blood product collection following change of status of request: Collection of blood/blood product (with or without a full cross-match) where, after the original request was delivered to the blood bank by the courier as a routine request, the status of the request was subsequently changed by the hospital or clinic to an emergency necessitating a non-routine collection by the courier. Blood/blood product to be taken to hospital/clinic for patient.	Accredited Blood and Blood Product Couriers	0.000	
740	Long distance: Additional per km fee for collections further than 50km. This fee applies only to those kilometres in excess of 50 km. Supporting documentation required, illustrating distance traveled.	Accredited Blood and Blood Product Couriers	0.000	

Tissue Transportation 2008

	NATIONAL REFERENCE PRICE LIST FOR TISSUE TRANSPORTATION, EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.	2006.00	
	GENERAL RULES		
001	Items in the section on blood transportation are only chargeable by providers with a "003" practice number (Accredited Blood and Blood Product Couriers)	2006.00	
1	BLOOD TRANSPORTATION		
700	Routine compat collection: Collection of patient's blood compat by courier from hospital / clinic, other than as an emergency. Compat to be delivered to blood bank for cross match.	2006.00	
710	Routine blood / blood product collection: Collection and delivery of cross-matched blood/blood produce by courier from blood bank, other than as an emergency. Blood/blood product to be taken to hospital/clinic for patient.	2006.00	
720	Emergency blood / blood product collection: Collection of blood/blood product (without a full cross-match) where the driver has to wait for the blood/blood product and deliver it to the hospital (i.e. ROUND TRIP).	2006.00	
	Medical scheme may require verification of emergency and determine the nature of such required verification. May not be billed with 700, 710 or 730.	2006.00	
730	Emergency blood / blood product collection following change of status of request: Collection of blood/blood product (with or without a full cross-match) where, after the original request was delivered to the blood bank by the courier as a routine request, the status of the request was subsequently changed by the hospital or clinic to an emergency necessitating a non-routine collection by the courier. Blood/blood product to be taken to hospital/clinic for patient.	2006.00	
	Medical scheme may require verification of change of status and determine the nature of such required verification. Typically billed with 700. May not be billed with 710.	2006.00	
740	Long distance: Additional per km fee for collections further than 50km. This fee applies only to those kilometres in excess of 50 km. Supporting documentation required, illustrating distance traveled.	2006.00	

UNATTACHED OPERATING THEATRE UNITS

Unattached Operating Theatre Units 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76' WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
C	All accounts submitted by unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	04.00
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	04.00
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	04.00
F	Accommodation fees includes the services listed below: A. The minimum services that are required are items 3, 5 and 6. B. If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1 Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2 Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3 Notification of admission 4 Immediate notification of changes to: · length of stay · level of care · theatre procedures 5 Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6 Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. · Including coding of complications and co-morbidity. To be done as accurately as practically possible by the hospital. 7 Case management by means of standard documentation and liaison between scheme and hospital appointed case managers · Liaison means communication and sharing of information between case managers, but does not include active case management by the hospital.	04.00

SCHEDULE

9 UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
005	Local anaesthetic theatre, Per minute	04.00		0.294	8.06 (7.07)
010	General anaesthetic theatre, Per minute	04.00		0.923	25.30 (22.20)
015	Dental anaesthetic theatre (Applicable to units registered for dental procedures only), Per minute	04.00		0.623	17.10 (15.00)
061	Excimer laser theatre fee, per minute	04.00		0.662	18.10 (15.90)

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
Ward fees (including recovery room)					
019	Out-patients facility fee for ambulatory admission - chargeable for patients NOT requiring general anaesthetic- No ward fees applicable. Definition: Item 019 may only be used in conjunction with item 071 which is for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335.	04.00		10.850	297.30 (260.80)
025	Day rate.	04.00		12.442	341.00 (299.10)
Emergency units					
035	Theatre drugs The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).	04.00		-	-
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	04.00		-	-
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	04.00		10.700	293.20 (257.20)
Non-chargeable items (1)					
040	Theatre items: Refer to Appendix B.	05.03		-	-
Non chargeable items (2)					
060	Wards: Refer to Appendix B.	05.03		-	-
THE CHARGE FOR A MONITOR HAS BEEN INCLUDED IN THE THEATRE FEE. NO EXTRA CHARGE IS PAYABLE					
STANDARD CHARGES FOR EQUIPEMENT AND MATERIALS					
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	04.00		10.773	295.20 (258.90)
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	04.00		5.327	146.00 (128.10)
335	Excimer laser: Hire fee per eye	04.00		75.258	2062.40 (1809.10)
337	Microkeratome used with an excimer laser, per operation	04.00		13.823	378.80 (332.30)
GASES					
Oxygen and Nitrous Oxide					
	For both gases together, per minute				04.00
283	PWV area	04.00		0.112	3.07 (2.69)
701	Cape Town	04.00		0.154	4.22 (3.70)
702	Port Elizabeth	04.00		0.137	3.75 (3.29)
703	East London	04.00		0.151	4.14 (3.63)
704	Durban	04.00		0.140	3.84 (3.37)
705	Other areas	04.00		0.125	3.43 (3.01)
Oxygen, ward use					
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex				04.00
284	PWV area	04.00		0.164	4.49 (3.94)
710	Cape Town	04.00		0.273	7.48 (6.56)
711	Port Elizabeth	04.00		0.262	7.18 (6.30)
712	East London	04.00		0.252	6.91 (6.06)
713	Durban	04.00		0.213	5.84 (5.12)
714	Other areas	04.00		0.203	5.56 (4.88)
Oxygen, recovery room and emergency units					
	Flat rate for oxygen per case				04.00
720	PWV area	04.00		0.327	8.96 (7.86)
721	Cape Town	04.00		0.542	14.90 (13.10)
722	Port Elizabeth	04.00		0.519	14.20 (12.50)
723	East London	04.00		0.500	13.70 (12.00)
724	Durban	04.00		0.427	11.70 (10.30)
725	Other areas	04.00		0.404	11.10 (9.74)

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
Oxygen in Theatre					
	Fee for oxygen per minute in the operating theatre when no other gas administered.				04.00
730	PWV area	04.00		0.010	0.27 (0.24)
731	Cape Town	04.00		0.018	0.49 (0.43)
732	Port Elizabeth	04.00		0.017	0.47 (0.41)
733	East London	04.00		0.017	0.47 (0.41)
734	Durban	04.00		0.014	0.38 (0.33)
735	Other areas	04.00		0.013	0.36 (0.32)
Carbon Dioxide					
291	Per minute	04.00		0.020	0.55 (0.48)
Laser					
292	Per minute	04.00		0.392	10.70 (9.39)
Entonox					
293	Per 30 minutes	04.00		3.731	102.20 (89.60)
Inhalation anaesthetics					
	All prices will be expressed per millilitre and will be based on the Single Exit Price (SEP)				08.00
285	Halothane (Halothane): per ml	08.00		-	-
752	Ethrane (Enflurane): per ml	08.00		-	-
753	Forane (Isoflurane): per ml	08.00		-	-
754	Isofor (Isoflurane); per ml	08.00		-	-
755	Ultane (Sevoflurane): per ml	08.00		-	-
756	Suprane (Desflurane); per ml	08.00		-	-
757	Aerrane (Isoflurane): per ml	08.00		-	-
758	Alyrane (enflurane): per ml	08.00		-	-
759	Fluothane (Halothane): per ml	08.00		-	-
ANNEXURES					
	APPENDIX A LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES CATEGORY 1 (CPT4 2000 code numbers included where possible) Diagnostic laparoscopy (49320) Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670) Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771) Hysteroscopy diagnostic (58555) Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C (58558) THORACOSCOPY, DIAGNOSTIC THORACOSCOPY, DIAGNOSTIC with biopsy THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy CATEGORY 2 Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673) Laparoscopy, surgical; with fimbrioplasty (58672) Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface, any method (58662) Laparoscopy, surgical; with lysis of adhesions (changed 1998 to salpigolysis, ovariolysis) (58660) Laparoscopy, surgical; with removal leiomyomata (58551) Laparoscopy surgical; withenterolysis (freeing intestinal adhesion) (44200) Laparoscopy, surgical; with retropritoneal node sampling (biopsy) (38570) Laparoscopy,surgical, abdomen, peritoneum, omentum; with drainage lymphocele to peritoneal cavity (49323) Laparoscopy, surgical; appendectomy (44970) Laparoscopy, surgical, abdomen, peritoneum and omentum; with biopsy (49321) Laparoscopy, surgical, abdominal, peritoneum and omentum; with aspiration of cavity or cyst (e.g. ovarian cyst) single or multiple (49322) Laparoscopy, surgical; with removal of adnexal structures (partial or total oopherectomy and/or salpingectomy) (58661) Laparoscopy, surgical; orchiopexy for intra-abdominal testis (54692) Laparoscopy, surgical; ligation spermatic veins for varicocele (55550) Laparoscopy, surgical; ablation of renal cysts (50541) Laparoscopy, surgical; urethral suspension for stress incontinence (51990) Laparoscopy, surgical; sling operation for stress incontinence (51992) Hysteroscopy with lysis intra-uterine adhesions (58559) Hysteroscopy with removal impacted foreign body (58562)				05.03

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	Hysteroscopy with removal leiomyomata \ (58561) Hysteroscopy with endometrial ablation \ (58563) Laparoscopic treatment of ectopic pregnancy, without salpingectomy and/or oopherectomy (59150) Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oopherectomy (59151) Laparoscopy, surgical; with vaginal hysterectomy. (Lap assisted vag. Hyst) (58550) Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy (38571) Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) (38572) Laparoscopy with adrenalectomy (60650) Laparoscopy, surgical; pyeloplasty (50544) Laparoscopy, surgical; nephrectomy (50540) Laparoscopy, surgical; donor nephrectomy (50547) Laparoscopically assisted nephroureterectomy (50548) Laparoscopy, surgical, ureterolithotomy 50945) Laparoscopy, surgical; transection of Vagus nerve, truncal (43651) Laparoscopy, surgical; transection of Vagus nerves, selective or highly selective (43652) Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy (47560) Laparoscopy, surgical; with guided transhepatic cholangiography, with biopsy (47561) Laparoscopy, surgical; cholecystoenterostomy (47570) Laparoscopy, surgical; cholecystectomy with cholangiography (47563) Laparoscopy, surgical; cholecystectomy with explor. common bile duct (47564) Laparoscopy, surgical; splenectomy (38120) Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g. Stamm procedure) (43653) Laparoscopy, surgical; jejunostomy (44201) Laparoscopy, surgical; intestinal resection, with anastomosis (44202) Laparoscopy, surgical; oesophagogastric fundoplasty eg Nissen, Toupet procedures) (43280) Unlisted laparoscopic procedure, uterus(58578) Unlisted hysteroscopy procedure, uterus (58579) Unlisted laparoscopic procedure, oviduct, ovary (58679) Unlisted laparoscopic spleen procedure (38129) Unlisted laparoscopic lymphatic procedure (38589) Unlisted laparoscopic oesophagus procedure (43289) Unlisted laparoscopic stomach procedure (43659) Unlisted laparoscopic intestinal procedure (except rectum) (44209) Unlisted laparoscopic appendix procedure (44979) Unlisted laparoscopic biliary tract procedure (47579) Unlisted laparoscopy procedure, abdomen, peritoneum & omentum (49329) Unlisted laparoscopic hernia procedure (49659) Unlisted laparoscopic renal procedure (50549) Unlisted laparoscopic procedure, testis (54699) Unlisted laparoscopic procedure, spermatic cord (55559) Unlisted laparoscopic procedure, maternity care and delivery (59898) Unlisted laparoscopic endocrine procedure (60659) THORACOSCOPY, SURGICAL THORACOSCOPY, SURGICAL pleurodesis THORACOSCOPY, SURGICAL partial pulmonary decortication THORACOSCOPY, SURGICAL total pulm. Decortication THORACOSCOPY, SURGICAL removal interpleural foreign body THORACOSCOPY, SURGICAL control traum. Haemorrhage THORACOSCOPY, SURGICAL exc./plication bullae THORACOSCOPY, SURGICAL parietal pleurectomy THORACOSCOPY, SURGICAL wedge resection THORACOSCOPY, SURGICAL removal clot/foreign body from pericardial space THORACOSCOPY, SURGICAL creation pericardial window THORACOSCOPY, SURGICAL total pericardectomy THORACOSCOPY, SURGICAL exc pericard. Cyst, tumor, mass THORACOSCOPY, SURGICAL exc mediastinal cyst, tumor, mass THORACOSCOPY, SURGICAL lobectomy, total or segmental THORACOSCOPY, SURGICAL with sympathectomy THORACOSCOPY, SURGICAL with esophagomyotomy New codes for Category 2 CPT42000 CPT4 2001 Laparoscopy, surgical; radical nephrectomy 50545 Laparoscopy, surgical; nephrectomy including partial ureterectomy 50546 Laparoscopy, surgical; nephrectomy with total ureterectomy 50548 Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement 50948 Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement 50948 Unlisted laparoscopic procedure, ureter 50949				
	APPENDIX B PRINCIPLES The following principles are applicable:				05.03

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee

1. At all times best clinical practice must be adhered too.

2. Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only. Photocopies of all documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documentation at the hospital/sameday surgical facilities concerned. The Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Sub-Acute Facilities, Private Hospitals and Sameday Surgery Facilities will be reviewed half-yearly.

3. The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows:

¢ Items included in the per minute theatre fee.
¢ Items included in the per day ward or unit fee.
¢ Items are charged to the patient's account where reimbursement is not granted by a medical scheme.

4. Any agreed difference on the basic interpretation of the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities list will be made in accordance with the approval of the duly appointed representatives of the individual contractor, medical aid, MCO and representatives of private hospitals. Such approval shall be ratified in writing and circulated to all parties concerned. Where the hospital uses an excessively priced product, a review process should be conducted, and appropriate price adjustment made.

5. Disposable items are single use only and must never be reused.
¢ Single use items will be charged at 100%.
¢ Hospitals will sign an ethical undertaking that single use items will only be used once. If a hospital does not conform it may be reported to the group head office. If an acceptable explanation is not supplied within 14 days, payment on that account may be withheld.

6. Limited life re-usable products are products intended for multiple use and endorsed as such by the manufacturers. Such products will be charged according to the "Fractional" charges as detailed and are under continual review. The item will be considered life re-usable (limited multiple use) if it can re re-used less than 100 times (endorsed as such by the manufacturer).

7. Where a hospital uses an excessively priced product, a review process with the parties as listed under 3 above should be conducted, and appropriate price adjustment made.

8. TTO's will be issued and charged according to the rules of the scheme.

9. All prescribed items will be recoverable according to the rules of the scheme.

Key Indicators

The different key indicators in the Recommended Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities List are as follows:

All prescribed items dispensed in wards or theatre are fully recoverable according to scheme's rules.

Key	Description
THR	Theatre consumable and disposable items
WRD	Ward consumable and disposable items
NR	Item is non-recoverable
C	Item is chargeable under certain circumstance
R	Item is recoverable
P	Item is recoverable from patient
F	Fractional (re-usable) and is charged out on a pro-rata basis (as per 5.5.1-5.5.4).
N/A	Not used/not applicable
Disposable	Means the manufacturer states one time use only. S/U(Single use) Item =Payable 100%
Medical Prescribed Meals	See List
Practice Code	References to the NRPL-HS includes 57/58, 76 and 77

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	APPENDIX C Infectious Diseases CONDITION Acute Flaccid Paralysis Anthrax Chicken Pox Diptheria Haemophyllis Influenza Haemorrhagic fevers of Africa: ¢ Crimean-Congo Ebola ¢ Lassa ¢ Marburg ¢ Rift Valley ¢ Dengue Herpes Zoster HIV/AIDS Legionnaires Disease Measles: ¢ Rubeola ¢ Rubella Meningococcal infections Multi-drug Resistant Bacteria: ¢ MRSA ¢ VRE ¢ MRSE Poliomyelitis Pyrexia unknown origin Rabies Small Pox Tuberculosis Pulmonary Typhus Fever Viral Hepatitis Whooping Cough (Pertussis) Note: The above is a general list and the clinical appropriate use of items for specific conditions is subject to Case Management.				05.03
	APPENDIX D Medically Prescribed Meals: ORAL SUPPLEMENTS (oral and tube feeds) Standard: Ensure; Fortisip; Fortimel; Fresubin Original drink (Vanilla); Nutren And Nutren Jnr (Gluten -free) Standard & Fibre: Ensure with Fibre; Nutren with Fibre Isotonic: Fresubin Original Isotonic &Fibre: Fresubin Original Fibre; Jevity; Osmolite Low Residue: Modulen N; Osmolite HN; Peptamen & Peptamen Jnr High Energy, High Protein & Fibre: Fresubin Energy Fibre drink (Lemon, Banana, Chocolate & Capuchino) High Energy & High Protein: Fresubin Energy drink (Strawberry & Vanilla) TUBE FEEDS Semi-Elemental: Alitraq; Peptamen & Peptamen Jnr RTH; Peptisorb; Survimed OPD (Liquid); Vital Standard: Nutren RTH; Nutrison; Nutrison Energy; Nutrison Paediatric High Energy & High Protein: Fresubin 750 MCT(HP Energy) Semi-Elemental High Protein Perative, And High Fibre				05.03

Code	Description			Ver	Add	Unattached operating theatres / Day clinics	
						RVU	Fee
			Nutren Fibre RTH				
	DISEASE SPECIFIC	MaximumGlucose Tolerance	Fresubin Diabetes				
			Glucerna				
			Nutren Diabetes				
		Pulmonary Insufficiency	Pulmocare				
			Supportan				
		Renal Failure	Suplena				
		HIV/Aids	Advera				
			Survimed OPD				
			Supportan				
		Cancer Patients	Supportan drink (Milk Coffee),				
			Stresson Multi				
	Fibre, Peptisorb						
	MODULAR	Protein	Promod				
			Protifar				
		MCT Oil	MCT Oil				
			Fresubin 750MCT(HP Energy)				
		Glutamine	Glutapack-10				
			Dipeptiven 50ml & 100ml				
		Food thickener	Thick & Easy				
		Carbohydrate	Fantomalt				
			Polycose				
	Note: Or generic equivalents. All tubes feeds subject to Case Management						

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				57600				
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76' WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.	2004.00						
	GENERAL RULES							
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
C	All accounts submitted by unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.	2004.00						
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documents at the rehabilitation hospital concerned.	2004.00						
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.	2004.00						

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	Accommodation fees includes the services listed below: A.□The minimum services that are required are items 3, 5 and 6. B.□If managed care organisations or medical schemes request any of the other services included in this list, no additional charge may be levied by the hospital. 1□Pre-authorisation (up to the date of admission) of: · length of stay · level of care · theatre procedures 2□Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation 3□Notification of admission 4□Immediate notification of changes to: · length of stay · level of care · theatre procedures 5□Reporting of length of stay and level of care · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system. 6□Discharge ICD-10 and CPT-4 coding · In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.								
F	· Including coding of complications and co-morbidity. To be done as accurately as practically	2004.00							
	SCHEDULE								
9	UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'								
005	Local anaesthetic theatre, Per minute	2004.00		540	0.294	1.0	R	8.06	
010	General anaesthetic theatre, Per minute	2004.00		540	0.923	1.0	R	25.30	
015	Dental anaesthetic theatre (Applicable to units registered for dental procedures only), Per minute	2004.00		540	0.623	1.0	R	17.10	
061	Excimer laser theatre fee, per minute	2004.00		540	0.662	1.0	R	18.10	
	Ward fees (including recovery room)								
019	Out-patients facility fee for ambulatory admission - chargeable for patients NOT requiring general anaesthetic- No ward fees applicable. Definition: Item 019 may only be used in conjunction with item 071 which is for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335.	2004.00		540	10.850	1.0	R	297.30	
025	Day rate.	2004.00		540	12.442	1.0	R	341.00	
	Emergency units								

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035	Theatre drugs The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).	2004.00		540	-	0.0	R	-	
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	2004.00		540	-	0.0	R	-	
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	2004.00		540	10.700	1.0	R	293.20	
	Non-chargeable items (1)								
040	Theatre items: Refer to Appendix B.	2005.03		540	-	0.0	R	-	
	Non chargeable items (2)								
060	Wards: Refer to Appendix B.	2005.03		540	-	0.0	R	-	
	THE CHARGE FOR A MONITOR HAS BEEN INCLUDED IN THE THEATRE FEE. NO EXTRA CHARGE IS PAYABLE								
	STANDARD CHARGES FOR EQUIPEMENT AND MATERIALS								
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	2004.00		540	10.773	1.0	R	295.20	
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	2004.00		540	5.327	1.0	R	146.00	
335	Excimer laser: Hire fee per eye	2004.00		540	75.258	1.0	R	2 062.40	
337	Microkeratome used with an excimer laser, per operation	2004.00		540	13.823	1.0	R	378.80	
	GASES								
	Oxygen and Nitrous Oxide								
	For both gases together, per minute	2004.00							
283	PWV area	2004.00		540	0.112	1.0	R	3.07	
701	Cape Town	2004.00		540	0.154	1.0	R	4.22	
702	Port Elizabeth	2004.00		540	0.137	1.0	R	3.75	
703	East London	2004.00		540	0.151	1.0	R	4.14	
704	Durban	2004.00		540	0.140	1.0	R	3.84	
705	Other areas	2004.00		540	0.125	1.0	R	3.43	
	Oxygen, ward use								
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex	2004.00							
284	PWV area	2004.00		540	0.164	1.0	R	4.49	
710	Cape Town	2004.00		540	0.273	1.0	R	7.48	
711	Port Elizabeth	2004.00		540	0.262	1.0	R	7.18	
712	East London	2004.00		540	0.252	1.0	R	6.91	
713	Durban	2004.00		540	0.213	1.0	R	5.84	
714	Other areas	2004.00		540	0.203	1.0	R	5.56	
	Oxygen, recovery room and emergency units								
	Flat rate for oxygen per case	2004.00							
720	PWV area	2004.00		540	0.327	1.0	R	8.96	

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721	Cape Town	2004.00		540	0.542	1.0	R	14.90	
722	Port Elizabeth	2004.00		540	0.519	1.0	R	14.20	
723	East London	2004.00		540	0.500	1.0	R	13.70	
724	Durban	2004.00		540	0.427	1.0	R	11.70	
725	Other areas	2004.00		540	0.404	1.0	R	11.10	
	Oxygen in Theatre								
	Fee for oxygen per minute in the operating theatre when no other gas administered.	2004.00							
730	PWV area	2004.00		540	0.010	1.0	R	0.27	
731	Cape Town	2004.00		540	0.018	1.0	R	0.49	
732	Port Elizabeth	2004.00		540	0.017	1.0	R	0.47	
733	East London	2004.00		540	0.017	1.0	R	0.47	
734	Durban	2004.00		540	0.014	1.0	R	0.38	
735	Other areas	2004.00		540	0.013	1.0	R	0.36	
	Carbon Dioxide								
291	Per minute	2004.00		540	0.020	1.0	R	0.55	
	Laser								
292	Per minute	2004.00		540	0.392	1.0	R	10.70	
	Entonox								
293	Per 30 minutes	2004.00		540	3.731	1.0	R	102.20	
	Inhalation anaesthetics								
	All prices will be expressed per millilitre and will be based on the Single Exit Price (SEP)	2008.00							
285	Halothane (Halothane): per ml	2008.00		540	-	1.0	R	-	
752	Ethrane (Enflurane): per ml	2008.00		540	-	1.0	R	-	
753	Forane (Isoflurane): per ml	2008.00		540	-	1.0	R	-	
754	Isofor (Isoflurane); per ml	2008.00		540	-	1.0	R	-	
755	Ultane (Sevoflurane): per ml	2008.00		540	-	1.0	R	-	
756	Suprane (Desflurane); per ml	2008.00		540	-	1.0	R	-	
757	Aerrane (Isoflurane): per ml	2008.00		540	-	1.0	R	-	
758	Alyrane (enflurane): per ml	2008.00		540	-	1.0	R	-	
759	Fluothane (Halothane): per ml	2008.00		540	-	1.0	R	-	
	ANNEXURES								

	APPENDIX A □ □ LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES□□ □ CATEGORY 1□(CPT4 2000 code numbers included where possible)□ □□ Diagnostic laparoscopy (49320)□ Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670)□ Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771)□ Hysteroscopy diagnostic (58555)□ Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C (58558)□ □ THORACOSCOPY, DIAGNOSTIC □□ THORACOSCOPY, DIAGNOSTIC with biopsy □□ THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy□□ THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy□□ THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy□□ THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy□□ THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy□□ □□ CATEGORY 2 □□ □□ Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673)□ Laparoscopy, surgical; with fimbrioplasty (58672)□ Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface,	2005.03						

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	APPENDIX B□ □ PRINCIPLES□ □ The following principles are applicable:□ □ 1. □At all times best clinical practice must be adhered too.□ □ 2. □Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only. Photocopies of all documents pertaining to the patients account must be provided on request. Medical schemes shall have the right to inspect the original source documentation at the hospital/sameday surgical facilities concerned. The Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Sub-Acute Facilities, Private Hospitals and Sameday Surgery Facilities will be reviewed half-yearly.□ □ 3. □The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows:□ □ ¢□Items included in the per minute theatre fee.□ ¢□Items included in the per day ward or unit fee.□	2005.03						

	APPENDIX C□ □ □ Infectious □iseases□ □ CONDITION□ □ Acute Flaccid Paralysis□ Anthrax□ Chicken Pox□ Diptheria□ Haemophyllis Influenza□ Haemorrhagic fevers of Africa:□ ¢□Crimean-Congo Ebola□ ¢□Lassa□ ¢□Marburg□ ¢□Rift Valley□ ¢□Dengue□ Herpes Zoster□ HIV/AIDS□ Legionnaires Disease□ Measles:□ ¢□Rubeola□ ¢□Rubella□ Meningococcal Infections□ Multi-drug Resistant Bacteria:□ ¢□MRSA□ ¢□VRE□ ¢□MRSE□ Poliomyelitis□ Pyrexia unknown origin□ Rabies□ Small Pox□ Tuberculosis Pulmonary□ Typhus Fever□ Viral Hepatitis□	2005.03						

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	APPENDIX D□							
	□							
	Medically Prescribed Meals:□							
	□							
	□□□							
	ORAL SUPPLEMENTS□Standard□□□□Ensure□							
	(oral and tube feeds)□□□□□□Fortisip□							
	□□□□□□□□□Fortimel□							
	□□□□□□□□□Fresubin Original drink (Vanilla)□							
	□□□□□□□□□Nutren And Nutren Jnr (Gluten -free)□							
	□□□□Standard & Fibre□□□Ensure with Fibre□							
	□□□□□□□□□Nutren with Fibre□							
	□□□□Isotonic□□□□Fresubin Original□							
	□□□□Isotonic &Fibre□□□Fresubin Original Fibre□							
	□□□□□□□□□Jevity□							
	□□□□□□□□□Osmolite□							
	□□□□Low Residue□□□Modulen N□							
	□□□□□□□□□Osmolite HN□							
	□□□□□□□□□Peptamen & Peptamen Jnr□							
	□□□□High Energy, High Protein & Fibre□Fresubin Energy Fibre drink□							
	□□□□□□□□□(Lemon, Banana, Chocolate & Capuchino)□							
	□□□□High Energy & High Protein□□Fresubin Energy drink□							
	□□□□□□□□□(Strawberry & Vanilla)□							
	□□□							
	TUBE FEEDS□□□Semi-Elemental□□□Alitraq□							
	□□□□□□□□□Peptamen & Peptamen Jnr RTH□							
	□□□□□□□□□Peptisorb□							
	□□□□□□□□□Survimed OPD (Liquid)□							
	□□□□□□□□□Vital□							
	□□□□Standard□□□□Nutren RTH□							
	□□□□□□□□□Nutrison□							
	□□□□□□□□□Nutrison Energy□							
	□□□□□□□□□Nutrison Paediatric□							
	□□□□High Energy & High Protein□□Fresubin 750 MCT(HP Energy)□							
	□□□□Semi-Elemental High Protein□Perative, □	2005.03						

Unattached Operating Theatre Units 2008

Code	Description
57600	Unattached operating theatres / Day clinics

Unattached Operating Theatre Units 2008

Code	Description	RCF
540	Unattached operating theatres / Day clinics	27.404

AMBULANCE SERVICES

Ambulance Services 2008

NATIONAL REFERENCE PRICE LIST FOR AMBULANCE SERVICES, EFFECTIVE FROM 1 JANUARY 2008		
The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well. In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL PRICES ARE VAT EXCLUSIVE.		
Preamble		
It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules: · The limitation, if any, for such benefits.		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE		
GENERAL RULES		
001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.	04.00
002	No after hours fees may be charged	04.00
003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.	04.00
004	Guidelines for information required on each account : · Name of service · BHF practice number · Address · Telephone number · Pre-authorisation number · The name of the member · The name of the patient · The name of the medical scheme · The membership number of the member · Diagnosis of patient's condition · Summary of medical procedures undertaken on patient and vital signs of patient · Summary of all equipment used · The date on which the service was rendered. · Name and HPCSA registration number of care providers · Name, practice number and HPCSA registration number of medical doctor · Response vehicle: Details of vehicle driver and intervention undertaken on patient · The code number of the procedure used in the National Reference Price List.	04.00
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.	05.04
Definitions of Ambulance Patient Transfer		
	Basic Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient in transit. Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA). (e.g. Initiating and/or maintaining IV therapy, nebulisation etc.) whilst patient in transit. Advanced Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Paramedic	04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	(CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers. NOTES: Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ALS to be charged. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ILS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ILS to be charged. · In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital. · In order to bill as an intermediate life support call, a registered intermediate life support provider must have examined, treated and monitored the patient while in transit to hospital. · Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient or ALS monitoring and presence is not required, the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call not an ALS call). Where an ILS provider is in attendance at a callout but does not do any interventions at an ILS level on the patient or ILS monitoring and presence is not required, the billing will be BLS. · Where the management undertaken by a paramedic or AEA fall within the scope of practice of a BAA the call must be at a BLS level. Please Note : · The amounts reflected in the NRPL for each level of care is inclusive of any disposables (except for pacing pads, heimlich valves, high capacity giving sets, dial a flow, intra-osseous needles) and drugs used in the management of the patient, as per attached nationally approved medication protocols. · Haemaccel and colloid solution may be charged separately. · Claims for patient discharges home will only be entertained if accompanied by a written motivation from the attending physician who requested such transport - clearly stating why an ambulance is required for such a transport and what medical assistance the patient requires on route.								

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
DEFINITION: RESPONSE VEHICLES									
	Response vehicles only - Advance Life Support (ALS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under items 131 and 133. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered. 2. In the event of a service rendering ALS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ALS bill under items 131 and 133. Since the ALS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ALS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ALS services rendered. 3. Should a response vehicle go to a scene and not render any ALS treatment then the said response vehicle may not levy a bill. 4. Notwithstanding that, item 151 applies to all ALS resuscitation per the notes in this schedule. Response vehicle only - Intermediate Life Support (ILS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ILS rate under items 125 and 127. Furthermore the ILS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ILS services rendered. 2. In the event of a service rendering ILS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ILS bill under items 125 and 127. Since the ILS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ILS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ILS services rendered. 3. Should a response vehicle go to a scene and not render any ILS treatment then the said response vehicle may not levy a bill.								04.00
1	**BASIC LIFE SUPPORT**								
Metropolitan area									
100	Up to 45 minutes	05.04		171.276	766.10	171.276	766.10	171.276	766.10
102	Up to 60 minutes	05.04		228.156	1020.50	228.156	1020.50	228.156	1020.50
103	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		57.084	255.40	57.084	255.40	57.084	255.40
Long distance									
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		2.843	12.70	2.843	12.70	2.843	12.70

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.47	1.000	4.47	1.000	4.47
2	**INTERMEDIATE LIFE SUPPORT**								
Metropolitan area									
125	Up to 45 minutes	05.04		231.226	1034.20	231.226	1034.20	-	-
127	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		77.075	344.70	77.075	344.70	-	-
Long distance									
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		3.850	17.20	3.850	17.20	-	-
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.47	1.000	4.47	-	-
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**								
Metropolitan area									
131	Up to 60 minutes	05.04		406.641	1818.90	-	-	-	-
133	Every 15 minutes thereafter or part thereof, where specially motivated.	05.04		101.660	454.70	-	-	-	-
Long distance									
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		5.072	22.70	-	-	-	-
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.47	-	-	-	-
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**								
151	Resuscitation fee, per incident	04.00		454.000	2030.60	454.000	2030.60	-	-
153	Doctor per hour	04.00		130.000	581.50	130.000	581.50	-	-
	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion-synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (Oral or nasal) with assisted ventilation	04.00							
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.								04.00
5.	**AEROMEDICAL TRANSFERS**								
	BY ARRANGEMENT WITH MEDICAL SCHEME								04.00
Rotorwing Rates									
	Definitions: 1. Helicopter rates are determined according to aircraft type 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C) 4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated. 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 7. Rates are calculated according to time; from throttle open, to throttle closed. 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 9. Hot loads restricted to 8 minutes ground time and must be denoted.								04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	AIRCRAFT TYPE A (RA): HB206L, HB204 / 205, HB407, AS360, EC120, MD500, AS350, A119 AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC) BO105, 206CT, AS355, A109 AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC) HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100								04.00
500	Basic Call Cost (Start up)	04.00							
Flying Time									
531	30 minutes	04.00							
533	45 minutes	04.00							
535	60 minutes	04.00							
537	75 minutes	04.00							
539	90 minutes	04.00							
541	105 minutes	04.00							
543	120 minutes	04.00							
Staff and Consumables									
581	30 minutes	04.00							
583	45 - 75 minutes	04.00							
585	90 - 105 minutes	04.00							
587	120 minutes	04.00							
Aircraft Type D									
591	Hourly rate plus 20%	04.00							
Winching									
595	Winching, per lift	04.00							
Fixed Wing Rates									
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. Please note that no fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee would be advised. The definition of use of these aircraft needs to be narrowed down further to eliminate abuse. 3. Staff and consumables cost can only be used if patient has been treated. 5. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)								04.00
Group A (FA)									
	Composed of flying cost per kilometer, staff cost per hour and equipment cost								04.00
Staff cost per hour									
621	Doctor	04.00							

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
623	ICU Sister	04.00							
625	Paramedic	04.00							
Equipment Cost									
631	Per patient, per hour	04.00							
Aircraft cost (per kilometer)									
651	Beechcraft Duke	04.00							
653	Lear 24F	04.00							
655	Lear 35	04.00							
657	Falcon 10	04.00							
659	King Air 200	04.00							
661	Mitsubishi MU2	04.00							
663	Cessna 402	04.00							
665	Beechcraft Baron	04.00							
667	Citation II	04.00							
669	Pilatus PC12	04.00							
Group B - Emergency Charters									
	1. No staff and equipment fee allowed. 2. Cost to be reviewed per case. 3. Only allowed if a Group A aircraft is not available within an optimal period for transportation and stabilisation of the patient.								04.00
6	**NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**								
	Registered Basic Ambulance Assistant Qualification · Oxygen · Entonox · Oral Glucose Registered Ambulance Emergency Assistant Qualification As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Soluble Aspirin Registered Paramedic Qualification As above, plus · Oral glyceryl trinitrate, activated charcoal · Ipratropium bromide inhalant solution · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer. · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.								04.00

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				51000						51100					51200					
	NATIONAL REFERENCE PRICE LIST FOR	Version	Add	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag	
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest ALL PRICES ARE VAT EXCLUSIVE.	2005.05																	
	Preamble																			
	It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules: □ □ · The limitation, if any, for such benefits.	2004.00																	
	REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE																			
	GENERAL RULES																			
001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.	2004.00																	
002	No after hours fees may be charged	2004.00																	

003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.	2004.00																	
004	Guidelines for information required on each account : · Name of service · BHF practice number · Address · Telephone number · Pre-authorisation number · The name of the member · The name of the patient · The name of the medical scheme · The membership number of the member · Diagnosis of patient's condition · Summary of medical procedures undertaken on patient and vital signs of patient · Summary of all equipment used · The date on which the service was rendered. · Name and HPCSA registration number of care providers · Name, practice number and HPCSA registration number of medical doctor · Response vehicle: Details of vehicle driver and intervention undertaken on patient · The code number of the procedure used in the National Reference Price List.	2004.00																	
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00																	
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.	2005.04																	
	Definitions of Ambulance Patient Transfer																		

	Basic Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient in transit.□ □ Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA). (e.g. Initiating and/or maintaining IV therapy, nebulisation etc.) whilst patient in transit.□ □ Advanced Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Paramedic (CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers.□ □ NOTES:□ □ Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling.□ □ · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor re □ · If a hospital or the attending physician requires a Parame	2004.00																			
	DEFINITION: RESPONSE VEHICLES																			

	Response vehicles only - Advance Life Support (ALS)□ □ A clear definition must be drawn between the acute primary response and a booked call.□ □ 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under items 131 and 133. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered.□ □ 2. In the event of a service rendering ALS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the □ 3. Should a response vehicle go to a scene and not render □ 4. Notwithstanding that, item 151 applies to all ALS resusc □ Response vehicle only - Intermediate Life Support (ILS)□ □ A clear definition must be drawn between the acute primar □ 1. The Acute Primary Response is defined as follows: A c □ 2. In the event of a service rendering ILS and not having its	2004.00																	
1	BASIC LIFE SUPPORT																		
	Metropolitan area																		
100	Up to 45 minutes	2005.04		160	171.276	1.0	R 766.10		160	171.276	1.0	R 766.10		160	171.276	1.0	R 766.10		
102	Up to 60 minutes	2005.04		160	228.156	1.0	R1 020.50		160	228.156	1.0	R1 020.50		160	228.156	1.0	R1 020.50		
103	Every 15 minutes thereafter or part thereof, where specially motivated	2005.04		160	57.084	1.0	R 255.40		160	57.084	1.0	R 255.40		160	57.084	1.0	R 255.40		
	Long distance																		

Ambulance Services 2008

111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	2005.04		160	2.843	1.0	R 12.70		160	2.843	1.0	R 12.70		160	2.843	1.0	R 12.70		
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	2006.02		160	1.000	1.0	R 4.47		160	1.000	1.0	R 4.47		160	1.000	1.0	R 4.47		
2	INTERMEDIATE LIFE SUPPORT																		
	Metropolitan area																		
125	Up to 45 minutes	2005.04		160	231.226	1.0	R1 034.20		160	231.226	1.0	R1 034.20		160	-	0.0	R -		
127	Every 15 minutes thereafter or part thereof, where specially motivated	2005.04		160	77.075	1.0	R 344.70		160	77.075	1.0	R 344.70		160	-	0.0	R -		
	Long distance																		
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	2005.04		160	3.850	1.0	R 17.20		160	3.850	1.0	R 17.20		160	-	0.0	R -		
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	2006.02		160	1.000	1.0	R 4.47		160	1.000	1.0	R 4.47		160	-	0.0	R -		
3	ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT																		
	Metropolitan area																		
131	Up to 60 minutes	2005.04		160	406.641	1.0	R1 818.90		160	-	0.0	R -		160	-	0.0	R -		
133	Every 15 minutes thereafter or part thereof, where specially motivated.	2005.04		160	101.660	1.0	R 454.70		160	-	0.0	R -		160	-	0.0	R -		
	Long distance																		
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	2005.04		160	5.072	1.0	R 22.70		160	-	0.0	R -		160	-	0.0	R -		
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	2006.02		160	1.000	1.0	R 4.47		160	-	0.0	R -		160	-	0.0	R -		
4	ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT																		
151	Resuscitation fee, per incident	2004.00		160	454.000	1.0	R2 030.60		160	454.000	1.0	R2 030.60		160	-	0.0	R -		
153	Doctor per hour	2004.00		160	130.000	1.0	R 581.50		160	130.000	1.0	R 581.50		160	-	0.0	R -		
	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following:□ · Administration of advanced cardiac life support drugs.□ · Cardioversion-synchronised or unsynchronised (defibrillation)□ · External cardiac pacing□ · Endotracheal intubation (Oral or nasal) with assisted ventilation□	2004.00																	
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.	2004.00																	
5.	AEROMEDICAL TRANSFERS																		

Ambulance Services 2008

	BY ARRANGEMENT WITH MEDICAL SCHEME	2004.00																		
	Rotorwing Rates																			
	Definitions:□ □ 1. Helicopter rates are determined according to aircraft type□ 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise)□ 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C)□ 4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated.□ 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments.□ 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients)□ 7. Rates are calculated according to time; from throttle open, to throttle closed.□ 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation.□ 9. Hot loads restricted to 8 minutes ground time and must	2004.00																			
	AIRCRAFT TYPE A (RA):□ HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119□ □ AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC)□ BO105, 206CT, AS355, A109□ □ AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC)□ HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105□ □ AIRCRAFT TYPE D (RESCUE)□ H500, HB206B, AS350, AS315, FH1100□	2004.00																			
500	Basic Call Cost (Start up)	2004.00																		
	Flying Time																			
531	30 minutes	2004.00																		
533	45 minutes	2004.00																		
535	60 minutes	2004.00																		
537	75 minutes	2004.00																		

Ambulance Services 2008

539	90 minutes	2004.00
541	105 minutes	2004.00
543	120 minutes	2004.00
	Staff and Consumables	
581	30 minutes	2004.00
583	45 - 75 minutes	2004.00
585	90 - 105 minutes	2004.00
587	120 minutes	2004.00
	Aircraft Type D	
591	Hourly rate plus 20%	2004.00
	Winching	
595	Winching, per lift	2004.00
	Fixed Wing Rates	
	DEFINITIONS:□ □ 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation.□ 2. Please note that no fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee would be advised. The definition of use of these aircraft needs to be narrowed down further to eliminate abuse.□ 3. Staff and consumables cost can only be used if patient has been treated.□ 5. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)	2004.00
	Group A (FA)	
	Composed of flying cost per kilometer, staff cost per hour and equipment cost	2004.00
	Staff cost per hour	
621	Doctor	2004.00
623	ICU Sister	2004.00
625	Paramedic	2004.00
	Equipment Cost	
631	Per patient, per hour	2004.00
	Aircraft cost (per kilometer)	
651	Beechcraft Duke	2004.00
653	Lear 24F	2004.00
655	Lear 35	2004.00
657	Falcon 10	2004.00

659	King Air 200	2004.00																		
661	Mitsubishi MU2	2004.00																		
663	Cessna 402	2004.00																		
665	Beechcraft Baron	2004.00																		
667	Citation II	2004.00																		
669	Pilatus PC12	2004.00																		
	Group B - Emergency Charters																			
	1. No staff and equipment fee allowed.□ 2. Cost to be reviewed per case.□ 3. Only allowed if a Group A aircraft is not available within an optimal period for transportation and stabilisation of the patient.	2004.00																		
6	NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS																			
	Registered Basic Ambulance Assistant Qualification□ · Oxygen□ · Entonox□ · Oral Glucose□ □ Registered Ambulance Emergency Assistant Qualification□ As above, plus□ · Intravenous fluid therapy □ · Intravenous dextrose 50%□ · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol)□ · Soluble Aspirin□ □ Registered Paramedic Qualification□ As above, plus□ · Oral glyceryl trinitrate, activated charcoal□ · Ipratropium bromide inhalant solution□ · Endotracheal Adrenaline and Atropine□ · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hataclopramide□ · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer.□ · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.	2004.00																			

Ambulance Services 2008

Code	Description	RCF
160	Ambulance Services	5.099

Ambulance Services 2008

Code	Description
51000	Ambulance Services : Advanced Life Support
51100	Ambulance Services : Intermediate Life Support
51200	Ambulance Services : Basic Life Support

CLINICAL TECHNOLOGISTS

Clinical Technologists 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

001	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

MODIFIERS

0001	Fee prorated according to number of treatment days; fee = ([number of treatment days] / 30) X (item fee)	05.03

ITEMS

Surgical Support

Code	Description	Ver	Add	Clinical Technology RVU	Clinical Technology Fee
010	Ablations	04.00		219.700	1667.30 (1462.50)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1492.80 (1309.50)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1667.30 (1462.50)
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	04.00		20.300	154.10 (135.20)
014	Radiofrequency Catheter Ablations	04.00		219.700	1667.30 (1462.50)
	Not to be charged with item 012	05.03			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	04.00		19.400	147.20 (129.10)
	May only submit once in theatre and once in catheterisation laboratory	05.03			
017	Standby with extra-corporeal equipment for surgery within hospital	04.00		58.800	446.20 (391.40)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	147.20 (129.10)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	446.20 (391.40)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	04.00		10.000	75.90 (66.60)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	04.00		196.700	1492.80 (1309.50)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	147.20 (129.10)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	585.10 (513.20)
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	04.00		61.700	468.20 (410.70)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	110.80 (97.20)
034	Lymph compression treatment.	04.00		22.500	170.80 (149.80)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1667.30 (1462.50)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	253.50 (222.40)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	04.00		26.300	199.60 (175.10)

Pulmonology

	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.				04.00
035	Nebulization (per one procedure).	04.00		12.300	93.30 (81.80)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	183.70 (161.10)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
039	Flow-volume determinations.	04.00		30.600	232.20 (203.70)
041	Flow-volume (Pre-post B-D).	04.00		50.800	385.50 (338.20)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	183.70 (161.10)
045	Gas distribution measurements.	04.00		24.200	183.70 (161.10)
047	Diffusion determinations.	04.00		24.200	183.70 (161.10)
049	Exercise testing (EIA).	04.00		17.100	129.80 (113.90)
050	ECMO change-out and re-establishment.	04.00		46.300	351.40 (308.20)
051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	04.00		24.200	183.70 (161.10)
053	Allergy tests.	04.00		11.400	86.50 (75.90)
055	If RAST included add (per allergen).	04.00	+	11.400	86.50 (75.90)
057	Bronchial provocation testing.	04.00		40.800	309.60 (271.60)
059	Compliance measurements.	04.00		24.200	183.70 (161.10)
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	04.00		6.000	45.50 (39.90)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	226.90 (199.00)
063	Cardiac catheterisation for the first hour.	04.00		40.300	305.80 (268.20)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	75.90 (66.60)
064	Intravascular Ultrasound (IVUS)	04.00		25.700	195.00 (171.10)
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	05.03			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	75.90 (66.60)
066	Cardiac Cath Right Heart Studies	04.00		56.000	425.00 (372.80)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	515.30 (452.00)
069	Temporary and single Pacemaker procedures.	04.00		40.300	305.80 (268.20)
070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	04.00		46.300	351.40 (308.20)
	Not to be charged in conjunction with items 063 or 065	05.03			
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	75.90 (66.60)
072	Multisite Pacing (Bi-ventricular pacing)	04.00		46.300	351.40 (308.20)
073	Dilatation procedures and stents.	04.00		55.400	420.40 (368.80)
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	04.00		10.000	75.90 (66.60)
075	Pacemaker checking and/or reprogramming.	04.00		14.000	106.20 (93.20)
077	24 Hour Holter ambulatory monitoring.	04.00		55.400	420.40 (368.80)
079	Cardiac exercise stress testing.	04.00		29.100	220.80 (193.70)
081	Recording of twelve lead ECG.	04.00		7.700	58.40 (51.20)
087	M Mode echocardiogram.	04.00		16.600	126.00 (110.50)
089	2D echocardiogram.	04.00		29.400	223.10 (195.70)
091	Doppler flow.	04.00		32.300	245.10 (215.00)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
093	Colour imaging.	04.00		32.300	245.10 (215.00)
095	ECG signal averaging (Hi-Res).	04.00		53.700	407.50 (357.50)
097	Ambulatory bloodpressure monitoring.	04.00		18.600	141.20 (123.90)
099	Vector cardiogram.	04.00		55.400	420.40 (368.80)
111	Transoesophageal echocardiogram.	04.00		43.100	327.10 (286.90)
Neurology					
	Preparation, recording and analyses/technical report of:				04.00
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	05.03		74.100	562.30 (493.20)
179	Auditory evoked potentials, full audiological examination, bilateral	05.03		74.100	562.30 (493.20)
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	05.03		37.110	281.60 (247.00)
181	Somatosensory evoked potentials, unilateral, upper limb	05.03		37.110	281.60 (247.00)
182	Somatosensory evoked potentials, unilateral, lower limb	05.03		37.110	281.60 (247.00)
115	Additional 2 nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	04.00		14.900	113.10 (99.20)
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	04.00		43.100	327.10 (286.90)
183	Electronystagmography for spontaneous and positional nystagmus (3253)	05.03		24.150	183.30 (160.80)
184	Caloric test done with electronystagmography (3255)	05.03		67.570	512.80 (449.80)
119	Sleep EEG.	04.00		31.400	238.30 (209.00)
185	Overnight polysomnography	05.03		264.830	2009.80 (1763.00)
186	Obstructive sleep apnea screening	05.03		137.170	1041.00 (913.20)
187	Long term EEG monitoring with a minimum of 8 hours (but less than 16 hours) recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	05.03		137.890	1046.40 (917.90)
188	Long term EEG monitoring with 16 to 24 hours recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	05.03		264.830	2009.80 (1763.00)
125	Multiple sleep latency test (MSLT)	04.00		111.100	843.10 (739.60)
127	Overnight CPAP titration.	04.00		104.200	790.80 (693.70)
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	05.02	+	17.420	132.20 (116.00)
133	EEG with special activation.	04.00		49.400	374.90 (328.90)
135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	04.00		14.900	113.10 (99.20)
137	Intra-operative evoked potentials for the 1st hour	04.00		55.400	420.40 (368.80)
139	Each additional hour or part theraof provided that such part comprises 50% or more of the time.	04.00		37.100	281.60 (247.00)
141	Intra-operative EEG (carotid endarterectomy).	04.00		26.300	199.60 (175.10)
143	Transcranial or Carotid Doppler (bilateral).	04.00		39.400	299.00 (262.30)
Dialysis					
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT).	04.00		46.300	351.40 (308.20)
146	Chronic haemodialysis (acetate dialysate)	04.00		149.400	1133.80 (994.60)
148	Chronic haemodialysis (bicarbonate dialysate)	04.00		159.600	1211.20 (1062.50)
	In the case of items 148 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning materials, equipment set-up, up to 5 hours treatment time, equipment rental	05.03			

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
147	Peritoneal dialysis, per day	04.00		16.800	127.50 (111.80)
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies; b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	05.03			
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period.	05.03		1700.000	12901.30 (11316.90)
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	05.03		2360.000	17910.00 (15710.50)
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	04.00		33.400	253.50 (222.40)
150	Acute haemodialysis	04.00		317.200	2407.20 (2111.60)
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental	05.03			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	04.00		24.800	188.20 (165.10)
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	04.00		49.700	377.20 (330.90)
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	04.00		74.500	565.40 (496.00)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	04.00		99.300	753.60 (661.10)
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	04.00		16.600	126.00 (110.50)
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours).	04.00		29.100	220.80 (193.70)
Reproductive Health					
	As schemes will not necessarily grant benefits in respect of some items below, they fall into the "By arrangement with the scheme" category				04.00
159	Post Vasectomy semen analysis.	04.00		10.000	75.90 (66.60)
161	Complete semen analysis.	04.00		31.700	240.60 (211.10)
163	Semen wash for A I.	04.00		30.300	229.90 (201.70)
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	04.00		368.700	2798.10 (2454.50)
	Cannot be used with items 161, 163, 167 and 169	05.03			
167	Ovum and embryo freezing.	04.00		131.300	996.40 (874.00)
169	Semen freezing.	04.00		30.300	229.90 (201.70)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	5.12 (4.49)
173	Equipment hire (By arrangement with scheme).	04.00		-	-
175	Medication / Material	04.00		-	-
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	05.03			

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				37500					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**	
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00							
	GENERAL RULES								
001	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00							
	MODIFIERS								
0001	Fee prorated according to number of treatment days;. fee = ([number of treatment days] / 30) X (item fee)	2005.03							
	ITEMS								
	Surgical Support								
010	Ablations	2004.00		190	219.700	1.0	R 1 667.30		
011	Preparation of extra-corporeal equipment for surgical procedures.	2004.00		190	196.700	1.0	R 1 492.80		
012	Operation of heart laser during myocardial revascularisation	2004.00		190	219.700	1.0	R 1 667.30		
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	2004.00		190	20.300	1.0	R 154.10		
014	Radiofrequency Catheter Ablations	2004.00		190	219.700	1.0	R 1 667.30		
	Not to be charged with item 012	2005.03							
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	2004.00		190	19.400	1.0	R 147.20		
	May only submit once in theatre and once in catheterisation laboratory	2005.03							
017	Standby with extra-corporeal equipment for surgery within hospital	2004.00		190	58.800	1.0	R 446.20		
	Cannot be used with 011	2005.03							
019	Standby within the hospital for coronary angioplasty.	2004.00		190	19.400	1.0	R 147.20		
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	2004.00		190	58.800	1.0	R 446.20		
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	2004.00		190	10.000	1.0	R 75.90		
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	2004.00		190	196.700	1.0	R 1 492.80		
027	Preparation and operation of a pre- and post-operative blood salvage device.	2004.00		190	19.400	1.0	R 147.20		

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029	Preparation and operation of an autotransfusion cell washing system.	2004.00		190	77.100	1.0	R	585.10		
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	2004.00		190	61.700	1.0	R	468.20		
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	2004.00		190	14.600	1.0	R	110.80		
034	Lymph compression treatment.	2004.00		190	22.500	1.0	R	170.80		
116	Preparation and operation of an artificial heart (Berlin-Heart)	2004.00		190	219.700	1.0	R	1 667.30		
118	Daily monitoring of artificial heart, per hour	2004.00		190	33.400	1.0	R	253.50		
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	2004.00		190	26.300	1.0	R	199.60		
	Pulmonology									
	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.	2004.00								
035	Nebulization (per one procedure).	2004.00		190	12.300	1.0	R	93.30		
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	2004.00		190	24.200	1.0	R	183.70		
039	Flow-volume determinations.	2004.00		190	30.600	1.0	R	232.20		
041	Flow-volume (Pre-post B-D).	2004.00		190	50.800	1.0	R	385.50		
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	2004.00		190	24.200	1.0	R	183.70		
045	Gas distribution measurements.	2004.00		190	24.200	1.0	R	183.70		
047	Diffusion determinations.	2004.00		190	24.200	1.0	R	183.70		
049	Exercise testing (EIA).	2004.00		190	17.100	1.0	R	129.80		
050	ECMO change-out and re-establishment.	2004.00		190	46.300	1.0	R	351.40		
051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	2004.00		190	24.200	1.0	R	183.70		
053	Allergy tests.	2004.00		190	11.400	1.0	R	86.50		
055	If RAST included add (per allergen).	2004.00	+	190	11.400	1.0	R	86.50		
057	Bronchial provocation testing.	2004.00		190	40.800	1.0	R	309.60		
059	Compliance measurements.	2004.00		190	24.200	1.0	R	183.70		
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	2004.00		190	6.000	1.0	R	45.50		
	Cardiology									
062	Assist in preparations and operations of Rotablator Procedures	2004.00		190	29.900	1.0	R	226.90		
063	Cardiac catheterisation for the first hour.	2004.00		190	40.300	1.0	R	305.80		
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	2004.00		190	10.000	1.0	R	75.90		
064	Intravascular Ultrasound (IVUS)	2004.00		190	25.700	1.0	R	195.00		
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	2005.03								
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	2004.00		190	10.000	1.0	R	75.90		
066	Cardiac Cath Right Heart Studies	2004.00		190	56.000	1.0	R	425.00		
067	Cardiac Electro physiology and related procedures for first FOUR hours.	2004.00		190	67.900	1.0	R	515.30		
069	Temporary and single Pacemaker procedures.	2004.00		190	40.300	1.0	R	305.80		

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070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	2004.00		190	46.300	1.0	R	351.40		
	Not to be charged in conjunction with items 063 or 065	2005.03								
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	2004.00		190	10.000	1.0	R	75.90		
072	Multisite Pacing (Bi-ventricular pacing)	2004.00		190	46.300	1.0	R	351.40		
073	Dilatation procedures and stents.	2004.00		190	55.400	1.0	R	420.40		
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	2004.00		190	10.000	1.0	R	75.90		
075	Pacemaker checking and/or reprogramming.	2004.00		190	14.000	1.0	R	106.20		
077	24 Hour Holter ambulatory monitoring.	2004.00		190	55.400	1.0	R	420.40		
079	Cardiac exercise stress testing.	2004.00		190	29.100	1.0	R	220.80		
081	Recording of twelve lead ECG.	2004.00		190	7.700	1.0	R	58.40		
087	M Mode echocardiogram.	2004.00		190	16.600	1.0	R	126.00		
089	2D echocardiogram.	2004.00		190	29.400	1.0	R	223.10		
091	Doppler flow.	2004.00		190	32.300	1.0	R	245.10		
093	Colour imaging.	2004.00		190	32.300	1.0	R	245.10		
095	ECG signal averaging (HI-Res).	2004.00		190	53.700	1.0	R	407.50		
097	Ambulatory bloodpressure monitoring.	2004.00		190	18.600	1.0	R	141.20		
099	Vector cardiogram.	2004.00		190	55.400	1.0	R	420.40		
111	Transoesophageal echocardiogram.	2004.00		190	43.100	1.0	R	327.10		
	Neurology									
	Preparation, recording and analyses/technical report of:	2004.00								
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	2005.03		190	74.100	1.0	R	562.30		
179	Auditory evoked potentials, full audiological examination, bilateral	2005.03		190	74.100	1.0	R	562.30		
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	2005.03		190	37.110	1.0	R	281.60		
181	Somatosensory evoked potentials, unilateral, upper limb	2005.03		190	37.110	1.0	R	281.60		
182	Somatosensory evoked potentials, unilateral, lower limb	2005.03		190	37.110	1.0	R	281.60		
115	Additional 2 nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	2004.00		190	14.900	1.0	R	113.10		
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	2004.00		190	43.100	1.0	R	327.10		
183	Electronystagmography for spontaneous and positional nystagmus (3253)	2005.03		190	24.150	1.0	R	183.30		
184	Caloric test done with electronystagmography (3255)	2005.03		190	67.570	1.0	R	512.80		
119	Sleep EEG.	2004.00		190	31.400	1.0	R	238.30		
185	Overnight polysomnography	2005.03		190	264.830	1.0	R	2 009.80		
186	Obstructive sleep apnea screening	2005.03		190	137.170	1.0	R	1 041.00		
187	Long term EEG monitoring with a minimum of 8 hours (but less than 16 hours) recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	2005.03		190	137.890	1.0	R	1 046.40		
188	Long term EEG monitoring with 16 to 24 hours recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	2005.03		190	264.830	1.0	R	2 009.80		
125	Multiple sleep latency test (MSLT)	2004.00		190	111.100	1.0	R	843.10		
127	Overnight CPAP titration.	2004.00		190	104.200	1.0	R	790.80		
132	Mobile EEG setup in ICU (to be added to item 133 if appropriate)	2005.02	+	190	17.420	1.0	R	132.20		
133	EEG with special activation.	2004.00		190	49.400	1.0	R	374.90		

135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	2004.00		190	14.900	1.0	R	113.10		
137	Intra-operative evoked potentials for the 1st hour	2004.00		190	55.400	1.0	R	420.40		
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	2004.00		190	37.100	1.0	R	281.60		
141	Intra-operative EEG (carotid endarterectomy).	2004.00		190	26.300	1.0	R	199.60		
143	Transcranial or Carotid Doppler (bilateral).	2004.00		190	39.400	1.0	R	299.00		
	Dialysis									
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT).	2004.00		190	46.300	1.0	R	351.40		
146	Chronic haemodialysis (acetate dialysate)	2004.00		190	149.400	1.0	R	1 133.80		
148	Chronic haemodialysis (bicarbonate dialysate)	2004.00		190	159.600	1.0	R	1 211.20		
	In the case of items 146 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning materials, equipment set-up, up to 5 hours treatment time, equipment rental	2005.03								
147	Peritoneal dialysis, per day	2004.00		190	16.800	1.0	R	127.50		
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly).□ □ These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient):□ □ a. if the period of treatment is 26 days or more in that cycle, the full fee applies;□ □ b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	2005.03								
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period.	2005.03		190	1700.000	1.0	R	12 901.30		
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	2005.03		190	2360.000	1.0	R	17 910.00		
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	2004.00		190	33.400	1.0	R	253.50		
150	Acute haemodialysis	2004.00		190	317.200	1.0	R	2 407.20		
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental	2005.03								
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	2004.00		190	24.800	1.0	R	188.20		
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	2004.00		190	49.700	1.0	R	377.20		

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154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	2004.00		190	74.500	1.0	R	565.40		
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	2004.00		190	99.300	1.0	R	753.60		
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	2004.00		190	16.600	1.0	R	126.00		
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours).	2004.00		190	29.100	1.0	R	220.80		
	Reproductive Health									
	As schemes will not necessarily grant benefits in respect of some items below, they fall into the "By arrangement with the scheme" category	2004.00								
159	Post Vasectomy semen analysis.	2004.00		190	10.000	1.0	R	75.90		
161	Complete semen analysis.	2004.00		190	31.700	1.0	R	240.60		
163	Semen wash for A I.	2004.00		190	30.300	1.0	R	229.90		
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	2004.00		190	368.700	1.0	R	2 798.10		
	Cannot be used with items 161, 163, 167 and 169	2005.03								
167	Ovum and embryo freezing.	2004.00		190	131.300	1.0	R	996.40		
169	Semen freezing.	2004.00		190	30.300	1.0	R	229.90		
	Miscellaneous									
171	Travelling per km in excess of 16km (in own car).	2004.00		190	0.675	1.0	R	5.12		
173	Equipment hire (By arrangement with scheme).	2004.00		190	-	0.0	R	-		
175	Medication / Material	2004.00		190	-	0.0	R	-		
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).□ □ In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus -□ □ * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and□ □ * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	2005.03								

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Code	Description	RCF
190	Clinical Technologists	7.589

Clinical Technologists 2008

Code	Description
37500	Clinical Technology

CHIROPRACTORS

Chiropractors 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

001	All accounts must be presented with the following information clearly stated: · name of chiropractor; · qualifications of the chiropractor; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · a statement of whether the account is in accordance with the National Reference Price List; and . the name and practice number of the referring practitioner, if applicable.	04.00
002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation.	04.00
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include physical examination, neurological examination, orthopaedic examination, ergonomical analysis, postural analysis and radiological examination	05.06
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. Treatment procedures include, inter alia: spinal or extra-spinal manipulation, acupuncture, cold applications, non-heating modalities, deep heating radiation, soft tissue manipulation, superficial heating therapy and therapeutic exercises (other than in relation to preparation or fitting of appliances).	05.02
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.	05.03
006	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	05.03

MODIFIERS

CHIROPRACTORS RECOMMENDED REIMBURSEMENT RATES

Code	Description	Ver	Add	Chiropractice RVU	Chiropractice Fee
1	**Consultations**				
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	05.02			
301	Consultation	05.03		25.000	97.60 (85.60)
2	**Diagnostic procedures**				
	Only a single item from this section may be charged per patient encounter				05.03
	Radiation Control Council Certificate number to be on account if X-Rays charged				04.00
311	Single diagnostic procedure	05.03		25.000	97.60 (85.60)
312	Two diagnostic procedures	05.03		37.500	146.40 (128.40)
313	Three diagnostic procedures	05.05		50.000	195.30 (171.30)
3	**Immobilisation or therapeutic exercises in relation to preparation or fitting of appliances**				
	Only a single item from this section may be charged per patient encounter				05.03
321	Single instance of immobilization or therapeutic exercises	05.03		10.000	39.10 (34.30)
322	Two instances of immobilization or therapeutic exercises	05.03		15.000	58.60 (51.40)
4	**Treatment (therapeutic procedures)**				
	Only a single item from this section may be charged per patient encounter				05.03

Code	Description	Ver	Add	Chiropractice	
				RVU	Fee
331	Single treatment procedure	05.03		10.000	39.10 (34.30)
332	Two treatment procedures	05.03		15.000	58.60 (51.40)
333	Three treatment procedures	05.03		20.000	78.10 (68.50)
334	Four treatment procedures	05.03		25.000	97.60 (85.60)
335	Five treatment procedures	05.03		30.000	117.20 (102.80)
336	Six treatment procedures	05.03		35.000	136.70 (119.90)
5	**Consumables**				
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				05.03
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.	05.06		-	-
110	X-Ray films	06.00		-	-

Chiropractors 2008

				40400					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**	
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00							
	GENERAL RULES								
001	All accounts must be presented with the following information clearly stated: · name of chiropractor; · qualifications of the chiropractor; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · a statement of whether the account is in accordance with the National Reference Price List; and . the name and practice number of the referring practitioner, if applicable.	2004.00							
002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation.	2004.00							
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include physical examination, neurological examination, orthopaedic examination, ergonomical analysis, postural analysis and radiological examination	2005.06							
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. Treatment procedures include, inter alia: spinal or extra-spinal manipulation, acupuncture, cold applications, non-heating modalities, deep heating radiation, soft tissue manipulation, superficial heating therapy and therapeutic exercises (other than in relation to preparation or fitting of appliances).	2005.02							

005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.	2005.03								
006	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2005.03								
	MODIFIERS									
	CHIROPRACTORS RECOMMENDED REIMBURSEMENT RATES									
1	Consultations									
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2005.02								
301	Consultation	2005.03		180	25.000	1.0	R	97.60		
2	Diagnostic procedures									
	Only a single item from this section may be charged per patient encounter	2005.03								
	Radiation Control Council Certificate number to be on account if X-Rays charged	2004.00								
311	Single diagnostic procedure	2005.03		180	25.000	1.0	R	97.60		
312	Two diagnostic procedures	2005.03		180	37.500	1.0	R	146.40		
313	Three diagnostic procedures	2005.05		180	50.000	1.0	R	195.30		
3	Immobilisation or therapeutic exercises in relation to preparation or fitting of appliances									
	Only a single item from this section may be charged per patient encounter	2005.03								
321	Single instance of immobilization or therapeutic exercises	2005.03		180	10.000	1.0	R	39.10		
322	Two instances of immobilization or therapeutic exercises	2005.03		180	15.000	1.0	R	58.60		
4	Treatment (therapeutic procedures)									
	Only a single item from this section may be charged per patient encounter	2005.03								
331	Single treatment procedure	2005.03		180	10.000	1.0	R	39.10		
332	Two treatment procedures	2005.03		180	15.000	1.0	R	58.60		
333	Three treatment procedures	2005.03		180	20.000	1.0	R	78.10		
334	Four treatment procedures	2005.03		180	25.000	1.0	R	97.60		
335	Five treatment procedures	2005.03		180	30.000	1.0	R	117.20		
336	Six treatment procedures	2005.03		180	35.000	1.0	R	136.70		
5	Consumables									

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	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).□ □ In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus -□ □ * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and□ □ * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.	2005.03								
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.	2005.06		180	-	0.0	R	-		
110	X-Ray films	2006.00		180	-	0.0	R	-		

Chiropractors 2008

Code	Description	RCF
180	Chiropractors	3.905

BIOKINETICS

Biokinetics 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF BIOKINETICS WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation	04.00
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include the full range of diagnostic and evaluation procedures within the scope of practice of the biokineticist, including for example: anthropometric / body composition assessments, ergological testing evaluations and perceptual motor evaluation.	05.06
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. This limitation shall be inclusive of a maximum of one group treatment procedure (code 12), where applicable. Treatment procedures include the full range of rehabilitative or preventive treatment or care procedures within the scope of practice of the biokineticist, including for example: hydrotherapy, callisthenics exercises and programme prescription for individuals with CHD.	04.00
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Further continuance of treatment should only be considered if recommended by the medical practitioner(s) and others involved in the rehabilitation of the patient.	04.00
010	Every biokineticist must acquaint himself with the provisions of the Medical Schemes Act, 1998, and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the refering practitioner . · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered	04.00
011	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

MODIFIERS

ITEMS

1. Consultations / Patient Education / Counseling

Code	Description	Ver	Add	Biokinetics RVU	Biokinetics Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
901	Initial consultation including: a problem focused history; a short problem focused examination; and straightforward biokinetic decision making but excluding evaluation. To be charged only once per course of treatment. (inclusive of lung function tests)	06.01		16.700	64.20 (56.30)
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination; and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment.	06.01		11.700	45.00 (39.50)
905	Consultation at hospital (global fee including a problem focused history; a problem focused examination; and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment.	06.01		16.700	64.20 (56.30)
922	Patient education (based upon the evaluation outcomes)	06.01		16.300	62.60 (54.90)
936	Health promotion and lifestyle modifications	06.01		-	-
2.	**Evaluation / Diagnostic Procedures**				
908	Simple evaluation at the first visit only (to be fully documented)	06.01		10.000	38.40 (33.70)
909	Complex evaluation at the first visit only (to be fully documented).	06.01		16.700	64.20 (56.30)
912	Anthropometric/body composition assessment	06.01		10.000	38.40 (33.70)
913	Ergological testing evaluation of body segment, limb or joint	06.01		28.500	109.50 (96.10)

Code	Description	Ver	Add	Biokinetics	
				RVU	Fee
914	Neurological patients: Ergological evaluation	06.01		16.700	64.20 (56.30)
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	06.01		16.700	64.20 (56.30)
916	Perceptual motor evaluation (perception and gross motor function)	06.01		16.700	64.20 (56.30)
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	06.01		28.500	109.50 (96.10)
918	Physical work capacity with full ECG	06.01		28.500	109.50 (96.10)
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	06.01		28.500	109.50 (96.10)
921	Isokinetic testing by means of specialised electronic equipment	06.01		28.500	109.50 (96.10)
3.	**Therapeutic Procedures (Physical Rehabilitation)**				
	Maximum of 3 modalities, per diagnosis, may be charged per visit				04.00
923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	06.01		16.300	62.60 (54.90)
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	06.01		16.300	62.60 (54.90)
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	06.01		16.300	62.60 (54.90)
927	Posture, gait and activities of daily living (ADL), with/without equipment use	06.01		16.300	62.60 (54.90)
928	A rehabilitative exercise prescription	06.01		16.300	62.60 (54.90)
929	Callisthenics exercises	06.01		16.300	62.60 (54.90)
930	Group session with high risk patients, per patient (maximum 10 patients)	06.01		8.800	33.80 (29.60)
931	Passive and active range of motion exercise therapy	06.01		16.300	62.60 (54.90)
933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, Low-Back pain/ Lumbago etc.	06.01			
934	Group exercise sessions, per patient	06.01		8.800	33.80 (29.60)

Biokinetics 2008

				37700									
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF BIOKINETICS WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**					
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00											
	GENERAL RULES												
002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation	2004.00											
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include the full range of diagnostic and evaluation procedures within the scope of practice of the biokineticist, including for example: anthropometric / body composition assessments, ergological testing evaluations and perceptual motor evaluation.	2005.06											
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. This limitation shall be inclusive of a maximum of one group treatment procedure (code 12), where applicable. Treatment procedures include the full range of rehabilitative or preventive treatment or care procedures within the scope of practice of the biokineticist, including for example: hydrotherapy, callisthenics exercises and programme prescription for individuals with CHD.	2004.00											
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Further continuance of treatment should only be considered if recommended by the medical practitioner(s) and others involved in the rehabilitation of the patient.	2004.00											

918	Physical work capacity with full ECG	2006.01		340	28.500	1.0	R	109.50						
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	2006.01		340	28.500	1.0	R	109.50						
921	Isokinetic testing by means of specialised electronic equipment	2006.01		340	28.500	1.0	R	109.50						
3.	Therapeutic Procedures (Physical Rehabilitation)													
	Maximum of 3 modalities, per diagnosis, may be charged per visit	2004.00												
923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	2006.01		340	16.300	1.0	R	62.60						
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	2006.01		340	16.300	1.0	R	62.60						
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	2006.01		340	16.300	1.0	R	62.60						
927	Posture, gait and activities of daily living (ADL), with/without equipment use	2006.01		340	16.300	1.0	R	62.60						
928	A rehabilitative exercise prescription	2006.01		340	16.300	1.0	R	62.60						
929	Callisthenics exercises	2006.01		340	16.300	1.0	R	62.60						
930	Group session with high risk patients, per patient (maximum 10 patients)	2006.01		340	8.800	1.0	R	33.80						
931	Passive and active range of motion exercise therapy	2006.01		340	16.300	1.0	R	62.60						
933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, Low-Back pain/ Lumbago etc.	2006.01												
934	Group exercise sessions, per patient	2006.01		340	8.800	1.0	R	33.80						

Biokinetics 2008

	Every biokineticist must acquaint himself with the provisions of the Medical Schemes Act, 1998, and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner . · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service													
010	rendered	2004.00												
011	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00												
	MODIFIERS													
	ITEMS													
1.	Consultations / Patient Education / Counseling													
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		340	-	0.0	R	-						
901	Initial consultation including: a problem focused history; a short problem focused examination; and straightforward biokinetic decision making but excluding evaluation. To be charged only once per course of treatment. (inclusive of lung function tests)	2006.01		340	16.700	1.0	R	64.20						
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination; and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment.	2006.01		340	11.700	1.0	R	45.00						
905	Consultation at hospital (global fee including a problem focused history; a problem focused examination; and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment.	2006.01		340	16.700	1.0	R	64.20						
922	Patient education (based upon the evaluation outcomes)	2006.01		340	16.300	1.0	R	62.60						
936	Health promotion and lifestyle modifications	2006.01		340	-	0.0	R	-						
2.	Evaluation / Diagnostic Procedures													
908	Simple evaluation at the first visit only (to be fully documented)	2006.01		340	10.000	1.0	R	38.40						
909	Complex evaluation at the first visit only (to be fully documented).	2006.01		340	16.700	1.0	R	64.20						
912	Anthropometric/body composition assessment	2006.01		340	10.000	1.0	R	38.40						
913	Ergological testing evaluation of body segment, limb or joint	2006.01		340	28.500	1.0	R	109.50						
914	Neurological patients: Ergological evaluation	2006.01		340	16.700	1.0	R	64.20						
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	2006.01		340	16.700	1.0	R	64.20						
916	Perceptual motor evaluation (perception and gross motor function)	2006.01		340	16.700	1.0	R	64.20						
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	2006.01		340	28.500	1.0	R	109.50						

Biokinetics 2008

Code	Description	RCF
340	Biokinetics	3.843

DENTAL PRACTITIONERS

Dental Practitioners 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS; EFFECTIVE FROM 1 JANUARY 2008		
The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well. In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.		
The existence of a code in this publication does not mean that the procedure will be reimbursed by medical schemes. Medical schemes have the right to limit the scope, the frequency and/or combinations of dental procedures that is covered or reimbursed. It is the responsibility of the patient to know what procedures are covered and what are excluded from his/her dental benefit plan, and not that of the dental office. Certain medical schemes may require predetermination for particular procedures and/or when charges are expected to exceed a certain amount.		
The schedule includes procedures and services for use by Oral Health Care Providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and oral surgeons and dental therapists. The procedures codes listed in the schedule have, for the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of Oral Health Care Providers from performing such procedures. Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.		
I.	**INTRODUCTION**	
A.	**Administrative and invoicing rules**	
001	Invoices:	05.02
	a. A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.	05.02
	b. An invoice shall contain the following particulars:	05.02
	i. The surname and initials of the member; ii. The first name of the patient; iii. The name of the scheme; iv. The membership number of the member; v. The practice number; vi. The date on which every service was rendered; vii. The code number, description and fee/benefit of the procedure or service; viii. The name of the dentist rendering the service; ix. The name of the general dental practitioner/specialist assistant (when applicable); x. The appropriate ICD-10 code(s) for the procedures performed.	06.03
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.	05.02
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.	05.02
003	Dental laboratory services:	05.02
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code. The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.	05.02

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code 8099. The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the dentist for record purposes.										05.02
005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actuel services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/medical scheme may be billed. Use Modifier 8011 with a narrative description. Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.										05.02
B.	**General coding rules**										
006	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of Oral Health Care Provider are customary fees, should the procedure or service be rendered by that provider category. Specialists are however encouraged to confine their practice to the speciality or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25). Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being "by arrangement" until such fees are listed.										06.03
007	Procedures not listed in the Dental Schedule										05.02
	When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the NHRPL for medical practitioners may be reported.										06.03
	Unlisted procedures. Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 - Unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined "by arrangement" with the patient and/or medical scheme.										06.03
C.	**Services rules**										
008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – Treatment plan completed. Oral diagnosis defined. The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist. Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or maintenance of optimal oral health										06.03
009	Surgery guidelines:										05.02
	1. Follow-up care for therapeutic surgical procedures: The fee/benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.										05.02
	2. Multiple Procedures (Maxillo-facial and oral surgery): The fee/benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (Modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/benefit for the major operation plus: 75% for the second procedure/operation (Modifier 8009). 50% for the third and subsequent procedures/operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (Modifier 8006).										05.02

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	3. Assistant Surgeon (Maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 (of the fee of the practitioner performing the procedure (Modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% (of the fee of the practitioner performing the procedure (Modifier 8007). The patient must be informed beforehand that another dentist/specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.										05.02
	4. Surgical team (Maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (Modifier 8008).										05.02
010	Orthodontic guidelines:										05.02
	The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information: a. The treatment plan and type of treatment (treatment code number); b. A diagnostic code (ICD-10) and c. An orthodontic payment plan indicating the following: i. The total fee that will be levied for the treatment; ii. The total months of orthodontic treatment (retention period excluded); iii. The initial fee payable by the patient (approximately 20% of the total fee); and iv. The monthly payments of the balance of the fee.										06.03
	2. The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and 5 oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).										05.02
	3. The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).										05.02
	4. When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.										05.02
	5. The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.										05.02
	6. When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding - when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed. The balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (Orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to prior authorisation by the patient's medical scheme.										05.02
	7. When an established orthodontic patient requires re-treatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (Orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the patient's medical scheme.										05.02
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.										05.02

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
D.	**Modifiers**										
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. A service or procedure was performed by more than one practitioner. b. A service or procedure has been increased or reduced. c. Only part of a service was performed. d. An adjunctive service was performed. e. A service or procedure was provided more than once. f. The fee/benefit was altered due to a financial agreement.										06.03
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)										06.03
	Surgical assistant services should be identified by adding Modifier 8001 to the usual procedure code(s) – See Rule 009.										
8003	Minimum assistant surgeon	06.03	130.38 (114.37)	130.38 (114.37)		130.38 (114.37)					
	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.										
8005	Maximum multiple procedures (same incision) - MFO surgeon	06.03	202.42 (177.56)	202.42 (177.56)		202.42 (177.56)					
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.										
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)										06.03
	See Modifier 8009.										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)										06.03
	Surgical assistant services should be identified by adding Modifier 8007 to the usual procedure code(s) – See Rule 009.										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)										06.03
	When emergency surgery is performed after hours, such surgical procedures can be identified by adding Modifier 8008 to the procedure codes by each participating member of the surgical team.										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)										06.03
	When multiple procedures (under the same anaesthetic but through another incision) are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The additional procedures should be identified by adding the appropriate modifier (M8009 or M8006) to the additional procedure codes.										
8010	Open reduction (PLUS 75% of the appropriate benefit)										06.03
	When an open reduction is required for surgical procedures indicated in the schedule, the open reduction should be identified by adding Modifier 8010 in addition to the usual procedure code. TEMPORARY NOTE: Modifier 8010 applies only to codes 9035 and 9037. Two codes for "Open Reduction" was introduced so that the use of this modifier can be eliminated.										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)										06.03
	When the service provided by a practitioner is greater than that is usually required for the listed procedure, it may be identified by adding Modifier 8030 to the usual procedure code – See Rule 007.										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)										06.03
	Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.										
8013	Multiple modifiers										06.03

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations Modifier 8013 should be added to the basic procedure and the other applicable modifiers may be listed as part of the description of the service.										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)									06.03	
	When the direct technique is used to provide resin based inlays/onlays (see codes 8381 to 8384), laboratory costs do not apply. An additional fee may be levied by adding Modifier 8023 to the appropriate inlay/onlay codes.										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	06.03	-	-		-	-				
	When listed direct dental materials are provided by the practitioner, a handling fee may be levied by reporting Modifier 8025 in addition to the appropriate direct material code – See Rule 002.										
E.	**Explanations**										
Tooth identification and designation of areas of the oral cavity:											
	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.										04.00
Treatment categories:											
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows: Basic dentistry - designated as (B) in the treatment category column Advanced dentistry - designated as (A) in the treatment category column Surgery - designated as (S) in the treatment category column										04.00
Abbreviations used in Dental Coding											
	DM Direct Material Column +D Add fee/benefit for denture +L Add laboratory fee +M Add material fee										05.02
	MP Mouth Part Column M Maxilla/Mandible Q Quadrant S Sextant T Tooth										05.02
	TC Treatment Category Column A Advanced dentistry B Basic dentistry S Surgery										05.02
	Practice type codes: 25400 General Dental Practitioner 26200 Specialist Maxillo Facial and Oral Surgeon 26400 Specialist Orthodontist 29200 Specialist in Oral Medicine and Periodontics 29400 Specialist Prosthodontist 29800 Specialist Oral Pathologist 39500 Dental Therapist										06.03
F.	**Guidelines to medical schemes**										
	Age of a Child. The determination of a child or adult status of the patient should be based on the clinical development of the patient's dentition. Where administrative constraints preclude the use of clinical development so that the chronological age must be used to determine the child or adult status, the patient is defined as an adult beginning at age 12 with the exclusion of treatment for orthodontics or sealants.										05.02

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Frequency of benefits. The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as "twice a calendar year" rather than once in every six months.										05.02
	Radiographs and records. Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.										05.02
	New vs. established patient. A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.										05.02
II.	**DENTAL PROCEDURES AND SERVICES**										
A.	**DIAGNOSTIC SERVICES**										
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.										06.03
CLINICAL ORAL EXAMINATIONS											
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented. Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.										06.03
General Dental Practitioner											
Code	**Description**	**Ver**	**General Dental Practice**	**Maxillo-facial and Oral Surgery**	**Orthodontics**	**Oral Medicine and Periodontics**	**Prosthodontics**	**Oral Pathology**	**MP**	**Lab**	**TC**
8101	Oral examination	06.03	114.40 (100.40)								B
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).										
8102	Comprehensive oral examination	06.03	184.90 (162.20)								B

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008)										
8104	Limited oral examination	06.03	55.50 (48.70)								B
	An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment. Comment: This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g., recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.										
8189	Re-examination - existing condition	06.03	55.50 (48.70)								B
	An assessment performed on an established patient (patient of record) to assess the status of an untreated previously existing condition involving an examination and evaluation, limited to the previously existing condition. This type of assessment is conducted on patients (1) with a traumatic injury where no treatment was rendered but the patient needs follow-up monitoring; (2) requires evaluation for undiagnosed continuing pain after a limited oral examination and diagnostic tests did not reveal any findings; and (3) with soft tissue lesions such as a leukoplakia observed on a previous visit that require follow-up monitoring of pathological changes. Comment: (1) A re- examination is not a post-operative visit.										
8176	Periodontal screening	06.03	96.40 (84.60)								B
	Periodontal screenings include but are not limited to a periodontal charting of the complete dentition; plaque index and bleeding index. The findings should be recorded, is a part of the patient's clinical record and should be retained by the dentist.										
8190	Consultation - second opinion or advice	06.03	114.40 (100.40)								B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	A consultation is a diagnostic service rendered by a dentist, other than the practitioner providing treatment, whose opinion or advice for the purpose of determining the patient's dental needs and proposing treatment regarding a specific problem is requested. A consultation requires and includes a written report to the practitioner or patient who requested the consultation. It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded). Comment: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation. When the consulting dentist assumes responsibility for the continuing care of the patient, any service rendered by him/her will cease to be a consultation, and an appropriate oral examination code should be reported. Code 8106 (special report) may not be reported in addition to this code										
Maxillo Facial Surgeon											
8901	Consultation - MFOS	04.00		145.80 (127.90)							S
8902	Consultation - MFOS (detailed)	06.03		381.60 (334.70)							S
	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation. Code 8902 is a separate procedure from code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction.										
8840	Treatment planning for orthognathic surgery - ALL	06.03	329.30 (288.90)	494.00 (433.30)	494.00 (433.30)					+L	S
	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.										
Orthodontist											
8801	Consultation - Orthodontist	04.00			145.80 (127.90)						A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	04.00			84.90 (74.50)						A
8837	Diagnosis and treatment planning - Orthodontist	04.00			67.70 (59.40)						A
Periodontist/Oral Medicine											
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.										06.03
8701	Consultation - periodontist	06.03				145.80 (127.90)					A
	A periodontal consultation comprises a reasonably detailed examination and presentation and explanation of the findings to enable the patient to make a decision as to future treatment.										
8703	Consultation - Periodontist (detailed)	06.03				381.60 (334.70)					A
	Detailed clinical examination, records, radiographic interpretation, probing, percussion, diagnosis, treatment planning and case presentation for periodontal and/or implant cases. Code 8703 is always a separate procedure from code 8701 and comprises inspection, percussion, probing and other diagnostic procedures and the systematic recording of every important feature in order to permit correct treatment planning.										
8705	Re-examination - Periodontist	04.00				114.10 (100.10)					A

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8707	Periodontal screening - Periodontist	06.03				114.10 (100.10)					A
	A periodontal screening consists of the measurement and recording of a plaque index, a bleeding index, probing depths, a periodontal disease index, a microbiological assay and/or gingival crevicular fluid assay.										
8781	Consultation - Oral medicine (simple)	06.03				114.10 (100.10)					S
	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain-dysfunction - Straight forward case										
8782	Consultation - Oral medicine (complex)	06.03				200.70 (176.10)					S
	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain dysfunction - Complex case										
8783	Consultation - Oral medicine (subsequent)	06.03				84.90 (74.50)					S
	Subsequent consultation for same disease/condition.										
Prosthodontist											
8501	Consultation - Prosthodontis	04.00					145.80 (127.90)				A
8507	Comprehensive consultation - Prosthodontist	06.03					234.10 (205.40)				A
	Examination, diagnosis and treatment planning.										
8506	Detailed consultation - Prosthodontist	06.03					381.60 (334.70)				A
	Detailed clinical examination, records, radiographic interpretation, diagnosis, treatment planning and case presentation. Code 8506 is a separate procedure from 8507 and is applicable to craniomandibular disorders, implant placement or orthognathic surgery where extensive restorative procedures will be required. Note (Applicable to prosthodontists only - SADA's Dental Coding): In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist - See code 8840 for all other providers.										
Oral Pathologist											
9201	Consultation - oral pathologist	04.00						145.80 (127.90)			
9205	Consultation - oral pathologist (subsequent)	04.00						84.90 (74.50)			

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
RADIOGRAPHS/DIAGNOSTIC IMAGING											
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders. A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes. Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical practice.										06.03
8107	Intraoral radiograph - periapical	06.03	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)				B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.										
8108	Intraoral radiographs - complete series	06.03	358.60 (314.60)	358.60 (314.60)	358.60 (314.60)	358.60 (314.60)	358.60 (314.60)				B
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.										
8112	Intraoral radiograph - bitewing	06.03	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)	46.40 (40.70)				B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.										
8113	Intraoral radiograph - occlusal	04.00	79.80 (70.00)	79.80 (70.00)	79.80 (70.00)	79.80 (70.00)	79.80 (70.00)				B
8114	Extraoral radiograph - hand-wrist	06.03	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)				B
	Use to report extraoral radiographs such as hand-wrist radiographs.										
8115	Extraoral radiograph - panoramic	04.00	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)				B
8116	Extraoral radiograph - cephalometric	05.02	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)				B
8118	Extraoral radiograph - skull/facial bone	05.02	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)	185.20 (162.50)				B
8121	Oral and/or facial image (digital/conventional)	06.03	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)				B
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.										
OTHER DIAGNOSTIC PROCEDURES											
8117	Diagnostic models	06.03	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)	49.80 (43.70)			+L	B
	Also known as study models or diagnostic casts. Models used to aid diagnosis and treatment planning. Diagnostic models should be retained as part of the patient's clinical record and may only be used for diagnostic purposes. Includes diagnostic models mounted on a hinge articulator.										
8119	Diagnostic models mounted	06.03	125.20 (109.80)	125.20 (109.80)	125.20 (109.80)	125.20 (109.80)	125.20 (109.80)			+L	B
	See code 8117. Report this code when models are mounted on a movable condyle articulator.										
8122	Microbiological studies	06.03									B

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Studies performed to determine pathological agents. May include, but is not limited to tests for susceptability to periodontal disease. Report per visit. A perio risk assessment report must be made available at no cost when requested.										
8123	Caries susceptibility tests (By Arrangement)	06.03	51.70 (45.40)								B
	A caries susceptibility test is a diagnostic test for determining a patient's saliva pH with a litmus strip to evaluate the patient's propensity for caries. This code should not be used for a caries detectibility test (carious dentine staining), which is performed to determine if all the caries has been removed. A caries risk assessment report must be made available at no cost when requested.										
8124	Pulp tests	06.03	13.70 (12.00)								
	Diagnostic tests to determine clinical pulp vitality and/or abnormality. Includes traditional pulp testing methods such as thermal and electronic pulp testing as well as the use of optical devices to detect the blood supply of the pulp. The tests involve multiple teeth and contra-lateral comparison(s), as indicated. Report per visit.										
8503	Occlusion analysis mounted	04.00	156.00 (136.80)				234.10 (205.40)				A
8505	Pantographic recording	04.00	226.40 (198.60)				339.70 (298.00)				A
8508	Electrognathographic recording	04.00	242.40 (212.60)				363.70 (319.00)				A
8509	Electrognathographic recording with computer analysis	04.00	402.50 (353.10)				603.80 (529.60)				A
8811	Tracing and analysis of extra-oral film	04.00	21.50 (18.90)	21.50 (18.90)	21.50 (18.90)	21.50 (18.90)	21.50 (18.90)				B
8839	Diagnostic setup (orthodontics)	04.00	95.50 (83.80)		143.20 (125.60)						A
B.	**PREVENTIVE SERVICES**										
	Services/procedures intended to eliminate or reduce the need for future dental treatment.										06.03
DENTAL PROPHYLAXIS											
8155	Polishing - complete dentition	06.03	70.30 (61.70)			98.90 (85.00)	70.30 (61.70)				B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.										
8159	Prophylaxis - complete dentition	06.03	138.10 (121.10)			194.70 (170.80)	138.10 (121.10)				B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.										
8160	Removal of gross calculus	06.03									B
	This procedure is used when profuse bleeding prevents immediate polishing. May not be used concurrent with any other prophylactic procedure on the same day.										
8179	Polishing - complete dentition (periodontally compromised patient)	06.03	80.60 (70.70)								B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	A periodontally compromised patient is defined as a patient presenting with either chronic adult periodontitis, juvenile periodontitis or rapidly progressive periodontitis, confirmed by a CPITN index of 3 or 4. The diagnosis is made with information acquired from at least a periodontal screening (code 8176) and CPITN index, or a comprehensive oral evaluation (code 8102). This diagnosis must be reviewed within a period of three years by means of a periodontal screening (code 8176).										
8180	Prophylaxis - complete dentition (periodontally compromised patient)	06.03	150.10 (131.70)								B
	Comment: See code 8177 descriptor; Include codes 8155 (Polishing – complete dentition), 8159 (Prophylaxis – complete dentition) and 8179 (Plaque removal – periodontal compromised pst). Code 8180 should not be used concurrent with codes 8179.										
TOPICAL FLUORIDE TEATMENT											
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or "swish." For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.										06.03
8161	Topical application of fluoride - child	06.03	70.30 (61.70)			70.30 (61.70)	70.30 (61.70)				B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.										
8162	Topical application of fluoride - adult	06.03	70.30 (61.70)			70.30 (61.70)	70.30 (61.70)				B
	See code 8161.										
SPACE MAINTENANCE (PASSIVE APPLIANCES)											
	Passive appliances are designed to prevent tooth movement.										06.03
8173	Space maintainer - fixed, per abutment	05.02	130.40 (114.40)						T	+L	B
8175	Space maintainer - removable	04.00	168.10 (147.50)							+L	B
OTHER PREVENTIVE PROCEDURES											
8149	Nutritional counselling	06.03									B
	Involves a dietary habit and food selection analysis, and providing of advice and guidance to the patient and/or patient's family on dietary habits and food selection as part of treatment and control of dental decay and periodontal disease. Comment: (1) The need for nutritional counselling must be confirmed by a caries/perio risk assessment (See also codes 8122 and 8123). (2) A dietary habit analysis and food selection programme must, on request, be made available at no charge. (3) Certain funders do not provide benefits for nutritional counselling for the control of dental disease.										
8150	Tobacco counselling	06.03									B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Involves the providing of advice, guidance and support services to the patient on tobacco cessation to prevent and control the development of tobacco related oral diseases and conditions and improve prognosis for certain dental treatments. Limitation: (1) The need for tobacco counselling must be confirmed by a caries/perio risk assessment (See also codes 8122 and 8123). (2) If requested, a tobacco prevention and cessation services programme must be made available at no charge. (3) Treatment should be reserved for those persons who are not able to quite using tobacco by using basic intervention methods. Persons are only eligible for this treatment if a documented quit date has been established. Tobacco cessation is limited to 10 services. (4) Certain funders do not provide benefits for tobacco cessation treatment interventions.										
8151	Oral hygiene instruction	06.03	70.30 (61.70)			140.70 (123.40)	140.70 (123.40)				B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plague, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.										
8153	Oral hygiene instruction - each additional visit	06.03	51.50 (45.20)			67.70 (59.40)	67.70 (59.40)				B
	Report code 8153 when additional oral hygiene instructions is required as part of the treatment plan. No other preventive services may be reported at the same visit. See code 8151										
8163	Dental sealant	06.03	46.40 (40.70)				46.40 (40.70)		T		B
	Also known as pit-and fissure sealant. This procedure involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal decay-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in a restorative the decay penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant. Limitation: Certain funders limit benefits for sealants to two teeth per quadrant.										
8169	Occlusal guard	06.03	270.10 (236.90)							+L	B
	A removable intraoral appliance that is designed to cover the occlusal and incisal surfaces of the teeth of a dental arch to minimise the effects of bruxism (grinding) and other occlusal factors.										
8171	Mouth guard	06.03	81.70 (71.70)							+L	B
	A flexible intraoral appliance that is worn during participation in contact sports to reduce the potential for injury to the teeth and associated tissue. Limitation: Benefit by arrangement.										
8177	Oral hygiene instruction (periodontally compromised patient)	06.03	106.40 (93.30)								B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	A periodontally compromised patient is defined as a patient presenting with either chronic adult periodontitis, juvenile periodontitis or rapidly progressive periodontitis, confirmed by a CPITN index of 3 or 4. The diagnosis is made with information acquired from at least a periodontal screening (code 8176) and CPITN index, or a comprehensive oral evaluation (code 8102). This diagnosis must be reviewed within a period of three years by means of a periodontal screening (code 8176). Comment: The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Includes code 8151 (Oral hygiene instructions)										
8178	Oral hygiene instruction - each additional visit (periodontally compromised patient)	06.03	57.50 (50.40)								B
	See code 8177.										
C.	**RESTORATIVE SERVICES**										
	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/procedures intend to restore the function of a natural tooth. Anterior teeth include incisors and canines. Posterior teeth include premolars and molars. The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved. Limitations on amalgam and resin-based composite restorations: (1) The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the same day and may require the reporting of a MOD restoration instead of a separate MO and DO restoration. (2) The current NHRPL rates include direct pulp capping (code 8301) and rubber dam application (code 8304).										06.03
AMALGAM RESTORATIONS											
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately. See codes 8345, 8347 and 8348 for post and/or pin retention.										06.03
8341	Amalgam - one surface	04.00	139.80 (122.60)						T		B
8342	Amalgam - two surfaces	04.00	172.40 (151.20)						T		B
8343	Amalgam - three surfaces	04.00	210.10 (184.30)						T		B
8344	Amalgam - four or more surfaces	04.00	234.10 (205.40)						T		B
RESIN-BASED COMPOSITE RESTORATIONS											
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays" If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention.										06.03
8350	Resin crown - anterior primary tooth (direct)	06.03	305.00 (267.50)						T		B
	This procedure involves the full coverage of an anterior primary tooth with a resin based material.										
8351	Resin - one surface, anterior	04.00	153.50 (134.60)						T		B
8352	Resin - two surfaces, anterior	04.00	193.00 (169.30)						T		B

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8353	Resin - three surfaces, anterior	04.00	230.70 (202.40)						T		B
8354	Resin - four or more surfaces, anterior	06.03	257.30 (225.70)						T		B
	Use to report the involvement of four or more surfaces or the incisal line angle. The Incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.										
8367	Resin - one surface, posterior	06.03	166.40 (146.00)						T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.										
8368	Resin - two surfaces, posterior	04.00	205.80 (180.50)						T		B
8369	Resin - three surfaces, posterior	04.00	248.80 (218.20)						T		B
8370	Resin - four or more surfaces, posterior	04.00	267.60 (234.70)						T		B
GOLD FOIL RESTORATIONS											
8561	Gold foil class I or IV	04.00	407.10 (357.10)				610.60 (535.60)		T		A
8563	Gold foil class V	04.00	476.30 (417.80)				714.50 (626.80)		T		A
8565	Gold foil class III	04.00	599.20 (525.60)				898.80 (788.40)		T		A
INLAY/ONLAY RESTORATIONS											
	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.										06.03
Metal Inlays/Onlays											
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers. Metal components include structures manufactured by means of conventional casting and/or electroforming. The benefits provided by some medical schemes for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.										06.03
8361	Inlay - metal - one surface	04.00	213.50 (187.30)				421.20 (369.50)		T	+L	A
8362	Inlay/onlay - metal - two surfaces	04.00	312.20 (273.90)				610.60 (535.60)		T	+L	A
8363	Inlay/onlay - metal - three surfaces	04.00	520.60 (456.70)				946.90 (830.60)		T	+L	A
8364	Inlay/onlay - metal - four or more surfaces	04.00	629.60 (552.30)				946.90 (830.60)		T	+L	A
Porcelain/Ceramic Inlays/Onlays											
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers. Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.										06.03

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8371	Inlay - porcelain - one surface	05.02	257.30 (225.70)				508.60 (446.10)		T	(+L)	A
8372	Inlay/onlay - porcelain - two surfaces	05.02	379.90 (333.20)				732.50 (642.50)		T	(+L)	A
8373	Inlay/onlay - porcelain - three surfaces	05.02	626.10 (549.20)				1138.20 (998.40)		T	(+L)	A
8374	Inlay/onlay - porcelain - four or more surfaces	05.02	758.30 (665.20)				1138.20 (998.40)		T	(+L)	A
8560	Cost of ceramic block	06.03	-				-		T		A
	Applicable to computer generated prosthesis only. See Rule 002 and Modifier 8025.										
8570	Fabrication of computer generated ceramic restoration	06.03							A		
	This procedure involves the fabrication of a computer generated (CAD-CAM) ceramic restoration by the dental practitioner. Report code 8560 for the cost of the ceramic block in addition to this procedure.										
Resin-based Inlays/Onlays											
	Resin based inlays/onlays usually utilise the indirect technique. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting Modifier 8023 in addition to these codes.										06.03
8381	Inlay - resin - one surface	05.02	257.30 (225.70)				508.60 (446.10)		T	(+L)	A
8382	Inlay/onlay - resin - two surfaces	05.02	379.90 (333.20)				732.50 (642.50)		T	(+L)	A
8383	Inlay/onlay - resin - three surfaces	05.02	626.10 (549.20)				1138.20 (998.40)		T	(+L)	A
8384	Inlay/onlay - resin - four or more surfaces	05.02	758.30 (665.20)				1138.20 (998.40)		T	(+L)	A
CROWNS – SINGLE RESTORATIONS											
	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants. Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming. Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations. TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.										06.03
8401	Crown - full cast metal	04.00	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8403	Crown - 3/4 cast metal	04.00	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8404	Crown - 3/4 porcelain/ceramic	05.02	758.10 (665.00)				1138.20 (998.40)		T	+L	A
8405	Crown - resin laboratory	06.03	758.10 (665.00)				1138.20 (998.40)		T	+L	A
	Refers to all resin-based crowns that are indirectly fabricated. All fiber, porcelain or ceramic reinforced polymer materials/systems are considered resin-based crowns. Targis®/Vectris® crowns should be reported as resin crowns.										

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8407	Crown - resin with metal	04.00	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8409	Crown - porcelain/ceramic	04.00	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8411	Crown - porcelain with metal	04.00	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8410	Provisional crown	06.03	156.00 (136.80)			156.00 (136.80)	234.10 (205.40)		T	(+L)	A
	The intended use of a provisional crown is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis. Comment: Code 8410 excludes provisional pontics (code 8425) and provisional crown retainers (code 8447), which are listed in the Fixed Prosthodontics Section.										
VENEERS											
8355	Veneer - resin (chair-side)	06.03	243.60 (213.70)				243.60 (213.70)		T		B
	Involves direct layering of material over tooth. No laboratory processing.										
8552	Veneer - porcelain (laboratory)	06.03	539.10 (472.90)				808.80 (709.50)		T	+L	A
	Involves an impression being taken and laboratory processing. Porcelain/ceramic veneers presently include all ceramic, porcelain, and polymer-reinforced porcelain veneers.										
8554	Veneer - resin (laboratory)	06.03	539.10 (472.90)				808.80 (709.50)		T	+L	A
	Involves an impression being taken and laboratory processing.										
TEMPORARY RESTORATIONS											
8137	Emergency crown (chair-side)	06.03	241.00 (211.40)				241.00 (211.40)		T	(+L)	A
	A temporary crown, usually made of resin and in the surgery, which is fitted over a damaged tooth for the immediate protection in tooth injury. Includes emergency crowns manufactured for the replacement of previously fitted, lost or damaged permanent crowns. Comment: This code should not be used as an interim restoration during restorative treatment and should not be reported on the same day on which an impression is taken to replace a previously fitted lost or damaged permanent crown.										
8357	Prefabricated metal crown	06.03	143.20 (125.60)				143.20 (125.60)		T		B
	Includes all preformed metal crowns e.g. stainless steel, nickel-chrome and gold anodised crowns, with or without resin window.										
8375	Prefabricated resin crown	06.03	143.20 (125.60)				143.20 (125.60)		T		B
	Includes all preformed non-metal, non-strip- off crown forms e.g., resin and polycarbonate crowns.										
OTHER RESTORATIVE PROCEDURES											
Pin Retention and Cores											
8345	Prefabricated post retention, per post (in addition to restoration)	06.03	138.10 (121.10)						T		B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Should not be used with codes 8398 or 8376 (Core build-ups) Remuneration excludes cost of posts – See code 8379										
8347	Pin retention - first pin (in addition to restoration)	06.03	69.40 (60.90)						T		B
	Should not be used with codes 8398 or 8376 (Core build-ups).										
8348	Pin retention - each additional pin (in addition to restoration)	06.03	64.30 (56.40)						T		B
	Should not be used with codes 8398 or 8376 (Core build-ups). Limitation: A maximum of two additional pins may be levied.										
8366	Pin retention as part of cast restoration (any number of pins)	05.02	103.80 (91.10)				140.70 (123.40)		T	+L	A
8376	Core build-up with prefabricated posts	06.03	382.50 (335.50)				382.50 (335.50)		T		B
	The direct build-up of a mutilated crown around a prefabricated post to provide a rigid base for retention of a crown restoration. This procedure includes posts and core material. Remuneration excludes cost of posts – See code 8379.										
8379	Cost of prefabricated posts	06.03	-				-		T		A
	Applicable to pre-fabricated noble metal, ceramic, iridium and titanium posts – see code 8345 and 8376. Comment: See Rule 002 and Modifier 8025 for direct material costs.										
8391	Cast core with single post	06.03	161.30 (141.50)						T	+L	A
	Report in addition to crown.										
8392	Cast post (each additional)	06.03	96.00 (84.20)						T	+L	A
	To be used with 8391 for each additional cast posts on the same tooth.										
8397	Cast core with pins (any number of pins)	06.03	257.30 (225.70)				334.50 (293.40)		T	+L	A
	The cast core with pins is intended to be used on grossly broken down vital teeth. Report in addition to crown.										
8398	Core build-up with or without pins	06.03	312.20 (273.90)				312.20 (273.90)		T		B
	The direct build-up of a mutilated crown to provide a rigid base for retention of a crown restoration irrespective of the number of pins used. This code should not be reported when the procedure only involves a filler to eliminate any undercut, concave irregularity in the preparation, etc.										
8581	Cast core with single post	06.03					238.40 (209.10)		T	+L	A
	See also GDP code 8391										
8582	Cast core with double post	06.03					339.70 (298.00)		T	+L	A
	See also GDP code 8392										
8583	Cast core with triple post	06.03					421.20 (369.50)		T	+L	A
	See also GDP code 8392										

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
Unclassified Restorative Procedures											
8133	Recement inlay, onlay, crown or veneer	06.03	70.30 (61.70)				89.20 (78.20)		T	+L	B
	Use to report the recementation of a permanent single inlay, onlay, crown or veneer. See code 8514 in the Fixed Prosthodontic Section for the recementation of a bridge retainer. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration.										
8135	Remove inlay, onlay or crown	06.03	139.80 (122.60)				139.80 (122.60)		T	+L	A
	This procedure involves the removal of a permanent inlay, onlay or crown. Report code 8516 for the removal of a permanent bridge retainer. Comment: This code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration.										
8138	Remove retention post (prefabricated or cast)	06.03	91.70 (80.40)						T		B
	This procedure involves the removal of an intact prefabricated and/or cast posts intended for retention purposes. Report per post. See code 8330 in the "Endodontic Section" for the removal of endodontic posts or instruments.										
8146	Resin bonding for restorations	06.03							T		A
	Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges. Limitation: Benefits by arrangement.										
8157	Re-burnishing and polishing of restorations - complete dentition	06.03	70.30 (61.70)								B
	Not applicable to restorations recently done.										
8349	Carve restoration to accommodate existing removable prosthesis	04.00	28.30 (24.80)						T		B
8413	Repair crown (permanent or provisional)	06.03	156.00 (136.80)				156.00 (136.80)		T	+L	A
	This procedure involves the repair of a permanent crown (e.g. facing replacement). Excludes the removal (8153) and recementation (8133) of the crown. See code 8518 in the Fixed Prosthodontic Section for the repair of a bridge. This code may also be reported for the repair/replacement of a provisional crown (8410) after a period of two months. This code may not be used for the repair/replacement of a temporary restorations, which is included as part of the restoration.										
8414	Additional fee for provision of crown within an existing clasp or rest	04.00	46.40 (40.70)						T	+L	A
D.	**ENDODONTIC SERVICES**										
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.										06.03
PULP CAPPING											
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.										06.03
8301	Pulp cap - direct	06.03	93.50 (82.00)						T		B
	This procedure involves the covering of the exposed dental pulp with a pretective material to stimulate repair of the injured pulpal tissue. Excludes the final restoration.										
8303	Pulp cap - indirect	06.03	93.50 (82.00)						T		B
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
PULPOTOMY											
8307	Pulp amputation (pulpotomy)	06.03	91.70 (80.40)						T		B
	This procedure involves the removal of a portion of the tooth's pulp and the placement of a medicament to fix or modify the superficial pulp tissue. Excludes the final restoration. This code should not be used as the first stage of root canal therapy and may not be reported with other root canal therapy codes on the same tooth. Report code 8304 (application of a rubber dam) in addition to this code.										
8132	Pulp removal (pulpectomy)	06.03	114.90 (100.80)						T		B
	This procedure involves the removal of the complete pulp from the pulp chamber and root canal(s) for the relief of acute pain prior to root canal therapy. The code is intended to be used for the emergency treatment of acute pain and should not be reported as the first stage of scheduled endodontic treatment. The practitioner reappoints the patient for complete root canal theray at a later date. Report code 8304 (application of a rubber dam) in addition to this code.										
ENDODONTIC THERAPY											
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report code 8304 (application of a rubber dam) in addition to these codes.										06.03
Preparatoty Visits											
8332	Root canal preparatory visit - single canal tooth	06.03	70.30 (61.70)						T		B
	Limitation: A maximum of four visits per tooth may be charged.										
8333	Root canal preparatory visit - multi canal tooth	06.03	98.60 (86.50)						T		B
	Limitation: A maximum of four visits per tooth may be charged.										
Obtuation of Canals											
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).										06.03
8335	Root canal obturation - anteriors and premolars - first canal	04.00	319.00 (279.80)						T		B
8328	Root canal obturation - anteriors and premolars - each additional canal	04.00	130.40 (114.40)						T		B
8336	Root canal obturation - posteriors - first canal	04.00	439.10 (385.20)						T		B
8337	Root canal obturation - posteriors - each additional canal	04.00	130.40 (114.40)						T		B
Complete Therapy											
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).										06.03
8338	Root canal therapy - anteriors and premolars - first canal	04.00	488.00 (428.10)						T		B
8329	Root canal therapy - anteriors and premolars - each additional canal	04.00	163.00 (143.00)						T		B
8339	Root canal therapy - posteriors - first canal	04.00	670.70 (588.30)						T		B

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8340	Root canal therapy - posteriors - each additional canal	04.00	163.00 (143.00)						T		B
8631	Root canal therapy - first canal	06.03					828.50 (726.80)		T		B
	Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
8633	Root canal therapy - each additional canal	06.03					208.40 (182.80)		T		B
	Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
ENDODONTIC RETREATMENT											
8334	Re-preparation of previously obturated root canal	06.03	103.80 (91.10)				125.20 (109.80)		T		B
	This procedure includes the removal of old root canal filling material and the procedures necessary to prepare the canals to place the canal filling. Report 8334 per canal. See codes 8328, 8335, 8336 and 8337 for the obturation of root canals. This procedure excludes the removal of retentions posts (code 8138) and/or endodontic posts (code 8330). Report code 8304 (application of a rubber dam) in addition to this code. Note (Applicable to prosthodontist only): Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
APEXIFICATION/RECALCIFICATION PROCEDURES											
8635	Apexification/recalcification – per visit	06.03	93.50 (82.00)				138.10 (121.10)		T		S
	Apexification is the process of induced root development or apical closure of the root by hard tissue deposition. This code should also be used to report the repair of perforations and root resorbsion. Exclude the necessary radiographs. The first visit involves the opening of the tooth, pulpectomy, preparation of canal spaces, and the first placement of medication. This is followed by several visists to replace the intra-canal medication. The final visit includes the removal of the intra-canal medication and procedures necessary to place final root canal filling material. Code 8635 may not be reported with other root canal therapy codes on the same tooth. Report code 8304 (application of a rubber dam) in addition to this code.										
PERIRADICULAR PROCEDURES											
9015	Apicectomy - anteriors (including retrograde filling)	06.03	346.50 (303.90)	459.70 (403.20)		459.70 (403.20)	459.70 (403.20)		T		S
	Note applicable to periodontists only (according to SADA's Dental Coding): When Code 9015 is part of a flap operation that requires an apicectomy, Modifier 8006 applies.										
9016	Apicectomy - posteriors (including retrograde filling)	06.03	611.20 (536.10)	916.90 (804.30)		916.90 (804.30)	916.90 (804.30)		T		S
	Note applicable to periodontists only (according to SADA's Dental Coding): When Code 9016 is part of a flap operation that requires an apicectomy, Modifier 8006 applies.										
OTHER ENDODONTIC PROCEDURES											
8330	Removal of root canal obstruction	06.03	91.70 (80.40)						T		B

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	This procedure involves the treatment of a non-negotiable root canal blocked by foreign bodies (e.g., removal and/or bypassing of a fractured instrument) or calcification of 50% or more of a root to achieve an apical seal and forego surgical treatment – Report per canal. See code 8138 (Post removal) in the Restorative Section for the removal of retention posts. This code may be submitted by the servicing provider and on the same day as a root canal therapy if the obstruction is not iatrogenic by that provider.										
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	04.00	62.60 (54.90)						T		B
8640	Removal of fractured post or instrument from root canal	06.03					243.60 (213.70)		T		B
	See also GDP Code 8330.										
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	06.03	306.50 (268.90)			459.70 (403.20)	459.70 (403.20)		T		A
	Includes separation of a multirooted tooth into separate sections containing the root and overlying portion of the crown. It may also include the removal of one or more of those sections.										
E.	**PERIODONTIC SERVICES**										
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.										06.03
SURGICAL SERVICES											
	Surgical services includes usual postoperative care.										06.03
8741	Gingivectomy/gingivoplasty - four or more teeth per quadrant	06.03	367.10 (322.00)			503.50 (441.70)			Q		A
	A gingivectomy involves the surgical excision of unsupported gingival tissue to the level where it is attached, creating a new gingival margin apical in position of the old. A gingivoplasty involves the surgical contouring of the gingival tissues to secure the physiological architectural form necessary for the maintenance of tissue health and integrity. Edentulous areas are not counted as teeth. When this periodontal procedure extends over the midline, report a combination of procedure codes 8741 and 8743, as appropriate.										
8743	Gingivectomy or gingivoplasty - one to three teeth per quadrant	06.03	293.30 (257.30)			399.70 (350.60)			Q		A
	See code 8741 for descriptor										
8749	Flap procedure, root planing and one to three surgical services - per quadrant	06.03	762.20 (668.60)			1143.30 (1002.90)			Q		A
	Flap operation with root planing and curettage and which may include not more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant. NOTES:1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection and clinical crown lengthening shall be deemed to be one procedure. 2. Where a bone regeneration/repair procedure is included within a flap operation, Item 8766 shall apply in addition to the Item for the flap operation.3. Where an apicectomy is included within a flap operation, either Code 9015 or Code 9016 with Modifier 8006 shall apply in addition to the item for the flap operation.										
8751	Flap procedure, root planing and one to three surgical services - per sextant	06.03	631.30 (553.80)			946.90 (830.60)			S		A
	See code 8749, per sextant.										

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8753	Flap procedure, root planing and four or more surgical services - per quadrant	06.03	944.70 (828.70)			1417.00 (1243.00)			Q		A
	Flap operation with root planing and curettage and will include more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection, tooth hemisection, a mucogingival procedure, wedge resection, clinical crown lengthening, per quadrant. NOTES:1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection and clinical crown lengthening shall be deemed to be one procedure. 2. Where a bone regeneration/repair procedure is included within a flap operation, Item 8766 shall apply in addition to the item for the flap operation.3. Where an apicectomy is included within a flap operation, either Code 9015 or Code 9016 with Modifier 8006 shall apply in addition to the item for the flap operation.										
8755	Flap procedure, root planing and four or more surgical services - per sextant	06.03	765.60 (671.60)			1148.40 (1007.40)			S		A
	See code 8753, per sextant.										
8756	Clinical crown lengthening (isolated procedure)	06.03	464.20 (407.20)			696.40 (610.90)			T		A
	A surgical procedure designed to increase the amount of tooth structure projecting into the mouth to facilitate a reconstructive or operative procedure. The procedure involves the reflection of a flap and the removal of marginal bone and gingival tissues.										
8759	Pedicle flapped graft (isolated procedure)	06.03	348.80 (306.00)			523.20 (458.90)			M		A
	E.g. lateral sliding double papilla, rotated and similar.										
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	05.02	379.10 (332.50)	568.70 (498.90)		568.70 (498.90)			M	+L	A
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	05.02	569.50 (499.60)	854.30 (749.40)		854.30 (749.40)			M	+L	A
8763	Wedge resection (isolated procedure)	06.03	223.00 (195.60)			334.50 (293.40)			Q		A
	A surgical procedure that involves the removal of a wedge of tissue. This is normally done in an edentulous area, distal of the last molar of the maxilla or mandible, to result in minimal probing depth of the adjacent tooth. Do not use for a biopsy.										
8766	Bone regeneration/repair procedure - as part of a flap operation	06.03	182.40 (160.00)			273.70 (240.10)					A
	See code 8749, 8751, 8753 and 8755, per procedure. Excluding cost of regenerative material - See code 8770										
8767	Bone regeneration/repair procedure - at a single site	06.03	472.90 (414.80)	709.30 (622.20)		709.30 (622.20)					A
	Excluding cost of regenerative material - See code 8770										
8769	Membrane removal (used for guided tissue regeneration)	06.03	223.00 (195.60)	334.50 (293.40)		334.50 (293.40)					A
	Note: Maxillo-facial Surgeons may, according to SADA's Dental Coding, use codes 8761, 8767 and 8769 only as part of implant surgery.										
8770	Cost of bone regenerative/repair material	06.03	-	-		-					A
	See Rule 002 and Modifier 8025 for direct material costs										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8772	Submucosal connective tissue autograft (isolated procedure)	05.02	383.10 (336.10)	574.70 (504.10)		574.70 (504.10)					A
8995	Gingivectomy - per jaw	06.03	543.80 (477.00)	815.70 (715.50)					M	+L	S
	See also codes 8741 and 8743.										
NON-SURGICAL PERIODONTAL SERVICES											
8723	Provisional splinting - extracoronal (wire) - per sextant	05.02	130.40 (114.40)			195.60 (171.60)	195.60 (171.60)		M	+L	A
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	05.02	189.20 (166.00)			283.90 (249.00)	283.90 (249.00)		M	+L	A
8727	Provisional splinting - intracoronal - per tooth	06.03	59.40 (52.10)			89.20 (78.20)	89.20 (78.20)		T	+L	A
	Include intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint										
8737	Root planing - four or more teeth per quadrant	06.03	281.30 (246.80)			381.60 (334.70)			Q		A
	A procedure that smooths the surface of a root by removing abnormal toxic cementum or dentin that is rough, contaminated, or permeated with calculus. May include a subgingival curettage (controversial procedure). When this periodontal procedure extends over the midline, report a combination of procedure codes 8737 and 8739, as appropriate. Other separate procedures including, but not limited to a comprehensive oral evaluation (8102) or periodontal screening (8176) and diagnostic radiographs (8107/8108), are a prerequisite to reporting Code 8737. Should not be reported concurrent with Codes 8159, 8160, 8179 or 8180.										
8739	Root planing - one to three teeth per quadrant	06.03	223.90 (196.40)			304.50 (267.10)			Q		A
	See code 8737.										
8773	Cost of intrapocket chemotherapeutic agent	06.03	-			-					
	Used to report intrapocket chemotherapeutic agents provided by the practitioner. See Rule 002 and Modifier 8025 for direct material costs.										
OTHER PERIODONTAL SERVICES											
8768	Unlisted periodontal procedure	04.00	223.00 (195.60)			334.50 (293.40)			T		A
8787	Unlisted oral medicine procedure	04.00	80.00 (70.20)			120.10 (105.40)					S
F.	**REMOVABLE PROSTHODONTICS**										
	The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable. Removable prosthodontic services include routine post-operative care.										06.03
COMPLETE DENTURES											
8231	Complete dentures - maxillary and mandibular	06.03	1133.90 (994.60)				2367.30 (2076.60)		M	+L	B
	Inclusive of soft bases or metal bases, where applicable.										
8232	Complete denture - maxillary or mandibular	06.03	699.00 (613.20)				1656.20 (1452.80)		M	+L	B
	Inclusive of soft bases or metal bases, where applicable.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8244	Immediate denture - maxillary	06.03	699.00 (613.20)				1048.50 (919.70)			+L	
	A removable complete denture constructed for placement immediately after removal of the remaining natural teeth. This procedure includes limited follow-up care only and excludes subsequent rebasing/relining procedure(s) and/or the replacement with new complete denture. See interim prosthesis for immediate and/or provisional partial dentures.										
8245	Immediate denture - mandibular	06.03	699.00 (613.20)				1048.50 (919.70)			+L	
	See 8244 descriptor.										
8643	Complete dentures - maxillary and mandibular (with complications)	04.00					3072.20 (2694.90)			+L	B
8645	Complete dentures - maxillary and mandibular (with major complications)	04.00					3779.00 (3314.90)			+L	B
8649	Complete denture - maxillary or mandibular (with complications)	05.02					1890.40 (1658.20)		M	+L	B
8651	Complete denture - maxillary or mandibular (with major complications)	05.02					2126.20 (1865.10)		M	+L	B
PARTIAL DENTURES											
8233	Partial denture - resin base - one tooth	05.02	325.00 (285.10)						M	+L	B
8234	Partial denture - resin base - two teeth	05.02	325.00 (285.10)						M	+L	B
8235	Partial denture - resin base - three teeth	05.02	486.30 (426.60)						M	+L	B
8236	Partial denture - resin base - four teeth	05.02	486.30 (426.60)						M	+L	B
8237	Partial denture - resin base - five teeth	05.02	486.30 (426.60)						M	+L	B
8238	Partial denture - resin base - six teeth	05.02	645.00 (565.80)						M	+L	B
8239	Partial denture - resin base - seven teeth	05.02	645.00 (565.80)						M	+L	B
8240	Partial denture - resin base - eight teeth	05.02	645.00 (565.80)						M	+L	B
8241	Partial denture - resin base - nine or more teeth	05.02	645.00 (565.80)						M	+L	B
8281	Partial denture - cast metal framework only	06.03	758.30 (665.20)						M	+L	A
	The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., 8251, 8253, 8255 and 8257). See codes 8233 to 8241 for the resin denture base required concurrently with 8281.										
8671	Partial denture - cast metal framework with resin denture base	06.03					1890.40 (1658.20)		M	+L	A
	See also GDP Code 8281.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
ADJUSTMENTS TO DENTURES											
8275	Adjust complete or partial denture	06.03	51.50 (45.20)				51.50 (45.20)				B
	After six months or for patient of another practitioner.										
8662	Adjust complete or partial dentures (remounting)	04.00	181.90 (159.60)				272.80 (239.30)			+L	B
REPAIRS TO DENTURES											
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.										06.03
8269	Repair denture or other intra-oral appliance	06.03	89.20 (78.20)				96.00 (84.20)		M	+L	B
	See code 8273 (Impression to repair/modify a denture)										
8270	Add clasp to existing partial denture	06.03	64.30 (56.40)						M	+L	B
	One or more clasps. Code 8270 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).										
8271	Add tooth to existing partial denture	06.03	64.30 (56.40)						M	+L	B
	One or more teeth. Code 8271 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).										
8273	Impression to repair or modify a denture or other intra-oral appliance	06.03	51.50 (45.20)				51.50 (45.20)			+L	B
	May be reported in addition to the appropriate code in this subsection when an impression is required. Includes any number of impressions.										
DENTURE REBASE PROCEDURES											
	Rebase – The partial or complete removal and replacement of the denture base.										06.03
8259	Rebase complete or partial denture (laboratory)	05.02	265.00 (232.50)				382.50 (335.50)		M	+L	B
8261	Remodel complete or partial denture	05.02	425.40 (373.20)						M	+L	B
DENTURE RELINE PROCEDURES											
	Reline - The addition of material to the fitting surface of a denture base.										06.03
8263	Reline complete or partial denture (chair-side)	05.02	168.10 (147.50)				210.10 (184.30)		M		B
8267	Reline complete or partial denture (laboratory)	06.03	386.90 (339.40)				386.90 (339.40)		M	+L	B
	This procedure is intended to be used for the relining of existing dentures and should not be reported concurrently with codes 8231 to 8241. See code 8243 (soft base to new denture).										
INTERIM DENTURES											
	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.										06.03
8658	Interim complete denture	06.03	699.00 (613.20)				1048.50 (919.70)		M	+L	B
	See code 8659 for descriptor.										
8659	Interim partial denture	06.03	559.20 (490.50)				838.80 (735.80)		M	+L	B

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	May be used to submit the use of a flipper (stayplate). A stayplate is an acrylic partial, with or without wire clasps, that replaces one or more teeth usually temporary in nature. Includes any necessary clasps and rests. This code should not be used in lieu of space maintainers.										
8661	Diagnostic dentures (including tissue conditioning)	06.03					1890.40 (1658.20)			+L	A
	See also codes 8658, 8659 and 8265.										
OTHER REMOVABLE PROSTHETIC PROCEDURES											
8251	Clasp or rest - cast gold	06.03	64.30 (56.40)							+L	A
	Codes 8251, 8253, 8255 and 8257 may not be levied concurrently with codes 8169 (occlusal orthotic device), 8175 (space maintainer), 8269 (repair of denture) or 8281 (metal framework).										
8253	Clasp or rest - wrought gold	06.03	64.30 (56.40)							+L	B
	See code 8251 descriptor.										
8255	Clasp or rest - stainless steel	06.03	67.70 (59.40)							+L	B
	See code 8251 descriptor.										
8257	Bar - lingual or palatal	06.03	79.80 (70.00)						M	+L	B
	See code 8251 descriptor.										
8265	Tissues conditioning per arch (including soft self-cure reline)	05.02	109.80 (96.30)				140.70 (123.40)		M		B
8277	Inlay in denture	06.03								+L	A
	Limitation: Benefits by arrangement.										
8597	Locks and milled rests	04.00	64.10 (56.20)				96.00 (84.20)		T	+L	A
8599	Precision attachment (removable denture)	06.03	156.00 (136.80)				234.10 (205.40)		M	+L	A
	Each set of male and female components should be reported as one precision attachment. Includes semi-precision attachments.										
8652	Overdenture - complete	06.04	1260.20 (1105.40)				1890.40 (1658.20)		M	+L	B
	Other separate procedures may be required concurrent to 8652.										
8653	Overdenture - partial	06.04	1008.10 (884.30)				1512.30 (1326.60)		M	+L	B
	Other separate procedures may be required concurrent to 8653.										
8657	Replacement of precision attachment	06.03	89.20 (78.20)				96.00 (84.20)		M	+L	A
	This procedure involves the replacement of the replaceable part (male for female component) of a semi-precision or precision attachment. Report per denture.										
8663	Metal base to complete denture	06.03	379.70 (333.10)				569.50 (499.60)		M	+L	A
	E.g. chrome cobalt, gold, etc.										
8664	Remount crown or bridge for prosthetics	04.00	181.90 (159.60)				285.00 (250.00)				A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8667	Soft base to denture (heat cured)	05.02	379.70 (333.10)				569.50 (499.60)		M	+L	B
8672	Altered cast technique (in addition to partial denture)	05.02	48.70 (42.70)				73.00 (64.00)		M	+L	B
8674	Additive partial denture	05.02	571.80 (501.60)				857.70 (752.40)		M	+L	B
G.	**MAXILLO-FACIAL PROSTHETICS**										
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect. Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated										06.03
MAXILLIARY PROSTHESIS											
9101	Obturator prosthesis, surgical - modified denture	04.00	93.80 (82.30)				140.70 (123.40)			+L	
9102	Obturator prosthesis, surgical - continuous base	04.00	254.40 (223.20)				381.60 (334.70)			+L	
9103	Obturator prosthesis, surgical - split base	04.00	379.10 (332.50)				568.70 (498.90)			+L	
9104	Obturator prosthesis, interim - on existing denture	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9105	Obturator prosthesis, interim - on new denture	04.00	1765.80 (1548.90)				2648.60 (2323.30)			+L	
9106	Obturator prosthesis, definitive - open/hollow box	04.00	571.80 (501.60)				857.70 (752.40)			+D	
9107	Obturator prosthesis, definitive - silicone glove	04.00	1104.20 (968.60)				1656.20 (1452.80)			+D	
MANDIBULAR RESECTION PROSTHESES											
9108	Mandibular resection prosthesis w/ guide flange	04.00	1356.30 (1189.70)				2034.40 (1784.60)			+L	
9109	Mandibular resection prosthesis w/o guide flange	04.00	1260.20 (1105.40)				1890.40 (1658.20)			+L	
9110	Mandibular resection prosthesis, palatal augmentation	04.00	254.40 (223.20)				381.60 (334.70)			+D	
GLOSSAL RESECTION PROSTHESES											
9111	Glossal resection prosthesis - simple	04.00	530.60 (465.40)				796.00 (698.20)			+D	
9112	Glossal resection prosthesis - complex	04.00	794.90 (697.30)				1192.20 (1045.80)			+D	
RADIOTHERAPY APPLIANCES											
9113	Radiation carrier - simple	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9114	Radiation carrier - complex	04.00	1578.10 (1384.30)				2367.30 (2076.60)			+L	
9115	Radiation shield - simple	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9116	Radiation shield - complex	04.00	1578.10 (1384.30)				2367.30 (2076.60)			+L	

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9117	Radiation cone locator	04.00	571.80 (501.60)				857.70 (752.40)			+L	
CHEMOTHERAPY APPLIANCES											
9118	Chemotherapeutic agent carrier	04.00	571.80 (501.60)				857.70 (752.40)			+L	
CLEFT PALATE PROSTHESES											
8855	Consultation - cleft palate therapy (house or hospital)	04.00	130.40 (114.40)		195.60 (171.60)		195.60 (171.60)				S
8856	Consultation - cleft palate (subsequent)	04.00	64.10 (56.20)		96.00 (84.20)		96.00 (84.20)				S
8857	Consultation - cleft palate (maximum)	04.00	445.40 (390.70)		668.10 (586.10)		668.10 (586.10)				S
NEONATAL PROSTHESES											
9119	Feeding aid prosthesis, neonatal	04.00	506.10 (443.90)		759.10 (665.90)		759.10 (665.90)			+L	S
9120	Orthopaedic appliance, active presurgical - minor	04.00	506.10 (443.90)		759.10 (665.90)		759.10 (665.90)			+L	S
9121	Orthopaedic appliance, active presurgical - moderate	04.00	749.00 (657.00)		1123.60 (985.60)		1123.60 (985.60)			+L	S
9122	Orthopaedic appliance, active presurgical - severe	04.00	1260.20 (1105.40)		1890.40 (1658.20)		1890.40 (1658.20)			+L	S
9123	Orthopaedic appliance, active presurgical - modification	04.00	64.10 (56.20)		96.00 (84.20)		96.00 (84.20)				S
INTERMEDIATE/DEFINITIVE PROSTHESES											
9125	Speech aid/obturator prosthesis - palatal alteration	04.00	255.00 (223.70)				382.50 (335.50)			+D	
9126	Speech aid/obturator prosthesis - velar alteration	04.00	571.80 (501.60)				857.70 (752.40)			+D	
9127	Speech aid/obturator prosthesis - pharyngeal alteration	04.00	1260.20 (1105.40)				1890.40 (1658.20)			+D	
9128	Speech aid/obturator prosthesis - modification	04.00	64.10 (56.20)				96.00 (84.20)				
9129	Speech aid/obturator prosthesis - surgical	04.00	506.10 (443.90)				759.10 (665.90)			+L	
SPEACH APPLIANCES											
9130	Speech aid appliance - palatal lift	04.00	254.40 (223.20)				381.60 (334.70)			+D	
9131	Speech aid appliance - palatal stimulating	04.00	571.80 (501.60)				857.70 (752.40)			+D	
9132	Speech aid appliance - bulb	04.00	1260.20 (1105.40)				1890.40 (1658.20)			+D	
9133	Speech aid appliance - modification	04.00	64.10 (56.20)				96.00 (84.20)				
9134	Unspecified speech aid appliance	04.00	-				-			+L	
EXTRA-ORAL APPLIANCES											
9135	Auricular prosthesis - simple	04.00	1578.10 (1384.30)				2367.30 (2076.60)			+L	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9136	Auricular prosthesis - complex	04.00	2059.10 (1806.20)				3072.20 (2694.90)			+L	
9137	Nasal prosthesis - simple	04.00	1578.10 (1384.30)				2367.30 (2076.60)			+L	
9138	Nasal prosthesis - complex	04.00	2059.10 (1806.20)				3072.20 (2694.90)			+L	
9139	Ocular prosthesis - interim	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9140	Ocular prosthesis - modified stock appliance	04.00	1418.60 (1244.40)				2127.90 (1866.60)			+L	
9141	Ocular prosthesis - custom appliance	04.00	2059.10 (1806.20)				3072.20 (2694.90)			+L	
9142	Orbital prosthesis - simple	04.00	1418.60 (1244.40)				2127.90 (1866.60)			+L	
9143	Orbital prosthesis - complex	04.00	2059.10 (1806.20)				3072.20 (2694.90)			+L	
9144	Facial prosthesis, combination - small	04.00									
9145	Facial prosthesis, combination - medium	04.00									
9146	Facial prosthesis, combination - large	04.00									
9147	Facial prosthesis, combination - complex	04.00									
9148	Unspecified body prosthesis - simple	04.00	1418.60 (1244.40)				2127.90 (1866.60)			+L	
9149	Unspecified body prosthesis - complex	04.00	2059.10 (1806.20)				3072.20 (2694.90)			+L	
9150	Facial prosthesis, surgical - simple	04.00	1104.20 (968.60)				1656.20 (1452.80)			+L	
9151	Facial prosthesis, surgical - complex	04.00	1418.60 (1244.40)				2127.90 (1866.60)			+L	
9152	Extraoral appliance - additional prosthesis	04.00								+L	
9153	Extraoral appliance - replacement prosthesis	04.00								+L	
9155	Cranial prosthesis	04.00	571.80 (501.60)				857.70 (752.40)			+L	
CUSTOM IMPLANTS											
9156	Cranial implant prosthesis, custom made	04.00	690.20 (605.40)				1035.20 (908.10)			+L	
9157	Facial implant prosthesis, custom made - simple	04.00	344.80 (302.50)				517.20 (453.70)			+L	
9158	Facial implant prosthesis, custom made - complex	04.00	690.20 (605.40)				1035.20 (908.10)			+L	
9159	Ocular implant prosthesis, custom made	04.00	344.80 (302.50)				517.20 (453.70)			+L	
9160	Body implant prosthesis - custom made	04.00	1534.70 (1346.20)				2302.10 (2019.40)			+L	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
SURGICAL APPLIANCES											
9161	Surgical splint - simple	04.00	156.00 (136.80)				234.10 (205.40)			+L	
9162	Surgical splint - complex	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9163	Surgical template - simple	04.00	156.00 (136.80)				234.10 (205.40)			+L	
9164	Surgical template - complex	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9165	Surgical conformer - simple	04.00	156.00 (136.80)				234.10 (205.40)			+L	
9166	Surgical conformer - complex	04.00	571.80 (501.60)				857.70 (752.40)			+L	
TRISMUS APPLIANCES											
9167	Trismus appliance (simple)	04.00	64.10 (56.20)				96.00 (84.20)			+L	
9168	Trismus appliance (complex)	04.00	571.80 (501.60)				857.70 (752.40)			+L	
9169	Orthoses appliance	04.00	1260.20 (1105.40)				1890.40 (1658.20)			+L	
9170	Facial palsy appliance	04.00	379.10 (332.50)				568.70 (498.90)			+D	
9171	Commissure splint	04.00	156.00 (136.80)				234.10 (205.40)			+L	
9172	Oral retractor, dynamic - per arm	04.00	156.00 (136.80)				234.10 (205.40)			+L	
9173	Hand splint	05.02								+L	
9174	Unspecified burn appliance	05.02	-				-			+L	
ATTENDANCE IN THEATRE											
9175	Theatre attendance (MaxFac prosthod) /hour	04.00	211.00 (185.10)				316.50 (277.60)				
H.	**IMPLANT SERVICES**										
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.										06.03
SURGICAL IMPLANT PROCEDURES											
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.										06.03
9180	Surgical placement of sub-periosteal implant - preparatory stage	05.02	925.20 (811.60)	1387.80 (1217.40)					M		S
9181	Surgical placement of sub-periosteal implant - placement stage	05.02	925.20 (811.60)	1387.80 (1217.40)					M	+L	S
9182	Surgical placement of endosteal implant plate	04.00	463.10 (406.20)	694.70 (609.40)		694.70 (609.40)				+L	S
9183	Surgical placement of endosteal implant - first per jaw	06.03	651.90 (571.80)	886.00 (777.20)		886.00 (777.20)			T	+M	S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Also known as a root form implant; endosseus or an osseo-integrated implant. This procedure involves (1) the surgical placement of a one stage and/or the first stage of a two stage surgery endosteal implant (fixture) and (2) the placement of a healing abutment/cap (when appropriate). Code 9183 includes the surgical placement of a one-piece endosteal implant (incorporating both the implant and integral fixed abutment) and should also be used to report the placement of an endosteal plate form implant. In such instances laboratory fees applies. See code 9190 hereunder for second stage surgery and code 9187 located in the "Other implant services" section to report the cost of the endosteal implant body.										
9184	Surgical placement of endosteal implant - second per jaw	05.02	488.00 (428.10)	664.70 (583.10)		664.70 (583.10)			T	+M	S
9185	Surgical placement of endosteal implant - third and subsequent per jaw	05.02	326.70 (286.60)	445.20 (390.50)		445.20 (390.50)			T	+M	S
9190	Surgical placement of abutment - first per jaw	06.03	241.80 (212.10)	327.60 (287.40)		327.60 (287.40)	327.60 (287.40)		T	+M	S
	This procedure involves the (1) surgical re-exposure (uncovery or second stage surgery) of that portion of the submerged endosteal implant that receives the attachment device, and (2) the connection of a healing abutment or temporary prosthesis. This is usually done after the implant has matured in the bone for several months. The purpose of a healing abutment or collar is to create an emergence profile in the gum tissues for the future implant crown. Some implants are designed to remain exposed in the mouth right after they are placed, abolishing an uncovery procedure. Report codes 8578 or 8579 (in the prosthodontists' code list) for the placement of the final abutment to permit fabrication of a dental prosthesis in addition to this code. See Codes 9188 and 9189 located in the "Other implant services" section to submit the cost of other implant components.										
9191	Surgical placement of abutment - second per jaw	05.02	181.80 (159.50)	246.20 (216.00)		246.20 (216.00)	246.20 (216.00)		T	+M	S
9192	Surgical placement of abutment - third and subsequent per jaw	05.02	121.80 (106.80)	165.60 (145.30)		165.60 (145.30)	165.60 (145.30)		T	+M	S
IMPLANT SUPPORTED PROSTHETICS											
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.										06.03
Abutments and Bars											
	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g., healing abutments/collars, temporary abutments, caps, cylinders, etc.Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant.See Codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.										06.03
8584	Connector bar - implant supported	06.03	1260.20 (1105.40)				1890.40 (1658.20)				
	Any bar that connects two or more implants to stabilise and anchor removable overdentures or fixed-detachable dentures. Report code 8578 (prefabricated abutment) for implant abutments separated from connecting bar (bar attachment) and code 8579 (custom abutment) for implant abutments as part of connecting bar in addition to this code. Includes attachments that are inserted in the denture for holding onto the bar. Use to report Preci Bar (Dolder) System attached to implant abutments. When the prefabricated metal Preci Bar is soldered to prefabricated abutments, report codes 8584 and 8578. When the plastic-wax Preci Bar is cast directly with the abutments, report codes 8584 and 8579.										

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8578	Prefabricated abutment	06.03	130.40 (114.40)				195.60 (171.60)				
	A prefabricated connection (abutment/precision attachment) to an implant that serves to support and/or retain any prosthesis or superstructure. Modification of a prefabricated abutment may be necessary. Code 8578 should not be used to report the placement of a healing abutment. See Code 9188 located in the "Other implant services" section to submit the cost of the prefabricated abutment.										
8579	Custom abutment	06.03	594.70 (521.70)				892.00 (782.50)				
	A tailor-made connection to an implant that serves to support and/or retain any prosthesis or superstructure. A custom made abutment is usually manufactured by a dental laboratory using a casting process.										
Removable Dentures											
8533	Implant supported removable complete overdenture	06.03	1260.20 (1105.40)				1890.40 (1658.20)		M	+L	B
	A removable complete denture supported by dental implants to provide improved retention and stability. Overdentures are retained by abutments or bars (attachments) and can be removed by the patient at will. Currently includes acrylic and acrylic with metal base overdentures. A complete overdenture normally requires a minimum of two implants in the mandibula and four in the maxilla for effective support, retention and stability. Report the appropriate mesostructures in addition to this code.										
8534	Implant supported removable partial overdenture	06.03	1008.10 (884.30)				1512.30 (1326.60)		M	+L	B
	See code 8533 for descriptor.										
Fixed-detachable Dentures											
8654	Implant supported fixed-detachable complete overdenture	06.03	1417.50 (1243.40)				2126.20 (1865.10)		M	+L	A
	A fixed complete denture supported by dental implants, or abutments placed on implants, to provide improved retention and stability; may be screw retained or cemented and cannot be removed by the patient; also known as a "hybrid prosthesis." Currently includes acrylic and acrylic with metal base fixed dentures. A fixed-detachable complete denture normally requires a minimum of five implants in the mandibula and six in the maxilla for effective support, retention and stability. When abutments are used, report code 8578 (prefabricated abutment) or code 8579 (custom abutment), as appropriate, in addition to this code. When the denture is supported directly on the implant body (no mesostructure or abutments are used), report code 8660 in addition to this code. When the design of the denture includes a metal base, report code 8663 (Metal base to complete denture) in addition to this code.										
8655	Implant supported fixed-detachable partial overdenture	06.03	1133.90 (994.60)				1457.00 (1278.10)		M	+L	A
	See code 8654 for descriptor.										
8660	Additional fee to implant supported fixed-detachable denture - per implant	06.03	195.60 (171.60)				195.60 (171.60)		T		A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	This code may be reported when an implant supported fixed denture is attached to an implant body (no mesostructure or abutments are used). Report per implant and identify the position (replaced tooth's number) of the implant(s). May only be used in conjunction with codes 8654 and 8655.										
Crowns - Single Restorations											
8536	Crown - implant/abutment supported - porcelain/ceramic	06.03	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
	An artificial crown that is retained, supported, and stabilised by an implant or abutment on an implant; may be screw retained or cemented.										
8537	Crown - implant/abutment supported - porcelain with metal	05.02	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
8538	Crown - implant/abutment supported - cast metal	05.02	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
8592	Crown - implant/abutment supported	06.03					1378.30 (1209.00)		T	+L	A
	An artificial crown that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented. See also codes 8536, 8537 and 8538.										
Bridge Retainers - Crowns											
8546	Crown retainer - implant/abutment supported - porcelain/ceramic	06.03	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
	A crown attaching a pontic(s) that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented.										
8547	Crown retainer - implant/abutment supported - porcelain with metal	05.02	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
8548	Crown retainer - implant/abutment supported - cast metal	05.02	1042.10 (914.10)				1378.30 (1209.00)		T	+L	A
OTHER IMPLANT SERVICES											
8590	Implant maintenance procedures - per implant	06.03	57.70 (50.60)				86.60 (76.00)		T		A
	This procedure involves the (1) removal of the superstructure(s), cleansing and reinsertion; (2) active deposit removal (debriding) of the implant; (3) examination of all aspects of the implant system (periimplant and prosthetic evaluation, including the occlusion and stability of the superstructure); and (4) patient home care reinforcement and modification. Report per implant and identify the position of the implant (replaced tooth's number) from which the superstructure has been removed. This procedure involves the maintenance of the implant and should not be reported when the superstructure is not removed. See code 8159 (prophylaxis – complete dentition) in the "Preventive Section". The procedure also involves pasient home care reinforcement and modification, and codes 8151 (Oral hygine instructions) or code 8153 (Oral hygine instructions – each additional visit) should not be reported with this code. Radiographs, when indicated, may be reported in addition to this code (usually at each three months recall visit for the first year and annually thereafter).										
8594	Repair of implant supported prosthesis	06.03	64.10 (56.20)				96.00 (84.20)				
	Use this code to report the repair or replacement of any part of the implant supported prosthesis. See Codes 9189 to submit the cost of implant components (e.g. replacement clips).										
8595	Repair of implant abutment	06.03	64.10 (56.20)				96.00 (84.20)				

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Use this code to report the repair or replacement of any part of the implant abutment. See code 9188 to submit the cost of implant abutment and code 9189 to submit the cost of implant components (e.g. abutment screw).										
8600	Cost of implant components	06.03		-		-	-				S
	See Rule 002 and Modifier 8025 for direct material costs. See also codes 9187, 9188 and 9189.										
9187	Cost of endosteal implant body	06.03	-	-		-					S
	Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9187 and Modifier 8025 per implant body.										
9188	Cost of prefabricated abutment	06.03	-								S
	Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9187 and Modifier 8025 per implant abutment.										
9189	Cost of other implant compnts	06.03	-								S
	Use this code to report all other implant components (implant fixtures and abutments excluded) which are a component part of the definite implant/implant prosthesis system. Comment: See Rule 002 and Modifier 8025 for direct material costs. Report both code 9189 and Modifier 8025 per component.										
9198	Surgical removal of implant	06.03	301.40 (264.40)	452.00 (396.50)		452.00 (396.50)			T		S
	This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant, and closure.										
I.	**FIXED PROSTHODONTICS**										
	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable. A prosthetic retainer (e.g., crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge. Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics. Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.										06.03
PONTICS											
	Comment: Codes 8415, 8416, 8417and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.										06.03
8415	Pontic - porcelain/ceramic	05.03	655.30 (574.80)						T	+L	A
8416	Pontic - cast metal	05.03	520.60 (456.70)						T	+L	A
8417	Pontic - resin with metal	05.03	655.30 (574.80)						T	+L	A
8418	Pontic - porcelain fused to metal	05.03	655.30 (574.80)						T	+L	A
8419	Provisional pontic	06.03	156.00 (136.80)				234.10 (205.40)		T	(+L)	A
	The intented use of a provisional pontic is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis for routine bridges. Comment: Code 8410 (Provisional crown) previously included both provisional pontics (code 8419) and provisional crown retainers (code 8447)										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8611	Pontic - sanitary	06.03					714.50 (620.80)		T	+L	A
	See GDP codes 8415 to 8418.										
8613	Pontic - posterior	06.03					874.00 (766.70)		T	+L	A
	See GDP codes 8415 to 8418.										
8615	Pontic - anterior/premolar	06.03					944.30 (828.30)		T	+L	A
	See GDP codes 8415 to 8418.										
BRIDGE RETAINERS – INLAYS/ONLAYS											
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlayed to be considered an onlay. See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.										06.03
8432	Inlay/onlay retainer - metal - two surfaces	05.02	312.20 (273.90)				610.60 (535.60)		T	+L	A
8433	Inlay/onlay retainer - metal - three surfaces	05.02	520.60 (456.70)				946.90 (830.60)		T	+L	A
8434	Inlay/onlay retainer - metal - four or more surfaces	05.02	629.60 (552.30)				946.90 (830.60)		T	+L	A
8436	Inlay/onlay retainer - porcelain - two surfaces	05.02	379.90 (333.20)				732.50 (642.50)		T	+L	A
8437	Inlay/onlay retainer - porcelain - three surfaces	05.02	626.10 (549.20)				1138.20 (998.40)		T	+L	A
8438	Inlay/onlay retainer - porcelain - four or more surfaces	05.02	758.30 (665.20)				1138.20 (998.40)		T	+L	A
8617	Retainer cast metal (Maryland type retainer)	06.03	312.20 (273.90)				610.60 (535.60)		T	+L	A
	Use for Maryland type bridges; Report per retainer; See codes 8415 to 8418 for pontics.										
BRIDGE RETAINERS – CROWNS											
	A crown retainer for a bridge that gains retention, support and stability from a tooth.										06.03
8441	Crown retainer - full cast metal	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8442	Crown retainer - 3/4 cast metal	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8443	Crown retainer - porcelain/ceramic	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8444	Crown retainer - 3/4 porcelain/ceramic	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8445	Crown retainer - porcelain with metal	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A
8446	Crown retainer - resin with metal	05.02	802.80 (704.20)				1181.90 (1036.80)		T	+L	A

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8447	Provisional crown retainer	06.03	156.00 (136.80)				234.10 (205.40)		T	(+L)	A
	The intended use of a provisional crown retainer is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis. Comment: Code 8410 (Provisional crown) previously included both provisional pontics (code 8425) and provisional crown retainers (code 8447).										
OTHER FIXED PROSTHODONTIC PROCEDURES											
	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.										06.03
8514	Recement bridge	06.03	70.30 (61.70)				89.20 (78.20)		T		B
	Use to report the recementation of a permanent inlay-, onlay-, or crown retainer - reported per retainer. May be used to report the recementation of a Maryland bridge. Report code 8133 for the recementation of a single permananet inlay, onlay or crown. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration. Previouly code 8133 included the recementation of bridge retainers.										
8516	Remove bridge	06.03	139.80 (122.60)				139.80 (122.60)		T		A
	This procedure involves the removal of a permananet bridge retainer - reported per retainer. Report code 8135 for the removal of a single permananet inlay, onlay or crown. Comment: This code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration. Previouly code 8135 included the removal of bridge retainers.										
8518	Repair bridge	06.03	156.00 (136.80)				156.00 (136.80)		T	(+L)	A
	This procedure involves the repair or replacement of the face of a permanent crown retainer or pontic. Excludes the removal (8516) and recementation (8514) of the permanent bridge. This code may also be reported for the repair/replacement of a provisional crown retainer (8447) or pontic (8425) after a period of two months. The code may not be used for the repair/replacement of a temporary bridge, which is included as part of the restoration.										
8585	Connector bar	06.03	1260.20 (1105.40)				1890.40 (1658.20)		M	+L	A
	Any bar that connects two or more inlay/onlay/crown retainers or pontics to stabilise and anchor removable overdentures. Report the appropriate retainer(s) or pontic(s) in addition to this code. Use to report Preci Bar (Dolder) System attached to inlay/onlay/crown retainers or pontics. Report code 8585 for both the prefabricated metal Preci Bar which is soldered to and plastic-wax Preci Bar which is casted directly with the inlay/onlay/crown retainers or pontics. Report the appropriate retainer(s) or pontic(s) in addition to this code.										
8586	Stress breaker	06.03	470.10 (412.40)				705.10 (618.50)		M	+L	A
	A non-ridgid connector.										
8587	Coping metal	06.03	104.70 (91.80)				195.60 (171.60)		T	+L	A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	A thimble coping may utilise pins for additional retention. Generally used to parallel an abutment tooth for bridge and splints. May be similarly used to parallel an implant abutment where implant bodies are not parallel. A dome-shaped coping is generally used on an endodontically treated abutment tooth for an overdenture.										
J.	**ORAL AND MAXILLO-FACIAL SURGERY**										
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.									06.03	
EXTRACTIONS											
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	06.03	70.30 (61.70)	105.40 (92.50)					T		B
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.										
8202	Extraction - each additional tooth or exposed tooth roots	06.03	28.30 (24.80)	42.50 (37.30)					T		B
	To be reported for an additional extraction in the same quadrant at the same visit.										
SURGICAL EXTRACTIONS											
	Report code 8220 when sutures are provided by the practitioner.									06.03	
8213	Surgical removal of residual roots, first tooth - per tooth	06.03	303.70 (266.40)						T		S
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth roots and closure. Report per tooth. The removal of more than one root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown.										
8214	Surgical removal of residual roots, second and subsequent teeth's roots	04.00	234.10 (205.40)						T		S
8937	Surgical removal of tooth	06.03	303.70 (266.40)	409.90 (359.60)					T		S
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of the tooth and closure. Use code 8937 for the surgical removal of residual tooth roots following the failure of a normal extraction during the same visit.										
8941	Surgical removal of impacted tooth - first tooth	06.03	503.50 (441.70)	662.10 (580.80)					T		S
	Use to report when the occlusal surface of the tooth is covered by soft tissue and/or bone. This procedure requires mucoperiosteal flap elevation with or without bone removal, removal of the tooth and closure.										
8943	Surgical removal of impacted tooth - second tooth	04.00	270.10 (236.90)	356.70 (312.90)					T		S
8945	Surgical removal of impacted tooth - third and subsequent teeth	04.00	153.50 (134.60)	202.40 (177.50)					T		S
8953	Surgical removal of residual roots, first tooth - per tooth	06.03		409.90 (359.60)					T		S

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth structure and closure. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown. Note 1: Maxillo-Facial Surgeons - See Surgery Guidelines, Notes 2 and 3 for the removal of residual tooth roots of each subsequent tooth. Report per tooth. Note 2: General Dental Practitiones to report codes 8213 and 8214.										
OTHER SURGICAL PROCEDURES											
8517	Reimplantation of avulsed tooth (include stabilisation)	05.04	162.40 (142.50)				243.60 (213.70)		T	+L	S
8909	Oral antral fistula closure	04.00	711.90 (624.50)	1067.80 (936.70)							S
8911	Caldwell-Luc procedure	04.00	278.50 (244.30)	417.80 (366.50)							S
8917	Biopsy of oral tissue - soft	06.03	177.50 (155.70)	236.70 (207.60)		236.70 (207.60)			M		S
	Incisional/excisional (e.g. epulis). This procedure does not include the cost of the essential pathological evaluations.										
8919	Biopsy of bone - needle	05.02	273.30 (239.70)	409.90 (359.60)					M		S
8921	Biopsy – extra-oral bone/soft tissue	05.02	447.20 (392.30)	670.70 (588.30)					M		S
8961	Tooth transplantation	06.03	611.20 (536.10)	916.90 (804.30)					T	+L	S
	See Surgery Guidelines, Notes 2 and 3.										
8965	Peripheral neurectomy	04.00	611.20 (536.10)	916.90 (804.30)							S
8966	Repair of oronasal fistula (local flaps)	04.00	850.30 (745.90)	1275.50 (1118.90)							S
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	06.03	561.00 (492.10)	764.20 (670.40)		764.20 (670.40)			T		S
	An incision is made and the tissue is reflected and bone removed as necessary to expose the crown. This procedure may include but is not limited to a situation whereby an attachment is laced to facilitate eruption. In some instances, a free soft tissue graft is needed as a concurrent but separate procedure. Comment: The orthodontic attachment is usually supplied by the referring orthodontist.										
8983	Corticotomy - first tooth	04.00	405.90 (356.10)	608.90 (534.10)					T		S
8984	Corticotomy - each additional tooth	04.00	205.80 (180.50)	308.80 (270.90)					T		S
ALVEOLOPLASTY											
8957	Alveolotomy or alveolectomy (including extractions)	06.03	372.90 (327.10)	559.30 (490.60)					M		S
	Report per jaw.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9003	Reposition mental foramen and nerve - per side	05.02	849.20 (744.90)	1273.70 (1117.30)					M	+L	S
9004	Lateralization of inferior dental nerve	05.02	1368.30 (1200.30)	2052.50 (1800.40)							S
VESTIBULOPLASTY											
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.										06.03
8997	Sulcoplasty / Vestibuloplasty	05.02	1401.50 (1229.40)	2102.30 (1844.10)		2102.30 (1844.10)			M	+L	S
SURGICAL EXCISION OF SOFT TISSUE LESIONS											
8971	Excision of tumour of the soft tissue	04.00	273.30 (239.70)	409.90 (359.60)		409.90 (359.60)					S
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS											
8967	Surgical removal of jaw cyst - intra-oral approach	05.02	849.20 (744.90)	1273.70 (1117.30)					M		S
8969	Surgical removal of jaw cyst - extra-oral approach	05.02	1360.20 (1193.20)	2040.40 (1789.80)					M		S
8973	Surgical excision of tumours of the jaw	05.02	1360.20 (1193.20)	2040.40 (1789.80)					M		S
9290	Maxillectomy - Alveolus only, Level I	06.03									
	Report per side.										
9292	Maxillectomy - Alveolus and sinus or nasal floor, Level II	06.03									
	Report per side.										
9294	Maxillectomy - Alveolus, sinus, nasal floor and zygoma excluding orbital rim Level III	06.03									
	Report per side.										
9296	Maxillectomy - Alveolus, sinus, nasal floor and zygoma including orbital rim Level IV	06.03									
	Report per side.										
9298	Maxillectomy - Alveolus, sinus, nasal floor, zygoma, orbital rim and pterygoid plates Level V	06.03									
	Report per side.										
9300	Hemiresection of jaw including condyle and coronoid process	06.03									
	Report per side.										
EXCISION OF BONE TISSUE											
8975	Hemiresection of jaw excluding condyl	06.03	1428.90 (1253.40)	2143.40 (1880.20)					M		S
	Include splintage of segments.										
8987	Reduction of mylohyoid ridges - per side	04.00	611.20 (536.10)	916.90 (804.30)						+L	S
8989	Removal torus mandibularis	04.00	611.20 (536.10)	916.90 (804.30)						+L	S
8991	Removal of torus palatinus	04.00	611.20 (536.10)	916.90 (804.30)						+L	S

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8993	Surgical reduction of osseous tuberosity - per side	06.03	273.30 (239.70)	409.90 (359.60)					M	+L	S
	See procedure code 8971 for excision of denture granuloma.										
SURGICAL INCISION											
8731	Incision & drainage of abscess - intra-oral	06.03	112.10 (98.30)			168.10 (147.50)					A
	Periodontal abscess - treatment of acute phase (with or without flap procedure).										
8908	Surgical removal of roots from maxillary antrum	06.03	928.60 (814.60)	1392.90 (1221.80)							S
	Involves Caldwell-Luc and closure of oral antral communication.										
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	173.90 (152.50)	260.70 (228.70)					M		S
9013	Incision & drainage of abscess - extra-oral (pyogenic)	05.03	237.80 (208.60)	356.70 (312.90)					M		S
	E.g., Ludwig's angina.										
9017	Decortication, saucerisation and sequestrectomy	06.03	1258.50 (1103.90)	1887.80 (1656.00)							S
	For osteomyelitis of the mandible.										
9019	Sequestrectomy - intra oral per sextant and or ramus	05.02	273.30 (239.70)	409.90 (359.60)					M		S
TREATMENT OF FRACTURES											
Alveolus Fractures											
9024	Dento-alveolar fracture - per sextant	04.00	306.50 (268.90)	459.70 (403.20)						+L	S
Mandibular Fractures											
9025	Mandible fracture - closed reduction	06.03	678.70 (595.40)	1018.10 (893.10)							S
	Includes intermaxillary fixation.										
9027	Mandible fracture - compound, with eyelet wiring	04.00	953.20 (836.10)	1429.80 (1254.20)							S
9029	Mandible fracture - splints	06.03	1055.50 (925.90)	1583.30 (1388.90)						+L	S
	Metal cap splintage or Gunning's splints.										
9031	Mandible fracture - open reduction	06.03	1564.50 (1372.40)	2346.70 (2058.50)						+L	S
	Includes restoration of occlusion by splintage.										
Maxillary Fractures											
9035	Maxilla fracture - Le Fort I or Guerin	06.03	954.90 (837.60)	1432.40 (1256.50)						+L	S
	When open reduction is required for Codes 9035 and 9037, Modifier 8010 may be applied.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9037	Maxilla fracture - Le Fort II or middle third face	06.03	1564.50 (1372.40)	2346.70 (2058.50)						+L	S
	When open reduction is required for Codes 9035 and 9037, Modifier 8010 may be applied.										
9039	Maxilla fracture - Le Fort III or craniofacial disjunction	06.03	2243.80 (1968.20)	3365.60 (2952.30)						+L	S
	Includes comminuted mid-facial fractures requiring open reduction and splintage.										
Zygoma/Orbital/Antral Fractures											
9041	Zygomatic arch fracture - closed reduction	06.03	678.70 (595.40)	1018.10 (893.10)							S
	Gillies or temporal elevation.										
9043	Zygomatic arch fracture - open reduction	06.03	1360.20 (1193.20)	2040.40 (1789.80)							S
	Unstable and/or comminuted zygoma, treatment by open reduction or Caldwell-Luc operation										
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)	04.00	2037.90 (1787.60)	3056.90 (2681.50)							S
9046	Placement of Zygomaticus fixture, per fixture	05.02	1346.10 (1180.80)	2019.10 (1771.10)							S
Nasal Fractures											
9260	Open reduction and fixation of nasal fractures	04.00									
9262	Manipulation and immobilisation of nasal fracture	04.00									
TEMPOROMANDIBULAR JOINT											
	Procedures which are an integral part of a primary procedure should not be reported separately.										06.03
8172	Cost of orthotic appliance	06.03	-	-	-	-	-				
	Comment: Applicable to pre-fabricated devices. See Rule 002 and Modifier 8025 for direct material costs.										
8850	Treatment of MPDS - first visit	04.00	107.50 (94.30)		161.30 (141.50)		161.30 (141.50)				A
8851	Treatment of MPDS - subsequent visit	04.00	56.60 (49.60)		84.90 (74.50)		84.90 (74.50)				A
8852	Occlusal orthotic appliance	06.03	270.10 (236.90)	355.90 (312.20)	355.90 (312.20)	355.90 (312.20)	355.90 (312.20)			+L	S
	Presently includes splints provided for treatment of temporomandibular joint dysfunction and NTI Tention Supression System (NTI-tss) devices.										
9053	Coronoidectomy (intra-oral approach)	04.00	848.50 (744.30)	1272.90 (1116.60)							S
9074	Tmj arthroscopy diagnostic	04.00	675.30 (592.40)	1012.90 (888.50)							S
9075	Condylectomy, coronoidectomy or both	04.00	1696.50 (1488.20)	2544.80 (2232.30)							S
9076	TMJ artrocentesis	04.00	372.90 (327.10)	559.30 (490.60)							S
9077	TMJ intra-articular injection	04.00	101.70 (89.20)	152.60 (133.90)							S

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9079	Trigger point injection	04.00	79.40 (69.60)	119.20 (104.60)							S
9081	Condylectomy (Ward/Kostecka)	06.03	678.70 (595.40)	1018.10 (893.10)							S
	For Codes 9081, 9083 and 9092 the full fee may be charged per side.										
9083	TMJ srthroplasty	06.03	1696.50 (1488.20)	2544.80 (2232.30)							S
	For Codes 9081, 9083 and 9092 the full fee may be charged per side.										
9085	Reduction of TMJ disloc w/o anaesthetic	04.00	134.90 (118.30)	202.40 (177.50)							S
9087	Reduction of TMJ disloc w/ anaesthetic	04.00	273.30 (239.70)	409.90 (359.60)							S
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	04.00	678.70 (595.40)	1018.10 (893.10)							S
9091	Reduction of TMJ dislocation - open reduction	04.00	1696.50 (1488.20)	2544.80 (2232.30)							S
9092	Joint reconstruction	06.03	4529.30 (3973.10)	6793.90 (5959.60)						+L	S
	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy) For Codes 9081, 9083 and 9092 the full fee may be charged per side.										
REPAIR OF TRAUMATIC WOUNDS											
8192	Suture - minor	06.03	346.50 (303.90)								S
	Use to report the suturing of recent small wounds. Excludes the closure of surgical incisions.										
COMPLICATED SUTURING											
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.										06.03
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)	04.00	346.50 (303.90)	459.70 (403.20)							S
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	04.00	645.00 (565.80)	967.50 (848.70)							S
OTHER REPAIR PROCEDURES											
8958	Emergency tracheotomy	04.00	313.30 (274.80)	470.00 (412.30)							
8959	Pharyngostomy	04.00	313.30 (274.80)	470.00 (412.30)							
8962	Harvest iliac crest graft	04.00	225.30 (197.60)	277.00 (243.00)							S
8963	Harvest rib graft	04.00	258.50 (226.80)	387.70 (340.10)							S
8964	Harvest cranium graft	04.00	202.40 (177.50)	303.70 (266.40)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8977	Surgical repair of maxilla or mandible - major	06.03	1427.80 (1252.50)	2141.70 (1878.70)							S
	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage) Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure.										
8979	Harvesting of autogenous grafts (intra-oral)	04.00	117.70 (103.20)	176.70 (155.00)		176.70 (155.00)					S
8985	Frenulectomy/frenulotomy	04.00	372.90 (327.10)	559.30 (490.60)		559.30 (490.60)					S
9005	Alveolar ridge augmentation - total (by bone graft)	05.02	1428.90 (1253.40)	2143.40 (1880.20)		2143.40 (1880.20)			M	+L	S
9007	Alveolar ridge augmentation - total (by alloplastic material)	05.02	899.40 (788.90)	1349.10 (1183.40)					M	+L	S
9008	Alveolar ridge augmentation - one to two tooth sites	05.02	278.00 (243.90)	508.60 (446.10)		508.60 (446.10)			M	+L	S
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	05.02	618.10 (542.20)	927.10 (813.20)		927.10 (813.20)			M	+L	S
9010	Sinus lift procedure	05.02	928.60 (814.60)	1392.90 (1221.80)		1392.90 (1221.80)			M	+L	S
9032	Reduction of masseter muscle and bone - extra-oral approach	06.03									
	Eg., for treatment of benign masseteric hypertrophy; extraoral approach (Alt Code: CPT 21295)										
9033	Reduction of masseter muscle and bone - intra-oral approach	06.03									
	Eg., for treatment of benign masseteric hypertrophy; intraoral approach (Alt Code: CPT 21296)										
9048	Surgical removal of internal fixation devices, per site	05.02	261.30 (229.20)	392.00 (343.90)							S
Functional Correction of Malocclusion											
	For Codes 9047 to 9072 the full fee may be charged.										06.03
9047	Osteotomy - open with stabilisation	06.03	2852.10 (2501.80)	4278.30 (3752.90)						+L	S
	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation)										
9049	Osteotomy - mandible body, anterior segmental	06.03	2377.00 (2085.10)	3565.50 (3127.60)						+L	S
	E.g. Köle										
9050	Osteotomy - total subapical	04.00	4348.00 (3814.00)	6521.90 (5721.00)							S
9051	Genioplasty	04.00	1360.20 (1193.20)	2040.40 (1789.80)							S
9052	Midfacial exposure	06.03	2153.40 (1888.90)	3230.10 (2833.40)							S
	For maxillary and nasal augmentation or pyramidal Le Fort II osteotomy.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9055	Osteotomy - segmented, posterior	06.03	2377.00 (2085.10)	3565.50 (3127.60)					M	+L	S
	Maxillary posterior segment osteotomy (Schukardt) - 1 or 2 stage procedure.										
9057	Osteotomy - segmented, anterior	06.03	2377.00 (2085.10)	3565.50 (3127.60)					M	+L	S
	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure.										
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	04.00	4472.70 (3923.40)	6709.00 (5885.10)						+L	S
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	05.02	5021.00 (4404.40)	7531.40 (6606.50)						+L	S
9061	Palatal osteotomy	04.00	1564.50 (1372.40)	2346.70 (2058.50)							S
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	04.00	5709.50 (5008.30)	8564.20 (7512.50)						+L	S
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and post-traumatic deformities)	04.00	5712.30 (5010.80)	8568.50 (7516.20)						+L	S
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	06.03	8561.00 (7509.60)	12841.50 (11264.50)						+L	S
	Le Fort III osteotomy for correction of severe congenital deformities, viz. Crouzon's disease and malunited craniomaxillary disjunction.										
9066	Surgical expansion - maxilliary or mandibular	06.03	1360.20 (1193.20)	2040.40 (1789.80)					M		S
	This procedure is to expand the maxilla or mandible to facilitate orthodontic aligning of constricted dental arches.										
9069	Glossectomy - partial	04.00	1018.90 (893.80)	1528.40 (1340.70)							S
9071	Geniohyoidotomy	04.00	611.20 (536.10)	916.90 (804.30)							S
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	04.00	4472.70 (3923.40)	6709.00 (5885.10)						+L	S
Salivary Glands											
9093	Removal of salivary stone (Sialolithotomy)	04.00	306.50 (268.90)	459.70 (403.20)							S
9095	Excision of sublingual salivary gland	04.00	755.30 (662.50)	1133.10 (993.90)							S
9096	Excision of salivary gland - extra oral approach	04.00	1119.00 (981.60)	1678.60 (1472.50)							S
Pedicle Flaps											
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post –cancer/ trauma/ tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.	06.03									
9284	Musculofascial flap	04.00									
9286	Musculocranial flap	04.00									
9288	Buccal fat pad (major repair)	04.00									

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
Repair of Frontal Bones											
	The use of codes 9274, 9275 and 9278 imply the bicoronal/ hemicoronal approach.										06.03
9274	Repair anterior table, frontal sinus and/or supraorbital rim	04.00									
9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus	04.00									
9278	Repair medial canthal ligament (canthopexy), per side	04.00									
Cleft lip and Palat											
9220	Repair cleft hard palate - unilateral	04.00	2498.20 (2191.40)	3747.30 (3287.10)							S
9222	Repair cleft hard palate - bilateral (one procedure)	04.00	3171.20 (2781.80)	4756.80 (4172.60)							S
9224	Repair cleft hard palate - bilateral (two procedures)	04.00	4725.40 (4145.10)	7087.30 (6216.90)							S
9226	Repair cleft soft palate - w/o muscle reconstruction	04.00	2093.40 (1836.30)	3140.10 (2754.50)							S
9228	Repair cleft soft palate - w/ muscle reconstruction	04.00	3039.60 (2666.30)	4559.50 (3999.60)							S
9230	Repair submucosal cleft and/or bifid uvula - w/ muscle reconstruction	04.00	2263.20 (1985.30)	3394.80 (2977.90)							S
9232	Velopharyngeal reconstruction - uncomplicated	04.00	2329.00 (2043.00)	3493.40 (3064.40)							S
9234	Velopharyngeal reconstruction - complicated	04.00	2490.30 (2184.50)	3735.30 (3276.60)							S
9238	Repair oronasal fistula (one procedure)	04.00	1424.40 (1249.50)	2136.60 (1874.20)							S
9240	Repair oronasal fistula (two procedures)	04.00	2485.00 (2179.80)	3727.50 (3269.70)							S
9246	Secondary periosteal flaps	04.00	1241.90 (1089.40)	1862.90 (1634.10)							S
9248	Lipadhesion	04.00	464.20 (407.20)	696.40 (610.90)							S
9250	Repair cleft lip - unilateral w/o muscle reconstruction	04.00	817.70 (717.30)	1226.50 (1075.90)							S
9252	Repair cleft lip - unilateral w/ muscle reconstruction	04.00	1108.70 (972.50)	1663.10 (1458.90)							S
9254	Repair cleft lip - bilateral w/o muscle reconstruction	04.00	1141.80 (1001.60)	1712.80 (1502.50)							S
9256	Repair cleft lip - bilateral w/ muscle reconstruction	04.00	1764.10 (1547.50)	2646.10 (2321.10)							S
9258	Repair anterior nasal floor	04.00	445.40 (390.70)	668.10 (586.10)							S
9260	Revision of secondary cleft lip deformity - partial	04.00	445.40 (390.70)	668.10 (586.10)							S
9262	Revision of secondary cleft lip deformity - total w/ muscle reconstruction	04.00	1006.40 (882.80)	1509.60 (1324.20)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9264	Abbe-flap - two stages	04.00	1139.70 (999.70)	1709.40 (1499.50)							S
9266	Reconstruct columella	04.00	673.60 (590.90)	1010.30 (886.20)							S
9268	Reconstruct nose due to cleft deformity - partial	04.00	856.00 (750.90)	1284.00 (1126.30)							S
9270	Reconstruct nose due to cleft deformity - complete	04.00	1352.90 (1186.80)	2029.30 (1780.10)							S
9272	Paranasal augmentation for nasal base deviation	04.00	673.60 (590.90)	1010.30 (886.20)							S
K.	**ORTHODONTIC SERVICES**										
	The branch of dentistry used to correct malocclusions of the mouth and restore it to proper alignment and function. Includes all services/procedures concerned with the supervision, guidnance and correction of the growing and mature dentofacial structures.										06.03
REMOVABLE APPLIANCE THERAPY											
	Removable indicates patient can remove; includes appliances for limited orthodontic treatment (e.g., partial treatment to open spaces or upright of a tooth) and minor orthodontic treatment to control harmful habits (e.g., thumb sucking and tongue trusting).										06.03
8862	Ortho Tx - removable appliance	04.00	788.50 (691.70)		1182.70 (1037.50)					+L	A
8863	Ortho Tx - each additional removable appliance	06.03	396.30 (347.60)		594.40 (521.40)					+L	A
	Limitation: Code 8862 may only be charged once per malocclusion. A maximum of two additional removable appliances per treatment plan may be charged.										
FUNCTIONAL APPLIANCE THERAPY											
	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane. Orthodontic treatment by means of a functional appliance is usually followed by comprehensive orthodontic treatment utilising fixed orthodontic appliances. When both phases of orthodontic treatment is provided by the same practitioner, the fees levied for treatment by means of the functional appliance, will be deducted from the fee quoted for comprehensive orthodontic treatment.										06.03
8858	Ortho Tx - functional appliance	06.03	1420.40 (1246.00)		2130.60 (1868.90)					+L	A
	If additional functional appliances are required, +L can be charged but no further fee.										
FIXED APPLIANCE THERAPY											
Fixed Appliance Therapy - Partial											
	The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition. When the preliminary/interceptive phase(s) of orthodontic treatment is followed by comprehensive orthodontic treatment and both phases of orthodontic treatment is provided by the same practitioner, the fees levied for preliminary/interceptive orthodontic treatment will be deducted from the fee quoted for comprehensive orthodontic treatment.										06.03
8861	Ortho Tx - partial fixed appliance - minor	04.00	944.70 (828.70)		1417.00 (1243.00)						A
8865	Ortho Tx - partial fixed appliance - one arch	04.00	2519.90 (2210.40)		3779.90 (3315.70)						A
8866	Ortho Tx - partial fixed appliance - both arches	04.00	3465.70 (3040.10)		5198.50 (4560.10)						A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
Fixed Appliance Therapy - Comprehensive: Single Arch											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within an arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.										06.03
8867	Ortho Tx - fixed appliance - one arch	04.00	2708.70 (2376.10)		4062.90 (3563.90)						A
8868	Ortho Tx - fixed appliance - one arch, modeate	04.00	3341.00 (2930.70)		5011.50 (4396.10)						A
8869	Ortho Tx - fixed appliance - one arch, severe	04.00	3907.70 (3427.80)		5861.50 (5141.70)						A
Fixed Appliance Therapy - Comprehensive: Both Arches											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within both arches and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.										06.03
8873	Ortho Tx - fixed appliance - both arches, Class 1 mild	04.00	4957.00 (4348.20)		7435.40 (6522.30)						A
8875	Ortho Tx - fixed appliance - both arches, Class 1 moderate	04.00	6085.20 (5337.90)		9127.60 (8006.70)						A
8877	Ortho Tx - fixed appliance - both arches, Class 1 severe	04.00	7093.80 (6222.60)		10640.60 (9333.90)						A
8879	Ortho Tx - fixed appliance - both arches, Class 1 severe w/ complications	04.00	7972.10 (6993.10)		11958.00 (10489.50)						A
8881	Ortho Tx - fixed appliance - both arches, Class 2/3 mild	04.00	7093.80 (6222.60)		10640.60 (9333.90)						A
8883	Ortho Tx - fixed appliance - both arches, Class 2/3 moderate	04.00	7972.10 (6993.10)		11958.00 (10489.50)						A
8885	Ortho Tx - fixed appliance - both arches, Class 2/3 severe	04.00	8949.40 (7850.40)		13423.90 (11775.40)						A
8887	Ortho Tx - fixed appliance - both arches, Class 2/3 severe w/ complications	04.00	10083.20 (8844.90)		15124.70 (13267.30)						A
Lingual Orthodontics - Comprehensive: Single Arch											
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires.										06.03
8841	Ortho Tx - fixed lingual appliance - one arch	04.00	5090.80 (4465.60)		7636.10 (6698.30)						A
8842	Ortho Tx - fixed lingual appliance - one arch, modeate	04.00	5982.80 (5248.10)		8974.10 (7872.00)						A
8843	Ortho Tx - fixed lingual appliance - one arch, severe	04.00	6816.50 (5979.40)		10224.70 (8969.00)						A
Lingual Orthodontics - Comprehensive: Both Arches											
8874	Ortho Tx - fixed lingual appliance - both arches, Class 1 mild	04.00	9711.50 (8518.90)		14567.20 (12778.20)						A
8876	Ortho Tx - fixed lingual appliance - both arches, Class 1 moderate	04.00	11370.30 (9973.90)		17055.40 (14960.90)						A
8878	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe	04.00	12903.90 (11319.20)		19355.70 (16978.70)						A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8880	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe w/ complications	04.00	14318.00 (12559.60)		21476.80 (18839.30)						A
8882	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 mild	04.00	11853.50 (10397.80)		17780.10 (15596.60)						A
8884	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 moderate	04.00	13260.20 (11631.80)		19890.10 (17447.50)						A
8886	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe	04.00	14768.50 (12954.80)		22152.70 (19432.20)						A
8888	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe w/ complications	04.00	16433.10 (14415.00)		24649.40 (21622.30)						A
OTHER ORTHODONTIC SERVICES											
8846	Repair orthodontic appliance - removable	04.00	64.50 (56.60)		96.90 (85.00)					+L	A
8847	Replace orthodontic appliance - removable	04.00	223.00 (195.60)		334.50 (293.40)					+L	A
8848	Repair orthodontic appliance - fixed	06.03	95.50 (83.80)		143.20 (125.60)					+L	A
	As a result of the patient's negligence. Report per retainer.										
8849	Retainer (orthodontic)	04.00	223.00 (195.60)		334.50 (293.40)					+L	A
8890	Monthly instalment ortho tx	06.03	-		-						A
	Refer to code number of treatment.										
8891	Orthodontic transfer	06.03	-		-						A
	Limitation: Benefit by arrangement.										
8892	Orthodontic re-treatment	06.03	-		-						A
	Limitation: Benefit by arrangement.										
L	**SUPPLEMENTARY SERVICES**										
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.									06.03	
ANAESTHESIA											
8499	General anaesthetic	05.02	-								B
8141	Inhalation sedation - first 15 minutes or part thereof	06.03	51.50 (45.20)								B
	No additional fee/benefit to be charged for gases used in the case of items 8141 and 8143.										
8143	Inhalation sedation - each addnl 15 minutes	06.03	26.60 (23.30)								B
	See 8141 descriptor.										
8144	Intravenous sedation	04.00	30.90 (27.10)								B
8145	Local anaesthetic - per visit	06.03	44.70 (39.20)								B
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8147	Monitoring equipment for intravenous sedation	06.03	109.80 (96.30)								B
	Apllies to own monitoring equipment in rooms for procedures performed under intravenous sedation										
PROFESSIONAL VISITS											
8129	Office/hospital visit – after regularly scheduled hours	06.03	172.40 (151.20)								B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.										
8140	House/extended care facility/hospital call	06.03	114.10 (100.10)			114.10 (100.10)					B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.										
8903	House/Hosp/Nursing home consultation - MFOS	04.00		127.70 (112.00)							S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	06.03		84.90 (74.50)							S
	"Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation.										
8905	After regularly hours consultation - MFOS	04.00		187.00 (164.00)							S
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	06.03		212.70 (186.60)							S
	See Code 8904 descriptor.										
9203	House/Hosp/Nursing home consultation - Oral pathologist	04.00						127.70 (112.00)			
9207	After hours visit - Oral pathologist	04.00						187.00 (164.00)			
DRUGS, MEDICAMENTS AND MATERIALS											
8109	Infection control/barrier techniques	06.03	10.30 (9.04)								B
	Comment: This is typically reported on a "per visit" basis for new rubber gloves, masks, etc. provided by the dentist. Report per provider per visit.										
8110	Sterilized instrumentation	06.03	26.60 (23.30)								S
	Limitation: The use of this code is limited to autoclaved, vapour or heat sterilised instruments (i.e. set(s) of long handled instruments and/or forceps) provided by the dentist/hygienist for use in the surgery. Report per visit.										
8183	Therapeutic drug injection	06.03	30.90 (27.10)								B
	Not applicable to local anaesthetic.										
8220	Cost of suture material	06.03	-	-		-					B

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.										
8304	Rubber dam per arch	06.03	54.90 (48.20)								B
	The use of this code is limited to selected procedures for benefit purposes. These procedures are identified throughout the NHRPL.										
8306	Cost of MTA	06.03	-				-				B
	Comment: See Rule 002 and Modifier 8025 for direct material costs.										
8310	Supply of bleaching materials	06.03	-								
	See Rule 002 and Modifier 8025 for direct material costs. Limitation: Benefit by arrangement.										
ADMINISTRATIVE AND LABORATORY SERVICES											
8099	Dental laboratory service	06.03	-	-	-	-	-				
	Use to submit dental laboratory services. See Rule 003.										
8106	Special report	06.03	117.50 (103.10)	117.50 (103.10)	117.50 (103.10)	117.50 (103.10)	117.50 (103.10)				A
	Special written reports such as insurance forms requiring more than the information conveyed in the usual dental communications or standard reporting form. Excludes pre-treatment estimate and orthodontic treatment/payment plan.										
8111	Dental testimony	06.03									
	Use to report dento-legal fees when the practitioner is present at Court at the request of an advocate or attorney. Report per hour.										
8120	Treatment plan completed	06.03	-	-	-	-	-				
	Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.										
8139	Appointment not kept /30min	06.03	-	-	-	-	-				B
	Comment: By arrangement with patient										
MISCELLANEOUS SERVICES											
Palliative Treatment											
8131	Emergency dental treatment	06.03	70.30 (61.70)				143.20 (125.60)		T		B
	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).										
8166	Application of desensitising resin, per tooth	06.03	46.40 (40.70)						T		B
	This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.										
8167	Application of desensitising medicament, per visit	06.03	54.10 (47.50)								B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.										
8165	Sedative filling	06.03	70.30 (61.70)						T	+L	B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.										
Post Surgical Complications											
8931	Treatment of post-extraction haemorrhage	06.03	51.50 (45.20)	308.80 (270.90)							S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.										
8933	Treatment of haemorrhage (blood dyscracias)	04.00	711.90 (624.50)	1067.80 (936.70)							S
8935	Treatment of septic socket	06.03	51.50 (45.20)	80.60 (70.70)							S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.										
Bleaching											
8308	External bleaching - per arch	06.03							M		A
	Comment: (1) The unpredictability and lack of permanence of this procedure should be pointed out, and alternative procedures discussed with the patient. (2) The benefits provided by some medical schemes for external bleaching may be subject to pre-authorisation.										
8309	Home bleaching - instructions and applicator	06.03								+L	A
	See code 8310 in the section 'Adjunctive general services' for materials supplied Limitation: Benefits by arrangement.										
8311	Home bleaching - subsequent visit	06.03									A
	Limitation: A maximum of three additional visits may be charged. Benefits by arrangement.										
8325	Internal bleaching - per tooth	06.03	166.40 (146.00)				249.60 (218.90)		T		A
	Report code 8304 (application of a rubber dam) in addition to this code.										
8327	Internal bleaching - each additional visit	06.03	79.80 (70.00)				119.70 (105.00)		T		A
	Comment: (1) Report the application of a rubber dam code (8304) in addition to this code. (2) The submission of fees is limited to two additional visits.										
Unclassified Treatment											
8158	Enamel microabrasion	06.03	64.30 (56.40)								
	This procedure involves the removal of superficial enamel defects due to decalcification or altered mineralisation. It is typically used for complex procedures when removing stain from anterior teeth (e.g., fluorosis stain) and should not be confused with air abrasion. Submit per visit.										
8168	Behavior management	06.03									B

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Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Comment: (1) May be reported in addition to treatment provided, when the patient is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. (2) The Code can only be billed where an office treatment requires extraordinary effort and is the only alternative to general anaesthesia. Includes any and all pharmacological, psychological, physical management adjuncts required or utilised. (3) Notation and justification must be written in the patient record identifying the specific behaviour problem and the technique used to manage it. (4) Report in 15-minute units. (maximum 4 units per visit and allowed once per patient per day) Limit of 12 units per year. (5) If requested, the report must be made available at no charge. (6) The benefits provided by some medical schemes for behaviour management may be subject to pre-authorisation.										
8551	Occlusal adjustment - major	06.03	444.80 (390.20)		667.20 (585.30)		667.20 (585.30)				A
	Comment: (1) A complete occlusal adjustment involves the grinding of teeth to the equivalent of two or more quadrants. (2) Several appointments of varying length and sedation to attain relaxation of the muscularity muscles may be necessary. Submit code 8551 for payment at the last visit if several appointments to complete the procedure are required.										
8553	Occlusal adjustment - minor	06.03	155.20 (136.10)		212.70 (186.60)	212.70 (186.60)	212.70 (186.60)				A
	An occlusal adjustment involves the grinding of the occluding surfaces of teeth to develop harmonious relationships between each other, their supporting structures, muscles of mastication and temporomandibular joints. Comment: (1) Partial occlusal adjustment for the relief of symptomatic teeth involves the selective grinding of teeth to the equivalent of one quadrant or less. (2) Payment for this procedure is limited to one visit per treatment plan. (3) May not be submitted for the adjustment of dentures or restorations provided as part of a treatment plan (including opposing teeth).										
9099	Unlisted dental procedure or service (By report)	06.03	-								
	The intention of this code is to report a dental procedure or service which is not adequately described by a code. Describe procedure.										
MODIFIERS											
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)										06.03
	Surgical assistant services should be identified by adding Modifier 8001 to the usual procedure code(s) – See Rule 009.										
8003	Minimum assistant surgeon	06.03	130.38 (114.37)	130.38 (114.37)		130.38 (114.37)					
	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.										
8005	Maximum multiple procedures (same incision) - MFO surgeon	06.03	202.42 (177.56)	202.42 (177.56)		202.42 (177.56)					
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.										
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)										06.03
	See Modifier 8009.										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)										06.03

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Surgical assistant services should be identified by adding Modifier 8007 to the usual procedure code(s) – See Rule 009.										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)										06.03
	When emergency surgery is performed after hours, such surgical procedures can be identified by adding Modifier 8008 to the procedure codes by each participating member of the surgical team.										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)										06.03
	When multiple procedures (under the same anaesthetic but through another incision) are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The additional procedures should be identified by adding the appropriate modifier (M8009 or M8006) to the additional procedure codes.										
8010	Open reduction (PLUS 75% of the appropriate benefit)										06.03
	When an open reduction is required for surgical procedures indicated in the schedule, the open reduction should be identified by adding Modifier 8010 in addition to the usual procedure code. TEMPORARY NOTE: Modifier 8010 applies only to codes 9035 and 9037. Two codes for "Open Reduction" was introduced so that the use of this modifier can be eliminated.										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)										06.03
	When the service provided by a practitioner is greater than that is usually required for the listed procedure, it may be identified by adding Modifier 8030 to the usual procedure code – See Rule 007.										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)										06.03
	Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.										
8013	Multiple modifiers										06.03
	Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations Modifier 8013 should be added to the basic procedure and the other applicable modifiers may be listed as part of the description of the service.										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)										06.03
	When the direct technique is used to provide resin based inlays/onlays (see codes 8381 to 8384), laboratory costs do not apply. An additional fee may be levied by adding Modifier 8023 to the appropriate inlay/onlay codes.										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	06.03	-	-		-	-				
	When listed direct dental materials are provided by the practitioner, a handling fee may be levied by reporting Modifier 8025 in addition to the appropriate direct material code – See Rule 002.										

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Dental Practitioners 2008

				26400	26200	26400	29200	29400	29800			
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**Value**	**Value**	**Value**	**Value**	**Value**	**Value**	**MP**	**Lab**	**TC**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2005.02										
	The existence of a code in this publication does not mean that the procedure will be reimbursed by medical schemes. Medical schemes have the right to limit the scope, the frequency and/or combinations of dental procedures that is covered or reimbursed. It is the responsibility of the patient to know what procedures are covered and what are excluded from his/her dental benefit plan, and not that of the dental office. Certain medical schemes may require predetermination for particular procedures and/or when charges are expected to exceed a certain amount.	2005.02										
	The schedule includes procedures and services for use by Oral Health Care Providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and oral surgeons and dental therapists.□ □ The procedures codes listed in the schedule have, for the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of Oral Health Care Providers from performing such procedures. Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.	2006.03										
I.	INTRODUCTION											
A.	Administrative and invoicing rules											
001	Invoices:	2005.02										
	a.□A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.□□	2005.02										
	b.□An invoice shall contain the following particulars:□	2005.02										

	i. The surname and initials of the member;□ ii. The first name of the patient;□ iii. The name of the scheme;□ iv. The membership number of the member;□ v. The practice number;□ vi. The date on which every service was rendered;□ vii. The code number, description and fee/benefit of the procedure or service;□ viii. The name of the dentist rendering the service;□ ix. The name of the general dental practitioner/specialist assistant (when applicable);□ x. The appropriate ICD-10 code(s) for the procedures performed.	2006.03											
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.	2005.02											
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.	2005.02											
003	Dental laboratory services:	2005.02											
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code.□ The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.	2005.02											
	Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code 8099.□ The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the dentist for record purposes.	2005.02											

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005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/medical scheme may be billed. Use Modifier 8011 with a narrative description.□ Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.□	2005.02											
B.	General coding rules												
006	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of Oral Health Care Provider are customary fees, should the procedure or service be rendered by that provider category. Specialists are however encouraged to confine their practice to the speciality or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25). Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being "by arrangement" until such fees are listed.	2006.03											
007	Procedures not listed in the Dental Schedule	2005.02											
	When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the NHRPL for medical practitioners may be reported.	2006.03											
	Unlisted procedures. Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 - Unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined "by arrangement" with the patient and/or medical scheme.	2006.03											
C.	Services rules												

008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – Treatment plan completed. Oral diagnosis defined. The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist. Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or	2006.03										
009	Surgery guidelines:	2005.02										
	1.□Follow-up care for therapeutic surgical procedures: The fee/benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.	2005.02										
	2.□Multiple Procedures (Maxillo-facial and oral surgery): The fee/benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (Modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/benefit for the major operation plus: 75% for the second procedure/operation (Modifier 8009). 50% for the third and subsequent procedures/operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (Modifier 8006).	2005.02										
	3.□Assistant Surgeon (Maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 (of the fee of the practitioner performing the procedure (Modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% (of the fee of the practitioner performing the procedure (Modifier 8007). The patient must be informed beforehand that another dentist/specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.	2005.02										
	4.□Surgical team (Maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (Modifier 8008).	2005.02										
010	Orthodontic guidelines:	2005.02										

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	The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information:□ a. The treatment plan and type of treatment (treatment code number);□ b. A diagnostic code (ICD-10) and□ c. An orthodontic payment plan indicating the following:□ i. The total fee that will be levied for the treatment;□ ii. The total months of orthodontic treatment (retention period excluded);□ iii. The initial fee payable by the patient (approximately 20% of the total fee); and□ iv. The monthly payments of the balance of the fee.	2006.03										
	2.□The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and 5 oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).	2005.02										
	3.□The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).	2005.02										
	4.□When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.	2005.02										
	5.□The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.	2005.02										
	6.□When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding - when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed. The balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (Orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to prior	2005.02										

	7.□When an established orthodontic patient requires re-treatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (Orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the patient's medical scheme.	2005.02										
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.	2005.02										
D.	Modifiers											
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL.□ Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that:□ a.□A service or procedure was performed by more than one practitioner.□ b.□A service or procedure has been increased or reduced.□ c.□Only part of a service was performed.□ d.□An adjunctive service was performed.□ e.□A service or procedure was provided more than once.□ f.□The fee/benefit was altered due to a financial agreement.	2006.03										
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	2006.03										
8003	Minimum assistant surgeon	2006.03		R 130.38	R 130.38		R 130.38					
8005	Maximum multiple procedures (same incision) - MFO surgeon	2006.03		R 202.42	R 202.42		R 202.42					
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)	2006.03										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)	2006.03										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)	2006.03										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)	2006.03										
8010	Open reduction (PLUS 75% of the appropriate benefit)	2006.03										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)	2006.03										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)	2006.03										
8013	Multiple modifiers	2006.03										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)	2006.03										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	2006.03		R -	R -		R -	R -				
E.	Explanations											
	Tooth identification and designation of areas of the oral cavity:											

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	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.	2004.00											
	Treatment categories:												
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows:□ Basic dentistry□- designated as (B) in the treatment category column□ Advanced dentistry□- designated as (A) in the treatment category column□ Surgery□- designated as (S) in the treatment category column	2004.00											
	Abbreviations used in Dental Coding												
	DM□Direct Material Column□□ +D□Add fee/benefit for denture□□ +L□Add laboratory fee□□ +M□Add material fee□	2005.02											
	MP□Mouth Part Column□ M□Maxilla/Mandible□ Q□Quadrant□ S□Sextant□ T□Tooth	2005.02											
	TC□Treatment Category Column□ A□Advanced dentistry□ B□Basic dentistry□ S□Surgery	2005.02											
	Practice type codes:□ 25400 General Dental Practitioner□ 26200 Specialist Maxillo Facial and Oral Surgeon□ 26400 Specialist Orthodontist□ 29200 Specialist in Oral Medicine and Periodontics□ 29400 Specialist Prosthodontist□ 29800 Specialist Oral Pathologist□ 39500 Dental Therapist	2006.03											
F.	Guidelines to medical schemes												
	Age of a Child. □ The determination of a child or adult status of the patient should be based on the clinical development of the patient's dentition. Where administrative constraints preclude the use of clinical development so that the chronological age must be used to determine the child or adult status, the patient is defined as an adult beginning at age 12 with the exclusion of treatment for orthodontics or sealants.	2005.02											

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	Frequency of benefits.□ The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as "twice a calendar year" rather than once in every six months.	2005.02										
	Radiographs and records.□ Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.	2005.02										
	New vs. established patient.□ A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years.□ In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.	2005.02										
II.	DENTAL PROCEDURES AND SERVICES											
A.	DIAGNOSTIC SERVICES											
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.	2006.03										
	CLINICAL ORAL EXAMINATIONS											
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented.□ Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.	2006.03										
	General Dental Practitioner											
8101	Oral examination	2006.03		R 114.40								B
8102	Comprehensive oral examination	2006.03		R 184.90								B
8104	Limited oral examination	2006.03		R 55.50								B
8189	Re-examination - existing condition	2006.03		R 55.50								B
8176	Periodontal screening	2006.03		R 96.40								B
8190	Consultation - second opinion or advice	2006.03		R 114.40								B
	Maxillo Facial Surgeon											
8901	Consultation - MFOS	2004.00			R 145.80							S

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8902	Consultation - MFOS (detailed)	2006.03			R 381.60								S
8840	Treatment planning for orthognathic surgery - ALL	2006.03		R 329.30	R 494.00	R 494.00						+L	S
	Orthodontist												
8801	Consultation - Orthodontist	2004.00				R 145.80							A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	2004.00				R 84.90							A
8837	Diagnosis and treatment planning - Orthodontist	2004.00				R 67.70							A
	Periodontist/Oral Medicine												
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.	2006.03											
8701	Consultation - periodontist	2006.03					R 145.80						A
8703	Consultation - Periodontist (detailed)	2006.03					R 381.60						A
8705	Re-examination - Periodontist	2004.00					R 114.10						A
8707	Periodontal screening - Periodontist	2006.03					R 114.10						A
8781	Consultation - Oral medicine (simple)	2006.03					R 114.10						S
8782	Consultation - Oral medicine (complex)	2006.03					R 200.70						S
8783	Consultation - Oral medicine (subsequent)	2006.03					R 84.90						S
	Prosthodontist												
8501	Consultation - Prosthodontis	2004.00						R 145.80					A
8507	Comprehensive consultation - Prosthodontist	2006.03						R 234.10					A
8506	Detailed consultation - Prosthodontist	2006.03						R 381.60					A
	Oral Pathologist												
9201	Consultation - oral pathologist	2004.00							R 145.80				
9205	Consultation - oral pathologist (subsequent)	2004.00							R 84.90				
	RADIOGRAPHS/DIAGNOSTIC IMAGING												
	Diagnostic radiographs/diagnostic images include interpretation.□ Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders.□ A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes.□ Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical	2006.03											
8107	Intraoral radiograph - periapical	2006.03		R 46.40	R 46.40	R 46.40	R 46.40	R 46.40					B
8108	Intraoral radiographs - complete series	2006.03		R 358.60	R 358.60	R 358.60	R 358.60	R 358.60					B
8112	Intraoral radiograph - bitewing	2006.03		R 46.40	R 46.40	R 46.40	R 46.40	R 46.40					B
8113	Intraoral radiograph - occlusal	2004.00		R 79.80	R 79.80	R 79.80	R 79.80	R 79.80					B
8114	Extraoral radiograph - hand-wrist	2006.03		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8115	Extraoral radiograph - panoramic	2004.00		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8116	Extraoral radiograph - cephalometric	2005.02		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8118	Extraoral radiograph - skull/facial bone	2005.02		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8121	Oral and/or facial image (digital/conventional)	2006.03		R 49.80	R 49.80	R 49.80	R 49.80	R 49.80					B

	OTHER DIAGNOSTIC PROCEDURES												
8117	Diagnostic models	2006.03		R 49.80	R 49.80	R 49.80	R 49.80	R 49.80			+L		B
8119	Diagnostic models mounted	2006.03		R 125.20	R 125.20	R 125.20	R 125.20	R 125.20			+L		B
8122	Microbiological studies	2006.03											B
8123	Caries susceptibility tests (By Arrangement)	2006.03		R 51.70									B
8124	Pulp tests	2006.03		R 13.70									
8503	Occlusion analysis mounted	2004.00		R 156.00				R 234.10					A
8505	Pantographic recording	2004.00		R 226.40				R 339.70					A
8508	Electrognathographic recording	2004.00		R 242.40				R 363.70					A
8509	Electrognathographic recording with computer analysis	2004.00		R 402.50				R 603.80					A
8811	Tracing and analysis of extra-oral film	2004.00		R 21.50	R 21.50	R 21.50	R 21.50	R 21.50					B
8839	Diagnostic setup (orthodontics)	2004.00		R 95.50		R 143.20							A
B.	PREVENTIVE SERVICES												
	Services/procedures intended to eliminate or reduce the need for future dental treatment.	2006.03											
	DENTAL PROPHYLAXIS												
8155	Polishing - complete dentition	2006.03		R 70.30			R 96.90	R 70.30					B
8159	Prophylaxis - complete dentition	2006.03		R 138.10			R 194.70	R 138.10					B
8160	Removal of gross calculus	2006.03											B
8179	Polishing - complete dentition (periodontally compromised patient)	2006.03		R 80.60									B
8180	Prophylaxis - complete dentition (periodontally compromised patient)	2006.03		R 150.10									B
	TOPICAL FLUORIDE TEATMENT												
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or "swish."□ For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.	2006.03											
8161	Topical application of fluoride - child	2006.03		R 70.30			R 70.30	R 70.30					B
8162	Topical application of fluoride - adult	2006.03		R 70.30			R 70.30	R 70.30					B
	SPACE MAINTENANCE (PASSIVE APPLIANCES)												
	Passive appliances are designed to prevent tooth movement.	2006.03											
8173	Space maintainer - fixed, per abutment	2005.02		R 130.40						T	+L		B
8175	Space maintainer - removable	2004.00		R 168.10							+L		B
	OTHER PREVENTIVE PROCEDURES												
8149	Nutritional counselling	2006.03											B
8150	Tobacco counselling	2006.03											B
8151	Oral hygiene instruction	2006.03		R 70.30			R 140.70	R 140.70					B
8153	Oral hygiene instruction - each additional visit	2006.03		R 51.50			R 67.70	R 67.70					B
8163	Dental sealant	2006.03		R 46.40				R 46.40		T			B
8169	Occlusal guard	2006.03		R 270.10							+L		B
8171	Mouth guard	2006.03		R 81.70							+L		B
8177	Oral hygiene instruction (periodontally compromised patient)	2006.03		R 106.40									B
8178	Oral hygiene instruction - each additional visit (periodontally compromised patient)	2006.03		R 57.50									B
C.	RESTORATIVE SERVICES												

	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/procedures intend to restore the function of a natural tooth.□ Anterior teeth include incisors and canines. Posterior teeth include premolars and molars.□ The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved.□ Limitations on amalgam and resin-based composite restorations:□ (1) The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the	2006.03											
	AMALGAM RESTORATIONS												
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately.□ See codes 8345, 8347 and 8348 for post and/or pin retention.	2006.03											
8341	Amalgam - one surface	2004.00		R 139.80							T		B
8342	Amalgam - two surfaces	2004.00		R 172.40							T		B
8343	Amalgam - three surfaces	2004.00		R 210.10							T		B
8344	Amalgam - four or more surfaces	2004.00		R 234.10							T		B
	RESIN-BASED COMPOSITE RESTORATIONS												
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. □ Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays"□ If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention.	2006.03											
8350	Resin crown - anterior primary tooth (direct)	2006.03		R 305.00							T		B
8351	Resin - one surface, anterior	2004.00		R 153.50							T		B
8352	Resin - two surfaces, anterior	2004.00		R 193.00							T		B
8353	Resin - three surfaces, anterior	2004.00		R 230.70							T		B
8354	Resin - four or more surfaces, anterior	2006.03		R 257.30							T		B
8367	Resin - one surface, posterior	2006.03		R 166.40							T		B
8368	Resin - two surfaces, posterior	2004.00		R 205.80							T		B
8369	Resin - three surfaces, posterior	2004.00		R 248.80							T		B
8370	Resin - four or more surfaces, posterior	2004.00		R 267.60							T		B
	GOLD FOIL RESTORATIONS												
8561	Gold foil class I or IV	2004.00		R 407.10				R 610.60			T		A
8563	Gold foil class V	2004.00		R 476.30				R 714.50			T		A
8565	Gold foil class III	2004.00		R 599.20				R 898.80			T		A
	INLAY/ONLAY RESTORATIONS												

	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.	2006.03										
	Metal Inlays/Onlays											
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers.□ Metal components include structures manufactured by means of conventional casting and/or electroforming.□ The benefits provided by some medical schemes for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.	2006.03										
8361	Inlay - metal - one surface	2004.00		R 213.50				R 421.20		T	+L	A
8362	Inlay/onlay - metal - two surfaces	2004.00		R 312.20				R 610.60		T	+L	A
8363	Inlay/onlay - metal - three surfaces	2004.00		R 520.60				R 946.90		T	+L	A
8364	Inlay/onlay - metal - four or more surfaces	2004.00		R 629.60				R 946.90		T	+L	A
	Porcelain/Ceramic Inlays/Onlays											
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers.□ Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays.□ Fees for the application of a rubber dam (8304) may be levied in addition to these codes.□ TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.	2006.03										
8371	Inlay - porcelain - one surface	2005.02		R 257.30				R 508.60		T	(+L)	A
8372	Inlay/onlay - porcelain - two surfaces	2005.02		R 379.90				R 732.50		T	(+L)	A
8373	Inlay/onlay - porcelain - three surfaces	2005.02		R 626.10				R 1 138.20		T	(+L)	A
8374	Inlay/onlay - porcelain - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	(+L)	A
8560	Cost of ceramic block	2006.03		R -				R -		T		A
8570	Fabrication of computer generated ceramic restoration	2006.03								A		
	Resin-based Inlays/Onlays											
	Resin based inlays/onlays usually utilise the indirect technique.□ Fees for the application of a rubber dam (8304) may be levied in addition to these codes.□ When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting Modifier 8023 in addition to these codes.	2006.03										
8381	Inlay - resin - one surface	2005.02		R 257.30				R 508.60		T	(+L)	A
8382	Inlay/onlay - resin - two surfaces	2005.02		R 379.90				R 732.50		T	(+L)	A
8383	Inlay/onlay - resin - three surfaces	2005.02		R 626.10				R 1 138.20		T	(+L)	A
8384	Inlay/onlay - resin - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	(+L)	A
	CROWNS – SINGLE RESTORATIONS											

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	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants.□ Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.□ Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations.□ TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.	2006.03											
8401	Crown - full cast metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8403	Crown - 3/4 cast metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8404	Crown - 3/4 porcelain/ceramic	2005.02		R 758.10				R 1 138.20		T	+L	A
8405	Crown - resin laboratory	2006.03		R 758.10				R 1 138.20		T	+L	A
8407	Crown - resin with metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8409	Crown - porcelain/ceramic	2004.00		R 802.80				R 1 181.90		T	+L	A
8411	Crown - porcelain with metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8410	Provisional crown	2006.03		R 156.00			R 156.00	R 234.10		T	(+L)	A
	VENEERS											
8355	Veneer - resin (chair-side)	2006.03		R 243.60				R 243.60		T		B
8552	Veneer - porcelain (laboratory)	2006.03		R 539.10				R 808.80		T	+L	A
8554	Veneer - resin (laboratory)	2006.03		R 539.10				R 808.80		T	+L	A
	TEMPORARY RESTORATIONS											
8137	Emergency crown (chair-side)	2006.03		R 241.00				R 241.00		T	(+L)	A
8357	Prefabricated metal crown	2006.03		R 143.20				R 143.20		T		B
8375	Prefabricated resin crown	2006.03		R 143.20				R 143.20		T		B
	OTHER RESTORATIVE PROCEDURES											
	Pin Retention and Cores											
8345	Prefabricated post retention, per post (in addition to restoration)	2006.03		R 138.10						T		B
8347	Pin retention - first pin (in addition to restoration)	2006.03		R 69.40						T		B
8348	Pin retention - each additional pin (in addition to restoration)	2006.03		R 64.30						T		B
8366	Pin retention as part of cast restoration (any number of pins)	2005.02		R 103.60				R 140.70		T	+L	A
8376	Core build-up with prefabricated posts	2006.03		R 382.50				R 382.50		T		B
8379	Cost of prefabricated posts	2006.03		R -				R -		T		A
8391	Cast core with single post	2006.03		R 161.30						T	+L	A
8392	Cast post (each additional)	2006.03		R 96.00						T	+L	A
8397	Cast core with pins (any number of pins)	2006.03		R 257.30				R 334.50		T	+L	A
8398	Core build-up with or without pins	2006.03		R 312.20				R 312.20		T		B
8581	Cast core with single post	2006.03						R 238.40		T	+L	A
8582	Cast core with double post	2006.03						R 339.70		T	+L	A
8583	Cast core with triple post	2006.03						R 421.20		T	+L	A
	Unclassified Restorative Procedures											

8133	Recement inlay, onlay, crown or veneer	2006.03		R 70.30				R 89.20		T	+L	B
8135	Remove inlay, onlay or crown	2006.03		R 139.80				R 139.80		T	+L	A
8138	Remove retention post (prefabricated or cast)	2006.03		R 91.70						T		B
8146	Resin bonding for restorations	2006.03								T		A
8157	Re-burnishing and polishing of restorations - complete dentition	2006.03		R 70.30								B
8349	Carve restoration to accommodate existing removable prosthesis	2004.00		R 28.30						T		B
8413	Repair crown (permanent or provisional)	2006.03		R 156.00				R 156.00		T	+L	A
8414	Additional fee for provision of crown within an existing clasp or rest	2004.00		R 46.40						T	+L	A
D.	ENDODONTIC SERVICES											
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.	2006.03										
	PULP CAPPING											
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.	2006.03										
8301	Pulp cap - direct	2006.03		R 93.50						T		B
8303	Pulp cap - indirect	2006.03		R 93.50						T		B
	PULPOTOMY											
8307	Pulp amputation (pulpotomy)	2006.03		R 91.70						T		B
8132	Pulp removal (pulpectomy)	2006.03		R 114.90						T		B
	ENDODONTIC THERAPY											
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images.□ Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy.□ Report code 8304 (application of a rubber dam) in addition to these codes.	2006.03										
	Preparatoty Visits											
8332	Root canal preparatory visit - single canal tooth	2006.03		R 70.30						T		B
8333	Root canal preparatory visit - multi canal tooth	2006.03		R 98.60						T		B
	Obtuation of Canals											
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).	2006.03										
8335	Root canal obturation - anteriors and premolars - first canal	2004.00		R 319.00						T		B
8328	Root canal obturation - anteriors and premolars - each additional canal	2004.00		R 130.40						T		B
8336	Root canal obturation - posteriors - first canal	2004.00		R 439.10						T		B
8337	Root canal obturation - posteriors - each additional canal	2004.00		R 130.40						T		B
	Complete Therapy											
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).	2006.03										
8338	Root canal therapy - anteriors and premolars - first canal	2004.00		R 488.00						T		B
8329	Root canal therapy - anteriors and premolars - each additional canal	2004.00		R 163.00						T		B
8339	Root canal therapy - posteriors - first canal	2004.00		R 670.70						T		B
8340	Root canal therapy - posteriors - each additional canal	2004.00		R 163.00						T		B
8631	Root canal therapy - first canal	2006.03						R 828.50		T		B
8633	Root canal therapy - each additional canal	2006.03						R 208.40		T		B

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	ENDODONTIC RETREATMENT												
8334	Re-preparation of previously obturated root canal	2006.03	R 103.80				R 125.20		T		B
	APEXIFICATION/RECALCIFICATION PROCEDURES										
8635	Apexification/recalcification – per visit	2006.03	R 93.50				R 138.10		T		S
	PERIRADICULAR PROCEDURES										
9015	Apicectomy - anteriors (including retrograde filling)	2006.03	R 346.50	R 459.70		R 459.70	R 459.70		T		S
9016	Apicectomy - posteriors (including retrograde filling)	2006.03	R 611.20	R 916.90		R 916.90	R 916.90		T		S
	OTHER ENDODONTIC PROCEDURES										
8330	Removal of root canal obstruction	2006.03	R 91.70						T		B
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	2004.00	R 62.60						T		B
8640	Removal of fractured post or instrument from root canal	2006.03					R 243.60		T		B
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	2006.03	R 306.50			R 459.70	R 459.70		T		A
E.	PERIODONTIC SERVICES										
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.	2006.03									
	SURGICAL SERVICES										
	Surgical services includes usual postoperative care.	2006.03									
8741	Gingivectomy/gingivoplasty - four or more teeth per quadrant	2006.03	R 367.10			R 503.50			Q		A
8743	Gingivectomy or gingivoplasty - one to three teeth per quadrant	2006.03	R 293.30			R 399.70			Q		A
8749	Flap procedure, root planing and one to three surgical services - per quadrant	2006.03	R 762.20			R 1 143.30			Q		A
8751	Flap procedure, root planing and one to three surgical services - per sextant	2006.03	R 631.30			R 946.90			S		A
8753	Flap procedure, root planing and four or more surgical services - per quadrant	2006.03	R 944.70			R 1 417.00			Q		A
8755	Flap procedure, root planing and four or more surgical services - per sextant	2006.03	R 765.60			R 1 148.40			S		A
8756	Clinical crown lengthening (isolated procedure)	2006.03	R 464.20			R 696.40			T		A
8759	Pedicle flapped graft (isolated procedure)	2006.03	R 348.80			R 523.20			M		A
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	2005.02	R 379.10	R 568.70		R 568.70			M	+L	A
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	2005.02	R 569.50	R 854.30		R 854.30			M	+L	A
8763	Wedge resection (isolated procedure)	2006.03	R 223.00			R 334.50			Q		A
8766	Bone regeneration/repair procedure - as part of a flap operation	2006.03	R 182.40			R 273.70					A
8767	Bone regeneration/repair procedure - at a single site	2006.03	R 472.90	R 709.30		R 709.30					A
8769	Membrane removal (used for guided tissue regeneration)	2006.03	R 223.00	R 334.50		R 334.50					A
8770	Cost of bone regenerative/repair material	2006.03	R -	R -		R -					A
8772	Submucosal connective tissue autograft (isolated procedure)	2005.02	R 383.10	R 574.70		R 574.70					A
8995	Gingivectomy - per jaw	2006.03	R 543.80	R 815.70					M	+L	S
	NON-SURGICAL PERIODONTAL SERVICES										
8723	Provisional splinting - extracoronal (wire) - per sextant	2005.02	R 130.40			R 195.60	R 195.60		M	+L	A
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	2005.02	R 189.20			R 283.90	R 283.90		M	+L	A
8727	Provisional splinting - intracoronal - per tooth	2006.03	R 59.40			R 89.20	R 89.20		T	+L	A
8737	Root planing - four or more teeth per quadrant	2006.03	R 281.30			R 381.60			Q		A
8739	Root planing - one to three teeth per quadrant	2006.03	R 223.90			R 304.50			Q		A
8773	Cost of intrapocket chemotherapeutic agent	2006.03	R -			R -					
	OTHER PERIODONTAL SERVICES										
8768	Unlisted periodontal procedure	2004.00	R 223.00			R 334.50			T		A
8787	Unlisted oral medicine procedure	2004.00	R 80.00			R 120.10					S
F.	REMOVABLE PROSTHODONTICS										

	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.	2006.03											
8658	Interim complete denture	2006.03		R 699.00				R 1 048.50			M	+L	B
8659	Interim partial denture	2006.03		R 559.20				R 838.80			M	+L	B
8661	Diagnostic dentures (including tissue conditioning)	2006.03						R 1 890.40				+L	A
	OTHER REMOVABLE PROSTHETIC PROCEDURES												
8251	Clasp or rest - cast gold	2006.03		R 64.30								+L	A
8253	Clasp or rest - wrought gold	2006.03		R 64.30								+L	B
8255	Clasp or rest - stainless steel	2006.03		R 67.70								+L	B
8257	Bar - lingual or palatal	2006.03		R 79.80							M	+L	B
8265	Tissues conditioning per arch (including soft self-cure reline)	2005.02		R 109.80				R 140.70			M		B
8277	Inlay in denture	2006.03										+L	A
8597	Locks and milled rests	2004.00		R 64.10				R 96.00			T	+L	A
8599	Precision attachment (removable denture)	2006.03		R 156.00				R 234.10			M	+L	A
8652	Overdenture - complete	2006.04		R 1 260.20				R 1 890.40			M	+L	B
8653	Overdenture - partial	2006.04		R 1 008.10				R 1 512.30			M	+L	B
8657	Replacement of precision attachment	2006.03		R 89.20				R 96.00			M	+L	A
8663	Metal base to complete denture	2006.03		R 379.70				R 569.50			M	+L	A
8664	Remount crown or bridge for prosthetics	2004.00		R 181.90				R 285.00					A
8667	Soft base to denture (heat cured)	2005.02		R 379.70				R 569.50			M	+L	B
8672	Altered cast technique (in addition to partial denture)	2005.02		R 48.70				R 73.00			M	+L	B
8674	Additive partial denture	2005.02		R 571.80				R 857.70			M	+L	B
G.	MAXILLO-FACIAL PROSTHETICS												
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect.□ Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated	2006.03											
	MAXILLIARY PROSTHESIS												
9101	Obturator prosthesis, surgical - modified denture	2004.00		R 93.80				R 140.70				+L	
9102	Obturator prosthesis, surgical - continuous base	2004.00		R 254.40				R 381.60				+L	
9103	Obturator prosthesis, surgical - split base	2004.00		R 379.10				R 568.70				+L	
9104	Obturator prosthesis, interim - on existing denture	2004.00		R 571.80				R 857.70				+L	
9105	Obturator prosthesis, interim - on new denture	2004.00		R 1 765.80				R 2 648.60				+L	
9106	Obturator prosthesis, definitive - open/hollow box	2004.00		R 571.80				R 857.70				+D	
9107	Obturator prosthesis, definitive - silicone glove	2004.00		R 1 104.20				R 1 656.20				+D	
	MANDIBULAR RESECTION PROSTHESES												
9108	Mandibular resection prosthesis w/ guide flange	2004.00		R 1 356.30				R 2 034.40				+L	
9109	Mandibular resection prosthesis w/o guide flange	2004.00		R 1 260.20				R 1 890.40				+L	
9110	Mandibular resection prosthesis, palatal augmentation	2004.00		R 254.40				R 381.60				+D	
	GLOSSAL RESECTION PROSTHESES												
9111	Glossal resection prosthesis - simple	2004.00		R 530.60				R 796.00				+D	
9112	Glossal resection prosthesis - complex	2004.00		R 794.90				R 1 192.20				+D	

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	The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable.□ Removable prosthodontic services include routine post-operative care.	2006.03											
	COMPLETE DENTURES												
8231	Complete dentures - maxillary and mandibular	2006.03		R 1 133.90				R 2 367.30		M	+L	B
8232	Complete denture - maxillary or mandibular	2006.03		R 699.00				R 1 656.20		M	+L	B
8244	Immediate denture - maxillary	2006.03		R 699.00				R 1 048.50			+L	
8245	Immediate denture - mandibular	2006.03		R 699.00				R 1 048.50			+L	
8643	Complete dentures - maxillary and mandibular (with complications)	2004.00						R 3 072.20			+L	B
8645	Complete dentures - maxillary and mandibular (with major complications)	2004.00						R 3 779.00			+L	B
8649	Complete denture - maxillary or mandibular (with complications)	2005.02						R 1 890.40		M	+L	B
8651	Complete denture - maxillary or mandibular (with major complications)	2005.02						R 2 126.20		M	+L	B
	PARTIAL DENTURES											
8233	Partial denture - resin base - one tooth	2005.02		R 325.00						M	+L	B
8234	Partial denture - resin base - two teeth	2005.02		R 325.00						M	+L	B
8235	Partial denture - resin base - three teeth	2005.02		R 486.30						M	+L	B
8236	Partial denture - resin base - four teeth	2005.02		R 486.30						M	+L	B
8237	Partial denture - resin base - five teeth	2005.02		R 486.30						M	+L	B
8238	Partial denture - resin base - six teeth	2005.02		R 645.00						M	+L	B
8239	Partial denture - resin base - seven teeth	2005.02		R 645.00						M	+L	B
8240	Partial denture - resin base - eight teeth	2005.02		R 645.00						M	+L	B
8241	Partial denture - resin base - nine or more teeth	2005.02		R 645.00						M	+L	B
8281	Partial denture - cast metal framework only	2006.03		R 758.30						M	+L	A
8671	Partial denture - cast metal framework with resin denture base	2006.03						R 1 890.40		M	+L	A
	ADJUSTMENTS TO DENTURES											
8275	Adjust complete or partial denture	2006.03		R 51.50				R 51.50				B
8862	Adjust complete or partial dentures (remounting)	2004.00		R 181.90				R 272.80			+L	B
	REPAIRS TO DENTURES											
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.	2006.03										
8269	Repair denture or other intra-oral appliance	2006.03		R 89.20				R 96.00		M	+L	B
8270	Add clasp to existing partial denture	2006.03		R 64.30						M	+L	B
8271	Add tooth to existing partial denture	2006.03		R 64.30						M	+L	B
8273	Impression to repair or modify a denture or other intra-oral appliance	2006.03		R 51.50				R 51.50			+L	B
	DENTURE REBASE PROCEDURES											
	Rebase – The partial or complete removal and replacement of the denture base.	2006.03										
8259	Rebase complete or partial denture (laboratory)	2005.02		R 265.00				R 382.50		M	+L	B
8261	Remodel complete or partial denture	2005.02		R 425.40						M	+L	B
	DENTURE RELINE PROCEDURES											
	Reline - The addition of material to the fitting surface of a denture base.	2006.03										
8263	Reline complete or partial denture (chair-side)	2005.02		R 168.10				R 210.10		M		B
8267	Reline complete or partial denture (laboratory)	2006.03		R 386.90				R 386.90		M	+L	B
	INTERIM DENTURES											

	RADIOTHERAPY APPLIANCES												
9113	Radiation carrier - simple	2004.00		R 571.80				R 857.70			+L		
9114	Radiation carrier - complex	2004.00		R 1 578.10				R 2 367.30			+L		
9115	Radiation shield - simple	2004.00		R 571.80				R 857.70			+L		
9116	Radiation shield - complex	2004.00		R 1 578.10				R 2 367.30			+L		
9117	Radiation cone locator	2004.00		R 571.80				R 857.70			+L		
	CHEMOTHERAPY APPLIANCES												
9118	Chemotherapeutic agent carrier	2004.00		R 571.80				R 857.70			+L		
	CLEFT PALATE PROSTHESES												
8855	Consultation - cleft palate therapy (house or hospital)	2004.00		R 130.40		R 195.60		R 195.60					S
8856	Consultation - cleft palate (subsequent)	2004.00		R 64.10		R 96.00		R 96.00					S
8857	Consultation - cleft palate (maximum)	2004.00		R 445.40		R 668.10		R 668.10					S
	NEONATAL PROSTHESES												
9119	Feeding aid prosthesis, neonatal	2004.00		R 506.10		R 759.10		R 759.10			+L		S
9120	Orthopaedic appliance, active presurgical - minor	2004.00		R 506.10		R 759.10		R 759.10			+L		S
9121	Orthopaedic appliance, active presurgical - moderate	2004.00		R 749.00		R 1 123.60		R 1 123.60			+L		S
9122	Orthopaedic appliance, active presurgical - severe	2004.00		R 1 260.20		R 1 890.40		R 1 890.40			+L		S
9123	Orthopaedic appliance, active presurgical - modification	2004.00		R 64.10		R 96.00		R 96.00					S
	INTERMEDIATE/DEFINITIVE PROSTHESES												
9125	Speech aid/obturator prosthesis - palatal alteration	2004.00		R 255.00				R 382.50			+D		
9126	Speech aid/obturator prosthesis - velar alteration	2004.00		R 571.80				R 857.70			+D		
9127	Speech aid/obturator prosthesis - pharyngeal alteration	2004.00		R 1 260.20				R 1 890.40			+D		
9128	Speech aid/obturator prosthesis - modification	2004.00		R 64.10				R 96.00					
9129	Speech aid/obturator prosthesis - surgical	2004.00		R 506.10				R 759.10			+L		
	SPEACH APPLIANCES												
9130	Speech aid appliance - palatal lift	2004.00		R 254.40				R 381.60			+D		
9131	Speech aid appliance - palatal stimulating	2004.00		R 571.80				R 857.70			+D		
9132	Speech aid appliance - bulb	2004.00		R 1 260.20				R 1 890.40			+D		
9133	Speech aid appliance - modification	2004.00		R 64.10				R 96.00					
9134	Unspecified speech aid appliance	2004.00		R -				R -			+L		
	EXTRA-ORAL APPLIANCES												
9135	Auricular prosthesis - simple	2004.00		R 1 578.10				R 2 367.30			+L		
9136	Auricular prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9137	Nasal prosthesis - simple	2004.00		R 1 578.10				R 2 367.30			+L		
9138	Nasal prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9139	Ocular prosthesis - interim	2004.00		R 571.80				R 857.70			+L		
9140	Ocular prosthesis - modified stock appliance	2004.00		R 1 418.60				R 2 127.90			+L		
9141	Ocular prosthesis - custom appliance	2004.00		R 2 059.10				R 3 072.20			+L		
9142	Orbital prosthesis - simple	2004.00		R 1 418.60				R 2 127.90			+L		
9143	Orbital prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9144	Facial prosthesis, combination - small	2004.00											
9145	Facial prosthesis, combination - medium	2004.00											
9146	Facial prosthesis, combination - large	2004.00											
9147	Facial prosthesis, combination - complex	2004.00											
9148	Unspecified body prosthesis - simple	2004.00		R 1 418.60				R 2 127.90			+L		

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9149	Unspecified body prosthesis - complex	2004.00	R 2 059.10				R 3 072.20			+L		
9150	Facial prosthesis, surgical - simple	2004.00	R 1 104.20				R 1 656.20			+L		
9151	Facial prosthesis, surgical - complex	2004.00	R 1 418.60				R 2 127.90			+L		
9152	Extraoral appliance - additional prosthesis	2004.00								+L		
9153	Extraoral appliance - replacement prosthesis	2004.00								+L		
9155	Cranial prosthesis	2004.00	R 571.80				R 857.70			+L		
	CUSTOM IMPLANTS											
9156	Cranial implant prosthesis, custom made	2004.00	R 690.20				R 1 035.20			+L		
9157	Facial implant prosthesis, custom made - simple	2004.00	R 344.80				R 517.20			+L		
9158	Facial implant prosthesis, custom made - complex	2004.00	R 690.20				R 1 035.20			+L		
9159	Ocular implant prosthesis, custom made	2004.00	R 344.80				R 517.20			+L		
9160	Body implant prosthesis - custom made	2004.00	R 1 534.70				R 2 302.10			+L		
	SURGICAL APPLIANCES											
9161	Surgical splint - simple	2004.00	R 156.00				R 234.10			+L		
9162	Surgical splint - complex	2004.00	R 571.80				R 857.70			+L		
9163	Surgical template - simple	2004.00	R 156.00				R 234.10			+L		
9164	Surgical template - complex	2004.00	R 571.80				R 857.70			+L		
9165	Surgical conformer - simple	2004.00	R 156.00				R 234.10			+L		
9166	Surgical conformer - complex	2004.00	R 571.80				R 857.70			+L		
	TRISMUS APPLIANCES											
9167	Trismus appliance (simple)	2004.00	R 64.10				R 96.00			+L		
9168	Trismus appliance (complex)	2004.00	R 571.80				R 857.70			+L		
9169	Orthoses appliance	2004.00	R 1 260.20				R 1 890.40			+L		
9170	Facial palsy appliance	2004.00	R 379.10				R 568.70			+D		
9171	Commissure splint	2004.00	R 156.00				R 234.10			+L		
9172	Oral retractor, dynamic - per arm	2004.00	R 156.00				R 234.10			+L		
9173	Hand splint	2005.02								+L		
9174	Unspecified burn appliance	2005.02	R -				R -			+L		
	ATTENDANCE IN THEATRE											
9175	Theatre attendance (MaxFac prosthod) /hour	2004.00	R 211.00				R 316.50					
H.	IMPLANT SERVICES											
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.	2006.03										
	SURGICAL IMPLANT PROCEDURES											
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.	2006.03										
9180	Surgical placement of sub-periosteal implant - preparatory stage	2005.02	R 925.20	R 1 387.80					M		S	
9181	Surgical placement of sub-periosteal implant - placement stage	2005.02	R 925.20	R 1 387.80					M	+L	S	
9182	Surgical placement of endosteal implant plate	2004.00	R 463.10	R 694.70		R 694.70				+L	S	
9183	Surgical placement of endosteal implant - first per jaw	2006.03	R 651.90	R 886.00		R 886.00			T	+M	S	
9184	Surgical placement of endosteal implant - second per jaw	2005.02	R 488.00	R 664.70		R 664.70			T	+M	S	
9185	Surgical placement of endosteal implant - third and subsequent per jaw	2005.02	R 326.70	R 445.20		R 445.20			T	+M	S	

9190	Surgical placement of abutment - first per jaw	2006.03		R 241.80	R 327.60		R 327.60	R 327.60		T	+M	S
9191	Surgical placement of abutment - second per jaw	2005.02		R 181.80	R 246.20		R 246.20	R 246.20		T	+M	S
9192	Surgical placement of abutment - third and subsequent per jaw	2005.02		R 121.80	R 165.60		R 165.60	R 165.60		T	+M	S
	IMPLANT SUPPORTED PROSTHETICS											
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.	2006.03										
	Abutments and Bars											
	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g., healing abutments/collars, temporary abutments, caps, cylinders, etc.Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant.See Codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.	2006.03										
8584	Connector bar - implant supported	2006.03		R 1 260.20				R 1 890.40				
8578	Prefabricated abutment	2006.03		R 130.40				R 195.60				
8579	Custom abutment	2006.03		R 594.70				R 892.00				
	Removable Dentures											
8533	Implant supported removable complete overdenture	2006.03		R 1 260.20				R 1 890.40		M	+L	B
8534	Implant supported removable partial overdenture	2006.03		R 1 008.10				R 1 512.30		M	+L	B
	Fixed-detachable Dentures											
8654	Implant supported fixed-detachable complete overdenture	2006.03		R 1 417.50				R 2 126.20		M	+L	A
8655	Implant supported fixed-detachable partial overdenture	2006.03		R 1 133.90				R 1 457.00		M	+L	A
8660	Additional fee to implant supported fixed-detachable denture - per implant	2006.03		R 195.60				R 195.60		T		A
	Crowns - Single Restorations											
8536	Crown - implant/abutment supported - porcelain/ceramic	2006.03		R 1 042.10				R 1 378.30		T	+L	A
8537	Crown - implant/abutment supported - porcelain with metal	2005.02		R 1 042.10				R 1 378.30		T	+L	A
8538	Crown - implant/abutment supported - cast metal	2005.02		R 1 042.10				R 1 378.30		T	+L	A
8592	Crown - implant/abutment supported	2006.03						R 1 378.30		T	+L	A
	Bridge Retainers - Crowns											
8546	Crown retainer - implant/abutment supported - porcelain/ceramic	2006.03		R 1 042.10				R 1 378.30		T	+L	A
8547	Crown retainer - implant/abutment supported - porcelain with metal	2005.02		R 1 042.10				R 1 378.30		T	+L	A
8548	Crown retainer - implant/abutment supported - cast metal	2005.02		R 1 042.10				R 1 378.30		T	+L	A
	OTHER IMPLANT SERVICES											
8590	Implant maintenance procedures - per implant	2006.03		R 57.70				R 86.60		T		A
8594	Repair of implant supported prosthesis	2006.03		R 64.10				R 96.00				
8595	Repair of implant abutment	2006.03		R 64.10				R 96.00				
8600	Cost of implant components	2006.03			R -		R -	R -				S
9187	Cost of endosteal implant body	2006.03		R -	R -		R -					S
9188	Cost of prefabricated abutment	2006.03		R -								S
9189	Cost of other implant compnts	2006.03		R -								S
9198	Surgical removal of implant	2006.03		R 301.40	R 452.00		R 452.00			T		S
I.	FIXED PROSTHODONTICS											

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	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable.□ A prosthetic retainer (e.g., crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge.□ Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics.□ Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials.□ Metal components include structures manufactured by means of conventional casting and/or electroforming.	2006.03											
	PONTICS												
	Comment: Codes 8415, 8416, 8417and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.	2006.03											
8415	Pontic - porcelain/ceramic	2005.03		R 655.30						T	+L	A	
8416	Pontic - cast metal	2005.03		R 520.60						T	+L	A	
8417	Pontic - resin with metal	2005.03		R 655.30						T	+L	A	
8418	Pontic - porcelain fused to metal	2005.03		R 655.30						T	+L	A	
8419	Provisional pontic	2006.03		R 156.00				R 234.10		T	(+L)	A	
8611	Pontic - sanitary	2006.03						R 714.50		T	+L	A	
8613	Pontic - posterior	2006.03						R 874.00		T	+L	A	
8615	Pontic - anterior/premolar	2006.03						R 944.30		T	+L	A	
	BRIDGE RETAINERS – INLAYS/ONLAYS												
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlayed to be considered an onlay.□ See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.	2006.03											
8432	Inlay/onlay retainer - metal - two surfaces	2005.02		R 312.20				R 610.60		T	+L	A	
8433	Inlay/onlay retainer - metal - three surfaces	2005.02		R 520.60				R 946.90		T	+L	A	
8434	Inlay/onlay retainer - metal - four or more surfaces	2005.02		R 629.60				R 946.90		T	+L	A	
8436	Inlay/onlay retainer - porcelain - two surfaces	2005.02		R 379.90				R 732.50		T	+L	A	
8437	Inlay/onlay retainer - porcelain - three surfaces	2005.02		R 626.10				R 1 138.20		T	+L	A	
8438	Inlay/onlay retainer - porcelain - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	+L	A	
8617	Retainer cast metal (Maryland type retainer)	2006.03		R 312.20				R 610.60		T	+L	A	
	BRIDGE RETAINERS – CROWNS												
	A crown retainer for a bridge that gains retention, support and stability from a tooth.	2006.03											
8441	Crown retainer - full cast metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8442	Crown retainer - 3/4 cast metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8443	Crown retainer - porcelain/ceramic	2005.02		R 802.80				R 1 181.90		T	+L	A	
8444	Crown retainer - 3/4 porcelain/ceramic	2005.02		R 802.80				R 1 181.90		T	+L	A	
8445	Crown retainer - porcelain with metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8446	Crown retainer - resin with metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8447	Provisional crown retainer	2006.03		R 156.00				R 234.10		T	(+L)	A	
	OTHER FIXED PROSTHODONTIC PROCEDURES												

	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.	2006.03										
8514	Recement bridge	2006.03		R 70.30				R 89.20		T		B
8516	Remove bridge	2006.03		R 139.80				R 139.80		T		A
8518	Repair bridge	2006.03		R 156.00				R 156.00		T	(+L)	A
8585	Connector bar	2006.03		R 1 260.20				R 1 890.40		M	+L	A
8586	Stress breaker	2006.03		R 470.10				R 705.10		M	+L	A
8587	Coping metal	2006.03		R 104.70				R 195.60		T	+L	A
J.	ORAL AND MAXILLO-FACIAL SURGERY											
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.	2006.03										
	EXTRACTIONS											
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	2006.03		R 70.30	R 105.40					T		B
8202	Extraction - each additional tooth or exposed tooth roots	2006.03		R 28.30	R 42.50					T		B
	SURGICAL EXTRACTIONS											
	Report code 8220 when sutures are provided by the practitioner.	2006.03										
8213	Surgical removal of residual roots, first tooth - per tooth	2006.03		R 303.70						T		S
8214	Surgical removal of residual roots, second and subsequent teeth's roots	2004.00		R 234.10						T		S
8937	Surgical removal of tooth	2006.03		R 303.70	R 409.90					T		S
8941	Surgical removal of impacted tooth - first tooth	2006.03		R 503.50	R 662.10					T		S
8943	Surgical removal of impacted tooth - second tooth	2004.00		R 270.10	R 356.70					T		S
8945	Surgical removal of impacted tooth - third and subsequent teeth	2004.00		R 153.50	R 202.40					T		S
8953	Surgical removal of residual roots, first tooth - per tooth	2006.03			R 409.90					T		S
	OTHER SURGICAL PROCEDURES											
8517	Reimplantation of avulsed tooth (include stabilisation)	2005.04		R 162.40				R 243.60		T	+L	S
8909	Oral antral fistula closure	2004.00		R 711.90	R 1 067.80							S
8911	Caldwell-Luc procedure	2004.00		R 278.50	R 417.80							S
8917	Biopsy of oral tissue - soft	2006.03		R 177.50	R 236.70		R 236.70			M		S
8919	Biopsy of bone - needle	2005.02		R 273.30	R 409.90					M		S
8921	Biopsy – extra-oral bone/soft tissue	2005.02		R 447.20	R 670.70					M		S
8961	Tooth transplantation	2006.03		R 611.20	R 916.90					T	+L	S
8965	Peripheral neurectomy	2004.00		R 611.20	R 916.90							S
8966	Repair of oronasal fistula (local flaps)	2004.00		R 850.30	R 1 275.50							S
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	2006.03		R 561.00	R 764.20		R 764.20			T		S
8983	Corticotomy - first tooth	2004.00		R 405.90	R 608.90					T		S
8984	Corticotomy - each additional tooth	2004.00		R 205.80	R 308.80					T		S
	ALVEOLOPLASTY											
8957	Alveolotomy or alveolectomy (including extractions)	2006.03		R 372.90	R 559.30					M		S
9003	Reposition mental foramen and nerve - per side	2005.02		R 849.20	R 1 273.70					M	+L	S
9004	Lateralization of inferior dental nerve	2005.02		R 1 368.30	R 2 052.50							S
	VESTIBULOPLASTY											
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.	2006.03										
8997	Sulcoplasty / Vestibuloplasty	2005.02		R 1 401.50	R 2 102.30		R 2 102.30			M	+L	S
	SURGICAL EXCISION OF SOFT TISSUE LESIONS											
8971	Excision of tumour of the soft tissue	2004.00		R 273.30	R 409.90		R 409.90					S

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	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS												
8967	Surgical removal of jaw cyst - intra-oral approach	2005.02		R 849.20	R 1 273.70						M		S
8969	Surgical removal of jaw cyst - extra-oral approach	2005.02		R 1 360.20	R 2 040.40						M		S
8973	Surgical excision of tumours of the jaw	2005.02		R 1 360.20	R 2 040.40						M		S
9290	Maxillectomy - Alveolus only, Level I	2006.03											
9292	Maxillectomy - Alveolus and sinus or nasal floor, Level II	2006.03											
9294	Maxillectomy - Alveolus, sinus, nasal floor and zygoma excluding orbital rim Level III	2006.03											
9296	Maxillectomy - Alveolus, sinus, nasal floor and zygoma including orbital rim Level IV	2006.03											
9298	Maxillectomy - Alveolus, sinus, nasal floor, zygoma, orbital rim and pterygoid plates Level V	2006.03											
9300	Hemiresection of jaw including condyle and coronoid process	2006.03											
	EXCISION OF BONE TISSUE												
8975	Hemiresection of jaw excluding condyl	2006.03		R 1 428.90	R 2 143.40						M		S
8987	Reduction of mylohyoid ridges - per side	2004.00		R 611.20	R 916.90							+L	S
8989	Removal torus mandibularis	2004.00		R 611.20	R 916.90							+L	S
8991	Removal of torus palatinus	2004.00		R 611.20	R 916.90							+L	S
8993	Surgical reduction of osseous tuberosity - per side	2006.03		R 273.30	R 409.90						M	+L	S
	SURGICAL INCISION												
8731	Incision & drainage of abscess - intra-oral	2006.03		R 112.10			R 168.10						A
8908	Surgical removal of roots from maxillary antrum	2006.03		R 928.60	R 1 392.90								S
9011	Incision & drainage of abscess - intra-oral (pyogenic)	2005.02		R 173.90	R 260.70						M		S
9013	Incision & drainage of abscess - extra-oral (pyogenic)	2006.03		R 237.80	R 356.70						M		S
9017	Decortication, saucerisation and sequestrectomy	2006.03		R 1 258.50	R 1 887.80								S
9019	Sequestrectomy - intra oral per sextant and or ramus	2005.02		R 273.30	R 409.90						M		S
	TREATMENT OF FRACTURES												
	Alveolus Fractures												
9024	Dento-alveolar fracture - per sextant	2004.00		R 306.50	R 459.70							+L	S
	Mandibular Fractures												
9025	Mandible fracture - closed reduction	2006.03		R 678.70	R 1 018.10								S
9027	Mandible fracture - compound, with eyelet wiring	2004.00		R 953.20	R 1 429.80								S
9029	Mandible fracture - splints	2006.03		R 1 055.50	R 1 583.30							+L	S
9031	Mandible fracture - open reduction	2006.03		R 1 564.50	R 2 346.70							+L	S
	Maxillary Fractures												
9035	Maxilla fracture - Le Fort I or Guerin	2006.03		R 954.90	R 1 432.40							+L	S
9037	Maxilla fracture - Le Fort II or middle third face	2006.03		R 1 564.50	R 2 346.70							+L	S
9039	Maxilla fracture - Le Fort III or craniofacial disjunction	2006.03		R 2 243.80	R 3 365.60							+L	S
	Zygoma/Orbital/Antral Fractures												
9041	Zygomatic arch fracture - closed reduction	2006.03		R 678.70	R 1 018.10								S
9043	Zygomatic arch fracture - open reduction	2006.03		R 1 360.20	R 2 040.40								S
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)	2004.00		R 2 037.90	R 3 056.90								S
9048	Placement of Zygomaticus fixture, per fixture	2005.02		R 1 346.10	R 2 019.10								S
	Nasal Fractures												
9280	Open reduction and fixation of nasal fractures	2004.00											
9282	Manipulation and immobilisation of nasal fracture	2004.00											
	TEMPOROMANDIBULAR JOINT												

	Procedures which are an integral part of a primary procedure should not be reported separately.	2006.03											
8172	Cost of orthotic appliance	2006.03		R -	R -	R -	R -	R -					
8850	Treatment of MPDS - first visit	2004.00		R 107.50		R 161.30		R 161.30					A
8851	Treatment of MPDS - subsequent visit	2004.00		R 56.60		R 84.90		R 84.90					A
8852	Occlusal orthotic appliance	2006.03		R 270.10	R 355.90	R 355.90	R 355.90	R 355.90				+L	S
9053	Coronoidectomy (intra-oral approach)	2004.00		R 848.50	R 1 272.90								S
9074	Tmj arthroscopy diagnostic	2004.00		R 675.30	R 1 012.90								S
9075	Condylectomy, coronoidectomy or both	2004.00		R 1 696.50	R 2 544.80								S
9076	TMJ artrocentesis	2004.00		R 372.90	R 559.30								S
9077	TMJ intra-articular injection	2004.00		R 101.70	R 152.60								S
9079	Trigger point injection	2004.00		R 79.40	R 119.20								S
9081	Condylectomy (Ward/Kostecka)	2006.03		R 678.70	R 1 018.10								S
9083	TMJ srthroplasty	2006.03		R 1 696.50	R 2 544.80								S
9085	Reduction of TMJ disloc w/o anaesthetic	2004.00		R 134.90	R 202.40								S
9087	Reduction of TMJ disloc w/ anaesthetic	2004.00		R 273.30	R 409.90								S
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	2004.00		R 678.70	R 1 018.10								S
9091	Reduction of TMJ dislocation - open reduction	2004.00		R 1 696.50	R 2 544.80								S
9092	Joint reconstruction	2006.03		R 4 529.30	R 6 793.90							+L	S
	REPAIR OF TRAUMATIC WOUNDS												
8192	Suture - minor	2006.03		R 346.50									S
	COMPLICATED SUTURING												
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.	2006.03											
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)	2004.00		R 346.50	R 459.70								S
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	2004.00		R 645.00	R 967.50								S
	OTHER REPAIR PROCEDURES												
8958	Emergency tracheotomy	2004.00		R 313.30	R 470.00								
8959	Pharyngostomy	2004.00		R 313.30	R 470.00								
8962	Harvest iliac crest graft	2004.00		R 225.30	R 277.00								S
8963	Harvest rib graft	2004.00		R 258.50	R 387.70								S
8964	Harvest cranium graft	2004.00		R 202.40	R 303.70								S
8977	Surgical repair of maxilla or mandible - major	2006.03		R 1 427.80	R 2 141.70								S
8979	Harvesting of autogenous grafts (intra-oral)	2004.00		R 117.70	R 176.70		R 176.70						S
8985	Frenulectomy/frenulotomy	2004.00		R 372.90	R 559.30		R 559.30						S
9005	Alveolar ridge augmentation - total (by bone graft)	2005.02		R 1 428.90	R 2 143.40		R 2 143.40				M	+L	S
9007	Alveolar ridge augmentation - total (by alloplastic material)	2005.02		R 899.40	R 1 349.10						M	+L	S
9008	Alveolar ridge augmentation - one to two tooth sites	2005.02		R 278.00	R 508.60		R 508.60				M	+L	S
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	2005.02		R 618.10	R 927.10		R 927.10				M	+L	S
9010	Sinus lift procedure	2005.02		R 928.60	R 1 392.90		R 1 392.90				M	+L	S
9032	Reduction of masseter muscle and bone - extra-oral approach	2006.03											
9033	Reduction of masseter muscle and bone - intra-oral approach	2006.03											
9048	Surgical removal of internal fixation devices, per site	2005.02		R 261.30	R 392.00								S
	Functional Correction of Malocclusion												
	For Codes 9047 to 9072 the full fee may be charged.	2006.03											

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9047	Osteotomy - open with stabilisation	2006.03		R 2 852.10	R 4 278.30							+L	S
9049	Osteotomy - mandible body, anterior segmental	2006.03		R 2 377.00	R 3 565.50							+L	S
9050	Osteotomy - total subapical	2004.00		R 4 348.00	R 6 521.90								S
9051	Genioplasty	2004.00		R 1 360.20	R 2 040.40								S
9052	Midfacial exposure	2006.03		R 2 153.40	R 3 230.10								S
9055	Osteotomy - segmented, posterior	2006.03		R 2 377.00	R 3 565.50						M	+L	S
9057	Osteotomy - segmented, anterior	2006.03		R 2 377.00	R 3 565.50						M	+L	S
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	2004.00		R 4 472.70	R 6 709.00							+L	S
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	2005.02		R 5 021.00	R 7 531.40							+L	S
9061	Palatal osteotomy	2004.00		R 1 564.50	R 2 346.70								S
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	2004.00		R 5 709.50	R 8 564.20							+L	S
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and post-traumatic deformities)	2004.00		R 5 712.30	R 8 568.50							+L	S
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	2006.03		R 8 561.00	R 12 841.50							+L	S
9066	Surgical expansion - maxilliary or mandibular	2006.03		R 1 360.20	R 2 040.40						M		S
9069	Glossectomy - partial	2004.00		R 1 018.90	R 1 528.40								S
9071	Geniohyoidotomy	2004.00		R 611.20	R 916.90								S
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	2004.00		R 4 472.70	R 6 709.00							+L	S
	Salivary Glands												
9093	Removal of salivary stone (Sialolithotomy)	2004.00		R 306.50	R 459.70								S
9095	Excision of sublingual salivary gland	2004.00		R 755.30	R 1 133.10								S
9096	Excision of salivary gland - extra oral approach	2004.00		R 1 119.00	R 1 678.60								S
	Pedicle Flaps												
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post –cancer/ trauma/ tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.	2006.03											
9284	Musculofascial flap	2004.00											
9286	Musculocranial flap	2004.00											
9288	Buccal fat pad (major repair)	2004.00											
	Repair of Frontal Bones												
	The use of codes 9274, 9275 and 9278 imply the bicoronal/ hemicoronal approach.	2006.03											
9274	Repair anterior table, frontal sinus and/or supraorbital rim	2004.00											
9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus	2004.00											
9278	Repair medial canthal ligament (canthopexy), per side	2004.00											
	Cleft lip and Palat												
9220	Repair cleft hard palate - unilateral	2004.00		R 2 498.20	R 3 747.30								S
9222	Repair cleft hard palate - bilateral (one procedure)	2004.00		R 3 171.20	R 4 756.80								S
9224	Repair cleft hard palate - bilateral (two procedures)	2004.00		R 4 725.40	R 7 087.30								S
9226	Repair cleft soft palate - w/o muscle reconstruction	2004.00		R 2 093.40	R 3 140.10								S
9228	Repair cleft soft palate - w/ muscle reconstruction	2004.00		R 3 039.60	R 4 559.50								S
9230	Repair submucosal cleft and/or bifid uvula - w/ muscle reconstruction	2004.00		R 2 263.20	R 3 394.80								S
9232	Velopharyngeal reconstruction - uncomplicated	2004.00		R 2 329.00	R 3 493.40								S
9234	Velopharyngeal reconstruction - complicated	2004.00		R 2 490.30	R 3 735.30								S
9238	Repair oronasal fistula (one procedure)	2004.00		R 1 424.40	R 2 136.60								S
9240	Repair oronasal fistula (two procedures)	2004.00		R 2 485.00	R 3 727.50								S
9246	Secondary periosteal flaps	2004.00		R 1 241.90	R 1 862.90								S

9248	Lipadhesion	2004.00		R 464.20	R 696.40							S
9250	Repair cleft lip - unilateral w/o muscle reconstruction	2004.00		R 817.70	R 1 226.50							S
9252	Repair cleft lip - unilateral w/ muscle reconstruction	2004.00		R 1 108.70	R 1 663.10							S
9254	Repair cleft lip - bilateral w/o muscle reconstruction	2004.00		R 1 141.80	R 1 712.80							S
9256	Repair cleft lip - bilateral w/ muscle reconstruction	2004.00		R 1 764.10	R 2 646.10							S
9258	Repair anterior nasal floor	2004.00		R 445.40	R 668.10							S
9260	Revision of secondary cleft lip deformity - partial	2004.00		R 445.40	R 668.10							S
9262	Revision of secondary cleft lip deformity - total w/ muscle reconstruction	2004.00		R 1 006.40	R 1 509.60							S
9264	Abbe-flap - two stages	2004.00		R 1 139.70	R 1 709.40							S
9266	Reconstruct columella	2004.00		R 673.60	R 1 010.30							S
9268	Reconstruct nose due to cleft deformity - partial	2004.00		R 856.00	R 1 284.00							S
9270	Reconstruct nose due to cleft deformity - complete	2004.00		R 1 352.90	R 2 029.30							S
9272	Paranasal augmentation for nasal base deviation	2004.00		R 673.60	R 1 010.30							S
K.	ORTHODONTIC SERVICES											
	The branch of dentistry used to correct malocclusions of the mouth and restore it to proper alignment and function. Includes all services/procedures concerned with the supervision, guidnance and correction of the growing and mature dentofacial structures.	2006.03										
	REMOVABLE APPLIANCE THERAPY											
	Removable indicates patient can remove; includes appliances for limited orthodontic treatment (e.g., partial treatment to open spaces or upright of a tooth) and minor orthodontic treatment to control harmful habits (e.g., thumb sucking and tongue trusting).	2006.03										
8862	Ortho Tx - removable appliance	2004.00		R 788.50		R 1 182.70					+L	A
8863	Ortho Tx - each additional removable appliance	2006.03		R 396.30		R 594.40					+L	A
	FUNCTIONAL APPLIANCE THERAPY											
	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane.□ Orthodontic treatment by means of a functional appliance is usually followed by comprehensive orthodontic treatment utilising fixed orthodontic appliances. When both phases of orthodontic treatment is provided by the same practitioner, the fees levied for treatment by means of the functional appliance, will be deducted from the fee quoted for comprehensive orthodontic treatment.	2006.03										
8858	Ortho Tx - functional appliance	2006.03		R 1 420.40		R 2 130.60					+L	A
	FIXED APPLIANCE THERAPY											
	Fixed Appliance Therapy - Partial											
	The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition.□ When the preliminary/interceptive phase(s) of orthodontic treatment is followed by comprehensive orthodontic treatment and both phases of orthodontic treatment is provided by the same practitioner, the fees levied for preliminary/interceptive orthodontic treatment will be deducted from the fee quoted for comprehensive orthodontic treatment.	2006.03										
8861	Ortho Tx - partial fixed appliance - minor	2004.00		R 944.70		R 1 417.00						A
8865	Ortho Tx - partial fixed appliance - one arch	2004.00		R 2 519.90		R 3 779.90						A

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8866	Ortho Tx - partial fixed appliance - both arches	2004.00		R 3 465.70		R 5 198.50							A
	Fixed Appliance Therapy - Comprehensive: Single Arch												
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within an arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.	2006.03											
8867	Ortho Tx - fixed appliance - one arch	2004.00		R 2 708.70		R 4 062.90							A
8868	Ortho Tx - fixed appliance - one arch, modeate	2004.00		R 3 341.00		R 5 011.50							A
8869	Ortho Tx - fixed appliance - one arch, severe	2004.00		R 3 907.70		R 5 861.50							A
	Fixed Appliance Therapy - Comprehensive: Both Arches												
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within both arches and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.	2006.03											
8873	Ortho Tx - fixed appliance - both arches, Class 1 mild	2004.00		R 4 957.00		R 7 435.40							A
8875	Ortho Tx - fixed appliance - both arches, Class 1 moderate	2004.00		R 6 085.20		R 9 127.60							A
8877	Ortho Tx - fixed appliance - both arches, Class 1 severe	2004.00		R 7 093.80		R 10 640.60							A
8879	Ortho Tx - fixed appliance - both arches, Class 1 severe w/ complications	2004.00		R 7 972.10		R 11 958.00							A
8881	Ortho Tx - fixed appliance - both arches, Class 2/3 mild	2004.00		R 7 093.80		R 10 640.60							A
8883	Ortho Tx - fixed appliance - both arches, Class 2/3 moderate	2004.00		R 7 972.10		R 11 958.00							A
8885	Ortho Tx - fixed appliance - both arches, Class 2/3 severe	2004.00		R 8 949.40		R 13 423.90							A
8887	Ortho Tx - fixed appliance - both arches, Class 2/3 severe w/ complications	2004.00		R 10 083.20		R 15 124.70							A
	Lingual Orthodontics - Comprehensive: Single Arch												
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires.	2006.03											
8841	Ortho Tx - fixed lingual appliance - one arch	2004.00		R 5 090.80		R 7 636.10							A
8842	Ortho Tx - fixed lingual appliance - one arch, modeate	2004.00		R 5 982.80		R 8 974.10							A
8843	Ortho Tx - fixed lingual appliance - one arch, severe	2004.00		R 6 816.50		R 10 224.70							A
	Lingual Orthodontics - Comprehensive: Both Arches												
8874	Ortho Tx - fixed lingual appliance - both arches, Class 1 mild	2004.00		R 9 711.50		R 14 567.20							A
8876	Ortho Tx - fixed lingual appliance - both arches, Class 1 moderate	2004.00		R 11 370.30		R 17 055.40							A
8878	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe	2004.00		R 12 903.90		R 19 355.70							A
8880	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe w/ complications	2004.00		R 14 318.00		R 21 476.80							A
8882	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 mild	2004.00		R 11 853.50		R 17 780.10							A
8884	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 moderate	2004.00		R 13 260.20		R 19 890.10							A
8886	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe	2004.00		R 14 768.50		R 22 152.70							A
8888	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe w/ complications	2004.00		R 16 433.10		R 24 649.40							A
	OTHER ORTHODONTIC SERVICES												
8846	Repair orthodontic appliance - removable	2004.00		R 64.50		R 96.90						+L	A
8847	Replace orthodontic appliance - removable	2004.00		R 223.00		R 334.50						+L	A
8848	Repair orthodontic appliance - fixed	2006.03		R 95.50		R 143.20						+L	A
8849	Retainer (orthodontic)	2004.00		R 223.00		R 334.50						+L	A
8890	Monthly instalment ortho tx	2006.03		R -		R -							A
8891	Orthodontic transfer	2006.03		R -		R -							A
8892	Orthodontic re-treatment	2006.03		R -		R -							A
L.	SUPPLEMENTARY SERVICES												

	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.	2006.03										
	ANAESTHESIA											
8499	General anaesthetic	2005.02	R -									B
8141	Inhalation sedation - first 15 minutes or part thereof	2006.03	R 51.50									B
8143	Inhalation sedation - each addnl 15 minutes	2006.03	R 26.60									B
8144	Intravenous sedation	2004.00	R 30.90									B
8145	Local anaesthetic - per visit	2006.03	R 44.70									B
8147	Monitoring equipment for intravenous sedation	2006.03	R 109.80									B
	PROFESSIONAL VISITS											
8129	Office/hospital visit – after regularly scheduled hours	2006.03	R 172.40									B
8140	House/extended care facility/hospital call	2006.03	R 114.10			R 114.10						B
8903	House/Hosp/Nursing home consultation - MFOS	2004.00		R 127.70								S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	2006.03		R 84.90								S
8905	After regularly hours consultation - MFOS	2004.00		R 187.00								S
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	2006.03		R 212.70								S
9203	House/Hosp/Nursing home consultation - Oral pathologist	2004.00							R 127.70			
9207	After hours visit - Oral pathologist	2004.00							R 187.00			
	DRUGS, MEDICAMENTS AND MATERIALS											
8109	Infection control/barrier techniques	2006.03	R 10.30									B
8110	Sterilized instrumentation	2006.03	R 26.60									S
8183	Therapeutic drug injection	2006.03	R 30.90									B
8220	Cost of suture material	2006.03	R -	R -		R -						B
8304	Rubber dam per arch	2006.03	R 54.90									B
8306	Cost of MTA	2006.03	R -				R -					B
8310	Supply of bleaching materials	2006.03	R -									
	ADMINISTRATIVE AND LABORATORY SERVICES											
8099	Dental laboratory service	2006.03	R -	R -	R -	R -	R -					
8106	Special report	2006.03	R 117.50	R 117.50	R 117.50	R 117.50	R 117.50					A
8111	Dental testimony	2006.03										
8120	Treatment plan completed	2006.03	R -	R -	R -	R -	R -					
8139	Appointment not kept /30min	2006.03	R -	R -	R -	R -	R -					B
	MISCELLANEOUS SERVICES											
	Palliative Treatment											
8131	Emergency dental treatment	2006.03	R 70.30				R 143.20			T		B
8166	Application of desensitising resin, per tooth	2006.03	R 46.40							T		B
8167	Application of desensitising medicament, per visit	2006.03	R 54.10									B
8165	Sedative filling	2006.03	R 70.30							T	+L	B
	Post Surgical Complications											
8931	Treatment of post-extraction haemorrhage	2006.03	R 51.50	R 308.80								S
8933	Treatment of haemorrhage (blood dyscracias)	2004.00	R 711.90	R 1 067.80								S
8935	Treatment of septic socket	2006.03	R 51.50	R 80.60								S
	Bleaching											
8308	External bleaching - per arch	2006.03								M		A
8309	Home bleaching - instructions and applicator	2006.03									+L	A
8311	Home bleaching - subsequent visit	2006.03										A

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8325	Internal bleaching - per tooth	2006.03		R 166.40				R 249.60		T		A
8327	Internal bleaching - each additional visit	2006.03		R 79.80				R 119.70		T		A
	Unclassified Treatment											
8158	Enamel microabrasion	2006.03		R 64.30								B
8168	Behavior management	2006.03										A
8551	Occlusal adjustment - major	2006.03		R 444.80		R 667.20		R 667.20				A
8553	Occlusal adjustment - minor	2006.03		R 155.20		R 212.70	R 212.70	R 212.70				A
9099	Unlisted dental procedure or service (By report)	2006.03		R -								
	MODIFIERS											
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	2006.03										
8003	Minimum assistant surgeon	2006.03		R 130.38	R 130.38		R 130.38					
8005	Maximum multiple procedures (same incision) - MFO surgeon	2006.03		R 202.42	R 202.42		R 202.42					
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)	2006.03										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)	2006.03										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)	2006.03										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)	2006.03										
8010	Open reduction (PLUS 75% of the appropriate benefit)	2006.03										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)	2006.03										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)	2006.03										
8013	Multiple modifiers	2006.03										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)	2006.03										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	2006.03		R -	R -		R -	R -				

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Code	Description	RCF
150	Dental	8.577
152	Dental - Modelled	11.443

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Code	Description
25400	General Dental Practice
26200	Maxillo-facial and Oral Surgery
26400	Orthodontics
29200	Oral Medicine and Periodontics
29400	Prosthodontics
29800	Oral Pathology

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				25400	26200	26400	29200	29400	29800			
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**Value**	**Value**	**Value**	**Value**	**Value**	**Value**	**MP**	**Lab**	**TC**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2005.02										
	The existence of a code in this publication does not mean that the procedure will be reimbursed by medical schemes. Medical schemes have the right to limit the scope, the frequency and/or combinations of dental procedures that is covered or reimbursed. It is the responsibility of the patient to know what procedures are covered and what are excluded from his/her dental benefit plan, and not that of the dental office. Certain medical schemes may require predetermination for particular procedures and/or when charges are expected to exceed a certain amount.	2005.02										
	The schedule includes procedures and services for use by Oral Health Care Providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and oral surgeons and dental therapists.□ □ The procedures codes listed in the schedule have, for the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of Oral Health Care Providers from performing such procedures. Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.	2006.03										
I.	INTRODUCTION											
A.	Administrative and invoicing rules											
001	Invoices:	2005.02										
	a.□A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.□□	2005.02										
	b.□An invoice shall contain the following particulars:□	2005.02										

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	i. The surname and initials of the member;□ ii. The first name of the patient;□ iii. The name of the scheme;□ iv. The membership number of the member;□ v. The practice number;□ vi. The date on which every service was rendered;□ vii. The code number, description and fee/benefit of the procedure or service;□ viii. The name of the dentist rendering the service;□ ix. The name of the general dental practitioner/specialist assistant (when applicable);□ x. The appropriate ICD-10 code(s) for the procedures performed.	2006.03										
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.	2005.02										
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.	2005.02										
003	Dental laboratory services:	2005.02										
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code.□ The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.	2005.02										
	Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code 8099.□ The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the dentist for record purposes.	2005.02										

005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/medical scheme may be billed. Use Modifier 8011 with a narrative description.□ Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.□	2005.02										
B.	General coding rules											
006	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of Oral Health Care Provider are customary fees, should the procedure or service be rendered by that provider category. Specialists are however encouraged to confine their practice to the specialty or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25). Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being "by arrangement" until such fees are listed.	2006.03										
007	Procedures not listed in the Dental Schedule	2005.02										
	When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the NHRPL for medical practitioners may be reported.	2006.03										
	Unlisted procedures. Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 - Unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined "by arrangement" with the patient and/or medical scheme.	2006.03										
C.	Services rules											

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008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – Treatment plan completed. Oral diagnosis defined. The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist. Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or	2006.03										
009	Surgery guidelines:	2005.02											
	1.□Follow-up care for therapeutic surgical procedures: The fee/benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.	2005.02											
	2.□Multiple Procedures (Maxillo-facial and oral surgery): The fee/benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (Modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/benefit for the major operation plus: 75% for the second procedure/operation (Modifier 8009). 50% for the third and subsequent procedures/operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (Modifier 8006).	2005.02											
	3.□Assistant Surgeon (Maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 (of the fee of the practitioner performing the procedure (Modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% (of the fee of the practitioner performing the procedure (Modifier 8007). The patient must be informed beforehand that another dentist/specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.	2005.02											
	4.□Surgical team (Maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (Modifier 8008).	2005.02											
010	Orthodontic guidelines:	2005.02											

	The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information:□ a. The treatment plan and type of treatment (treatment code number);□ b. A diagnostic code (ICD-10) and□ c. An orthodontic payment plan indicating the following:□ i. The total fee that will be levied for the treatment;□ ii. The total months of orthodontic treatment (retention period excluded);□ iii. The initial fee payable by the patient (approximately 20% of the total fee); and□ iv. The monthly payments of the balance of the fee.	2006.03										
	2.□The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and 5 oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).	2005.02										
	3.□The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).	2005.02										
	4.□When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.	2005.02										
	5.□The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.	2005.02										
	6.□When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding - when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed. The balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (Orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to prior	2005.02										

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	7.□When an established orthodontic patient requires re-treatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (Orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the patient's medical scheme.	2005.02										
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.	2005.02										
D.	Modifiers											
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL.□ Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that:□ a.□A service or procedure was performed by more than one practitioner.□ b.□A service or procedure has been increased or reduced.□ c.□Only part of a service was performed.□ d.□An adjunctive service was performed.□ e.□A service or procedure was provided more than once.□ f.□The fee/benefit was altered due to a financial agreement.	2006.03										
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	2006.03										
8003	Minimum assistant surgeon	2006.03		R 130.38	R 130.38		R 130.38					
8005	Maximum multiple procedures (same incision) - MFO surgeon	2006.03		R 202.42	R 202.42		R 202.42					
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)	2006.03										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)	2006.03										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)	2006.03										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)	2006.03										
8010	Open reduction (PLUS 75% of the appropriate benefit)	2006.03										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)	2006.03										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)	2006.03										
8013	Multiple modifiers	2006.03										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)	2006.03										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	2006.03		R -	R -		R -	R -				
E.	Explanations											
	Tooth identification and designation of areas of the oral cavity:											

	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.	2004.00										
	Treatment categories:											
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows:□ Basic dentistry□- designated as (B) in the treatment category column□ Advanced dentistry□- designated as (A) in the treatment category column□ Surgery□- designated as (S) in the treatment category column	2004.00										
	Abbreviations used in Dental Coding											
	DM□Direct Material Column□□ +D□Add fee/benefit for denture□□ +L□Add laboratory fee□□ +M□Add material fee□	2005.02										
	MP□Mouth Part Column□ M□Maxilla/Mandible□ Q□Quadrant□ S□Sextant□ T□Tooth	2005.02										
	TC□Treatment Category Column□ A□Advanced dentistry□ B□Basic dentistry□ S□Surgery	2005.02										
	Practice type codes:□ 25400 General Dental Practitioner□ 26200 Specialist Maxillo Facial and Oral Surgeon□ 26400 Specialist Orthodontist□ 29200 Specialist in Oral Medicine and Periodontics□ 29400 Specialist Prosthodontist□ 29800 Specialist Oral Pathologist□ 39500 Dental Therapist	2006.03										
F.	Guidelines to medical schemes											
	Age of a Child. □ The determination of a child or adult status of the patient should be based on the clinical development of the patient's dentition. Where administrative constraints preclude the use of clinical development so that the chronological age must be used to determine the child or adult status, the patient is defined as an adult beginning at age 12 with the exclusion of treatment for orthodontics or sealants.	2005.02										

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	Frequency of benefits.□ The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as "twice a calendar year" rather than once in every six months.	2005.02											
	Radiographs and records.□ Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.	2005.02											
	New vs. established patient.□ A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years.□ In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.	2005.02											
II.	DENTAL PROCEDURES AND SERVICES												
A.	DIAGNOSTIC SERVICES												
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.	2006.03											
	CLINICAL ORAL EXAMINATIONS												
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented.□ Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.	2006.03											
	General Dental Practitioner												
8101	Oral examination	2006.03		R 114.40									B
8102	Comprehensive oral examination	2006.03		R 184.90									B
8104	Limited oral examination	2006.03		R 55.50									B
8189	Re-examination - existing condition	2006.03		R 55.50									B
8176	Periodontal screening	2006.03		R 96.40									B
8190	Consultation - second opinion or advice	2006.03		R 114.40									B
	Maxillo Facial Surgeon												
8901	Consultation - MFOS	2004.00			R 145.80								S

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8902	Consultation - MFOS (detailed)	2006.03			R 381.60								S
8840	Treatment planning for orthognathic surgery - ALL	2006.03		R 329.30	R 494.00	R 494.00						+L	S
	Orthodontist												
8801	Consultation - Orthodontist	2004.00				R 145.80							A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	2004.00				R 84.90							A
8837	Diagnosis and treatment planning - Orthodontist	2004.00				R 67.70							A
	Periodontist/Oral Medicine												
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.	2006.03											
8701	Consultation - periodontist	2006.03					R 145.80						A
8703	Consultation - Periodontist (detailed)	2006.03					R 381.60						A
8705	Re-examination - Periodontist	2004.00					R 114.10						A
8707	Periodontal screening - Periodontist	2006.03					R 114.10						A
8781	Consultation - Oral medicine (simple)	2006.03					R 114.10						S
8782	Consultation - Oral medicine (complex)	2006.03					R 200.70						S
8783	Consultation - Oral medicine (subsequent)	2006.03					R 84.90						S
	Prosthodontist												
8501	Consultation - Prosthodontis	2004.00						R 145.80					A
8507	Comprehensive consultation - Prosthodontist	2006.03						R 234.10					A
8506	Detailed consultation - Prosthodontist	2006.03						R 381.60					A
	Oral Pathologist												
9201	Consultation - oral pathologist	2004.00							R 145.80				
9205	Consultation - oral pathologist (subsequent)	2004.00							R 84.90				
	RADIOGRAPHS/DIAGNOSTIC IMAGING												
	Diagnostic radiographs/diagnostic images include interpretation.□ Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders.□ A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes.□ Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical	2006.03											
8107	Intraoral radiograph - periapical	2006.03		R 46.40	R 46.40	R 46.40	R 46.40	R 46.40					B
8108	Intraoral radiographs - complete series	2006.03		R 358.60	R 358.60	R 358.60	R 358.60	R 358.60					B
8112	Intraoral radiograph - bitewing	2006.03		R 46.40	R 46.40	R 46.40	R 46.40	R 46.40					B
8113	Intraoral radiograph - occlusal	2004.00		R 79.80	R 79.80	R 79.80	R 79.80	R 79.80					B
8114	Extraoral radiograph - hand-wrist	2006.03		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8115	Extraoral radiograph - panoramic	2004.00		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8116	Extraoral radiograph - cephalometric	2005.02		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8118	Extraoral radiograph - skull/facial bone	2005.02		R 185.20	R 185.20	R 185.20	R 185.20	R 185.20					B
8121	Oral and/or facial image (digital/conventional)	2006.03		R 49.80	R 49.80	R 49.80	R 49.80	R 49.80					B

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	OTHER DIAGNOSTIC PROCEDURES												
8117	Diagnostic models	2006.03	R 49.80	R 49.80	R 49.80	R 49.80	R 49.80			+L	B
8119	Diagnostic models mounted	2006.03	R 125.20	R 125.20	R 125.20	R 125.20	R 125.20			+L	B
8122	Microbiological studies	2006.03									B
8123	Caries susceptibility tests (By Arrangement)	2006.03	R 51.70								B
8124	Pulp tests	2006.03	R 13.70								
8503	Occlusion analysis mounted	2004.00	R 156.00				R 234.10				A
8505	Pantographic recording	2004.00	R 226.40				R 339.70				A
8508	Electrognathographic recording	2004.00	R 242.40				R 363.70				A
8509	Electrognathographic recording with computer analysis	2004.00	R 402.50				R 603.80				A
8811	Tracing and analysis of extra-oral film	2004.00	R 21.50	R 21.50	R 21.50	R 21.50	R 21.50				B
8839	Diagnostic setup (orthodontics)	2004.00	R 95.50		R 143.20						A
B.	PREVENTIVE SERVICES										
	Services/procedures intended to eliminate or reduce the need for future dental treatment.	2006.03									
	DENTAL PROPHYLAXIS										
8155	Polishing - complete dentition	2006.03	R 70.30			R 96.90	R 70.30				B
8159	Prophylaxis - complete dentition	2006.03	R 138.10			R 194.70	R 138.10				B
8160	Removal of gross calculus	2006.03									B
8179	Polishing - complete dentition (periodontally compromised patient)	2006.03	R 80.60								B
8180	Prophylaxis - complete dentition (periodontally compromised patient)	2006.03	R 150.10								B
	TOPICAL FLUORIDE TEATMENT										
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or "swish."□ For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.	2006.03									
8161	Topical application of fluoride - child	2006.03	R 70.30			R 70.30	R 70.30				B
8162	Topical application of fluoride - adult	2006.03	R 70.30			R 70.30	R 70.30				B
	SPACE MAINTENANCE (PASSIVE APPLIANCES)										
	Passive appliances are designed to prevent tooth movement.	2006.03									
8173	Space maintainer - fixed, per abutment	2005.02	R 130.40						T	+L	B
8175	Space maintainer - removable	2004.00	R 168.10							+L	B
	OTHER PREVENTIVE PROCEDURES										
8149	Nutritional counselling	2006.03									B
8150	Tobacco counselling	2006.03									B
8151	Oral hygiene instruction	2006.03	R 70.30			R 140.70	R 140.70				B
8153	Oral hygiene instruction - each additional visit	2006.03	R 51.50			R 67.70	R 67.70				B
8163	Dental sealant	2006.03	R 46.40				R 46.40		T		B
8169	Occlusal guard	2006.03	R 270.10							+L	B
8171	Mouth guard	2006.03	R 81.70							+L	B
8177	Oral hygiene instruction (periodontally compromised patient)	2006.03	R 106.40								B
8178	Oral hygiene instruction - each additional visit (periodontally compromised patient)	2006.03	R 57.50								B
C.	RESTORATIVE SERVICES										

	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/procedures intend to restore the function of a natural tooth.□ Anterior teeth include incisors and canines. Posterior teeth include premolars and molars.□ The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved.□ Limitations on amalgam and resin-based composite restorations:□ (1) The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the	2006.03											
	AMALGAM RESTORATIONS												
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately.□ See codes 8345, 8347 and 8348 for post and/or pin retention.	2006.03											
8341	Amalgam - one surface	2004.00		R 139.80						T		B
8342	Amalgam - two surfaces	2004.00		R 172.40						T		B
8343	Amalgam - three surfaces	2004.00		R 210.10						T		B
8344	Amalgam - four or more surfaces	2004.00		R 234.10						T		B
	RESIN-BASED COMPOSITE RESTORATIONS												
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. □ Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays"□ If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention.	2006.03											
8350	Resin crown - anterior primary tooth (direct)	2006.03		R 305.00						T		B
8351	Resin - one surface, anterior	2004.00		R 153.50						T		B
8352	Resin - two surfaces, anterior	2004.00		R 193.00						T		B
8353	Resin - three surfaces, anterior	2004.00		R 230.70						T		B
8354	Resin - four or more surfaces, anterior	2006.03		R 257.30						T		B
8367	Resin - one surface, posterior	2006.03		R 166.40						T		B
8368	Resin - two surfaces, posterior	2004.00		R 205.80						T		B
8369	Resin - three surfaces, posterior	2004.00		R 248.80						T		B
8370	Resin - four or more surfaces, posterior	2004.00		R 267.60						T		B
	GOLD FOIL RESTORATIONS												
8561	Gold foil class I or IV	2004.00		R 407.10				R 610.60		T		A
8563	Gold foil class V	2004.00		R 476.30				R 714.50		T		A
8565	Gold foil class III	2004.00		R 599.20				R 898.80		T		A
	INLAY/ONLAY RESTORATIONS												

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	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.	2006.03											
	Metal Inlays/Onlays												
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers.□ Metal components include structures manufactured by means of conventional casting and/or electroforming.□ The benefits provided by some medical schemes for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.	2006.03											
8361	Inlay - metal - one surface	2004.00		R 213.50				R 421.20		T	+L	A	
8362	Inlay/onlay - metal - two surfaces	2004.00		R 312.20				R 610.60		T	+L	A	
8363	Inlay/onlay - metal - three surfaces	2004.00		R 520.60				R 946.90		T	+L	A	
8364	Inlay/onlay - metal - four or more surfaces	2004.00		R 629.60				R 946.90		T	+L	A	
	Porcelain/Ceramic Inlays/Onlays												
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers.□ Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays.□ Fees for the application of a rubber dam (8304) may be levied in addition to these codes.□ TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.	2006.03											
8371	Inlay - porcelain - one surface	2005.02		R 257.30				R 508.60		T	(+L)	A	
8372	Inlay/onlay - porcelain - two surfaces	2005.02		R 379.90				R 732.50		T	(+L)	A	
8373	Inlay/onlay - porcelain - three surfaces	2005.02		R 626.10				R 1 138.20		T	(+L)	A	
8374	Inlay/onlay - porcelain - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	(+L)	A	
8560	Cost of ceramic block	2006.03		R -				R -		T		A	
8570	Fabrication of computer generated ceramic restoration	2006.03								A			
	Resin-based Inlays/Onlays												
	Resin based inlays/onlays usually utilise the indirect technique.□ Fees for the application of a rubber dam (8304) may be levied in addition to these codes.□ When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting Modifier 8023 in addition to these codes.	2006.03											
8381	Inlay - resin - one surface	2005.02		R 257.30				R 508.60		T	(+L)	A	
8382	Inlay/onlay - resin - two surfaces	2005.02		R 379.90				R 732.50		T	(+L)	A	
8383	Inlay/onlay - resin - three surfaces	2005.02		R 626.10				R 1 138.20		T	(+L)	A	
8384	Inlay/onlay - resin - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	(+L)	A	
	CROWNS – SINGLE RESTORATIONS												

	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants.□ Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.□ Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations.□ TO BE CONFIRMED: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.	2006.03											
8401	Crown - full cast metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8403	Crown - 3/4 cast metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8404	Crown - 3/4 porcelain/ceramic	2005.02		R 758.10				R 1 138.20		T	+L	A
8405	Crown - resin laboratory	2006.03		R 758.10				R 1 138.20		T	+L	A
8407	Crown - resin with metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8409	Crown - porcelain/ceramic	2004.00		R 802.80				R 1 181.90		T	+L	A
8411	Crown - porcelain with metal	2004.00		R 802.80				R 1 181.90		T	+L	A
8410	Provisional crown	2006.03		R 156.00			R 156.00	R 234.10		T	(+L)	A
	VENEERS											
8355	Veneer - resin (chair-side)	2006.03		R 243.60				R 243.60		T		B
8552	Veneer - porcelain (laboratory)	2006.03		R 539.10				R 808.80		T	+L	A
8554	Veneer - resin (laboratory)	2006.03		R 539.10				R 808.80		T	+L	A
	TEMPORARY RESTORATIONS											
8137	Emergency crown (chair-side)	2006.03		R 241.00				R 241.00		T	(+L)	A
8357	Prefabricated metal crown	2006.03		R 143.20				R 143.20		T		B
8375	Prefabricated resin crown	2006.03		R 143.20				R 143.20		T		B
	OTHER RESTORATIVE PROCEDURES											
	Pin Retention and Cores											
8345	Prefabricated post retention, per post (in addition to restoration)	2006.03		R 138.10						T		B
8347	Pin retention - first pin (in addition to restoration)	2006.03		R 69.40						T		B
8348	Pin retention - each additional pin (in addition to restoration)	2006.03		R 64.30						T		B
8366	Pin retention as part of cast restoration (any number of pins)	2005.02		R 103.80				R 140.70		T	+L	A
8376	Core build-up with prefabricated posts	2006.03		R 382.50				R 382.50		T		B
8379	Cost of prefabricated posts	2006.03		R -				R -		T		A
8391	Cast core with single post	2006.03		R 161.30						T	+L	A
8392	Cast post (each additional)	2006.03		R 96.00						T	+L	A
8397	Cast core with pins (any number of pins)	2006.03		R 257.30				R 334.50		T	+L	A
8398	Core build-up with or without pins	2006.03		R 312.20				R 312.20		T		B
8581	Cast core with single post	2006.03						R 238.40		T	+L	A
8582	Cast core with double post	2006.03						R 339.70		T	+L	A
8583	Cast core with triple post	2006.03						R 421.20		T	+L	A
	Unclassified Restorative Procedures											

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8133	Recement inlay, onlay, crown or veneer	2006.03		R 70.30				R 89.20		T	+L	B
8135	Remove inlay, onlay or crown	2006.03		R 139.80				R 139.80		T	+L	A
8138	Remove retention post (prefabricated or cast)	2006.03		R 91.70						T		B
8146	Resin bonding for restorations	2006.03								T		A
8157	Re-burnishing and polishing of restorations - complete dentition	2006.03		R 70.30								B
8349	Carve restoration to accommodate existing removable prosthesis	2004.00		R 28.30						T		B
8413	Repair crown (permanent or provisional)	2006.03		R 156.00				R 156.00		T	+L	A
8414	Additional fee for provision of crown within an existing clasp or rest	2004.00		R 46.40						T	+L	A
D.	ENDODONTIC SERVICES											
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.	2006.03										
	PULP CAPPING											
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.	2006.03										
8301	Pulp cap - direct	2006.03		R 93.50						T		B
8303	Pulp cap - indirect	2006.03		R 93.50						T		B
	PULPOTOMY											
8307	Pulp amputation (pulpotomy)	2006.03		R 91.70						T		B
8132	Pulp removal (pulpectomy)	2006.03		R 114.90						T		B
	ENDODONTIC THERAPY											
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/ diagnostic images.□ Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy.□ Report code 8304 (application of a rubber dam) in addition to these codes.	2006.03										
	Preparatoty Visits											
8332	Root canal preparatory visit - single canal tooth	2006.03		R 70.30						T		B
8333	Root canal preparatory visit - multi canal tooth	2006.03		R 98.60						T		B
	Obtuation of Canals											
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).	2006.03										
8335	Root canal obturation - anteriors and premolars - first canal	2004.00		R 319.00						T		B
8328	Root canal obturation - anteriors and premolars - each additional canal	2004.00		R 130.40						T		B
8336	Root canal obturation - posteriors - first canal	2004.00		R 439.10						T		B
8337	Root canal obturation - posteriors - each additional canal	2004.00		R 130.40						T		B
	Complete Therapy											
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).	2006.03										
8338	Root canal therapy - anteriors and premolars - first canal	2004.00		R 488.00						T		B
8329	Root canal therapy - anteriors and premolars - each additional canal	2004.00		R 163.00						T		B
8339	Root canal therapy - posteriors - first canal	2004.00		R 670.70						T		B
8340	Root canal therapy - posteriors - each additional canal	2004.00		R 163.00						T		B
8631	Root canal therapy - first canal	2006.03						R 828.50		T		B
8633	Root canal therapy - each additional canal	2006.03						R 208.40		T		B

	ENDODONTIC RETREATMENT												
8334	Re-preparation of previously obturated root canal	2006.03		R 103.80				R 125.20		T		B
	APEXIFICATION/RECALCIFICATION PROCEDURES												
8635	Apexification/recalcification – per visit	2006.03		R 93.50				R 138.10		T		S
	PERIRADICULAR PROCEDURES												
9015	Apicectomy - anteriors (including retrograde filling)	2006.03		R 346.50	R 459.70		R 459.70	R 459.70		T		S
9016	Apicectomy - posteriors (including retrograde filling)	2006.03		R 611.20	R 916.90		R 916.90	R 916.90		T		S
	OTHER ENDODONTIC PROCEDURES												
8330	Removal of root canal obstruction	2006.03		R 91.70						T		B
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	2004.00		R 62.60						T		B
8640	Removal of fractured post or instrument from root canal	2006.03						R 243.60		T		B
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	2006.03		R 306.50			R 459.70	R 459.70		T		A
E.	PERIODONTIC SERVICES												
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.	2006.03											
	SURGICAL SERVICES												
	Surgical services includes usual postoperative care.	2006.03											
8741	Gingivectomy/gingivoplasty - four or more teeth per quadrant	2006.03		R 367.10			R 503.50			Q		A
8743	Gingivectomy or gingivoplasty - one to three teeth per quadrant	2006.03		R 293.30			R 399.70			Q		A
8749	Flap procedure, root planing and one to three surgical services - per quadrant	2006.03		R 762.20			R 1 143.30			Q		A
8751	Flap procedure, root planing and one to three surgical services - per sextant	2006.03		R 631.30			R 946.90			S		A
8753	Flap procedure, root planing and four or more surgical services - per quadrant	2006.03		R 944.70			R 1 417.00			Q		A
8755	Flap procedure, root planing and four or more surgical services - per sextant	2006.03		R 765.60			R 1 148.40			S		A
8756	Clinical crown lengthening (isolated procedure)	2006.03		R 464.20			R 696.40			T		A
8759	Pedicle flapped graft (isolated procedure)	2006.03		R 348.80			R 523.20			M		A
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	2005.02		R 379.10	R 568.70		R 568.70			M	+L	A
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	2005.02		R 569.50	R 854.30		R 854.30			M	+L	A
8763	Wedge resection (isolated procedure)	2006.03		R 223.00			R 334.50			Q		A
8766	Bone regeneration/repair procedure - as part of a flap operation	2006.03		R 182.40			R 273.70					A
8767	Bone regeneration/repair procedure - at a single site	2006.03		R 472.90	R 709.30		R 709.30					A
8769	Membrane removal (used for guided tissue regeneration)	2006.03		R 223.00	R 334.50		R 334.50					A
8770	Cost of bone regenerative/repair material	2006.03		R -	R -		R -					A
8772	Submucosal connective tissue autograft (isolated procedure)	2005.02		R 383.10	R 574.70		R 574.70					A
8995	Gingivectomy - per jaw	2006.03		R 543.80	R 815.70					M	+L	S
	NON-SURGICAL PERIODONTAL SERVICES												
8723	Provisional splinting - extracoronal (wire) - per sextant	2005.02		R 130.40			R 195.60	R 195.60		M	+L	A
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	2005.02		R 189.20			R 283.90	R 283.90		M	+L	A
8727	Provisional splinting - intracoronal - per tooth	2006.03		R 59.40			R 89.20	R 89.20		T	+L	A
8737	Root planing - four or more teeth per quadrant	2006.03		R 281.30			R 381.60			Q		A
8739	Root planing - one to three teeth per quadrant	2006.03		R 223.90			R 304.50			Q		A
8773	Cost of intrapocket chemotherapeutic agent	2006.03		R -			R -					
	OTHER PERIODONTAL SERVICES												
8768	Unlisted periodontal procedure	2004.00		R 223.00			R 334.50			T		A
8787	Unlisted oral medicine procedure	2004.00		R 80.00			R 120.10					S
F.	REMOVABLE PROSTHODONTICS												

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	The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable.□ Removable prosthodontic services include routine post-operative care.	2006.03											
	COMPLETE DENTURES												
8231	Complete dentures - maxillary and mandibular	2006.03		R 1 133.90				R 2 367.30		M	+L	B
8232	Complete denture - maxillary or mandibular	2006.03		R 699.00				R 1 656.20		M	+L	B
8244	Immediate denture - maxillary	2006.03		R 699.00				R 1 048.50			+L	
8245	Immediate denture - mandibular	2006.03		R 699.00				R 1 048.50			+L	
8643	Complete dentures - maxillary and mandibular (with complications)	2004.00						R 3 072.20			+L	B
8645	Complete dentures - maxillary and mandibular (with major complications)	2004.00						R 3 779.00			+L	B
8649	Complete denture - maxillary or mandibular (with complications)	2005.02						R 1 890.40		M	+L	B
8651	Complete denture - maxillary or mandibular (with major complications)	2005.02						R 2 126.20		M	+L	B
	PARTIAL DENTURES											
8233	Partial denture - resin base - one tooth	2005.02		R 325.00						M	+L	B
8234	Partial denture - resin base - two teeth	2005.02		R 325.00						M	+L	B
8235	Partial denture - resin base - three teeth	2005.02		R 486.30						M	+L	B
8236	Partial denture - resin base - four teeth	2005.02		R 486.30						M	+L	B
8237	Partial denture - resin base - five teeth	2005.02		R 486.30						M	+L	B
8238	Partial denture - resin base - six teeth	2005.02		R 645.00						M	+L	B
8239	Partial denture - resin base - seven teeth	2005.02		R 645.00						M	+L	B
8240	Partial denture - resin base - eight teeth	2005.02		R 645.00						M	+L	B
8241	Partial denture - resin base - nine or more teeth	2005.02		R 645.00						M	+L	B
8281	Partial denture - cast metal framework only	2006.03		R 758.30						M	+L	A
8671	Partial denture - cast metal framework with resin denture base	2006.03						R 1 890.40		M	+L	A
	ADJUSTMENTS TO DENTURES											
8275	Adjust complete or partial denture	2006.03		R 51.50				R 51.50				B
8662	Adjust complete or partial dentures (remounting)	2004.00		R 181.90				R 272.80			+L	B
	REPAIRS TO DENTURES											
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.	2006.03										
8269	Repair denture or other intra-oral appliance	2006.03		R 89.20				R 96.00		M	+L	B
8270	Add clasp to existing partial denture	2006.03		R 64.30						M	+L	B
8271	Add tooth to existing partial denture	2006.03		R 64.30						M	+L	B
8273	Impression to repair or modify a denture or other intra-oral appliance	2006.03		R 51.50				R 51.50			+L	B
	DENTURE REBASE PROCEDURES											
	Rebase – The partial or complete removal and replacement of the denture base.	2006.03										
8259	Rebase complete or partial denture (laboratory)	2005.02		R 265.00				R 382.50		M	+L	B
8261	Remodel complete or partial denture	2005.02		R 425.40						M	+L	B
	DENTURE RELINE PROCEDURES											
	Reline - The addition of material to the fitting surface of a denture base.	2006.03										
8263	Reline complete or partial denture (chair-side)	2005.02		R 168.10				R 210.10		M		B
8267	Reline complete or partial denture (laboratory)	2006.03		R 386.90				R 386.90		M	+L	B
	INTERIM DENTURES											

	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.	2006.03											
8658	Interim complete denture	2006.03		R 699.00				R 1 048.50			M	+L	B
8659	Interim partial denture	2006.03		R 559.20				R 838.80			M	+L	B
8661	Diagnostic dentures (including tissue conditioning)	2006.03						R 1 890.40				+L	A
	OTHER REMOVABLE PROSTHETIC PROCEDURES												
8251	Clasp or rest - cast gold	2006.03		R 64.30								+L	A
8253	Clasp or rest - wrought gold	2006.03		R 64.30								+L	B
8255	Clasp or rest - stainless steel	2006.03		R 67.70								+L	B
8257	Bar - lingual or palatal	2006.03		R 79.80							M	+L	B
8265	Tissues conditioning per arch (including soft self-cure reline)	2005.02		R 109.80				R 140.70			M		B
8277	Inlay in denture	2006.03										+L	A
8597	Locks and milled rests	2004.00		R 64.10				R 96.00			T	+L	A
8599	Precision attachment (removable denture)	2006.03		R 156.00				R 234.10			M	+L	A
8652	Overdenture - complete	2006.04		R 1 260.20				R 1 890.40			M	+L	B
8653	Overdenture - partial	2006.04		R 1 008.10				R 1 512.30			M	+L	B
8657	Replacement of precision attachment	2006.03		R 89.20				R 96.00			M	+L	A
8663	Metal base to complete denture	2006.03		R 379.70				R 569.50			M	+L	A
8664	Remount crown or bridge for prosthetics	2004.00		R 181.90				R 285.00					A
8667	Soft base to denture (heat cured)	2005.02		R 379.70				R 569.50			M	+L	B
8672	Altered cast technique (in addition to partial denture)	2005.02		R 48.70				R 73.00			M	+L	B
8674	Additive partial denture	2005.02		R 571.80				R 857.70			M	+L	B
G.	MAXILLO-FACIAL PROSTHETICS												
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect.□ Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Where "+D" appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated	2006.03											
	MAXILLIARY PROSTHESIS												
9101	Obturator prosthesis, surgical - modified denture	2004.00		R 93.80				R 140.70				+L	
9102	Obturator prosthesis, surgical - continuous base	2004.00		R 254.40				R 381.60				+L	
9103	Obturator prosthesis, surgical - split base	2004.00		R 379.10				R 568.70				+L	
9104	Obturator prosthesis, interim - on existing denture	2004.00		R 571.80				R 857.70				+L	
9105	Obturator prosthesis, interim - on new denture	2004.00		R 1 765.80				R 2 648.60				+L	
9106	Obturator prosthesis, definitive - open/hollow box	2004.00		R 571.80				R 857.70				+D	
9107	Obturator prosthesis, definitive - silicone glove	2004.00		R 1 104.20				R 1 656.20				+D	
	MANDIBULAR RESECTION PROSTHESES												
9108	Mandibular resection prosthesis w/ guide flange	2004.00		R 1 356.30				R 2 034.40				+L	
9109	Mandibular resection prosthesis w/o guide flange	2004.00		R 1 260.20				R 1 890.40				+L	
9110	Mandibular resection prosthesis, palatal augmentation	2004.00		R 254.40				R 381.60				+D	
	GLOSSAL RESECTION PROSTHESES												
9111	Glossal resection prosthesis - simple	2004.00		R 530.60				R 796.00				+D	
9112	Glossal resection prosthesis - complex	2004.00		R 794.90				R 1 192.20				+D	

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	RADIOTHERAPY APPLIANCES												
9113	Radiation carrier - simple	2004.00		R 571.80				R 857.70			+L		
9114	Radiation carrier - complex	2004.00		R 1 578.10				R 2 367.30			+L		
9115	Radiation shield - simple	2004.00		R 571.80				R 857.70			+L		
9116	Radiation shield - complex	2004.00		R 1 578.10				R 2 367.30			+L		
9117	Radiation cone locator	2004.00		R 571.80				R 857.70			+L		
	CHEMOTHERAPY APPLIANCES												
9118	Chemotherapeutic agent carrier	2004.00		R 571.80				R 857.70			+L		
	CLEFT PALATE PROSTHESES												
8855	Consultation - cleft palate therapy (house or hospital)	2004.00		R 130.40		R 195.60		R 195.60					S
8856	Consultation - cleft palate (subsequent)	2004.00		R 64.10		R 96.00		R 96.00					S
8857	Consultation - cleft palate (maximum)	2004.00		R 445.40		R 668.10		R 668.10					S
	NEONATAL PROSTHESES												
9119	Feeding aid prosthesis, neonatal	2004.00		R 506.10		R 759.10		R 759.10			+L		S
9120	Orthopaedic appliance, active presurgical - minor	2004.00		R 506.10		R 759.10		R 759.10			+L		S
9121	Orthopaedic appliance, active presurgical - moderate	2004.00		R 749.00		R 1 123.60		R 1 123.60			+L		S
9122	Orthopaedic appliance, active presurgical - severe	2004.00		R 1 260.20		R 1 890.40		R 1 890.40			+L		S
9123	Orthopaedic appliance, active presurgical - modification	2004.00		R 64.10		R 96.00		R 96.00					S
	INTERMEDIATE/DEFINITIVE PROSTHESES												
9125	Speech aid/obturator prosthesis - palatal alteration	2004.00		R 253.00				R 382.50			+D		
9126	Speech aid/obturator prosthesis - velar alteration	2004.00		R 571.80				R 857.70			+D		
9127	Speech aid/obturator prosthesis - pharyngeal alteration	2004.00		R 1 260.20				R 1 890.40			+D		
9128	Speech aid/obturator prosthesis - modification	2004.00		R 64.10				R 96.00					
9129	Speech aid/obturator prosthesis - surgical	2004.00		R 503.10				R 759.10			+L		
	SPEACH APPLIANCES												
9130	Speech aid appliance - palatal lift	2004.00		R 254.40				R 381.60			+D		
9131	Speech aid appliance - palatal stimulating	2004.00		R 571.80				R 857.70			+D		
9132	Speech aid appliance - bulb	2004.00		R 1 260.20				R 1 890.40			+D		
9133	Speech aid appliance - modification	2004.00		R 64.10				R 96.00					
9134	Unspecified speech aid appliance	2004.00		R -				R -			+L		
	EXTRA-ORAL APPLIANCES												
9135	Auricular prosthesis - simple	2004.00		R 1 578.10				R 2 367.30			+L		
9136	Auricular prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9137	Nasal prosthesis - simple	2004.00		R 1 578.10				R 2 367.30			+L		
9138	Nasal prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9139	Ocular prosthesis - interim	2004.00		R 571.80				R 857.70			+L		
9140	Ocular prosthesis - modified stock appliance	2004.00		R 1 418.60				R 2 127.90			+L		
9141	Ocular prosthesis - custom appliance	2004.00		R 2 059.10				R 3 072.20			+L		
9142	Orbital prosthesis - simple	2004.00		R 1 418.60				R 2 127.90			+L		
9143	Orbital prosthesis - complex	2004.00		R 2 059.10				R 3 072.20			+L		
9144	Facial prosthesis, combination - small	2004.00											
9145	Facial prosthesis, combination - medium	2004.00											
9146	Facial prosthesis, combination - large	2004.00											
9147	Facial prosthesis, combination - complex	2004.00											
9148	Unspecified body prosthesis - simple	2004.00		R 1 418.60				R 2 127.90			+L		

9149	Unspecified body prosthesis - complex	2004.00		R 2 059.10				R 3 072.20				+L		
9150	Facial prosthesis, surgical - simple	2004.00		R 1 104.30				R 1 656.20				+L		
9151	Facial prosthesis, surgical - complex	2004.00		R 1 418.60				R 2 127.90				+L		
9152	Extraoral appliance - additional prosthesis	2004.00										+L		
9153	Extraoral appliance - replacement prosthesis	2004.00										+L		
9155	Cranial prosthesis	2004.00		R 571.80				R 857.70				+L		
	CUSTOM IMPLANTS													
9156	Cranial implant prosthesis, custom made	2004.00		R 690.20				R 1 035.20				+L		
9157	Facial implant prosthesis, custom made - simple	2004.00		R 344.80				R 517.20				+L		
9158	Facial implant prosthesis, custom made - complex	2004.00		R 690.20				R 1 035.20				+L		
9159	Ocular implant prosthesis, custom made	2004.00		R 344.80				R 517.20				+L		
9160	Body implant prosthesis - custom made	2004.00		R 1 534.70				R 2 302.10				+L		
	SURGICAL APPLIANCES													
9161	Surgical splint - simple	2004.00		R 156.00				R 234.10				+L		
9162	Surgical splint - complex	2004.00		R 571.80				R 857.70				+L		
9163	Surgical template - simple	2004.00		R 156.00				R 234.10				+L		
9164	Surgical template - complex	2004.00		R 571.80				R 857.70				+L		
9165	Surgical conformer - simple	2004.00		R 156.00				R 234.10				+L		
9166	Surgical conformer - complex	2004.00		R 571.80				R 857.70				+L		
	TRISMUS APPLIANCES													
9167	Trismus appliance (simple)	2004.00		R 64.10				R 96.00				+L		
9168	Trismus appliance (complex)	2004.00		R 571.80				R 857.70				+L		
9169	Orthoses appliance	2004.00		R 1 260.20				R 1 890.40				+L		
9170	Facial palsy appliance	2004.00		R 379.10				R 568.70				+D		
9171	Commissure splint	2004.00		R 156.00				R 234.10				+L		
9172	Oral retractor, dynamic - per arm	2004.00		R 156.00				R 234.10				+L		
9173	Hand splint	2005.02										+L		
9174	Unspecified burn appliance	2005.02		R -				R -				+L		
	ATTENDANCE IN THEATRE													
9175	Theatre attendance (MaxFac prosthod) /hour	2004.00		R 211.00				R 316.50						
H.	IMPLANT SERVICES													
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.	2006.03												
	SURGICAL IMPLANT PROCEDURES													
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.	2006.03												
9180	Surgical placement of sub-periosteal implant - preparatory stage	2005.02		R 925.20	R 1 387.80						M		S	
9181	Surgical placement of sub-periosteal implant - placement stage	2005.02		R 925.20	R 1 387.80						M	+L	S	
9182	Surgical placement of endosteal implant plate	2004.00		R 463.10	R 694.70		R 694.70					+L	S	
9183	Surgical placement of endosteal implant - first per jaw	2006.03		R 651.90	R 886.00		R 886.00				T	+M	S	
9184	Surgical placement of endosteal implant - second per jaw	2005.02		R 488.00	R 664.70		R 664.70				T	+M	S	
9185	Surgical placement of endosteal implant - third and subsequent per jaw	2005.02		R 326.70	R 445.20		R 445.20				T	+M	S	

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9190	Surgical placement of abutment - first per jaw	2006.03	R 241.80	R 327.60		R 327.60	R 327.60		T	+M	S
9191	Surgical placement of abutment - second per jaw	2005.02	R 181.80	R 246.20		R 246.20	R 246.20		T	+M	S
9192	Surgical placement of abutment - third and subsequent per jaw	2005.02	R 121.80	R 165.60		R 165.60	R 165.60		T	+M	S
	IMPLANT SUPPORTED PROSTHETICS										
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.	2006.03									
	Abutments and Bars										
	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g., healing abutments/collars, temporary abutments, caps, cylinders, etc.Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant.See Codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.	2006.03									
8584	Connector bar - implant supported	2006.03	R 1 260.20				R 1 890.40				
8578	Prefabricated abutment	2006.03	R 130.40				R 195.60				
8579	Custom abutment	2006.03	R 594.70				R 892.00				
	Removable Dentures										
8533	Implant supported removable complete overdenture	2006.03	R 1 260.20				R 1 890.40		M	+L	B
8534	Implant supported removable partial overdenture	2006.03	R 1 008.10				R 1 512.30		M	+L	B
	Fixed-detachable Dentures										
8654	Implant supported fixed-detachable complete overdenture	2006.03	R 1 417.50				R 2 126.20		M	+L	A
8655	Implant supported fixed-detachable partial overdenture	2006.03	R 1 133.90				R 1 457.00		M	+L	A
8660	Additional fee to implant supported fixed-detachable denture - per implant	2006.03	R 195.60				R 195.60		T		A
	Crowns - Single Restorations										
8536	Crown - implant/abutment supported - porcelain/ceramic	2006.03	R 1 042.10				R 1 378.30		T	+L	A
8537	Crown - implant/abutment supported - porcelain with metal	2005.02	R 1 042.10				R 1 378.30		T	+L	A
8538	Crown - implant/abutment supported - cast metal	2005.02	R 1 042.10				R 1 378.30		T	+L	A
8592	Crown - implant/abutment supported	2006.03					R 1 378.30		T	+L	A
	Bridge Retainers - Crowns										
8546	Crown retainer - implant/abutment supported - porcelain/ceramic	2006.03	R 1 042.10				R 1 378.30		T	+L	A
8547	Crown retainer - implant/abutment supported - porcelain with metal	2005.02	R 1 042.10				R 1 378.30		T	+L	A
8548	Crown retainer - implant/abutment supported - cast metal	2005.02	R 1 042.10				R 1 378.30		T	+L	A
	OTHER IMPLANT SERVICES										
8590	Implant maintenance procedures - per implant	2006.03	R 57.70				R 86.60		T		A
8594	Repair of implant supported prosthesis	2006.03	R 64.10				R 96.00				
8595	Repair of implant abutment	2006.03	R 64.10				R 96.00				
8600	Cost of implant components	2006.03		R -		R -	R -				S
9187	Cost of endosteal implant body	2006.03	R -	R -		R -					S
9188	Cost of prefabricated abutment	2006.03	R -								S
9189	Cost of other implant compnts	2006.03	R -								S
9198	Surgical removal of implant	2006.03	R 301.40	R 452.00		R 452.00			T		S
I.	FIXED PROSTHODONTICS										

	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable.□ A prosthetic retainer (e.g., crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge.□ Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics.□ Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials.□ Metal components include structures manufactured by means of conventional casting and/or electroforming.	2006.03											
	PONTICS												
	Comment: Codes 8415, 8416, 8417and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.	2006.03											
8415	Pontic - porcelain/ceramic	2005.03		R 655.30						T	+L	A	
8416	Pontic - cast metal	2005.03		R 520.60						T	+L	A	
8417	Pontic - resin with metal	2005.03		R 655.30						T	+L	A	
8418	Pontic - porcelain fused to metal	2005.03		R 655.30						T	+L	A	
8419	Provisional pontic	2006.03		R 156.00				R 234.10		T	(+L)	A	
8611	Pontic - sanitary	2006.03						R 714.50		T	+L	A	
8613	Pontic - posterior	2006.03						R 874.00		T	+L	A	
8615	Pontic - anterior/premolar	2006.03						R 944.30		T	+L	A	
	BRIDGE RETAINERS – INLAYS/ONLAYS												
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlayed to be considered an onlay.□ See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.	2006.03											
8432	Inlay/onlay retainer - metal - two surfaces	2005.02		R 312.20				R 610.60		T	+L	A	
8433	Inlay/onlay retainer - metal - three surfaces	2005.02		R 520.60				R 946.90		T	+L	A	
8434	Inlay/onlay retainer - metal - four or more surfaces	2005.02		R 629.60				R 946.90		T	+L	A	
8436	Inlay/onlay retainer - porcelain - two surfaces	2005.02		R 379.90				R 732.50		T	+L	A	
8437	Inlay/onlay retainer - porcelain - three surfaces	2005.02		R 626.10				R 1 138.20		T	+L	A	
8438	Inlay/onlay retainer - porcelain - four or more surfaces	2005.02		R 758.30				R 1 138.20		T	+L	A	
8617	Retainer cast metal (Maryland type retainer)	2006.03		R 312.20				R 610.60		T	+L	A	
	BRIDGE RETAINERS – CROWNS												
	A crown retainer for a bridge that gains retention, support and stability from a tooth.	2006.03											
8441	Crown retainer - full cast metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8442	Crown retainer - 3/4 cast metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8443	Crown retainer - porcelain/ceramic	2005.02		R 802.80				R 1 181.90		T	+L	A	
8444	Crown retainer - 3/4 porcelain/ceramic	2005.02		R 802.80				R 1 181.90		T	+L	A	
8445	Crown retainer - porcelain with metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8446	Crown retainer - resin with metal	2005.02		R 802.80				R 1 181.90		T	+L	A	
8447	Provisional crown retainer	2006.03		R 156.00				R 234.10		T	(+L)	A	
	OTHER FIXED PROSTHODONTIC PROCEDURES												

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	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.	2006.03											
8514	Recement bridge	2006.03		R 70.30				R 89.20		T		B
8516	Remove bridge	2006.03		R 139.80				R 139.80		T		A
8518	Repair bridge	2006.03		R 156.00				R 156.00		T	(+L)	A
8585	Connector bar	2006.03		R 1 260.20				R 1 890.40		M	+L	A
8586	Stress breaker	2006.03		R 470.10				R 705.10		M	+L	A
8587	Coping metal	2006.03		R 104.70				R 195.60		T	+L	A
J.	ORAL AND MAXILLO-FACIAL SURGERY											
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.	2006.03										
	EXTRACTIONS											
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	2006.03		R 70.30	R 105.40					T		B
8202	Extraction - each additional tooth or exposed tooth roots	2006.03		R 28.30	R 42.50					T		B
	SURGICAL EXTRACTIONS											
	Report code 8220 when sutures are provided by the practitioner.	2006.03										
8213	Surgical removal of residual roots, first tooth - per tooth	2006.03		R 303.70						T		S
8214	Surgical removal of residual roots, second and subsequent teeth's roots	2004.00		R 234.10						T		S
8937	Surgical removal of tooth	2006.03		R 303.70	R 409.90					T		S
8941	Surgical removal of impacted tooth - first tooth	2006.03		R 503.50	R 662.10					T		S
8943	Surgical removal of impacted tooth - second tooth	2004.00		R 270.10	R 356.70					T		S
8945	Surgical removal of impacted tooth - third and subsequent teeth	2004.00		R 153.50	R 202.40					T		S
8953	Surgical removal of residual roots, first tooth - per tooth	2006.03			R 409.90					T		S
	OTHER SURGICAL PROCEDURES											
8517	Reimplantation of avulsed tooth (include stabilisation)	2005.04		R 162.40				R 243.60		T	+L	S
8909	Oral antral fistula closure	2004.00		R 711.90	R 1 067.80							S
8911	Caldwell-Luc procedure	2004.00		R 278.50	R 417.80							S
8917	Biopsy of oral tissue - soft	2006.03		R 177.50	R 236.70		R 236.70			M		S
8919	Biopsy of bone - needle	2005.02		R 273.30	R 409.90					M		S
8921	Biopsy – extra-oral bone/soft tissue	2005.02		R 447.20	R 670.70					M		S
8961	Tooth transplantation	2006.03		R 611.20	R 916.90					T	+L	S
8965	Peripheral neurectomy	2004.00		R 611.20	R 916.90							S
8966	Repair of oronasal fistula (local flaps)	2004.00		R 850.30	R 1 275.50							S
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	2006.03		R 561.00	R 764.20		R 764.20			T		S
8983	Corticotomy - first tooth	2004.00		R 405.90	R 608.90					T		S
8984	Corticotomy - each additional tooth	2004.00		R 205.80	R 308.80					T		S
	ALVEOLOPLASTY											
8957	Alveolotomy or alveolectomy (including extractions)	2006.03		R 372.90	R 559.30					M		S
9003	Reposition mental foramen and nerve - per side	2005.02		R 849.20	R 1 273.70					M	+L	S
9004	Lateralization of inferior dental nerve	2005.02		R 1 368.30	R 2 052.50							S
	VESTIBULOPLASTY											
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.	2006.03										
8997	Sulcoplasty / Vestibuloplasty	2005.02		R 1 401.50	R 2 102.30		R 2 102.30			M	+L	S
	SURGICAL EXCISION OF SOFT TISSUE LESIONS											
8971	Excision of tumour of the soft tissue	2004.00		R 273.30	R 409.90		R 409.90					S

	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS												
8967	Surgical removal of jaw cyst - intra-oral approach	2005.02		R 849.20	R 1 273.70						M		S
8969	Surgical removal of jaw cyst - extra-oral approach	2005.02		R 1 360.20	R 2 040.40						M		S
8973	Surgical excision of tumours of the jaw	2005.02		R 1 360.20	R 2 040.40						M		S
9290	Maxillectomy - Alveolus only, Level I	2006.03											
9292	Maxillectomy - Alveolus and sinus or nasal floor, Level II	2006.03											
9294	Maxillectomy - Alveolus, sinus, nasal floor and zygoma excluding orbital rim Level III	2006.03											
9296	Maxillectomy - Alveolus, sinus, nasal floor and zygoma including orbital rim Level IV	2006.03											
9298	Maxillectomy - Alveolus, sinus, nasal floor, zygoma, orbital rim and pterygoid plates Level V	2006.03											
9300	Hemiresection of jaw including condyle and coronoid process	2006.03											
	EXCISION OF BONE TISSUE												
8975	Hemiresection of jaw excluding condyl	2006.03		R 1 428.90	R 2 143.40						M		S
8987	Reduction of mylohyoid ridges - per side	2004.00		R 611.20	R 916.90							+L	S
8989	Removal torus mandibularis	2004.00		R 611.20	R 916.90							+L	S
8991	Removal of torus palatinus	2004.00		R 611.20	R 916.90							+L	S
8993	Surgical reduction of osseous tuberosity - per side	2006.03		R 273.30	R 409.90						M	+L	S
	SURGICAL INCISION												
8731	Incision & drainage of abscess - intra-oral	2006.03		R 112.10			R 168.10						A
8908	Surgical removal of roots from maxillary antrum	2006.03		R 928.60	R 1 392.90								S
9011	Incision & drainage of abscess - intra-oral (pyogenic)	2005.02		R 173.90	R 260.70						M		S
9013	Incision & drainage of abscess - extra-oral (pyogenic)	2006.03		R 237.80	R 356.70						M		S
9017	Decortication, saucerisation and sequestrectomy	2006.03		R 1 258.50	R 1 887.80								S
9019	Sequestrectomy - intra oral per sextant and or ramus	2005.02		R 273.30	R 409.90						M		S
	TREATMENT OF FRACTURES												
	Alveolus Fractures												
9024	Dento-alveolar fracture - per sextant	2004.00		R 306.50	R 459.70							+L	S
	Mandibular Fractures												
9025	Mandible fracture - closed reduction	2006.03		R 678.70	R 1 018.10								S
9027	Mandible fracture - compound, with eyelet wiring	2004.00		R 953.20	R 1 429.80								S
9029	Mandible fracture - splints	2006.03		R 1 055.50	R 1 583.30							+L	S
9031	Mandible fracture - open reduction	2006.03		R 1 564.50	R 2 346.70							+L	S
	Maxillary Fractures												
9035	Maxilla fracture - Le Fort I or Guerin	2006.03		R 954.90	R 1 432.40							+L	S
9037	Maxilla fracture - Le Fort II or middle third face	2006.03		R 1 564.50	R 2 346.70							+L	S
9039	Maxilla fracture - Le Fort III or craniofacial disjunction	2006.03		R 2 243.80	R 3 365.60							+L	S
	Zygoma/Orbital/Antral Fractures												
9041	Zygomatic arch fracture - closed reduction	2006.03		R 678.70	R 1 018.10								S
9043	Zygomatic arch fracture - open reduction	2006.03		R 1 360.20	R 2 040.40								S
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)	2004.00		R 2 037.90	R 3 056.90								S
9046	Placement of Zygomaticus fixture, per fixture	2005.02		R 1 346.10	R 2 019.10								S
	Nasal Fractures												
9280	Open reduction and fixation of nasal fractures	2004.00											
9282	Manipulation and immobilisation of nasal fracture	2004.00											
	TEMPOROMANDIBULAR JOINT												

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	Procedures which are an integral part of a primary procedure should not be reported separately.	2006.03											
8172	Cost of orthotic appliance	2006.03		R -	R -	R -	R -	R -					
8850	Treatment of MPDS - first visit	2004.00		R 107.50		R 161.30		R 161.30					A
8851	Treatment of MPDS - subsequent visit	2004.00		R 56.60		R 84.90		R 84.90					A
8852	Occlusal orthotic appliance	2006.03		R 270.10	R 355.90	R 355.90	R 355.90	R 355.90				+L	S
9053	Coronoidectomy (intra-oral approach)	2004.00		R 848.50	R 1 272.90								S
9074	Tmj arthroscopy diagnostic	2004.00		R 675.30	R 1 012.90								S
9075	Condylectomy, coronoidectomy or both	2004.00		R 1 696.50	R 2 544.80								S
9076	TMJ artrocentesis	2004.00		R 372.90	R 559.30								S
9077	TMJ intra-articular injection	2004.00		R 101.70	R 152.60								S
9079	Trigger point injection	2004.00		R 79.40	R 119.20								S
9081	Condylectomy (Ward/Kostecka)	2006.03		R 678.70	R 1 018.10								S
9083	TMJ srthroplasty	2006.03		R 1 696.50	R 2 544.80								S
9085	Reduction of TMJ disloc w/o anaesthetic	2004.00		R 134.90	R 202.40								S
9087	Reduction of TMJ disloc w/ anaesthetic	2004.00		R 273.30	R 409.90								S
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	2004.00		R 678.70	R 1 018.10								S
9091	Reduction of TMJ dislocation - open reduction	2004.00		R 1 696.50	R 2 544.80								S
9092	Joint reconstruction	2006.03		R 4 529.30	R 6 793.90							+L	S
	REPAIR OF TRAUMATIC WOUNDS												
8192	Suture - minor	2006.03		R 346.50									S
	COMPLICATED SUTURING												
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.	2006.03											
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)	2004.00		R 346.50	R 459.70								S
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	2004.00		R 645.00	R 967.50								S
	OTHER REPAIR PROCEDURES												
8958	Emergency tracheotomy	2004.00		R 313.30	R 470.00								
8959	Pharyngostomy	2004.00		R 313.30	R 470.00								
8962	Harvest iliac crest graft	2004.00		R 225.30	R 277.00								S
8963	Harvest rib graft	2004.00		R 258.50	R 387.70								S
8964	Harvest cranium graft	2004.00		R 202.40	R 303.70								S
8977	Surgical repair of maxilla or mandible - major	2006.03		R 1 427.80	R 2 141.70								S
8979	Harvesting of autogenous grafts (intra-oral)	2004.00		R 117.70	R 176.70		R 176.70						S
8985	Frenulectomy/frenulotomy	2004.00		R 372.90	R 559.30		R 559.30						S
9005	Alveolar ridge augmentation - total (by bone graft)	2005.02		R 1 428.90	R 2 143.40		R 2 143.40				M	+L	S
9007	Alveolar ridge augmentation - total (by alloplastic material)	2005.02		R 899.40	R 1 349.10						M	+L	S
9008	Alveolar ridge augmentation - one to two tooth sites	2005.02		R 278.00	R 508.60		R 508.60				M	+L	S
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	2005.02		R 618.10	R 927.10		R 927.10				M	+L	S
9010	Sinus lift procedure	2005.02		R 928.60	R 1 392.90		R 1 392.90				M	+L	S
9032	Reduction of masseter muscle and bone - extra-oral approach	2006.03											
9033	Reduction of masseter muscle and bone - intra-oral approach	2006.03											
9048	Surgical removal of internal fixation devices, per site	2005.02		R 261.30	R 392.00								S
	Functional Correction of Malocclusion												
	For Codes 9047 to 9072 the full fee may be charged.	2006.03											

9047	Osteotomy - open with stabilisation	2006.03		R 2 852.10	R 4 278.30						+L	S
9049	Osteotomy - mandible body, anterior segmental	2006.03		R 2 377.00	R 3 565.50						+L	S
9050	Osteotomy - total subapical	2004.00		R 4 348.00	R 6 521.90							S
9051	Genioplasty	2004.00		R 1 360.20	R 2 040.40							S
9052	Midfacial exposure	2006.03		R 2 153.40	R 3 230.10							S
9055	Osteotomy - segmented, posterior	2006.03		R 2 377.00	R 3 565.50					M	+L	S
9057	Osteotomy - segmented, anterior	2006.03		R 2 377.00	R 3 565.50					M	+L	S
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	2004.00		R 4 472.70	R 6 709.00						+L	S
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	2005.02		R 5 021.00	R 7 531.40						+L	S
9061	Palatal osteotomy	2004.00		R 1 564.50	R 2 346.70							S
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	2004.00		R 5 709.50	R 8 564.20						+L	S
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and post-traumatic deformities)	2004.00		R 5 712.30	R 8 568.50						+L	S
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	2006.03		R 8 561.00	R 12 841.50						+L	S
9066	Surgical expansion - maxilliary or mandibular	2006.03		R 1 360.20	R 2 040.40					M		S
9069	Glossectomy - partial	2004.00		R 1 018.90	R 1 528.40							S
9071	Geniohyoidotomy	2004.00		R 611.20	R 916.90							S
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	2004.00		R 4 472.70	R 6 709.00						+L	S
	Salivary Glands											
9093	Removal of salivary stone (Sialolithotomy)	2004.00		R 306.50	R 459.70							S
9095	Excision of sublingual salivary gland	2004.00		R 755.30	R 1 133.10							S
9096	Excision of salivary gland - extra oral approach	2004.00		R 1 119.00	R 1 678.60							S
	Pedicle Flaps											
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post –cancer/ trauma/ tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.	2006.03										
9284	Musculofascial flap	2004.00										
9286	Musculocranial flap	2004.00										
9288	Buccal fat pad (major repair)	2004.00										
	Repair of Frontal Bones											
	The use of codes 9274, 9275 and 9278 imply the bicoronal/ hemicoronal approach.	2006.03										
9274	Repair anterior table, frontal sinus and/or supraorbital rim	2004.00										
9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus	2004.00										
9278	Repair medial canthal ligament (canthopexy), per side	2004.00										
	Cleft lip and Palat											
9220	Repair cleft hard palate - unilateral	2004.00		R 2 498.20	R 3 747.30							S
9222	Repair cleft hard palate - bilateral (one procedure)	2004.00		R 3 171.20	R 4 756.80							S
9224	Repair cleft hard palate - bilateral (two procedures)	2004.00		R 4 725.40	R 7 087.30							S
9226	Repair cleft soft palate - w/o muscle reconstruction	2004.00		R 2 093.40	R 3 140.10							S
9228	Repair cleft soft palate - w/ muscle reconstruction	2004.00		R 3 039.60	R 4 559.50							S
9230	Repair submucosal cleft and/or bifid uvula - w/ muscle reconstruction	2004.00		R 2 263.20	R 3 394.80							S
9232	Velopharyngeal reconstruction - uncomplicated	2004.00		R 2 329.00	R 3 493.40							S
9234	Velopharyngeal reconstruction - complicated	2004.00		R 2 490.30	R 3 735.30							S
9238	Repair oronasal fistula (one procedure)	2004.00		R 1 424.40	R 2 136.60							S
9240	Repair oronasal fistula (two procedures)	2004.00		R 2 485.00	R 3 727.50							S
9246	Secondary periosteal flaps	2004.00		R 1 241.90	R 1 862.90							S

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9248	Lipadhesion	2004.00		R 464.20	R 696.40								S
9250	Repair cleft lip - unilateral w/o muscle reconstruction	2004.00		R 817.70	R 1 226.50								S
9252	Repair cleft lip - unilateral w/ muscle reconstruction	2004.00		R 1 108.70	R 1 663.10								S
9254	Repair cleft lip - bilateral w/o muscle reconstruction	2004.00		R 1 141.80	R 1 712.80								S
9256	Repair cleft lip - bilateral w/ muscle reconstruction	2004.00		R 1 764.10	R 2 646.10								S
9258	Repair anterior nasal floor	2004.00		R 445.40	R 668.10								S
9260	Revision of secondary cleft lip deformity - partial	2004.00		R 445.40	R 668.10								S
9262	Revision of secondary cleft lip deformity - total w/ muscle reconstruction	2004.00		R 1 006.40	R 1 509.60								S
9264	Abbe-flap - two stages	2004.00		R 1 139.70	R 1 709.40								S
9266	Reconstruct columella	2004.00		R 673.60	R 1 010.30								S
9268	Reconstruct nose due to cleft deformity - partial	2004.00		R 856.00	R 1 284.00								S
9270	Reconstruct nose due to cleft deformity - complete	2004.00		R 1 352.90	R 2 029.30								S
9272	Paranasal augmentation for nasal base deviation	2004.00		R 673.60	R 1 010.30								S
K.	ORTHODONTIC SERVICES												
	The branch of dentistry used to correct malocclusions of the mouth and restore it to proper alignment and function. Includes all services/procedures concerned with the supervision, guidnance and correction of the growing and mature dentofacial structures.	2006.03											
	REMOVABLE APPLIANCE THERAPY												
	Removable indicates patient can remove; includes appliances for limited orthodontic treatment (e.g., partial treatment to open spaces or upright of a tooth) and minor orthodontic treatment to control harmful habits (e.g., thumb sucking and tongue trusting).	2006.03											
8862	Ortho Tx - removable appliance	2004.00		R 788.50		R 1 182.70						+L	A
8863	Ortho Tx - each additional removable appliance	2006.03		R 396.30		R 594.40						+L	A
	FUNCTIONAL APPLIANCE THERAPY												
	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane.□ Orthodontic treatment by means of a functional appliance is usually followed by comprehensive orthodontic treatment utilising fixed orthodontic appliances. When both phases of orthodontic treatment is provided by the same practitioner, the fees levied for treatment by means of the functional appliance, will be deducted from the fee quoted for comprehensive orthodontic treatment.	2006.03											
8858	Ortho Tx - functional appliance	2006.03		R 1 420.40		R 2 130.60						+L	A
	FIXED APPLIANCE THERAPY												
	Fixed Appliance Therapy - Partial												
	The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition.□ When the preliminary/interceptive phase(s) of orthodontic treatment is followed by comprehensive orthodontic treatment and both phases of orthodontic treatment is provided by the same practitioner, the fees levied for preliminary/interceptive orthodontic treatment will be deducted from the fee quoted for comprehensive orthodontic treatment.	2006.03											
8861	Ortho Tx - partial fixed appliance - minor	2004.00		R 944.70		R 1 417.00							A
8865	Ortho Tx - partial fixed appliance - one arch	2004.00		R 2 519.90		R 3 779.90							A

8866	Ortho Tx - partial fixed appliance - both arches	2004.00		R 3 465.70		R 5 198.50						A
	Fixed Appliance Therapy - Comprehensive: Single Arch											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within an arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.	2006.03										
8867	Ortho Tx - fixed appliance - one arch	2004.00		R 2 708.70		R 4 062.90						A
8868	Ortho Tx - fixed appliance - one arch, modeate	2004.00		R 3 341.00		R 5 011.50						A
8869	Ortho Tx - fixed appliance - one arch, severe	2004.00		R 3 907.70		R 5 861.50						A
	Fixed Appliance Therapy - Comprehensive: Both Arches											
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within both arches and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.	2006.03										
8873	Ortho Tx - fixed appliance - both arches, Class 1 mild	2004.00		R 4 957.00		R 7 435.40						A
8875	Ortho Tx - fixed appliance - both arches, Class 1 moderate	2004.00		R 6 085.20		R 9 127.60						A
8877	Ortho Tx - fixed appliance - both arches, Class 1 severe	2004.00		R 7 093.80		R 10 640.60						A
8879	Ortho Tx - fixed appliance - both arches, Class 1 severe w/ complications	2004.00		R 7 972.10		R 11 958.00						A
8881	Ortho Tx - fixed appliance - both arches, Class 2/3 mild	2004.00		R 7 093.80		R 10 640.60						A
8883	Ortho Tx - fixed appliance - both arches, Class 2/3 moderate	2004.00		R 7 972.10		R 11 958.00						A
8885	Ortho Tx - fixed appliance - both arches, Class 2/3 severe	2004.00		R 8 949.40		R 13 423.90						A
8887	Ortho Tx - fixed appliance - both arches, Class 2/3 severe w/ complications	2004.00		R 10 083.20		R 15 124.70						A
	Lingual Orthodontics - Comprehensive: Single Arch											
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires.	2006.03										
8841	Ortho Tx - fixed lingual appliance - one arch	2004.00		R 5 090.80		R 7 636.10						A
8842	Ortho Tx - fixed lingual appliance - one arch, modeate	2004.00		R 5 982.80		R 8 974.10						A
8843	Ortho Tx - fixed lingual appliance - one arch, severe	2004.00		R 6 816.50		R 10 224.70						A
	Lingual Orthodontics - Comprehensive: Both Arches											
8874	Ortho Tx - fixed lingual appliance - both arches, Class 1 mild	2004.00		R 9 711.50		R 14 567.20						A
8876	Ortho Tx - fixed lingual appliance - both arches, Class 1 moderate	2004.00		R 11 370.30		R 17 055.40						A
8878	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe	2004.00		R 12 903.90		R 19 355.70						A
8880	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe w/ complications	2004.00		R 14 318.00		R 21 476.80						A
8882	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 mild	2004.00		R 11 853.50		R 17 780.10						A
8884	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 moderate	2004.00		R 13 260.20		R 19 890.10						A
8886	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe	2004.00		R 14 768.50		R 22 152.70						A
8888	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe w/ complications	2004.00		R 16 433.10		R 24 649.40						A
	OTHER ORTHODONTIC SERVICES											
8846	Repair orthodontic appliance - removable	2004.00		R 64.50		R 96.90					+L	A
8847	Replace orthodontic appliance - removable	2004.00		R 223.00		R 334.50					+L	A
8848	Repair orthodontic appliance - fixed	2006.03		R 95.50		R 143.20					+L	A
8849	Retainer (orthodontic)	2004.00		R 223.00		R 334.50					+L	A
8890	Monthly instalment ortho tx	2006.03		R -		R -						A
8891	Orthodontic transfer	2006.03		R -		R -						A
8892	Orthodontic re-treatment	2006.03		R -		R -						A
L.	SUPPLEMENTARY SERVICES											

Dental Practitioners 2008

	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.	2006.03										
	ANAESTHESIA											
8499	General anaesthetic	2005.02	R -									B
8141	Inhalation sedation - first 15 minutes or part thereof	2006.03	R 51.50									B
8143	Inhalation sedation - each addnl 15 minutes	2006.03	R 26.60									B
8144	Intravenous sedation	2004.00	R 30.90									B
8145	Local anaesthetic - per visit	2006.03	R 44.70									B
8147	Monitoring equipment for intravenous sedation	2006.03	R 109.60									B
	PROFESSIONAL VISITS											
8129	Office/hospital visit – after regularly scheduled hours	2006.03	R 172.40									B
8140	House/extended care facility/hospital call	2006.03	R 114.10				R 114.10					B
8903	House/Hosp/Nursing home consultation - MFOS	2004.00		R 127.70								S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	2006.03		R 84.90								S
8905	After regularly hours consultation - MFOS	2004.00		R 187.00								S
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	2006.03		R 212.70								S
9203	House/Hosp/Nursing home consultation - Oral pathologist	2004.00							R 127.70			
9207	After hours visit - Oral pathologist	2004.00							R 187.00			
	DRUGS, MEDICAMENTS AND MATERIALS											
8109	Infection control/barrier techniques	2006.03	R 10.30									B
8110	Sterilized instrumentation	2006.03	R 26.60									S
8183	Therapeutic drug injection	2006.03	R 30.90									B
8220	Cost of suture material	2006.03	R -	R -			R -					B
8304	Rubber dam per arch	2006.03	R 54.90									B
8306	Cost of MTA	2006.03	R -					R -				B
8310	Supply of bleaching materials	2006.03	R -									
	ADMINISTRATIVE AND LABORATORY SERVICES											
8099	Dental laboratory service	2006.03	R -	R -	R -	R -	R -					
8106	Special report	2006.03	R 117.50	R 117.50	R 117.50	R 117.50	R 117.50					A
8111	Dental testimony	2006.03										
8120	Treatment plan completed	2006.03	R -	R -	R -	R -	R -					
8139	Appointment not kept /30min	2006.03	R -	R -	R -	R -	R -					B
	MISCELLANEOUS SERVICES											
	Palliative Treatment											
8131	Emergency dental treatment	2006.03	R 70.30					R 143.20		T		B
8166	Application of desensitising resin, per tooth	2006.03	R 46.40							T		B
8167	Application of desensitising medicament, per visit	2006.03	R 54.10									B
8165	Sedative filling	2006.03	R 70.30							T	+L	B
	Post Surgical Complications											
8931	Treatment of post-extraction haemorrhage	2006.03	R 51.50	R 308.80								S
8933	Treatment of haemorrhage (blood dyscracias)	2004.00	R 711.90	R 1 067.80								S
8935	Treatment of septic socket	2006.03	R 51.50	R 80.60								S
	Bleaching											
8308	External bleaching - per arch	2006.03								M		A
8309	Home bleaching - instructions and applicator	2006.03									+L	A
8311	Home bleaching - subsequent visit	2006.03										A

8325	Internal bleaching - per tooth	2006.03		R 166.40				R 249.60		T		A
8327	Internal bleaching - each additional visit	2006.03		R 79.80				R 119.70		T		A
	Unclassified Treatment											
8158	Enamel microabrasion	2006.03		R 64.30								
8168	Behavior management	2006.03										B
8551	Occlusal adjustment - major	2006.03		R 444.80		R 667.20		R 667.20				A
8553	Occlusal adjustment - minor	2006.03		R 155.20		R 212.70	R 212.70	R 212.70				A
9099	Unlisted dental procedure or service (By report)	2006.03		R -								
	MODIFIERS											
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	2006.03										
8003	Minimum assistant surgeon	2006.03		R 130.38	R 130.38		R 130.38					
8005	Maximum multiple procedures (same incision) - MFO surgeon	2006.03		R 202.42	R 202.42		R 202.42					
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)	2006.03										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)	2006.03										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)	2006.03										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)	2006.03										
8010	Open reduction (PLUS 75% of the appropriate benefit)	2006.03										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)	2006.03										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)	2006.03										
8013	Multiple modifiers	2006.03										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)	2006.03										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	2006.03		R -	R -		R -	R -				

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Dental Practitioners 2008

Code	Description
25400	General Dental Practice
26200	Maxillo-facial and Oral Surgery
26400	Orthodontics
29200	Oral Medicine and Periodontics
29400	Prosthodontics
29800	Oral Pathology

Dental Practitioners 2008

Code	Description	RCF
150	Dental	8.577
152	Dental - Modelled	11.443

DENTAL THERAPY

Dental Therapy 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as e baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

001	Item 001 refers to a Full Mouth Examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.	06.03
002	(a) Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been. (b) Every account shall contain the following particulars : (i) the surname and initials of the member; (ii) the first name of the patient; (iii) the name of the scheme; (iv) the membership number of the member; (v) the practice number; (vi) date on which every service was rendered; (vii) where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist ; (viii) a statement of whether the account is in accordance with the National Reference Price List ; (ix) the name of the dental therapist rendering the service must be shown on the account;and (x) the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered;.	06.03
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	06.03

ITEMS

Code	Description	Ver	Dental Therapy	M P	Lab	T C
8139	Appointment not kept /30min	06.03	-			B
	Comment: By arrangement with patient					
8109	Infection control/barrier techniques	06.03	10.30 (9.04)			B
	Comment: This is typically reported on a "per visit" basis for new rubber gloves, masks, etc. provided by the dentist. Report per provider per visit.					
8110	Sterilized instrumentation	06.03	26.60 (23.30)			S
	Limitation: The use of this code is limited to autoclaved, vapour or heat sterilised instruments (i.e. set(s) of long handled instruments and/or forceps) provided by the dentist/hygienist for use in the surgery. Report per visit.					
8120	Treatment plan completed	06.03	-			
	Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.					
Diagnostic services						
8101	Oral examination	06.03	59.60 (52.30)			B
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).					
8102	Comprehensive oral examination	06.03	96.20 (84.40)			B

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008)					
8104	Limited oral examination	06.03	46.40 (40.70)			B
	An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment. Comment: This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g., recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.					
8189	Re-examination - existing condition	06.03	46.40 (40.70)			B
	An assessment performed on an established patient (patient of record) to assess the status of an untreated previously existing condition involving an examination and evaluation, limited to the previously existing condition. This type of assessment is conducted on patients (1) with a traumatic injury where no treatment was rendered but the patient needs follow-up monitoring; (2) requires evaluation for undiagnosed continuing pain after a limited oral examination and diagnostic tests did not reveal any findings; and (3) with soft tissue lesions such as a leukoplakia observed on a previous visit that require follow-up monitoring of pathological changes. Comment: (1) A re- examination is not a post-operative visit.					
8129	Office/hospital visit – after regularly scheduled hours	06.03	142.90 (125.40)			B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.					
8140	House/extended care facility/hospital call	06.03	94.50 (82.90)			B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.					
8190	Consultation - second opinion or advice	06.03	-			B
	A consultation is a diagnostic service rendered by a dentist, other than the practitioner providing treatment, whose opinion or advice for the purpose of determining the patient's dental needs and proposing treatment regarding a specific problem is requested. A consultation requires and includes a written report to the practitioner or patient who requested the consultation. It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded). Comment: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation. When the consulting dentist assumes responsibility for the continuing care of the patient, any service rendered by him/her will cease to be a consultation, and an appropriate oral examination code should be reported. Code 8106 (special report) may not be reported in addition to this code					
Radiographs/diagnostic imaging						
8107	Intraoral radiograph - periapical	06.03	44.70 (39.20)			B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.					
8108	Intraoral radiographs - complete series	06.03	358.40 (314.40)			B
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.					
8112	Intraoral radiograph - bitewing	06.03	44.70 (39.20)			B

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.					
8113	Intraoral radiograph - occlusal	04.00	76.80 (67.40)			B
8114	Extraoral radiograph - hand-wrist	06.03	-			B
	Use to report extraoral radiographs such as hand-wrist radiographs.					
8115	Extraoral radiograph - panoramic	04.00	178.70 (156.80)			B
8116	Extraoral radiograph - cephalometric	05.02	178.70 (156.80)			B
8118	Extraoral radiograph - skull/facial bone	05.02	-			B
8121	Oral and/or facial image (digital/conventional)	06.03	47.90 (42.00)			B
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.					
Preventive services						
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.					06.03
8151	Oral hygiene instruction	06.03	46.70 (41.00)			B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plague, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.					
8153	Oral hygiene instruction - each additional visit	06.03	34.20 (30.00)			B
	Report code 6153 when additional oral hygiene instructions is required as part of the treatment plan. No other preventive services may be reported at the same visit. See code 8151					
8155	Polishing - complete dentition	06.03	57.20 (50.20)			B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.					
8159	Prophylaxis - complete dentition	06.03	104.20 (91.40)			B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.					
8161	Topical application of fluoride - child	06.03	57.20 (50.20)			B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.					
8182	Topical application of fluoride - adult	06.03	57.20 (50.20)			B
	See code 8161.					
8163	Dental sealant	06.03	42.30 (37.10)	T		B
	Also known as pit-and fissure sealant. This procedure involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal decay-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in a restorative the decay penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant. Limitation: Certain funders limit benefits for sealants to two teeth per quadrant.					
	Note : 8163 chargeable once only in respect of a tooth per annum. 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.	06.03				

Code	Description	Ver	Dental Therapy	MP	Lab	TC
Extractions during a single visit.						
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	06.03	66.70 (58.50)	T		B
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.					
8202	Extraction - each additional tooth or exposed tooth roots	06.03	25.70 (22.50)	T		B
	To be reported for an additional extraction in the same quadrant at the same visit.					
8145	Local anaesthetic - per visit	06.03	10.10 (8.86)			B
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.					
8220	Cost of suture material	06.03	-			B
	Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.					
8931	Treatment of post-extraction haemorrhage	06.03	43.50 (38.20)			S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.					
8935	Treatment of septic socket	06.03	43.50 (38.20)			S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.					
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	82.10 (72.00)	M		S
8303	Pulp cap - indirect	06.03	84.60 (74.20)	T		B
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.					
Amalgam restorations (including polishing).						
8341	Amalgam - one surface	04.00	122.00 (107.00)	T		B
8342	Amalgam - two surfaces	04.00	150.40 (131.90)	T		B
8343	Amalgam - three surfaces	04.00	183.40 (160.90)	T		B
8344	Amalgam - four or more surfaces	04.00	204.30 (179.20)	T		B
	Only one of the above items may be charged per tooth within a year.	06.03				
Resin restorations (using resin bonding technique)						
8351	Resin - one surface, anterior	04.00	147.70 (129.60)	T		B
8352	Resin - two surfaces, anterior	04.00	185.60 (162.80)	T		B
8367	Resin - one surface, posterior	06.03	160.10 (140.40)	T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.					
8369	Resin - three surfaces, posterior	04.00	239.20 (209.80)	T		B
8370	Resin - four or more surfaces, posterior	04.00	257.30 (225.70)	T		B
8368	Resin - two surfaces, posterior	04.00	198.00 (173.70)	T		B
8353	Resin - three surfaces, anterior	04.00	221.80 (194.60)	T		B
8354	Resin - four or more surfaces, anterior	06.03	247.50 (217.10)	T		B
	Use to report the involvement of four or more surfaces or the incisal line angle. The incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.					
8350	Resin crown - anterior primary tooth (direct)	06.03	266.10 (233.40)	T		B

Code	Description	Ver	Dental Therapy	M P	Lab	T C
	This procedure involves the full coverage of an anterior primary tooth with a resin based material.					
	Note: Only one of the above codes may be charged per tooth within a year.	06.03				
Palliative Treatment						
8131	Emergency dental treatment	06.03	59.60 (52.30)	T		B
	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).					
8165	Sedative filling	06.03	59.60 (52.30)	T	+L	B
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.					
8166	Application of desensitising resin, per tooth	06.03	39.30 (34.50)	T		B
	This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.					
8167	Application of desensitising medicament, per visit	06.03	45.80 (40.20)			B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.					

Dental Therapy 2008

				39500					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**		**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2006.03							
	GENERAL RULES								
001	Item 001 refers to a Full Mouth Examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.	2006.03							
002	(a) Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been. (b) Every account shall contain the following particulars : (i) the surname and initials of the member; (ii) the first name of the patient; (iii) the name of the scheme; (iv) the membership number of the member; (v) the practice number; (vi) date on which every service was rendered; (vii) where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist ; (viii) a statement of whether the account is in accordance with the National Reference Price List ; (ix) the name of the dental therapist rendering the service must be shown on the account;and (x) the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered;.	2006.03							
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2006.03							
	ITEMS								
8139	Appointment not kept /30min	2006.03		210	-	1.0	R	-	
8109	Infection control/barrier techniques	2006.03		210	1.730	1.0	R	10.30	
8110	Sterilized instrumentation	2006.03		210	4.460	1.0	R	26.60	
8120	Treatment plan completed	2006.03		210	-	1.0	R	-	
	Diagnostic services								
8101	Oral examination	2006.03		210	10.000	1.0	R	59.60	

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8102	Comprehensive oral examination	2006.03		210	16.147	1.0	R	96.20	
8104	Limited oral examination	2006.03		210	7.791	1.0	R	46.40	
8189	Re-examination - existing condition	2006.03		210	7.791	1.0	R	46.40	
8129	Office/hospital visit – after regularly scheduled hours	2006.03		210	24.000	1.0	R	142.90	
8140	House/extended care facility/hospital call	2006.03		210	15.875	1.0	R	94.50	
8190	Consultation - second opinion or advice	2006.03		210	-	1.0	R	-	
	Radiographs/diagnostic imaging								
8107	Intraoral radiograph - periapical	2006.03		210	7.500	1.0	R	44.70	
8108	Intraoral radiographs - complete series	2006.03		210	60.187	1.0	R	358.40	
8112	Intraoral radiograph - bitewing	2006.03		210	7.500	1.0	R	44.70	
8113	Intraoral radiograph - occlusal	2004.00		210	12.894	1.0	R	76.80	
8114	Extraoral radiograph - hand-wrist	2006.03		210	-	1.0	R	-	
8115	Extraoral radiograph - panoramic	2004.00		210	30.000	1.0	R	178.70	
8116	Extraoral radiograph - cephalometric	2005.02		210	30.000	1.0	R	178.70	
8118	Extraoral radiograph - skull/facial bone	2005.02		210	-	1.0	R	-	
8121	Oral and/or facial image (digital/conventional)	2006.03		210	8.044	1.0	R	47.90	
	Preventive services								
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.	2006.03							
8151	Oral hygiene instruction	2006.03		210	7.850	1.0	R	46.70	
8153	Oral hygiene instruction - each additional visit	2006.03		210	5.746	1.0	R	34.20	
8155	Polishing - complete dentition	2006.03		210	9.603	1.0	R	57.20	
8159	Prophylaxis - complete dentition	2006.03		210	17.491	1.0	R	104.20	
8161	Topical application of fluoride - child	2006.03		210	9.603	1.0	R	57.20	
8162	Topical application of fluoride - adult	2006.03		210	9.603	1.0	R	57.20	
8163	Dental sealant	2006.03		210	7.109	1.0	R	42.30	
	Note : 8163 chargeable once only in respect of a tooth per annum.□ □ 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.	2006.03							
	Extractions during a single visit.								
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	2006.03		210	11.200	1.0	R	66.70	
8202	Extraction - each additional tooth or exposed tooth roots	2006.03		210	4.324	1.0	R	25.70	
8145	Local anaesthetic - per visit	2006.03		210	1.700	1.0	R	10.10	
8220	Cost of suture material	2006.03		210	-	1.0	R	-	
8931	Treatment of post-extraction haemorrhage	2006.03		210	7.304	1.0	R	43.50	
8935	Treatment of septic socket	2006.03		210	7.304	1.0	R	43.50	
9011	Incision & drainage of abscess - intra-oral (pyogenic)	2005.02		210	13.790	1.0	R	82.10	
8303	Pulp cap - indirect	2006.03		210	14.200	1.0	R	84.60	
	Amalgam restorations (including polishing).								
8341	Amalgam - one surface	2004.00		210	20.491	1.0	R	122.00	
8342	Amalgam - two surfaces	2004.00		210	25.263	1.0	R	150.40	
8343	Amalgam - three surfaces	2004.00		210	30.795	1.0	R	183.40	
8344	Amalgam - four or more surfaces	2004.00		210	34.301	1.0	R	204.30	

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	Only one of the above items may be charged per tooth within a year.	2006.03							
	Resin restorations (using resin bonding technique)								
8351	Resin - one surface, anterior	2004.00		210	24.795	1.0	R	147.70	
8352	Resin - two surfaces, anterior	2004.00		210	31.165	1.0	R	185.60	
8367	Resin - one surface, posterior	2006.03		210	26.880	1.0	R	160.10	
8369	Resin - three surfaces, posterior	2004.00		210	40.164	1.0	R	239.20	
8370	Resin - four or more surfaces, posterior	2004.00		210	43.202	1.0	R	257.30	
8368	Resin - two surfaces, posterior	2004.00		210	33.249	1.0	R	198.00	
8353	Resin - three surfaces, anterior	2004.00		210	37.242	1.0	R	221.80	
8354	Resin - four or more surfaces, anterior	2006.03		210	41.566	1.0	R	247.50	
8350	Resin crown - anterior primary tooth (direct)	2006.03		210	44.683	1.0	R	266.10	
	Note: Only one of the above codes may be charged per tooth within a year.	2006.03							
	Palliative Treatment								
8131	Emergency dental treatment	2006.03		210	10.000	1.0	R	59.60	
8165	Sedative filling	2006.03		210	10.000	1.0	R	59.60	
8166	Application of desensitising resin, per tooth	2006.03		210	6.603	1.0	R	39.30	
8167	Application of desensitising medicament, per visit	2006.03		210	7.694	1.0	R	45.80	

Dental Therapy 2008

Code	Description
39500	Dental Therapy

Dental Therapy 2008

Code	Description	RCF
210	Dental Therapists	5.955

Dental Therapy 2008

				39500					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value		Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2006.03							
	GENERAL RULES								
001	Item 001 refers to a Full Mouth Examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.	2006.03							
002	(a) Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been. (b) Every account shall contain the following particulars : (i) the surname and initials of the member; (ii) the first name of the patient; (iii) the name of the scheme; (iv) the membership number of the member; (v) the practice number; (vi) date on which every service was rendered; (vii) where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist ; (viii) a statement of whether the account is in accordance with the National Reference Price List ; (ix) the name of the dental therapist rendering the service must be shown on the account;and (x) the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered;.	2006.03							
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2006.03							
	ITEMS								
8139	Appointment not kept /30min	2006.03		210	-	1.0	R	-	
8109	Infection control/barrier techniques	2006.03		210	1.730	1.0	R	10.30	
8110	Sterilized instrumentation	2006.03		210	4.460	1.0	R	26.60	
8120	Treatment plan completed	2006.03		210	-	1.0	R	-	
	Diagnostic services								
8101	Oral examination	2006.03		210	10.000	1.0	R	59.60	

Dental Therapy 2008

8102	Comprehensive oral examination	2006.03		210	16.147	1.0	R	96.20	
8104	Limited oral examination	2006.03		210	7.791	1.0	R	46.40	
8189	Re-examination - existing condition	2006.03		210	7.791	1.0	R	46.40	
8129	Office/hospital visit – after regularly scheduled hours	2006.03		210	24.000	1.0	R	142.90	
8140	House/extended care facility/hospital call	2006.03		210	15.875	1.0	R	94.50	
8190	Consultation - second opinion or advice	2006.03		210	-	1.0	R	-	
	Radiographs/diagnostic imaging								
8107	Intraoral radiograph - periapical	2006.03		210	7.500	1.0	R	44.70	
8108	Intraoral radiographs - complete series	2006.03		210	60.187	1.0	R	358.40	
8112	Intraoral radiograph - bitewing	2006.03		210	7.500	1.0	R	44.70	
8113	Intraoral radiograph - occlusal	2004.00		210	12.894	1.0	R	76.80	
8114	Extraoral radiograph - hand-wrist	2006.03		210	-	1.0	R	-	
8115	Extraoral radiograph - panoramic	2004.00		210	30.000	1.0	R	178.70	
8116	Extraoral radiograph - cephalometric	2005.02		210	30.000	1.0	R	178.70	
8118	Extraoral radiograph - skull/facial bone	2005.02		210	-	1.0	R	-	
8121	Oral and/or facial image (digital/conventional)	2006.03		210	8.044	1.0	R	47.90	
	Preventive services								
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.	2006.03							
8151	Oral hygiene instruction	2006.03		210	7.850	1.0	R	46.70	
8153	Oral hygiene instruction - each additional visit	2006.03		210	5.746	1.0	R	34.20	
8155	Polishing - complete dentition	2006.03		210	9.603	1.0	R	57.20	
8159	Prophylaxis - complete dentition	2006.03		210	17.491	1.0	R	104.20	
8161	Topical application of fluoride - child	2006.03		210	9.603	1.0	R	57.20	
8162	Topical application of fluoride - adult	2006.03		210	9.603	1.0	R	57.20	
8163	Dental sealant	2006.03		210	7.109	1.0	R	42.30	
	Note : 8163 chargeable once only in respect of a tooth per annum.□ □ 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.	2006.03							
	Extractions during a single visit.								
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	2006.03		210	11.200	1.0	R	66.70	
8202	Extraction - each additional tooth or exposed tooth roots	2006.03		210	4.324	1.0	R	25.70	
8145	Local anaesthetic - per visit	2006.03		210	1.700	1.0	R	10.10	
8220	Cost of suture material	2006.03		210	-	1.0	R	-	
8931	Treatment of post-extraction haemorrhage	2006.03		210	7.304	1.0	R	43.50	
8935	Treatment of septic socket	2006.03		210	7.304	1.0	R	43.50	
9011	Incision & drainage of abscess - intra-oral (pyogenic)	2005.02		210	13.790	1.0	R	82.10	
8303	Pulp cap - indirect	2006.03		210	14.200	1.0	R	84.60	
	Amalgam restorations (including polishing).								
8341	Amalgam - one surface	2004.00		210	20.491	1.0	R	122.00	
8342	Amalgam - two surfaces	2004.00		210	25.263	1.0	R	150.40	
8343	Amalgam - three surfaces	2004.00		210	30.795	1.0	R	183.40	
8344	Amalgam - four or more surfaces	2004.00		210	34.301	1.0	R	204.30	

Dental Therapy 2008

	Only one of the above items may be charged per tooth within a year.	2006.03							
	Resin restorations (using resin bonding technique)								
8351	Resin - one surface, anterior	2004.00		210	24.795	1.0	R	147.70	
8352	Resin - two surfaces, anterior	2004.00		210	31.165	1.0	R	185.60	
8367	Resin - one surface, posterior	2006.03		210	26.880	1.0	R	160.10	
8369	Resin - three surfaces, posterior	2004.00		210	40.164	1.0	R	239.20	
8370	Resin - four or more surfaces, posterior	2004.00		210	43.202	1.0	R	257.30	
8368	Resin - two surfaces, posterior	2004.00		210	33.249	1.0	R	198.00	
8353	Resin - three surfaces, anterior	2004.00		210	37.242	1.0	R	221.80	
8354	Resin - four or more surfaces, anterior	2006.03		210	41.566	1.0	R	247.50	
8350	Resin crown - anterior primary tooth (direct)	2006.03		210	44.683	1.0	R	266.10	
	Note: Only one of the above codes may be charged per tooth within a year.	2006.03							
	Palliative Treatment								
8131	Emergency dental treatment	2006.03		210	10.000	1.0	R	59.60	
8165	Sedative filling	2006.03		210	10.000	1.0	R	59.60	
8166	Application of desensitising resin, per tooth	2006.03		210	6.603	1.0	R	39.30	
8167	Application of desensitising medicament, per visit	2006.03		210	7.694	1.0	R	45.80	

Dental Therapy 2008

Code	Description
39500	Dental Therapy

Dental Therapy 2008

Code	Description	RCF
210	Dental Therapists	5.955

DIETICIANS

Dieticians 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES		
003	Dietary services are per individual patient.	04.00
004	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.	04.00
010	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.03
MODIFIERS		
0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	04.00

ITEMS

1. INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT

Code	Description	Ver	Add	Dietetics RVU	Dietetics Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00			
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	05.03		0.500	24.20 (21.20)
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	05.03		1.500	72.50 (63.60)
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	05.03		2.500	120.80 (106.00)
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	05.03		3.500	169.20 (148.40)
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	05.03		4.500	217.50 (190.80)
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	05.03		5.500	265.80 (233.20)
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	05.03		6.500	314.10 (275.50)
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	05.03		7.500	362.50 (318.00)
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	05.03		8.500	410.80 (360.40)
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	05.03		9.500	459.10 (402.70)
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	05.03		10.500	507.50 (445.20)
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	05.03		11.500	555.80 (487.50)
2.	**GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT**				
	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.				05.03
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	05.03		0.100	4.83 (4.24)
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	05.03		0.300	14.50 (12.70)
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	05.03		0.500	24.20 (21.20)

Code	Description	Ver	Add	Dietetics	
				RVU	Fee
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	05.03		0.700	33.80 (29.60)
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	05.03		0.900	43.50 (38.20)
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	05.03		1.100	53.20 (46.70)
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	05.03		1.300	62.80 (55.10)
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	05.03		1.500	72.50 (63.60)
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	05.03		1.700	82.20 (72.10)
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	05.03		1.900	91.80 (80.50)
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	05.03		2.100	101.50 (89.00)
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	05.03		2.300	111.20 (97.50)

Dieticians 2008

				38400				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
003	Dietary services are per individual patient.	2004.00						
004	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2004.00						
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.	2004.00						
010	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	2005.03						
	MODIFIERS							
0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	2004.00						
	ITEMS							
1.	INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT							

Dieticians 2008

107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00							
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	2005.03		200	0.500	1.0	R	24.20	
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	2005.03		200	1.500	1.0	R	72.50	
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	2005.03		200	2.500	1.0	R	120.80	
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	2005.03		200	3.500	1.0	R	169.20	
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	2005.03		200	4.500	1.0	R	217.50	
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	2005.03		200	5.500	1.0	R	265.80	
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	2005.03		200	6.500	1.0	R	314.10	
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	2005.03		200	7.500	1.0	R	362.50	
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	2005.03		200	8.500	1.0	R	410.80	
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	2005.03		200	9.500	1.0	R	459.10	
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	2005.03		200	10.500	1.0	R	507.50	
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	2005.03		200	11.500	1.0	R	555.80	
2.	GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT								
	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.	2005.03							
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	2005.03		200	0.100	1.0	R	4.83	
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	2005.03		200	0.300	1.0	R	14.50	
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	2005.03		200	0.500	1.0	R	24.20	
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	2005.03		200	0.700	1.0	R	33.80	
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	2005.03		200	0.900	1.0	R	43.50	
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	2005.03		200	1.100	1.0	R	53.20	
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	2005.03		200	1.300	1.0	R	62.80	
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	2005.03		200	1.500	1.0	R	72.50	
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	2005.03		200	1.700	1.0	R	82.20	
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	2005.03		200	1.900	1.0	R	91.80	
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	2005.03		200	2.100	1.0	R	101.50	
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	2005.03		200	2.300	1.0	R	111.20	

Dieticians 2008

Code	Description
38400	Dietetics

Dieticians 2008

Code	Description	RCF
200	Dieticians	48.330

HEARING AID ACOUSTICIANS

Hearing Aid Acousticians 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HEARING AID ACOUSTICIANS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

003	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	04.00
004	Each practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars : · The practice code number of the supplier of service · The name of the collaborating medical practitioner or audiologist. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

ITEMS

Code	Description	Ver	Add	Hearing Aid Acousticians	
				RVU	Fee
001	First consultation (comprehensive)	04.00		15.700	74.90 (65.70)
003	Consultation (screening interview)	04.00		10.000	47.70 (41.80)
021	Test - air conduction	04.00		10.000	47.70 (41.80)
023	Test - bone conduction	04.00		10.000	47.70 (41.80)
025	Test - speech hearing tests	04.00		14.000	66.80 (58.60)
027	Test - free field	04.00		12.800	61.10 (53.60)
029	Test - insertion gain (per ear)	04.00		10.900	52.00 (45.60)
031	Test - binaural loudness balance test, per ear	04.00		12.800	61.10 (53.60)
051	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme)	04.00		-	-
053	Hearing Aid Evaluation, per ear (refer to General Rule 003)	04.00		12.800	61.10 (53.60)
055	Technical adjustment or replacement of earmolds	04.00		21.100	100.60 (88.20)
057	Repairs/service per instrument (3 X services/4 year cycle)	04.00		-	-
059	Tympanogram	04.00		10.000	47.70 (41.80)
061	Reflex test (stapedial reflex)	04.00		10.000	47.70 (41.80)
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-

Hearing Aid Acousticians 2008

				38300					
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HEARING AID ACOUSTICIANS EFFECTIVE FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**		**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00							
	GENERAL RULES								
003	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.	2004.00							
004	Each practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars : · The practice code number of the supplier of service · The name of the collaborating medical practitioner or audiologist. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	2004.00							
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00							
	ITEMS								
001	First consultation (comprehensive)	2004.00		220	15.700	1.0	R	74.90	
003	Consultation (screening interview)	2004.00		220	10.000	1.0	R	47.70	
021	Test - air conduction	2004.00		220	10.000	1.0	R	47.70	
023	Test - bone conduction	2004.00		220	10.000	1.0	R	47.70	
025	Test - speech hearing tests	2004.00		220	14.000	1.0	R	66.80	
027	Test - free field	2004.00		220	12.800	1.0	R	61.10	
029	Test - insertion gain (per ear)	2004.00		220	10.900	1.0	R	52.00	
031	Test - binaural loudness balance test, per ear	2004.00		220	12.800	1.0	R	61.10	

Hearing Aid Acousticians 2008

051	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme)	2004.00		220	-	0.0	R	-	
053	Hearing Aid Evaluation, per ear (refer to General Rule 003)	2004.00		220	12.800	1.0	R	61.10	
055	Technical adjustment or replacement of earmolds	2004.00		220	21.100	1.0	R	100.60	
057	Repairs/service per instrument (3 X services/4 year cycle)	2004.00		220	-	0.0	R	-	
059	Tympanogram	2004.00		220	10.000	1.0	R	47.70	
061	Reflex test (stapedial reflex)	2004.00		220	10.000	1.0	R	47.70	
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		220	-	0.0	R	-	

Hearing Aid Acousticians 2008

Code	Description
38300	Hearing Aid Acousticians

Hearing Aid Acousticians 2008

Code	Description	RCF
220	Hearing Aid Acousticians	4.770

HOMOEOPATHS

Homoeopaths 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HOMOEOPATHS EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES		
1	All accounts must be presented with the following information clearly stated: · name of homoeopath; · qualifications of the homoeopath; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the nature of treatment; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the homoeopath; and · a statement of whether the account is in accordance with the National Reference Price List.	04.00
2	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
Definition: Consultations		
	Consultation: A situation where a Homoeopathic Practitioner takes down a patient's full history and (where applicable) performs an appropriate examination, and repertorisation of the case and study of Materia Medica and/or prescribes or administers treatment and/or medicine or assists the patient with advice. (The method of repertorisation and selection of medicine is determined by the practitioner). or A voluntary scheduled consultation for the same condition within four (4) months (although the symptoms may differ from those presented during the first consultation). It may imply taking down a history and/or repertorisation of the case and study of Materia Medica and/or examination and/or prescribing or administering of treatment and/or medicine and/or counselling. Multiple complaints attended to during same visit: Only one consultation fee is chargeable although the patient may present with a number of complaints. If the patient has an unrelated complaint at the time of administering e.g. a homoeopathic injection as part of a course only a fee for a visit is appropriate. Hospital visits: at hospital or nursing home (all hours). By arrangement with scheme/patient.	06.04
Definition: Medicines		
	Prescribed medicine: Homoeopathic medicines are prescribed in accordance with the homoeopathic principles and philosophy. The philosophy may consist a classical, a clinical or a combined classical/clinical approach. The prescription may include proprietary homoeopathic medicine, or patient specific compounded medicine or a combination of both. The prescription may also include specially imported medicine. The medicine may be prescribed in the form of a tablet, capsules, ampoules, liquid drops, liquid syrup, ear drops, nose drops, eye drops, pillules, granules, powders, ointments, creams, suppositories, stickers, etc. The medicine may be prescribed in a simplex potency, mother tincture (Æ), low potency, multi-potency, etc and/or complex form. Proprietary homoeopathic medicine: These are registered homoeopathic medicines that are available in the open market or trade, or which are bought in bulk from manufacturers or wholesalers and dispensed to patients in smaller volumes without any compounding or manipulation. The dispensing of such medicine requires the appropriate NAPPI Code provided by the Manufacturer/Distributor. Non-proprietary homoeopathic medicine: These are homoeopathic medicines which are formulated and/or prepared and/or manipulated, and/or compounded in-house by the registered homoeopathic practitioner, and/or by a registered homoeopathic medicine manufacturer in accordance with the prescription and/or formula of the registered homoeopathic practitioner and which is not available in the market/trade.	06.05

Code	Description	Ver	Add	Homoeopathy	
				RVU	Fee
General Rules on Medicines, supplies, material and use of own equipment in treatment and procedures					
	Items 201 and 209 provide for the charge of material and medicine used in treatment. · All materials used should be specified on all accounts. · Medicine, bandages and other essential materials for home-use by the patient must be obtained from a chemist on prescription or, if a chemist is not readily available, the practitioner may supply it from own stock provided a relevant prescription is attached to the account. · Not appropriate for items such as spatulas that are normally used in examinations in the rooms. · Not appropriate for items such as syringes, needles and gloves, etc. · Practitioners are not allowed to sell sphygmomanometers (blood pressure meters) or electro-medical devices to patients. · For side room testing by practitioners no extra charge in terms of item 201 is applicable for material or kits used. The amount charged in respect of proprietary medicines shall be at net acquisition price. In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				06.05
ITEMS					
1.	**Consultations**				
Code	**Description**	**Ver**	**Add**	**Homoeopathy**	
				RVU	**Fee**
301	Consultation (initial or follow up). Duration 1 - 15 mins	06.04		7.500	37.00 (32.50)
302	Consultation (initial or follow up). Duration 16 - 30 mins	06.04		22.500	111.10 (97.50)
303	Consultation (initial or follow up). Duration 31 - 45 mins	06.04		37.500	185.20 (162.50)
304	Consultation (initial or follow up). Duration 46 - 60 mins	06.04		52.500	259.30 (227.50)
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	06.04		15.000	74.10 (65.00)
003	Hospital visit (BY ARRANGEMENT)	04.00		-	-
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
2.	**Medicines and Materials**				
201	Proprietary homeopathic medicine, all forms. The amount charged in respect of proprietary homeopathic medicines shall be at cost.	06.02		-	-
202	Non-proprietary Homoeopathic Medicine - Tablets & Capsules (each)	06.04		0.100	1.01 (0.89)
203	Non-proprietary Homoeopathic Medicine - Liquid drops (per ml)	06.04		0.230	2.32 (2.04)
204	Non-proprietary Homoeopathic Medicine - Pillules & granules (per ml)	06.04		0.230	2.32 (2.04)
209	Proprietary materials	06.05			

Homoeopaths 2008

				40800				
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HOMOEOPATHS EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
1	All accounts must be presented with the following information clearly stated: · name of homoeopath; · qualifications of the homoeopath; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the nature of treatment; · the surname and initials of the member; · the first name of the patient; · the name of the scheme; · the membership number of the member; · where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the homoeopath; and · a statement of whether the account is in accordance with the National Reference Price List.	2004.00						
2	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
	Definition: Consultations							

	Consultation: A situation where a Homoeopathic Practitioner takes down a patient's full history and (where applicable) performs an appropriate examination, and repertorisation of the case and study of Materia Medica and/or prescribes or administers treatment and/or medicine or assists the patient with advice. (The method of repertorisation and selection of medicine is determined by the practitioner).□ or□ A voluntary scheduled consultation for the same condition within four (4) months (although the symptoms may differ from those presented during the first consultation). It may imply taking down a history and/or repertorisation of the case and study of Materia Medica and/or examination and/or prescribing or administering of treatment and/or medicine and/or counselling.□ □ Multiple complaints attended to during same visit: Only one consultation fee is chargeable although the patient may present with a number of complaints. If the patient has an unrelated complaint at the time of administering e.g. a homoeopathic injection as part of a course only a fee for a visit is appropriate.□	2006.04						
	Definition: Medicines							
	Prescribed medicine: Homoeopathic medicines are prescribed in accordance with the homoeopathic principles and philosophy. The philosophy may consist a classical, a clinical or a combined classical/clinical approach. The prescription may include proprietary homoeopathic medicine, or patient specific compounded medicine or a combination of both. The prescription may also include specially imported medicine. The medicine may be prescribed in the form of a tablet, capsules, ampoules, liquid drops, liquid syrup, ear drops, nose drops, eye drops, pillules, granules, powders, ointments, creams, suppositories, stickers, etc. The medicine may be prescribed in a simplex potency, mother tincture (Æ), low potency, multi-potency, etc and/or complex form.□ □ Proprietary homoeopathic medicine: These are registered homoeopathic medicines that are available in the open market or trade, or which are bought in bulk from manufacturers or wholesalers and dispensed to patients in smaller volumes without any compounding or manipulation. The dispensing of such medicine requires the appropriate NAPPI Code provided by the Manufacturer/Distributor.□ □	2006.05						
	General Rules on Medicines, supplies, material and use of own equipment in treatment and procedures							

STAATSKOERANT, 16 NOVEMBER 2007 No. 30410 603

Homoeopaths 2008

	Items 201 and 209 provide for the charge of material and medicine used in treatment. □ · All materials used should be specified on all accounts.□ · Medicine, bandages and other essential materials for home-use by the patient must be obtained from a chemist on prescription or, if a chemist is not readily available, the practitioner may supply it from own stock provided a relevant prescription is attached to the account. □ · Not appropriate for items such as spatulas that are normally used in examinations in the rooms.□ · Not appropriate for items such as syringes, needles and gloves, etc.□ · Practitioners are not allowed to sell sphygmomanometers (blood pressure meters) or electro-medical devices to patients.□ · For side room testing by practitioners no extra charge in terms of item 201 is applicable for material or kits used.□ □ The amount charged in respect of proprietary medicines shall be at net acquisition price.□ □ In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus -□	2006.05							
	ITEMS								
1.	Consultations								
301	Consultation (initial or follow up). Duration 1 - 15 mins	2006.04		231	7.500	1.0	R	37.00	
302	Consultation (initial or follow up). Duration 16 - 30 mins	2006.04		231	22.500	1.0	R	111.10	
303	Consultation (initial or follow up). Duration 31 - 45 mins	2006.04		231	37.500	1.0	R	185.20	
304	Consultation (initial or follow up). Duration 46 - 60 mins	2006.04		231	52.500	1.0	R	259.30	
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	2006.04		231	15.000	1.0	R	74.10	
003	Hospital visit (BY ARRANGEMENT)	2004.00		230	-	1.0	R	-	
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	2004.00		230	-	0.0	R	-	
2.	Medicines and Materials								
201	Proprietary homeopathic medicine, all forms. The amount charged in respect of proprietary homeopathic medicines shall be at cost.	2006.02		230	-	1.0	R	-	
202	Non-proprietary Homoeopathic Medicine - Tablets & Capsules (each)	2006.04		230	0.100	1.0	R	1.01	
203	Non-proprietary Homoeopathic Medicine - Liquid drops (per ml)	2006.04		230	0.230	1.0	R	2.32	
204	Non-proprietary Homoeopathic Medicine - Pillules & granules (per ml)	2006.04		230	0.230	1.0	R	2.32	
209	Proprietary materials	2006.05							

Homoeopaths 2008

Code	Description
40800	Homoeopathy

HOSPICES

Hospices 2008

NATIONAL REFERENCE PRICE LIST IN RESPECT OF HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79" WITH EFFECT FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00

SCHEDULE

10 HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"

Code	Description	Ver	Add	Hospices	
				RVU	Fee
950	Ward fee, per day (Inclusive of professional fees and disposables, except for pharmacy dispensed medication).	05.02		30.552	671.10 (588.70)
955	Home health care, per visit	04.00		10.000	219.70 (192.70)
960	Global fee for a terminally ill patient - By arrangement with medical scheme/patient	05.02		-	-

Hospices 2008

				57900					
	NATIONAL REFERENCE PRICE LIST IN RESPECT OF HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79" WITH EFFECT FROM 1 JANUARY 2008	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2004.00						
	GENERAL RULES							
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	2004.00						
	SCHEDULE							
10	HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"							
950	Ward fee, per day (inclusive of professional fees and disposables, except for pharmacy dispensed medication).	2005.02		550	30.552	1.0	R 671.10	
955	Home health care, per visit	2004.00		550	10.000	1.0	R 219.70	
960	Global fee for a terminally ill patient - By arrangement with medical scheme/patient	2005.02		550	-	0.0	R -	

Hospices 2008

Code	Description
57900	Hospices

Hospices 2008

Code	Description	RCF
550	Hospices	21.965

MEDICAL PRACTITIONERS

Medical Practitioners 2008

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2008

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

RULES GOVERNING THE STRUCTURE

A.	Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.	04.00
B.	Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 0173-0175, 0161-0164, 0166-0169)	06.04
C.	Comparable services: A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; (4) A description of the complexity of the symptoms and concurrent problems must be supplied; (5) Final diagnosis supported by the appropriate ICD-10 code(s); (6) Pertinent physical findings (size, location and number of lesions if applicable); (7) Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; (8) Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and (9) Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure	05.02
D.	Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be	04.00
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital	04.00
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself	04.00
G.	Post-operative care: (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions	04.00
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	04.00
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.	04.00
K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists	04.00
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged	04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion								04.00
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention								04.00
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme								04.00
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.								04.00
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)								06.05
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)								04.00
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.								04.00
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring								04.00
U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.								04.00
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods								04.00
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used								04.00
Z.	No fee is subject to more than one reduction								04.00
AA.	Procedures to exclude cost of isotope								04.00
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes								04.00
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp								04.00

STAATSKOERANT, 16 NOVEMBER 2007 No. 30410 621

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist								04.00
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.								04.00
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years								04.00
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").								04.00
XX.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic								04.00
YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)								04.00
MODIFIERS GOVERNING THE STRUCTURE									
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere								04.00
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms								06.05
0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d) Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee. e) "+" Means that this item is used in addition to another definitive procedure and is therefore not subject to reduction according to Modifier 0005 (see also Modifier 0082)								04.00
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0007	a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation - 15,00 clinical procedure units irrespective of the number of items of equipment provided. b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - 15,00 clinical procedure units irrespective of the number of items of equipment provided.	04.00		15.000	105.42 (92.47)	15.000	105.42 (92.47)		
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon								04.00
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units								04.00
0010	Local anaesthesic: (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. (b) The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.								04.00
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)								06.04
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged								04.00
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff								04.00
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions								04.00
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	05.06		7.500	85.12 (74.67)	7.500	85.12 (74.67)		
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists								04.00
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists								04.00
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable								04.00
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis								04.00
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	04.00		27.000	189.76 (166.46)	27.000	189.76 (166.46)		
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		

STAATSKOERANT, 16 NOVEMBER 2007 No. 30410 623

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	04.00		115.500	811.73 (712.04)	115.500	811.73 (712.04)		
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	04.00		32.000	224.90 (197.28)	32.000	224.90 (197.28)		
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot								04.00
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%								04.00
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed								04.00
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure								04.00
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts								04.00
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere								04.00
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee								04.00
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff)								04.00
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083								04.00
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope	04.00		45.000	316.26 (277.42)	45.000	316.26 (277.42)		
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins								04.00
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%								04.00
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.								04.00
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	04.00		21.000	147.59 (129.46)	21.000	147.59 (129.46)		
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)								04.00
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure								04.00
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)								04.00
0080	Multiple examinations: Full Fee								04.00
0081	Repeat examinations: No reduction								04.00
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used									04.00
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)									04.00
0085	Left Side' modifier to be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined									04.00
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations									04.00
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)									04.00
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)									04.00
0092	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)									04.00
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials									04.00
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope									04.00
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee									04.00
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units									04.00
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	04.00		6.000	40.19 (35.25)	6.000	40.19 (35.25)			
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%									04.00
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes									04.00
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region									04.00
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee									04.00
6103	Post-contrast study: Bone tumour: 100% of the fee									04.00
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable									04.00
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items									04.00
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability									04.00
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability									04.00
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"									04.00
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain									04.00
6110	MRI spectroscopy: 50% of fee									04.00
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)									04.00
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)									04.00
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure									04.00

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value								04.00
I.	**Consultative Services**								
I.a	**General Practitioner visits**								
I.b	**Specialists tiered consultation structure**								
I.b.1	**New and established patients: Consultations/visits by psychiatrists (22) only**								
Code	**Description**	**Ver**	**Add**	**Specialists**		**General Practitioners / non-designated Specialists**		**Anaesthesiology**	
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.02		15.000	203.00 (178.10)				
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.02		27.500	372.20 (326.50)				
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.02		40.000	541.40 (474.90)				
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	06.02		52.500	710.60 (623.30)				
0166	Psychiatry (22): First hospital consultation/visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes	06.06		15.000	203.00 (178.10)				
0167	Psychiatry (22): First hospital consultation/visit with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 21 and 35 minutes	06.06		27.500	372.20 (326.50)				
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes	06.06		40.000	541.40 (474.90)				
0169	Psychiatry (22): First hospital consultation/visit with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 46 and 60 minutes	06.06		52.500	710.60 (623.30)				
I.c	**General practitioner and specialist services**								
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02	
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02	

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology		
				RVU	Fee	RVU	Fee	RVU	Fee	
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure							06.02		
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02		
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02		
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)							06.02		
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)							06.04		
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists (may only be charged once per day) (not to be used with items 0109 or ICU items 1204-1214). For a healthy neonate please use item 0109 for a hospital follow-up visit							06.04		
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes							06.06	+	
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof							06.04	+	
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof							06.05	+	
0147	For an unscheduled emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof							06.05	+	
0148	For elective after-hours services on request of the patient or family (non emergency) (refer to general rule B): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0148. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the normal hours period as reflected in general rule B.							06.05	+	
0149	After-hours bona fide emergency consultation/visit (21:00-6:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0149. Note: The after-hour period applicable to this item is from Monday to Sunday 21:00-6:00							06.05		

Practice Type	0190	0191	0192	0173	0174	0175	0109	0111	0129	0145	0146	0147	0148	0149
Anaesthesiology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)								
Cardiology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								
Cardiothoracic Surgery	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								
Dermatology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)								
Gastroenterology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								
General Medical Practice	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	190.80 (167.40)	170.20 (149.30)		170.20 (149.30)	68.10 (59.70)	90.80 (79.60)	158.90 (139.40)	-	-
Medical Oncology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								
Medicine (Specialist Physician)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								
Neurology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)								

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Code	Description							Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
										RVU	Fee	RVU	Fee	RVU	Fee
Neurosurgery	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)									
Nuclear Medicine	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)									
Obstetrics and Gynaecology	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)	204.30 (179.20)									
Opthalmology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Orthopaedics	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Otorhinolaryngology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Paediatric Cardiology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)		255.40 (224.00)							
Paediatrics	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)		255.40 (224.00)							
Pathology (Anatomical)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Pathology (Clinical)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Physical Medicine	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)									
Plastic and Reconstructive Surgery	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Psychiatry							203.00 (178.10)			203.00 (178.10)	81.20 (71.20)	108.30 (95.00)	189.50 (166.20)	-	-
Pulmonology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)									
Radiation Oncology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Radiology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Rheumatology	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)	295.10 (258.90)									
Specialists							170.20 (149.30)			170.20 (149.30)	68.10 (59.70)	90.80 (79.60)	158.90 (139.40)	-	-
Surgery	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
Urology	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)	192.90 (169.20)									
I.e	**Pre-anaesthetic assessment**														
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes							06.04				16.000	181.60 (159.30)	16.000	181.60 (159.30)

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes	06.04				16.000	181.60 (159.30)	16.000	181.60 (159.30)
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes	06.04				16.000	181.60 (159.30)	16.000	181.60 (159.30)
I.f	**Prenatal visits and new born attendance**								
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107)	06.02		33.000	374.50 (328.50)	33.000	374.50 (328.50)		
	Item 0107 can be used once only for given confinement	04.00							
0113	New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113)	06.02		45.000	510.70 (448.00)	45.000	510.70 (448.00)		
I.g	**Consultative services: Miscellaneous**								
0130	Telephone consultation (all hours)							04.00	
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) ("Consultation" via SMS or electronic media included)							04.00	
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent							04.00	
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent							04.00	

Practice Type	0130	0132	0133	0199
Anaesthesiology	136.20 (119.50)			
Cardiology	204.30 (179.20)			
Cardiothoracic Surgery	192.90 (169.20)			
Dermatology	136.20 (119.50)			
Gastroenterology	204.30 (179.20)			
General Medical Practice	136.20 (119.50)	56.70 (49.70)	102.10 (89.60)	243.20 (213.30)
Medical Oncology	204.30 (179.20)			
Medicine (Specialist Physician)	204.30 (179.20)			
Neurology	204.30 (179.20)			
Neurosurgery	204.30 (179.20)			
Nuclear Medicine	204.30 (179.20)			
Obstetrics and Gynaecology	136.20 (119.50)			
Opthalmology	136.20 (119.50)			
Orthopaedics	136.20 (119.50)			
Otorhinolaryngology	136.20 (119.50)			
Paediatric Cardiology	204.30 (179.20)			
Paediatrics	204.30 (179.20)			
Pathology (Anatomical)	136.20 (119.50)			
Pathology (Clinical)	136.20 (119.50)			
Physical Medicine	204.30 (179.20)			
Plastic and Reconstructive Surgery	136.20 (119.50)			
Psychiatry	162.40 (142.50)	67.70 (59.40)	135.40 (118.80)	

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
Pulmonology	204.30 (179.20)								
Radiation Oncology	136.20 (119.50)								
Radiology	136.20 (119.50)								
Rheumatology	204.30 (179.20)								
Specialists	56.70 (49.70)				102.10 (89.60)				243.20 (213.30)
Surgery	136.20 (119.50)								
Urology	136.20 (119.50)								
II.	**Medicine, material, supplies and use of own equipment**								
II.a	**Medicine codes**								
II.a.1	**Dispensing of medicine by licensed dispensing medical practitioners**								
0197	Licenced dispensing medical practitioners: Dispensing cost - R16.00 for medicine with a cost of R100,00 or more (VAT inclusive), or 16% for medicine costing less than R100,00 (VAT inclusive). Add to each Nappi code to provide for the dispensing cost.	06.02							
II.a.2	**Once-off administration of medicine used during a consultation**								
0198	Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS R16,00 for medicine with a cost of R100,00 or more, or 16% for medicine costing less than R100,00 PLUS VAT on the 16%/R16,00. (Where applicable, VAT should be added to the 16%/R 16,00 only and not to the SEP, since the SEP is VAT inclusive). [According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.	06.02							
II.a.3	**Cost of chemotherapy drugs**								
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.	06.02							
II.b	**Material codes**								
II.b.1	**Prosthesis and/or internal fixation**								
0200	Prosthesis and/or internal fixation: This item provides for a charge for prosthesis and/or internal fixation. Charge for prosthesis and/or internal fixation at cost price PLUS 26% (up to a maximum of R 26,00). (Where applicable, VAT should be added to the above). The appropriate Nappi code(s), where applicable, for the prosthesis and/or internal fixation used, must be provided.	06.02							
II.b.2	**Material used during a consultation**								
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.	06.02							
II.c	**Setting of sterile tray**								
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate	05.06		10.000	70.30 (61.70)	10.000	70.30 (61.70)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
II.d	**Own equipment used in treatment**								
5930	Surgical laser apparatus: Hire fee for own equipment	04.00		109.000	766.10 (672.00)	109.000	766.10 (672.00)		
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)	04.00							
III.	**PROCEDURES**								
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999	05.03							
GENERAL MODIFIERS GOVERNING THIS SECTION									
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)								06.04
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged								04.00
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff								04.00
MODIFIERS GOVERNING SECTION 1									
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions								04.00
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	05.06		7.500	85.12 (74.67)	7.500	85.12 (74.67)		
1	**General**								
1.1	**Injections, Infusions and Inhalation Sedation Treatment**								
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0204	Inhalation sedation: Per additional quarter-hour or part thereof	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
0209	Umbilical artery cannulation at birth	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)		
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	04.00		3.250	22.80 (20.00)	3.250	22.80 (20.00)		
0211	Exchange transfusion: First and subsequent (including after-care)	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)	04.00							
1.2	**Chemotherapy treatment (not in chemotherapy facilities)**								
0213	Treatment with cytostatic agents: Administering of Chemotherapy: Intramuscular or subcutaneous: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
0214	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous bolus technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
0215	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous infusion technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)		
1.3	**Oncology related services in non-oncology facilties**								
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included	06.06		394.860	2775.10 (2434.30) Z	315.890	2220.10 (1947.50) Z		
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included	06.02		262.410	1844.20 (1617.70) Z	209.930	1475.40 (1294.20) Z		
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included	06.02		77.810	546.80 (479.60) Z	77.810	546.80 (479.60) Z		
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)	06.02		42.650	299.70 (262.90) Z	42.650	299.70 (262.90) Z		
MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS									
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.								06.06
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see Modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448								06.04
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.								06.05
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.								06.05
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.								06.05
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units								06.04
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute								06.06

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic								06.04
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute								06.06
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time								06.04
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added								06.04
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.								06.05
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added								06.04
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).								06.05
0036	Anaesthetic administered by general practitioners: The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time [refer to modifier 0023] plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.								06.05
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	06.04						3.000	132.33 (116.08)
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage								06.04
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof								06.04
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units								06.04
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	06.04						3.000	132.33 (116.08)
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	06.04						3.000	132.33 (116.08)
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added	06.04						3.000	132.33 (116.08)
0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to Modifier 0043: Cases under one year of age	06.04						3.000	132.33 (116.08)
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.								06.06
	Modifiers 5441 to 5448 Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items)								06.04
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	06.04						1.000	44.11 (38.69)
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units	06.04						2.000	88.22 (77.39)
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	06.04						3.000	132.33 (116.08)
5444	Shaft of femur: Add four (4,00) anaesthetic units	06.04						4.000	176.44 (154.77)

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	06.04						5.000	220.55 (193.46)
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	06.04						8.000	352.88 (309.54)
POST-OPERATIVE ALLEVIATION OF PAIN									
0045	Post-operative alleviation of pain: (a) When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique (b) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (c) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)								06.04
2	**Integumentary System**								
2.1	**Allergy**								
0217	Allergy: Patch tests: First patch	04.00		4.000	28.10 (24.60)	4.000	28.10 (24.60)		
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	04.00		2.800	19.70 (17.30)	2.800	19.70 (17.30)		
0219	Allergy: Patch tests: Each additional patch	04.00		2.000	14.10 (12.40)	2.000	14.10 (12.40)		
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	04.00		1.900	13.40 (11.80)	1.900	13.40 (11.80)		
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	04.00		2.800	19.70 (17.30)	2.800	19.70 (17.30)		
2.2	**Skin (general)**								
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	04.00		4.000	28.10 (24.60)	4.000	28.10 (24.60)		
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
0225	Epilation: Per session	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)	4.000	176.40 (154.70) T
0228	PUVA Treatment: Maximum of 21 treatments	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
0229	PUVA: Follow-up or maintenance therapy once a week	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
0230	UVR-Treatment	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
0231	UVR-Follow-up - for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp	04.00		5.500	38.70 (33.90)	5.500	38.70 (33.90)		
0233	Biopsy without suturing: First lesion	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)	3.000	132.30 (116.10) T
0234	Biopsy without suturing: Subsequent lesions (each)	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)	3.000	132.30 (116.10) T
0235	Biopsy without suturing: Maximum for multiple additional lesions	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)	3.000	132.30 (116.10) T
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)	3.000	132.30 (116.10) T
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)	3.000	132.30 (116.10) T
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	3.000	132.30 (116.10) T
0244	Repair of nail bed	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10) T
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10) T
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10) T
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	04.00		87.000	611.40 (536.30)	87.000	611.40 (536.30)	3.000	132.30 (116.10) T
0259	Removal of foreign body superficial to deep fascia (except hands)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
0261	Removal of foreign body deep to deep fascia (except hands)	04.00		31.000	217.90 (191.10)	31.000	217.90 (191.10)	3.000	132.30 (116.10) T
0271	Kurtin planing for acne scarring: Whole face	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0273	Kurtin planing for acne scarring: Extensive	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	4.000	176.40 (154.70) T
0275	Kurtin planing for acne scarring: Limited	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	4.000	176.40 (154.70) T
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	04.00		103.000	723.90 (635.00)	103.000	723.90 (635.00)	4.000	176.40 (154.70) T
0279	Surgical treatment for axillary hyperhidrosis	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	4.000	176.40 (154.70) T
0280	Laser treatment for small skin lesions: First lesion	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10) T
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	04.00		56.000	393.60 (345.30)	56.000	393.60 (345.30)	3.000	132.30 (116.10) T
0283	Laser treatment for large skin lesions: Limited area	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	4.000	176.40 (154.70) T
0284	Laser treatment for large skin lesions: Extensive area	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	4.000	176.40 (154.70) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	04.00		56.630	398.00 (349.10) Z	56.630	398.00 (349.10) Z		
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	04.00		43.440	305.30 (267.80) Z	43.440	305.30 (267.80) Z		
2.3	**Major plastic repair**								
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	04.00		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70) T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	04.00		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	4.000	176.40 (154.70) T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	04.00		800.000	5622.40 (4931.90)	640.000	4497.90 (3945.50)	4.000	176.40 (154.70) T
0292	Distant flaps: First stage	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0293	Contour grafts (excluding cost of material)	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	04.11		1200.000	8433.60 (7397.90)	960.000	6746.90 (5918.30)	6.000	264.70 (232.20) T
0295	Local skin flaps (large, complicated)	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0296	Other procedures of major technical nature	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
0297	Subsequent major procedures for repair of same lesion	04.00		104.000	730.90 (641.10)	104.000	730.90 (641.10)	4.000	176.40 (154.70) T
0298	Lower abdominal dermo-lipectomy	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	5.000	220.60 (193.50) T
0299	Major abdominal lipectomy with repositioning of umbilicus	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50) T
2.4	**Lacerations, scars, tumours, cysts and other skin lesions**								
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10) T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	4.000	176.40 (154.70) T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
0304	Major debridement of wound, sloughectomy or secondary suture	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) T
0305	Needle biopsy - soft tissue	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10) T
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0308	Each additional small procedure done at the same time	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
0310	Radical excision of nailbed	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10) T
0311	Excision of large benign tumour (more than 5 cm)	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)	3.000	132.30 (116.10) T
0313	Extensive resection for malignant soft tissue tumour including muscle	04.00		283.900	1995.20 (1750.20)	227.120	1596.20 (1400.20)	4.000	176.40 (154.70) T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	04.00		104.000	730.90 (641.10)	104.000	730.90 (641.10)	4.000	176.40 (154.70) T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)	3.000	132.30 (116.10) T
2.6	**Breasts**								
0316	Fine needle aspiration for soft tissue (all areas)	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
0317	Aspiration of cyst or tumour	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	3.000	132.30 (116.10) T
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	04.00		94.200	662.00 (580.70)	94.200	662.00 (580.70)	3.000	132.30 (116.10) T
0323	Subareolar cone excision of ducts of wedge excision of breast	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) T
0324	Wedge excision of breast and axillary dissection	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	5.000	220.60 (193.50) T
0325	Total mastectomy	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	5.000	220.60 (193.50) T
0327	Total mastectomy with axillary gland biopsy	04.00		185.000	1300.20 (1140.50)	148.000	1040.10 (912.40)	5.000	220.60 (193.50) T
0329	Total mastectomy with axillary gland dissection	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50) T
0330	Nipple and areola reconstruction	04.00		95.000	667.70 (585.70)	95.000	667.70 (585.70)	4.000	176.40 (154.70) T
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	04.00		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70) T
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	04.00		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	4.000	176.40 (154.70) T
0334	Removal of breast implant by means of capsulectomy: Per breast	04.00		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	4.000	176.40 (154.70) T
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	04.00		234.000	1644.60 (1442.60)	187.200	1315.60 (1154.00)	5.000	220.60 (193.50) T
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	04.00		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	5.000	220.60 (193.50) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0341	Gynaecomastia: Unilateral	04.00		92.000	646.60 (567.20)	92.000	646.60 (567.20)	3.000	132.30 (116.10) T
0343	Gynaecomastia: Bilateral	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	3.000	132.30 (116.10) T
2.6	**Burns**								
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	04.00		276.000	1939.70 (1701.50)	220.800	1551.80 (1361.20)	5.000	220.60 (193.50) T
0353	Tangential excision and grafting: Small	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	5.000	220.60 (193.50) T
0354	Tangential excision and grafting: Large	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	5.000	220.60 (193.50) T
2.7	**Hands (skin)**								
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	04.00		147.400	1035.90 (908.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
0357	Small skin graft in acute hand injury	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
0361	Z-plasty	04.00		220.100	1546.90 (1356.90)	176.080	1237.50 (1085.50)	3.000	132.30 (116.10) T
0363	Local flap and skin graft	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0365	Cross finger flap (all stages)	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
0367	Palmar flap (all stages)	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
0369	Distant flap: First stage	04.00		158.000	1110.40 (974.00)	126.400	888.30 (779.20)	3.000	132.30 (116.10) T
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) T
0373	Transfer neurovascular island flap	04.00		230.500	1620.00 (1421.10)	184.400	1296.00 (1136.80)	3.000	132.30 (116.10) T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	04.00		242.400	1703.60 (1494.40)	193.920	1362.90 (1195.50)	3.000	132.30 (116.10) T
0375	Dupuytren's contracture: Fasciotomy	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) T
0376	Dupuytren's contracture: Fasciectomy	04.00		218.000	1532.10 (1343.90)	174.400	1225.70 (1075.20)	3.000	132.30 (116.10) T
2.8	**Acupuncture**								
	Please note: General Rule M not applicable to section 2.8 of this price list								04.00
0377	Standard acupuncture	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
0378	Laser acupuncture using more than 6 points	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)		
0379	Electro-acupuncture	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)		
0380	Scalp acupuncture	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0381	Micro-acupuncture (ear, hand)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
RULES GOVERNING THE SECTION ACUPUNCTURE									
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp								04.00
3	**Musculo-skeletal System**								
MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS									
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis								04.00
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	04.00		27.000	189.76 (166.46)	27.000	189.76 (166.46)		
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	04.00		115.500	811.73 (712.04)	115.500	811.73 (712.04)		
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	04.00		32.000	224.90 (197.28)	32.000	224.90 (197.28)		
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	04.11		77.000	541.16 (474.70)	77.000	541.16 (474.70)		
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot								04.00
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%								04.00
3.1	**Bones**								
3.1.1	**Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)**								
0383	Fracture (reduction under general anaesthetic): Scapula	04.00		-	- v	-	- v	3.000	132.30 (116.10) TM
0387	Fracture (reduction under general anaesthetic): Clavicle	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	04.00		175.700	1234.80 (1083.20)	140.560	987.90 (866.60)	3.000	132.30 (116.10) TM
0389	Fracture (reduction under general anaesthetic): Humerus	04.00		111.600	784.30 (688.00)	111.600	784.30 (688.00)	3.000	132.30 (116.10) TM
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	3.000	132.30 (116.10) TM
0402	Fracture (reduction under general anaesthetic): Carpal bone	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) TM

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				RVU	Fee	RVU	Fee	RVU	Fee
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	04.00		118.300	831.40 (729.30)	118.300	831.40 (729.30)	3.000	132.30 (116.10) TM
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) TM
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	04.00		52.000	365.50 (320.60)	52.000	365.50 (320.60)	3.000	132.30 (116.10) TM
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	04.00		48.000	337.30 (295.90)	48.000	337.30 (295.90)	3.000	132.30 (116.10) T
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	04.00		102.000	716.90 (628.90)	102.000	716.90 (628.90)	3.000	132.30 (116.10) TM
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) T
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	04.00		237.000	1665.60 (1461.10)	189.600	1332.50 (1168.90)	3.000	132.30 (116.10) TM
0425	Fracture (reduction under general anaesthetic): Patella	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0433	Fracture (reduction under general anaesthetic): Fibula shaft	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) TM
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)	3.000	132.30 (116.10) TM
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	04.00		198.700	1396.50 (1225.00)	158.960	1117.20 (980.00)	3.000	132.30 (116.10) TM
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) TM
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	04.00		403.500	2835.80 (2487.50)	322.500	2266.50 (1988.20)	3.000	132.30 (116.10) TM
0441	Fracture (reduction under general anaesthetic): Metatarsal	04.00		41.800	293.80 (257.70)	41.800	293.80 (257.70)	3.000	132.30 (116.10) TM
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal Simple	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) T
0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	3.000	132.30 (116.10) TM
0447	Fracture (reduction under general anaesthetic): Other: Simple	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)	3.000	132.30 (116.10) T
0449	Fracture (reduction under general anaesthetic): Other: Compound	04.00		52.000	365.50 (320.60)	52.000	365.50 (320.60)	3.000	132.30 (116.10) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) T
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	04.00		230.000	1616.40 (1417.90)	184.000	1293.20 (1134.40)	3.000	132.30 (116.10) TM
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) TM
0456	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Rest	04.00		-	- ß	-	- ß	3.000	132.30 (116.10) TM
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical	04.00		-	- v	-	- v	3.000	132.30 (116.10) TM
0462	Fracture (reduction under general anaesthetic): Compression fracture: Rest	04.00		-	- v	-	- v	3.000	132.30 (116.10) TM
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical	04.00		-	- v	-	- v	3.000	132.30 (116.10) TM
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest	04.00		-	- v	-	- v	3.000	132.30 (116.10) TM
3.1.1.1	**Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047): Operations for fractures**								
0465	Fractures involving large joints (includes the item for the relative bone) (this item may not be used as a modifier)	04.00		288.000	2024.10 (1775.50)	230.400	1619.30 (1420.40)	3.000	132.30 (116.10) TM
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	04.00		43.000	302.20 (265.10)	43.000	302.20 (265.10)	3.000	132.30 (116.10) T
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	3.000	132.30 (116.10) TM
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	04.00		154.000	1082.30 (949.40)	123.200	865.80 (759.50)	3.000	132.30 (116.10) TM
3.1.2	**Bony operations**								
3.1.2.1	**Bony operations: Bone grafting**								
0497	Resection of bone or tumour with or without grafting (benign)	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	3.000	132.30 (116.10) TM
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits	04.00		340.000	2389.50 (2096.10)	272.000	1911.60 (1676.80)	3.000	132.30 (116.10) TM
0499	Grafts to cysts: Large bones	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) TM
0501	Grafts to cysts: Small bones	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0503	Grafts to cysts: Cartilage graft	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	3.000	132.30 (116.10) TM
0505	Grafts to cysts: Inter-metacarpal bone graft	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) TM
3.1.2.2	**Bony operations: Acute or chronic osteomyelitis**								
0509	Acute or chronic osteomyelitis: Conservative treatment	04.00		-	- v	-	- v		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care	04.00							
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including six weeks after-care	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
3.1.2.3	**Bony operations: Osteotomy**								
0514	Osteotomy: Sternum: Repair of pectus excavatum	04.00		330.000	2319.20 (2034.40)	264.000	1855.40 (1627.50)	3.000	132.30 (116.10) TM
0515	Osteotomy: Sternum: Repair of pectus carinatum	04.00		330.000	2319.20 (2034.40)	264.000	1855.40 (1627.50)	3.000	132.30 (116.10) TM
0516	Osteotomy: Pelvic	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0521	Osteotomy: Femoral: Proximal	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0527	Osteotomy: Knee region	04.11		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0528	Osteotomy: Os Calcis (Dwyer operation)	04.00		115.000	808.20 (708.90)	115.000	808.20 (708.90)	3.000	132.30 (116.10) TM
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0531	Rotational osteotomy of tibia and fibula - stand alone procedure	04.00		278.900	1960.10 (1719.40)	223.120	1568.10 (1375.50)	3.000	132.30 (116.10) TM
0532	Osteotomy: Rotation osteotomy of the Radius, Ulna or Humerus	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0533	Osteotomy: Single metatarsal	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) TM
0534	Osteotomy: Multiple metatarsal osteotomies	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
3.1.2.4	**Bony operations: Exostosis**								
0535	Exostosis: Excision: Readily accessible sites	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) TM
0537	Exostosis: Excision: Less accessible sites	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
3.1.2.5	**Bony operations: Biopsy**								
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	4.000	176.40 (154.70) T
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)		
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3.2	**Joints**								
3.2.1	**Joints: Dislocations**								
0547	Joint: Dislocation: Clavicle either end	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10) TM
0549	Joint: Dislocation: Shoulder	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0551	Joint: Dislocation: Elbow	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0552	Joint: Dislocation: Wrist	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation	04.00		130.000	913.60 (801.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0555	Joint: Dislocation: Lunate	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0556	Joint: Dislocation: Carpo-metacarpo dislocation	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)	3.000	132.30 (116.10) TM
0559	Joint: Dislocation: Hip	04.00		109.000	766.10 (672.00)	109.000	766.10 (672.00)	3.000	132.30 (116.10) TM
0561	Joint: Dislocation: Knee	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
0563	Joint: Dislocation: Patella	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	3.000	132.30 (116.10) TM
0565	Joint: Dislocation: Ankle	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) TM
0567	Joint: Dislocation: Sub-Talar dislocation	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) TM
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) TM
0573	Joint: Dislocation: Spine with or without paralysis	04.00		-	- v	-	- v		
3.2.2	**Joints: Operations for dislocations**								
0578	Operations for dislocations: Recurrent dislocation of shoulder	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	3.000	132.30 (116.10) TM
0579	Operations for dislocations: Recurrent dislocation of all other joints	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	3.000	132.30 (116.10) TM
3.2.3	**Joints: Capsular operations**								
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) TM
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0585	Capsulectomy digital joint	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) TM
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) TM
0587	Release of digital joint contracture	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
3.2.4	**Joints: Synovectomy**								
0589	Synovectomy: Digital joint	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) TM
0592	Synovectomy: Large joint	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0593	Tendon synovectomy	04.00		203.700	1431.60 (1255.80)	162.960	1145.30 (1004.60)	3.000	132.30 (116.10) TM
3.2.5	**Joints: Arthrodesis**								
0597	Arthrodesis: Shoulder	04.00		224.000	1574.30 (1381.00)	179.200	1259.40 (1104.70)	3.000	132.30 (116.10) TM
0598	Arthrodesis: Elbow	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
0599	Arthrodesis: Wrist	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
0600	Arthrodesis: Digital joint	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0601	Arthrodesis: Hip	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0602	Arthrodesis: Knee	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
0603	Arthrodesis: Ankle	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
0604	Arthrodesis: Sub-talar	04.00		130.000	913.60 (801.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
0607	Arthrodesis: Mid-tarsal wedge resection	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	3.000	132.30 (116.10) TM
3.2.6	**Joints: Arthroplasty**								
0614	Arthroplasty: Debridement large joints	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0615	Arthroplasty: Excision medial or lateral end of clavicle	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	3.000	132.30 (116.10) TM
0617	Shoulder: Acromioplasty	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) TM
0619	Shoulder: Partial replacement	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	5.000	220.60 (193.50) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0620	Shoulder: Total replacement	04.00		416.000	2923.60 (2564.60)	332.800	2338.90 (2051.70)	5.000	220.60 (193.50) TM
0621	Elbow: Excision head of radius	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
0622	Elbow: Excision	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) TM
0623	Elbow: Partial replacement	04.00		188.000	1321.30 (1159.00)	150.400	1057.00 (927.20)	3.000	132.30 (116.10) TM
0624	Elbow: Total replacement	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	3.000	132.30 (116.10) TM
0625	Wrist: Excision distal end of ulna	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
0626	Wrist: Excision single bone	04.00		110.000	773.10 (678.20)	110.000	773.10 (678.20)	3.000	132.30 (116.10) TM
0627	Wrist: Excision proximal row	04.00		166.000	1166.60 (1023.30)	132.800	933.30 (818.70)	3.000	132.30 (116.10) TM
0631	Wrist: Total replacement	04.00		249.000	1750.00 (1535.10)	199.200	1400.00 (1228.10)	3.000	132.30 (116.10) TM
0635	Digital Joint: Total replacement	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) TM
0637	Hip: Total replacement	04.00		416.000	2923.60 (2564.60)	332.800	2338.90 (2051.70)	3.000	132.30 (116.10) TM
0641	Hip: Prosthetic replacement of femoral head	04.00		288.000	2024.10 (1775.50)	230.400	1619.30 (1420.40)	3.000	132.30 (116.10) TM
0643	Hip: Girdlestone	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
0645	Knee: Partial replacement	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	3.000	132.30 (116.10) TM
0646	Knee: Total replacement	04.00		416.000	2923.60 (2564.60)	332.800	2338.90 (2051.70)	3.000	132.30 (116.10) TM
0649	Ankle: Total replacement	04.00		290.400	2040.90 (1790.30)	232.320	1632.70 (1432.20)	3.000	132.30 (116.10) TM
0650	Ankle: Astragalectomy	04.00		154.000	1082.30 (949.40)	123.200	865.80 (759.50)	3.000	132.30 (116.10) TM
3.2.7	**Joints: Miscellaneous (joints)**								
0661	Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint	04.00		7.500	52.70 (46.20)	7.500	52.70 (46.20)	3.000	132.30 (116.10) T
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	04.00		4.000	28.10 (24.60)	4.000	28.10 (24.60)	3.000	132.30 (116.10) T
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) T
0669	Manipulation large joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0669a	Manipulation large joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	05.01		14.000	98.40 (86.30)	14.000	98.40 (86.30)	4.000	176.40 (154.70) T
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic	06.04		-	- F	-	- F	3.000	132.30 (116.10) T
0670a	The consultation fee only should be charged when manipulation of a large joint is performed with or without local anaesthetic	05.01		-	- F	-	- F	4.000	176.40 (154.70) T
0673	Meniscectomy or operation for other internal derangement of knee	04.00		109.000	766.10 (672.00)	109.000	766.10 (672.00)	3.000	132.30 (116.10) TM
3.2.8	**Joints: Joint ligament reconstruction or suture**								
0675	Joint ligament reconstruction or suture: Ankle: Collateral	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0677	Joint ligament reconstruction or suture: Knee: Collateral	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0678	Joint ligament reconstruction or suture: Knee: Cruciate	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	3.000	132.30 (116.10) TM
0680	Joint ligament reconstruction or suture: Digital joint ligament	04.00		165.000	1159.60 (1017.20)	132.000	927.70 (813.80)	3.000	132.30 (116.10) TM
3.3	**Amputations**								
3.3.1	**Amputations: Specific Amputations**								
0682	Amputation: Fore-quarter amputation	04.00		294.000	2066.20 (1812.50)	235.200	1653.00 (1450.00)	9.000	397.00 (348.20) TM
0683	Amputation: Through shoulder	04.00		148.000	1040.10 (912.40)	120.000	843.40 (739.80)	5.000	220.60 (193.50) TM
0685	Amputation: Upper arm or fore-arm	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	3.000	132.30 (116.10) TM
0687	Partial amputation of the hand: One ray	04.00		102.000	716.90 (628.90)	102.000	716.90 (628.90)	3.000	132.30 (116.10) TM
0691	Amputation: Whole or part of finger	06.04		116.800	820.90 (720.10)	116.800	820.90 (720.10)	3.000	132.30 (116.10) TM
0693	Hindquarter amputation	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	6.000	264.70 (232.20) TM
0695	Amputation: Through hip joint region	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	6.000	264.70 (232.20) TM
0697	Amputation: Through thigh	04.00		205.000	1440.70 (1263.80)	164.000	1152.60 (1011.10)	6.000	264.70 (232.20) TM
0699	Amputation: Below knee, through knee or Syme	04.00		194.000	1363.40 (1196.00)	155.200	1090.70 (956.80)	5.000	220.60 (193.50) TM
0701	Amputation: Trans-metatarsal or trans-tarsal	04.00		142.000	998.00 (875.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0703	Amputation: Foot: One ray	04.00		97.000	681.70 (598.00)	97.000	681.70 (598.00)	3.000	132.30 (116.10) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0705	Amputation: Toe	04.00		66.000	463.80 (406.80)	66.000	463.80 (406.80)	3.000	132.30 (116.10) TM
3.3.2	**Amputations: Post-amputation reconstruction**								
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	3.000	132.30 (116.10) TM
0707	Post-amputation reconstruction: Krukenberg reconstruction	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	3.000	132.30 (116.10) TM
0709	Post-amputation reconstruction: Metacarpal transfer	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) TM
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	3.000	132.30 (116.10) TM
0712	Post-amputation reconstruction: Toe to thumb transfer	04.00		800.000	5622.40 (4931.90)	640.000	4497.90 (3945.50)	3.000	132.30 (116.10) TM
3.4	**Muscles, tendons and fasciae**								
3.4.1	**Muscles, tendons and fasciae: Investigations**								
0713	Electromyography	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	3.000	132.30 (116.10) T
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)	06.04		57.000	400.60 (351.40)	57.000	400.60 (351.40)	3.000	132.30 (116.10) T
0715	Strength duration curve per session	04.00		10.500	73.80 (64.70)	10.500	73.80 (64.70)	3.000	132.30 (116.10) T
0717	Electrical examination of single nerve or muscle	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
0718	Oxidative study for mitochondrial function	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)		
0721	Voltage integration during isometric contraction	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	3.000	132.30 (116.10) T
0723	Tonometry with edrophonium	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)	3.000	132.30 (116.10) T
0725	Isometric tension studies with edrophonium	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)	3.000	132.30 (116.10) T
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
0729	Tendon reflex time	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10) T
0730	Limb brain somatosensory studies (per limb)	04.00		49.000	344.40 (302.10)	49.000	344.40 (302.10)		
0731	Vision and audio-sensory studies	04.00		49.000	344.40 (302.10)	49.000	344.40 (302.10)		
0733	Motor nerve conduction studies (single nerve)	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)		
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)		
1240	Signal averaged electrocardiogram	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)		
1241	X-ray Screening: Chest	04.00		4.000	28.10 (24.60)	4.000	28.10 (24.60)		
1242	X-ray screening: Prosthetic valves	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
1243	Two week event triggered ambulatory ECG monitoring: Hire fee	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)		
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)		
1245	Angiography cerebral: First two series	04.00		34.300	241.10 (211.50)	34.300	241.10 (211.50)	4.000	176.40 (154.70) T
1246	Angiography peripheral: Per limb	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	4.000	176.40 (154.70) T
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	6.000	264.70 (232.20) T
1248	Paracentesis of pericardium	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	9.000	397.00 (348.20) T
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)		
MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER									
0073	When item 1286 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%								04.00
6.2	**Invasive Cardiology**								
6.2.1	**Invasive cardiology: Cardiac catheterisation**								
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	04.00		140.000	983.90 (863.10)			9.000	397.00 (348.20) T
1250	Endomyocardial biopsy	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	9.000	397.00 (348.20) T
1251	Transeptal puncture	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	9.000	397.00 (348.20) T
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	04.00		140.000	983.90 (863.10)			9.000	397.00 (348.20) T
1253	Right heart catheterisation (with or without biopsy)	04.00		70.000	492.00 (431.60)			9.000	397.00 (348.20) T
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	9.000	397.00 (348.20) T
1255	Tilt test	04.00		31.300	220.00 (193.00)	31.300	220.00 (193.00)		
6.2.2	**Invasive cardiology: Electrophysiological study**								
1256	Ventricular stimulation study	04.00		160.000	1124.50 (986.40)			9.000	397.00 (348.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1257	Full electrophysiological study	04.00		300.000	2108.40 (1849.50)			9.000	397.00 (348.20) T
6.2.3	**Invasive cardiology: Pacemakers**								
1258	Pacemaker: Permanent - single chamber	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	9.000	397.00 (348.20) T
1259	Pacemaker: Permanent - dual chamber	04.00		230.000	1616.40 (1417.90)	184.000	1293.20 (1134.40)	9.000	397.00 (348.20) T
1260	AV nodal ablation	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	9.000	397.00 (348.20) T
1261	Accessory pathway ablation	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	9.000	397.00 (348.20) T
1262	Electrophysiological mapping	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)		
1263	Insertion transvenous implantable defibrillator	04.00		212.000	1489.90 (1306.90)	169.600	1191.90 (1045.50)	15.000	661.70 (580.40) T
1264	Test for implantable transvenous defibrillator	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	15.000	661.70 (580.40) T
1265	Renewal of pacemaker unit only, team fee	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	9.000	397.00 (348.20) T
1266	Resiting pacemaker generator	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)		
1267	Repositioning of catheter electrode	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	9.000	397.00 (348.20) T
1268	Threshold testing: Own equipment	04.00		15.000	105.40 (92.50)				
1269	Threshold testing: Hospital equipment	04.00		11.000	77.30 (67.80)				
1270	Programming of atrio-ventricular sequential pacemaker	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)		
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	9.000	397.00 (348.20) T
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	9.000	397.00 (348.20) T
6.2.4	**Invasive cardiology: Percutaneous translumical angioplasty**								
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	04.00		260.000	1827.30 (1602.90)	208.000	1461.80 (1282.30)	13.000	573.40 (503.00) T
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	13.000	573.40 (503.00) T
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	13.000	573.40 (503.00) T
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	13.000	573.40 (503.00) T
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	13.000	573.40 (503.00) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	13.000	573.40 (503.00) T
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty	04.00		260.000	1827.30 (1602.90)	208.000	1461.80 (1282.30)	15.000	661.70 (580.40) T
1283	Use of balloon procedure as in item 1282: Second cardiologist	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	15.000	661.70 (580.40) T
1284	Atherectomy: Single lesion: First cardiologist	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)		
1285	Atherectomy: Single lesion: Second cardiologist	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)		
1286	Insertion of intravascular stent: First cardiologist	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)		
1287	Insertion of intravascular stent: Second cardiologist	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)		
1290	Use of balloon procedures including: First paediatric cardiologist (33): Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty; Closure atrial septal defect; Closure of patient ductus arteriosus	04.00		300.000	2108.40 (1849.50)			15.000	661.70 (580.40) T
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)	04.00		160.000	1124.50 (986.40)			15.000	661.70 (580.40) T
6.2.5	**Invasive cardiology: Paediatric cardiac catheterisation**								
1288	Cardiac catheterisation for congenital heart disease: All ages above 1 year old	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	12.000	529.30 (464.30) T
1289	Paediatric cardiac catheterisation: Infants below the age of one year	04.00		263.000	1848.40 (1621.40)	210.400	1478.70 (1297.10)	12.000	529.30 (464.30) T
6.3	**Cardiac surgery**								
1294	Patent ductus arteriosus	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	13.000	573.40 (503.00) T
1295	Pericardiectomy for constrictive pericarditis	04.00		400.000	2811.20 (2466.00)	320.000	2249.00 (1972.80)	15.000	661.70 (580.40) T
1297	Coarctation of aorta	04.00		425.000	2986.90 (2620.10)	340.000	2389.50 (2096.10)	15.000	661.70 (580.40) T
1299	Systemo-pulmonary anastomosis	04.00		425.000	2986.90 (2620.10)	340.000	2389.50 (2096.10)	15.000	661.70 (580.40) T
1301	Mitral valvotomy: Closed heart technique	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	15.000	661.70 (580.40) T
1302	Heart transplant	04.00		875.000	6149.50 (5394.30)	700.000	4919.60 (4315.40)	15.000	661.70 (580.40) T
1303	Harvesting donor heart	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	5.000	220.60 (193.50) T
1305	Operative implantation of cardiac pacemaker by thoracotomy	04.00		220.000	1546.20 (1356.30)	176.000	1236.90 (1085.00)	15.000	661.70 (580.40) T
1307	Re-exploration after cardiac surgery	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	15.000	661.70 (580.40) T
1308	Heart and lung transplant	04.00		1000.000	7028.00 (6164.90)	800.000	5622.40 (4931.90)	15.000	661.70 (580.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1309	Harvesting donor heart and lungs	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1311	Pericardial drainage	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	13.000	573.40 (503.00) T
6.3.1	**Cardiac surgery: Open heart surgery**								
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	04.00		25.000	175.70 (154.10)				
1320	Repeat open heart surgery (additional fee above procedure fee)	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	15.000	661.70 (580.40) T
1321	Stand-by fee for coronary angioplasty	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour	04.00		20.000	140.60 (123.30)				
6.3.1.1	**Cardiac surgery: Open heart surgery: Congenital conditions**								
1323	Atrial septal defect: Osteum secundum	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	15.000	661.70 (580.40) T
1325	Atrial septal defect: Sinus venosus or osteum primum	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1327	Atrial septal defect: Ventricular septal defect	04.00		603.800	4243.50 (3722.40)	483.040	3394.80 (2977.90)	15.000	661.70 (580.40) T
1329	Atrial septal defect: Fallot's tetralogy	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1330	Atrial septal defect: Pulmonary stenosis	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	15.000	661.70 (580.40) T
1331	Transposition of large vessels (venous repair)	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1332	Transposition of great arteries (arterial repair)	04.00		750.000	5271.00 (4623.70)	600.000	4216.80 (3698.90)	15.000	661.70 (580.40) T
1333	Ebstein's Anomaly	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	04.00		548.800	3857.00 (3383.30)	439.040	3085.60 (2706.70)	20.000	882.20 (773.90) T
1335	Total anomalous venous drainage	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	04.00		658.900	4630.70 (4062.00)	527.120	3704.60 (3249.60)	20.000	882.20 (773.90) T
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	15.000	661.70 (580.40) T
1338	Fontan type repair	04.00		750.000	5271.00 (4623.70)	600.000	4216.80 (3698.90)	15.000	661.70 (580.40) T
6.3.1.2	**Cardiac surgery: Open heart surgery: Acquired conditions**								
1339	Mitral valve replacement	04.00		657.000	4617.40 (4050.40)	525.600	3693.90 (3240.30)	15.000	661.70 (580.40) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1340	Mitral valvuloplasty	04.00		688.000	4835.30 (4241.50)	550.400	3868.20 (3393.20)	15.000	661.70 (580.40) T
1341	Aortic valve replacement	04.00		623.800	4384.10 (3845.70)	499.040	3507.30 (3076.60)	15.000	661.70 (580.40) T
1342	Tricuspid annulo plasty	04.00		188.000	1321.30 (1159.00)	150.400	1057.00 (927.20)	15.000	661.70 (580.40) T
1343	Double valve replacement	04.00		968.900	6809.40 (5973.20)	775.120	5447.50 (4778.50)	15.000	661.70 (580.40) T
1344	Acute dissecting aneurysm repair	04.00		750.000	5271.00 (4623.70)	600.000	4216.80 (3698.90)	15.000	661.70 (580.40) T
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	04.00		1000.000	7028.00 (6164.90)	800.000	5622.40 (4931.90)	15.000	661.70 (580.40) T
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)		
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)		
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	04.00		750.000	5271.00 (4623.70)	600.000	4216.80 (3698.90)	15.000	661.70 (580.40) T
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery	04.00		781.000	5488.90 (4814.80)	624.800	4391.10 (3851.80)	15.000	661.70 (580.40) T
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery	04.00		813.000	5713.80 (5012.10)	650.400	4571.00 (4009.60)	15.000	661.70 (580.40) T
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	04.00		875.000	6149.50 (5394.30)	700.000	4919.60 (4315.40)	15.000	661.70 (580.40) T
1352	Cardiac aneurysm	04.00		563.000	3956.80 (3470.90)	450.400	3165.40 (2776.70)	15.000	661.70 (580.40) T
1353	Ascending/descending thoracic aortic aneurysm repair	04.00		625.000	4392.50 (3853.10)	500.000	3514.00 (3082.50)	15.000	661.70 (580.40) T
1354	Arrhythmia surgery	04.00		688.000	4835.30 (4241.50)	550.400	3868.20 (3393.20)	15.000	661.70 (580.40) T
1355	Cardiac tumour	04.00		625.000	4392.50 (3853.10)	500.000	3514.00 (3082.50)	15.000	661.70 (580.40) T
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	04.00		188.000	1321.30 (1159.00)	150.400	1057.00 (927.20)	15.000	661.70 (580.40) T
1358	Harvesting of radial artery	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)		
6.4	**Peripheral vascular system**								
MODIFIER GOVERNING THIS SECTION									
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins								04.00
6.4.1	**Peripheral vascular system: Investigations**								
1357	Skin temperature test: Response to reflex heating	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
1359	Skin temperature test: Response to reflex cooling	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1381	Cold sensitivity test	04.00		17.000	119.50 (104.80)	17.000	119.50 (104.80)		
1363	Oscillometry test	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
1365	Sweating test	04.00		17.000	119.50 (104.80)	17.000	119.50 (104.80)		
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	04.00		26.300	184.80 (162.10)	26.300	184.80 (162.10)		
1367	Doppler blood tests	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
5369	Doppler arterial pressures	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
5371	Doppler arterial pressures with exercise	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
5373	Doppler segmental pressures and wave forms	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
5375	Venous doppler examination (both limbs)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
5377	Venous plethysmography	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)		
5379	Supra-orbital doppler test	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
5381	Carotid non-invasive complex tests	04.00		39.000	274.10 (240.40)	39.000	274.10 (240.40)		
6.4.2	**Peripheral vascular system: Arterio-venous abnormalities**								
1369	Fistula or aneurysm (as for grafting of various arteries)	04.00							
6.4.3	**Arteries**								
6.4.3.1	**Peripheral vascular system: Arteries: Aorta-iliac and major branches**								
1372	Abdominal aorta and iliac artery: Unruptured	04.00		540.000	3795.10 (3329.00)	432.000	3036.10 (2663.20)	15.000	661.70 (580.40) T
1373	Abdominal aorta and iliac artery: Ruptured	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	15.000	661.70 (580.40) T
1375	Grafting and/or thrombo-endarterectomy for thrombosis	04.00		444.000	3120.40 (2737.20)	355.200	2496.30 (2189.70)	15.000	661.70 (580.40) T
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	04.00		594.000	4174.60 (3661.90)	475.200	3339.70 (2929.60)	15.000	661.70 (580.40) T
6.4.3.2	**Peripheral vascular system: Arteries: Iliac artery**								
1379	Prosthetic grafting and/or thrombo-endarterectomy	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	13.000	573.40 (503.00) T
6.4.3.3	**Peripheral vascular system: Arteries: Peripheral**								
1385	Prosthetic grafting	04.00		255.000	1792.10 (1572.00)	204.000	1433.70 (1257.60)	5.000	220.60 (193.50) T
1387	Grafting vein: Vein grafting proximal to knee joint	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	5.000	220.60 (193.50) T
1388	Grafting vein: Distal to knee joint	04.00		444.000	3120.40 (2737.20)	355.200	2496.30 (2189.70)	5.000	220.60 (193.50) T
1389	Grafting vein: Endarterectomy when not part of another specified procedure	04.00		264.000	1855.40 (1627.50)	211.200	1484.30 (1302.00)	5.000	220.60 (193.50) T
1390	Grafting vein: Carotid endarterectomy	04.00		321.000	2256.00 (1978.90)	256.800	1804.80 (1583.20)	15.000	661.70 (580.40) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1393	Embolectomy: Peripheral embolectomy transfemoral	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	5.000	220.60 (193.50) T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	04.00		125.000	878.50 (770.60)	100.000	702.80 (616.50)	5.000	220.60 (193.50) T
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure	04.00		264.000	1855.40 (1627.50)	211.200	1484.30 (1302.00)	15.000	661.70 (580.40) T
1397	Profundoplasty	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
1399	Distal tibial (ankle region)	04.00		456.000	3204.80 (2811.20)	364.800	2563.80 (2248.90)	5.000	220.60 (193.50) T
1401	Femoro-femoral	04.00		254.000	1785.10 (1565.90)	203.200	1428.10 (1252.70)	5.000	220.60 (193.50) T
1402	Carotid-subclavian	04.00		288.000	2024.10 (1775.50)	230.400	1619.30 (1420.40)	8.000	352.90 (309.60) T
1403	Axillo-femoral: (Bifemoral + 50%)	04.00		288.000	2024.10 (1775.50)	230.400	1619.30 (1420.40)	8.000	352.90 (309.60) T
6.4.4	**Peripheral vascular system: Veins**								
1407	Ligation of saphenous vein	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) T
1408	Placement of Hickman catheter or similar	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	4.000	176.40 (154.70) T
1410	Litigation of inferior vena cava: Abdominal	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	8.000	352.90 (309.60) T
1412	Umbrella operation on inferior vena cava: Abdominal	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	8.000	352.90 (309.60) T
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral	04.00		141.000	990.90 (869.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral	04.00		247.000	1735.90 (1522.70)	197.600	1388.70 (1218.20)	3.000	132.30 (116.10) T
1417	Extensive sub-fascial ligation of perforating veins	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
1419	Lesser varicose vein procedures	04.00		31.000	217.90 (191.10)	31.000	217.90 (191.10)	3.000	132.30 (116.10) T
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9) injections per leg (excluding cost of material)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	11.000	485.20 (425.60) T
1427	Thrombectomy: Illio-femoral	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	6.000	264.70 (232.20) T
6.4.5	**Peripheral vascular system: Portal hypertension**								
1429	Porto-caval shunt	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	11.000	485.20 (425.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6.6	**Cardiac rehabilitation**								
1431	Cardiac rehabilitation: Phase II: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 5 patients per group	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
	Please note : a. A practitioner is only allowed to instruct one group at a time. b. Benefits are limited to 3 times per week for a period of 60 minutes with a maximum of 3 months.	04.00							
7	**Lympho Reticular System**								
7.1	**Spleen**								
1435	Splenectomy (in all cases)	04.00		221.300	1555.30 (1364.30)	177.040	1244.20 (1091.40)	9.000	397.00 (348.20) T
1436	Splenorrhaphy	04.00		231.800	1629.10 (1429.00)	185.440	1303.30 (1143.20)	9.000	397.00 (348.20) T
7.2	**Lymph nodes and lymphatic channels**								
1439	Excision of lymph node for biopsy: Neck or axilla	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	4.000	176.40 (154.70) T
1441	Excision of lymph node for biopsy: Groin	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	3.000	132.30 (116.10) T
1443	Simple excision of lymph nodes for tuberculosis	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	3.000	132.30 (116.10) T
1445	Radical excision of lymph nodes of neck: Total: Unilateral	04.00		315.000	2213.80 (1941.90)	252.000	1771.10 (1553.60)	5.000	220.60 (193.50) T
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral	04.00		235.000	1651.60 (1448.80)	188.000	1321.30 (1159.00)	5.000	220.60 (193.50) T
1449	Radical excision of lymph nodes of axilla	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	4.000	176.40 (154.70) T
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)	5.000	220.60 (193.50) T
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	4.000	176.40 (154.70) T
1453	Radical excision of lymph nodes of groin: Inguinal	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	04.00		39.000	274.10 (240.40)	39.000	274.10 (240.40)	5.000	220.60 (193.50) T
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	6.000	264.70 (232.20) T
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	5.000	220.60 (193.50) T
1457	Bone marrow biopsy: By trephine	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	3.000	132.30 (116.10) T
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
1459	Staging laparotomy for lymphoma (including splenectomy	04.00		245.000	1721.90 (1510.40)	196.000	1377.50 (1208.30)	7.000	308.80 (270.90) T

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				RVU	Fee	RVU	Fee	RVU	Fee
8	**Digestive System**								
MODIFIERS GOVERNING THIS SECTION									
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.								04.00
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	04.00		21.000	147.59 (129.46)	21.000	147.59 (129.46)		
8.1	**Oral cavity**								
1461	All dental procedures	04.00						4.000	176.40 (154.70) T
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	4.000	176.40 (154.70) T
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)	4.000	176.40 (154.70) T
1467	Drainage of intra-oral abscess	04.00		31.000	217.90 (191.10)	31.000	217.90 (191.10)	4.000	176.40 (154.70) T
1469	Local excision of mucosal lesion of oral cavity	04.00		23.000	161.60 (141.80)	23.000	161.60 (141.80)	4.000	176.40 (154.70) T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	04.00		549.000	3858.40 (3384.60)	439.200	3086.70 (2707.60)	7.000	308.80 (270.90) T
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	04.00		-	- q	-	- q	7.000	308.80 (270.90) T
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	6.000	264.70 (232.20) T
1477	Cleft palate: Secondary repair	04.00		174.200	1224.30 (1073.90)	139.360	979.40 (859.10)	6.000	264.70 (232.20) T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	6.000	264.70 (232.20) T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	6.000	264.70 (232.20) T
1480	Repair of oronasal fistula (large) e.g. distant flap	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	6.000	264.70 (232.20) T
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1482	Repair of oronasal fistula (large): Second stage	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1483	Alveolar periosteal or other flaps for arch closure	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1486	Closure of anterior nasal floor	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
8.2	**Lips**								
1484	Cleft lip repair: Lip adhesion (cleft lip)	04.00		95.000	667.70 (585.70)	95.000	667.70 (585.70)	5.000	220.60 (193.50) T

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				RVU	Fee	RVU	Fee	RVU	Fee
1485	Local excision of benign lesion of lip	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	4.000	176.40 (154.70) T
1487	Resection for lip malignancy	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	4.000	176.40 (154.70) T
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	5.000	220.60 (193.50) T
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages	04.00		251.600	1768.20 (1551.10)	201.280	1414.60 (1240.90)	5.000	220.60 (193.50) T
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage	04.00		329.900	2318.50 (2033.80)	263.920	1854.80 (1627.00)	5.000	220.60 (193.50) T
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	5.000	220.60 (193.50) T
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	04.00		251.600	1768.20 (1551.10)	201.280	1414.60 (1240.90)	5.000	220.60 (193.50) T
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	5.000	220.60 (193.50) T
1495	Abbé or Estlander type flap (all stages included)	04.00		273.100	1919.30 (1683.60)	218.480	1535.50 (1346.90)	5.000	220.60 (193.50) T
1497	Vermilionectomy	04.00		94.900	667.00 (585.10)	94.900	667.00 (585.10)	4.000	176.40 (154.70) T
1499	Lip reconstruction following an injury: Direct repair	04.00		105.600	742.20 (651.10)	105.600	742.20 (651.10)	4.000	176.40 (154.70) T
1501	Lip reconstruction following an injury or tumour removal: Flap repair	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)	04.00		104.000	730.90 (641.10)	104.000	730.90 (641.10)	4.000	176.40 (154.70) T
8.3	**Tongue**								
1505	Partial glossectomy	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
1507	Local excision of lesion of tongue	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	4.000	176.40 (154.70) T
8.4	**Palate, uvula and salivary glands**								
1509	Wide excision of lesion of palate	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	5.000	220.60 (193.50) T
1511	Radical resection of palate (including skin graft)	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	7.000	308.80 (270.90) T
1513	Excision of ranula	04.00		85.600	601.60 (527.70)	85.600	601.60 (527.70)	5.000	220.60 (193.50) T
1515	Excision of sublingual salivary gland	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1517	Excision of submandibular salivary gland	04.00		146.000	1026.10 (900.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1519	Excision of submandibular salivary gland with suprahyoid dissection	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1521	Excision of submandibular salivary gland: With radical neck dissection	04.00		352.000	2473.90 (2170.10)	281.600	1979.10 (1736.10)	6.000	264.70 (232.20) T
1523	Local resection of parotid tumour	04.00		169.600	1191.90 (1045.50)	135.680	953.60 (836.50)	5.000	220.60 (193.50) T
1525	Partial parotidectomy	04.00		310.000	2178.70 (1911.10)	248.000	1742.90 (1528.90)	5.000	220.60 (193.50) T
1526	Total parotidectomy with preservation of facial nerve	04.00		358.500	2519.50 (2210.10)	286.800	2015.60 (1768.10)	5.000	220.60 (193.50) T
1527	Total parotidectomy	04.00		358.500	2519.50 (2210.10)	286.800	2015.60 (1768.10)	5.000	220.60 (193.50) T
1529	Parotidectomy: Extracapsular	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	5.000	220.60 (193.50) T
1531	Drainage of parotid abscess	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	4.000	176.40 (154.70) T
1533	Closure of salivary fistula	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	4.000	176.40 (154.70) T
1535	Dilatation of salivary duct	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
1537	Operative removal of salivary calculus	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)	4.000	176.40 (154.70) T
1539	Salivary duct: Meatotomy	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	4.000	176.40 (154.70) T
1541	Branchial cyst and/or fistula: Excision	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1543	Excision of cystic hygroma	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1544	Ludwig's Angina: Drainage	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	9.000	397.00 (348.20) T
8.5	**Oesophagus**								
1545	Oesophagoscopy with rigid instrument: First and subsequent	04.00		47.000	330.30 (289.70)	47.000	330.30 (289.70)	4.000	176.40 (154.70) T
1549	Oesophagoscopy with dilatation of stricture	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	4.000	176.40 (154.70) T
1550	Oesophagoscopy with removal of foreign body	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	4.000	176.40 (154.70) T
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	4.000	176.40 (154.70) T
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	4.000	176.40 (154.70) T
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	4.000	176.40 (154.70) T
1554	Per-oral small bowel biopsy	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	04.00		400.000	2811.20 (2466.00)	320.000	2249.00 (1972.80)	15.000	661.70 (580.40) T
1557	Oesophageal dilatation	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	4.000	176.40 (154.70) T
1559	Oesophagectomy: Two stage	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	11.000	485.20 (425.60) T
1560	Oesophagectomy: Three stage	04.00		550.000	3865.40 (3390.70)	440.000	3092.30 (2712.50)	11.000	485.20 (425.60) T
1561	Thoraco-abdominal oesophagogastrectomy	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	11.000	485.20 (425.60) T
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	11.000	485.20 (425.60) T
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	11.000	485.20 (425.60) T
1566	Private fee: Gastroplasty	04.00		325.000	2284.10 (2003.60)	260.000	1827.30 (1602.90)	8.000	352.90 (309.60) T
1567	Bochdalek hernia repair in newborn	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	14.000	617.50 (541.70) T
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	11.000	485.20 (425.60) T
1569	Heller's operation	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	14.000	617.50 (541.70) T
1575	Insertion of indwelling oesophageal tube by laparotomy	04.00		142.000	998.00 (875.40)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
1578	Oesophageal motility (4 channel + pneumograph)	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	4.000	176.40 (154.70) T
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	04.00		400.000	2811.20 (2466.00)	320.000	2249.00 (1972.80)	11.000	485.20 (425.60) T
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	04.00		110.000	773.10 (678.20)	110.000	773.10 (678.20)	4.000	176.40 (154.70) T
1581	Removal of benign oesophageal tumours	04.00		285.000	2003.00 (1757.00)	228.000	1602.40 (1405.60)	11.000	485.20 (425.60) T
1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1583	Excision of intrathoracic oesophageal diverticulum	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	11.000	485.20 (425.60) T
1584	24 Hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe: 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)		
1585	24 Hour oesophageal pH studies: Interpretation	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)		
8.6	**Stomach**								
1587	Upper gastro-intestinal endoscopy: Hospital equipment	04.00		48.750	342.60 (300.50) Z	48.750	342.60 (300.50) Z	4.000	176.40 (154.70) T
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587)	04.00	+	25.000	175.70 (154.10) Z	25.000	175.70 (154.10) Z	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (item 1587) or colonoscopy (item 1653)	04.00	+	34.000	239.00 (209.60)	34.000	239.00 (209.60)	6.000	264.70 (232.20) T
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (Item 1587)	04.00	+	25.000	175.70 (154.10) Z	25.000	175.70 (154.10) Z	4.000	176.40 (154.70) T
1593	Augmented histamine test: Gastric intubation with x-ray screening	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
1597	Gastrostomy or Gastrotomy	04.00		147.500	1036.60 (909.30)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
1598	Gastrotomy with suture repair of bleeding ulcer	05.03		251.200	1765.40 (1548.60) Z	200.960	1412.30 (1238.90) Z	6.000	264.70 (232.20) T
1599	Pyloromyotomy (Rammstedt)	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	6.000	264.70 (232.20) T
1601	Local excision of ulcer or benign neoplasm	04.00		195.600	1374.70 (1205.90)	156.480	1099.70 (964.60)	6.000	264.70 (232.20) T
1603	Vagotomy: Abdominal	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
1604	Vagotomy: Thoracic	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	11.000	485.20 (425.60) T
1605	Truncal or selective with drainage procedures	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	6.000	264.70 (232.20) T
1607	Vagotomy and antrectomy	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	6.000	264.70 (232.20) T
1609	Highly selective vagotomy	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	6.000	264.70 (232.20) T
1611	Pyloroplasty	04.00		180.200	1266.40 (1110.90)	144.160	1013.20 (888.80)	6.000	264.70 (232.20) T
1613	Gastroenterostomy	04.00		203.600	1430.90 (1255.20)	162.880	1144.70 (1004.10)	6.000	264.70 (232.20) T
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	7.000	308.80 (270.90) T
1617	Partial gastrectomy	04.00		328.300	2307.30 (2023.90)	262.640	1845.80 (1619.10)	7.000	308.80 (270.90) T
1619	Total gastrectomy	04.00		384.430	2701.80 (2370.00)	307.540	2161.40 (1896.00)	7.000	308.80 (270.90) T
1621	Revision of gastrectomy or gastro-enterostomy	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	7.000	308.80 (270.90) T
1625	Gastro-esophageal operation for portal hypertension (Tanner)	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	11.000	485.20 (425.60) T
8.7	**Duodenum**								
1626	Endoscopic examination of the small bowel beyond the duodenojejunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
1627	Duodenal intubation (under X-ray screening)	04.00		8.000	56.20 (49.30)				
1629	Duodenal intubation with biliary drainage after gall bladder stimulation	04.00		21.000	147.60 (129.50)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1631	Duodenal intubation: Under 3 years of age	06.04		15.000	105.40 (92.50)				
8.8	**Intestines**								
1632	H2 breath test (intestines)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
1633	Complete test using lactose or lactulose	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)		
1634	Enterotomy or Enterostomy	04.11		202.600	1423.90 (1249.00)	162.080	1139.10 (999.20)	6.000	264.70 (232.20) T
1635	Intestinal obstruction of the newborn	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	7.000	308.80 (270.90) T
1637	Operation for relief of intestinal obstruction	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	7.000	308.80 (270.90) T
1639	Resection of small bowel with enterostomy or anastomosis	04.00		244.900	1721.20 (1509.80)	195.920	1376.90 (1207.80)	6.000	264.70 (232.20) T
1641	Entero-enterostomy or entero-colostomy for bypass	04.00		213.100	1497.70 (1313.80)	170.480	1198.10 (1051.00)	6.000	264.70 (232.20) T
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (item 0201 applicable for video capsule - disposable single patient use) (Please note: All patients should have had a normal gastroscopy and colonoscopy)	05.03		150.000	1054.20 (924.70) Z	120.000	843.40 (739.80) Z		
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	05.03		90.000	632.50 (554.80) Z	90.000	632.50 (554.80) Z		
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	04.00		185.200	1301.60 (1141.80)	148.160	1041.30 (913.40)	6.000	264.70 (232.20) T
1647	Closure of intestinal fistula	04.00		258.000	1813.20 (1590.50)	206.400	1450.60 (1272.50)	6.000	264.70 (232.20) T
1649	Excision of Meckel's diverticulum	04.00		179.800	1263.60 (1108.40)	143.840	1010.90 (886.80)	6.000	264.70 (232.20) T
1651	Excision of lesion of mesentery	04.00		171.600	1206.00 (1057.90)	137.280	964.80 (846.30)	4.000	176.40 (154.70) T
1652	Laparotomy for mesenteric thrombosis	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	8.000	352.90 (309.60) T
1653	Total colonoscopy: With hospital equipment (including biopsy)	04.00		90.000	632.50 (554.80) Z	90.000	632.50 (554.80) Z	4.000	176.40 (154.70) T
1654	Plus removal of polyps: ADD to colonoscopy (Item 1653)	04.00	+	30.000	210.80 (184.90) Z	30.000	210.80 (184.90) Z	4.000	176.40 (154.70) T
1656	Left-sided colonoscopy	04.00		60.000	421.70 (369.90) Z	60.000	421.70 (369.90) Z	4.000	176.40 (154.70) T
1657	Right or left hemicolectomy or segmental colectomy	04.00		325.000	2284.10 (2003.60)	260.000	1827.30 (1602.90)	6.000	264.70 (232.20) T
1658	Reconstruction of colon after Hartman's procedure	04.00		359.400	2525.90 (2215.70)	287.520	2020.70 (1772.50)	6.000	264.70 (232.20) T
1661	Colotomy: Including removal of tumour or foreign body	04.00		205.700	1445.70 (1268.20)	164.560	1156.50 (1014.50)	6.000	264.70 (232.20) T
1663	Total colectomy	04.00		390.000	2740.90 (2404.30)	312.000	2192.70 (1923.40)	6.000	264.70 (232.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1665	Colostomy or ileostomy isolated procedure	04.00		233.800	1643.10 (1441.30)	187.040	1314.50 (1153.10)	6.000	264.70 (232.20) T
1666	Continent ileostomy pouch (all types)	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	6.000	264.70 (232.20) T
1667	Colostomy: Closure	04.00		179.100	1258.70 (1104.10)	143.280	1007.00 (883.30)	5.000	220.60 (193.50) T
1668	Revision of ileostomy pouch	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	6.000	264.70 (232.20) T
1669	Total proctocolectomy and ileostomy	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	7.000	308.80 (270.90) T
1670	Proctocolectomy, ileostomy and ileostomy pouch	04.00		540.000	3795.10 (3329.00)	432.000	3036.10 (2663.20)	7.000	308.80 (270.90) T
1671	Colomyotomy (Reilly operation)	04.00		185.000	1300.20 (1140.50)	148.000	1040.10 (912.40)	6.000	264.70 (232.20) T
8.9	**Appendix**								
1673	Drainage of appendix abscess	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1675	Appendicectomy	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	4.000	176.40 (154.70) T
8.10	**Rectum and anus**								
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	04.00		48.750	342.60 (300.50) Z	48.750	342.60 (300.50) Z	3.000	132.30 (116.10) T
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	3.000	132.30 (116.10) T
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	04.00	+	25.000	175.70 (154.10) Z	25.000	175.70 (154.10) Z	3.000	132.30 (116.10) T
1679	Sigmoidoscopy with removal of polyps, first and subsequent	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10) T
1681	Proctoscopy with removal of polyps: First time	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)	3.000	132.30 (116.10) T
1683	Proctoscopy with removal of polyps: Subsequent times	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
1685	Endoscopic fulguration of tumour	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	04.00		381.300	2679.80 (2350.70)	305.040	2143.60 (1880.50)	6.000	264.70 (232.20) T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	04.00		445.000	3127.50 (2743.40)	356.000	2502.00 (2194.70)	8.000	352.90 (309.60) T
1689	Perineal resection of rectum	04.00		141.000	990.90 (869.20)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
	Please note: Items 1691 and 1692: Abdominal and/or perineal assistant's fee to be charged additionally.	04.00							
1691	Abdomino-perineal resection of rectum: Abdominal surgeon	04.00		409.300	2876.60 (2523.30)	327.440	2301.20 (2018.60)	7.000	308.80 (270.90) T

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				RVU	Fee	RVU	Fee	RVU	Fee
1692	Abdomino-perineal resection of rectum: Perineal surgeon	04.00		158.500	1113.90 (977.10)	126.800	891.20 (781.80)		
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	4.000	176.40 (154.70) T
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	04.00		400.000	2811.20 (2466.00)	320.000	2249.00 (1972.80)	7.000	308.80 (270.90) T
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	6.000	264.70 (232.20) T
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	6.000	264.70 (232.20) T
1701	Repair of prolapsed rectum: Abdominal: Perineal	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1703	Repair of prolapsed rectum: Abdominal: Thierisch suture	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	4.000	176.40 (154.70) T
1705	Incision and drainage of peri-anal abscess	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	3.000	132.30 (116.10) T
1707	Drainage of submucous abscess	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	3.000	132.30 (116.10) T
1709	Drainage of ischio-rectal abscess	04.00		87.000	611.40 (536.30)	87.000	611.40 (536.30)	3.000	132.30 (116.10) T
1711	Excision of pelvi-rectal fistula	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	5.000	220.60 (193.50) T
1713	Excision of fistula-in-ano	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	3.000	132.30 (116.10) T
1715	Operation for fissure-in-ano	04.00		66.800	469.50 (411.80)	66.800	469.50 (411.80)	3.000	132.30 (116.10) T
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
1721	Sclerosing injection for haemorrhoids: Per injection	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
1723	Haemorrhoidectomy	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
1725	Drainage of external thrombosed pile	04.00		12.500	87.90 (77.10)	12.500	87.90 (77.10)	3.000	132.30 (116.10) T
1727	Multiple procedures (haemorrhoids, fissure, etc.)	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) T
1728	Biopsy of ano-rectal wall, for congenital megacolon	05.03		60.600	425.90 (373.60) Z	60.600	425.90 (373.60) Z	5.000	220.60 (193.50) T
1729	Excision of anal skin tags	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10) T
1731	Operation for low imperforate anus	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
1733	Anoplasty: Y-V-plasty	04.00		41.000	288.10 (252.70)	41.000	288.10 (252.70)	3.000	132.30 (116.10) T
1735	Anal sphincteroplasty for incontinence	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1737	Dilation of ano-rectal stricture	04.00		12.500	87.90 (77.10)	12.500	87.90 (77.10)	3.000	132.30 (116.10) T
1739	Closure of recto-vesical fistula	04.00		241.000	1693.70 (1485.70)	192.800	1355.00 (1188.60)	5.000	220.60 (193.50) T
1741	Closure of recto-urethral fistula	04.00		241.000	1693.70 (1485.70)	192.800	1355.00 (1188.60)	5.000	220.60 (193.50) T
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)		
8.11	**Liver**								
1743	Needle biopsy of liver	04.00		30.300	212.90 (186.80)	30.300	212.90 (186.80)	3.000	132.30 (116.10) T
1745	Biopsy of liver by laparotomy	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1747	Drainage of liver abscess or cyst	04.00		179.100	1258.70 (1104.10)	143.280	1007.00 (883.30)	7.000	308.80 (270.90) T
1748	Body composition measured by bio-electrical impedance	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
1749	Hemi-hepatectomy: Right	04.00		564.000	3963.80 (3477.00)	451.200	3171.00 (2781.60)	9.000	397.00 (348.20) T
1751	Hemi-hepatectomy: Left	04.00		521.100	3662.30 (3212.50)	416.880	2929.80 (2570.00)	9.000	397.00 (348.20) T
1752	Extended right or left hepatectomy	04.00		570.900	4012.30 (3519.60)	456.720	3209.80 (2815.60)	9.000	397.00 (348.20) T
1753	Partial or segmental hepatectomy	04.00		378.000	2656.60 (2330.40)	302.400	2125.30 (1864.30)	9.000	397.00 (348.20) T
1754	Hepatico-jejunostomy	04.00		369.200	2594.70 (2276.10)	295.360	2075.80 (1820.90)	9.000	397.00 (348.20) T
1755	Liver transplant	04.00		1400.80 0	9844.80 (8635.80)	1120.64 0	7875.90 (6908.70)	15.000	661.70 (580.40) T
1756	Harvesting donor hepatectomy	04.00		616.200	4330.70 (3798.90)	492.960	3464.50 (3039.00)	5.000	220.60 (193.50) T
1757	Suture of liver wound or injury	04.00		214.200	1505.40 (1320.50)	171.360	1204.30 (1056.40)	9.000	397.00 (348.20) T
8.12	**Biliary tract**								
1759	Cholecystostomy	04.00		171.600	1206.00 (1057.90)	137.280	964.80 (846.30)	6.000	264.70 (232.20) T
1761	Cholecystectomy	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
1762	Cholecystectomy and operative cholangiogram	04.00		255.000	1792.10 (1572.00)	204.000	1433.70 (1257.60)	6.000	264.70 (232.20) T
1763	With exploration of common bile duct	04.00		264.500	1858.90 (1630.60)	211.600	1487.10 (1304.50)	6.000	264.70 (232.20) T
1765	Exploration of common bile duct: Secondary operation	04.00		327.700	2303.10 (2020.30)	262.160	1842.50 (1616.20)	6.000	264.70 (232.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1767	Reconstruction of common bile duct	04.00		371.700	2612.30 (2291.50)	297.360	2089.80 (1833.20)	6.000	264.70 (232.20) T
1768	Resection bile duct tumour with reconstruction	04.00		327.700	2303.10 (2020.30)	262.160	1842.50 (1616.20)	6.000	264.70 (232.20) T
1769	Cholecysto-enterostomy or gastrostomy	04.00		236.300	1660.70 (1456.80)	189.040	1328.60 (1165.40)	6.000	264.70 (232.20) T
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	06.04	+	25.600	179.90 (157.80)	25.600	179.90 (157.80)	6.000	264.70 (232.20) T
1773	Transduodenal sphincteroplasty	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
1774	Balloon dilatation of common bile duct strictures	04.00		125.000	878.50 (770.60)	100.000	702.80 (616.50)	6.000	264.70 (232.20) T
1775	Excision choledochal cyst with reconstruction	04.00		327.700	2303.10 (2020.30)	262.160	1842.50 (1616.20)	6.000	264.70 (232.20) T
1777	Porto-enterostomy for biliary atresia	04.00		400.000	2811.20 (2466.00)	320.000	2249.00 (1972.80)	11.000	485.20 (425.60) T
8.13	**Pancreas**								
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	04.00		105.900	744.30 (652.90)	105.900	744.30 (652.90)	4.000	176.40 (154.70) T
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	04.00	+	15.820	111.20 (97.50)	15.820	111.20 (97.50)	4.000	176.40 (154.70) T
1780	Gastric and duodenal intubation	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
1781	Procedure (excluding laboratory tests)	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)		
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	04.00	+	30.000	210.80 (184.90)	30.000	210.80 (184.90)	4.000	176.40 (154.70) T
1783	Drainage of pancreatic abscess	04.00		239.300	1681.80 (1475.30)	191.440	1345.40 (1180.20)	6.000	264.70 (232.20) T
1784	Debridement pancreatic necrosis	04.00		348.400	2448.60 (2147.90)	278.720	1958.80 (1718.20)	6.000	264.70 (232.20) T
1785	Internal drainage of pancreatic cyst	04.00		250.600	1761.20 (1544.90)	200.480	1409.00 (1236.00)	6.000	264.70 (232.20) T
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	04.00	+	30.000	210.80 (184.90)	30.000	210.80 (184.90)	6.000	264.70 (232.20) T
1786	Internal drainage of pancreatic cyst with Roux-Y	04.00		306.800	2156.20 (1891.40)	245.440	1725.00 (1513.20)	6.000	264.70 (232.20) T
1787	Operative pancreatogram: ADD	04.00	+	10.000	70.30 (61.70)	10.000	70.30 (61.70)		
1788	Biopsy of pancreas	04.00		177.700	1248.90 (1095.50)	142.160	999.10 (876.40)	6.000	264.70 (232.20) T
1789	Pancreatico-duodenectomy	04.00		704.800	4953.30 (4345.00)	563.840	3962.70 (3476.10)	8.000	352.90 (309.60) T
1791	Local, partial or subtotal pancreatectomy	04.00		351.300	2468.90 (2165.70)	281.040	1975.10 (1732.50)	8.000	352.90 (309.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1793	Distal pancreatectomy with internal drainage	04.00		377.400	2652.40 (2326.70)	301.920	2121.90 (1861.30)	8.000	352.90 (309.60) T
8.14	**Peritoneal cavity**								
1797	Pneumo-peritoneum: First	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	4.000	176.40 (154.70) T
1799	Pneumo-peritoneum: Repeat	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)	4.000	176.40 (154.70) T
1800	Peritoneal lavage	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
1801	Diagnostic paracentesis: Abdomen	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
1803	Therapeutic paracentesis: Abdomen	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)		
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	04.00	+	45.000	316.30 (277.50)	45.000	316.30 (277.50)	5.000	220.60 (193.50) T
1809	Laparotomy	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	4.000	176.40 (154.70) T
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	7.000	308.80 (270.90) T
1811	Suture of burst abdomen	04.00		188.300	1323.40 (1160.90)	150.640	1058.70 (928.70)	7.000	308.80 (270.90) T
1812	Laparotomy for control of surgical haemorrhage	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	9.000	397.00 (348.20) T
1813	Drainage of sub-phrenic abscess	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	7.000	308.80 (270.90) T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	04.00		248.400	1745.80 (1531.40)	198.720	1396.60 (1225.10)	5.000	220.60 (193.50) T
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	4.000	176.40 (154.70) T
9	**Herniae**								
1819	Inguinal or femoral hernia: Adult	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1821	Inguinal or femoral hernia: Child under 14 years	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	4.000	176.40 (154.70) T
1823	Inguinal hernia: Infant under one year	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	4.000	176.40 (154.70) T
1825	Recurrent inguinal or femoral hernia	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	4.000	176.40 (154.70) T
1827	Strangulated hernia or femoral hernia	04.00		238.000	1672.70 (1467.30)	190.400	1338.10 (1173.80)	7.000	308.80 (270.90) T
1829	Epigastric hernia	04.00		93.300	655.70 (575.20)	93.300	655.70 (575.20)	4.000	176.40 (154.70) T
1831	Umbilical hernia: Adult	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1833	Umbilical hernia: Child under 14 years	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1835	Incisional hernia	04.00		166.800	1172.30 (1028.30)	133.440	937.80 (822.60)	4.000	176.40 (154.70) T
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to item for the incisional or ventral hernia repair)	04.00	+	77.000	541.20 (474.70)	77.000	541.20 (474.70)	4.000	176.40 (154.70) T
1837	Repair of omphalocele in new-born (one or more procedures)	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	7.000	308.80 (270.90) T
10	**Urinary System**								
RULES GOVERNING THE SECTION URINARY SYSTEM									
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.	04.00							
10.1	**Kidney**								
1839	Renal biopsy: Per kidney: Open	04.00		71.000	499.00 (437.70)	71.000	499.00 (437.70)	5.000	220.60 (193.50) T
1841	Renal biopsy: Needle	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10) T
1843	Peritoneal dialysis: First day	04.00		33.000	231.90 (203.40)	33.000	231.90 (203.40)		
1845	Peritoneal dialysis: Every subsequent day	04.00		33.000	231.90 (203.40)	33.000	231.90 (203.40)		
1847	Haemodialysis: Per hour or part thereof	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)		
1849	Haemodialysis: Maximum: Eight hours	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)		
1851	Haemodialysis: Thereafter per week	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)		
1852	Continuous haemodiafiltration per day in intensive or high care unit	04.00		33.000	231.90 (203.40)	33.000	231.90 (203.40)		
1853	Nephrectomy: Primary nephrectomy	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	5.000	220.60 (193.50) T
1855	Nephrectomy: Secondary nephrectomy	04.00		267.000	1876.50 (1646.10)	213.600	1501.20 (1316.80)	5.000	220.60 (193.50) T
1857	Radical with regional lymph adenectomy for tumour	04.11		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	6.000	264.70 (232.20) T
1859	Nephrectomy: Partial	04.00		267.000	1876.50 (1646.10)	213.600	1501.20 (1316.80)	5.000	220.60 (193.50) T
1861	Symphysiotomy for horse-shoe kidney	04.00		287.000	2017.00 (1769.30)	229.600	1613.60 (1415.40)	6.000	264.70 (232.20) T
1863	Nephro-ureterectomy	04.00		305.000	2143.50 (1880.30)	244.000	1714.80 (1504.20)	5.000	220.60 (193.50) T
1865	Nephrotomy with drainage nephrostomy	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	6.000	264.70 (232.20) T
1869	Nephrolithotomy	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	04.00		31.000	217.90 (191.10)	31.000	217.90 (191.10)	3.000	132.30 (116.10) T
0737	Biopsy for motor nerve terminals and end plates	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	04.00		34.000	239.00 (209.60)	34.000	239.00 (209.60)	8.000	352.90 (309.60) T
0740	Muscle fatigue studies	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
0741	Muscle biopsy	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	8.000	352.90 (309.60) T
0742	Global fee for all muscle studies, including histochemical studies	04.00		262.000	1841.30 (1615.20)				
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	04.00		20.250	142.30 (124.80)				
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	04.00		33.300	234.00 (205.30)				
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	04.00		5.700	40.10 (35.20)				
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	04.00		1.600	11.20 (9.82)				
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	04.00		9.900	69.60 (61.10)				
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	04.00		13.700	96.30 (84.50)				
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	04.00		25.900	182.00 (159.60)				
4715	Biochemical estimations on muscle biopsy specimens: Enolase	04.00		32.700	229.80 (201.60)				
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	04.00		37.700	265.00 (232.50)				
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	04.00		15.750	110.70 (97.10)				
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	04.00		11.060	77.70 (68.20)				
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	04.00		34.700	243.90 (213.90)				
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	04.00		40.300	283.20 (248.40)				
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase	04.00		28.800	202.40 (177.50)				
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	04.00		43.000	302.20 (265.10)				
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	04.00		14.000	98.40 (86.30)				
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	04.00		20.000	140.60 (123.30)				
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	04.00		71.000	499.00 (437.70)				
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	04.00		69.000	484.90 (425.40)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation	04.00		82.000	576.30 (505.50)				
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	04.00		143.000	1005.00 (881.60)				
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	04.00		75.000	527.10 (462.40)				
3.4.2	**Muscles, tendons and fasciae: Decompression Operations**								
0743	Major compartmental decompression	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0744	Decompression operation: Fasciotomy only	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) T
3.4.3	**Muscles, tendons and fasciae: Muscle and tendon repair**								
0745	Muscle and tendon repair: Biceps humeri	04.00		109.000	766.10 (672.00)	109.000	766.10 (672.00)	3.000	132.30 (116.10) T
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
0747	Muscle and tendon repair: Rotator cuff	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
0748	Muscle and tendon repair: Debridement rotator cuff	04.00		139.700	981.80 (861.20)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	04.00		271.900	1910.90 (1676.20)	217.520	1528.70 (1341.00)	4.000	176.40 (154.70) T
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0757	Muscle and tendon repair: Achilles tendon repair	04.00		197.600	1388.70 (1218.20)	158.080	1111.00 (974.60)	4.000	176.40 (154.70) T
0759	Muscle and tendon repair: Other single tendon	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	3.000	132.30 (116.10) T
0763	Muscle and tendon repair: Tendon or ligament injection	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
0767	Hand: Flexor tendon suture: Primary (per tendon)	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0769	Hand: Flexor tendon suture: Secondary (per tendon)	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) T
0771	Extensor tendon suture: Primary (per tendon)	04.00		129.700	911.50 (799.60)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0773	Extensor tendon suture: Secondary (per tendon)	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	3.000	132.30 (116.10) T
0774	Repair of Boutonniere deformity or Mallet finger with graft	04.00		183.700	1291.00 (1132.50)	146.960	1032.80 (906.00)	3.000	132.30 (116.10) T
3.4.4	**Muscles, tendons and fasciae: Tendon graft**								
0775	Free tendon graft	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0776	Reconstruction of pulley for flexor tendon	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) T
0777	Tendon graft: Finger: Flexor	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
0779	Tendon graft: Finger: Extensor	04.00		122.000	857.40 (752.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0780	Two stage flexor tendon graft using silastic rod	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	3.000	132.30 (116.10) T
3.4.5	**Muscles, tendons and fasciae: Tendolysis**								
0781	Tendon freeing operation, except where specified elsewhere	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) T
0782	Carpal tunnel syndrome	04.00		98.700	693.70 (608.50)	98.700	693.70 (608.50)	3.000	132.30 (116.10) T
0783	Tenolysis: De Quervain	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10) T
0784	Trigger finger	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10) T
0785	Flexor tendon freeing operation following free tendon graft or suture	04.00		186.800	1312.80 (1151.60)	149.440	1050.30 (921.30)	3.000	132.30 (116.10) T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	04.00		180.900	1271.40 (1115.30)	144.720	1017.10 (892.20)	3.000	132.30 (116.10) T
0788	Intrinsic tendon release per finger	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) T
0789	Central tendon tenotomy for Boutonniere deformity	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) T
3.4.6	**Muscles, tendons and fasciae: Tenodesis**								
0790	Tenodesis: Digital joint	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	3.000	132.30 (116.10) T
3.4.7	**Muscles, tendons and fasciae: Muscle tendon and facia transfer**								
0791	Single tendon transfer	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T
0792	Multiple tendon transfer	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0793	Hamstring to quadriceps transfer	04.00		141.000	990.90 (869.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	5.000	220.60 (193.50) T
0795	Tendon transfer at elbow	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	3.000	132.30 (116.10) T
0802	Radial club hand repair - stand alone procedure	04.00		360.300	2532.20 (2221.20)	288.240	2025.80 (1777.00)	3.000	132.30 (116.10) T
0803	Hand tendons: Single tendon transfer (first)	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0809	Hand tendons: Substitution for intrinsic paralysis of hand	04.00		224.000	1574.30 (1381.00)	179.200	1259.40 (1104.70)	3.000	132.30 (116.10) T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	04.00		220.600	1550.40 (1360.00)	176.480	1240.30 (1088.00)	3.000	132.30 (116.10) T
3.4.8	**Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening**								
0812	Percutaneous Tenotomy: All sites	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	3.000	132.30 (116.10) T
0813	Torticollis	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	5.000	220.60 (193.50) T
0815	Scalenotomy	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
0817	Scalenotomy with excision of first rib	04.00		190.000	1335.30 (1171.30)	152.000	1068.30 (937.10)	3.000	132.30 (116.10) TM
0821	Tennis elbow	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T
0822	Open release elbow (Mitals) - stand alone procedure	04.00		278.200	1955.20 (1715.10)	222.560	1564.20 (1372.10)	3.000	132.30 (116.10) TM
0823	Excision or slide for Volkmann's Contracture	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
0825	Hip: Open muscle release	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	7.000	308.80 (270.90) T
0829	Knee: Quadriceps plasty	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) T
0831	Knee: Open tenotomy	04.00		141.000	990.90 (869.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
0835	Calf	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	4.000	176.40 (154.70) T
0837	Open elongation tendon Achilles	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	4.000	176.40 (154.70) T
0838	Percutaneous "Hoke" elongation tendo Achilles	04.00		79.300	557.30 (488.90)	79.300	557.30 (488.90)	4.000	176.40 (154.70) T
0845	Foot: Plantar fasciotomy	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)	3.000	132.30 (116.10) T
0846	Foot: Postero-medial release for club-foot	04.00		192.000	1349.40 (1183.70)	153.600	1079.50 (946.90)	3.000	132.30 (116.10) T
3.5	**Bursae and ganglia**								
0847	Excision: Semimembranosus	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	4.000	176.40 (154.70) T
0849	Excision: Prepatellar	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
0851	Excision: Olecranon	04.00		81.800	574.90 (504.30)	81.800	574.90 (504.30)	3.000	132.30 (116.10) T
0853	Excision: Small bursa or ganglion	04.00		80.900	568.60 (498.80)	80.900	568.60 (498.80)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0855	Excision: Compound palmar ganglion or synovectomy	04.00		128.000	899.60 (789.10)	128.000	899.60 (789.10)	3.000	132.30 (116.10) T
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
3.6	**Musculo-skeletal system: Miscellaneous**								
3.6.1	**Musculo-skeletal system: Miscellaneous: Leg equalisation and congenital hips and feet**								
0859	Leg equalisation and congenital hips and feet: Leg shortening	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	3.000	132.30 (116.10) TM
0861	Leg equalisation and congenital hips and feet: Leg lengthening	04.00		416.000	2923.60 (2564.60)	332.800	2338.90 (2051.70)	3.000	132.30 (116.10) TM
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	3.000	132.30 (116.10) TM
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip	04.00		109.000	766.10 (672.00)	109.000	766.10 (672.00)	3.000	132.30 (116.10) TM
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips	06.04		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0868	Open reduction of congenital dislocation of the hip	04.00		186.000	1307.20 (1146.70)	148.800	1045.80 (917.40)	3.000	132.30 (116.10) TM
0869	Subsequent plasters	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)		
0873	Congenital club foot: Manipulation and plaster: One foot	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)	3.000	132.30 (116.10) T
0874	Ponseti technique assistant (medical practitioner)	05.03		13.000	91.40 (80.20) Z	13.000	91.40 (80.20) Z		
3.6.2	**Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis**								
0883	Removal of internal fixatives or prosthesis: Readily accessible	04.00		36.600	257.20 (225.60)	36.600	257.20 (225.60)		
0884	Removal of internal fixatives: Less accessible	04.00		75.500	530.60 (465.40)	75.500	530.60 (465.40)		
0885	Removal of prosthesis for infection soon after operation	04.00		128.000	899.60 (789.10)	120.000	843.40 (739.80)		
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the item for total joint replacement of the specific joint	04.00	+	64.000	449.80 (394.60)	64.000	449.80 (394.60)	6.000	264.70 (232.20) TM
3.7	**Plasters (exclusive of after-care)**								
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)	04.00		13.000	91.40 (80.20) ò	13.000	91.40 (80.20) ò	3.000	132.30 (116.10) T
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	4.000	176.40 (154.70) T
0891	Turnbuckle cast for scoliosis (excluding after-care)	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	5.000	220.60 (193.50) T
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	04.00		19.000	133.50 (117.10)	19.000	133.50 (117.10)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3.8	**Musculo-skeletal system: Special areas**								
3.8.1	**Special areas: Foot and Ankle**								
0895	Club foot: Revision club foot release - stand alone procedure	04.00		302.700	2127.40 (1866.10)	242.160	1701.90 (1492.90)	3.000	132.30 (116.10) TM
0896	Club foot: Posterior release only - stand alone procedure	04.00		159.300	1119.60 (982.10)	127.440	895.60 (785.60)	3.000	132.30 (116.10) TM
0900	Excision tarsal coalition - stand alone procedure	04.00		141.500	994.50 (872.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0901	Tenotomy: Single tendon	04.00		63.300	444.90 (390.30)	63.300	444.90 (390.30)	3.000	132.30 (116.10) TM
0903	Hammer toe: One toe	04.00		99.500	699.30 (613.40)	99.500	699.30 (613.40)	3.000	132.30 (116.10) TM
0905	Filleting of toe or Ruiz-Mora procedure	04.00		99.500	699.30 (613.40)	99.500	699.30 (613.40)	3.000	132.30 (116.10) TM
0906	Arthrodesis Hallux	04.00		148.000	1040.10 (912.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0907	Silver bunionectomy or similar for Hallux Valgus	04.00		126.200	886.90 (778.00)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0909	Excision arthroplasty	04.00		145.200	1020.50 (895.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
0910	Cheilectomy or metatarsophangeal implant Hallux	04.00		183.000	1286.10 (1128.20)	146.400	1028.90 (902.50)	3.000	132.30 (116.10) TM
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	04.00		189.200	1329.70 (1166.40)	151.360	1063.80 (933.20)	3.000	132.30 (116.10) TM
5730	Hallux Valgus double osteotomy etc.	04.00		182.600	1283.30 (1125.70)	146.080	1026.70 (900.60)	3.000	132.30 (116.10) TM
5731	Distal soft tissue procedure for Hallux Valgus	04.00		173.600	1220.10 (1070.30)	138.880	976.00 (856.10)	3.000	132.30 (116.10) TM
5732	Aitkin procedure or similar	04.00		166.800	1172.30 (1028.30)	133.440	937.80 (822.60)	3.000	132.30 (116.10) T
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)	04.00		91.000	639.50 (561.00)	91.000	639.50 (561.00)	3.000	132.30 (116.10) TM
5735	Repair angular deformity toe (lesser toes)	04.00		97.200	683.10 (599.20)	97.200	683.10 (599.20)	3.000	132.30 (116.10) TM
5736	Sesamoidectomy	04.00		97.800	687.30 (602.90)	97.800	687.30 (602.90)	3.000	132.30 (116.10) TM
5737	Repair major foot tendons e.g. Tib Post	04.00		147.300	1035.20 (908.10)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
5738	Repair of dislocating peroneal tendons	04.00		173.200	1217.20 (1067.70)	138.560	973.80 (854.20)	3.000	132.30 (116.10) T
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot	04.00		202.300	1421.80 (1247.20)	161.840	1137.40 (997.70)	3.000	132.30 (116.10) TM
5740	Steindler strip - plantar fascia	04.00		97.200	683.10 (599.20)	97.200	683.10 (599.20)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5741	Kelikian syndactilly (one web space)	04.00		97.200	683.10 (599.20)	97.200	683.10 (599.20)	3.000	132.30 (116.10) T
5742	Tendon transfer foot	04.00		172.000	1208.80 (1060.40)	137.600	967.10 (848.30)	3.000	132.30 (116.10) T
5743	Capsulotomy metatarsophalangeal joints: Foot	04.00		86.800	610.00 (535.10)	86.800	610.00 (535.10)	3.000	132.30 (116.10) T
3.8.2	**Big toe (refer to section 3.8.1 for procedures on big toe)**								
3.8.3	**Special areas: Reimplantations**								
0912	Replantation of amputated upper limb proximal to wrist joint	04.00		730.000	5130.40 (4500.40)	584.000	4104.40 (3600.40)	3.000	132.30 (116.10) TM
0913	Replantation of thumb	04.00		670.000	4708.80 (4130.50)	536.000	3767.00 (3304.40)	3.000	132.30 (116.10) TM
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	04.00		580.000	4076.20 (3575.60)	464.000	3261.00 (2860.50)	3.000	132.30 (116.10) TM
0915	Replantation operation through the palm	04.00		1270.000	8925.60 (7829.50)	1016.000	7140.40 (6263.50)	3.000	132.30 (116.10) TM
3.8.4	**Special areas: Hands: (Note: Skin: See Integumentary System)**								
0919	Tumours: Epidermoid cysts	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) TM
0920	Tumours: Ganglion or fibroma	04.00		77.500	544.70 (477.80)	77.500	544.70 (477.80)	3.000	132.30 (116.10) TM
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)	04.00		86.000	604.40 (530.20)	86.000	604.40 (530.20)	3.000	132.30 (116.10) TM
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	04.00		19.000	133.50 (117.10)	19.000	133.50 (117.10)	3.000	132.30 (116.10) TM
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	3.000	132.30 (116.10) TM
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum	05.01		37.000	260.00 (228.10)	37.000	260.00 (228.10)	3.000	132.30 (116.10) TM
	Item 0924: The number of units chargeable under this item ranges from 37.00 to 110.00 for Specialists and General Practitioners.	04.00							
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)	3.000	132.30 (116.10) TM
3.8.5	**Special areas: Spine**								
	Please note the following with regard to section 3.8.5: Spine a) Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together: 1. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis. 2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition. b) Modifier 0005 (multiple procedures/operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. Osteotomy, laminectomy.	04.00							
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	04.00		207.000	1454.80 (1276.10)	165.600	1163.80 (1020.90)	3.000	132.30 (116.10) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	04.00	+	42.000	295.20 (258.90)	42.000	295.20 (258.90)	3.000	132.30 (116.10) TM
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	5.000	220.60 (193.50) TM
0930	Posterior osteotomy of spine: One vertebral segment	04.00		339.000	2382.50 (2089.90)	271.200	1906.00 (1671.90)	3.000	132.30 (116.10) TM
0931	Posterior spinal fusion: One level	04.00		385.000	2705.80 (2373.50)	308.000	2164.60 (1898.80)	3.000	132.30 (116.10) TM
0932	Posterior osteotomy of spine: Each additional vertebral segment	04.00	+	103.000	723.90 (635.00)	103.000	723.90 (635.00)	3.000	132.30 (116.10) TM
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	04.00		315.000	2213.80 (1941.90)	252.000	1771.10 (1553.60)	3.000	132.30 (116.10) TM
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	04.00	+	103.000	723.90 (635.00)	103.000	723.90 (635.00)	3.000	132.30 (116.10) TM
0938	Anterior fusion base of skull to C2	04.00		449.000	3155.60 (2768.10)	359.200	2524.50 (2214.50)	4.000	176.40 (154.70) TM
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	3.000	132.30 (116.10) TM
0941	Anterior interbody fusion: One level	04.00		360.000	2530.10 (2219.40)	288.000	2024.10 (1775.50)	3.000	132.30 (116.10) TM
0942	Anterior interbody fusion: Each additional level	04.00	+	102.000	716.90 (628.90)	102.000	716.90 (628.90)	3.000	132.30 (116.10) TM
0944	Posterior fusion: Occiput to C2	04.00		390.000	2740.90 (2404.30)	312.000	2192.70 (1923.40)	4.000	176.40 (154.70) TM
0946	Posterior spinal fusion: Each additional level	04.00	+	111.000	780.10 (684.30)	111.000	780.10 (684.30)	3.000	132.30 (116.10) TM
0948	Posterior interbody lumbar fusion: One level	04.00		364.000	2558.20 (2244.00)	291.200	2046.60 (1795.30)	3.000	132.30 (116.10) TM
0950	Posterior interbody lumbar fusion: Each additional interspace	04.00	+	95.000	667.70 (585.70)	95.000	667.70 (585.70)	3.000	132.30 (116.10) TM
0959	Excision of coccyx	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) TM
0961	Costo-transversectomy	04.00		198.000	1391.50 (1220.60)	158.400	1113.20 (976.50)	3.000	132.30 (116.10) TM
0963	Antero-lateral decompression of spinal cord or anterior debridement	04.00		326.000	2291.10 (2009.70)	260.800	1832.90 (1607.80)	3.000	132.30 (116.10) T
MODIFIER									
0081	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed								04.00
3.8.6	**Special areas: Spinal deformities**								
	Please note : Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).								04.00

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0952	Posterior fusion for spinal deformity: Up to 6 levels	04.00		359.000	2523.10 (2213.20)	287.200	2018.40 (1770.50)	3.000	132.30 (116.10) TM
0954	Posterior fusion for spinal deformity: 7 to 12 levels	04.00		547.000	3844.30 (3372.20)	437.600	3075.50 (2697.80)	3.000	132.30 (116.10) TM
0955	Posterior fusion for spinal deformity: 13 or more levels	04.00		593.000	4167.60 (3655.80)	474.400	3334.10 (2924.60)	3.000	132.30 (116.10) TM
0956	Anterior fusion for spinal deformity: 2 or 3 levels	04.00		410.000	2881.50 (2527.60)	328.000	2305.20 (2022.10)	3.000	132.30 (116.10) TM
0957	Anterior fusion for spinal deformity: 4 to 7 levels	04.00		444.000	3120.40 (2737.20)	355.200	2496.30 (2189.70)	3.000	132.30 (116.10) TM
0958	Anterior fusion for spinal deformity: 8 or more levels	04.00		539.000	3788.10 (3322.90)	431.200	3030.50 (2658.30)	3.000	132.30 (116.10) TM
MODIFIER									
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere								04.00
3.8.7	**Special areas: All spinal problems**								
0943	Laminectomy with decompression of nerve roots and disc removal: One level	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	3.000	132.30 (116.10) TM
0960	Posterior non-segmental instrumentation	04.00		167.000	1173.70 (1029.60)	133.600	938.90 (823.60)	5.000	220.60 (193.50) TM
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	04.00		176.000	1236.90 (1085.00)	140.800	989.50 (868.00)	5.000	220.60 (193.50) TM
0984	Posterior segmental instrumentation: 7 to 12 vertebrae	04.00		201.000	1412.60 (1239.10)	160.800	1130.10 (991.30)	5.000	220.60 (193.50) TM
0966	Posterior segmental instrumentation:13 or more vertebrae	04.00		245.000	1721.90 (1510.40)	196.000	1377.50 (1208.30)	5.000	220.60 (193.50) TM
0968	Anterior instrumentation: 2 to 3 vertebrae	04.00		159.000	1117.50 (980.30)	127.200	894.00 (784.20)	5.000	220.60 (193.50) TM
0969	Skull or skull-femoral traction including two weeks after-care	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)		
0970	Anterior instrumentation: 4 to 7 vertebrae	04.00		185.000	1300.20 (1140.50)	148.000	1040.10 (912.40)	5.000	220.60 (193.50) TM
0971	Halo-splint and POP jacket including two weeks after-care	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)		
0972	Anterior instrumentation: 8 or more vertebrae	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	5.000	220.60 (193.50) TM
0974	Additional pelvic fixation of instrumentation other than sacrum	04.00		108.000	759.00 (665.80)	108.000	759.00 (665.80)	5.000	220.60 (193.50) TM
5750	Reinsertion of instrumentation	04.00		276.000	1939.70 (1701.50)	220.800	1551.80 (1361.20)	6.000	264.70 (232.20) TM
5751	Removal of posterior non-segmental instrumentation	04.00		173.000	1215.80 (1066.50)	138.400	972.70 (853.20)	6.000	264.70 (232.20) TM
5752	Removal of posterior segmental instrumentation	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	6.000	264.70 (232.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5753	Removal of anterior instrumentation	04.00		204.000	1433.70 (1257.60)	163.200	1147.00 (1006.10)	6.000	264.70 (232.20) TM
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	04.00		295.000	2073.30 (1818.70)	236.000	1658.60 (1454.90)	3.000	132.30 (116.10) TM
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	04.00		304.000	2136.50 (1874.10)	243.200	1709.20 (1499.30)	3.000	132.30 (116.10) TM
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	04.00		321.000	2256.00 (1978.90)	256.800	1804.80 (1583.20)	3.000	132.30 (116.10) TM
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	04.00	+	63.000	442.80 (388.40)	63.000	442.80 (388.40)	3.000	132.30 (116.10) TM
5759	Laminectomy for decompression diskectomy, etc. revision operation	04.00		352.000	2473.90 (2170.10)	281.600	1979.10 (1736.10)	4.000	176.40 (154.70) TM
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	04.00		301.000	2115.40 (1855.60)	240.800	1692.30 (1484.50)	3.000	132.30 (116.10) TM
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	04.00	+	68.000	477.90 (419.20)	68.000	477.90 (419.20)	3.000	132.30 (116.10) TM
5763	Anterior disc removal and spinal decompression cervical: One level	04.00		344.000	2417.60 (2120.70)	275.200	1934.10 (1696.60)	3.000	132.30 (116.10) TM
5764	Anterior disc removal and spinal decompression cervical: Each additional level	04.00	+	81.000	569.30 (499.40)	81.000	569.30 (499.40)	3.000	132.30 (116.10) TM
5765	Vertebral corpectomy for spinal decompression: One level	04.00		466.000	3275.00 (2872.80)	372.800	2620.00 (2298.20)	3.000	132.30 (116.10) TM
5766	Vertebral corpectomy for spinal decompression: Each additional level	04.00		88.000	618.50 (542.50)	88.000	618.50 (542.50)	3.000	132.30 (116.10) TM
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	04.00		71.000	499.00 (437.70)	71.000	499.00 (437.70)		
3.9	**Facial bone procedures**								
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9								04.00
0987	Repair of orbital floor (blowout fracture)	04.00		184.600	1297.40 (1138.10)	147.680	1037.90 (910.40)	4.000	176.40 (154.70) TM
0988	Genioplasty	04.00		263.000	1848.40 (1621.40)	210.400	1478.70 (1297.10)	4.000	176.40 (154.70) TM
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	04.00		202.200	1421.10 (1246.60)	161.760	1136.80 (997.20)	4.000	176.40 (154.70) TM
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	04.00		302.000	2122.50 (1861.80)	241.600	1698.00 (1489.50)	4.000	176.40 (154.70) TM
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	04.00		433.000	3043.10 (2669.40)	346.400	2434.50 (2135.50)	4.000	176.40 (154.70) TM
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	04.00		970.000	6817.20 (5980.00)	776.000	5453.70 (4783.90)	4.000	176.40 (154.70) TM
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	04.00		302.000	2122.50 (1861.80)	241.600	1698.00 (1489.50)	4.000	176.40 (154.70) TM
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	04.00		1103.000	7751.90 (6799.90)	882.400	6201.50 (5439.90)	4.000	176.40 (154.70) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	04.00		1654.000	11624.30 (10196.80)	1323.200	9299.40 (8157.40)	4.000	176.40 (154.70) TM
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement	04.00		-	- F	-	- F		
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation	04.00		302.000	2122.50 (1861.80)	241.600	1698.00 (1489.50)	3.000	132.30 (116.10) TM
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	04.00		184.000	1293.20 (1134.40)	147.200	1034.50 (907.50)	3.000	132.30 (116.10) TM
1001	Temporo-mandibular joint: Reconstruction for dysfunction	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) TM
1003	Manipulation: Immobilisation and follow-up of fractured nose	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) TM
1005	Nasal fracture without manipulation	04.00		-	- F	-	- F		
1007	Mandibulectomy	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	5.000	220.60 (193.50) TM
1009	Maxillectomy	04.00		382.500	2688.20 (2358.10)	306.000	2150.60 (1886.50)	4.000	176.40 (154.70) TM
1011	Bone graft to mandible	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) TM
1012	Adjustment of occlusion by ramisection	04.00		227.000	1595.40 (1399.50)	181.600	1276.30 (1119.60)	4.000	176.40 (154.70) TM
1013	Fracture of arch of zygoma without displacement	04.00		-	- F	-	- F		
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	04.00		131.000	920.70 (807.60)	120.000	843.40 (739.80)	3.000	132.30 (116.10) TM
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	04.00		262.000	1841.30 (1615.20)	209.600	1473.10 (1292.20)	3.000	132.30 (116.10) TM
4	**Respiratory System**								
4.1	**Nose and sinuses**								
1018	Flexible nasopheryngolaryngoscope examination	04.00		51.940	365.00 (320.20)	51.940	365.00 (320.20)		
1019	ENT endoscopy in rooms with rigid endoscope	04.00		12.000	84.30 (73.90)				
1020	Repair of perforated septum: Any method	06.04		141.900	997.30 (874.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1022	Functional reconstruction of nasal septum	04.00		121.200	851.80 (747.20)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	4.000	176.40 (154.70) T
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	06.04		64.600	454.00 (398.20)	64.600	454.00 (398.20)	4.000	176.40 (154.70) T
1027	Dacrocystorhinostomy	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	06.04		62.600	440.00 (386.00)	62.600	440.00 (386.00)	4.000	176.40 (154.70) T
1030	Endoscopic turbinectomy: Laser or microdebrider	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1031	Removal of single nasal polyp at rooms (at initial consultation only)	04.00		25.400	178.50 (156.60)	25.400	178.50 (156.60)		
1033	Removal of multiple polyps in hospital under general anaesthetic	04.00		81.800	574.90 (504.30)	81.800	574.90 (504.30)	4.000	176.40 (154.70) T
1034	Autogenous nasal bone transplant: Bone removal included	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	4.000	176.40 (154.70) T
1035	Functional endoscopic sinus surgery: Unilateral	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1036	Functional endoscopic sinus surgery: Bilateral	04.00		245.000	1721.90 (1510.40)	196.000	1377.50 (1208.30)	4.000	176.40 (154.70) T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	4.000	176.40 (154.70) T
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	6.000	264.70 (232.20) T
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	6.000	264.70 (232.20) T
1045	Ligation anterior ethmoidal artery	04.00		135.400	951.60 (834.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
1047	Caldwell-Luc operation: Unilateral	04.00		137.300	964.90 (846.40)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1049	Ligation internal maxillary artery	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	6.000	264.70 (232.20) T
1050	Vidian neurectomy (transantral or transnasal)	04.00		113.000	794.20 (696.70)	113.000	794.20 (696.70)	4.000	176.40 (154.70) T
1051	Removal nasopharyngeal fibroma	04.00		285.000	2003.00 (1757.00)	228.000	1602.40 (1405.60)	6.000	264.70 (232.20) T
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
1053	Frontal sinus drainage, trephine operation	04.00		93.100	654.30 (573.90)	93.100	654.30 (573.90)	4.000	176.40 (154.70) T
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	06.04		37.300	262.10 (229.90)				
1055	External frontal ethmoidectomy	04.00		190.700	1340.20 (1175.60)	152.560	1072.20 (940.50)	4.000	176.40 (154.70) T
1057	External ethmoidectomy and/or sphenoidectomy	04.00		199.400	1401.40 (1229.30)	159.520	1121.10 (983.40)	4.000	176.40 (154.70) T
1058	Sublabial transseptal sphenoidotomy	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
1059	Frontal osteomyelitis	04.00		194.000	1363.40 (1196.00)	155.200	1090.70 (956.80)	4.000	176.40 (154.70) T
1060	Obliteration of frontal sinus	04.00		291.100	2045.90 (1794.60)	232.880	1636.70 (1435.70)	4.000	176.40 (154.70) T
1061	Lateral rhinotomy	04.00		164.000	1152.60 (1011.10)	131.200	922.10 (808.90)	4.000	176.40 (154.70) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1062	Excision nasolabial cyst	04.00		186.100	1307.90 (1147.30)	148.880	1046.30 (917.80)	4.000	176.40 (154.70) T
1063	Removal of foreign bodies from nose: At rooms	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
1065	Removal of foreign body from nose: Under general anaesthetic	04.00		38.600	271.30 (238.00)	38.600	271.30 (238.00)	4.000	176.40 (154.70) T
1067	Proof puncture at rooms: Unilateral	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
1069	Proof puncture, uni- or bilateral under general anaesthetic	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	4.000	176.40 (154.70) T
1071	Proetz treatment (consultation fee only to be charged for first treatment)	04.00		4.000	28.10 (24.60)	4.000	28.10 (24.60)		
1077	Septum abscess: At rooms, including after-care	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
1079	Septum abscess: Under general anaesthetic	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	4.000	176.40 (154.70) T
1081	Oro-antral fistula (without Caldwell-Luc)	04.00		111.800	785.70 (689.20)	111.800	785.70 (689.20)	4.000	176.40 (154.70) T
1083	Choanal atresia: Intranasal approach	04.00		113.000	794.20 (696.70)	113.000	794.20 (696.70)	5.000	220.60 (193.50) T
1084	Choanal atresia: Transpalatal approach	04.00		194.000	1363.40 (1196.00)	155.200	1090.70 (956.80)	7.000	308.80 (270.90) T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	5.000	220.60 (193.50) T
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
1089	Forehead rhinoplasty (all stages): Total	04.00		552.000	3879.50 (3403.10)	441.600	3103.60 (2722.50)	5.000	220.60 (193.50) T
1091	Forehead rhinoplasty (all stages): Partial	04.00		414.000	2909.60 (2552.30)	331.200	2327.70 (2041.80)	5.000	220.60 (193.50) T
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1095	Full nasal reconstruction for secondary cleft lip deformity	04.00		357.900	2515.30 (2206.40)	286.320	2012.30 (1765.20)	5.000	220.60 (193.50) T
1097	Partial nasal reconstruction for cleft lip deformity	04.00		199.700	1403.50 (1231.10)	159.760	1122.80 (984.90)	5.000	220.60 (193.50) T
1099	Columella reconstruction or lengthening	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
MODIFIERS GOVERNING NASAL OPERATIONS									
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083								04.00
4.2	**Throat**								
1101	Tonsillectomy (dissection of the tonsils)	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	4.000	176.40 (154.70) T
1102	Laser tonsillectomy	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	6.000	264.70 (232.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1105	Removal of adenoids	04.11		40.000	281.10 (246.60)	40.000	281.10 (246.60)	4.000	176.40 (154.70) T
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)	04.00		168.300	1182.80 (1037.50)	134.640	946.20 (830.00)	5.000	220.60 (193.50) T
1107	Opening of quinsy: At rooms	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	6.000	264.70 (232.20) T
1108	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser): Follow-up operation performed by the same surgeon	04.00		85.000	597.40 (524.00)	85.000	597.40 (524.00)	5.000	220.60 (193.50) T
1109	Opening of quinsy: Under general anaesthetic	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	6.000	264.70 (232.20) T
1110	Ludwig's Angina: Drainage	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	9.000	397.00 (348.20) T
1111	Post tonsillectomy or adenoidectomy haemorrhage	04.00		46.000	323.30 (283.60)	46.000	323.30 (283.60)	6.000	264.70 (232.20) T
1112	Pharyngeal pouch operation	04.11		231.800	1629.10 (1429.00)	185.440	1303.30 (1143.20)	5.000	220.60 (193.50) T
1113	Retropharyngeal abscess: Internal approach	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	6.000	264.70 (232.20) T
1115	Retropharyngeal abscess: External approach	04.00		85.000	597.40 (524.00)	85.000	597.40 (524.00)	6.000	264.70 (232.20) T
1116	Functional reconstruction of palate and uvula	04.00		168.300	1182.80 (1037.50)	134.640	946.20 (830.00)	5.000	220.60 (193.50) T
4.3	**Larynx**								
1117	Laryngeal intubation	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
1118	Laryngeal stroboscopy with video capture	04.00		39.000	274.10 (240.40)	39.000	274.10 (240.40)	6.000	264.70 (232.20) T
1119	Laryngectomy without block dissection of the neck	04.00		430.000	3022.00 (2650.90)	344.000	2417.60 (2120.70)	7.000	308.80 (270.90) T
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)	04.00		35.000	246.00 (215.80)				
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	04.00		81.100	570.00 (500.00)	81.100	570.00 (500.00)	6.000	264.70 (232.20) T
1126	Post laryngectomy for voice restoration	04.00		139.500	980.40 (860.00)	120.000	843.40 (739.80)	9.000	397.00 (348.20) T
1127	Tracheotomy	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	9.000	397.00 (348.20) T
1128	Endolaryngeal operations	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	8.000	352.90 (309.60) T
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	04.00		294.400	2069.00 (1814.90)	235.520	1655.20 (1451.90)	8.000	352.90 (309.60) T
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	04.00		41.400	291.00 (255.30)	41.400	291.00 (255.30)	6.000	264.70 (232.20) T
1131	Direct laryngoscopy plus foreign body removal	04.00		64.600	454.00 (398.20)	64.600	454.00 (398.20)	6.000	264.70 (232.20) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
MODIFIERS									
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff)								04.00
4.4	**Bronchial procedures**								
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy								04.00
1132	Bronchoscopy: Diagnostic bronchoscopy	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	6.000	264.70 (232.20) T
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	8.000	352.90 (309.60) T
1134	Bronchoscopy: Bronchoscopy with laser	04.00		75.000	527.10 (462.40)			8.000	352.90 (309.60) T
1136	Nebulisation (in rooms)	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	12.000	84.30 (73.90) ç
1137	Bronchial lavage	04.00						8.000	352.90 (309.60) T
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	12.000	529.30 (464.30) T
4.5	**Pleura**								
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) T
1141	Insertion of intercostal catheter (under water drainage)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	6.000	264.70 (232.20) T
1142	Intra-pleural block	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)	36.000	253.00 (221.90) ç
1143	Paracentesis chest: Diagnostic	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)	3.000	132.30 (116.10) T
1145	Paracentesis chest: Therapeutic	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	3.000	132.30 (116.10) T
1147	Pneumothorax: Induction (diagnostic)	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)		
1149	Pleurectomy	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	11.000	485.20 (425.60) T
1151	Decortication of lung	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	11.000	485.20 (425.60) T
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)	3.000	132.30 (116.10) T
4.6	**Pulmonary procedures**								
4.6.1	**Pulmonary procedures: Surgical**								
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)	5.000	220.60 (193.50) T
1157	Pneumonectomy	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	11.000	485.20 (425.60) T
1159	Pulmonary lobectomy	04.00		389.500	2737.40 (2401.20)	311.600	2189.90 (1921.00)	11.000	485.20 (425.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1161	Segmental lobectomy	04.00		365.000	2565.20 (2250.20)	292.000	2052.20 (1800.20)	11.000	485.20 (425.60) T
1163	Excision tracheal stenosis: Cervical	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	8.000	352.90 (309.60) T
1164	Excision tracheal stenosis: Intra thoracic	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	12.000	529.30 (464.30) T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	12.000	529.30 (464.30) T
1168	Thoracoplasty: Complete	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	11.000	485.20 (425.60) T
1169	Thoracoplasty: Limited (osteoplastic)	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	11.000	485.20 (425.60) T
1171	Drainage empyema (including six weeks after treatment)	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	11.000	485.20 (425.60) T
1173	Drainage of lung abscess (including six weeks after treatment)	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	11.000	485.20 (425.60) T
1175	Thoracotomy (limited): For lung or pleural biopsy	04.00		115.000	808.20 (708.90)	115.000	808.20 (708.90)	11.000	485.20 (425.60) T
1177	Major: Diagnostic, as for inoperable carcinoma	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	11.000	485.20 (425.60) T
1179	Thoracoscopy	04.00		89.000	625.50 (548.70)	89.000	625.50 (548.70)	11.000	485.20 (425.60) T
1181	Lung transplant: Unilateral	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	15.000	661.70 (580.40) T
1182	Harvesting donor lung: Unilateral	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1183	Excision or plication of emphysematous cyst: Unilateral	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	11.000	485.20 (425.60) T
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	04.00		438.000	3078.30 (2700.30)	350.400	2462.60 (2160.20)	11.000	485.20 (425.60) T
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	11.000	485.20 (425.60) T
4.6.2	**Pulmonary function tests**								
1186	Flow volume test: Inspiration/expiration	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation - thereafter item 1186 applies)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	50.000	351.40 (308.20) ç
1189	Forced expirogram only	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	10.000	70.30 (61.70) ç
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	04.00		45.310	318.40 (279.30)				
1191	N2 single breath distribution	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	10.000	70.30 (61.70) ç
1192	Peak expiratory flow only	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)	5.000	35.10 (30.80) ç

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	04.00		37.760	265.40 (232.80)				
1195	Thoracic gas volume	04.00		37.930	266.60 (233.90)				
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	04.00		45.310	318.40 (279.30)				
1197	Compliance and resistance, using oesophageal balloon	04.00		24.000	168.70 (148.00)	24.000	168.70 (148.00)	24.000	168.70 (148.00) ç
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry	04.00		55.890	392.80 (344.60)	55.890	392.80 (344.60)		
1199	Pulmonary stress testing: For determination of VO2 max	04.00		96.500	678.20 (594.90)	96.500	678.20 (594.90)		
1200	Carbon monoxide diffusing capacity, any method	04.00		38.060	267.50 (234.60)				
1201	Maximum inspiratory/expiratory pressure	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)	5.000	35.10 (30.80) ç
4.7	**Intensive care**								
RULES GOVERNING THIS SECTION									
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)								06.05
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)								04.00
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.								04.00
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring								04.00
4.7.1	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Neonatal procedures**								
1202	Insertion of central venous catheter via peripheral vein in neonates	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	40.000	281.10 (246.60) ç
4.7.2	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Tariff items for intensive care**								
1204	Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per day	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç
1205	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): First day	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	100.000	702.80 (616.50) ç
1206	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): Subsequent days, per day	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	50.000	351.40 (308.20) ç
1207	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): After two weeks, per day	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç
	Please Note: The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109	04.00							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1208	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	137.000	962.80 (844.60) ç
1209	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)	58.000	407.60 (357.50) ç
1210	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	50.000	351.40 (308.20) ç
4.7.3	**Intensive care: (In intensive care or high care unit): Respiratory, cardiac, general: Procedures**								
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) - 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.	04.00							
1212	Ventilation: First day	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	75.000	527.10 (462.40) ç
1213	Ventilation: Subsequent days, per day	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	50.000	351.40 (308.20) ç
1214	Ventilation: After two weeks, per day	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	25.000	175.70 (154.10) ç
1215	Insertion of arterial pressure cannula	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	25.000	175.70 (154.10) ç
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	04.11		50.000	351.40 (308.20)	50.000	351.40 (308.20)	50.000	351.40 (308.20) ç
1217	Insertion of central venous line via peripheral vein	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	10.000	70.30 (61.70) ç
1218	Insertion of central venous line via subclavian or jugular veins	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	25.000	175.70 (154.10) ç
1219	Hyperalimentation (daily tariff)	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)	15.000	105.40 (92.50) ç
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	30.000	210.80 (184.90) ç

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4.8	**Hyperbaric Oxygen Therapy**								
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic). b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias. f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis. i. Bone and soft tissue radiation necrosis. j. Compromised skin grafts and flaps. k. Acute thermal burns. l. Acute bloodloss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia). m. Cerebral abscesses								04.00
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)		
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT	05.03		101.130	710.70 (623.40) Z	101.130	710.70 (623.40) Z		
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Routine HBO table (2-2,5 ATA x 90-120 min): PROFESSIONAL COMPONENT	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)		
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT	05.03		131.260	922.50 (809.20) Z	131.260	922.50 (809.20) Z		
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Emergency HBO table (2,5-3 ATA x 90-120 min): PROFESSIONAL COMPONENT	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)		
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT	05.03		131.260	922.50 (809.20) Z	131.260	922.50 (809.20) Z		
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT5 (2,8 ATA x 135 min): PROFESSIONAL COMPONENT	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)		
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT	05.03		214.180	1505.30 (1320.40) Z	214.180	1505.30 (1320.40) Z		
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6 (2,8 ATA x 285 min): PROFESSIONAL COMPONENT	04.00		190.000	1335.30 (1171.30)	190.000	1335.30 (1171.30)		
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	05.03		386.420	2715.80 (2382.30) Z	386.420	2715.80 (2382.30) Z		
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min): PROFESSIONAL COMPONENT	04.00		327.000	2298.20 (2016.00)	327.000	2298.20 (2016.00)		
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		680.850	4785.00 (4197.40) Z	680.850	4785.00 (4197.40) Z		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		678.280	4767.00 (4181.60) Z	678.280	4767.00 (4181.60) Z		
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		671.850	4721.80 (4141.90) Z	671.850	4721.80 (4141.90) Z		
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour: Minimum 40,00 clinical procedure units; maximum 320,00 clinical procedure units	04.00							
5	**Mediastinal Procedures**								
1222	Mediastinal tumours	04.00		285.000	2003.00 (1757.00)	228.000	1602.40 (1405.60)	11.000	485.20 (425.60) T
1223	Mediastinoscopy	04.00		95.000	667.70 (585.70)	95.000	667.70 (585.70)	5.000	220.60 (193.50) T
1224	Mediastinotomy	04.00		115.000	808.20 (708.90)	115.000	808.20 (708.90)	11.000	485.20 (425.60) T
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	11.000	485.20 (425.60) T
1226	Removal of single rib with a lesion	04.00		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	11.000	485.20 (425.60) T
6	**Cardiovascular System**								
MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP									
6.1	**Cardiovascular system: General**								
1227	Prolonged neonatal resuscitation	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	20.000	140.60 (123.30) ç
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG	04.00							
1228	General Practitioner's fee for the taking of an ECG only: Without effort: ½ (item 1232)	04.00				4.500	31.60 (27.70)		
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: ½ (item 1233)	04.00				6.500	45.70 (40.10)		
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added	04.00							
1230	Physician's fee for interpreting an ECG: Without effort	04.00		6.000	42.20 (37.00)				
1231	Physician's fee for interpreting an ECG: With and without effort	06.04		10.000	70.30 (61.70)				
	A specialist physician is entitled to the fees specified in item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation	04.00							
1232	Electrocardiogram: Without effort	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
1233	Electrocardiogram: With and without effort	06.04		13.000	91.40 (80.20)	13.000	91.40 (80.20)		
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)		
1235	Multi-stage treadmill test	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)		
1236	Electrocardiogram without effort: Under 4 years old	06.04		18.000	126.50 (111.00)	18.000	126.50 (111.00)		
1237	24 Hour ambulatory blood pressure: Hire fee	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	04.00		284.000	1996.00 (1750.90)	227.200	1596.80 (1400.70)	5.000	220.60 (193.50) T
1871	Staghorn stone: Surgical	04.00		341.000	2396.50 (2102.20)	272.800	1917.20 (1681.80)	6.000	264.70 (232.20) T
1873	Suture renal laceration (renorraphy)	04.00		193.000	1356.40 (1189.80)	154.400	1085.10 (951.80)	6.000	264.70 (232.20) T
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	04.00		34.000	239.00 (209.60)	34.000	239.00 (209.60)	3.000	132.30 (116.10) T
1877	Operation for renal cyst: Marsupialisation or excision	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1879	Closure renal fistula	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1881	Pyeloplasty	06.04		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	5.000	220.60 (193.50) T
1883	Pyelostomy	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1885	Pyelolithotomy	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	04.00		223.000	1567.20 (1374.70)	178.400	1253.80 (1099.80)	5.000	220.60 (193.50) T
1889	Nephrectomy for Allograft: Living or dead	04.00		255.000	1792.10 (1572.00)	204.000	1433.70 (1257.60)	5.000	220.60 (193.50) T
1891	Perinephric abscess or renal abscess: Drainage	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	7.000	308.80 (270.90) T
1893	Aberrant renal vessels: Repositioning with pyeloplasty	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
1894	Auto transplantation of kidney	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	10.000	441.10 (386.90) T
1895	Allo transplantation of kidney	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	10.000	441.10 (386.90) T
10.2	**Ureter**								
1897	Ureterorraphy: Suture of ureter	04.11		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1898	Ureterorraphy: Lumbar approach	04.11		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1899	Ureteroplasty	04.00		181.000	1272.10 (1115.90)	144.800	1017.70 (892.70)	5.000	220.60 (193.50) T
1901	Ureterolysis	04.00		118.000	829.30 (727.50)	118.000	829.30 (727.50)	5.000	220.60 (193.50) T
1902	Ureterolysis: Lumbar approach	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1903	Ureterectomy only	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1905	Ureterolithotomy	04.00		265.800	1868.00 (1638.60)	212.640	1494.40 (1310.90)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1907	Cutaneous ureterostomy: Unilateral	04.00		108.000	759.00 (665.80)	108.000	759.00 (665.80)	5.000	220.60 (193.50) T
1909	Cutaneous ureterostomy: Bilateral	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
1911	Uretero-enterostomy: Unilateral	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1913	Uretero-enterostomy: Bilateral	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	5.000	220.60 (193.50) T
1915	Uretero-ureterostomy	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1917	Transuretero-ureterostomy	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	5.000	220.60 (193.50) T
1919	Closure of ureteric fistula	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1921	Immediate deligation of ureter	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1923	Ureterolysis for retrocaval ureter with anastomosis	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	5.000	220.60 (193.50) T
1925	Uretero-pyelostomy	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	5.000	220.60 (193.50) T
1927	Uretero-neo-cystostomy: Unilateral	04.00		316.100	2221.60 (1948.80)	252.880	1777.20 (1558.90)	5.000	220.60 (193.50) T
1929	Uretero-neo-cystostomy: Bilateral	04.00		474.150	3332.30 (2923.10)	379.320	2665.90 (2338.50)	5.000	220.60 (193.50) T
1931	Uretero-neo-cystostomy: With Boariplasty	04.00		351.800	2472.50 (2168.90)	281.440	1978.00 (1735.10)	5.000	220.60 (193.50) T
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	5.000	220.60 (193.50) T
1935	Uretero-ileal conduit	04.00		388.000	2726.90 (2392.00)	310.400	2181.50 (1913.60)	5.000	220.60 (193.50) T
1937	Replacement of ureter by bowel segment: Unilateral	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	5.000	220.60 (193.50) T
1939	Replacement of ureter by bowel segment: Bilateral	04.00		485.000	3408.60 (2990.00)	388.000	2726.90 (2392.00)	5.000	220.60 (193.50) T
1941	Ureterostomy-in-situ: Unilateral	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	5.000	220.60 (193.50) T
1943	Ureterostomy-in-situ: Bilateral	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	5.000	220.60 (193.50) T
10.3	**Bladder**								
1952	J J Stent catheter	04.00	+	44.000	309.20 (271.20)	44.000	309.20 (271.20)	3.000	132.30 (116.10) T
1953	With hydrodilatation of the bladder for interstitial cystitis	04.00	+	5.000	35.10 (30.80)	5.000	35.10 (30.80)	3.000	132.30 (116.10) T
1954	Uretroscopy	04.00	+	35.000	246.00 (215.80)			3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	04.00	+	35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
1957	With dilatation of the ureter or ureters	04.00	+	25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10) T
1959	With manipulation of ureteral calculus	04.00	+	20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
1961	With removal of foreign body or calculus from urethra or bladder	04.00	+	20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
1983	With fulguration or treatment of minor lesions, with or without biopsy	04.00	+	15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
1964	And control of haemorrhage and blood clot evacuation	04.00	+	15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
1965	And catheterisation of the ejaculatory duct	04.00	+	10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
1967	With ureteric meatotomy: Unilateral or bilateral	04.00	+	15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
1969	And cold biopsy	04.00	+	15.000	105.40 (92.50)	15.000	105.40 (92.50)	3.000	132.30 (116.10) T
1971	With cryosurgery for bladder or prostatic disease	04.00	+	55.000	386.50 (339.00)	55.000	386.50 (339.00)	3.000	132.30 (116.10) T
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	04.00	+	35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
1975	Ultraviolet cystoscopy for bladder tumour	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) T
1976	Optic urethrotomy	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	3.000	132.30 (116.10) T
1977	Transurethral resection of ejaculatory duct	04.00		60.700	426.60 (374.20)	60.700	426.60 (374.20)	3.000	132.30 (116.10) T
1979	Internal urethrotomy: Female	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	3.000	132.30 (116.10) T
1981	Internal urethrotomy: Male	04.00		76.200	535.50 (469.70)	76.200	535.50 (469.70)	3.000	132.30 (116.10) T
1983	Transurethral resection of bladder tumour	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	5.000	220.60 (193.50) T
1984	Transurethral resection of bladder tumours: Large multiple tumours	04.00		115.000	808.20 (708.90)	115.000	808.20 (708.90)	5.000	220.60 (193.50) T
1985	Transurethral resection of bladder neck: Female or child	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	5.000	220.60 (193.50) T
1986	Transurethral resection of bladder neck: Male	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
1987	Litholapaxy	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	5.000	220.60 (193.50) T
1989	Cystometrogram	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1991	Flometric bladder, studies with videocystograph	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	3.000	132.30 (116.10) T
1992	Without videocystograph	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	3.000	132.30 (116.10) T
1993	Voiding cysto-urethrogram	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)	3.000	132.30 (116.10) T
1994	Rigiscan examination	04.00		66.000	463.80 (406.80)	66.000	463.80 (406.80)		
1995	Percutaneous aspiration of bladder	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
1996	Bladder catheterisation: Male (not at operation)	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)	3.000	132.30 (116.10) T
1997	Bladder catheterisation: Female (not at operation)	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
1999	Percutaneous cystostomy	04.00		24.000	168.70 (148.00)	24.000	168.70 (148.00)	3.000	132.30 (116.10) T
1945	Instillation of radio-opaque material for cystography or urethrocystography	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)	3.000	132.30 (116.10) T
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
1949	Cystoscopy: Hospital equipment	04.00		44.000	309.20 (271.20)	44.000	309.20 (271.20)	3.000	132.30 (116.10) T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	04.00	+	10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
2001	Total cystectomy: After previous urinary diversion	04.00		294.000	2066.20 (1812.50)	235.200	1653.00 (1450.00)	8.000	352.90 (309.60) T
2003	Total cystectomy: With conduit construction and ureteric anastomosis	04.00		554.700	3898.40 (3419.60)	443.760	3118.70 (2735.70)	8.000	352.90 (309.60) T
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	04.00		650.000	4568.20 (4007.20)	520.000	3654.60 (3205.80)	8.000	352.90 (309.60) T
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	8.000	352.90 (309.60) T
2007	Partial cystectomy	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	8.000	352.90 (309.60) T
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	04.00		462.000	3246.90 (2848.20)	369.600	2597.50 (2278.50)	8.000	352.90 (309.60) T
2010	Reversion of temporary conduit	04.00		360.000	2530.10 (2219.40)	288.000	2024.10 (1775.50)	8.000	352.90 (309.60) T
2011	Partial cystectomy with uretero-neo-cystostomy	04.00		202.000	1419.70 (1245.40)	161.600	1135.70 (996.20)	6.000	264.70 (232.20) T
2012	Reversion of conduit with major urinary tract reconstruction	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	8.000	352.90 (309.60) T
2013	Diverticulectomy (independent procedure): Multiple or single	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2015	Suprapubic cystostomy	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	5.000	220.60 (193.50) T
2016	Abdomino-neo-urethrostomy	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	5.000	220.60 (193.50) T
2017	Open loop fulguration or excision of bladder tumour	04.00		101.000	709.80 (622.60)	101.000	709.80 (622.60)	5.000	220.60 (193.50) T
2019	Operation for vesico-vaginal or urethra-vaginal fistula	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)	5.000	220.60 (193.50) T
2020	Repair of vesico vaginal fistula: Abdominal approach	04.00		255.000	1792.10 (1572.00)	204.000	1433.70 (1257.60)	5.000	220.60 (193.50) T
2021	Vesico-plication (Hamilton Stewart)	04.00		118.000	829.30 (727.50)	118.000	829.30 (727.50)	5.000	220.60 (193.50) T
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	04.11		195.000	1370.50 (1202.20)	156.000	1096.40 (961.80)	5.000	220.60 (193.50) T
2025	Vesico-urethropexy with rectus sling	04.11		229.400	1612.20 (1414.20)	183.520	1289.80 (1131.40)	5.000	220.60 (193.50) T
2027	Open operation for ureterocele: Unilateral	04.00		118.000	829.30 (727.50)	118.000	829.30 (727.50)	5.000	220.60 (193.50) T
2029	Open operation for ureterocele: Bilateral	04.00		207.000	1454.80 (1276.10)	165.600	1163.80 (1020.90)	5.000	220.60 (193.50) T
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	04.00		264.000	1855.40 (1627.50)	211.200	1484.30 (1302.00)	8.000	352.90 (309.60) T
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	04.00		53.000	372.50 (326.80)	53.000	372.50 (326.80)	8.000	352.90 (309.60) T
2035	Cutaneous vesicostomy	04.00		118.000	829.30 (727.50)	118.000	829.30 (727.50)	5.000	220.60 (193.50) T
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	04.00		126.000	885.50 (776.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2039	Operation for ruptured bladder	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2042	Enterocystoplasty plus bowel anastomosis	04.00		419.900	2951.10 (2588.70)	335.920	2360.80 (2070.90)	5.000	220.60 (193.50) T
2043	Cysto-lithotomy	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2045	Excision of patent-urachus or urachal cyst	04.00		112.000	787.10 (690.40)	112.000	787.10 (690.40)	5.000	220.60 (193.50) T
2047	Drainage of perivesical or prevesical abscess	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	5.000	220.60 (193.50) T
2049	Evacuation of clots from bladder: Other than post-operative	04.00		132.100	928.40 (814.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2050	Evacuation of clots from bladder: Post-operative	04.00						4.000	176.40 (154.70) T
2051	Simple bladder lavage: Including catheterisation	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2053	Bladder neck plasty: Male	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2057	Bladder neck plasty: Female	04.00		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
10.4	**Urethra**								
2059	Open biopsy of urethra: Male	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
2061	Open biopsy of urethra: Female	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
2069	Dilatation of female urethra	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)	3.000	132.30 (116.10) T
2071	Urethrorraphy: Suture of urethral wound or injury	04.00		139.000	976.90 (856.90)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2073	External urethrotomy: Pendulous urethra (anterior)	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	3.000	132.30 (116.10) T
2075	Urethraplasty: Pendulous urethra: First stage	04.00		71.000	499.00 (437.70)	71.000	499.00 (437.70)	4.000	176.40 (154.70) T
2077	Urethraplasty: Pendulous urethra: Second stage	04.00		145.000	1019.10 (893.90)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2079	Reconstruction of female urethra	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2081	Reconstruction or repair of male anterior urethra (one stage)	04.00		261.600	1838.50 (1612.70)	209.280	1470.80 (1290.20)	4.000	176.40 (154.70) T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	6.000	264.70 (232.20) T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	6.000	264.70 (232.20) T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	04.00		294.000	2066.20 (1812.50)	235.200	1653.00 (1450.00)	6.000	264.70 (232.20) T
2087	Urethral diverticulectomy: Male or female	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units	04.00		86.000	604.40 (530.20)	86.000	604.40 (530.20)		
2089	Marsupialisation of urethral diverticula: Male or female	04.00		115.100	808.90 (709.60)	115.100	808.90 (709.60)	4.000	176.40 (154.70) T
2091	Total urethrectomy: Female	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2093	Total urethrectomy: Male	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2095	Drainage of simple localised perineal urinary extravasation	04.00		128.800	905.20 (794.00)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	05.05		137.000	962.80 (844.60)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2099	Fulguration for urethral caruncle or polyp	04.00		53.600	376.70 (330.40)	53.600	376.70 (330.40)	3.000	132.30 (116.10) T
2101	Excision of urethral caruncle	04.00		53.600	376.70 (330.40)	53.600	376.70 (330.40)	3.000	132.30 (116.10) T
2103	Simple urethral meatotomy	04.00		26.300	184.80 (162.10)	26.300	184.80 (162.10)	3.000	132.30 (116.10) T
2105	Incision of deep peri-urethral abscess: Female	04.00		123.100	865.10 (758.90)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2107	Incision of deep peri-urethral abscess: Male	04.00		123.100	865.10 (758.90)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2109	Badenoch pull-through for intractable stricture or incontinence	04.00		181.000	1272.10 (1115.90)	144.800	1017.70 (892.70)	5.000	220.60 (193.50) T
2111	External sphincterotomy	06.04		108.000	759.00 (665.80)	108.000	759.00 (665.80)	5.000	220.60 (193.50) T
2113	Drainage of Skene gland abscess or cyst	04.00		42.300	297.30 (260.80)	42.300	297.30 (260.80)	3.000	132.30 (116.10) T
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	5.000	220.60 (193.50) T
2116	Urethral meatoplasty	04.00		101.500	713.30 (625.70)	101.500	713.30 (625.70)	3.000	132.30 (116.10) T
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	04.00		150.300	1056.30 (926.60)	120.240	845.00 (741.20)	3.000	132.30 (116.10) T
2121	Closure of urethrovaginal fistula: Including diversionary procedures	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	5.000	220.60 (193.50) T
11	**Male Genital System**								
11.1	**Penis**								
2123	Biopsy of penis (independent procedure)	04.00		52.100	366.20 (321.20)	52.100	366.20 (321.20)	3.000	132.30 (116.10) T
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)	06.04		16.600	116.70 (102.40)	16.600	116.70 (102.40)	3.000	132.30 (116.10) T
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	06.04		41.600	292.40 (256.50)	41.600	292.40 (256.50)	3.000	132.30 (116.10) T
2129	Electrodesiccation: Limited number	04.00		20.800	146.20 (128.20)	20.800	146.20 (128.20)	3.000	132.30 (116.10) T
2131	Electrodesiccation: Multiple extensive	04.00		41.600	292.40 (256.50)	41.600	292.40 (256.50)	3.000	132.30 (116.10) T
2132	Ligation of abnormal venous drainage	04.00		106.100	745.70 (654.10)	106.100	745.70 (654.10)	3.000	132.30 (116.10) T
2133	Circumcision: Clamp procedure	04.00		42.300	297.30 (260.80)	42.300	297.30 (260.80)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) T
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	04.00		36.800	258.60 (226.80)	36.800	258.60 (226.80)	3.000	132.30 (116.10) T
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	04.00		101.000	709.80 (622.60)	101.000	709.80 (622.60)	3.000	132.30 (116.10) T
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	04.00		188.600	1325.50 (1162.70)	150.880	1060.40 (930.20)	3.000	132.30 (116.10) T
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	04.00		224.600	1578.50 (1384.60)	179.680	1262.80 (1107.70)	3.000	132.30 (116.10) T
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	3.000	132.30 (116.10) T
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	3.000	132.30 (116.10) T
2153	Reconstructive operation for epispadias with incontinence	04.00		168.000	1180.70 (1035.70)	134.400	944.60 (828.60)	3.000	132.30 (116.10) T
2154	Induction of artificial erection	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)	3.000	132.30 (116.10) T
2155	Hypospadias: Urethral reconstruction	04.00		187.000	1314.20 (1152.80)	149.600	1051.40 (922.30)	3.000	132.30 (116.10) T
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	04.00		84.000	590.40 (517.90)	84.000	590.40 (517.90)	3.000	132.30 (116.10) T
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	3.000	132.30 (116.10) T
2161	Total amputation of penis: Without gland dissection	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	4.000	176.40 (154.70) T
2163	Total amputation of penis: With gland-dissection	04.00		336.000	2361.40 (2071.40)	268.800	1889.10 (1657.10)	6.000	264.70 (232.20) T
2165	Partial amputation of penis: With gland-dissection	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	6.000	264.70 (232.20) T
2167	Partial amputation of penis: Without gland-dissection	04.00		84.000	590.40 (517.90)	84.000	590.40 (517.90)	4.000	176.40 (154.70) T
2169	Injection procedure for Peyronie's disease	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	04.00		42.000	295.20 (258.90)	42.000	295.20 (258.90)	3.000	132.30 (116.10) T
2173	Priapism operation: Shunt procedure: Any type	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	4.000	176.40 (154.70) T
2174	Priapism operation: Stab shunt	04.00		114.400	804.00 (705.30)	114.400	804.00 (705.30)	4.000	176.40 (154.70) T
11.2	**Testis and epididymis**								
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure								04.00
2175	Testis biopsy: Needle (independent procedure)	04.00		18.500	130.00 (114.00)	18.500	130.00 (114.00)	3.000	132.30 (116.10) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2177	Testis biopsy: Incisional: Independent procedure: Unilateral	04.00		58.900	413.90 (363.10)	58.900	413.90 (363.10)	3.000	132.30 (116.10) T
2179	Testis biopsy: Incisional: Independent procedure: Bilateral	04.00		58.900	413.90 (363.10)	58.900	413.90 (363.10)	3.000	132.30 (116.10) T
2181	Epididymis biopsy: Needle	04.00		86.100	605.10 (530.80)	86.100	605.10 (530.80)	3.000	132.30 (116.10) T
2183	Puncture aspiration hydrocele with or without injection of medication	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	3.000	132.30 (116.10) T
2185	Operation for maldescended testicle: Including herniotomy	04.00		135.000	948.80 (832.30)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2187	Operation for torsion appendix testis	04.00		119.200	837.70 (734.80)	119.200	837.70 (734.80)	4.000	176.40 (154.70) T
2189	Operation for torsion testis with fixation of contralateral testis	04.00		119.200	837.70 (734.80)	119.200	837.70 (734.80)	4.000	176.40 (154.70) T
2191	Orchidectomy (total or subcapsular): Unilateral	04.00		98.000	688.70 (604.10)	98.000	688.70 (604.10)	3.000	132.30 (116.10) T
2193	Orchidectomy (total or subcapsular): Bilateral	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2195	Radical operation for malignant testis: Excluding gland dissection	04.00		155.300	1091.40 (957.40)	124.240	873.20 (766.00)	6.000	264.70 (232.20) T
2197	Operation for hydrocele or spermatocele	04.00		99.800	701.40 (615.30)	99.800	701.40 (615.30)	4.000	176.40 (154.70) T
2199	Varicocelectomy	04.00		106.100	745.70 (654.10)	106.100	745.70 (654.10)	4.000	176.40 (154.70) T
2201	Abdominal ligation of spermatic vein for varicocele	04.00		112.800	792.80 (695.40)	112.800	792.80 (695.40)	4.000	176.40 (154.70) T
2203	Epididymectomy: Unilateral	04.00		114.400	804.00 (705.30)	114.400	804.00 (705.30)	3.000	132.30 (116.10) T
2205	Epididymectomy: Bilateral	04.00		158.200	1111.80 (975.30)	126.560	889.50 (780.30)	3.000	132.30 (116.10) T
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	04.00		55.900	392.90 (344.60)	55.900	392.90 (344.60)	3.000	132.30 (116.10) T
2209	Vasotomy: Unilateral or bilateral	04.00		70.400	494.80 (434.00)	70.400	494.80 (434.00)	3.000	132.30 (116.10) T
2210	Vasogram, seminal vesiculogram: Unilateral	04.00		58.100	408.30 (358.20)	58.100	408.30 (358.20)	3.000	132.30 (116.10) T
2211	Vasogram, seminal vesiculogram: Bilateral	04.00		58.100	408.30 (358.20)	58.100	408.30 (358.20)	3.000	132.30 (116.10) T
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	04.00		91.200	641.00 (562.30)	91.200	641.00 (562.30)	4.000	176.40 (154.70) T
2213	Suture or repair of testicular injury	04.00		110.300	775.20 (680.00)	110.300	775.20 (680.00)	4.000	176.40 (154.70) T
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	04.00		90.000	632.50 (554.80)	90.000	632.50 (554.80)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2217	Excision of local lesion of testis or epididymis	04.00		90.800	638.10 (559.70)	90.800	638.10 (559.70)	4.000	176.40 (154.70) T
2219	Vaso-vasostomy: Unilateral	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	3.000	132.30 (116.10) T
2221	Vaso-vasostomy: Bilateral	04.00		117.000	822.30 (721.30)	117.000	822.30 (721.30)	3.000	132.30 (116.10) T
2223	Epididymo-vasostomy: Unilateral	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	3.000	132.30 (116.10) T
2225	Epididymo-vasostomy: Bilateral	04.00		117.000	822.30 (721.30)	117.000	822.30 (721.30)	3.000	132.30 (116.10) T
2227	Incision and drainage of scrotal wall abscess	04.00		42.700	300.10 (263.20)	42.700	300.10 (263.20)	3.000	132.30 (116.10) T
2229	Excision of Mullerian duct cyst	04.00		189.000	1328.30 (1165.20)	151.200	1062.60 (932.10)	4.000	176.40 (154.70) T
2231	Excision of lesion of spermatic cord	04.00		84.000	590.40 (517.90)	84.000	590.40 (517.90)	3.000	132.30 (116.10) T
2233	Seminal Vesiculectomy	04.00		220.000	1546.20 (1356.30)	176.000	1236.90 (1085.00)	5.000	220.60 (193.50) T
11.3	**Prostate**								
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	04.00		23.300	163.80 (143.70)	23.300	163.80 (143.70)	3.000	132.30 (116.10) T
2237	Biopsy prostate: Incisional, any approach	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	4.000	176.40 (154.70) T
2239	Transurethral drainage of prostatic abscess	04.00		117.400	825.10 (723.80)	117.400	825.10 (723.80)	4.000	176.40 (154.70) T
2241	Perineal drainage of prostatic abscess	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	4.000	176.40 (154.70) T
2243	Trans-urethral cryo-surgical removal of prostate	04.00		126.000	885.50 (776.80)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2245	Trans-urethral resection of prostate	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	6.000	264.70 (232.20) T
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	04.00		126.000	885.50 (776.80)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2249	Trans-urethral resection of post-operative bladder neck contracture	04.00		126.000	885.50 (776.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2251	Prostatectomy: Perineal: Sub-total	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	6.000	264.70 (232.20) T
2253	Prostatectomy: Perineal: Radical	04.00		336.000	2361.40 (2071.40)	268.800	1889.10 (1657.10)	8.000	352.90 (309.60) T
2254	Pelvic lymph adenectomy	04.11		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	8.000	352.90 (309.60) T
2255	Supra-pelvic, transversical	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	6.000	264.70 (232.20) T
2257	Retropubic: Sub-total	04.00		252.000	1771.10 (1553.60)	201.600	1416.80 (1242.80)	6.000	264.70 (232.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2259	Retropubic: Radical	04.00		336.000	2361.40 (2071.40)	268.800	1889.10 (1657.10)	8.000	352.90 (309.60) T
2260	Prostate brachytherapy	04.00		230.000	1616.40 (1417.90)	184.000	1293.20 (1134.40)	8.000	352.90 (309.60) T
12	**Female Genital System**								
12.1	**Vulva and introitus**								
2271	Removal of tag or polyp	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)	3.000	132.30 (116.10) T
2272	Removal of small superficial benign lesions	04.00		23.000	161.60 (141.80)	23.000	161.60 (141.80)	3.000	132.30 (116.10) T
2273	Biopsy with suture in theatre (excluding after-care)	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	3.000	132.30 (116.10) T
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	04.00		71.000	499.00 (437.70)	71.000	499.00 (437.70)	3.000	132.30 (116.10) T
2275	Reduction labial hypertrophy	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	4.000	176.40 (154.70) T
2277	Removal of extensive benign vulva tumour	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	4.000	176.40 (154.70) T
2279	Secondary perineal repair: Repair second degree tear	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	6.000	264.70 (232.20) T
2280	Secondary perineal repair: Repair third degree tear	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	6.000	264.70 (232.20) T
2281	Excision of inclusion cyst	04.00		43.000	302.20 (265.10)	43.000	302.20 (265.10)	4.000	176.40 (154.70) T
2283	Hymenectomy	04.00		43.000	302.20 (265.10)	43.000	302.20 (265.10)	4.000	176.40 (154.70) T
2285	Drainage haematocolpos	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	4.000	176.40 (154.70) T
2287	Clitoris repair for injury: Including skin graft, if required	04.00		87.000	470.90 (413.10)	67.000	470.90 (413.10)	4.000	176.40 (154.70) T
2288	Clitoral reduction	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	4.000	176.40 (154.70) T
2289	Denervation or alcohol infiltration vulva (Woodruff)	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	4.000	176.40 (154.70) T
2291	Vulva: Undercutting skin (ball)	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)	4.000	176.40 (154.70) T
2293	Vulva and introitus: Drainage of abscess	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	3.000	132.30 (116.10) T
2295	Bartholin gland: Bartholin abscess marsupialisation	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)	3.000	132.30 (116.10) T
2297	Bartholin gland: Bartholin gland excision	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
2299	Bartholin gland: Bartholin radical excision for malignant lesion	04.00		357.000	2509.00 (2200.90)	285.600	2007.20 (1760.70)	6.000	264.70 (232.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2301	Operation for enlarging introitus: Fenton plasty	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2303	Operation for enlarging introitus: Bilateral Z-plastic	04.00		88.000	618.50 (542.50)	88.000	618.50 (542.50)	4.000	176.40 (154.70) T
2305	Vulvectomy: Partial	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	4.000	176.40 (154.70) T
2307	Vulvectomy	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
2309	Radical vulvectomy with bilateral lymphdenectomy	04.00		357.000	2509.00 (2200.90)	285.600	2007.20 (1760.70)	6.000	264.70 (232.20) T
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	04.00		402.000	2825.30 (2478.30)	321.600	2260.20 (1982.60)	6.000	264.70 (232.20) T
12.2	**Vaginal procedures and operations**								
2312	Artificial insemination	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)		
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure	04.00		25.500	179.20 (157.20)	25.500	179.20 (157.20)	3.000	132.30 (116.10) T
2314	Intra uterine insemination	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)		
2315	Simms Hühner test plus wet smear	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	3.000	132.30 (116.10) T
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)	3.000	132.30 (116.10) T
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	04.00		56.000	393.60 (345.30)	56.000	393.60 (345.30)	3.000	132.30 (116.10) T
2319	Excision of cysts or tumours	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	3.000	132.30 (116.10) T
2321	Drainage of vaginal abscess	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	3.000	132.30 (116.10) T
2322	Pudendal nerve block	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
2323	Reconstruction of vagina after atresia	04.00		107.000	752.00 (659.60)	107.000	752.00 (659.60)	5.000	220.60 (193.50) T
2325	Construction of artificial vagina: Labial fusion	04.00		179.000	1258.00 (1103.50)	143.200	1006.40 (882.80)	4.000	176.40 (154.70) T
2327	Construction of artificial vagina: Macindoe type	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	5.000	220.60 (193.50) T
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each	04.11		241.000	1693.70 (1485.70)	192.800	1355.00 (1188.60)	6.000	264.70 (232.20) T
2331	Vaginal septum removal	04.00		107.000	752.00 (659.60)	107.000	752.00 (659.60)	4.000	176.40 (154.70) T
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	04.00		243.300	1709.90 (1499.90)	194.640	1367.90 (1199.90)	6.000	264.70 (232.20) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	04.00		243.300	1709.90 (1499.90)	194.640	1367.90 (1199.90)	6.000	264.70 (232.20) T
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	04.00		166.900	1173.00 (1028.90)	133.520	938.40 (823.20)	6.000	264.70 (232.20) T
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	04.00		166.900	1173.00 (1028.90)	133.520	938.40 (823.20)	6.000	264.70 (232.20) T
2339	Colpotomy: Diagnostic (excluding after-care)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	4.000	176.40 (154.70) T
2341	Colpotomy: Therapeutic, with or without sterilisation	04.00		103.000	723.90 (635.00)	103.000	723.90 (635.00)	4.000	176.40 (154.70) T
2343	Vaginal hysterectomy: Without repair	04.00		210.500	1479.40 (1297.70)	168.400	1183.50 (1038.20)	6.000	264.70 (232.20) T
2345	Vaginal hysterectomy: With repair	04.00		231.700	1628.40 (1428.40)	185.360	1302.70 (1142.70)	6.000	264.70 (232.20) T
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	6.000	264.70 (232.20) T
2361	Vaginal hysterectomy and repair for total prolapse	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	6.000	264.70 (232.20) T
2363	Fothergill or Manchester repair operation	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	5.000	220.60 (193.50) T
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	04.00		232.000	1630.50 (1430.30)	185.600	1304.40 (1144.20)	5.000	220.60 (193.50) T
2366	Posterior repair alone	04.00		107.000	752.00 (659.60)	107.000	752.00 (659.60)	5.000	220.60 (193.50) T
2367	Other operations for prolapse: Anterior repair - with or without posterior repair	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	5.000	220.60 (193.50) T
2368	Uterovesical fistula	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
2369	Repair of Vesico- or urethro-vaginal fistula	04.00		179.000	1258.00 (1103.50)	143.200	1006.40 (882.80)	5.000	220.60 (193.50) T
2370	Repair of VVF - Obstetric or radiation	04.00		232.000	1630.50 (1430.30)	185.600	1304.40 (1144.20)	5.000	220.60 (193.50) T
2371	Closure of uretero-vaginal fistula	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	5.000	220.60 (193.50) T
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	5.000	220.60 (193.50) T
2373	Closure of recto-vaginal fistula	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2374	Closure of recto-vaginal fistula: Obstetric or radiation	04.00		151.000	1061.20 (930.90)	120.800	849.00 (744.70)	5.000	220.60 (193.50) T
2375	Colpocleisis	04.00		129.000	906.60 (795.30)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2377	Le Fort operation	04.00		129.000	906.60 (795.30)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2379	Schauta operation	04.00		357.000	2509.00 (2200.90)	285.600	2007.20 (1760.70)	8.000	352.90 (309.60) T
2381	Vaginectomy	04.00		268.000	1883.50 (1652.20)	214.400	1506.80 (1321.80)	8.000	352.90 (309.60) T
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee	04.00		429.000	3015.00 (2644.70)	343.200	2412.00 (2115.80)	8.000	352.90 (309.60) T
2385	Vaginal laceration or trauma: Repair	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
12.3	**Cervix**								
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)	06.05		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
2391	Cervix: Canal reconstruction	04.00		147.000	1033.10 (906.20)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)		
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	04.00		22.000	154.60 (135.60)	22.000	154.60 (135.60)	3.000	132.30 (116.10) T
2396	Laser or harmonic scalpel treatment of the cervix	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	3.000	132.30 (116.10) T
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	04.00		31.000	217.90 (191.10)	31.000	217.90 (191.10)	3.000	132.30 (116.10) T
2399	Punch biopsy (excluding after-care)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	3.000	132.30 (116.10) T
2400	Biopsy during pregnancy (excluding after-care)	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	3.000	132.30 (116.10) T
2403	Wedge biopsy: Cervix (excluding after-care)	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)	3.000	132.30 (116.10) T
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	04.00		24.000	168.70 (148.00)	24.000	168.70 (148.00)	3.000	132.30 (116.10) T
2405	Cone biopsy: Cervix (excluding after-care)	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	3.000	132.30 (116.10) T
2407	Amputation: Cervix	04.00		67.000	470.90 (413.10)	67.000	470.90 (413.10)	3.000	132.30 (116.10) T
2409	Cervix encirclage: McDonald stitch	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
2411	Cervix encirclage: Shirodkar suture	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	3.000	132.30 (116.10) T
2413	Cervix encirclage: Lash	04.00		49.000	344.40 (302.10)	49.000	344.40 (302.10)	3.000	132.30 (116.10) T
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
2416	Cervix: Removal items 2409 and 2411: With anaesthetic in theatre	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	3.000	132.30 (116.10) T
2417	Repair of tears: Emmet repair of tears	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2418	Repair of tears: Sturmdorff repair of tears	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	3.000	132.30 (116.10) T
2421	Extirpation of cervical stump: Vaginal	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2423	Extirpation of cervical stump: Abdominal	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2425	Removal of cervical polyps (excluding after-care)	04.00		13.000	91.40 (80.20)	13.000	91.40 (80.20)	3.000	132.30 (116.10) T
2427	Removal of cervical myomata	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	3.000	132.30 (116.10) T
2429	Colposcopy (excluding after-care)	04.00		27.000	189.80 (166.50)	27.000	189.80 (166.50)	3.000	132.30 (116.10) T
12.4	**Uterus**								
2433	Embryo transfer	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	4.000	176.40 (154.70) T
2434	Endometrial biopsy (excluding after-care)	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)	3.000	132.30 (116.10) T
2435	Hysterosalpingogram (excluding after-care)	04.00		22.000	154.60 (135.60)	22.000	154.60 (135.60)	3.000	132.30 (116.10) T
2436	Hysteroscopy (excluding after-care)	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)	3.000	132.30 (116.10) T
2437	Hysteroscopy and D&C (excluding after-care)	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)	3.000	132.30 (116.10) T
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	3.000	132.30 (116.10) T
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	04.00		63.000	442.80 (388.40)	63.000	442.80 (388.40)	3.000	132.30 (116.10) T
2440	Hysteroscopy and polypectomy (excluding after-care)	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	3.000	132.30 (116.10) T
2441	Hysteroscopy and myomectomy (excluding after-care)	04.00		130.000	913.60 (801.40)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	06.04		18.000	126.50 (111.00)	18.000	126.50 (111.00)	3.000	132.30 (116.10) T
2443	Dilatation and curettage (D&C) (excluding after-care)	06.04		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
2444	Fractional dilatation and curettage (D&C) (excluding after-care)	06.04		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	04.00		71.000	499.00 (437.70)	71.000	499.00 (437.70)	4.000	176.40 (154.70) T
2448	Termination of pregnancy before 12 weeks	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2449	Evacuation: Missed abortion: Before 12 weeks gestation	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2451	Evacuation: Missed abortion: After 12 weeks gestation	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	4.000	176.40 (154.70) T
2452	Termination of pregnancy after 12 weeks - administration of intra/extra amniotic prostaglandin	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	4.000	176.40 (154.70) T
2453	Evacuation hydatidiform mole	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	5.000	220.60 (193.50) T
2455	Evacuation uterus post-partum	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)	6.000	264.70 (232.20) T
2461	Ventrosuspension	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	4.000	176.40 (154.70) T
2463	Uteroplasty: Strassman	04.00		143.000	1005.00 (881.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2465	Uteroplasty: Tompkins	04.00		143.000	1005.00 (881.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2467	Myomectomy	04.00		143.000	1005.00 (881.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	04.00		254.100	1785.80 (1566.50)	203.280	1428.70 (1253.20)	6.000	264.70 (232.20) T
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy - uncomplicated	04.00		252.200	1772.50 (1554.80)	201.760	1418.00 (1243.90)	6.000	264.70 (232.20) T
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	04.00		355.000	2494.90 (2188.50)	284.000	1996.00 (1750.90)	6.000	264.70 (232.20) T
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	04.00		472.800	3322.80 (2914.70)	378.240	2658.30 (2331.80)	8.000	352.90 (309.60) T
2477	Abdominal hysterotomy with or without sterilisation	04.00		188.000	1321.30 (1159.00)	150.400	1057.00 (927.20)	6.000	264.70 (232.20) T
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	6.000	264.70 (232.20) T
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)	04.00		120.000	843.40 (739.80)				
12.5	**Fallopian tubes**								
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee								04.00
2481	Insufflation Fallopian tubes (excluding after-care)	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)	3.000	132.30 (116.10) T
2483	Salpingolysis	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2485	Salpingostomy	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	4.000	176.40 (154.70) T
2487	Tuboplasty tubal anastomosis or re-implantation	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	4.000	176.40 (154.70) T
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	04.00		125.000	878.50 (770.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	6.000	264.70 (232.20) T
2491	Ectopic pregnancy - after 12 weeks	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	6.000	264.70 (232.20) T
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	04.00		94.000	660.60 (579.50)	94.000	660.60 (579.50)	5.000	220.60 (193.50) T
	Note: Use item 1807 for open procedures performed with a laparoscope instead of item 2493. Item 1807 may only be added once, and may not be charged together with item 2493 for more than one procedure performed laparoscopically	04.00							
2493	Diagnostic laparoscopy (excluding after-care)	04.00		94.400	663.40 (581.90)	94.400	663.40 (581.90)	5.000	220.60 (193.50) T
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	04.00	+	18.000	126.50 (111.00)	18.000	126.50 (111.00)	5.000	220.60 (193.50) T
2497	Laparoscopy: Plus sterilisation	04.00	+	40.000	281.10 (246.60)	40.000	281.10 (246.60)	5.000	220.60 (193.50) T
2499	Laparoscopy: Plus biopsy (excluding after-care)	04.00	+	18.000	126.50 (111.00)	18.000	126.50 (111.00)	5.000	220.60 (193.50) T
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	04.00	+	51.000	358.40 (314.40)	51.000	358.40 (314.40)	5.000	220.60 (193.50) T
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	04.00	+	18.000	126.50 (111.00)	18.000	126.50 (111.00)	5.000	220.60 (193.50) T
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	04.00	+	52.000	365.50 (320.60)	52.000	365.50 (320.60)	5.000	220.60 (193.50) T
2503	Laparoscopy: Plus ovarian drilling	04.00	+	40.000	281.10 (246.60)	40.000	281.10 (246.60)	5.000	220.60 (193.50) T
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	04.00	+	107.000	752.00 (659.60)	107.000	752.00 (659.60)	5.000	220.60 (193.50) T
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	04.00	+	52.000	365.50 (320.60)	52.000	365.50 (320.60)	5.000	220.60 (193.50) T
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	04.00		58.000	407.60 (357.50)	58.000	407.60 (357.50)		
12.6	**Ovaries**								
2525	Wedge resection of ovaries, unilateral or bilateral	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	4.000	176.40 (154.70) T
2527	Removal of ovarian tumour or cyst	04.00		187.000	1314.20 (1152.80)	149.600	1051.40 (922.30)	4.000	176.40 (154.70) T
2529	Oophorectomy: Uni- or bilateral	04.00		134.500	945.30 (829.20)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2531	Ovarian carcinoma debulking and omentectomy	04.00		357.000	2509.00 (2200.90)	285.600	2007.20 (1760.70)	6.000	264.70 (232.20) T
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	04.00		469.000	3296.10 (2891.30)	375.200	2636.90 (2313.10)	6.000	264.70 (232.20) T
12.7	**Miscellaneous procedures**								
2535	Exenteration: Anterior Exenteration	04.00		402.000	2825.30 (2478.30)	321.600	2260.20 (1982.60)	8.000	352.90 (309.60) T

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				RVU	Fee	RVU	Fee	RVU	Fee
2537	Exenteration: Posterior Exenteration	04.00		402.000	2825.30 (2478.30)	321.600	2260.20 (1982.60)	8.000	352.90 (309.60) T
2539	Exenteration: Total	04.00		625.000	4392.50 (3853.10)	500.000	3514.00 (3082.50)	8.000	352.90 (309.60) T
2541	Presacral neurectomy	04.00		98.000	688.70 (604.10)	98.000	688.70 (604.10)	5.000	220.60 (193.50) T
2543	Moschowitz operation	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be used together with this item)	04.00		193.100	1357.10 (1190.40)	154.480	1085.70 (952.40)	5.000	220.60 (193.50) T
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	04.00		195.000	1370.50 (1202.20)	156.000	1096.40 (961.80)	5.000	220.60 (193.50) T
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach	04.00		149.000	1047.20 (918.60)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2547	Operations for stress incontinence: Burch colposuspension	04.00		161.000	1131.50 (992.50)	128.800	905.20 (794.00)	5.000	220.60 (193.50) T
2548	Operation for stress incontinence: Use of tape	04.00		229.400	1612.20 (1414.20)	183.520	1289.80 (1131.40)	5.000	220.60 (193.50) T
2550	Operations for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	5.000	220.60 (193.50) T
2551	Laparotomy	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	4.000	176.40 (154.70) T
2552	Removal benign retroperitoneal tumour	04.00		223.000	1567.20 (1374.70)	178.400	1253.80 (1099.80)	6.000	264.70 (232.20) T
2553	Radical removal of malignant retroperitoneal tumour	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	8.000	352.90 (309.60) T
2554	Drainage of pelvic abscess per abdomen	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	6.000	264.70 (232.20) T
2556	Drainage of pelvic abscess per vagina (refer to item 2341)	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	5.000	220.60 (193.50) T
2558	Drainage intra-abdominal abscess: Delayed closure	04.00		268.000	1883.50 (1652.20)	214.400	1506.80 (1321.80)	6.000	264.70 (232.20) T
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2561	Surgery for severe endometriosis (AFS stage 4 - retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	6.000	264.70 (232.20) T
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	6.000	264.70 (232.20) T
2565	Implantation hormone pellets (excluding after-care)	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
2570	Ligation of internal iliac vessels (when not part of another procedure)	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	8.000	352.90 (309.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
13	**Obstetric Procedures**								
RULES GOVERNING THIS SECTION									
U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.								04.00
13.1	**Pre-natal care and procedures**								
2603	External cephalic version (excluding after-care)	04.00		22.000	154.60 (135.60)	22.000	154.60 (135.60)		
2605	Amniocentesis (excluding after-care)	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)		
2607	Amnioscopy (excluding after-care)	04.00		18.000	126.50 (111.00)	18.000	126.50 (111.00)		
2609	Intra-uterine transfusion of foetus or cordocentesis	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)		
2610	Tococardiography - pre-natal and intrapartum (including stress and non-stress test: Own machine) (excluding after-care)	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)		
2611	Chorion villus sampling (excluding after-care)	04.00		54.000	379.50 (332.90)	54.000	379.50 (332.90)		
13.2	**Confinements**								
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding Caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit)	04.11		282.000	1981.90 (1738.50)	225.600	1585.50 (1390.80)	6.000	264.70 (232.20) T
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit). See modifier 0011 for emergency caesarean section (all hours)	04.00		267.000	1876.50 (1646.10)	213.600	1501.20 (1316.80)	6.000	264.70 (232.20) T
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	04.00		190.000	1335.30 (1171.30)	152.000	1068.30 (937.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
	Global obstetric care includes o All modes of delivery (including Caesarean) o All inductions of labour (medical or surgical) o Intrapartum paracervical and pudential blocks o Intrapartum amnioscopy o Foetal blood sampling o Application of scalp leads o Symphysiotomy o Manual removal of placenta o Repair cervical tears o Correction of uterine inversion o Drainage of vulval haematoma o Repair third degree tear o Repair second degree tear o Repair episiotomy o Resuscitation of newborn by obstetrician o Tracheal intubation o Missed confinement	04.00							
	Global obstetric care excludes o Prenatal consultations o Prenatal procedures (Items 2603 - 2611) o Emergency hysterectomy for obstetrical reasons o Abdominal operation for repair of ruptured gravid uterus o Intensive care for obstetrical emergencies o Tubal ligation performed as a post-partum procedure o Post-partum complications occurring after discharge from the hospital								04.00
13.3	**Operative procedures (excluding antenatal care)**								
2653	Caesarean-hysterectomy	04.00		335.000	2354.40 (2065.30)	268.000	1883.50 (1652.20)	9.000	397.00 (348.20) T
2657	Post-partum hysterectomy	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	8.000	352.90 (309.60) T
2669	Abdominal operation for ruptured gravid uterus: Repair	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	9.000	397.00 (348.20) T
14	**Nervous System**								
14.1	**Diagnostic procedures**								
2681	Visual evoked potentials (VEP): Unilateral	04.00		50.000	351.40 (308.20)				
2682	Visual evoked potentials (VEP): Bilateral	04.00		88.000	618.50 (542.50)				
2683	Electro-retinography (Ganzfeld method): Unilateral	04.00		60.000	421.70 (369.90)				
2684	Electro-retinography (Ganzfeld method): Bilateral	04.00		105.000	737.90 (647.30)				
2685	Electro-oculography: Unilateral	04.00		30.000	210.80 (184.90)				

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2686	Electro-oculography: Bilateral	04.00		53.000	372.50 (326.80)				
2687	VEP stable condition (photic drive): Unilateral	04.00		50.000	351.40 (308.20)				
2689	VEP stable condition (photic drive): Bilateral	04.00		88.000	618.50 (542.50)				
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	04.00		150.000	1054.20 (924.70)				
	Note: See items 2691 to 2702 under section 17.5.1: Audiometry	04.00							
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex	04.00		48.000	337.30 (295.90)				
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	04.00		6.000	42.20 (37.00)	6.000	42.20 (37.00)		
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation	04.00		220.000	1546.20 (1356.30)				
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	04.00		80.000	562.20 (493.20)				
2709	Full spinogram including bilateral median and posterior-tibial studies	04.00		140.000	983.90 (863.10)				
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)	04.00							
2711	Electro-encephalography: Taking of record	04.00		36.100	253.70 (222.50)	36.100	253.70 (222.50)		
2712	Electro-encephalography: Interpretation	04.00		24.000	168.70 (148.00)	24.000	168.70 (148.00)		
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	06.02		18.400	129.30 (113.40)	18.400	129.30 (113.40) Z		
2714	Cisternal puncture and/or intrathecal injections	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
2715	8 Hour ambulatory EEG monitoring (Holter): Hire	04.00		136.000	955.80 (838.40)				
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation	04.00		30.000	210.80 (184.90)				
2717	Electromyography: First	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)		
2718	Electromyography: Subsequent	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)		
2719	Overnight polysomnogram and sleep staging: Hire	04.00		125.000	878.50 (770.60)				
2720	Overnight polysomnogram and sleep staging: Interpretation	04.00		23.000	161.60 (141.80)				
2721	Daytime polysomnogram: Hire	04.00		125.000	878.50 (770.60)				
2722	Daytime polysomnogram: Interpretation	04.00		17.000	119.50 (104.80)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2723	Multiple sleep latency test: Interpretation	04.00		125.000	878.50 (770.60)				
2724	Overnight continuous positive airways pressure (CPAP) titration	04.00		155.000	1089.30 (955.50)	124.000	871.50 (764.50)		
2725	Angiography carotis: Unilateral	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	4.000	176.40 (154.70) T
2726	Angiography carotis: Bilateral	04.00		44.000	309.20 (271.20)	44.000	309.20 (271.20)	4.000	176.40 (154.70) T
2727	Vertebral artery: Direct needling	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2729	Vertebral catheterisation	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with item 0714)	06.02		60.000	421.70 (369.90) Z				
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	04.00		14.500	101.90 (89.40)			4.000	176.40 (154.70) T
2733	Cortical Stimulation	04.00		58.900	413.90 (363.10)	58.900	413.90 (363.10)		
2734	Sodium Amytal Testing (WADA test)	04.00		88.700	623.40 (546.80)	88.700	623.40 (546.80)	13.000	573.40 (503.00) T
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	04.00		31.500	221.40 (194.20)	-	- v		
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
2739	Ventricular needling without burring: Tapping only	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)	4.000	176.40 (154.70) T
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	04.00		43.000	302.20 (265.10)	43.000	302.20 (265.10)	4.000	176.40 (154.70) T
2743	Subdural tapping: First sitting	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)	4.000	176.40 (154.70) T
2745	Subdural tapping: Subsequent	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
6001	Sleep electro-encephalography: Infants that fit into a perambulator: Taking of record	04.00		36.100	253.70 (222.50)	36.100	253.70 (222.50)		
6002	Sleep electro-encephalography: Infants that fit into a perambulator: Interpretation	04.00		24.500	172.20 (151.10)	24.500	172.20 (151.10)		
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record	04.00		36.100	253.70 (222.50)	36.100	253.70 (222.50)		
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation	04.00		24.500	172.20 (151.10)	24.500	172.20 (151.10)		
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised sixteen or more channel EEG, which may include video recording (e.g. for pre-operative localisation): Each full 24 hour period	04.00		294.600	2070.40 (1816.10)	235.680	1656.40 (1453.00)		
6011	Interpretation of item 6010: Electro-encephalogram monitoring: To be charged once only for each full 24 hour period of monitoring	04.00		128.600	903.80 (792.80)	120.000	843.40 (739.80)		

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				RVU	Fee	RVU	Fee	RVU	Fee
14.2	**Introduction of burr holes for**								
2747	Ventriculography	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2749	Catheterisation for ventriculography and/or drainage	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2751	Biopsy of brain tumour	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2753	Subdural haematoma or hygroma	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2755	Subdural empyema	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2757	Brain abscess	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
14.3	**Nerve procedures**								
2759	Nerve biopsy: Peripheral	04.00		37.000	260.00 (228.10)	37.000	260.00 (228.10)	4.000	176.40 (154.70) T
2763	Nerve biopsy: Cranial nerves: Extra-cranial	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	4.000	176.40 (154.70) T
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)	4.000	176.40 (154.70) T
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)	04.00		25.000	175.70 (154.10)				
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)	04.00		30.000	210.80 (184.90)				
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)	04.00		35.000	246.00 (215.80)				
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)	04.00		35.000	246.00 (215.80)				
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)	04.00		50.000	351.40 (308.20)				
14.3.1	**Nerve procedures: Nerve repair or suture**								
2767	Suture brachial plexus (see also items 2837 and 2839)	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	6.000	264.70 (232.20) T
2769	Suture: Large nerve: Primary	04.00		134.000	941.80 (826.10)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
2771	Suture: Large nerve: Secondary	04.00		202.000	1419.70 (1245.40)	161.600	1135.70 (996.20)	5.000	220.60 (193.50) T
2773	Digital nerve: Primary	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	3.000	132.30 (116.10) T
2775	Digital nerve: Secondary	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T
2777	Nerve graft: Simple	04.00		202.000	1419.70 (1245.40)	161.600	1135.70 (996.20)	4.000	176.40 (154.70) T

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				RVU	Fee	RVU	Fee	RVU	Fee
2779	Fascicular: First fasciculus	04.00		202.000	1419.70 (1245.40)	161.600	1135.70 (996.20)	4.000	176.40 (154.70) T
2781	Fascicular: Each additional fasciculus	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)	4.000	176.40 (154.70) T
2783	Fascicular: Nerve flap: To include all stages	04.00		224.000	1574.30 (1381.00)	179.200	1259.40 (1104.70)	4.000	176.40 (154.70) T
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	04.00		124.000	871.50 (764.50)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2787	Fascicular: Grafting of facial nerve	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	5.000	220.60 (193.50) T
14.3.2	**Nerve procedures: Neurectomy**								
2789	Trigeminal ganglion: Injection of alcohol	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
2791	Trigeminal ganglion: Injection of cortisone	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	3.000	132.30 (116.10) T
2793	Trigeminal ganglion: Coagulation through high frequency	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	3.000	132.30 (116.10) T
2799	Procedures for pain relief: Intrathecal injections for pain	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)	4.000	176.40 (154.70) T
2800	Procedures for pain relief: Plexus nerve block	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)	36.000	253.00 (221.90) Ç
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) (refer to modifier 0021 for epidural anaesthetic)	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)		
2802	Procedures for pain relief: Peripheral nerve block	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)	25.000	175.70 (154.10) Ç
2803	Alcohol injection in peripheral nerves for pain: Unilateral	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique)	04.00	+	10.000	70.30 (61.70)	10.000	70.30 (61.70)	10.000	70.30 (61.70) Ç
2805	Alcohol injection in peripheral nerves for pain: Bilateral	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
2809	Peripheral nerve section for pain	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)	3.000	132.30 (116.10) T
2811	Pudendal neurectomy: Bilateral	04.00		116.000	815.20 (715.10)	116.000	815.20 (715.10)	3.000	132.30 (116.10) T
2813	Obturator or Stoffels	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T
2815	Interdigital	04.00		82.300	578.40 (507.40)	82.300	578.40 (507.40)	3.000	132.30 (116.10) T
2825	Excision: Neuroma: Peripheral	04.00		109.500	769.60 (675.10)	109.500	769.60 (675.10)	3.000	132.30 (116.10) T
14.3.3	**Nerve procedures: Other nerve procedures**								
2827	Transposition of ulnar nerve	04.00		100.000	702.80 (616.50)	100.000	702.80 (616.50)	3.000	132.30 (116.10) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2829	Neurolysis: Minor	04.00		51.000	358.40 (314.40)	51.000	358.40 (314.40)	3.000	132.30 (116.10) T
2831	Neurolysis: Major	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	3.000	132.30 (116.10) T
2833	Neurolysis: Digital	04.00		96.000	674.70 (591.80)	96.000	674.70 (591.80)	3.000	132.30 (116.10) T
2835	Scalenotomy	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
2837	Brachial plexus, suture or neurolysis (item 2767)	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	6.000	264.70 (232.20) T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	04.00		895.200	6291.50 (5518.90)	716.160	5033.20 (4415.10)	6.000	264.70 (232.20) T
2841	Carpal Tunnel	04.00		64.000	449.80 (394.60)	64.000	449.80 (394.60)	3.000	132.30 (116.10) T
2843	Lumbar sympathectomy: Unilateral	04.00		153.000	1075.30 (943.20)	122.400	860.20 (754.60)	4.000	176.40 (154.70) T
2845	Lumbar sympathectomy: Bilateral	04.00		268.000	1883.50 (1652.20)	214.400	1506.80 (1321.80)	6.000	264.70 (232.20) T
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)	04.00						11.000	485.20 (425.60) T
2847	Cervical sympathectomy: Unilateral	04.00		153.000	1075.30 (943.20)	122.400	860.20 (754.60)	4.000	176.40 (154.70) T
2848	Cervical sympathectomy: Bilateral	04.00		268.000	1883.50 (1652.20)	214.400	1506.80 (1321.80)	6.000	264.70 (232.20) T
2849	Sympathetic block: Other levels: Unilateral	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	3.000	132.30 (116.10) T
2851	Sympathetic block: Other levels: Bilateral	04.00		35.000	246.00 (215.80)	35.000	246.00 (215.80)	3.000	132.30 (116.10) T
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	4.000	176.40 (154.70) T
14.4	**Skull procedures**								
2855	Removal of skull tumour: With or without plastic repair: Small	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	5.000	220.60 (193.50) T
2857	Removal of skull tumour: With or without plastic repair: Major	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	8.000	352.90 (309.60) T
2859	Repair of depressed fracture of skull: Without brain laceration: Major	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	8.000	352.90 (309.60) T
2860	Repair of depressed fracture of skull: Without brain laceration: Small	04.00		170.000	1194.80 (1048.10)	136.000	955.80 (838.40)	8.000	352.90 (309.60) T
2861	Repair of depressed fracture of skull: With brain lacerations: Small	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	8.000	352.90 (309.60) T
2862	Repair of depressed fracture of skull: With brain lacerations: Major	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	8.000	352.90 (309.60) T
2863	Cranioplasty	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	8.000	352.90 (309.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2864	Encephalocele (excluding frontal)	04.11		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	8.000	352.90 (309.60) T
2865	Craniostenosis: Few suturae	04.00		213.000	1497.00 (1313.20)	170.400	1197.60 (1050.50)	9.000	397.00 (348.20) T
2867	Craniostenosis: Multiple suturae	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	9.000	397.00 (348.20) T
14.5	**Shunt procedures**								
2869	Ventriculo-cisternostomy	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	8.000	352.90 (309.60) T
2871	Ventriculo-caval shunt	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	11.000	485.20 (425.60) T
2873	Ventriculo-peritoneal shunt	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	8.000	352.90 (309.60) T
2875	Theco-peritoneal C.S.F. shunt	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	8.000	352.90 (309.60) T
14.6	**Aneurysm repair**								
2876	Repair of aneurysms or arteriovenous anomalies (Intracranial)	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	15.000	661.70 (580.40) T
2877	Extracranial to intracranial vascular	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	15.000	661.70 (580.40) T
2878	Posterior fossa arteriovenous anomalies	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	15.000	661.70 (580.40) T
14.7	**Posterior fossa surgery**								
2879	Glosso pharyngeal nerve	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	6.000	264.70 (232.20) T
2881	Eighth nerve: Intracranial	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	8.000	352.90 (309.60) T
2883	Eighth nerve: Extracranial	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	4.000	176.40 (154.70) T
2884	Sub-temporal section of the trigeminal nerve	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	9.000	397.00 (348.20) T
2885	Trigeminal tractotomy	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	9.000	397.00 (348.20) T
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	9.000	397.00 (348.20) T
2887	Vestibular nerve	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	9.000	397.00 (348.20) T
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	06.04		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	11.000	485.20 (425.60) T
2891	Posterior fossa tumour removal: Glioma, secondary deposits	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2893	Posterior fossa tumour removal: Abscess	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2895	Excision of tumour of glomus jugulare: Intracranial	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	11.000	485.20 (425.60) T
2897	Excision of tumour of glomus jugulare: Extracranial	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	9.000	397.00 (348.20) T
2898	Excision of tumour of glomus jugulare: Hemispherectomy	04.00		500.000	3514.00 (3082.50)	400.000	2811.20 (2466.00)	15.000	661.70 (580.40) T
14.7.1	**Posterior fossa surgery: Supratentorial procedures**								
2899	Craniectomy for extra-dural haematoma or empyema	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	11.000	485.20 (425.60) T
14.8	**Craniotomy for**								
2900	Craniotomy for Extra-dural orbital decompression or excision of orbital tumour	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	11.000	485.20 (425.60) T
2901	Craniotomy for Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	11.000	485.20 (425.60) T
2903	Craniotomy for Abscess, Glioma	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2905	Craniotomy for Focal epilepsy: Excision of cortical scar	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	04.11		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	11.000	485.20 (425.60) T
2907	Craniotomy for Temporal lobectomy	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2908	Craniotomy for Torkildsen anastomosis	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	11.000	485.20 (425.60) T
2909	Craniotomy for CSF-leaks	04.00		450.000	3162.60 (2774.20)	360.000	2530.10 (2219.40)	11.000	485.20 (425.60) T
2910	Craniotomy for removal of arteriovenous malformation	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	11.000	485.20 (425.60) T
14.8.1	**Craniotomy for Stereo-tactic cerebral and spinal cord procedures**								
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	4.000	176.40 (154.70) T
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	04.00		196.000	1377.50 (1208.30)	156.800	1102.00 (966.70)	4.000	176.40 (154.70) T
2915	Transnasal hypophysectomy	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	11.000	485.20 (425.60) T
2916	Transfrontal hypophysectomy	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	11.000	485.20 (425.60) T
2917	Transnasal hypophyseal implants	04.00		172.000	1208.80 (1060.40)	137.600	967.10 (848.30)	11.000	485.20 (425.60) T
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)	04.00		-	-	-	-		
14.9	**Spinal operations**								
	See section 3.8.7 for laminectomy procedures								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2923	Chordotomy: Unilateral	04.00		178.000	1251.00 (1097.40)	142.400	1000.80 (877.90)	3.000	132.30 (116.10) TM
2925	Chordotomy: Open	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	3.000	132.30 (116.10) TM
2927	Rhizotomy: Extradural, but intraspinal	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	3.000	132.30 (116.10) TM
2928	Rhizotomy: Intradural	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	3.000	132.30 (116.10) TM
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	8.000	352.90 (309.60) T
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	8.000	352.90 (309.60) T
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	3.000	132.30 (116.10) TM
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach	04.00		350.000	2459.80 (2157.70)	280.000	1967.80 (1726.10)	8.000	352.90 (309.60) T
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	7.000	308.80 (270.90) T
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	3.000	132.30 (116.10) T
2937	Repair of meningocele, involving nerve tissue	04.00		250.000	1757.00 (1541.20)	200.000	1405.60 (1233.00)	9.000	397.00 (348.20) T
2938	Simple	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	9.000	397.00 (348.20) T
2939	Excision of arterial vascular malformations and cysts of the spinal cord	04.00		700.000	4919.60 (4315.40)	560.000	3935.70 (3452.40)	9.000	397.00 (348.20) T
2940	Lumbar osteophyte removal	04.00		187.000	1314.20 (1152.80)	149.600	1051.40 (922.30)	3.000	132.30 (116.10) TM
2941	Cervical or thoracic osteophyte removal	04.00		285.000	2003.00 (1757.00)	228.000	1602.40 (1405.60)	3.000	132.30 (116.10) TM
14.10	**Arterial ligations**								
2951	Carotis: Trauma	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2953	Carotis: For aneurysm (AV anomaly)	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	8.000	352.90 (309.60) T
2955	Removal of carotid body tumour (without vascular reconstruction)	04.00		335.600	2358.60 (2068.90)	268.480	1886.90 (1655.20)	8.000	352.90 (309.60) T
14.11	**Medical psychotherapy**								
2957	Individual psychotherapy (specify type): Including play therapy for children: Per short session (20 minutes)	04.00		20.000	270.70 (237.50)	16.000	112.40 (98.60)		
2958	Psychoanalytic therapy: Per 60-minute session	04.00		60.000	812.10 (712.40)	48.000	337.30 (295.90)		
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session	04.00		20.000	270.70 (237.50)	16.000	112.40 (98.60)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2963	Pairs, marriage or sex therapy: Per 20-minute session	04.00		20.000	270.70 (237.50)	16.000	112.40 (98.60)		
2968	Group therapy: Adults (specify number): Tariff per person per 80-minute session; Children (specify number): Tariff per person per 80-minute session	04.00		26.000	351.90 (308.70)	8.000	56.20 (49.30)		
2974	Individual psychotherapy (specify type): Including play therapy for children: Per intermediate session (40 minutes)	04.00		40.000	541.40 (474.90)	32.000	224.90 (197.30)		
2975	Individual psychotherapy (specify type): Including play therapy for children: Per extended session (60 minutes or longer)	04.00		60.000	812.10 (712.40)	48.000	337.30 (295.90)		
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session	04.00		40.000	541.40 (474.90)	32.000	224.90 (197.30)		
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session	04.00		60.000	812.10 (712.40)	48.000	337.30 (295.90)		
RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY									
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods								04.00
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)								04.00
14.12	**Physical treatment methods**								
2970	Electro-convulsive treatment (ECT): Each time (See rule Va)	04.00		15.000	203.00 (178.10)	17.000	119.50 (104.80)	3.000	132.30 (116.10) T
14.13	**Psychiatric examination methods**								
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per 60 min session	06.05		60.000	812.10 (712.40)	16.000	112.40 (98.60)		
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)	04.00		20.000	270.70 (237.50)	16.000	112.40 (98.60)		
16	**Endocrine System**								
15.1	**Thyroid**								
2983	Lobectomy: Partial	04.00		198.100	1392.20 (1221.20)	158.480	1113.80 (977.00)	5.000	220.60 (193.50) T
2985	Lobectomy: Total	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	5.000	220.60 (193.50) T
2987	Thyroidectomy: Subtotal	04.00		266.000	1869.40 (1639.80)	212.800	1495.60 (1311.90)	5.000	220.60 (193.50) T
2989	Thyroidectomy: Total	04.00		279.000	1960.80 (1720.00)	223.200	1568.60 (1376.00)	5.000	220.60 (193.50) T
2991	Thyroglossal cyst or fistula excision	04.00		126.200	886.90 (778.00)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
15.2	**Parathyroid**								
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50) T
15.3	**Adrenals**								
2995	Adrenalectomy: Unilateral	04.00		225.000	1581.30 (1387.10)	180.000	1265.00 (1109.60)	9.000	397.00 (348.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2997	Bilateral exploration of adrenal glands: Including removal	04.00		394.000	2769.00 (2428.90)	315.200	2215.20 (1943.20)	11.000	485.20 (425.60) T
15.4	**Hypophysis**								
2999	Transethmoidal hypophysectomy	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	11.000	485.20 (425.60) T
3000	Transnasal hypophysectomy (see also item 2915)	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	11.000	485.20 (425.60) T
15.5	**Endocrine system: General**								
3001	Implantation of pellets (excluding cost of material) (excluding after-care)	04.00		3.000	21.10 (18.50)	3.000	21.10 (18.50)		
16	**Eye**								
16.1	**Eye: Procedures performed in rooms**								
	(a) Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions (b) Material used is excluded (c) The fee for photography is not related to the number of photographs taken								04.00
16.1.1	**Eye investigations**								
3002	Gonioscopy	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3006	Keratometry	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	04.00	+	11.680	82.10 (72.00)				
3012	Pre-surgical retinal examination before retinal surgery	04.00		32.000	224.90 (197.30)	32.000	224.90 (197.30)		
3013	Ocular motility assessment: Comprehensive examination	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
16.1.2	**Special eye investigations**								
3005	Endothelial cell count	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3007	Potential acuity measurement	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3008	Contrast sensitivity test	04.00		7.000	49.20 (43.20)	7.000	49.20 (43.20)		
3010	Orthoptics consultation	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
3011	Orthoptic subsequent sessions	04.00		5.000	35.10 (30.80)	5.000	35.10 (30.80)		
3015	Charting of visual field with manual perimeter	04.00		28.000	196.80 (172.60)	28.000	196.80 (172.60)		
3016	Retinal threshold test without storage facilities	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)		
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	04.00		74.000	520.10 (456.20)	74.000	520.10 (456.20)		
3018	Retinal threshold trend evaluation (additional to item 3017)	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)		
3019	Ocular muscle function with Hess screen or perimeter	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	04.00		46.000	323.30 (283.60)	46.000	323.30 (283.60)		
3022	Digital fluorescein video angiography	04.00		68.000	477.90 (419.20)	68.000	477.90 (419.20)	9.000	397.00 (348.20) T
3023	Digital indocyanine video angiography	04.00		110.000	773.10 (678.20)	110.000	773.10 (678.20)	9.000	397.00 (348.20) T
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)		
3025	Electronic tonography	04.00		19.000	133.50 (117.10)	19.000	133.50 (117.10)		
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	04.00		19.300	135.60 (118.90)	19.300	135.60 (118.90)		
3027	Fundus photography	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)		
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	04.00		40.000	281.10 (246.60)	40.000	281.10 (246.60)		
3029	Anterior segment microphotography	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)		
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)	04.00		45.000	316.30 (277.50)	45.000	316.30 (277.50)		
3032	Eyelid and orbit photography	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)		
3034	Determination of lens implant power per eye	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged	04.00		22.000	154.60 (135.60)	22.000	154.60 (135.60)		
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	04.00		36.000	253.00 (221.90)	36.000	253.00 (221.90)		
16.2	**Retina**								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	04.00		306.900	2156.90 (1892.00)	245.520	1725.50 (1513.60)	6.000	264.70 (232.20) T
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
3041	Pan retinal photocoagulation (per eye): Done in one sitting	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3044	Removal of encircling band and/or buckling material	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
16.3	**Cataract**								
3045	Cataract: Intra-capsular	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	7.000	308.80 (270.90) T
3047	Cataract: Extra-capsular (including capsulotomy)	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	7.000	308.80 (270.90) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	04.00		57.000	400.60 (351.40)	57.000	400.60 (351.40)	7.000	308.80 (270.90) T
3050	Repositioning of intra ocular lens	04.00		171.100	1202.50 (1054.80)	136.880	962.00 (843.90)	7.000	308.80 (270.90) T
3051	Needling or capsulotomy	04.00		130.000	913.60 (801.40)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3052	Laser capsulotomy	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	4.000	176.40 (154.70) T
3057	Removal of lenticulus	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	7.000	308.80 (270.90) T
3058	Exchange of intra ocular lens	04.00		236.000	1658.60 (1454.90)	188.800	1326.90 (1163.90)	7.000	308.80 (270.90) T
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	7.000	308.80 (270.90) T
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)	04.00		4.000	28.10 (24.60)				
16.4	**Glaucoma**								
3061	Drainage operation	04.00		247.600	1740.10 (1526.40)	198.080	1392.10 (1221.10)	6.000	264.70 (232.20) T
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	04.00		60.000	421.70 (369.90)	60.000	421.70 (369.90)	6.000	264.70 (232.20) T
3063	Cyclocryotherapy or cyclodiathermy	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
3064	Laser trabeculoplasty	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
3065	Removal of blood from anterior chamber	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	4.000	176.40 (154.70) T
3067	Goniotomy	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	7.000	308.80 (270.90) T
16.5	**Intra-ocular foreign body**								
3071	Intra-ocular foreign body: Anterior to Iris	04.00		127.000	892.60 (783.00)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	6.000	264.70 (232.20) T
16.6	**Strabismus**								
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to item 0202)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	04.00		175.600	1234.10 (1082.50)	140.480	987.30 (866.10)	5.000	220.60 (193.50) T
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)	5.000	220.60 (193.50) T
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	04.00		120.000	843.40 (739.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
16.7	**Globe**								
3079	Transcleral biopsy	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3080	Examination of eyes under general anaesthetic where no surgery is done	04.00		80.000	562.20 (493.20)	80.000	562.20 (493.20)	4.000	176.40 (154.70) T
3081	Treatment of minor perforating injury	04.00		161.600	1135.70 (996.20)	129.280	908.60 (797.00)	6.000	264.70 (232.20) T
3083	Treatment of major perforating injury	04.00		267.500	1880.00 (1649.10)	214.000	1504.00 (1319.30)	6.000	264.70 (232.20) T
3085	Enucleation or Evisceration	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	5.000	220.60 (193.50) T
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	04.00		160.000	1124.50 (986.40)	128.000	899.60 (789.10)	5.000	220.60 (193.50) T
3088	Hydroxyapetite insertion (additional to item 3087)	04.00	+	40.000	281.10 (246.60)	40.000	281.10 (246.60)	5.000	220.60 (193.50) T
3089	Subconjunctival injection if not done at time of operation	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	5.000	220.60 (193.50) T
3090	Intra vitreal injection drug	05.06		47.600	334.50 (293.40)	47.600	334.50 (293.40)	4.000	176.40 (154.70) T
3091	Retrobulbar injection (if not done at time of operation)	04.00		16.000	112.40 (98.60)	16.000	112.40 (98.60)	4.000	176.40 (154.70) T
3092	External laser treatment for superficial lesions	04.00		53.000	372.50 (326.80)	53.000	372.50 (326.80)		
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	04.00		209.000	1468.90 (1288.50)	167.200	1175.10 (1030.80)	6.000	264.70 (232.20) T
3094	Implantation of intra vitreal drug delivery system	04.00		247.600	1740.10 (1526.40)	198.080	1392.10 (1221.10)	4.000	176.40 (154.70) T
3095	Biopsy of vitreous body or anterior chamber contents	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	6.000	264.70 (232.20) T
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	04.00		130.000	913.60 (801.40)	120.000	843.40 (739.80)	7.000	308.80 (270.90) T
3097	Anterior vitrectomy	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	6.000	264.70 (232.20) T
3098	Removal of silicon from globe	04.00		280.000	1967.80 (1726.10)	224.000	1574.30 (1381.00)	6.000	264.70 (232.20) T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	04.00		419.000	2944.70 (2583.10)	335.200	2355.80 (2066.50)	6.000	264.70 (232.20) T
3100	Lensectomy done at time of posterior vitrectomy	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	7.000	308.80 (270.90) T
16.8	**Orbit**								
3101	Drainage of orbital abscess	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3103	Orbit: Removal of tumour	04.00		240.000	1686.70 (1479.60)	192.000	1349.40 (1183.70)	5.000	220.60 (193.50) T
3104	Removal orbital prosthesis	04.00		212.700	1494.90 (1311.30)	170.160	1195.90 (1049.00)	5.000	220.60 (193.50) T
3105	Orbit: Exenteration	04.00		275.000	1932.70 (1695.40)	220.000	1546.20 (1356.30)	5.000	220.60 (193.50) T
3107	Orbitotomy requiring bone flap	04.00		393.000	2762.00 (2422.80)	314.400	2209.60 (1938.20)	5.000	220.60 (193.50) T
3108	Eye socket reconstruction	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	5.000	220.60 (193.50) T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	04.00		300.000	2108.40 (1849.50)	240.000	1686.70 (1479.60)	5.000	220.60 (193.50) T
3110	Second stage hydroxyapetite implantation	04.00		110.000	773.10 (678.20)	110.000	773.10 (678.20)	5.000	220.60 (193.50) T
16.9	**Cornea**								
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	04.00		-	- F	-	- F		
3112	Fitting of contact lens for treatment of disease including supply of lens	04.00		12.200	85.70 (75.20)	12.200	85.70 (75.20)		
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one (1) year	04.00		200.000	1405.60 (1233.00)	160.000	1124.50 (986.40)		
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only	04.00		78.850	554.20 (486.10)				
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	04.00		166.000	1166.60 (1023.30)	132.800	933.30 (818.70)		
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	04.00		135.200	950.20 (833.50)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3117	Removal of foreign body: On the basis of fee per consultation	04.00		-	- F	-	- F	4.000	176.40 (154.70) T
3118	Curettage of cornea after removal of foreign body (after-care excluded)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
3119	Tattooing	04.00		26.000	182.70 (160.30)	26.000	182.70 (160.30)	4.000	176.40 (154.70) T
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3121	Corneal graft (Lamellar or full thickness)	04.00		289.000	2031.10 (1781.70)	231.200	1624.90 (1425.40)	6.000	264.70 (232.20) T
3122	Epikeratophakia	04.00		289.000	2031.10 (1781.70)	231.200	1624.90 (1425.40)		
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	04.00		254.000	1785.10 (1565.90)	203.200	1428.10 (1252.70)	6.000	264.70 (232.20) T
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see item 0202)	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)		
3125	Keratectomy	04.00		127.000	892.60 (783.00)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	04.00	+	52.180	366.70 (321.70)	52.180	366.70 (321.70)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3129	Additional to item 3128 for the use of own diamond knives	04.00	+	40.000	281.10 (246.60)	40.000	281.10 (246.60)		
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	04.00		96.900	681.00 (597.40)	96.900	681.00 (597.40)	4.000	176.40 (154.70) T
3131	Cornea: Paracentesis	04.00		53.000	372.50 (326.80)	53.000	372.50 (326.80)	4.000	176.40 (154.70) T
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	04.00		150.000	1054.20 (924.70)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure	04.00		116.300	817.40 (717.00)	116.300	817.40 (717.00)	4.000	176.40 (154.70) T
3136	Conjunctival flap or graft (not for use with pterigium surgery)	04.00		95.700	672.60 (590.00)	95.700	672.60 (590.00)	6.000	264.70 (232.20) T
3138	Removal corneal epithelium and chelating agent for band keratopathy	04.00		69.500	488.40 (428.40)	69.500	488.40 (428.40)	4.000	176.40 (154.70) T
16.10	**Ducts**								
3133	Probing and/or syringing, per duct	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
3135	Insert polythene tubes	04.00		51.800	364.10 (319.40)	51.800	364.10 (319.40)	4.000	176.40 (154.70) T
3137	Excision of lacrimal sac: Unilateral	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3139	Dacrocystorhinostomy (Single) with or without polythene tube	04.00		210.000	1475.90 (1294.60)	168.000	1180.70 (1035.70)	5.000	220.60 (193.50) T
3141	Sealing Punctum surgical or by cautery: Per eye	04.00		24.900	175.00 (153.50)	24.900	175.00 (153.50)	4.000	176.40 (154.70) T
3142	Sealing Punctum with plugs: Per eye	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)	4.000	176.40 (154.70) T
3143	Three-snip operation	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
3145	Repair of canaliculus: Primary procedure	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3147	Repair of canaliculus: Secondary procedure	04.00		175.000	1229.90 (1078.90)	140.000	983.90 (863.10)	4.000	176.40 (154.70) T
16.11	**Iris**								
3149	Iridectomy or iridotomy by open operation as isolated procedure	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3151	Excision of iris tumour	04.00		185.000	1300.20 (1140.50)	148.000	1040.10 (912.40)	6.000	264.70 (232.20) T
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	04.00		105.000	737.90 (647.30)	105.000	737.90 (647.30)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3155	Iridocyclectomy for tumour	04.00		266.000	1869.40 (1639.80)	212.800	1495.60 (1311.90)	6.000	264.70 (232.20) T
3157	Division of anterior synechiae as isolated procedure	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3158	Repair iris as in dialysis: Anterior chamber reconstruction	04.00		142.400	1000.80 (877.90)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
16.12	**Lids**								
3161	Tarsorrhaphy	04.00		47.000	330.30 (289.70)	47.000	330.30 (289.70)	4.000	176.40 (154.70) T
3163	Excision of superficial lid tumour	04.00		47.000	330.30 (289.70)	47.000	330.30 (289.70)	4.000	176.40 (154.70) T
3165	Repair of skin laceration lid: Simple	04.00		27.300	191.90 (168.30)	27.300	191.90 (168.30)	4.000	176.40 (154.70) T
3167	Diathermy to wart on lid margin	04.00		12.000	84.30 (73.90)	12.000	84.30 (73.90)	4.000	176.40 (154.70) T
3169	Electrolysis of any number of eyelashes: Per eye	04.00		15.000	105.40 (92.50)	15.000	105.40 (92.50)		
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see item 0202)	04.00		20.400	143.40 (125.80)	20.400	143.40 (125.80)	4.000	176.40 (154.70) T
3173	Epicanthal folds	04.00		128.700	904.50 (793.40)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)	04.00		25.000	175.70 (154.10)				
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)	04.00		35.000	246.00 (215.80)				
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	04.00		187.000	1314.20 (1152.80)	149.600	1051.40 (922.30)	4.000	176.40 (154.70) T
16.12.1	**Lids: Entropion or ectropion by**								
3177	Entropion or ectropion by Cautery	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)	4.000	176.40 (154.70) T
3179	Entropion or ectropion by Suture	04.00		49.400	347.20 (304.60)	49.400	347.20 (304.60)	4.000	176.40 (154.70) T
3181	Entropion or ectropion by Open operation	04.00		111.500	783.60 (687.40)	111.500	783.60 (687.40)	4.000	176.40 (154.70) T
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	04.00		122.600	861.60 (755.80)	122.600	861.60 (755.80)	4.000	176.40 (154.70) T
16.12.2	**Lids: Reconstruction of eyelid**								
3185	Staged procedure for partial or total loss of eyelid: First stage	04.00		259.000	1820.30 (1596.80)	207.200	1456.20 (1277.40)	4.000	176.40 (154.70) T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	04.00		206.000	1447.80 (1270.00)	164.800	1158.20 (1016.00)	4.000	176.40 (154.70) T
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	04.00		136.500	959.30 (841.50)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	04.00		150.200	1055.60 (926.00)	120.160	844.50 (740.80)	4.000	176.40 (154.70) T
3172	Blepharoplasty lower eyelid plus fat pad	04.00		125.800	884.10 (775.50)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
16.12.3	**Lids: Ptosis**								
3193	Repair by superior rectus, levator or frontalis muscle operation	04.00		190.000	1335.30 (1171.30)	152.000	1068.30 (937.10)	4.000	176.40 (154.70) T
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	04.00		137.600	967.10 (848.30)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	04.00		166.000	1166.60 (1023.30)	132.800	933.30 (818.70)	4.000	176.40 (154.70) T
16.13	**Conjunctiva**								
3199	Repair of conjunctiva by grafting	04.00		132.000	927.70 (813.80)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T
3200	Repair of lacerated conjunctiva	04.00		47.000	330.30 (289.70)	47.000	330.30 (289.70)	4.000	176.40 (154.70) T
16.14	**Eye: General**								
	OWN EQUIPMENT USED IN TREATMENT: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.								04.00
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting	04.00		109.000	766.10 (672.00)				
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of R15,00 per minute may be charged	04.00							
3196	Diamond knife: Use of own diamond knife during intraocular surgery	04.00		12.000	84.30 (73.90)				
3198	Excimer laser: Hire fee (per eye)	04.00		284.130	1996.90 (1751.70)				
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting (Not to be used with IOL Master)	04.00		109.000	766.10 (672.00)				
3202	Phako emulsification apparatus: Hire fee	04.00		109.000	766.10 (672.00)				
3203	Vitrectomy apparatus: Hire fee	04.00		120.000	843.40 (739.80)				
17	**Ear**								
17.1	**External ear (Pinna)**								
3267	Major congenital deformity reconstruction of external ear: Unilateral	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
3269	Major congenital deformity reconstruction of external ear: Bilateral	04.00		242.000	1700.80 (1491.90)	193.600	1360.60 (1193.50)	5.000	220.60 (193.50) T
3270	Excision of superficial pre-auricular fistula	04.00		55.000	386.50 (339.00)	55.000	386.50 (339.00)	4.000	176.40 (154.70) T
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear	04.00		-	- f				
3272	Excision of complicated pre-auricular fistula	04.00		140.000	983.90 (863.10)	120.000	843.40 (739.80)	4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
17.2	**External ear canal**								
3204	External ear canal: Removal of foreign body: At rooms	04.00		-	- F	-	- F		
3205	External ear canal: Removal of foreign body: Under general anaesthetic	04.00		21.000	147.60 (129.50)	21.000	147.60 (129.50)	4.000	176.40 (154.70) T
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	04.00		164.000	1152.60 (1011.10)	131.200	922.10 (808.90)	4.000	176.40 (154.70) T
3217	Meatus atresia: Congenital	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	4.000	176.40 (154.70) T
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	04.00		77.000	541.20 (474.70)	77.000	541.20 (474.70)	4.000	176.40 (154.70) T
3221	Meatus atresia: Removal of osteoma from meatus: Multiple	04.00		215.000	1511.00 (1325.40)	172.000	1208.80 (1060.40)	4.000	176.40 (154.70) T
17.3	**Middle ear**								
3206	Microscopic examination of tympanic membrane including microsuction	04.00		8.000	56.20 (49.30)	8.000	56.20 (49.30)		
3207	Myringotomy: Unilateral	04.00		28.000	196.80 (172.60)	28.000	196.80 (172.60)	4.000	176.40 (154.70) T
3209	Myringotomy: Bilateral	04.00		46.000	323.30 (283.60)	46.000	323.30 (283.60)	4.000	176.40 (154.70) T
3211	Unilateral myringotomy with insertion of ventilation tube	04.00		38.000	267.10 (234.30)	38.000	267.10 (234.30)	4.000	176.40 (154.70) T
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	04.00		57.000	400.60 (351.40)	57.000	400.60 (351.40)	4.000	176.40 (154.70) T
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	04.00		65.000	456.80 (400.70)	65.000	456.80 (400.70)	4.000	176.40 (154.70) T
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	04.00		255.000	1792.10 (1572.00)	204.000	1433.70 (1257.60)	5.000	220.60 (193.50) T
3237	Exploratory tympanotomy	04.00		158.900	1116.70 (979.60)	127.120	893.40 (783.70)	5.000	220.60 (193.50) T
3243	Myringoplasty	04.00		138.000	969.90 (850.80)	120.000	843.40 (739.80)	5.000	220.60 (193.50) T
3245	Functional reconstruction of tympanic membrane	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	5.000	220.60 (193.50) T
3249	Stapedotomy and stapedectomy	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	5.000	220.60 (193.50) T
3257	Cortical mastoidectomy	04.00		188.500	1324.80 (1162.10)	150.800	1059.80 (929.60)	5.000	220.60 (193.50) T
3259	Radical mastoidectomy (excluding minor procedures)	04.00		277.400	1949.60 (1710.20)	221.920	1559.70 (1368.20)	5.000	220.60 (193.50) T
3261	Muscle grafting to mastoid cavity without tympanoplasty	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	5.000	220.60 (193.50) T
3263	Autogenous bone graft to mastoid cavity	04.00		180.000	1265.00 (1109.60)	144.000	1012.00 (887.70)	5.000	220.60 (193.50) T
3264	Tympanomastoidectomy	04.00		375.000	2635.50 (2311.80)	300.000	2108.40 (1849.50)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3265	Reconstruction of posterior canal wall, following radical mastoid	04.00		320.000	2249.00 (1972.80)	256.000	1799.20 (1578.20)	5.000	220.60 (193.50) T
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	04.00		30.000	210.80 (184.90)	30.000	210.80 (184.90)	5.000	220.60 (193.50) T
17.4	**Facial nerve**								
17.4.1	**Facial nerve: Facial nerve tests**								
3223	Percutaneous stimulation of the facial nerve	04.00		9.000	63.30 (55.50)	9.000	63.30 (55.50)	4.000	176.40 (154.70) T
3224	Electroneurography (ENOG)	04.00		75.000	527.10 (462.40)	75.000	527.10 (462.40)	4.000	176.40 (154.70) T
17.4.2	**Facial nerve: Facial nerve surgery**								
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	04.00		297.000	2087.30 (1831.00)	237.600	1669.90 (1464.80)	5.000	220.60 (193.50) T
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)	04.00		436.000	3064.20 (2687.90)	348.800	2451.40 (2150.40)	5.000	220.60 (193.50) T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	04.00		436.000	3064.20 (2687.90)	348.800	2451.40 (2150.40)	5.000	220.60 (193.50) T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	04.00		124.000	871.50 (764.50)	120.000	843.40 (739.80)	6.000	264.70 (232.20) T
17.5	**Inner ear**								
17.5.1	**Inner ear: Audiometry**								
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	04.00		50.000	351.40 (308.20)				
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	04.00		88.000	618.50 (542.50)				
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels	04.00		60.000	421.70 (369.90)				
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels	04.00		105.000	737.90 (647.30)				
2695	Audiology 40Hz response: Unilateral	04.00		30.000	210.80 (184.90)				
2696	Audiology 40Hz response: Bilateral	04.00		53.000	372.50 (326.80)				
2697	Mid- and long latency auditory evoked potentials: Unilateral	04.00		30.000	210.80 (184.90)				
2698	Mid- and long latency auditory evoked potentials: Bilateral	04.00		53.000	372.50 (326.80)				
2699	Electro-cochleography: Unilateral	04.00		50.000	351.40 (308.20)				
2700	Electro-cochleography: Bilateral	04.00		88.000	618.50 (542.50)				
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	04.00		140.000	983.90 (863.10)			4.000	176.40 (154.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3248	Otoacoustic emission performed as a screening test	05.03		33.240	233.60 (204.90) Z	33.240	233.60 (204.90) Z		
3250	Otoacoustic emission (high risk patients only)	04.00		66.480	467.20 (409.80)	66.480	467.20 (409.80)		
3273	Pure tone audiometry (air conduction)	04.00		6.500	45.70 (40.10)	6.500	45.70 (40.10)		
3274	Pure tone audiometry (bone conduction with masking)	04.00		6.500	45.70 (40.10)	6.500	45.70 (40.10)		
3275	Impedance audiometry (tympanometry)	04.00		6.500	45.70 (40.10)	6.500	45.70 (40.10)		
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.	04.00		6.500	45.70 (40.10)	6.500	45.70 (40.10)		
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	06.04		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	04.00		6.500	45.70 (40.10)	6.500	45.70 (40.10)		
17.5.2	**Inner ear: Balance tests**								
3251	Minimal caloric test (excluding consultation fee)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
3252	Bithermal Halpike caloric test (excluding consultation fee)	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
3253	Electro-nystagmography for spontaneous and positional nystagmus	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)		
3254	Video nystagmoscopy (monocular)	04.00		25.000	175.70 (154.10)	25.000	175.70 (154.10)		
3255	Caloric test done with electronystamography	04.00		70.000	492.00 (431.60)	70.000	492.00 (431.60)		
3256	Video nystagmoscopy (binocular)	04.00		50.000	351.40 (308.20)	50.000	351.40 (308.20)		
3258	Otolith repositioning manoeuvre	04.00		14.000	98.40 (86.30)	14.000	98.40 (86.30)	4.000	176.40 (154.70) T
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	04.00		71.480	502.40 (440.70) Z	71.480	502.40 (440.70) Z		
17.5.3	**Inner ear surgery**								
3233	Labyrinthectomy via the middle ear or mastoid	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	5.000	220.60 (193.50) T
3240	Endolymphatic sac surgery	04.00		277.000	1946.80 (1707.70)	221.600	1557.40 (1366.10)	4.000	176.40 (154.70) T
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	04.00		310.000	2178.70 (1911.10)	248.000	1742.90 (1528.90)	5.000	220.60 (193.50) T
3246	Cochlear implant surgery	04.00		340.500	2393.00 (2099.10)	272.400	1914.40 (1679.30)	5.000	220.60 (193.50) T
17.6	**Microsurgery of the skull base**								
17.6.1	**Microsurgery of the skull base: Middel fossa approach (i.e transtemporal or supralabyrinthine)**								
3229	Facial nerve: Exploration of the labyrinthine segment	04.00		420.000	2951.80 (2589.30)	336.000	2361.40 (2071.40)	5.000	220.60 (193.50) T
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	06.04		510.000	3584.30 (3144.10)	408.000	2867.40 (2515.30)	11.000	485.20 (425.60) T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	06.04		620.000	4357.40 (3822.30)	496.000	3485.90 (3057.80)	11.000	485.20 (425.60) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	04.00		530.000	3724.80 (3267.40)	424.000	2979.90 (2613.90)	11.000	485.20 (425.60) T
5224	Removal of acoustic neuroma via the middle fossa approach	04.00		660.000	4638.50 (4068.90)	528.000	3710.80 (3255.10)	11.000	485.20 (425.60) T
17.6.2	**Microsurgery of the skull base: Translabyrinthe approach**								
3239	Acoustic neuroma removal translabyrinthine	04.00		660.000	4638.50 (4068.90)	528.000	3710.80 (3255.10)	5.000	220.60 (193.50) T
5227	Cochleo-vestibular neurectomy	04.00		530.000	3724.80 (3267.40)	424.000	2979.90 (2613.90)	11.000	485.20 (425.60) T
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)	06.04		660.000	4638.50 (4068.90)	528.000	3710.80 (3255.10)	11.000	485.20 (425.60) T
17.6.3	**Microsurgery of the skull base: Transotic approach to the cerebellopontime angle**								
5232	Removal of acoustic neuroma or cyst of the internal auditory canal	04.00		660.000	4638.50 (4068.90)	528.000	3710.80 (3255.10)	11.000	485.20 (425.60) T
17.6.4	**Microsurgery of the skull base: Intratemporal fossa approach type A**								
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours	04.00		710.000	4989.90 (4377.10)	568.000	3991.90 (3501.70)	11.000	485.20 (425.60) T
17.6.5	**Microsurgery of the skull base: Intratemporal fossa approach type B**								
5238	Removal of tumour of the petrous apex	04.00		620.000	4357.40 (3822.30)	496.000	3485.90 (3057.80)	11.000	485.20 (425.60) T
5239	Removal of tumour of the clivus	04.00		620.000	4357.40 (3822.30)	496.000	3485.90 (3057.80)	11.000	485.20 (425.60) T
17.6.6	**Microsurgery of the skull base: Intrafemoral approach type C**								
5242	Removal of nasopharyngeal angiofibroma or carcinoma	04.00		520.000	3654.60 (3205.80)	416.000	2923.60 (2564.60)	8.000	352.90 (309.60) T
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	04.00		520.000	3654.60 (3205.80)	416.000	2923.60 (2564.60)	11.000	485.20 (425.60) T
17.6.7	**Microsurgery of the skull base: Subtotal petrosectomy**								
5246	Subtotal petrosectomy for removal of temporal bone tumour	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	11.000	485.20 (425.60) T
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	04.00		480.000	3373.40 (2959.10)	384.000	2698.80 (2367.40)	11.000	485.20 (425.60) T
17.6.8	**Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa**								
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland	04.00		520.000	3654.60 (3205.80)	416.000	2923.60 (2564.60)	11.000	485.20 (425.60) T
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	04.00		600.000	4216.80 (3698.90)	480.000	3373.40 (2959.10)	8.000	352.90 (309.60) T
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	04.00		660.000	4638.50 (4068.90)	528.000	3710.80 (3255.10)	8.000	352.90 (309.60) T
18	**Physical Treatment**								
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	04.00	+	0.750	5.27 (4.62)				
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	04.00		13.500	94.90 (83.20)				
3281	Ultrasonic therapy	04.00		10.000	70.30 (61.70)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3282	Shortwave diathermy	04.00		10.000	70.30 (61.70)				
3284	Sensory nerve conduction studies	04.00		31.000	217.90 (191.10)				
3285	Motor nerve conduction studies	04.00		26.000	182.70 (160.30)				
3287	Spinal joint and ligament injection	04.00		20.000	140.60 (123.30)	20.000	140.60 (123.30)		
3288	Epidural injection	04.00		36.000	253.00 (221.90)				
3289	Multiple injections: First joint	04.00		7.500	52.70 (46.20)				
3290	Multiple injections: Each additional joint	04.00		4.500	31.60 (27.70)				
3291	Tendon or ligament injection	04.00		9.000	63.30 (55.50)				
3292	Aspiration of joint or inter-articular injection	04.00		9.000	63.30 (55.50)				
3293	Aspiration or injection of bursa or ganglion	04.00		9.000	63.30 (55.50)				
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389)	06.05		20.000	140.60 (123.30)				
3295	Paravertebral root block: Unilateral	04.00		20.000	140.60 (123.30)				
3296	Paravertebral root block: Bilateral	04.00		30.000	210.80 (184.90)				
3297	Manipulation of spine performed by a specialist in Physical Medicine	04.00		14.000	98.40 (86.30)				
3298	Spinal traction	04.00		6.000	42.20 (37.00)				
3299	Manipulation of large joints: Under general anaesthesia	04.00		14.000	98.40 (86.30)			3.000	132.30 (116.10) T
3299a	Manipulation of large joints: Under general anaesthesia	05.01		14.000	98.40 (86.30)			4.000	176.40 (154.70) T
3300	Manipulation of large joints: Without anaesthetic	04.00		-	- F	-	- F		
3301	Muscle fatigue studies	04.00		20.000	140.60 (123.30)				
3302	Strength duration curve per session	04.00		10.500	73.80 (64.70)				
3303	Electromyography	04.00		75.000	527.10 (462.40)				
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (For subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment: A fee for the treatment only, is applicable: See general rules L and M)	04.00		10.000	70.30 (61.70)	10.000	70.30 (61.70)		
SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT									
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)								04.00
19	**Radiology**								
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values								04.00
RULES GOVERNING THE SECTION RADIOLOGY									
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used								04.00
Z.	No fee is subject to more than one reduction								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years								04.00
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").								04.00
MODIFIERS GOVERNING THE SECTION									
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere								04.00
0080	Multiple examinations: Full Fee								04.00
0081	Repeat examinations: No reduction								04.00
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction								04.00
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used								04.00
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)								04.00
19.1	**Skeleton**								
19.1.1	**Skeleton: Limbs**								
3305	Finger, toe	04.00				6.300	62.70 (55.00)		
3309	Smith-Petersen or equivalent control, in theatre	04.00				38.700	385.30 (338.00)		
3311	Stress studies, e.g. joint	04.00				7.700	76.70 (67.30)		
3313	Full length study, both legs	04.00				15.500	154.30 (135.40)		
3315	Skeletal survey under 5 years	04.00				19.900	198.10 (173.80)		
3317	Skeletal survey over 5 years	04.00				28.000	278.80 (244.60)		
3319	Arthrography per joint	04.00				15.400	153.30 (134.50)		
3320	Introduction of contrast medium or air: ADD	04.00	+			13.800	137.40 (120.50)		
6500	Hand	04.00				7.700	76.70 (67.30)		
6501	Wrist (specify region)	04.00				7.700	76.70 (67.30)		
6503	Scaphoid	04.00				7.700	76.70 (67.30)		
6504	Radius and ulna	04.00				7.700	76.70 (67.30)		
6505	Elbow	04.00				7.700	76.70 (67.30)		
6506	Humerus	04.00				7.700	76.70 (67.30)		
6507	Shoulder	04.00				7.700	76.70 (67.30)		
6508	Acromio-Clavicula joint	04.00				7.700	76.70 (67.30)		
6509	Clavicle	04.00				7.700	76.70 (67.30)		
6510	Scapula	04.00				7.700	76.70 (67.30)		
6511	Foot	04.00				7.700	76.70 (67.30)		
6512	Ankle	04.00				7.700	76.70 (67.30)		
6513	Calcaneus	04.00				7.700	76.70 (67.30)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6514	Tibia and fibula	04.00				7.700	76.70 (67.30)		
6515	Knee	04.00				7.700	76.70 (67.30)		
6516	Patella	04.00				7.700	76.70 (67.30)		
6517	Femur	04.00				7.700	76.70 (67.30)		
6518	Hip	04.00				7.700	76.70 (67.30)		
6519	Sesamoid Bone	04.00				7.700	76.70 (67.30)		
19.1.2	**Skeleton: Spinal column**								
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic	04.00				11.000	109.50 (96.10)		
3325	Stress studies	04.00				11.000	109.50 (96.10)		
3329	Scoliosis studies	04.00				21.000	209.10 (183.40)		
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)	04.00				11.000	109.50 (96.10)		
3333	Myelography: Lumbar	04.00				28.900	287.70 (252.40)	4.000	176.40 (154.70) T
3334	Myelography: Thoracic	04.00				22.200	221.00 (193.90)	4.000	176.40 (154.70) T
3335	Myelography: Cervical	04.00				35.500	353.40 (310.00)	4.000	176.40 (154.70) T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	04.00						4.000	176.40 (154.70) T
3344	Introduction of contrast medium	04.00	+			18.700	186.20 (163.30)		
3345	Discography	04.00				34.600	344.50 (302.20)	4.000	176.40 (154.70) T
3347	Introduction of contrast medium per disc level: ADD	04.00	+			28.200	280.80 (246.30)		
19.1.3	**Skeleton: Skull**								
3349	Skull studies	04.00				15.700	156.30 (137.10)		
3351	Paranasal sinuses	04.00				11.000	109.50 (96.10)		
3353	Facial bones and/or orbits	04.00				12.600	125.40 (110.00)		
3355	Mandible	04.00				9.400	93.60 (82.10)		
3357	Nasal bone	04.00				7.800	77.70 (68.20)		
3359	Mastoid: Bilateral	04.00				18.000	179.20 (157.20)		
3361	Teeth: One quadrant	04.00				3.700	36.80 (32.30)		
3363	Teeth: Two quadrants	04.00				6.300	62.70 (55.00)		
3365	Teeth: Full mouth	04.00				11.000	109.50 (96.10)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3366	Teeth: Rotation tomography of the teeth and jaws	04.00				13.300	132.40 (116.10)		
3367	Teeth: Tempero-mandibular joints: Per side	04.00				11.000	109.50 (96.10)		
3369	Teeth: Tomography: Per side	04.00				11.000	109.50 (96.10)		
3371	Localisation of foreign body in the eye	04.00				15.700	156.30 (137.10)		
3381	Ventriculography	04.00				27.300	271.80 (238.40)	4.000	176.40 (154.70) T
3385	Post-nasal studies: Lateral neck	04.00				6.300	62.70 (55.00)		
3387	Maxillo-facial cephalometry	04.00				8.800	87.60 (76.80)		
3389	Dacrocystography	04.00				11.000	109.50 (96.10)	4.000	176.40 (154.70) T
3391	For introduction of contrast medium: ADD	04.00	+			11.000	109.50 (96.10)		
19.2	**Alimentary tract**								
3393	Bowel washout: ADD	04.00	+			4.800	47.80 (41.90)		
3395	Sialography (plus 80% for each additional gland)	04.00				12.700	126.40 (110.90)	4.000	176.40 (154.70) T
3397	Introduction of contrast medium (plus 80% for each additional gland: ADD)	04.00	+			11.000	109.50 (96.10)		
3399	Pharynx and oesophagus	04.00				12.700	126.40 (110.90)		
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	04.00				20.000	199.10 (174.60)		
3405	Double contrast: ADD	04.00	+			7.300	72.70 (63.80)		
3406	Small bowel meal (control film of abdomen included except when part of item 3408)	04.00				20.000	199.10 (174.60)		
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	04.00				28.900	287.70 (252.40)		
3409	Barium enema (control film of abdomen included)	04.00				18.300	182.20 (159.80)		
3411	Air contrast study: ADD	04.00	+			19.300	192.20 (168.60)		
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included	04.00				23.300	232.00 (203.50)	4.000	176.40 (154.70) T
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included	04.00				15.500	154.30 (135.40)	4.000	176.40 (154.70) T
	Note: For items 3415 and 3416: Endoscopy (see item 1778)	04.00							
3417	Gastric/oesophageal/duodenal intubation control	04.00				5.900	58.70 (51.50)		
3419	Gastric/oesophageal intubation insertion of tube: ADD	04.00	+			5.600	55.80 (48.90)		
3421	Duodenal intubation: Insertion of tube: ADD	04.00	+			11.000	109.50 (96.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3423	Hypotonic duodenography (item 3403 and item 3405 included)	04.00	+			29.300	291.70 (255.90)		
19.3	**Biliary tract**								
3425	Oral cholecystography	04.00				15.700	156.30 (137.10)		
3427	Cholangiography: Intravenous	04.00				22.000	219.00 (192.10)		
3431	Operative cholangiography: First series: ADD item 3607 only when the Radiologist attends personally in theatre	04.00				21.000	209.10 (183.40)		
3433	Post operative: T-tube	04.00				16.700	166.30 (145.90)		
3435	Introduction of contrast medium: ADD	04.00	+			5.600	55.80 (48.90)		
3437	Trans hepatic, percutaneous	04.00				18.300	182.20 (159.80)		
3439	Introduction of contrast medium: ADD	04.00	+			33.100	329.50 (289.00)		
3441	Tomography of biliary tract: ADD	04.00	+			9.400	93.60 (82.10)		
19.4	**Chest**								
3443	Larynx (Tomography included)	04.00				12.500	124.50 (109.20)		
3445	Chest (item 3601 included)	04.00				9.400	93.60 (82.10)		
3447	Chest and cardiac studies (item 3601)	04.00				12.600	125.40 (110.00)		
3449	Ribs	04.00				12.300	122.50 (107.50)		
3451	Sternum or sterno-clavicular joints	04.00				12.600	125.40 (110.00)		
3453	Bronchography: Unilateral	04.00				12.600	125.40 (110.00)	8.000	352.90 (309.60) T
3455	Bronchography: Bilateral	04.00				22.100	220.00 (193.00)	8.000	352.90 (309.60) T
3457	Introduction of contrast medium included	04.00				35.700	355.40 (311.80)		
3461	Pleurography	04.00				12.600	125.40 (110.00)	3.000	132.30 (116.10) T
3463	For introduction of contrast medium: ADD	04.00	+			2.800	27.90 (24.50)		
3465	Laryngography	04.00				11.000	109.50 (96.10)		
3467	For introduction of contrast medium: ADD	04.00	+			10.000	99.60 (87.40)		
3468	Thoracic inlet	04.00				6.300	62.70 (55.00)		
19.5	**Abdomen**								
3477	Control films of the Abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)	04.00				9.400	93.60 (82.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3479	Acute abdomen or equivalent studies	04.00				15.700	156.30 (137.10)		
19.6	**Urinary tract**								
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)	04.00				25.100	249.90 (219.20)		
3493	Waterload test: ADD	04.00	+			12.200	121.50 (106.60)		
3497	Cystography only or urethrography only (retrograde)	04.00				19.300	192.20 (168.60)		
3499	Cysto-urethrography: Retrograde	04.00				31.900	317.60 (278.60)		
3503	Cysto-urethrography: Introduction of contrast medium	04.00	+			3.700	36.80 (32.30)		
3505	Retrograde-prograde pyelography	04.00				18.300	182.20 (159.80)	3.000	132.30 (116.10) T
3511	Aspiration renal cyst	04.00				18.400	183.20 (160.70)		
3513	Tomography of renal tract: ADD	04.00	+			9.400	93.60 (82.10)		
19.7	**Gynaecology and obstetrics**								
3515	Pregnancy	04.00				9.400	93.60 (82.10)		
3517	Pelvimetry	04.00				17.400	173.20 (151.90)		
3519	Hystero-salpingography	04.00				12.500	124.50 (109.20)	3.000	132.30 (116.10) T
3521	Introduction of contrast medium: ADD	04.00	+			15.300	152.30 (133.60)		
19.8	**Vascular studies**								
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii All fluoroscopy (item 3601 does not apply). iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note : Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
MODIFIER GOVERNING VASCULAR STUDIES									
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations								04.00
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)								04.00
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)								04.00
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)								04.00
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure								04.00
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value								04.00
19.8.1	**Vascular studies: Film Series**								
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.								04.00
3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment	04.00							
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment	04.00							
3538	Analogue monoplane table with DSA attachment	04.00							
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment	04.00							
3540	Radiography fee for coronary catheterisation laboratory, per radiographer, per half hour or part thereof	04.00							
3545	Venography: Per limb	04.00				16.500	164.30 (144.10)		
3548	Analogue monoplane screening table	04.00							
3550	Digital monoplane screening table	04.00							
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)	04.00				166.800	1660.70 (1456.80)		
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	04.00				48.600	483.90 (424.50)	4.000	176.40 (154.70) T
3558	Translumbar aortic puncture, with full study	04.00				69.600	692.90 (607.80)	5.000	220.60 (193.50) T
3559	Selective first order catheterisation, arterial or venous, with anglogram/venogram	04.00				57.000	567.50 (497.80)	4.000	176.40 (154.70) T
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram	06.04				65.400	651.10 (571.10)	4.000	176.40 (154.70) T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	04.00				73.200	728.80 (639.30)	4.000	176.40 (154.70) T
3564	Direct femoral arterial or venous or jugular venous puncture	04.00				37.200	370.40 (324.90)		
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	04.00				85.800	854.20 (749.30)	5.000	220.60 (193.50) T
3569	Intravascular pressure studies, arterial or venous, once off per case	04.00				19.800	197.10 (172.90)		
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	04.00				130.800	1302.20 (1142.30)	5.000	220.60 (193.50) T
3572	Transcatheter selective blood sampling, arterial or venous	04.00				32.400	322.60 (283.00)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3574	Spinal angiogram (global fee) including all selective catheterisations	04.00				480.000	4778.90 (4192.00)	5.000	220.60 (193.50) T
19.8.2	**Vascular studies: Introduction of contrast medium**								
3563	Direct intravenous for limb	04.00	+			7.400	73.70 (64.60)		
3575	Cut-downs for venography: ADD	04.00	+			11.000	109.50 (96.10)		
19.9	**Tomography and cinematography**								
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values								04.00
3577	Tomography (conventional except where otherwise specified): ADD 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations	04.00							
3579	Tomography (multi-dimensional in motion): ADD 150%	04.00							
3581	Cinematography: For first series: ADD 100%	04.00							
3583	Cinematography: For each series after the first: ADD 80% of the primary fee	04.00							
19.9.1	**Tomography and cinematography: Computed Tomography**								
3592	Where a fully digital C-arm portable x-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour	04.00							
3597	Contrast media: General Rule Y applies (Please note: Item 0201 is not applicable for contrast media)	04.00							
3598	Electron beam computed tomography (EBCT) for assessment of coronary artery calcification (complete fee - no additions)	04.00				-	-		
3599	Electron beam computed tomography (EBCT) of the heart. Total fee for contract examination excluding cost of contrast medium (not to be used for coronary artery calcium assessment or scoring - see Item 3598)	04.00				-	-		
6400	Plus spiral CT	04.00							
6401	Plus 3D reconstruction	04.00							
6402	Plus high resolution study	04.00							
6403	CT limb uncontrasted	04.00						5.000	220.60 (193.50) T
6404	CT limb with contrast only	04.00						5.000	220.60 (193.50) T
6405	CT limb pre- AND post contrast	04.00						5.000	220.60 (193.50) T
6406	CT joint uncontrasted	04.00						5.000	220.60 (193.50) T
6407	CT joint with contrast only	04.00						5.000	220.60 (193.50) T
6408	CT joint pre AND post contrast	04.00						5.000	220.60 (193.50) T
6409	CT brain uncontrasted (including posterior fossa)	04.00						5.000	220.60 (193.50) T
6410	CT brain with contrast only (including posterior fossa)	04.00						5.000	220.60 (193.50) T
6411	CT brain pre AND post contrast (including posterior fossa)	04.00						5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6412	CT orbits complete study, axial OR coronal, uncontrasted	04.00						5.000	220.60 (193.50) T
6413	CT orbits complete study, axial AND coronal, uncontrasted	04.00						5.000	220.60 (193.50) T
6414	CT orbits complete study, axial OR coronal pre AND post contrast	04.00						5.000	220.60 (193.50) T
6415	CT orbits complete study, axial AND coronal pre AND post contrast	04.00						5.000	220.60 (193.50) T
6416	CT paranasal sinuses limited study axial OR coronal	04.00						5.000	220.60 (193.50) T
6417	CT paranasal sinuses limited study axial AND coronal	04.00						5.000	220.60 (193.50) T
6418	CT paranasal sinuses complete study, axial or coronal, uncontrasted	04.00						5.000	220.60 (193.50) T
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	04.00						5.000	220.60 (193.50) T
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	04.00						5.000	220.60 (193.50) T
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	04.00						5.000	220.60 (193.50) T
6422	CT pituitary fossa, uncontrasted	04.00						5.000	220.60 (193.50) T
6423	CT pituitary fossa, pre AND post contrast	04.00						5.000	220.60 (193.50) T
6424	CT internal auditory meati, uncontrasted	04.00						5.000	220.60 (193.50) T
6425	CT internal audiory meati, pre AND post contrast	04.00						5.000	220.60 (193.50) T
6426	CT mastoids	04.00						5.000	220.60 (193.50) T
6427	CT ear structures, limited study	04.00						5.000	220.60 (193.50) T
6428	CT middle AND inner ear, complete study including reconstructions	04.00						5.000	220.60 (193.50) T
6429	CT facial bones	04.00						5.000	220.60 (193.50) T
6430	CT neck soft tissue, uncontrasted	04.00						5.000	220.60 (193.50) T
6431	CT neck soft tissue with contrast only	04.00						5.000	220.60 (193.50) T
6432	CT neck pre AND post contrast	04.00						5.000	220.60 (193.50) T
6433	CT cervical spine uncontrasted	04.00						5.000	220.60 (193.50) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6434	CT cervical spine pre AND post contrast	04.00						5.000	220.60 (193.50) T
6435	CT cervical spine post myelogram	04.00						5.000	220.60 (193.50) T
6436	CT dorsal spine uncontrasted	04.00						5.000	220.60 (193.50) T
6437	CT dorsal spine pre AND post contrast	04.00						5.000	220.60 (193.50) T
6438	CT dorsal spine post myelogram	04.00						5.000	220.60 (193.50) T
6439	CT lumbar spine uncontrasted	04.00						5.000	220.60 (193.50) T
6440	CT lumbar spine pre AND post contrast	04.00						5.000	220.60 (193.50) T
6441	CT lumbar spine post myelogram	04.00						5.000	220.60 (193.50) T
6442	CT pelvimetry (topogram only)	04.00						5.000	220.60 (193.50) T
6443	CT chest uncontrasted	04.00						5.000	220.60 (193.50) T
6444	CT chest with contrast	04.00						5.000	220.60 (193.50) T
6445	CT chest pre AND post contrast	04.00						5.000	220.60 (193.50) T
6446	CT chest high resolution lungs, limited study	04.00						5.000	220.60 (193.50) T
6447	CT high resolution lungs, complete study	04.00						5.000	220.60 (193.50) T
6448	CT abdomen uncontrasted	04.00						5.000	220.60 (193.50) T
6449	CT abdomen with contrast	04.00						5.000	220.60 (193.50) T
6450	CT abdomen pre AND post contrast	04.00						5.000	220.60 (193.50) T
6451	CT abdomen triphasic study	04.00						5.000	220.60 (193.50) T
6452	CT pelvis uncontrasted	04.00						5.000	220.60 (193.50) T
6453	CT pelvis with contrast	04.00						5.000	220.60 (193.50) T
6454	CT pelvis pre AND post contrast	04.00						5.000	220.60 (193.50) T
6455	CT abdomen AND pelvis uncontrasted	04.00						5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6456	CT abdomen AND pelvis with contrast	04.00						5.000	220.60 (193.50) T
6457	CT abdomen AND pelvis pre AND post contrast	04.00						5.000	220.60 (193.50) T
6458	CT chest, abdomen AND pelvis with contrast	04.00						5.000	220.60 (193.50) T
6459	CT base of skull to symphysis pubis with contrast	04.00						5.000	220.60 (193.50) T
6460	CT for dental implants maxilla OR mandible	04.00							
6461	CT for dental implants maxilla AND mandible	04.00							
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)	04.00						5.000	220.60 (193.50) T
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	04.00						5.000	220.60 (193.50) T
6464	CT limited study, any region. Region to be identified on the account	04.00						5.000	220.60 (193.50) T
6465	CT guidance for aspiration, biopsy or drainage	04.00						11.000	485.20 (425.60) T
6466	CT guidance for aspiration at time of CT diagnostic study	04.00							
6467	CT stereotactic localisation for biopsy	04.00						11.000	485.20 (425.60) T
6468	CT for radiotherapy planning (not to be used as an add-on)	04.00							
6469	Quantitative CT for bone mineral density	04.00							
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast	04.00						5.000	220.60 (193.50) T
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast	04.00						5.000	220.60 (193.50) T
6472	Computer Aided Diagnosis for Mammography	04.00							
19.10	**Radiology: Miscellaneous**								
3594	Mammogram of surgically removed breast biopsy specimen	04.00							
3600	Peripheral bone densitometry utilizing ionizing radiation	04.00		13.000	129.40 (113.50)	13.000	129.40 (113.50)		
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445 and 3447)	04.00	+			7.700	76.70 (67.30)		
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD	04.00				10.700	106.50 (93.40)		
3603	Sinography	04.00				18.400	183.20 (160.70)		
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	04.00		77.000	766.60 (672.50)	77.000	766.60 (672.50)		
3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This item may not be used together with an item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, item 3629 is used	04.00				33.000	328.50 (288.20)		
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour	04.00				21.000	209.10 (183.40)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except item 3309): Per half hour: Plus fee or examination performed (Only to be used by radiological technical staff)	04.00				5.600	55.80 (48.90)		
3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position	04.00				40.000	398.20 (349.30)	3.000	132.30 (116.10) T
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done	04.00				-	-		
3611	Foreign body localisation: Introduction of sterile needle markers: ADD	04.00	+			11.000	109.50 (96.10)		
3613	Setting of sterile trays	04.00				3.300	32.90 (28.90)		
5029	Mammotome - stereotaxis: Hand held	04.00							
5034	Fine needle aspiration or biopsy or core biopsy of mamma	04.00				25.000	248.90 (218.30)	6.000	264.70 (232.20) T
19.11	**Ultrasound Investigations**								
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values								04.00
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.								04.00
3596	Intravascular ultrasound per case, arterial or venous, for intervention	04.00		30.000	201.00 (176.30)	30.000	201.00 (176.30)		
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	04.00		110.000	736.90 (646.40)	110.000	736.90 (646.40)	5.000	220.60 (193.50) T
3612	Ultrasonic bone densitometry	04.00		19.000	127.30 (111.70)	19.000	127.30 (111.70)		
3614	Transvaginal aspiration of ova	04.00		110.000	736.90 (646.40)	110.000	736.90 (646.40)		
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3616	Contrast media: General Rule Y applies	04.00							
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)	04.00		40.000	268.00 (235.10)	40.000	268.00 (235.10)		
3619	Intravascular ultrasound imaging assesses the atheroschlerotic process to guide the placement of an intracoronary stent. This item may be applied once per vessel (left anterior descending territory, circumflex territory and/or right coronary territory) in which a stent or multiple stents are deployed	04.00		30.000	201.00 (176.30)	30.000	201.00 (176.30)	9.000	397.00 (348.20) T
3620	Cardiac examination plus Doppler colour mapping	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3621	Cardiac examination (MMode)	04.00		25.000	167.50 (146.90)	25.000	167.50 (146.90)		
3622	Cardiac examination: 2 Dimensional	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3623	Cardiac examination + effort	04.00	+	10.000	67.00 (58.80)	10.000	67.00 (58.80)		
3624	Cardiac examinations + contrast	04.00	+	10.000	67.00 (58.80)	10.000	67.00 (58.80)		
3625	Cardiac examinations + doppler	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3626	Cardiac examination + phonocardiography	04.00	+	10.000	67.00 (58.80)	10.000	67.00 (58.80)		
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)	04.00		60.000	401.90 (352.50)	60.000	401.90 (352.50)		
3628	Renal tract	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3631	Ophthalmic examination	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3633	Neonatal head scan	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
3634	Peripheral vascular study, B mode only	04.00		39.000	261.30 (229.20)	39.000	261.30 (229.20)		
3635	+ Doppler	04.00		39.000	261.30 (229.20)	39.000	261.30 (229.20)		
3636	Trans-oesophageal echocardiography including passing the device	04.00		100.000	669.90 (587.60)	100.000	669.90 (587.60)		
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)	04.00		78.000	522.50 (458.30)	78.000	522.50 (458.30)		
5026	Ultrasound guided amniocentesis	04.00		39.000	261.30 (229.20)			6.000	264.70 (232.20) T
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
5101	Pleural space ultrasound	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
5103	Ultrasound soft tissue, any region	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy	04.00		25.000	167.50 (146.90)	25.000	167.50 (146.90)		
5107	Ultrasound after 24 weeks - motivation required	04.00		25.000	167.50 (146.90)	25.000	167.50 (146.90)		
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)		
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy	04.00		128.000	857.50 (752.20)	120.000	803.90 (705.20)		
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with items 5110, 5112, 5113 or 5114)	04.00		206.000	1380.00 (1210.50)	164.800	1104.00 (968.40)		
5112	Peripheral arterial ultrasound vascular study: B mode, pulsed and colour Doppler; per limb; to include waveforms at minimum of three levels, pressure studies at two levels and full interpretation of results	04.00		117.000	783.80 (687.50)	117.000	783.80 (687.50)		
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis	04.00		117.000	783.80 (687.50)	117.000	783.80 (687.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally	04.00		178.000	1192.40 (1046.00)	142.400	953.90 (836.80)		
5115	Intra-operative ultrasound study	04.00		50.000	335.00 (293.90)	50.000	335.00 (293.90)	3.000	132.30 (116.10) T
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure	04.00		88.000	589.50 (517.10)	88.000	589.50 (517.10)		
5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery [LAD (left anterior desending), Circumflex or Right coronary artery]). May be used a maximum of twice per angiographic procedure	04.00		44.000	294.80 (258.60)	44.000	294.80 (258.60)		
MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS									
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units								04.00
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	04.00		6.000	40.19 (35.25)	6.000	40.19 (35.25)		
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%								04.00
GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY									
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist								04.00
19.12	**Portable unit examinations**								
3639	Where portable X-ray unit is used in the hospital or theatre: ADD	04.00	+			7.000	69.70 (61.10)		
3640	Theatre investigations with fixed installation	04.00	+			3.000	29.90 (26.20)		
19.13	**Diagnostic procedures requiring the use of radio-isotopes**								
AA.	Procedures to exclude cost of isotope								04.00
3641	Tracer test	04.00		33.200	330.50 (289.90)	22.100	220.00 (193.00)		
3642	Repeat of further tracer tests for same investigation: Half of above fee	04.00		16.600	165.30 (145.00)	11.100	110.50 (96.90)		
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee	04.00							
3644	Tracer test of complete body or brain tumour location	04.00		82.200	818.40 (717.90)	54.800	545.60 (478.60)		
3645	Other organ scanning with use of relevant radio isotopes	04.00		82.200	818.40 (717.90)	54.800	545.60 (478.60)		
3646	Thyroid scanning	04.00		28.800	286.70 (251.50)	19.200	191.20 (167.70)		
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera	04.00							
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera	04.00							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
19.14	**Interventional radiological procedures**								
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii All fluoroscopy (item 3601 does not apply). iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note : Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)								04.00
	Note: In regard to multiple examinations see modifier 0080								04.00
5002	Percutaneous transluminal angioplasty: Aortic/IVC	04.00				102.600	1021.50 (896.10)	13.000	573.40 (503.00) T
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel	04.00				102.600	1021.50 (896.10)	13.000	573.40 (503.00) T
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial	04.00				102.600	1021.50 (896.10)	13.000	573.40 (503.00) T
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral - stand alone procedure	04.00				172.200	1714.40 (1503.90)	13.000	573.40 (503.00) T
5014	Atherectomy (per vessel)	04.00				204.600	2037.00 (1786.80)		
5016	Aspiration thrombectomy (per vessel)	04.00				131.400	1308.20 (1147.50)		
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite	04.00				106.800	1063.30 (932.70)	5.000	220.60 (193.50) T
5022	Embolisation non-intracranial, per vessel	04.00				106.800	1063.30 (932.70)	9.000	397.00 (348.20) T
5030	Percutaneous nephrostomy for further procedure or drainage	04.00				73.800	734.80 (644.60)	6.000	264.70 (232.20) T
5031	Antegrade ureteric stent insertion	04.00				69.600	692.90 (607.80)	6.000	264.70 (232.20) T
5033	Percutaneous cystostomy in radiology suite	04.00				30.000	298.70 (262.00)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5035	Urethral balloon dilatation in radiology suite	04.00				22.800	227.00 (199.10)		
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality	04.00				34.200	340.50 (298.70)		
5037	Urethral stenting in radiology suite	04.00				102.600	1021.50 (896.10)		
5038	Intracranial/spinal AVM embolisation (per session)	04.00				335.400	3339.20 (2929.10)	13.000	573.40 (503.00) T
5039	Intracranial thrombolysis (on-table) per session	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5040	Intracranial aneurysm occlusion	04.00				286.800	2855.40 (2504.70)	13.000	573.40 (503.00) T
5041	Balloon occlusion/Wada test	04.00				106.800	1063.30 (932.70)	9.000	397.00 (348.20) T
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation	06.04				286.800	2855.40 (2504.70)	13.000	573.40 (503.00) T
5043	Intracranial angioplasty	04.00				204.600	2037.00 (1786.80)	13.000	573.40 (503.00) T
5044	Transhepatic portogram	04.00				139.200	1385.90 (1215.70)	9.000	397.00 (348.20) T
5045	Hepatic arterial infusion catheter insertion	04.00				156.000	1553.10 (1362.40)	6.000	264.70 (232.20) T
5046	Percutaneous biliary drainage (external)	04.00				102.600	1021.50 (896.10)	9.000	397.00 (348.20) T
5047	Combined internal/external biliary drainage	04.00				102.600	1021.50 (896.10)	9.000	397.00 (348.20) T
5048	Biliary stent insertion	04.00				139.200	1385.90 (1215.70)	9.000	397.00 (348.20) T
5049	Percutaneous gall bladder drainage	04.00				69.600	692.90 (607.80)	9.000	397.00 (348.20) T
5050	Percutaneous or renal gall bladder stone removal	04.00				172.200	1714.40 (1503.90)	5.000	220.60 (193.50) T
5058	Stent insertion: Aortic/IVC - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5060	Stent insertion: Iliac/subclavian/AV fistula - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1385.90 (1215.70)	13.000	573.40 (503.00) T
5064	Stent insertion: Sub-popliteal - including percutaneous transluminal angioplasty (PTA)	04.00				172.200	1714.40 (1503.90)	13.000	573.40 (503.00) T
5066	Stent insertion: Renal/visceral/brachiocephalic - including percutaneous transluminal angioplasty (PTA)	04.00				204.600	2037.00 (1786.80)	13.000	573.40 (503.00) T
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure	04.00				204.600	2037.00 (1786.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5070	Stent insertion: Aorto-iliac stent graft - including percutaneous transluminal angioplasty (PTA)	04.00				311.400	3100.30 (2719.60)	13.000	573.40 (503.00) T
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite	04.00				82.200	818.40 (717.90)	5.000	220.60 (193.50) T
5074	IVC filter insertion jugular or femoral route	04.00				156.000	1553.10 (1362.40)	9.000	397.00 (348.20) T
5076	Intravascular foreign body removal, arterial or venous, any route	04.00				204.600	2037.00 (1786.80)	9.000	397.00 (348.20) T
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)	04.00				70.200	698.90 (613.10)	5.000	220.60 (193.50) T
5080	Transjugular intrahepatic porto-systemic shunt	04.00				335.400	3339.20 (2929.10)	13.000	573.40 (503.00) T
5082	Transjugular liver biopsy	04.00				69.600	692.90 (607.80)	9.000	397.00 (348.20) T
5084	Endoluminal fallopian tube recanalisation	04.00				172.200	1714.40 (1503.90)	6.000	264.70 (232.20) T
5086	Renal cyst aspiration/ablation	04.00				22.800	227.00 (199.10)		
5088	Oesophageal stent insertion in radiology suite	04.00				102.600	1021.50 (896.10)	6.000	264.70 (232.20) T
5090	Tracheal stent insertion	04.00				102.600	1021.50 (896.10)	6.000	264.70 (232.20) T
5091	GIT balloon dilatation under fluoroscopy	04.00				66.600	663.10 (581.70)	6.000	264.70 (232.20) T
5092	Other GIT stent insertion	04.00				102.600	1021.50 (896.10)	6.000	264.70 (232.20) T
5093	Percutaneous gastrostomy in radiology suite	04.00				85.800	854.20 (749.30)		
5094	Cutting needle biopsy with image guidance	04.00				22.800	227.00 (199.10)		
5095	Chest drain insertion in radiology suite	04.00				32.400	322.60 (283.00)		
5096	Percutaneous cyst or tumour ablation (non aspiration)	04.00				54.600	543.60 (476.80)		
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level	04.00						13.000	573.40 (503.00) T
MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES									
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)								04.00
19.15	**Magnetic Resonance Imaging (MRI)**								
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes								04.00
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee								04.00
6103	Post-contrast study: Bone tumour: 100% of the fee								04.00
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable								04.00
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items								04.00
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability								04.00
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability								04.00
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"								04.00
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain								04.00
6110	MRI spectroscopy: 50% of fee								04.00
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.								04.00
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.								04.00
6200	Magnetic Resonance Imaging: Per anatomical region: Brain	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6201	Magnetic Resonance Imaging: Per anatomical region: Orbitae	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6202	Magnetic Resonance Imaging: Per anatomical region: Paranasal sinuses	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6203	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Face/skull	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6204	Magnetic Resonance Imaging: Per anatomical region: Skull basis/cranio-cervical joint	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6205	Magnetic Resonance Imaging: Per anatomical region: Middle and internal ears	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6206	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Neck	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6207	Magnetic Resonance Imaging: Per anatomical region: Thyroid/para-thyroid	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6208	Magnetic Resonance Imaging: Per anatomical region: Hypophysis (see modifiers 6104 and 6105 for limited examinations)	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6209	Magnetic Resonance Imaging: Per anatomical region: Bone tumour (see modifier 6103)	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6210	Magnetic Resonance Imaging: Per anatomical region: Cervical vertebrae	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6211	Magnetic Resonance Imaging: Per anatomical region: Thoracic vertebrae	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6212	Magnetic Resonance Imaging: Per anatomical region: Lumbar vertebrae	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6213	Magnetic Resonance Imaging: Per anatomical region: Sacrum	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6214	Magnetic Resonance Imaging: Per anatomical region: Pelvis	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6215	Magnetic Resonance Imaging: Per anatomical region: Pelvic organs	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6216	Magnetic Resonance Imaging: Per anatomical region: Abdomen	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6217	Magnetic Resonance Imaging: Per anatomical region: Thorax wall	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6218	Magnetic Resonance Imaging: Per anatomical region: Mediastinum	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6219	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Back	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6220	Magnetic Resonance Imaging: Per anatomical region: Left shoulder	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6221	Magnetic Resonance Imaging: Per anatomical region: Right shoulder	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6222	Magnetic Resonance Imaging: Per anatomical region: Both hips	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6223	Magnetic Resonance Imaging: Per anatomical region: Left hip	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6224	Magnetic Resonance Imaging: Per anatomical region: Right hip	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6225	Magnetic Resonance Imaging: Per anatomical region: Left upper-arm	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6226	Magnetic Resonance Imaging: Per anatomical region: Right upper-arm	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6227	Magnetic Resonance Imaging: Per anatomical region: Left elbow	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6228	Magnetic Resonance Imaging: Per anatomical region: Right elbow	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6229	Magnetic Resonance Imaging: Per anatomical region: Left fore-arm	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6230	Magnetic Resonance Imaging: Per anatomical region: Right fore-arm	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6231	Magnetic Resonance Imaging: Per anatomical region: Left wrist and hand	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6232	Magnetic Resonance Imaging: Per anatomical region: Right wrist and hand	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6233	Magnetic Resonance Imaging: Per anatomical region: Left upper-leg	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6234	Magnetic Resonance Imaging: Per anatomical region: Right upper-leg	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6235	Magnetic Resonance Imaging: Per anatomical region: Left knee	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6236	Magnetic Resonance Imaging: Per anatomical region: Right knee	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6237	Magnetic Resonance Imaging: Per anatomical region: Left lower-leg	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6238	Magnetic Resonance Imaging: Per anatomical region: Right lower-leg	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6239	Magnetic Resonance Imaging: Per anatomical region: Left ankle	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6240	Magnetic Resonance Imaging: Per anatomical region: Right ankle	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6241	Magnetic Resonance Imaging: Per anatomical region: Left foot	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6242	Magnetic Resonance Imaging: Per anatomical region: Right foot	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6250	Magnetic Resonance angiography (See modifiers 6106 to 6108): Brain	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6251	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Neck	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6252	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Chest	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6253	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Abdomen	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6254	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Legs	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6255	Magnetic Resonance angiography (See modifiers 6106 to 6108): Heart	04.00				400.000	3030.80 (2658.60)	5.000	220.60 (193.50) T
6260	Contrast medium: Current price according the regular price list published by the Radiology Society of SA	04.00							
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations	04.00				70.000	530.40 (465.30)	5.000	220.60 (193.50) T
20	**Radiation Oncology**								
	GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST (a) Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services. (b) The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.								04.00
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes								04.00
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values								04.00
20.1	**Kilovolt therapy**								
20.2	**Radium therapy**								
20.3	**Isotope therapy**								
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
20.4	**Megavolt therapy**								
20.5	**Beta-ray therapy with strontium-90-applicator**								
20.6	**Planning of therapy**								
20.7	**Technical aids**								
5141	Radiation materials (see modifier 0095)	05.03							
20.8	**Oncological surgical procedures**								
20.9	**Special procedures**								
20.10	**Chemotherapy**								
	Where patients are not treated in chemotherapy facilities, items 0213, 0214 and 0215 are used instead of items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.								04.11
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities								04.11
5790	Non Infusional Chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day - for exclusive use by doctors with appropriate oncology training (consultations to be charged separately) - (not applicable to oral hormonal therapy)	04.11		42.950	301.90 (264.80) Z	42.950	301.90 (264.80) Z		
5791	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured or scripted for oral chemotherapy, intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	05.03		24.490	172.10 (151.00) Z	24.490	172.10 (151.00) Z		
5792	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	05.03		30.610	215.10 (188.70) Z	30.610	215.10 (188.70) Z		
	Non-infusional chemotherapy: Consultations are charged separately.	05.05							
	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.								04.11
5793	Infusional Chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day - for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities(consultations to be charged separately)	04.11		159.470	1120.80 (983.20) Z	127.580	896.60 (786.50) Z		
5794	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured, stored, admixed and administered, and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee	05.03		90.030	632.70 (555.00) Z	90.030	632.70 (555.00) Z		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5795	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee	04.11		112.540	790.90 (693.80) Z	112.540	790.90 (693.80) Z		
	Item 5795 is chargeable in addition to item 5793 by the Oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to item 5793 if own or rented facility is used).	04.11							
20.11	**Radiation Therapy Planning**								
20.11.1	**Manual Radiotherapy Planning Procedures**								
5801	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		42.560	363.50 (318.90) Z				
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	05.01		99.320	848.40 (744.20) Z				
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		56.180	479.90 (421.00) Z				
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		131.100	1119.90 (982.40) Z				
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	05.03		76.620	654.50 (574.10) Z				
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	05.01		178.770	1527.10 (1339.60) Z				
20.11.2	**Conventional Radiotherapy Planning Procedures**								
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		170.260	1454.40 (1275.80) Z				
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	05.01		397.270	3393.50 (2976.80) Z				
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		238.360	2036.10 (1786.10) Z				
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		556.180	4750.90 (4167.50) Z				
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	05.03		297.950	2545.10 (2232.50) Z				
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	05.01		695.220	5938.60 (5209.30) Z				
20.11.3	**Three Dimensional Radiotherapy Planning Procedures**								
5820	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		240.230	2052.00 (1800.00) Z				
5620	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		977.200	8347.20 (7322.10) Z				
5821	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		407.750	3483.00 (3055.30) Z				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5621	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		1368.070	11686.10 (10251.00) Z				
5622	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		554.330	4735.10 (4153.60) Z				
5622	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		1710.090	14607.60 (12813.70) Z				
20.11.4	**Intensity Modulated Radiotherapy Planning Procedures**								
5823	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		642.920	5491.80 (4817.40) Z				
5623	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		1916.810	16373.40 (14362.60) Z				
5825	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		232.180	1983.30 (1739.70) Z				
5625	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		958.400	8186.70 (7181.30) Z				
5826	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		753.350	6435.10 (5644.80) Z				
5626	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	06.02		2174.480	18574.40 (16293.30) Z				
20.11.5	**Kilovolt Radiation Treatment**								
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT	05.03		49.080	419.20 (367.70) Z				
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT	05.01		114.520	978.20 (858.10) Z				
20.11.6	**Short Course Radiation Treatment**								
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		105.740	903.20 (792.30) Z				
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	05.01		246.730	2107.60 (1848.80) Z				
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		148.040	1264.60 (1109.30) Z				
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		345.410	2950.50 (2588.20) Z				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	05.03		190.330	1625.80 (1426.10) Z				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	05.01		444.110	3793.60 (3327.70) Z				

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
20.11.7	**Weekly Radiation Treatment Sessions**								
20.11.7.1	**Weekly Radiation Treatment Sessions - Conventional Techniques**								
5839	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		193.860	1656.00 (1452.60) Z				
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	05.01		452.330	3863.80 (3389.30) Z				
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		246.730	2107.60 (1848.80) Z				
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		575.690	4917.50 (4313.60) Z				
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	05.03		317.220	2709.70 (2376.90) Z				
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	05.01		740.180	6322.60 (5546.10) Z				
20.11.7.2	**Weekly Radiation Treatment Sessions - Advanced Techniques**								
5849	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		236.240	2018.00 (1770.20) Z				
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	05.01		551.210	4708.40 (4130.20) Z				
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		330.730	2825.10 (2478.20) Z				
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		771.710	6591.90 (5782.40) Z				
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	05.03		425.230	3632.30 (3186.20) Z				
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	05.01		992.190	8475.30 (7434.50) Z				
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	05.03		348.870	2980.00 (2614.00) Z				
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	05.01		814.030	6953.40 (6099.50) Z				
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	05.03		826.830	7062.80 (6195.40) Z				
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	05.01		1929.260	16479.70 (14455.90) Z				
20.11.8	**Stereotactic Radiation**								
5860	Stereotactic Radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee - PROFESSIONAL COMPONENT	05.03		3719.340	31770.60 (27868.90) Z				
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT	05.01		8678.460	74131.40 (65027.50) Z				
5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT	05.03		4277.240	36536.20 (32049.30) Z				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5661	Stereotactic Radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee - TECHNICAL COMPONENT	05.01		9980.230	85251.10 (74781.70) Z				
20.12	**Brachytherapy**								
20.12.1	**Isotope/Applicator Therapy**								
5870	Isotope/Applicator Therapy: Isotopes - Low Complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included	05.03		108.400	926.00 (812.30) Z				
5872	Isotope/Applicator Therapy: Isotopes - Intermediate Complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included	05.03		216.800	1851.90 (1624.50) Z				
5873	Isotope/Applicator Therapy: Isotopes - High Complexity, surface application of seed arrays requiring dosimetric assessment and/or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included	05.03		601.160	5135.10 (4504.50) Z				
20.12.2	**Brachytherapy Implants**								
5882	Brachytherapy Implants: Implants - Low Complexity, placement of a single guide tube for the administration of brachytherapy requiring <8 dwell points. The cost of materials are not included	05.03		216.800	1851.90 (1624.50) Z				
5883	Brachytherapy Implants: Implants - Intermediate Complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included	05.03		786.800	6720.80 (5895.40) Z				
5885	Brachytherapy Implants: Implants - High Complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included	05.03		1049.070	8961.20 (7860.70) Z				
20.12.3	**Brachytherapy Treatment**								
5890	Brachytherapy Treatment: Global fee for manual afterloading - includes storage, handling, calibration, planning (manual or computerized), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included	05.03		613.040	5236.60 (4593.50) Z				
5892	Brachytherapy Treatment: Global fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - PROFESSIONAL COMPONENT	05.03		415.960	3553.10 (3116.80) Z				
5893	Global Fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - TECHNICAL COMPONENT	05.03		970.560	8290.50 (7272.40) Z				
20.12.4	**Brachytherapy Imaging**								
5895	Brachytherapy Imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than items 5883 or 5885	05.03		156.770	1339.10 (1174.60) Z				
21	**Clinical Pathology**								
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee								04.00
	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values. Note: For fees for Histology and Cytology refer to items 4561-4593 under Section 22: Anatomical Pathology.								04.00
21.1	**Haematology**								
3705	Alkali resistant haemoglobin	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	04.00		3.650	29.70 (26.10)	2.450	19.90 (17.50)		
3710	Antibody titration	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
3711	Arneth count	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3712	Antibody identification	04.00		8.450	68.70 (60.30)	5.650	45.90 (40.30)		

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				RVU	Fee	RVU	Fee	RVU	Fee
3713	Bleeding time (does not include the cost of the simplate device)	04.00		6.940	56.40 (49.50)	4.630	37.60 (33.00)		
3714	Blood volume, dye method	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
3715	Buffy layer examination	04.00		19.900	161.70 (141.80)	13.270	107.80 (94.60)		
3716	Mean Cell Volume	04.00		2.250	-	1.500	-		
3717	Bone marrow cytological examination only	04.00		19.900	161.70 (141.80)	13.270	107.80 (94.60)		
3719	Bone marrow: Aspiration	04.00		8.400	68.30 (59.90)	5.600	45.50 (39.90)		
3720	Bone marrow trephine biopsy	04.00		32.600	264.90 (232.40)	21.700	176.30 (154.60)		
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	04.00		36.800	299.00 (262.30)	24.500	199.10 (174.60)		
3722	Capillary fragility: Hess	04.00		2.020	16.40 (14.40)	1.350	11.00 (9.65)		
3723	Circulating anticoagulants	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3724	Coagulation factor inhibitor assay	04.00		57.560	467.70 (410.30)	38.370	311.80 (273.50)		
3726	Activated protein C resistance	04.00		26.000	211.30 (185.40)	17.300	140.60 (123.30)		
3727	Coagulation time	04.00		3.160	25.70 (22.50)	2.110	17.10 (15.00)		
3728	Anti-factor Xa Activity	04.00		53.600	435.50 (382.00)	35.730	290.30 (254.60)		
3729	Cold agglutinins	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3730	Protein S: Functional	04.00		37.500	304.70 (267.30)	25.000	203.10 (178.20)		
3731	Compatibility for blood transfusion	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3732	Cryoglobulin	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3734	Protein C (chromogenic)	04.00		30.290	246.10 (215.90)	20.190	164.00 (143.90)		
3735	Anti-thrombin III (chromogenic)	04.00		22.000	178.80 (156.80)	14.700	119.40 (104.70)		
3736	Plasminogen (chromogenic)	04.00		61.650	500.90 (439.40)	41.100	333.90 (292.90)		
3737	Lupus Russel Viper method	04.00		17.000	138.10 (121.10)	11.300	91.80 (80.50)		
3738	Lupus Kaolin Exner method	04.00		25.000	203.10 (178.20)	16.700	135.70 (119.00)		
3739	Erythrocyte count	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3740	Factors V and VII: Qualitative	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
3741	Coagulation factor assay: Functional	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
3742	Coagulation factor assay: Immunological	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3743	Erythrocyte sedimentation rate	04.00		3.000	24.40 (21.40)	2.000	16.30 (14.30)		
3744	Fibrin stabilizing factor (urea test)	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3746	Fibrin monomers	04.00		2.700	21.90 (19.20)	1.800	14.60 (12.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3748	Plasminogen activator inhibitor (PAI-I)	04.00		65.950	535.80 (470.00)	43.970	357.30 (313.40)		
3750	Tissue plasminogen Activator (tPA)	04.00		67.790	550.80 (483.20)	45.190	367.20 (322.10)		
3751	Osmotic fragility (screen)	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3752	Osmotic fragility test: Quantitative	04.00		10.000	81.30 (71.30)	6.650	54.00 (47.40)		
3753	Osmotic fragility (before and after incubation)	04.00		18.000	146.30 (128.30)	12.000	97.50 (85.50)		
3754	ABO Reverse Group	04.00		5.500	-	3.670	-		
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	04.00		10.500	85.30 (74.80)	7.000	56.90 (49.90)		
3756	Full cross match	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
3757	Coagulation factors: Quantitative	04.00		32.200	261.60 (229.50)	21.470	174.40 (153.00)		
3758	Factor VIII related antigen	04.00		60.460	491.20 (430.90)	40.310	327.50 (287.30)		
3759	Coagulation factor correction study	04.00		11.720	95.20 (83.50)	7.810	63.50 (55.70)		
3761	Factor XIII related antigen	04.00		61.110	496.50 (435.50)	40.740	331.00 (290.40)		
3762	Haemoglobin estimation	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
3763	Contact activated product assay	04.00		16.200	131.60 (115.40)	10.800	87.80 (77.00)		
3764	Grouping: A B and O antigens	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3765	Grouping: Rh antigen	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3766	PIVKA	04.00		43.490	353.40 (310.00)	28.990	235.50 (206.60)		
3767	Euglobulin Lysis time	04.00		25.580	207.80 (182.30)	17.050	138.50 (121.50)		
3768	Haemoglobin A2 (column chromatography)	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
3769	Haemoglobin electrophoresis	04.00		26.820	217.90 (191.10)	17.880	145.30 (127.50)		
3770	Haemoglobin-S (solubility test)	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3771	Factor III-availability test	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3772	Haptoglobin: Quantitative	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
3773	Ham's acidified serum test	04.00		8.000	65.00 (57.00)	5.330	43.30 (38.00)		
3775	Heinz bodies	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3776	Haemosiderin in urinary sediment	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3781	Heparin tolerance	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
3783	Leucocyte differential count	04.00		6.200	50.40 (44.20)	4.150	33.70 (29.60)		
3785	Leucocytes: Total count	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
3786	QBC malaria concentration and fluorescent staining	04.00		25.000	203.10 (178.20)	16.700	135.70 (119.00)		
3787	LE-cells	04.00		8.300	67.40 (59.10)	5.550	45.10 (39.60)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3789	Neutrophil alkaline phosphatase	04.00		28.000	227.50 (199.60)	18.700	151.90 (133.20)		
3791	Packed cell volume: Haematocrit	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
3792	Plasmodium falciparum: Monoclonal immunological identification	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
3793	Plasma haemoglobin	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
3794	Platelet sensitivities	04.00		18.640	151.50 (132.90)	12.430	101.00 (88.60)		
3795	Platelet aggregation per aggregant	04.00		12.140	98.60 (86.50)	8.090	65.70 (57.60)		
3796	Platelet antibodies: Agglutination	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
3797	Platelet count	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3799	Platelet adhesiveness	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3801	Prothrombin consumption	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3803	Prothrombin determination (two stages)	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3805	Prothrombin index	04.00		6.000	48.80 (42.80)	4.000	32.50 (28.50)		
3806	Therapeutic drug level: Dosage	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3807	Recalcification time	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3809	Reticulocyte count	04.00		3.000	24.40 (21.40)	2.000	16.30 (14.30)		
3810	Schumm's test	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3811	Sickling test	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3814	Sucrose lysis test for PNH	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	04.00		21.100	171.40 (150.40)	14.070	114.30 (100.30)		
3820	Thrombo - Elastogram	04.00		26.000	211.30 (185.40)	17.330	140.80 (123.50)		
3825	Fibrinogen titre	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	04.00		8.000	65.00 (57.00)	5.330	43.30 (38.00)		
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	04.00		16.000	130.00 (114.00)	10.700	86.90 (76.20)		
3832	Red cell pyruvate kinase: Quantitative	04.00		16.000	130.00 (114.00)	10.700	86.90 (76.20)		
3834	Red cell Rhesus phenotype	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3835	Haemoglobin F in blood smear	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3837	Partial thromboplastin time	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3841	Thrombin time (screen)	04.00		7.160	58.20 (51.10)	4.770	38.80 (34.00)		
3843	Thrombin time (serial)	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
3847	Haemoglobin H	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3851	Fibrin degeneration products (diffusion plate)	04.00		10.350	84.10 (73.80)	6.900	56.10 (49.20)		
3853	Fibrin degeneration products (latex slide)	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3854	XDP (Dimer test or equivalent latex slide test)	04.00		8.500	69.10 (60.60)	5.670	46.10 (40.40)		
3855	Haemagglutination inhibition	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3856	D-Dimer (quantitative)	04.00		27.520	223.60 (196.10)	18.350	149.10 (130.80)		

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				RVU	Fee	RVU	Fee	RVU	Fee
3857	Ristocetin Cofactor	04.00		35.530	288.70 (253.20)	23.690	192.50 (168.90)		
3858	Heparin removal	04.00		28.880	234.70 (205.90)	19.250	156.40 (137.20)		
21.2	**Microscopic and miscellaneous tests**								
3863	Autogenous vaccine	04.00		12.600	102.40 (89.80)	8.400	68.30 (59.90)		
3864	Entomological examination	04.00		20.700	168.20 (147.50)	13.800	112.10 (98.30)		
3865	Parasites in blood smear	04.00		5.600	45.50 (39.90)	3.730	30.30 (26.60)		
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	04.00		4.900	39.80 (34.90)	3.300	26.80 (23.50)		
3868	Fungus identification	04.00		8.300	67.40 (59.10)	5.500	44.70 (39.20)		
3869	Faeces (including parasites)	04.00		4.900	39.80 (34.90)	3.270	26.60 (23.30)		
3873	Transmission electron microscopy	04.00		85.000	690.60 (605.80)	57.000	463.10 (406.20)		
3874	Scanning electron microscopy	04.00		100.000	812.50 (712.70)	67.000	544.40 (477.50)		
3875	Inclusion bodies	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3878	Crystal identification polarized light microscopy	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3879	Campylobacter in stool: Fastidious culture	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3880	Antigen detection with polyclonal antibodies	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3881	Mycobacteria	04.00		3.000	24.40 (21.40)	2.000	16.30 (14.30)		
3882	Antigen detection with monoclonal antibodies	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
3883	Concentration techniques for parasites	04.00		3.000	24.40 (21.40)	2.000	16.30 (14.30)		
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	04.00		6.300	51.20 (44.90)	4.200	34.10 (29.90)		
3885	Cytochemical stain	04.00		5.450	44.30 (38.90)	3.650	29.70 (26.10)		
21.3	**Bacteriology**								
3887	Antibiotic susceptibility test: Per organism	04.00		8.000	65.00 (57.00)	5.330	43.30 (38.00)		
3888	Adhesive tape preparation	04.00		2.700	21.90 (19.20)	1.800	14.60 (12.80)		
3889	Clostridium difficile toxin: Monoclonal immunological	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
3890	Antibiotic assay of tissues and fluids	04.00		13.900	112.90 (99.00)	9.270	75.30 (66.10)		
3891	Blood culture: Aerobic	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3892	Blood culture: Anaerobic	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3893	Bacteriological culture: Miscellaneous	04.00		6.300	51.20 (44.90)	4.200	34.10 (29.90)		
3894	Radiometric blood culture	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
3895	Bacteriological culture: Fastidious organisms	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3896	In vivo culture: Bacteria	04.00		16.000	130.00 (114.00)	10.650	86.50 (75.90)		
3897	In vivo culture: Virus	04.00		16.000	130.00 (114.00)	10.650	86.50 (75.90)		
3898	Bacterial exotoxin production (in vitro assay)	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3899	Bacterial exotoxin production (in vivo assay)	04.00		20.700	168.20 (147.50)	13.800	112.10 (98.30)		
3901	Fungal culture	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3902	Clostridium difficile (cytotoxicity neutralisation)	04.00		30.000	243.80 (213.90)	20.000	162.50 (142.50)		
3903	Antibiotic level: Biological fluids	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
3904	Rotavirus latex slide test	04.00		5.620	45.70 (40.10)	3.750	30.50 (26.80)		
3905	Identification of virus or rickettsia	04.00		20.700	168.20 (147.50)	13.800	112.10 (98.30)		
3906	Identification: Chlamydia	04.00		16.000	130.00 (114.00)	10.650	86.50 (75.90)		
3907	Culture for staphylococcus aureus	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3908	Anaerobe culture: Comprehensive	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3909	Anaerobe culture: Limited procedure	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3911	Beta-lactamase assay	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3914	Sterility control test: Biological method	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3915	Mycobacterium culture	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3916	Radiometric tuberculosis culture	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
3917	Mycoplasma culture: Limited	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3918	Mycoplasma culture: Comprehensive	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3919	Identification of mycobacterium	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3920	Mycobacterium: Antibiotic sensitivity	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3921	Antibiotic synergistic study	04.00		20.700	168.20 (147.50)	13.800	112.10 (98.30)		
3922	Viable cell count	04.00		1.350	11.00 (9.65)	0.900	7.31 (6.41)		
3923	Biochemical identification of bacterium: Abridged	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
3924	Biochemical identification of bacterium: Extended	04.00		12.500	101.60 (89.10)	8.330	67.70 (59.40)		
3925	Serological identification of bacterium: Abridged	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
3926	Serological identification of bacterium: Extended	04.00		10.200	82.90 (72.70)	6.800	55.30 (48.50)		
3927	Grouping for streptococci	04.00		7.300	59.30 (52.00)	4.850	39.40 (34.60)		
3928	Antimicrobic substances	04.00		3.800	30.90 (27.10)	2.500	20.30 (17.80)		
3929	Radiometric mycobacterium identification	04.00		14.000	113.80 (99.80)	9.300	75.60 (66.30)		
3930	Radiometric mycobacterium antibiotic sensitivity	04.00		25.000	203.10 (178.20)	16.700	135.70 (119.00)		
3931	Helicobacter: Monoclonal immunological	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
4650	Antibiotic MIC per organism per antibiotic	04.00		8.000	65.00 (57.00)	5.330	43.30 (38.00)		
4651	Non-radiometric automated blood cultures	04.00		13.900	112.90 (99.00)	9.270	75.30 (66.10)		
4652	Rapid automated bacterial identification per organism	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4653	Rapid automated antibiotic susceptibility per organism	04.00		17.000	138.10 (121.10)	11.330	92.10 (80.80)		
4654	Rapid automated MIC per organism per antibiotic	04.00		17.000	138.10 (121.10)	11.330	92.10 (80.80)		
4655	Mycobacteria: MIC determination - E Test	05.03		16.500	134.10 (117.60) Z	11.000	89.40 (78.40) Z		
4656	Mycobacteria: Identification HPLC	05.03		35.000	284.40 (249.50) Z	23.330	189.60 (166.30) Z		
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	05.03		9.900	80.40 (70.50) Z	6.600	53.60 (47.00) Z		
21.4	**Serology**								
3958	Anti Gad/Ia2 Ab	04.00		67.950	552.10 (484.30)	45.300	368.10 (322.90)		
3959	Rose Waaler agglutination test	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3960	Gonococcal, listeria or echinococcus agglutination	04.00		9.500	77.20 (67.70)	6.300	51.20 (44.90)		
3961	Slide agglutination test	04.00		2.630	21.40 (18.80)	1.750	14.20 (12.50)		
3962	Rebuck skin window	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
3963	Serum complement level: Each component	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
3965	Anti Ia2 Antibodies	04.00		36.000	292.50 (256.60)	24.000	195.00 (171.10)		
3966	Anti Gad Antibodies	04.00		36.000	292.50 (256.60)	24.000	195.00 (171.10)		
3967	Auto-antibody: Sensitized erythrocytes	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3968	Herpes virus typing: Monoclonal immunological	04.00		20.690	168.10 (147.50)	13.790	112.00 (98.20)		
3969	Western blot technique	04.00		74.000	601.30 (527.50)	49.000	398.10 (349.20)		
3970	Epstein-Barr virus antibody titer	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	04.00		14.100	114.60 (100.50)	9.400	76.40 (67.00)		
3933	IgE: Total: EMIT or ELISA	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
3934	Auto antibodies by labelled antibodies	04.00		16.000	130.00 (114.00)	10.650	86.50 (75.90)		
3935	Sperm antibodies	04.00		16.000	130.00 (114.00)	10.650	86.50 (75.90)		
3936	Virus neutralisation test: First antibody	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
3937	Virus neutralisation test: Each additional antibody	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
3938	Precipitation test per antigen	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3939	Agglutination test per antigen	04.00		5.500	44.70 (39.20)	3.670	29.80 (26.10)		
3940	Haemagglutination test: Per antigen	04.00		9.900	80.40 (70.50)	6.600	53.60 (47.00)		
3941	Modified Coombs' test for brucellosis	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3942	Hepatitis Rapid Viral Ab	04.00		12.240	99.50 (87.30)	8.160	66.30 (58.20)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3943	Antibody titer to bacterial exotoxin	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
3945	Complement fixation test	04.00		5.850	47.50 (41.70)	3.900	31.70 (27.80)		
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	04.00		14.050	114.20 (100.20)	9.370	76.10 (66.80)		
3947	C-reactive protein	04.00		10.840	88.10 (77.30)	7.227	58.70 (51.50)		
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.950	105.20 (92.30)	8.630	70.10 (61.50)		
3949	Qualitative Kahn, VDRL or other flocculation	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3950	Neutrophil phagocytosis	04.00		25.200	204.80 (179.60)	16.800	136.50 (119.70)		
3951	Quantitative Kahn, VDRL or other flocculation	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
3952	Neutrophil chemotaxis	04.00		67.950	552.10 (484.30)	45.300	368.10 (322.90)		
3953	Tube agglutination test	04.00		4.150	33.70 (29.60)	2.760	22.40 (19.60)		
3955	Paul Bunnell: Presumptive	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	04.00		8.500	69.10 (60.60)	5.670	46.10 (40.40)		
3957	Paul Bunnell: Absorption	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3971	Immuno-diffusion test: Per antigen	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
3972	Respiratory syncytial virus (ELISA technique)	04.00		35.000	284.40 (249.50)	23.000	186.90 (163.90)		
3973	Immuno electrophoresis: Per immune serum	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
3974	Polymerase chain reaction	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	04.00		12.000	97.50 (85.50)	8.000	65.00 (57.00)		
3977	Counter immuno-electrophoresis	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
3978	Lymphocyte transformation	04.00		51.700	420.10 (368.50)	34.500	280.30 (245.90)		
3980	Bilharzia Ag Serum/Urine	04.00		14.500	117.80 (103.30)	9.670	78.60 (68.90)		
3982	Histone Ab	04.00		16.000	130.00 (114.00)	10.670	86.70 (76.10)		
4600	Anti-CCP	05.03		17.460	141.90 (124.50) Z	11.640	94.60 (83.00) Z		
4601	Panel typing: Antibody detection: Class I	04.00		36.000	292.50 (256.60)	24.000	195.00 (171.10)		
4602	Panel typing: Antibody detection: Class II	04.00		44.000	357.50 (313.60)	29.300	238.10 (208.90)		
4603	HLA test for specific locus/antigen - serology	04.00		27.000	219.40 (192.50)	18.000	146.30 (128.30)		
4604	HLA typing: Class I - serology	04.00		52.000	422.50 (370.60)	34.700	281.90 (247.30)		

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				RVU	Fee	RVU	Fee	RVU	Fee
4605	HLA typing: Class II - serology	04.00		52.000	422.50 (370.60)	34.700	281.90 (247.30)		
4606	HLA typing: Class I & II - serology	04.00		90.000	731.30 (641.50)	60.000	487.50 (427.60)		
4607	Cross matching T-cells (per tray)	04.00		18.000	146.30 (128.30)	12.000	97.50 (85.50)		
4608	Cross matching B-cells	04.00		38.000	308.80 (270.90)	25.300	205.60 (180.40)		
4609	Cross matching T- & B-cells	04.00		48.000	390.00 (342.10)	32.000	260.00 (228.10)		
4610	Helicobacter: Pylori antigen test	04.00		34.600	281.10 (246.60)	23.070	187.40 (164.40)		
4611	Erythropoietin	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4612	HTLV I/II	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4613	Anti-Gm1 Antibody Assay	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
4614	HIV Ab - Rapid Test	04.00		12.000	97.50 (85.50)	8.000	65.00 (57.00)		
21.5	**Skin tests**								
	For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section								04.00
21.6	**Biochemical tests: Blood**								
3991	Abnormal pigments: Qualitative	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
3993	Abnormal pigments: Quantitative	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
3995	Acid phosphate	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
3996	Serum Amyloid A	04.00		8.280	67.30 (59.00)	5.520	44.90 (39.40)		
3997	Acid phosphatase fractionation	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
3998	Amino acids Quantitative (Post derivatisation HPLC)	04.00		78.120	634.70 (556.80)	52.080	423.20 (371.20)		
3999	Albumin	04.00		4.800	39.00 (34.20)	3.200	26.00 (22.80)		
4000	Alcohol	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
4001	Alkaline phosphatase	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4002	Alkaline phosphatase-iso-enzymes	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
4003	Ammonia: Enzymatic	04.00		7.710	62.60 (54.90)	5.140	41.80 (36.70)		
4004	Ammonia: Monitor	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4005	Alpha-1-antitrypsin: Total	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
4006	Amylase	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4007	Arsenic in blood, hair or nails	04.00		36.250	294.50 (258.30)	24.170	196.40 (172.30)		
4008	Bilirubin - Reflectance	04.00		4.770	38.80 (34.00)	3.180	25.80 (22.60)		
4009	Bilirubin: Total	04.00		4.770	38.80 (34.00)	3.180	25.80 (22.60)		
4010	Bilirubin: Conjugated	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		

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				RVU	Fee	RVU	Fee	RVU	Fee
4011	Breath Hydrogen Test	04.00		21.560	175.20 (153.70)	14.370	116.80 (102.50)		
4012	CSF Nicotinic Acid	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4013	CSF Glutamine	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4014	Cadmium: Atomic absorption	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
4016	Calcium: Ionized	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4017	Calcium: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4018	Calcium: Atomic absorption	04.00		7.250	58.90 (51.70)	4.830	39.20 (34.40)		
4019	Carotene	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4020	Carnitine (Total or free) in biological fluid: Each	04.00		11.690	95.00 (83.30)	7.790	63.30 (55.50)		
4021	Carnitine (Total or free) in muscle: Each	04.00		23.380	190.00 (166.70)	15.590	126.70 (111.10)		
4022	Acyl Carnitine	04.00		23.380	190.00 (166.70)	15.590	126.70 (111.10)		
4023	Chloride	04.00		2.590	21.00 (18.40)	1.730	14.10 (12.40)		
4025	Chol/HDL/LDL/Trig	04.00		27.070	219.90 (192.90)	18.050	146.70 (128.70)		
4026	LDL cholesterol (chemical determination)	04.00		6.900	56.10 (49.20)	4.600	37.40 (32.80)		
4027	Cholesterol total	04.00		5.340	43.40 (38.10)	3.560	28.90 (25.40)		
4028	HDL cholesterol	04.00		6.900	56.10 (49.20)	4.600	37.40 (32.80)		
4029	Cholinesterase: Serum or erythrocyte: Each	04.00		7.480	60.80 (53.30)	4.990	40.50 (35.50)		
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
4031	Total CO2	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4032	Creatinine	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4033	CSF-Immunoglobulin G	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4034	C1-Esterase Inhibitor	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4035	CSF-Albumin	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4036	CSF-IgG Index	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
4038	Glutamic acid	04.00		29.060	236.10 (207.10)	19.370	157.40 (138.10)		
4040	Homocysteine (random)	04.00		15.300	124.30 (109.00)	10.200	82.90 (72.70)		
4041	Homocysteine (after Methionine load)	04.00		18.100	147.10 (129.00)	12.060	98.00 (86.00)		
4042	D-Xylose absorption test: Two hours	04.00		13.150	106.80 (93.70)	8.750	71.10 (62.40)		
4045	Fibrinogen: Quantitative	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
4047	Hollander test	04.00		24.750	201.10 (176.40)	16.500	134.10 (117.60)		
4049	Glucose tolerance test (2 specimens)	04.00		8.970	72.90 (63.90)	5.980	48.60 (42.60)		

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				RVU	Fee	RVU	Fee	RVU	Fee
4050	Glucose strip-test with photometric reading	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
4051	Galactose	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4052	Glucose tolerance test (3 specimens)	04.00		13.170	107.00 (93.90)	8.780	71.30 (62.50)		
4053	Glucose tolerance test (4 specimens)	04.00		17.370	141.10 (123.80)	11.580	94.10 (82.50)		
4057	Glucose: Quantitative	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4061	Glucose tolerance test (5 specimens)	04.00		21.560	175.20 (153.70)	14.370	116.80 (102.50)		
4062	Galactose-1-phosphate uridyl transferase	04.00		16.000	130.00 (114.00)	10.700	86.90 (76.20)		
4063	Fructosamine	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
4064	HbA1C	06.04		14.250	115.80 (101.60)	9.500	77.20 (67.70)		
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.00		46.880	380.90 (334.10)	31.250	253.90 (222.70)		
4067	Lithium: Flame ionisation	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4068	Lithium: Atomic absorption	04.00		7.480	60.80 (53.30)	4.990	40.50 (35.50)		
4071	Iron	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4073	Iron-binding capacity	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4076	Blood gases: Astrup/pO2 and ancillary tests - can only be charged to a maximum of 6 times per patient per day	04.00		19.100	155.20 (136.10)	12.730	103.40 (90.70)		
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	04.11		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4079	Ketones in plasma: Qualitative	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4081	Drug level-biological fluid: Quantitative	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4082	Tacrolimus assay	04.00		20.100	163.30 (143.20)	13.400	108.90 (95.50)		
4083	Lysosomal enzyme assay	04.00		36.560	297.10 (260.60)	24.370	198.00 (173.70)		
4084	Thymidine kinase	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4085	Lipase	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4086	Lactate	04.00		16.000	130.00 (114.00)	10.670	86.70 (76.10)		
4091	Lipoprotein electrophoresis	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
4092	Orosmucoid	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4093	Osmolality: Serum or urine	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4094	Magnesium: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4095	Magnesium: Atomic absorption	04.00		7.250	58.90 (51.70)	4.830	39.20 (34.40)		
4096	Mercury: Atomic absorption	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
4098	Copper: Atomic absorption	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4105	Protein electrophoresis	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	04.00		20.000	162.50 (142.50)	13.200	107.30 (94.10)		
4109	Phosphate	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4111	Phospholipids	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
4113	Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4114	Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4117	Protein: Total	04.00		3.110	25.30 (22.20)	2.070	16.80 (14.70)		
4121	pH, pCO2 or pO2: Each	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4123	Pyruvic acid	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4125	Salicylates	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4126	Secretin-pancreozymin response	04.00		26.100	212.10 (186.10)	17.400	141.40 (124.00)		
4127	Caeruloplasmin	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4128	Phenylalanine: Quantitative	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4129	Glutamate dehydrogenase (GDH)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4130	Aspartate aminotransferase (AST)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4131	Alanine aminotransferase (ALT)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4132	Creatine kinase (CK)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4133	Lactate dehidrogenase (LD)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4134	Gamma glutamyl transferase (GGT)	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4135	Aldolase	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4136	Angiotensin converting enzyme (ACE)	04.00		9.000	73.10 (64.10)	6.000	48.80 (42.80)		
4137	Lactate dehydrogenase isoenzyme	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4138	CK-MB: Immunoinhibition/precipitation	04.11		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4139	Adenosine deaminase	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4142	Red cell enzymes: Each	04.00		7.800	63.40 (55.60)	5.200	42.30 (37.10)		
4143	Serum/plasma enzymes	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4144	Transferrin	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
4146	Lead: Atomic absorption	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
4147	Triglyceride	04.00		7.930	64.40 (56.50)	5.290	43.00 (37.70)		
4148	Tay - Sachs Study	04.00		36.560	297.10 (260.60)	24.370	198.00 (173.70)		
4149	Red cell magnesium	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
4151	Urea	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4152	CK-MB: Mass determination: Quantitative (Automated)	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
4153	CK-MB: Mass determination: Quantitative (Not automated)	04.00		17.470	141.90 (124.50)	11.650	94.70 (83.10)		
4154	Myoglobin quantitative: Monoclonal immunological	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4155	Uric acid	04.00		3.780	30.70 (26.90)	2.520	20.50 (18.00)		
4156	Vitamin D3	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4157	Vitamin A-saturation test	04.00		15.300	124.30 (109.00)	10.200	82.90 (72.70)		
4158	Vitamin E (tocopherol)	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
4159	Vitamin A	04.00		6.300	51.20 (44.90)	4.200	34.10 (29.90)		
4160	Vitamin C (ascorbic acid)	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4161	Troponin isoforms: Each	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4163	Apoprotein AI: Turbidometric method	04.00		8.280	67.30 (59.00)	5.520	44.90 (39.40)		
4165	Apoprotein AII: Turbidometric method	04.00		8.280	67.30 (59.00)	5.520	44.90 (39.40)		
4167	Apoprotein B: Turbidometric method	04.00		8.280	67.30 (59.00)	5.520	44.90 (39.40)		
4170	Lipoprotein (a)(Lp(a)) assay	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4171	Sodium + potassium + chloride + CO2 + urea	04.00		15.840	128.70 (112.90)	10.560	85.80 (75.30)		
4172	ELISA/EMIT technique	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4173	Sirolimus Assay	04.00		78.000	633.80 (556.00)	52.000	422.50 (370.60)		
4181	Quantitative protein estimation: Mancini method	04.00		7.760	63.10 (55.40)	5.170	42.00 (36.80)		
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	04.00		8.280	67.30 (59.00)	5.520	44.90 (39.40)		
4183	Quantitative protein estimation: Labelled antibody	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4184	C-reactive protein (Ultra sensitive)	04.00		11.680	94.90 (83.20)	7.790	63.30 (55.50)		
4185	Lactose	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4186	Vitamin B6	04.00		15.300	124.30 (109.00)	10.200	82.90 (72.70)		
4187	Zinc: Atomic absorption	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
21.7	**Biochemical tests: Urine**								
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	04.00		1.500	12.20 (10.70)	1.000	8.13 (7.13)		
4189	Abnormal pigments	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4193	Alkapton test: Homogentisic acid	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4194	Amino acids: Quantitative (Post derivatisation HPLC)	04.00		78.120	634.70 (556.80)	52.080	423.20 (371.20)		
4195	Amino laevulinic acid	04.00		18.000	146.30 (128.30)	12.000	97.50 (85.50)		
4197	Amylase	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4198	Arsenic	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
4199	Ascorbic acid	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4201	Bence-Jones protein	04.00		2.700	21.90 (19.20)	1.800	14.60 (12.80)		
4203	Phenol	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
4204	Calcium: Atomic absorption	04.00		7.250	58.90 (51.70)	4.830	39.20 (34.40)		
4205	Calcium: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4206	Calcium: Absorption and excretion studies	04.00		25.000	203.10 (178.20)	16.700	135.70 (119.00)		
4209	Lead: Atomic absorption	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
4210	Urine collagen telopeptides	04.00		36.500	296.60 (260.20)	24.330	197.70 (173.40)		
4211	Bile pigments: Qualitative	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4213	Protein: Quantitative	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4216	Mucopolysaccharides: Qualitative	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
4217	Oxalate	04.00		9.380	76.20 (66.80)	6.250	50.80 (44.60)		
4218	Glucose: Quantitative	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4219	Steroids: Chromatography (each)	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
4220	Klinolab Newborn Screen	04.00		36.560	297.10 (260.60)	24.370	198.00 (173.70)		
4221	Creatinine	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4223	Creatinine clearance	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4227	Electrophoresis: Qualitative	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4228	Fetal Lung Maturity	04.00		36.560	297.10 (260.60)	24.370	198.00 (173.70)		
4229	Uric acid clearance	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4230	Urine/Fluid - Specific Gravity	04.00		0.900	7.31 (6.41)	0.600	4.88 (4.28)		
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	05.03		37.500	304.70 (267.30) Z	25.000	203.10 (178.20) Z		
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	05.03		46.800	380.30 (333.60) Z	31.200	253.50 (222.40) Z		
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	05.03		37.500	304.70 (267.30) Z	25.000	203.10 (178.20) Z		
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	05.03		46.800	380.30 (333.60) Z	31.200	253.50 (222.40) Z		
4237	5-Hydroxy-indole-acetic acid: Screen test	04.00		2.700	21.90 (19.20)	1.800	14.60 (12.80)		
4238	5HIAA (Hplc)	04.00		78.120	634.70 (556.80)	52.080	423.20 (371.20)		
4239	5-Hydroxy-indole-acetic acid: Quantitative	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4247	Ketones: Excluding dip-stick method	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4248	Reducing substances	04.00		1.800	14.60 (12.80)	1.200	9.75 (8.55)		
4251	Metanephrines: Column chromatography	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
4252	Metanephrine (Hplc)	04.00		78.120	634.70 (556.80)	52.080	423.20 (371.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	04.00		27.000	219.40 (192.50)	18.000	146.30 (128.30)		
4254	Nitrosonaphtol test for tyrosine	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4255	Orotic Acid - Urine	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4256	Very long Chain Fatty Acids	04.00		129.380	1051.20 (922.10)	86.250	700.80 (614.70)		
4261	Micro Albumin: Quantitative	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4262	Micro Albumin: Qualitative	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4263	pH: Excluding dip-stick method	04.00		0.900	7.31 (6.41)	0.600	4.88 (4.28)		
4265	Thin layer chromatography: One way	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4266	Thin layer chromatography: Two way	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4267	Total organic matter screen: Infrared	04.00		31.250	253.90 (222.70)	20.830	169.20 (148.40)		
4268	Organic acids: Quantitative: GCMS	04.00		109.380	888.70 (779.60)	72.920	592.50 (519.70)		
4269	Phenylpyruvic acid: Ferric chloride	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4270	Chromium Total Urine	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
4271	Phosphate excretion index	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
4272	Porphobilinogen qualitative screen: Urine	04.00		5.000	40.60 (35.60)	3.330	27.10 (23.80)		
4273	Porphobilinogen/ALA: Quantitative each	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
4283	Magnesium: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4284	Magnesium: Atomic absorption	04.00		7.250	58.90 (51.70)	4.830	39.20 (34.40)		
4285	Identification of carbohydrate	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4287	Identification of drug: Qualitative	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4288	Identification of drug: Quantitative	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4293	Urea clearance	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4297	Copper: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4298	Copper: Atomic absorption	04.00		18.120	147.20 (129.10)	12.080	98.20 (86.10)		
4300	Indican or indole: Qualitative	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
4301	Chloride	04.00		2.590	21.00 (18.40)	1.730	14.10 (12.40)		
4307	Ammonium chloride loading test	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
4309	Urobilinogen: Quantitative	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4313	Phosphates	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4315	Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4316	Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4319	Urea	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4321	Uric acid	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4322	Fluoride	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4323	Total protein and protein electrophoresis	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4325	VMA: Quantitative	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4326	Catecholamines (HPLC)	04.00		76.120	634.70 (556.80)	52.080	423.20 (371.20)		
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.11		46.880	380.90 (334.10)	31.250	253.90 (222.70)		
4328	Immunoglobulin D	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4335	Cystine: Quantitative	04.00		12.600	102.40 (89.80)	8.400	68.30 (59.90)		
4336	Dinitrophenol hydrazine test: Ketoacids	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4337	Hydroxyproline: Quantitative	04.00		18.900	153.60 (134.70)	12.600	102.40 (89.80)		
21.8	**Biochemical tests: Faeces**								
4339	Chloride	04.00		2.590	21.00 (18.40)	1.730	14.10 (12.40)		
4343	Fat: Qualitative	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
4345	Fat: Quantitative	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
4347	Ph	04.00		0.900	7.31 (6.41)	0.600	4.88 (4.28)		
4351	Occult blood: Chemical test	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4352	Occult blood: Monoclonal antibodies	04.00		10.000	81.30 (71.30)	6.670	54.20 (47.50)		
4357	Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4358	Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4359	Secretory IgA	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4361	Stercobilin	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4362	Elastase quantitative ELISA	04.00		47.000	381.90 (335.00)	31.330	254.60 (223.30)		
4363	Stercobilinogen: Quantitative	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		
4364	Chymotrypsin determination: Enzymatic	04.00		7.470	60.70 (53.20)	4.980	40.50 (35.50)		
21.9	**Biochemical tests: Miscellaneous**								
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	04.00		5.000	40.60 (35.60)	3.330	27.10 (23.80)		
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	04.00		30.000	243.80 (213.90)	20.000	162.50 (142.50)		
4370	Drug level in biological fluid: Monoclonal immunological	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		
4371	Amylase in exudate	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
4372	Fluoride in biological fluids and water	04.00		15.620	126.90 (111.30)	10.410	84.60 (74.20)		
4373	Breast milk analysis	04.00		6.750	54.80 (48.10)	4.500	36.60 (32.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4374	Trace metals in biological fluid: Atomic absorption	04.00		18.130	147.30 (129.20)	12.090	98.20 (86.10)		
4375	Calcium in fluid: Spectrophotometric	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4376	Calcium in fluid: Atomic absorption	04.00		7.250	58.90 (51.70)	4.830	39.20 (34.40)		
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	04.11		21.880	177.80 (156.00)	14.590	118.50 (103.90)		
4378	Urea breath test	04.00		58.000	471.30 (413.40)	38.670	314.20 (275.60)		
4380	Lecithin in amniotic fluid: L/S ratio	04.00		27.000	219.40 (192.50)	18.000	146.30 (128.30)		
4381	Lamellar body count in amniotic fluid	04.00		10.000	81.30 (71.30)	6.700	54.40 (47.70)		
4382	Bilirubin in amniotic fluid: Spectrophotometric essay	04.00		9.450	76.80 (67.40)	6.300	51.20 (44.90)		
4386	Oestrogen/Progesterone receptors: Fluorescent method	04.00		20.700	168.20 (147.50)	13.800	112.10 (98.30)		
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique	04.00		230.000	1868.80 (1639.30)	153.000	1243.10 (1090.40)		
4388	Gastric contents: Maximal stimulation test	04.00		27.000	219.40 (192.50)	18.000	146.30 (128.30)		
4389	Gastric fluid: Total acid per specimen	04.00		2.250	18.30 (16.10)	1.500	12.20 (10.70)		
4390	Foam test: Amniotic fluid	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
4391	Renal calculus: Chemistry	04.00		5.400	43.90 (38.50)	3.600	29.30 (25.70)		
4392	Renal calculus: Crystallography	04.00		16.250	132.00 (115.80)	10.800	87.80 (77.00)		
4393	Saliva: Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4394	Saliva: Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4395	Sweat: Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4396	Sweat: Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4397	Sweat: Chloride	04.00		2.590	21.00 (18.40)	1.730	14.10 (12.40)		
4399	Sweat collection by iontophoresis (excluding collection material)	04.00		4.500	36.60 (32.10)	3.000	24.40 (21.40)		
4400	Tryptophane loading test	04.00		22.050	179.20 (157.20)	14.700	119.40 (104.70)		
21.10	**Cerebrospinal fluid**								
4401	Cell count	04.00		3.450	28.00 (24.60)	2.300	18.70 (16.40)		
4407	Cell count, protein, glucose and chloride	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4409	Chloride	04.00		2.590	21.00 (18.40)	1.730	14.10 (12.40)		
4415	Potassium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4416	Sodium	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4417	Protein: Qualitative	04.00		0.900	7.31 (6.41)	0.600	4.88 (4.28)		
4419	Protein: Quantitative	04.00		3.110	25.30 (22.20)	2.070	16.80 (14.70)		
4421	Glucose	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4423	Urea	04.00		3.620	29.40 (25.80)	2.410	19.60 (17.20)		
4425	Protein electrophoresis	04.00		12.600	102.40 (89.80)	8.400	68.30 (59.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
21.11	**RNA/DNA based tests and andrology**								
21.11.1	**RNA/DNA based tests and andrology: RNA/DNA based tests**								
4424	HLA test for specific allele DNA-PCR	04.00		36.000	292.50 (256.60)	24.000	195.00 (171.10)		
4426	HLA typing low resolution Class I DNA-PCR per locus	04.00		100.000	812.50 (712.70)	67.000	544.40 (477.50)		
4427	HLA typing low resolution Class II DNA-PCR per locus	04.00		74.000	601.30 (527.50)	49.300	400.60 (351.40)		
4428	HLA typing high resolution Class I or II DNA-PCR per locus	04.00		66.000	536.30 (470.40)	44.000	357.50 (313.60)		
4429	Quantitative PCR (DNA/RNA)	04.00		84.300	684.90 (600.80)	56.200	456.60 (400.50)		
4430	Recombinant DNA technique	04.00		25.000	203.10 (178.20)	16.670	135.40 (118.80)		
4431	Ribosomal RNA targeting for bacteriological identification	04.00		35.000	284.40 (249.50)	23.330	189.60 (166.30)		
4432	Ribosomal RNA amplification for bacteriological identification	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
4433	Bacteriological DNA identification (LCR)	04.00		25.000	203.10 (178.20)	16.670	135.40 (118.80)		
4434	Bacteriological DNA identification (PCR)	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	05.03		150.000	1218.80 (1069.10) Z	100.000	812.50 (712.70) Z		
21.11.2	**RNA/DNA based tests and andrology: Andrology**								
4435	Mixed antiglobulin reaction: Semen	04.00		6.600	53.60 (47.00)	4.400	35.80 (31.40)		
4436	Friberg test: Semen	04.00		14.500	117.80 (103.30)	9.670	78.60 (68.90)		
4437	Kremer test: Semen	04.00		3.600	29.30 (25.70)	2.400	19.50 (17.10)		
4440	Semen analysis: Cell count	04.00		7.650	62.20 (54.60)	5.100	41.40 (36.30)		
4441	Semen analysis: Cytology	04.00		7.200	58.50 (51.30)	4.800	39.00 (34.20)		
4442	Semen analysis: Viability + motility - 6 hours	04.00		6.000	48.80 (42.80)	4.000	32.50 (28.50)		
4443	Semen analysis: Supravital stain	04.00		5.440	44.20 (38.80)	3.630	29.50 (25.90)		
4445	Seminal fluid: Alpha glucosidase	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4446	Seminal fluid fructose	04.00		3.150	25.60 (22.50)	2.100	17.10 (15.00)		
4447	Seminal fluid: Acid phosphatase	04.00		5.180	42.10 (36.90)	3.450	28.00 (24.60)		
21.12	**Immunology**								
4448	HCG: Latex agglutination: Qualitative (side room)	04.00		4.000	32.50 (28.50)	2.670	21.70 (19.00)		
4449	HCG: Latex agglutination: Semi-quantitative (side room)	04.00		9.310	75.60 (66.30)	6.210	50.50 (44.30)		
4450	HCG: Monoclonal immunological: Qualitative	04.00		10.000	81.30 (71.30)	6.670	54.20 (47.50)		
4451	HCG: Monoclonal immunological: Quantitative	04.00		12.400	100.80 (88.40)	8.270	67.20 (58.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4452	Bone Specific Alk Phosphatase	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4455	Anti IgE receptor antibody test (10 samples and dilution)	04.00		161.560	1312.70 (1151.50)	107.710	875.10 (767.60)		
4456	Eosinophil cationic protein	04.00		27.810	226.00 (198.20)	18.540	150.60 (132.10)		
4457	Mast cell tryptase	04.00		96.870	787.10 (690.40)	64.580	524.70 (460.30)		
4458	Micro-albuminuria: Radio-isotope method	04.00		12.420	100.90 (88.50)	8.300	67.40 (59.10)		
4459	Acetyl choline receptor antibody	04.00		158.120	1284.70 (1126.90)	105.410	856.50 (751.30)		
4460	CA-199 tumour marker	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4461	Nuclear Matrix Protein 22	04.00		35.000	284.40 (249.50)	23.330	189.60 (166.30)		
4462	CA-125 tumour marker	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4463	C6 complement functional essay	04.00		45.000	365.60 (320.70)	30.000	243.80 (213.90)		
4464	House dust mite antigen ELIZA	04.00		20.310	165.00 (144.70)	13.540	110.00 (96.50)		
4466	Beta-2-microglobulin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4467	Chromograqnin A	04.00		47.000	381.90 (335.00)	31.330	254.60 (223.30)		
4468	CA-549	04.00		20.000	162.50 (142.50)	13.300	108.10 (94.80)		
4469	Tumour markers: Monoclonal immunological (each)	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4470	CA-195 tumour marker	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4471	Carcino-embryonic antigen	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4472	MCA antigen tumour marker	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4473	TSH Receptor Ab	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4474	Cast Per Allergen	04.00		27.810	226.00 (198.20)	18.540	150.60 (132.10)		
4475	CA-724	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4476	Neopterin	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4477	Neuron specific enolase	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4478	Osteocalcin	04.00		31.400	255.10 (223.80)	20.930	170.10 (149.20)		
4479	Vitamin B12-absorption: Shilling test	04.00		11.700	95.10 (83.40)	7.800	63.40 (55.60)		
4480	Serotonin	04.00		18.750	152.30 (133.60)	12.500	101.60 (89.10)		
4482	Free thyroxine (FT4)	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	04.00		37.080	301.30 (264.30)	24.720	200.90 (176.20)		
4485	Insulin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4486	C-Peptide	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4487	Calcitonin	04.00		18.900	153.60 (134.70)	12.600	102.40 (89.80)		
4488	B-Type Natriuretic Peptide	04.00		47.040	382.20 (335.30)	31.360	254.80 (223.50)		
4490	Releasing hormone response	04.00		50.000	406.30 (356.40)	33.350	271.00 (237.70)		
4491	Vitamin B12	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4492	Vitamin D3: Calcitroil (RIA)	04.00		75.000	609.40 (534.60)	50.000	406.30 (356.40)		
4493	Drug concentration: Quantitative	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4494	Free hormone assay	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4495	Growth hormone	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4496	Hormone concentration: Quantitative	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4497	Carbohydrate deficient transferrin	04.00		29.060	236.10 (207.10)	19.370	157.40 (138.10)		
4499	Cortisol	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4500	DHEA sulphate	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4501	Testosterone	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4502	Free testosterone	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4503	Oestradiol	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4505	Oestriol	04.00		10.800	87.80 (77.00)	7.200	58.50 (51.30)		
4506	Multiple antigen specific IgE screening test for Atopy	04.00		37.260	302.70 (265.50)	24.800	201.50 (176.80)		
4507	Thyrotropin (TSH)	04.00		19.600	159.30 (139.70)	13.070	106.20 (93.20)		
4508	Combined antigen specific IgE	04.00		24.480	198.90 (174.50)	16.600	134.90 (118.30)		
4509	Free tri-iodothyronine (FT3)	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4511	Renin activity	04.00		18.900	153.60 (134.70)	12.600	102.40 (89.80)		
4512	Parathormone	04.00		17.080	138.80 (121.80)	11.390	92.50 (81.10)		
4513	IgE: Total	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4514	Antigen specific IgE	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4515	Aldosterone	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4516	Follitropin (FSH)	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4517	Lutropin (LH)	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4518	Soluble transferrin receptor	04.00		11.250	91.40 (80.20)	7.500	60.90 (53.40)		
4519	Prostate specific antigen	04.00		14.490	117.70 (103.20)	9.660	78.50 (68.90)		
4520	17 Hydroxy progesterone	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4521	Progesterone	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4522	Alpha-feto protein	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4523	ACTH	04.00		21.740	176.60 (154.90)	14.490	117.70 (103.20)		
4524	Free PSA	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4526	Sex hormone binding globulin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4527	Gastrin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4528	Ferritin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4529	Anti-DNA antibodies	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4530	Antiplatelet antibodies	04.00		15.300	124.30 (109.00)	10.200	82.90 (72.70)		
4531	Hepatitis: Per antigen or antibody	04.00		14.490	117.70 (103.20)	9.660	78.50 (68.90)		
4532	Transcobalamine	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4533	Folic acid	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4534	Prostatic acid phosphatase	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4536	Erythrocyte folate	04.00		17.480	142.00 (124.60)	11.650	94.70 (83.10)		
4537	Prolactin	04.00		12.420	100.90 (88.50)	8.280	67.30 (59.00)		
4538	Procalcitonin: Semi-quantitative	04.00		32.000	260.00 (228.10)	21.330	173.30 (152.00)		
4539	Procalcitonin: Quantitative	04.00		46.000	373.80 (327.90)	30.670	249.20 (218.60)		
4540	HCG: Quantitative as used for Down's screen	04.00		15.000	121.90 (106.90)	10.000	81.30 (71.30)		
4546	First trimester Downs screen	04.00		53.500	434.70 (381.30)	35.670	289.80 (254.20)		
4552	Second Trimester Down's screen	04.00		33.620	273.20 (239.60)	22.410	182.10 (159.70)		
4553	Thyroglubulin	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
4554	SCC marker	04.00		20.000	162.50 (142.50)	13.330	108.30 (95.00)		
21.13	**Clinical pathology: Miscellaneous**								
4544	Attendance in theatre	04.00		27.000	219.40 (192.50)				
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays - Refer to General Rule B.	04.00							
4551	Unlisted pathology service: Fees for items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the fee for a comparable service in the coding structure. New items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note General Rule C and item 6999 are not applicable to pathology services (sections 21, 22 and 23)	04.00							
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be charged separately	04.00							
22	**Anatomical Pathology**								
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
22.1	**Exfoliative cytology**								
4561	Sputum, all body fluids and tumour aspirates: First unit	04.00		13.400	125.60 (110.20)	8.900	83.40 (73.20)		
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	04.00		7.800	73.10 (64.10)	5.200	48.70 (42.70)		
4564	Performance of fine-needle aspiration for cytology	04.00		15.000	140.60 (123.30)				
4565	Examination of fine needle aspiration in theatre	04.00		90.000	843.30 (739.70)	60.000	562.20 (493.20)		
4566	Vaginal or cervical smears, each	04.00		11.000	103.10 (90.40)	7.000	65.60 (57.50)		
22.2	**Histology**								
4567	Histology per sample	04.00		20.000	177.40 (155.60)	13.300	118.00 (103.50)		
4571	Histology per additional block, each	04.00		11.600	102.90 (90.30)	7.700	68.30 (59.90)		
4575	Histology and frozen section in laboratory	04.00		22.700	201.30 (176.60)	15.100	133.90 (117.50)		
4577	Histology and frozen section in theatre	04.00		90.000	798.30 (700.30)	60.000	532.20 (466.80)		
4578	Second and subsequent frozen sections, each	04.00		20.000	177.40 (155.60)	13.400	118.90 (104.30)		
4579	Attendance in theatre - no frozen section performed	04.00		45.000	399.20 (350.20)	30.000	266.10 (233.40)		
4582	Serial step sections (including item 4567)	04.00		23.300	206.70 (181.30)	15.600	138.40 (121.40)		
4584	Serial step sections per additional block, each	04.00		13.500	119.70 (105.00)	9.000	79.80 (70.00)		
4587	Histology consultation	04.00		10.100	89.60 (78.60)	6.700	59.40 (52.10)		
4589	Special stains	04.00		6.700	59.40 (52.10)	4.500	39.90 (35.00)		
4591	Immunofluorescence studies	04.00		20.700	183.60 (161.10)	13.800	122.40 (107.40)		
4592	Immunoperoxidase studies	04.00		40.000	354.80 (311.20)	26.670	236.60 (207.50)		
4593	Electron microscopy	04.00		94.000	833.80 (731.40)	63.000	558.80 (490.20)		
4595	Foetal autopsy excluding histology	04.00		73.000	647.50 (568.00)	48.670	431.70 (378.70)		
23	**Human Genetics**								
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values								04.00
23.1	**Cytogenitc**								
4750	Cell culture: Lymphocytes, cord blood	04.00		15.000	124.80 (109.50)	15.000	124.80 (109.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	04.00		45.000	374.50 (328.50)	45.000	374.50 (328.50)		
4752	Cell culture: Chorionic villi	04.00		60.000	499.30 (438.00)	60.000	499.30 (438.00)		
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	04.00		135.000	1123.50 (985.50)	135.000	1123.50 (985.50)		
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	04.00		270.000	2246.90 (1971.00)	270.000	2246.90 (1971.00)		
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	04.00		70.000	582.50 (511.00)	70.000	582.50 (511.00)		
4760	FISH procedure, including cell culture	04.00		115.000	957.00 (839.50)	115.000	957.00 (839.50)		
4761	FISH analysis per probe system	04.00		35.000	291.30 (255.50)	35.000	291.30 (255.50)		
23.2	**DNA-testing**								
4763	Blood: DNA extraction	04.00		45.000	374.50 (328.50)	45.000	374.50 (328.50)		
4764	Blood: Genotype per person: Southern blotting	04.00		89.000	740.70 (649.70)	89.000	740.70 (649.70)		
4765	Blood: Genotype per person: PCR	04.00		60.000	499.30 (438.00)	60.000	499.30 (438.00)		
4766	HIV Drug Resistance Testing	04.00		513.000	4269.20 (3744.90)	342.000	2846.10 (2496.60)		
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	04.00		90.000	749.00 (657.00)	90.000	749.00 (657.00)		
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	04.00		188.000	1564.50 (1372.40)	188.000	1564.50 (1372.40)		
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	04.00		120.000	998.60 (876.00)	120.000	998.60 (876.00)		
IV.	**Travelling Expenses**								
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.								04.00
5003	R6,67 for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16=3 X R6,67 = R20,01	04.00							
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof	04.00		18.000	126.50 (111.00)				
5007	Normal hours: General practitioner: 18,00 clinical procedure units per hour or part thereof	04.00				18.000	126.50 (111.00)		
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them	04.00							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
V.	**LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED**								
	Modifier 0004 is not applicable to the following sections: All anaesthetic services Section 19: Radiology Section 20: Radiation Oncology Section 21: Clinical Pathology (except for items 3719, 3720 and 3721 where modifier 0004 may be applied) Section 22: Anatomical Pathology Section 23: Human Genetic Please note : This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures.								04.00
II	REMUNERATION FOR SUPPLIES, MATERIALS AND SPECIAL MEDICINE USED IN TREATMENT								
0202	Setting of sterile tray								
1.	INJECTIONS, INFUSIONS AND INHALATION SEDATION								
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof								
0204	Inhalation sedation: Per additional quarter-hour or part thereof								
0206	Intravenous infusions (push-in), patients over two years: Insertion of cannula. Chargeable once per 24 hours								
0208	Therapeutic venesection (not to be used when blood is drawn for the purpose of laboratory investigations)								
0213	Chemotherapy: Intramuscular or subcutaneous: Per injection								
0214	Chemotherapy: Intravenous bolus technique: Per injection								
0215	Chemotherapy: Intravenous infusion technique: Per injection								
2.	INTEGUMENTARY SYSTEM								
0217	Allergy: First patch								
0219	Allergy: Each additional patch								
0222	Skin: Intralesional Injection: Single								
0223	Skin: Intralesional injection: Multiple								
0225	Skin: Epilation: per session								
0227	Skin: Special treatment of severe acne cases, including draining of cysts, expressing of comedomes and/or steaming, abrasive cleaning of skin and UVR per session								
0228	Skin: PUVA treatment: Maximum of 21 treatments								
0229	Skin: PUVA: Follow-up or maintenance once a week								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	0230	Skin: UVR treatment								
	0231	Skin: UVR follow-up: For use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp								
	0233	Skin: Biopsy without suturing: First lesion								
	0234	Skin: Biopsy without suturing: Subsequent lesions								
	0235	Skin: Biopsy without suturing: Maximum for multiple additional lesions								
	0237	Skin: Deep skin biopsy by surgical incision with local anaesthetic and suturing								
	0241	Skin: Treatment of benign skin lesion by chemo-cryotherapy: First lesion								
	0242	Skin: Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesion								
	0243	Skin: Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions								
	0244	Skin: Repair of nail bed								
	0245	Skin: Removal of benign lesion by curetting under local or general anaesthesia followed by diathermy and curetting or electrocautery: First lesio								
	0246	Skin: Removal of benign lesion by curetting under local or general anaesthesia followed by diathermy and curetting or electrocautery: Subsequent lesion								
	0251	Skin: Removal of malignant lesions by curetting under local or general anaesthesia followed by electrocautery: First lesion								
	0252	Skin: Removal of malignant lesions by curetting under local or general anaesthesia followed by electrocautery: Subsequent lesion								
	0255	Skin: Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail								
	0259	Skin: Removal of foreign body superficial to deep fascia (except hands)								
	0280	Skin: Laser treatment for small skin lesions: First lesion								
	0281	Skin: Laser treatment for small skin lesions: Second lesion								
	0282	Skin: Laser treatment for small skin lesions: Maximum for multiple additional lesions								
	0283	Skin: Laser treatment for large skin lesions: Limited area								
	0300	Lacerations, Scars, Tumours, Cysts & other Skin Lesions: Stitching of a wound (with or without local anaesthesia): Including normal after-care								
	0301	Lacerations, Scars, Tumours, Cysts & other Skin Lesions: Additional wounds stitched at same session (each)								
	0305	Lacerations, Scars, Tumours, Cysts & other Skin Lesions: Needle Biopsy: soft tissue								
	0307	Lacerations, Scars, Tumours, Cysts & other Skin Lesions: Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude								
	0308	Each additional small procedure done at the same time								
	0316	Breasts: Fine needle aspiration for soft tissue (all areas)								
	0317	Breasts: Aspiration of cyst or tumour								
	0377	Standard acupuncture								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	0378	Laser acupuncture using more than 6 points								
	0379	Electro-acupuncture								
	0380	Scalp acupuncture								
	0381	Micro-acupuncture (ear, hand)								
	3.	MUSCULO-SKELETAL SYSTEM								
	0547	Dislocation: Clavicle: either end								
	0549	Dislocation: Shoulder								
	0551	Dislocation: Elbow								
	0713	Electromyography								
	0715	Strength duration curve per session								
	0717	Electrical examination of single nerve or muscle								
	0721	Voltage integration during isometric contraction								
	0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral								
	0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral								
	0729	Tendon reflex time								
	0730	Limb-brain somatosensory studies (per limb)								
	0731	Visio and audio-sensory studies								
	0733	Motor nerve conduction studies (single nerve)								
	0735	Examinations of sensory nerve conduction by sweep averages (single nerve)								
	0740	Muscle fatigue studies								
	0759	Other single tendon								
	0887	Limb cast (modifier 0005 not applicable)								
	0922	Removal of foreign bodies requiring incision: Under local anaesthetic								
	4.	RESPIRATORY SYSTEM								
	1019	Nasendoscopy in rooms with either rigid or flexible endoscopy (may only be charged for together with a first consultation)								
	1031	Removal of single nasal polyp at rooms (at initial consultation only)								
	1037	Diathermy to nose or pharynx, exclusive of consultation fee, uni-or bilateral: Under local anaesthetic								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	1063	Removal of foreign body from nose at rooms								
	1067	Proof puncture at rooms (unilateral)								
	1071	Proetz treatment (consultation fee only to be charged for first treatment)								
	1077	Septum abscess, at rooms, including after-care								
	1107	Opening of quinsy, at rooms								
	1117	Laryngeal intubation								
	1123	Botulinum toxin injection for adductor disphonia (+ item 0201 + item 0202)								
	1136	Nebulisation (in rooms)								
	1143	Paracentesis chest: Diagnostic								
	1145	Paracentesis chest: Therapeutic								
	1186	Pulmonary Function Tests: Flow volume test: Inspiration/expiration								
	1188	Pulmonary Function Tests: Flow volume test: Inspiration/expiration, pre and post bronchodialator, (to be charged for only with first consultation - thereafter item 1186 applies)								
	1189	Forced expirogram only								
	1191	N2 single breath distribution								
	1192	Peak expiratory flow only								
	1193	Functional residual capacity or residual volume: helium, nitrogen open circuit, or other method								
	1195	Thoracic gas volume								
	1196	Determination of resistance to airflow, oscillatory or plethysnographic methods								
	1197	Compliance and resistance using oesophageal balloon								
	1198	Prolonged postexposure evaluation of bronchospasm with multiple sirometric determinations after antigen, cold air, methacholine or other chemical agents with subsequent spirometrics								
	1199	Pulmonary stress testing; simple (eg. prolonged exercise test for bronchospasm with pre- and post-spirometry)								
	1200	Carbon monoxide diffusing capacity, any method								
	1201	Maximum inspiratory/expiratory pressure								
	6.	CARDIOVASCULAR SYSTEM								
	1228	General practitioner's fee for the taking of an ECG only: without effort (1/2 of item 1232)								
	1229	General practitioner's fee for the taking of an ECG only: without and with effort (1/2 of item 1233)								
	1230	Physician's fee for interpreting an ECG: without effort								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	1231	Physician's fee for interpreting an ECG: without and with effort								
	1232	Electrocardiogram: without effort								
	1233	Electrocardiogram: without and with effort								
	1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus								
	1235	Multi-stage treadmill test								
	1236	Electrocardiogram: without effort: Under 4 years								
	1237	24 hour ambulatory blood pressure: Hire fee								
	1238	24 hour ambulatory ECG monitoring (holter): Hire fee								
	1239	24 hour ambulatory ECG monitoring (holter): Interpretation								
	1240	Signal averaged electrocardiogram								
	1241	X-ray screening: Chest								
	1242	X-ray screening: Prosthetic valves								
	1243	2 week event triggered ambulatory ECG monitoring: Hire fee								
	1244	2 week event triggered ambulatory ECG monitoring: Interpretation								
	1268	Threshold testing: Own equipment								
	1312	Evaluation of coronary angiogram by cardiothoracic surgeon								
	1357	Response to reflex heating								
	1359	Response to reflex cooling								
	1361	Cold sensitivity test								
	1363	Oscillometry test								
	1365	Sweat test								
	1367	Doppler blood tests								
	5369	Doppler arterial pressures								
	5371	Doppler arterial pressures with exercise								
	5373	Doppler segmental pressures and wave forms								
	5375	Venous doppler examination (both limbs)								
	5377	Venous plethysmography								
	5379	Supra-orbital doppler test								

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Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	5381	Carotid non-invasive complex tests								
	1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)								
	1431	Phase II: Exercise rehabilitation: Per patient per 60 min session with a maximum of 5 patients per group								
	1432	Phase III: Exercise rehabilitation: Per patient per 60 min session with a maximum of 10 patients per group								
	8.	DIGESTIVE SYSTEM								
	1469	Local excision of mucosal lesion of oral cavity								
	1485	Local excision of benign lesion of lip								
	1499	Lip reconstruction following an injury: Direct repair								
	1507	Local excision of lesion of tongue								
	1547	Oesophageal acid perfusion test								
	1580	Oesophageal motility (6 channel + pneumograph + pH pull-through)								
	1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)								
	1587	Upper gastro-intestinal fibre-optic endoscopy: own equipment								
	1593	Augmented histamine test: Gastric intubation with x-ray screening								
	1632	H2 breath test (intestines)								
	1633	Complete test using lactose or lactulose								
	1678	Fibre-optic sigmoidoscopy, plus polypectomy								
	1681	Proctoscopy with removal of polyps: First time								
	1683	Proctoscopy with removal of polyps: Subsequent times								
	1719	Rubber band ligation of haemorrhoids: Per haemorrhoid								
	1721	Sclerosing injection for haemorroids: Per injection								
	1725	Drainage of external thrombosed pile								
	1729	Excision of anal skin tags								
	1748	Body composition measured by bio-electrical impedance								
	1780	Gastric and duodenal intubation								
	1797	Pneumo-peritoneum: First								
	1799	Pneumo-peritoneum: Repeat								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1801	Diagnostic paracentesis: Abdomen								
1803	Therapeutic paracentesis: Abdomen								
10.	URINARY SYSTEM								
1841	Renal biopsy (needle)								
1847	Haemodialysis: Per hour or part thereof								
1849	Haemodialysis: Maximum: Eight hours								
1851	Haemodialysis: Thereafter per week								
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy								
1945	Instillation of radio-opague material for cystography or urethrocystography								
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydrodilatation of bladder								
1949	Cystoscopy								
1989	Cystometrogram								
1991	Flometric bladder studies with videocystograph								
1992	Flometric bladder studies without videocystograph								
1996	Bladder catheterisation: Male (not during operation)								
1997	Bladder catheterisation: Female (not during operation)								
11.	MALE GENITAL SYSTEM								
2154	Induction of artificial erection								
12.	FEMALE GENITAL SYSTEM								
2271	Removal of tag or polyp								
2272	Removal of small superficial benign lesions								
2312	Artificial insemination								
2314	Intra-uterine insemination								
2315	Simms Huhner test plus wet smear								
2339	Colpotomy: diagnostic								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	2389	Paracervical nerve block								
	2392	Cryo- or electro- cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting rooms								
	2399	Punch biopsy								
	2400	Biopsy during pregnancy								
	2415	Cervix encirclage: Removal items 2409 and 2411 without anaesthetic								
	2425	Removal of cervical polyps								
	2429	Colpomicroscopy								
	2434	Endometrial biopsy								
	2435	Hysterosalpingogram								
	2442	Insertion of IUCD								
	2506	Transcervical gamete/embryo intrafallopian tube transfer (TET/TEST)								
	2565	Implantation hormone pellets (excluding after-care)								
	13.	OBSTETRIC PROCEDURES								
	2603	External cephalic version								
	2605	Amniocentesis								
	2610	Tococardiography pre-natal and intrapartum: Including stress and non-stress test (own machine)								
	2611	Chorion villus biopsy								
	14.	NERVOUS SYSTEM								
	2681	Visual evoked potentials (VEP): Unilateral								
	2682	Visual evoked potentials (VEP): Bilateral								
	2683	Electroretinography (Ganzfeld method): Unilateral								
	2684	Electroretinography (Ganzfeld method): Bilateral								
	2685	Electro-oculography: Unilateral								
	2686	Electro-oculography: Bilateral								
	2687	VEP stable condition (photic drive): Unilateral								
	2689	VEP stable condition (photic drive): Bilateral								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and V.E.P.								
	2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial - or Lubosacral plexus, spinal cord and cortex.								
	2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain: Per treatment								
	2707	Full fee for complete neurological evoked potential evaluation, including neurological AEP, bilateral VEP and bilateral median and/or posterior tibial stimulation.								
	2708	Evaluation of cognitive evoked potential with visual or audiology stimulus								
	2709	Full spinogram including bilateral median and posterior-tibial studies								
	2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: intravenous infusion) (excluding injection material)								
	2711	Electro-encephalography: Taking of record								
	2712	Electro-encephalography: Interpretation								
	6001	Sleep electro-encephalography: infants that fit into a perambulator: taking of record								
	6002	Sleep electro-encephalography: infants that fit into a perambulator: interpretation								
	6003	Sleep electro-encephalography: adults and children over infant age: taking of record								
	6004	Sleep electro-encephalography: adults and children over infant age: interpretation								
	2717	Electromyography: First								
	2718	Electromyography: Subsequent								
	2725	Angiography carotis: Unilateral								
	2726	Angiography carotis: Bilateral								
	2727	Vertebral artery: Direct needling								
	2729	Vertebral catheterisation								
	2731	Air encephalography and posterior fossa tomography: injection of air (independent procedure)								
	2735	Posterior fossa tomography attendance by clinician								
	2737	Visual field charting on Bjerrum Screen								
	2739	Ventricular needling without burring: Tapping only								
	2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography								
	2743	Subdural tapping: First sitting								
	2745	Subdural tapping: Subsequent								
	2765	Nerve conduction studies (see item 0733 and 3285)								
	6005	Botulinum toxin injections: For blepharospasm (+ item 0201+ item 0202)								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6006	Botulinum toxin injections: For hemifacial spasm (+ item 0201 + item 0202)								
6007	Botulinum toxin injections: For adductor disphonia (+ item 0201 + item 0202)								
6008	Botulinum toxin injections: In extra-ocular muscles (+ item 0201 + item 0202)								
6009	Botulinum toxin injections: For spasmodic torticollis and/or cranial dystonia (+ item 0201 + item 0202)								
2789	Trigeminal: Injection of alcohol								
2791	Trigeminal: Injection of cortisone								
2793	Trigeminal: Coagulation through high frequency								
2800	Procedures for pain relief: Plexus nerve block								
2802	Procedures for pain relief: Peripheral nerve block								
2803	Alcohol injection in peripheral nerves for pain: Unilateral								
2805	Alcohol injection in peripheral nerves for pain: Bilateral								
2815	Interdigital								
2849	Sympathetic block: Other levels: Unilateral								
2851	Sympathetic block: Other levels: Bilateral								
2853	Sympathetic block: Other levels: Diagnostic								
2957	Individual psychotherapy (specific type): Including play therapy for children: Per short session (20 minutes)								
2974	Individual psychotherapy (specific type): Including play therapy for children: Per intermediate session (40 minutes)								
2975	Individual psychotherapy (specific type): Including play therapy for children: Per extended session (60 minutes)								
2958	Psychoanalytic therapy: Per 60-minute session								
2962	Directive therapy to family, parent(s), spouse: Per 20 minute session								
2963	Pairs, marriage or sex therapy: Per 20 minute session								
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40 minute session								
2977	Extended treatment where either items 2962 or 2963 are used: Per 60 minute session								
2968	Group therapy								
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)								
2970	Electro-convulsive treatment (ECT): Each time (See rule Va)								
2971	Intravenous anti-depressive medication through infusion: Per push in (Maximum 1 push in per 24 hours)								
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per session								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	15.	ENDOCRINE SYSTEM								
	3001	Implantation of pellets (excluding cost of material)								
	16.	EYE								
	3002	Gonioscopy								
	3003	Fundus contact lens or 90 D lens examination								
	3004	Peripheral fundus examination with indirect opthalmoscope								
	3005	Endothelial cell count								
	3006	Keratometry								
	3007	Potential acuity measurement								
	3008	Contrast sensitivity test								
	3010	Orthoptic consultation								
	3011	Orthoptic subsequent sessions								
	3012	Pre-surgical retinal examination before retinal surgery								
	3013	Ocular motility assessment: Comprehensive examination								
	3014	Tonometry: Per test with maximum of 2 tests for provocative tonometry(one or both eyes)								
	3015	Charting of visual field with manual perimeter								
	3016	Retinal threshold test without storage facilities								
	3017	Retinal threshold test inclusive of computer disc storage for Delta or Statpak programs								
	3018	Retinal threshold trend evaluation (additional to item 3017)								
	3019	Ocular muscle function with Hess screen or perimeter								
	3021	Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations								
	3022	Digital fluorescein video angiography								
	3023	Digital indocyanine video angiography								
	3025	Electronic tonography								
	3027	Fundus photography								
	3029	Anterior segment microphotography								
	3032	Eyelid and orbit photography								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	3033	Interpretation of item 3031 referred by other clinician								
	3034	Determination of lens implant power per eye								
	3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)								
	3060	Use of own surgical microscope for surgery or examination (not for slitlamp microscope) (for use by ophthalmologists only)								
	3074	Adjustment of sutures if not done at the time of operation (additional fee for sterile tray - see item 0202)								
	3089	Subconjunctival injection if not done at time of operation								
	3091	Retrobulbar injection if not done at time of operation								
	3092	External laser treatment for superficial								
	3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)								
	3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for 1 year								
	3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included								
	3117	Cornea: Removal of foreign body: On the basis of fee per consultation								
	3118	Curettage of cornea after removal of foreign body								
	3119	Cornea: Tattooing								
	3124	Removal of corneal stitches under microscope (maximum of 2 procedures) Additional fee for sterile tray (see item 0202)								
	3127	Cauterization of cornea (by chemical, thermal or cryotherapy methods)								
	3141	Sealing of punctum								
	3143	Three-snip operation								
	3163	Excision of superficial lid tumour								
	3167	Diathermy to wart on lid margin								
	3169	Electrolysis of any number of eyelashes								
	3171	Excision of meibomian cyst								
	3174	Botulinum toxin injection for blefarospasm								
	3177	Entropion or ectropion by: Cautery								
	3192	If a practitioner performs the procedure in his own facility an excimer laser theatre fee of R11.10 per minute may be charged								
	3198	Excimer laser: Hire fee								
	3201	Laser apparatus: Hire fee for one or both eyes done in one sitting								
	3202	Phako emulsification apparatus: Hire fee								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3203	Vitrectomy apparatus: Hire fee								
17.	EAR								
3204	External ear canal: Removal of foreign body at rooms								
3206	Microscopic examination of tympanic membrane including microsuction								
3210	Microscope instrument fee used in consulting rooms								
3260	Computerized static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems								
3223	Percutaneous stimulation of the facial nerve								
3224	Electroneurography (ENOG)								
2693	A.E.P. Audiological examination: unilateral at a minimum of 4 decibels: Unilateral								
2694	A.E.P. Audiological examination: unilateral at a minimum of 4 decibels: Bilateral								
2695	Audiology 40Hz response: unilateral								
2696	Audiology 40Hz response: Bilateral								
2697	Mid- and long latency auditory evoked potentials: unilateral								
2698	Mid- and long latency auditory evoked potentials: Bilateral								
3250	Otoacoustic emission (high risk patients only)								
3251	Minimal caloric test (excluding consultation fee)								
3252	Bithermal Halpike caloric test (excluding consultation fee)								
3253	Electro-nystagmography for spontaneous and positional nystagmus								
3254	Video nystagmoscopy (monocular)								
3255	Caloric test done with electro-nystagmography								
3256	Video nystagmoscopy (binocular)								
3273	Pure tone audiometry (air conduction)								
3274	Pure tone audiometry (bone conduction)								
3275	Impedance audiometry (tympanometry)								
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.								
3277	Speech audiometry: Inclusive fee (speech audiogram, speech reception threshold, discrimination score)								
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)								

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Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	2691	Short latency brainstem evoked potentials (A.E.P.) neurological examination, single decibel unilateral								
	2692	Bilateral.								
	18.	PHYSICAL TREATMENT								
	3279	Domiciliary or nursing/home treatment (only applicable where a patient is physically incapable of attending rooms, and equipment has to be transported to patient								
	3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)								
	3281	Ultrasonic therapy								
	3282	Shortwave diathermy								
	3284	Sensory nerve conduction studies								
	3285	Motor nerve conduction studies								
	3287	Spinal joint and ligament injection								
	3289	Multiple injections: First joint								
	3290	Multiple injections: Each additional joint								
	3291	Tendon or ligament injection								
	3292	Aspiration of joint or inter-articular injection								
	3293	Aspiration or injection of bursa or ganglion								
	3294	Paracervical nerve block								
	3295	Paravertebral root block: Unilateral								
	3296	Paravertebral root block: Bilateral								
	3297	Manipulation of spine performed by a specialist in Physical Medicine								
	3298	Spinal traction								
	3300	Manipulation of large joints without anaesthetic								
	3301	Muscle fatigue studies								
	3302	Strength duration curve per session								
	3303	Electromyography								
	3304	All other physical treatment: specify treatment								
	19.	RADIOLOGY								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)								
	3612	Ultrasonic bone densitometry								
	3615	Ultrasonic investigations: Fetal maturity								
	3617	Ultrasonic investigations: Fetal maturity follow up (same pregnancy)								
	3619	Intravascular ultrasound imaging assesses the atherosclerotic process to guide therapeutic interventions. The composition and distribution of the plaque can be visualised by a cross-sectional "slice" of the artery (per vessel)								
	3618	Ultrasonic investigations: Pelvic organs (vaginal or abdominal probe)								
	3620	Ultrasonic investigations: Cardiac examination plus Doppler colour mapping								
	3621	Ultrasonic investigations: Cardiac examination (M.Mode)								
	3622	Ultrasonic investigations: Cardiac examination: 2 Dimensional								
	3623	Ultrasonic investigations: Cardiac examination + effort								
	3624	Ultrasonic investigations: Cardiac examinations + contrast								
	3625	Ultrasonic investigations: Cardiac examinations + doppler								
	3626	Ultrasonic investigations: Cardiac examination + phonocardiography								
	3627	Ultrasonic investigations: Ultrasound examination must include whole abdomen (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)								
	3628	Ultrasonic investigations: Renal tract								
	3629	Ultrasonic investigations: High definition scan (small parts): Thyroid, breast lump, scrotum, etc.								
	3631	Ultrasonic investigations: Ophthalmic examination								
	3632	Ultrasonic investigations: Axial length measurement and calculation of intraocular lens power								
	3634	Ultrasonic investigations: Peripheral vascular scan								
	3635	Ultrasonic investigations: + Doppler								
	3636	Ultrasonic investigations: Trans-oesophageal echocardiography including passing the device.								
	3637	Ultrasonic investigations: + Colour Duplex (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)								

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				10000					11400					11		
	NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2008	Version	Add	CF	Units	BF	Value	Flag	CF	Units	BF	Value	Flag	CF	Units	BF
	The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.□ In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded	2006.06														
	RULES GOVERNING THE STRUCTURE															
A.	Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.	2004.00														
B.	Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 0173-0175, 0161-0164, 0166-0169)	2006.04														
C.	Comparable services: A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicate	2005.02														

D.	Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be	2004.00																
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital	2004.00																
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself	2004.00																
G.	Post-operative care: (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions	2004.00																
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	2004.00																
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.	2004.00																
K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists	2004.00																
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged	2004.00																
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion	2004.00																
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention	2004.00																

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O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme	2004.00																
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner	2004.00																
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221, but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily	2006.05																
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)	2004.00																
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.	2004.00																
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring	2004.00																
U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2814: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the	2004.00																

V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods	2004.00																
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used	2004.00																
Z.	No fee is subject to more than one reduction	2004.00																
AA.	Procedures to exclude cost of isotope	2004.00																
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes	2004.00																
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp	2004.00																
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3818 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter	2004.00																
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.	2004.00																
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years	2004.00																
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").	2004.00																

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XX.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic	2004.00																
YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)	2004.00																
	MODIFIERS GOVERNING THE STRUCTURE																	
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere	2004.00																
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms	2006.05																
0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) proc	2004.00																
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use	2004.00																

0007	a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation - 15,00 clinical procedure units irrespective of the number of items of equipment provided. b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - 15,00 clinical procedure units irrespective of the number of items of equipment provided.	2004.00		20	15.000	1.0	R 105.42		20	15.000	1.0	R 105.42				
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon	2004.00															
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units	2004.00															
0010	Local anaesthesic: (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. (b) The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.	2004.00															
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)	2006.04															
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged	2004.00															
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff	2004.00															
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions	2004.00															

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0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%	2004.00																
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed	2004.00																
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure	2004.00																
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts	2004.00																
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere	2004.00																
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee	2004.00																
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff)	2004.00																
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083	2004.00																
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thoracscope	2004.00		20	45.000	1.0	R	316.26		20	45.000	1.0	R	316.26				
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins	2004.00																
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%	2004.00																
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.	2004.00																
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	2004.00		20	21.000	1.0	R	147.59		20	21.000	1.0	R	147.59				
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)	2004.00																
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure	2004.00																
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)	2004.00																
0080	Multiple examinations: Full Fee	2004.00																
0081	Repeat examinations: No reduction	2004.00																

0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	2005.06		10	7.500	1.0	R	85.12		10	7.500	1.0	R	85.12				
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists	2004.00																
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists	2004.00																
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable	2004.00																
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis	2004.00																
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	2004.00		20	27.000	1.0	R	189.76		20	27.000	1.0	R	189.76				
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	2004.11		20	77.000	1.0	R	541.16		20	77.000	1.0	R	541.16				
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	2004.00		20	115.500	1.0	R	811.73		20	115.500	1.0	R	811.73				
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	2004.11		20	77.000	1.0	R	541.16		20	77.000	1.0	R	541.16				
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90				
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	2004.11		20	77.000	1.0	R	541.16		20	77.000	1.0	R	541.16				
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot	2004.00																

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0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction	2004.00																
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used	2004.00																
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)	2004.00																
0085	Left Side' modifier to be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined	2004.00																
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations	2004.00																
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)	2004.00																
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)	2004.00																
0092	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)	2004.00																
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials	2004.00																
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope	2004.00																
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee	2004.00																
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units	2004.00																
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	2004.00		60	6.000	1.0	R	40.19		60	6.000	1.0	R	40.19				
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%	2004.00																
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes	2004.00																

6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region	2004.00																
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee	2004.00																
6103	Post-contrast study: Bone tumour: 100% of the fee	2004.00																
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable	2004.00																
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items	2004.00																
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00																
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00																
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"	2004.00																
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain	2004.00																
6110	MRI spectroscopy: 50% of fee	2004.00																
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)	2004.00																
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00																
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00																
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure	2004.00																
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value	2004.00																
I.	Consultative Services																	
I.a	General Practitioner visits																	
I.b	Specialists tiered consultation structure																	
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only																	

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0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02																
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02																
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02																
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02																
0166	Psychiatry (22): First hospital consultation/visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes	2006.06																
0167	Psychiatry (22): First hospital consultation/visit with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 21 and 35 minutes	2006.06																
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes	2006.06																
0169	Psychiatry (22): First hospital consultation/visit with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 46 and 60 minutes	2006.06																
I.c	General practitioner and specialist services																	
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0	
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0	

0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02							130	15.000	1.0	R	190.80		10	17.000	1.0
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)	2006.04		10	15.000	1.0	R	170.20	10	15.000	1.0	R	170.20				
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists (may only be charged once per day) (not to be used with items 0109 or ICU items 1204-1214). For a healthy neonate please use item 0109 for a hospital follow-up visit	2006.04															
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes	2006.06	+	10	15.000	1.0	R	170.20	10	15.000	1.0	R	170.20				
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.04	+	10	6.000	1.0	R	68.10	10	6.000	1.0	R	68.10				
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.05	+	10	8.000	1.0	R	90.80	10	8.000	1.0	R	90.80				
0147	For an unscheduled emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.05	+	10	14.000	1.0	R	158.90	10	14.000	1.0	R	158.90				

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0148	For elective after-hours services on request of the patient or family (non emergency) (refer to general rule B): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0146. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the normal hours period as reflected in general rule B.	2006.05	+	10	-	1.0	R	-		10	-	1.0	R	-				
0149	After-hours bona fide emergency consultation/visit (21:00-6:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0149. Note: The after-hour period applicable to this item is from Monday to Sunday 21:00-6:00	2006.05		10	-	1.0	R	-		10	-	1.0	R	-				
I.e	Pre-anaesthetic assessment																	
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes	2006.04								10	16.000	1.0	R	181.60		10	16.000	1.0
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes	2006.04								10	16.000	1.0	R	181.60		10	16.000	1.0
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes	2006.04								10	16.000	1.0	R	181.60		10	16.000	1.0
I.f	Prenatal visits and new born attendance																	
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107)	2006.02		12	33.000	1.0	R	374.50		12	33.000	1.0	R	374.50				
	Item 0107 can be used once only for given confinement	2004.00																
0113	New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113)	2006.02		12	45.000	1.0	R	510.70		12	45.000	1.0	R	510.70				
I.g	Consultative services: Miscellaneous																	
0130	Telephone consultation (all hours)	2004.00								10	12.000	1.0	R	136.20		10	12.000	1.0
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) ("Consultation" via SMS or electronic media included)	2004.00		10	5.000	1.0	R	56.70		10	5.000	1.0	R	56.70				
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent	2004.00		10	9.000	1.0	R	102.10		10	9.000	1.0	R	102.10				
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent	2004.00		10	21.430	1.0	R	243.20		10	21.430	1.0	R	243.20				
II.	Medicine, material, supplies and use of own equipment																	
II.a	Medicine codes																	
II.a.1	Dispensing of medicine by licensed dispensing medical practitioners																	
0197	Licenced dispensing medical practitioners: Dispensing cost - R16.00 for medicine with a cost of R100,00 or more (VAT inclusive), or 16% for medicine costing less than R100,00 (VAT inclusive). Add to each Nappi code to provide for the dispensing cost.	2006.02																

II.a.2	Once-off administration of medicine used during a consultation																
0198	Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS R16,00 for medicine with a cost of R100,00 or more, or 16% for medicine costing less than R100,00 PLUS VAT on the 16%/R16,00. (Where applicable, VAT should be added to the 16%/R 16,00 only and not to the SEP, since the SEP is VAT inclusive). [According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.	2006.02															
II.a.3	Cost of chemotherapy drugs																
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.	2006.02															
II.b	Material codes																
II.b.1	Prosthesis and/or internal fixation																
0200	Prosthesis and/or internal fixation: This item provides for a charge for prosthesis and/or internal fixation. Charge for prosthesis and/or internal fixation at cost price PLUS 26% (up to a maximum of R 26,00). (Where applicable, VAT should be added to the above). The appropriate Nappi code(s), where applicable, for the prosthesis and/or internal fixation used, must be provided.	2006.02															
II.b.2	Material used during a consultation																
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.	2006.02															
II.c	Setting of sterile tray																
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate	2005.06		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30			
II.d	Own equipment used in treatment																
5930	Surgical laser apparatus: Hire fee for own equipment	2004.00		20	109.000	1.0	R	766.10		20	109.000	1.0	R	766.10			
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)	2004.00															
III.	PROCEDURES																
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999	2005.03															
	GENERAL MODIFIERS GOVERNING THIS SECTION																

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0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)	2006.04																	
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged	2004.00																	
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff	2004.00																	
	MODIFIERS GOVERNING SECTION 1																		
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions	2004.00																	
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	2005.06		10	7.500	1.0	R	85.12		10	7.500	1.0	R	85.12					
1	General																		
1.1	Injections, Infusions and Inhalation Sedation Treatment																		
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20					
0204	Inhalation sedation: Per additional quarter-hour or part thereof	2004.00		20	3.000	1.0	R	21.10		20	3.000	1.0	R	21.10					
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30					
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20					
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20					
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20					
0209	Umbilical artery cannulation at birth	2004.00		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50					
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	2004.00		20	3.250	1.0	R	22.80		20	3.250	1.0	R	22.80					
0211	Exchange transfusion: First and subsequent (including after-care)	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20					

	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS:□ Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)	2004.00																
1.2	Chemotherapy treatment (not in chemotherapy facilities)																	
0213	Treatment with cytostatic agents: Administering of Chemotherapy: Intramuscular or subcutaneous: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10				
0214	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous bolus technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30				
0215	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous infusion technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40				
1.3	Oncology related services in non-oncology facilties																	
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included	2006.06		20	394.860	1.0	R	2 775.10	Z	20	315.890	1.0	R	2 220.10	Z			
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included	2006.02		20	262.410	1.0	R	1 844.20	Z	20	209.930	1.0	R	1 475.40	Z			
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included	2006.02		20	77.810	1.0	R	546.80	Z	20	77.810	1.0	R	546.80	Z			
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)	2006.02		20	42.650	1.0	R	299.70	Z	20	42.650	1.0	R	299.70	Z			
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS																	
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.	2006.06																
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see Modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448	2006.04																

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0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.	2006.05																
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.	2006.05																
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.	2006.05																
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units	2006.04																
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute	2006.06																
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic	2006.04																
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute	2006.06																
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time	2006.04																
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added	2006.04																

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0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.	2006.05															
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added	2006.04															
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).	2006.05															
0036	Anaesthetic administered by general practitioners: The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time [refer to modifier 0023] plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.	2006.05															
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	2006.04													30	3.000	1.0
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage	2006.04															
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof	2006.04															
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units	2006.04															
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	2006.04													30	3.000	1.0
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	2006.04													30	3.000	1.0
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added	2006.04													30	3.000	1.0
0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to Modifier 0043: Cases under one year of age	2006.04													30	3.000	1.0
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.	2006.06															

	Modifiers 5441 to 5448□ □ Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items)	2006.04																	
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	2006.04															30	1.000	1.0
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units	2006.04															30	2.000	1.0
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	2006.04															30	3.000	1.0
5444	Shaft of femur: Add four (4,00) anaesthetic units	2006.04															30	4.000	1.0
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	2006.04															30	5.000	1.0
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	2006.04															30	8.000	1.0
	POST-OPERATIVE ALLEVIATION OF PAIN																		
0045	Post-operative alleviation of pain: (a) When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique (b) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (c) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)	2006.04																	
2	Integumentary System																		
2.1	Allergy																		
0217	Allergy: Patch tests: First patch	2004.00		20	4.000	1.0	R	28.10		20	4.000	1.0	R	28.10					
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	2004.00		20	2.800	1.0	R	19.70		20	2.800	1.0	R	19.70					
0219	Allergy: Patch tests: Each additional patch	2004.00		20	2.000	1.0	R	14.10		20	2.000	1.0	R	14.10					
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	2004.00		20	1.900	1.0	R	13.40		20	1.900	1.0	R	13.40					
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	2004.00		20	2.800	1.0	R	19.70		20	2.800	1.0	R	19.70					
2.2	Skin (general)																		
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	2004.00		20	4.000	1.0	R	28.10		20	4.000	1.0	R	28.10					
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20					
0225	Epilation: Per session	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20					
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20		30	4.000	1.0	
0228	PUVA Treatment: Maximum of 21 treatments	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60					

0229	PUVA: Follow-up or maintenance therapy once a week	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60					
0230	UVR-Treatment	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60					
0231	UVR-Follow-up - for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp	2004.00		20	5.500	1.0	R	38.70		20	5.500	1.0	R	38.70					
0233	Biopsy without suturing: First lesion	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20		30	3.000	1.0	
0234	Biopsy without suturing: Subsequent lesions (each)	2004.00		20	3.000	1.0	R	21.10		20	3.000	1.0	R	21.10		30	3.000	1.0	
0235	Biopsy without suturing: Maximum for multiple additional lesions	2004.00		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	3.000	1.0	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30		30	3.000	1.0	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20		30	3.000	1.0	
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	2004.00		20	3.000	1.0	R	21.10		20	3.000	1.0	R	21.10		30	3.000	1.0	
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	2004.00		20	42.000	1.0	R	295.20		20	42.000	1.0	R	295.20		30	3.000	1.0	
0244	Repair of nail bed	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	3.000	1.0	
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	3.000	1.0	
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20		30	3.000	1.0	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	3.000	1.0	
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0	
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0	
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	2004.00		20	87.000	1.0	R	611.40		20	87.000	1.0	R	611.40		30	3.000	1.0	
0259	Removal of foreign body superficial to deep fascia (except hands)	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0	
0261	Removal of foreign body deep to deep fascia (except hands)	2004.00		20	31.000	1.0	R	217.90		20	31.000	1.0	R	217.90		30	3.000	1.0	
0271	Kurtin planing for acne scarring: Whole face	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	4.000	1.0	
0273	Kurtin planing for acne scarring: Extensive	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00		30	4.000	1.0	
0275	Kurtin planing for acne scarring: Limited	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	4.000	1.0	
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	2004.00		20	103.000	1.0	R	723.90		20	103.000	1.0	R	723.90		30	4.000	1.0	
0279	Surgical treatment for axillary hyperhidrosis	2004.00		20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80		30	4.000	1.0	
0280	Laser treatment for small skin lesions: First lesion	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	3.000	1.0	
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20		30	3.000	1.0	
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	2004.00		20	56.000	1.0	R	393.60		20	56.000	1.0	R	393.60		30	3.000	1.0	
0283	Laser treatment for large skin lesions: Limited area	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	4.000	1.0	
0284	Laser treatment for large skin lesions: Extensive area	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00		30	4.000	1.0	
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	4.000	1.0	
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	2004.00		20	56.630	1.0	R	398.00	Z	20	56.630	1.0	R	398.00	Z				
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	2004.00		20	43.440	1.0	R	305.30	Z	20	43.440	1.0	R	305.30	Z				
2.3	Major plastic repair																		
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	2004.00		20	234.000	1.0	R	1 644.60		20	187.200	1.0	R	1 315.60		30	4.000	1.0	
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	2004.00		20	410.000	1.0	R	2 881.50		20	328.000	1.0	R	2 305.20		30	4.000	1.0	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	2004.00		20	800.000	1.0	R	5 622.40		20	640.000	1.0	R	4 497.90		30	4.000	1.0	
0292	Distant flaps: First stage	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	4.000	1.0	
0293	Contour grafts (excluding cost of material)	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	4.000	1.0	

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0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	2004.11		20	1200.000	1.0	R 8 433.60		20	960.000	1.0	R 6 746.90		30	6.000	1.0
0295	Local skin flaps (large, complicated)	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
0296	Other procedures of major technical nature	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
0297	Subsequent major procedures for repair of same lesion	2004.00		20	104.000	1.0	R 730.90		20	104.000	1.0	R 730.90		30	4.000	1.0
0298	Lower abdominal dermo-lipectomy	2004.00		20	170.000	1.0	R 1 194.80		20	136.000	1.0	R 955.80		30	5.000	1.0
0299	Major abdominal lipectomy with repositioning of umbilicus	2004.00		20	275.000	1.0	R 1 932.70		20	220.000	1.0	R 1 546.20		30	5.000	1.0
2.4	Lacerations, scars, tumours, cysts and other skin lesions															
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40		30	3.000	1.0
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	2004.00		20	7.000	1.0	R 49.20		20	7.000	1.0	R 49.20		30	3.000	1.0
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80		30	4.000	1.0
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	4.000	1.0
0304	Major debridement of wound, sloughectomy or secondary suture	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	3.000	1.0
0305	Needle biopsy - soft tissue	2004.00		20	25.000	1.0	R 175.70		20	25.000	1.0	R 175.70		30	3.000	1.0
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	2004.00		20	27.000	1.0	R 189.80		20	27.000	1.0	R 189.80		30	3.000	1.0
0308	Each additional small procedure done at the same time	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40		30	3.000	1.0
0310	Radical excision of nailbed	2004.00		20	38.000	1.0	R 267.10		20	38.000	1.0	R 267.10		30	3.000	1.0
0311	Excision of large benign tumour (more than 5 cm)	2004.00		20	55.000	1.0	R 386.50		20	55.000	1.0	R 386.50		30	3.000	1.0
0313	Extensive resection for malignant soft tissue tumour including muscle	2004.00		20	283.900	1.0	R 1 995.20		20	227.120	1.0	R 1 596.20		30	4.000	1.0
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	2004.00		20	104.000	1.0	R 730.90		20	104.000	1.0	R 730.90		30	4.000	1.0
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	2004.00		20	55.000	1.0	R 386.50		20	55.000	1.0	R 386.50		30	3.000	1.0
2.5	Breasts															
0316	Fine needle aspiration for soft tissue (all areas)	2004.00		20	15.000	1.0	R 105.40		20	15.000	1.0	R 105.40				
0317	Aspiration of cyst or tumour	2004.00		20	9.000	1.0	R 63.30		20	9.000	1.0	R 63.30		30	3.000	1.0
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	2004.00		20	42.000	1.0	R 295.20		20	42.000	1.0	R 295.20		30	3.000	1.0
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	2004.00		20	94.200	1.0	R 662.00		20	94.200	1.0	R 662.00		30	3.000	1.0
0323	Subareolar cone excision of ducts of wedge excision of breast	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	3.000	1.0
0324	Wedge excision of breast and axillary dissection	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	5.000	1.0
0325	Total mastectomy	2004.00		20	155.000	1.0	R 1 089.30		20	124.000	1.0	R 871.50		30	5.000	1.0
0327	Total mastectomy with axillary gland biopsy	2004.00		20	185.000	1.0	R 1 300.20		20	148.000	1.0	R 1 040.10		30	5.000	1.0
0329	Total mastectomy with axillary gland dissection	2004.00		20	275.000	1.0	R 1 932.70		20	220.000	1.0	R 1 546.20		30	5.000	1.0
0330	Nipple and areola reconstruction	2004.00		20	95.000	1.0	R 667.70		20	95.000	1.0	R 667.70		30	4.000	1.0
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	2004.00		20	234.000	1.0	R 1 644.60		20	187.200	1.0	R 1 315.60		30	4.000	1.0
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	2004.00		20	410.000	1.0	R 2 881.50		20	328.000	1.0	R 2 305.20		30	4.000	1.0
0334	Removal of breast implant by means of capsulectomy: Per breast	2004.00		20	234.000	1.0	R 1 644.60		20	187.200	1.0	R 1 315.60		30	4.000	1.0
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	4.000	1.0
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	2004.00		20	234.000	1.0	R 1 644.60		20	187.200	1.0	R 1 315.60		30	5.000	1.0
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	2004.00		20	410.000	1.0	R 2 881.50		20	328.000	1.0	R 2 305.20		30	5.000	1.0
0341	Gynaecomastia: Unilateral	2004.00		20	92.000	1.0	R 646.60		20	92.000	1.0	R 646.60		30	3.000	1.0
0343	Gynaecomastia: Bilateral	2004.00		20	161.000	1.0	R 1 131.50		20	128.800	1.0	R 905.20		30	3.000	1.0
2.6	Burns															

0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	2004.00		20	276.000	1.0	R 1 939.70		20	220.800	1.0	R 1 551.80		30	5.000	1.0
0353	Tangential excision and grafting: Small	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	5.000	1.0
0354	Tangential excision and grafting: Large	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	5.000	1.0
2.7	Hands (skin)															
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	2004.00		20	147.400	1.0	R 1 035.90		20	120.000	1.0	R 843.40		30	4.000	1.0
0357	Small skin graft in acute hand injury	2004.00		20	45.000	1.0	R 316.30		20	45.000	1.0	R 316.30		30	3.000	1.0
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	2004.00		20	192.000	1.0	R 1 349.40		20	153.600	1.0	R 1 079.50		30	3.000	1.0
0361	Z-plasty	2004.00		20	220.100	1.0	R 1 546.90		20	176.080	1.0	R 1 237.50		30	3.000	1.0
0363	Local flap and skin graft	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	3.000	1.0
0365	Cross finger flap (all stages)	2004.00		20	192.000	1.0	R 1 349.40		20	153.600	1.0	R 1 079.50		30	3.000	1.0
0367	Palmar flap (all stages)	2004.00		20	192.000	1.0	R 1 349.40		20	153.600	1.0	R 1 079.50		30	3.000	1.0
0369	Distant flap: First stage	2004.00		20	158.000	1.0	R 1 110.40		20	126.400	1.0	R 888.30		30	3.000	1.0
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	3.000	1.0
0373	Transfer neurovascular island flap	2004.00		20	230.500	1.0	R 1 620.00		20	184.400	1.0	R 1 296.00		30	3.000	1.0
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	2004.00		20	242.400	1.0	R 1 703.60		20	193.920	1.0	R 1 362.90		30	3.000	1.0
0375	Dupuytren's contracture: Fasciotomy	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	3.000	1.0
0376	Dupuytren's contracture: Fasciectomy	2004.00		20	218.000	1.0	R 1 532.10		20	174.400	1.0	R 1 225.70		30	3.000	1.0
2.8	Acupuncture															
	Please note: General Rule M not applicable to section 2.8 of this price list	2004.00														
0377	Standard acupuncture	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
0378	Laser acupuncture using more than 6 points	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40				
0379	Electro-acupuncture	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40				
0380	Scalp acupuncture	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
0381	Micro-acupuncture (ear, hand)	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
	RULES GOVERNING THE SECTION ACUPUNCTURE															
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp	2004.00														
3	Musculo-skeletal System															
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS															
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis	2004.00														
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	2004.00		20	27.000	1.0	R 189.76		20	27.000	1.0	R 189.76				
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	2004.11		20	77.000	1.0	R 541.16		20	77.000	1.0	R 541.16				

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0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	2004.00		20	115.500	1.0	R	811.73		20	115.500	1.0	R	811.73				
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	2004.11		20	77.000	1.0	R	541.16		20	77.000	1.0	R	541.16				
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90				
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	2004.11		20	77.000	1.0	R	541.16		20	77.000	1.0	R	541.16				
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot	2004.00																
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%	2004.00																
3.1	Bones																	
3.1.1	Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)																	
0383	Fracture (reduction under general anaesthetic): Scapula	2004.00		20	-	1.0	R	-	V	20	-	1.0	R	-	V	30	3.000	1.0
0387	Fracture (reduction under general anaesthetic): Clavicle	2004.00		20	77.000	1.0	R	541.20		20	77.000	1.0	R	541.20		30	3.000	1.0
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	2004.00		20	175.700	1.0	R	1 234.80		20	140.560	1.0	R	987.90		30	3.000	1.0
0389	Fracture (reduction under general anaesthetic): Humerus	2004.00		20	111.600	1.0	R	784.30		20	111.600	1.0	R	784.30		30	3.000	1.0
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	2004.00		20	77.000	1.0	R	541.20		20	77.000	1.0	R	541.20		30	3.000	1.0
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	3.000	1.0
0402	Fracture (reduction under general anaesthetic): Carpal bone	2004.00		20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80		30	3.000	1.0
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	2004.00		20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40		30	3.000	1.0
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	2004.00		20	118.300	1.0	R	831.40		20	118.300	1.0	R	831.40		30	3.000	1.0
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	2004.00		20	-	1.0	R	-	ß	20	-	1.0	R	-	ß	30	3.000	1.0
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	2004.00		20	52.000	1.0	R	365.50		20	52.000	1.0	R	365.50		30	3.000	1.0
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	2004.00		20	48.000	1.0	R	337.30		20	48.000	1.0	R	337.30		30	3.000	1.0
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	2004.00		20	102.000	1.0	R	716.90		20	102.000	1.0	R	716.90		30	3.000	1.0
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	2004.00		20	-	0.0	R	-	ß	20	-	0.0	R	-	ß	30	3.000	1.0
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	2004.00		20	320.000	1.0	R	2 249.00		20	256.000	1.0	R	1 799.20		30	3.000	1.0
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	2004.00		20	237.000	1.0	R	1 665.60		20	189.600	1.0	R	1 332.50		30	3.000	1.0
0425	Fracture (reduction under general anaesthetic): Patella	2004.00		20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40		30	3.000	1.0
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	2004.00		20	128.000	1.0	R	899.60		20	120.000	1.0	R	843.40		30	3.000	1.0
0433	Fracture (reduction under general anaesthetic): Fibula shaft	2004.00		20	-	0.0	R	-	ß	20	-	0.0	R	-	ß	30	3.000	1.0
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	2004.00		20	58.000	1.0	R	407.60		20	58.000	1.0	R	407.60		30	3.000	1.0

0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	2004.00		20	198.700	1.0	R 1 396.50		20	158.960	1.0	R 1 117.20		30	3.000	1.0
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80		30	3.000	1.0
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	2004.00		20	403.500	1.0	R 2 835.80		20	322.500	1.0	R 2 266.50		30	3.000	1.0
0441	Fracture (reduction under general anaesthetic): Metatarsal	2004.00		20	41.800	1.0	R 293.80		20	41.800	1.0	R 293.80		30	3.000	1.0
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal Simple	2004.00		20	-	0.0	R -	ß	20	-	0.0	R -	ß	30	3.000	1.0
0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound	2004.00		20	32.000	1.0	R 224.90		20	32.000	1.0	R 224.90		30	3.000	1.0
0447	Fracture (reduction under general anaesthetic): Other: Simple	2004.00		20	26.000	1.0	R 182.70		20	26.000	1.0	R 182.70		30	3.000	1.0
0449	Fracture (reduction under general anaesthetic): Other: Compound	2004.00		20	52.000	1.0	R 365.50		20	52.000	1.0	R 365.50		30	3.000	1.0
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed	2004.00		20	-	0.0	R -	ß	20	-	0.0	R -	ß	30	3.000	1.0
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	2004.00		20	230.000	1.0	R 1 616.40		20	184.000	1.0	R 1 293.20		30	3.000	1.0
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical	2004.00		20	-	0.0	R -	ß	20	-	0.0	R -	ß	30	3.000	1.0
0456	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Rest	2004.00		20	-	0.0	R -	ß	20	-	0.0	R -	ß	30	3.000	1.0
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical	2004.00		20	-	0.0	R -	v	20	-	0.0	R -	v	30	3.000	1.0
0462	Fracture (reduction under general anaesthetic): Compression fracture: Rest	2004.00		20	-	0.0	R -	v	20	-	0.0	R -	v	30	3.000	1.0
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical	2004.00		20	-	0.0	R -	v	20	-	0.0	R -	v	30	3.000	1.0
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest	2004.00		20	-	0.0	R -	v	20	-	0.0	R -	v	30	3.000	1.0
3.1.1.1	Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047): Operations for fractures															
0465	Fractures involving large joints (includes the item for the relative bone) (this item may not be used as a modifier)	2004.00		20	288.000	1.0	R 2 024.10		20	230.400	1.0	R 1 619.30		30	3.000	1.0
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	2004.00		20	43.000	1.0	R 302.20		20	43.000	1.0	R 302.20		30	3.000	1.0
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	2004.00		20	282.000	1.0	R 1 981.90		20	225.600	1.0	R 1 585.50		30	3.000	1.0
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	2004.00		20	154.000	1.0	R 1 082.30		20	123.200	1.0	R 865.80		30	3.000	1.0
3.1.2	Bony operations															
3.1.2.1	Bony operations: Bone grafting															
0497	Resection of bone or tumour with or without grafting (benign)	2004.00		20	282.000	1.0	R 1 981.90		20	225.600	1.0	R 1 585.50		30	3.000	1.0
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits	2004.00		20	340.000	1.0	R 2 389.50		20	272.000	1.0	R 1 911.60		30	3.000	1.0
0499	Grafts to cysts: Large bones	2004.00		20	192.000	1.0	R 1 349.40		20	153.600	1.0	R 1 079.50		30	3.000	1.0
0501	Grafts to cysts: Small bones	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0503	Grafts to cysts: Cartilage graft	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	3.000	1.0
0505	Grafts to cysts: Inter-metacarpal bone graft	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	3.000	1.0
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	3.000	1.0
3.1.2.2	Bony operations: Acute or chronic osteomyelitis															
0509	Acute or chronic osteomyelitis: Conservative treatment	2004.00		20	-	1.0	R -	v	20	-	1.0	R -	v			
0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care	2004.00														
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including six weeks after-care	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
3.1.2.3	Bony operations: Osteotomy															

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0514	Osteotomy: Sternum: Repair of pectus excavatum	2004.00		20	330.000	1.0	R 2 319.20		20	264.000	1.0	R 1 855.40		30	3.000	1.0
0515	Osteotomy: Sternum: Repair of pectus carinatum	2004.00		20	330.000	1.0	R 2 319.20		20	264.000	1.0	R 1 855.40		30	3.000	1.0
0516	Osteotomy: Pelvic	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	3.000	1.0
0521	Osteotomy: Femoral: Proximal	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	3.000	1.0
0527	Osteotomy: Knee region	2004.11		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	3.000	1.0
0528	Osteotomy: Os Calcis (Dwyer operation)	2004.00		20	115.000	1.0	R 808.20		20	115.000	1.0	R 808.20		30	3.000	1.0
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation	2004.00		20	120.000	1.0	R 843.40		20	120.000	1.0	R 843.40		30	3.000	1.0
0531	Rotational osteotomy of tibia and fibula - stand alone procedure	2004.00		20	278.900	1.0	R 1 960.10		20	223.120	1.0	R 1 568.10		30	3.000	1.0
0532	Osteotomy: Rotation osteotomy of the Radius, Ulna or Humerus	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	3.000	1.0
0533	Osteotomy: Single metatarsal	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	3.000	1.0
0534	Osteotomy: Multiple metatarsal osteotomies	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	3.000	1.0
3.1.2.4	Bony operations: Exostosis															
0535	Exostosis: Excision: Readily accessible sites	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	3.000	1.0
0537	Exostosis: Excision: Less accessible sites	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
3.1.2.5	Bony operations: Biopsy															
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	4.000	1.0
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)	2004.00		20	32.000	1.0	R 224.90		20	32.000	1.0	R 224.90		30	4.000	1.0
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80				
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70				
3.2	Joints															
3.2.1	Joints: Dislocations															
0547	Joint: Dislocation: Clavicle either end	2004.00		20	38.000	1.0	R 267.10		20	38.000	1.0	R 267.10		30	3.000	1.0
0549	Joint: Dislocation: Shoulder	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	3.000	1.0
0551	Joint: Dislocation: Elbow	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	3.000	1.0
0552	Joint: Dislocation: Wrist	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	3.000	1.0
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation	2004.00		20	130.000	1.0	R 913.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0555	Joint: Dislocation: Lunate	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	3.000	1.0
0556	Joint: Dislocation: Carpo-metacarpo dislocation	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	3.000	1.0
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)	2004.00		20	26.000	1.0	R 182.70		20	26.000	1.0	R 182.70		30	3.000	1.0
0559	Joint: Dislocation: Hip	2004.00		20	109.000	1.0	R 766.10		20	109.000	1.0	R 766.10		30	3.000	1.0
0561	Joint: Dislocation: Knee	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
0563	Joint: Dislocation: Patella	2004.00		20	32.000	1.0	R 224.90		20	32.000	1.0	R 224.90		30	3.000	1.0
0565	Joint: Dislocation: Ankle	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	3.000	1.0
0567	Joint: Dislocation: Sub-Talar dislocation	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	3.000	1.0
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	3.000	1.0
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40		30	3.000	1.0
0573	Joint: Dislocation: Spine with or without paralysis	2004.00		20	-	0.0	R -	v	20	-	0.0	R -	v			
3.2.2	Joints: Operations for dislocations															
0578	Operations for dislocations: Recurrent dislocation of shoulder	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	3.000	1.0
0579	Operations for dislocations: Recurrent dislocation of all other joints	2004.00		20	161.000	1.0	R 1 131.50		20	128.800	1.0	R 905.20		30	3.000	1.0
3.2.3	Joints: Capsular operations															
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	3.000	1.0
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0

0585	Capsulectomy digital joint	2004.00		20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80		30	3.000	1.0
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	2004.00		20	90.000	1.0	R	632.50		20	90.000	1.0	R	632.50		30	3.000	1.0
0587	Release of digital joint contracture	2004.00		20	128.000	1.0	R	899.60		20	120.000	1.0	R	843.40		30	3.000	1.0
3.2.4	Joints: Synovectomy																	
0589	Synovectomy: Digital joint	2004.00		20	77.000	1.0	R	541.20		20	77.000	1.0	R	541.20		30	3.000	1.0
0592	Synovectomy: Large joint	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0593	Tendon synovectomy	2004.00		20	203.700	1.0	R	1 431.60		20	162.960	1.0	R	1 145.30		30	3.000	1.0
3.2.5	Joints: Arthrodesis																	
0597	Arthrodesis: Shoulder	2004.00		20	224.000	1.0	R	1 574.30		20	179.200	1.0	R	1 259.40		30	3.000	1.0
0598	Arthrodesis: Elbow	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
0599	Arthrodesis: Wrist	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
0600	Arthrodesis: Digital joint	2004.00		20	128.000	1.0	R	899.60		20	120.000	1.0	R	843.40		30	3.000	1.0
0601	Arthrodesis: Hip	2004.00		20	320.000	1.0	R	2 249.00		20	256.000	1.0	R	1 799.20		30	3.000	1.0
0602	Arthrodesis: Knee	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
0603	Arthrodesis: Ankle	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
0604	Arthrodesis: Sub-talar	2004.00		20	130.000	1.0	R	913.60		20	120.000	1.0	R	843.40		30	3.000	1.0
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
0607	Arthrodesis: Mid-tarsal wedge resection	2004.00		20	180.000	1.0	R	1 265.00		20	144.000	1.0	R	1 012.00		30	3.000	1.0
3.2.6	Joints: Arthroplasty																	
0614	Arthroplasty: Debridement large joints	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0615	Arthroplasty: Excision medial or lateral end of clavicle	2004.00		20	116.000	1.0	R	815.20		20	116.000	1.0	R	815.20		30	3.000	1.0
0617	Shoulder: Acromioplasty	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
0619	Shoulder: Partial replacement	2004.00		20	277.000	1.0	R	1 946.80		20	221.600	1.0	R	1 557.40		30	5.000	1.0
0620	Shoulder: Total replacement	2004.00		20	416.000	1.0	R	2 923.60		20	332.800	1.0	R	2 338.90		30	5.000	1.0
0621	Elbow: Excision head of radius	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
0622	Elbow: Excision	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
0623	Elbow: Partial replacement	2004.00		20	188.000	1.0	R	1 321.30		20	150.400	1.0	R	1 057.00		30	3.000	1.0
0624	Elbow: Total replacement	2004.00		20	282.000	1.0	R	1 981.90		20	225.600	1.0	R	1 585.50		30	3.000	1.0
0625	Wrist: Excision distal end of ulna	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
0626	Wrist: Excision single bone	2004.00		20	110.000	1.0	R	773.10		20	110.000	1.0	R	773.10		30	3.000	1.0
0627	Wrist: Excision proximal row	2004.00		20	166.000	1.0	R	1 166.60		20	132.800	1.0	R	933.30		30	3.000	1.0
0631	Wrist: Total replacement	2004.00		20	249.000	1.0	R	1 750.00		20	199.200	1.0	R	1 400.00		30	3.000	1.0
0635	Digital Joint: Total replacement	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
0637	Hip: Total replacement	2004.00		20	416.000	1.0	R	2 923.60		20	332.800	1.0	R	2 338.90		30	3.000	1.0
0641	Hip: Prosthetic replacement of femoral head	2004.00		20	288.000	1.0	R	2 024.10		20	230.400	1.0	R	1 619.30		30	3.000	1.0
0643	Hip: Girdlestone	2004.00		20	320.000	1.0	R	2 249.00		20	256.000	1.0	R	1 799.20		30	3.000	1.0
0645	Knee: Partial replacement	2004.00		20	277.000	1.0	R	1 946.80		20	221.600	1.0	R	1 557.40		30	3.000	1.0
0646	Knee: Total replacement	2004.00		20	416.000	1.0	R	2 923.60		20	332.800	1.0	R	2 338.90		30	3.000	1.0
0649	Ankle: Total replacement	2004.00		20	290.400	1.0	R	2 040.90		20	232.320	1.0	R	1 632.70		30	3.000	1.0
0650	Ankle: Astragalectomy	2004.00		20	154.000	1.0	R	1 082.30		20	123.200	1.0	R	865.80		30	3.000	1.0
3.2.7	Joints: Miscellaneous (joints)																	
0661	Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30		30	3.000	1.0
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint	2004.00		20	7.500	1.0	R	52.70		20	7.500	1.0	R	52.70		30	3.000	1.0

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0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	2004.00		20	4.000	1.0	R	28.10		20	4.000	1.0	R	28.10		30	3.000	1.0
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	2004.00		20	60.000	1.0	R	421.70		20	60.000	1.0	R	421.70		30	3.000	1.0
0669	Manipulation large joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	3.000	1.0
0669a	Manipulation large joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	2005.01		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	4.000	1.0
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic	2006.04		20	-	0.0	R	-	F	20	-	0.0	R	-	F	30	3.000	1.0
0670a	The consultation fee only should be charged when manipulation of a large joint is performed with or without local anaesthetic	2005.01		20	-	0.0	R	-	F	20	-	0.0	R	-	F	30	4.000	1.0
0673	Meniscectomy or operation for other internal derangement of knee	2004.00		20	109.000	1.0	R	766.10		20	109.000	1.0	R	766.10		30	3.000	1.0
3.2.8	Joints: Joint ligament reconstruction or suture																	
0675	Joint ligament reconstruction or suture: Ankle: Collateral	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0677	Joint ligament reconstruction or suture: Knee: Collateral	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0678	Joint ligament reconstruction or suture: Knee: Cruciate	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	2004.00		20	280.000	1.0	R	1 967.80		20	224.000	1.0	R	1 574.30		30	3.000	1.0
0680	Joint ligament reconstruction or suture: Digital joint ligament	2004.00		20	165.000	1.0	R	1 159.60		20	132.000	1.0	R	927.70		30	3.000	1.0
3.3	Amputations																	
3.3.1	Amputations: Specific Amputations																	
0682	Amputation: Fore-quarter amputation	2004.00		20	294.000	1.0	R	2 066.20		20	235.200	1.0	R	1 653.00		30	9.000	1.0
0683	Amputation: Through shoulder	2004.00		20	148.000	1.0	R	1 040.10		20	120.000	1.0	R	843.40		30	5.000	1.0
0685	Amputation: Upper arm or fore-arm	2004.00		20	116.000	1.0	R	815.20		20	116.000	1.0	R	815.20		30	3.000	1.0
0687	Partial amputation of the hand: One ray	2004.00		20	102.000	1.0	R	716.90		20	102.000	1.0	R	716.90		30	3.000	1.0
0691	Amputation: Whole or part of finger	2006.04		20	116.800	1.0	R	820.90		20	116.800	1.0	R	820.90		30	3.000	1.0
0693	Hindquarter amputation	2004.00		20	420.000	1.0	R	2 951.80		20	336.000	1.0	R	2 361.40		30	6.000	1.0
0695	Amputation: Through hip joint region	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	6.000	1.0
0697	Amputation: Through thigh	2004.00		20	205.000	1.0	R	1 440.70		20	164.000	1.0	R	1 152.60		30	6.000	1.0
0699	Amputation: Below knee, through knee or Syme	2004.00		20	194.000	1.0	R	1 363.40		20	155.200	1.0	R	1 090.70		30	5.000	1.0
0701	Amputation: Trans-metatarsal or trans-tarsal	2004.00		20	142.000	1.0	R	998.00		20	120.000	1.0	R	843.40		30	3.000	1.0
0703	Amputation: Foot: One ray	2004.00		20	97.000	1.0	R	681.70		20	97.000	1.0	R	681.70		30	3.000	1.0
0705	Amputation: Toe	2004.00		20	66.000	1.0	R	463.80		20	66.000	1.0	R	463.80		30	3.000	1.0
3.3.2	Amputations: Post-amputation reconstruction																	
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	2004.00		20	75.000	1.0	R	527.10		20	75.000	1.0	R	527.10		30	3.000	1.0
0707	Post-amputation reconstruction: Krukenberg reconstruction	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	3.000	1.0
0709	Post-amputation reconstruction: Metacarpal transfer	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	2004.00		20	282.000	1.0	R	1 981.90		20	225.600	1.0	R	1 585.50		30	3.000	1.0
0712	Post-amputation reconstruction: Toe to thumb transfer	2004.00		20	800.000	1.0	R	5 622.40		20	640.000	1.0	R	4 497.90		30	3.000	1.0
3.4	Muscles, tendons and fasciae																	
3.4.1	Muscles, tendons and fasciae: Investigations																	
0713	Electromyography	2004.00		20	75.000	1.0	R	527.10		20	75.000	1.0	R	527.10		30	3.000	1.0
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)	2006.04		20	57.000	1.0	R	400.60		20	57.000	1.0	R	400.60		30	3.000	1.0
0715	Strength duration curve per session	2004.00		20	10.500	1.0	R	73.80		20	10.500	1.0	R	73.80		30	3.000	1.0

0717	Electrical examination of single nerve or muscle	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30		30	3.000	1.0
0718	Oxidative study for mitochondrial function	2004.00		20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80				
0721	Voltage integration during isometric contraction	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30		30	3.000	1.0
0723	Tonometry with edrophonium	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20		30	3.000	1.0
0725	Isometric tension studies with edrophonium	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20		30	3.000	1.0
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	3.000	1.0
0729	Tendon reflex time	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20		30	3.000	1.0
0730	Limb brain somatosensory studies (per limb)	2004.00		20	49.000	1.0	R	344.40		20	49.000	1.0	R	344.40				
0731	Vision and audio-sensory studies	2004.00		20	49.000	1.0	R	344.40		20	49.000	1.0	R	344.40				
0733	Motor nerve conduction studies (single nerve)	2004.00		20	26.000	1.0	R	182.70		20	26.000	1.0	R	182.70				
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	2004.00		20	31.000	1.0	R	217.90		20	31.000	1.0	R	217.90		30	3.000	1.0
0737	Biopsy for motor nerve terminals and end plates	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	2004.00		20	34.000	1.0	R	239.00		20	34.000	1.0	R	239.00		30	8.000	1.0
0740	Muscle fatigue studies	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0
0741	Muscle biopsy	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	8.000	1.0
0742	Global fee for all muscle studies, including histochemical studies	2004.00		20	262.000	1.0	R	1 841.30										
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	2004.00		20	20.250	1.0	R	142.30										
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	2004.00		20	33.300	1.0	R	234.00										
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	2004.00		20	5.700	1.0	R	40.10										
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	2004.00		20	1.600	1.0	R	11.20										
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	2004.00		20	9.900	1.0	R	69.60										
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	2004.00		20	13.700	1.0	R	96.30										
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	2004.00		20	25.900	1.0	R	182.00										
4715	Biochemical estimations on muscle biopsy specimens: Enolase	2004.00		20	32.700	1.0	R	229.80										
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	2004.00		20	37.700	1.0	R	265.00										
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	2004.00		20	15.750	1.0	R	110.70										
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	2004.00		20	11.060	1.0	R	77.70										
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	2004.00		20	34.700	1.0	R	243.90										
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	2004.00		20	40.300	1.0	R	283.20										
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose isomerase	2004.00		20	28.800	1.0	R	202.40										
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	2004.00		20	43.000	1.0	R	302.20										
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	2004.00		20	14.000	1.0	R	98.40										
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	2004.00		20	20.000	1.0	R	140.60										
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	2004.00		20	71.000	1.0	R	499.00										
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	2004.00		20	69.000	1.0	R	484.90										
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation	2004.00		20	82.000	1.0	R	576.30										
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	2004.00		20	143.000	1.0	R	1 005.00										
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	2004.00		20	75.000	1.0	R	527.10										
3.4.2	Muscles, tendons and fasciae: Decompression Operations																	
0743	Major compartmental decompression	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	3.000	1.0

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0744	Decompression operation: Fasciotomy only	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	3.000	1.0
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair															
0745	Muscle and tendon repair: Biceps humeri	2004.00		20	109.000	1.0	R 766.10		20	109.000	1.0	R 766.10		30	3.000	1.0
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
0747	Muscle and tendon repair: Rotator cuff	2004.00		20	134.000	1.0	R 941.80		20	120.000	1.0	R 843.40		30	4.000	1.0
0748	Muscle and tendon repair: Debridement rotator cuff	2004.00		20	139.700	1.0	R 981.80		20	120.000	1.0	R 843.40		30	4.000	1.0
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	2004.00		20	271.900	1.0	R 1 910.90		20	217.520	1.0	R 1 528.70		30	4.000	1.0
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0757	Muscle and tendon repair: Achilles tendon repair	2004.00		20	197.600	1.0	R 1 388.70		20	158.080	1.0	R 1 111.00		30	4.000	1.0
0759	Muscle and tendon repair: Other single tendon	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	3.000	1.0
0763	Muscle and tendon repair: Tendon or ligament injection	2004.00		20	9.000	1.0	R 63.30		20	9.000	1.0	R 63.30		30	3.000	1.0
0767	Hand: Flexor tendon suture: Primary (per tendon)	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0769	Hand: Flexor tendon suture: Secondary (per tendon)	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	3.000	1.0
0771	Extensor tendon suture: Primary (per tendon)	2004.00		20	129.700	1.0	R 911.50		20	120.000	1.0	R 843.40		30	3.000	1.0
0773	Extensor tendon suture: Secondary (per tendon)	2004.00		20	80.000	1.0	R 562.20		20	80.000	1.0	R 562.20		30	3.000	1.0
0774	Repair of Boutonniere deformity or Mallet finger with graft	2004.00		20	183.700	1.0	R 1 291.00		20	146.960	1.0	R 1 032.80		30	3.000	1.0
3.4.4	Muscles, tendons and fasciae: Tendon graft															
0775	Free tendon graft	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	3.000	1.0
0776	Reconstruction of pulley for flexor tendon	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	3.000	1.0
0777	Tendon graft: Finger: Flexor	2004.00		20	192.000	1.0	R 1 349.40		20	153.600	1.0	R 1 079.50		30	3.000	1.0
0779	Tendon graft: Finger: Extensor	2004.00		20	122.000	1.0	R 857.40		20	120.000	1.0	R 843.40		30	3.000	1.0
0780	Two stage flexor tendon graft using silastic rod	2004.00		20	240.000	1.0	R 1 686.70		20	192.000	1.0	R 1 349.40		30	3.000	1.0
3.4.5	Muscles, tendons and fasciae: Tendolysis															
0781	Tendon freeing operation, except where specified elsewhere	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80		30	3.000	1.0
0782	Carpal tunnel syndrome	2004.00		20	98.700	1.0	R 693.70		20	98.700	1.0	R 693.70		30	3.000	1.0
0783	Tenolysis: De Quervain	2004.00		20	38.000	1.0	R 267.10		20	38.000	1.0	R 267.10		30	3.000	1.0
0784	Trigger finger	2004.00		20	38.000	1.0	R 267.10		20	38.000	1.0	R 267.10		30	3.000	1.0
0785	Flexor tendon freeing operation following free tendon graft or suture	2004.00		20	186.800	1.0	R 1 312.80		20	149.440	1.0	R 1 050.30		30	3.000	1.0
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	2004.00		20	180.900	1.0	R 1 271.40		20	144.720	1.0	R 1 017.10		30	3.000	1.0
0788	Intrinsic tendon release per finger	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80		30	3.000	1.0
0789	Central tendon tenotomy for Boutonniere deformity	2004.00		20	64.000	1.0	R 449.80		20	64.000	1.0	R 449.80		30	3.000	1.0
3.4.6	Muscles, tendons and fasciae: Tenodesis															
0790	Tenodesis: Digital joint	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	3.000	1.0
3.4.7	Muscles, tendons and fasciae: Muscle tendon and facia transfer															
0791	Single tendon transfer	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
0792	Multiple tendon transfer	2004.00		20	128.000	1.0	R 899.60		20	120.000	1.0	R 843.40		30	3.000	1.0
0793	Hamstring to quadriceps transfer	2004.00		20	141.000	1.0	R 990.90		20	120.000	1.0	R 843.40		30	3.000	1.0
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	5.000	1.0
0795	Tendon transfer at elbow	2004.00		20	116.000	1.0	R 815.20		20	116.000	1.0	R 815.20		30	3.000	1.0
0802	Radial club hand repair - stand alone procedure	2004.00		20	360.300	1.0	R 2 532.20		20	288.240	1.0	R 2 025.80		30	3.000	1.0
0803	Hand tendons: Single tendon transfer (first)	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
0809	Hand tendons: Substitution for intrinsic paralysis of hand	2004.00		20	224.000	1.0	R 1 574.30		20	179.200	1.0	R 1 259.40		30	3.000	1.0
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	2004.00		20	220.600	1.0	R 1 550.40		20	176.480	1.0	R 1 240.30		30	3.000	1.0
3.4.8	Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening															

0812	Percutaneous Tenotomy: All sites	2004.00		20	38.000	1.0	R	267.10		20	38.000	1.0	R	267.10		30	3.000	1.0
0813	Torticollis	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	5.000	1.0
0815	Scalenotomy	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	5.000	1.0
0817	Scalenotomy with excision of first rib	2004.00		20	190.000	1.0	R	1 335.30		20	152.000	1.0	R	1 068.30		30	3.000	1.0
0821	Tennis elbow	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
0822	Open release elbow (Mitals) - stand alone procedure	2004.00		20	278.200	1.0	R	1 955.20		20	222.560	1.0	R	1 564.20		30	3.000	1.0
0823	Excision or slide for Volkmann's Contracture	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
0825	Hip: Open muscle release	2004.00		20	116.000	1.0	R	815.20		20	116.000	1.0	R	815.20		30	7.000	1.0
0829	Knee: Quadriceps plasty	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0831	Knee: Open tenotomy	2004.00		20	141.000	1.0	R	990.90		20	120.000	1.0	R	843.40		30	3.000	1.0
0835	Calf	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	4.000	1.0
0837	Open elongation tendon Achilles	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	4.000	1.0
0838	Percutaneous "Hoke" elongation tendo Achilles	2004.00		20	79.300	1.0	R	557.30		20	79.300	1.0	R	557.30		30	4.000	1.0
0845	Foot: Plantar fasciotomy	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00		30	3.000	1.0
0846	Foot: Postero-medial release for club-foot	2004.00		20	192.000	1.0	R	1 349.40		20	153.600	1.0	R	1 079.50		30	3.000	1.0
3.5	Bursae and ganglia																	
0847	Excision: Semimembranosus	2004.00		20	90.000	1.0	R	632.50		20	90.000	1.0	R	632.50		30	4.000	1.0
0849	Excision: Prepatellar	2004.00		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30		30	3.000	1.0
0851	Excision: Olecranon	2004.00		20	81.800	1.0	R	574.90		20	81.800	1.0	R	574.90		30	3.000	1.0
0853	Excision: Small bursa or ganglion	2004.00		20	80.900	1.0	R	568.60		20	80.900	1.0	R	568.60		30	3.000	1.0
0855	Excision: Compound palmar ganglion or synovectomy	2004.00		20	128.000	1.0	R	899.60		20	128.000	1.0	R	899.60		30	3.000	1.0
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30		30	3.000	1.0
3.6	Musculo-skeletal system: Miscellaneous																	
3.6.1	Musculo-skeletal system: Miscellaneous: Leg equalisation and congenital hips and feet																	
0859	Leg equalisation and congenital hips and feet: Leg shortening	2004.00		20	282.000	1.0	R	1 981.90		20	225.600	1.0	R	1 585.50		30	3.000	1.0
0861	Leg equalisation and congenital hips and feet: Leg lengthening	2004.00		20	416.000	1.0	R	2 923.60		20	332.800	1.0	R	2 338.90		30	3.000	1.0
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	2004.00		20	116.000	1.0	R	815.20		20	116.000	1.0	R	815.20		30	3.000	1.0
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip	2004.00		20	109.000	1.0	R	766.10		20	109.000	1.0	R	766.10		30	3.000	1.0
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips	2006.04		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	3.000	1.0
0868	Open reduction of congenital dislocation of the hip	2004.00		20	186.000	1.0	R	1 307.20		20	148.800	1.0	R	1 045.80		30	3.000	1.0
0869	Subsequent plasters	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90				
0873	Congenital club foot: Manipulation and plaster: One foot	2004.00		20	26.000	1.0	R	182.70		20	26.000	1.0	R	182.70		30	3.000	1.0
0874	Ponseti technique assistant (medical practitioner)	2005.03		20	13.000	1.0	R	91.40	Z	20	13.000	1.0	R	91.40	Z			
3.6.2	Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis																	
0883	Removal of internal fixatives or prosthesis: Readily accessible	2004.00		20	36.600	1.0	R	257.20		20	36.600	1.0	R	257.20				
0884	Removal of internal fixatives: Less accessible	2004.00		20	75.500	1.0	R	530.60		20	75.500	1.0	R	530.60				
0885	Removal of prosthesis for infection soon after operation	2004.00		20	128.000	1.0	R	899.60		20	120.000	1.0	R	843.40				
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the item for total joint replacement of the specific joint	2004.00	+	20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80		30	6.000	1.0
3.7	Plasters (exclusive of after-care)																	
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)	2004.00		20	13.000	1.0	R	91.40	ò	20	13.000	1.0	R	91.40	ò	30	3.000	1.0
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90		30	4.000	1.0
0891	Turnbuckle cast for scoliosis (excluding after-care)	2004.00		20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40		30	5.000	1.0

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0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	2004.00		20	19.000	1.0	R 133.50		20	19.000	1.0	R 133.50		30	5.000	1.0
3.8	Musculo-skeletal system: Special areas															
3.8.1	Special areas: Foot and Ankle															
0895	Club foot: Revision club foot release - stand alone procedure	2004.00		20	302.700	1.0	R 2 127.40		20	242.160	1.0	R 1 701.90		30	3.000	1.0
0896	Club foot: Posterior release only - stand alone procedure	2004.00		20	159.300	1.0	R 1 119.60		20	127.440	1.0	R 895.60		30	3.000	1.0
0900	Excision tarsal coalition - stand alone procedure	2004.00		20	141.500	1.0	R 994.50		20	120.000	1.0	R 843.40		30	3.000	1.0
0901	Tenotomy: Single tendon	2004.00		20	63.300	1.0	R 444.90		20	63.300	1.0	R 444.90		30	3.000	1.0
0903	Hammer toe: One toe	2004.00		20	99.500	1.0	R 699.30		20	99.500	1.0	R 699.30		30	3.000	1.0
0905	Filleting of toe or Ruiz-Mora procedure	2004.00		20	99.500	1.0	R 699.30		20	99.500	1.0	R 699.30		30	3.000	1.0
0906	Arthrodesis Hallux	2004.00		20	148.000	1.0	R 1 040.10		20	120.000	1.0	R 843.40		30	3.000	1.0
0907	Silver bunionectomy or similar for Hallux Valgus	2004.00		20	126.200	1.0	R 886.90		20	120.000	1.0	R 843.40		30	3.000	1.0
0909	Excision arthroplasty	2004.00		20	145.200	1.0	R 1 020.50		20	120.000	1.0	R 843.40		30	3.000	1.0
0910	Cheilectomy or metatarsophangeal implant Hallux	2004.00		20	183.000	1.0	R 1 286.10		20	146.400	1.0	R 1 028.90		30	3.000	1.0
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	2004.00		20	189.200	1.0	R 1 329.70		20	151.360	1.0	R 1 063.80		30	3.000	1.0
5730	Hallux Valgus double osteotomy etc.	2004.00		20	182.600	1.0	R 1 283.30		20	146.080	1.0	R 1 026.70		30	3.000	1.0
5731	Distal soft tissue procedure for Hallux Valgus	2004.00		20	173.600	1.0	R 1 220.10		20	138.880	1.0	R 976.00		30	3.000	1.0
5732	Aitkin procedure or similar	2004.00		20	166.800	1.0	R 1 172.30		20	133.440	1.0	R 937.80		30	3.000	1.0
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)	2004.00		20	91.000	1.0	R 639.50		20	91.000	1.0	R 639.50		30	3.000	1.0
5735	Repair angular deformity toe (lesser toes)	2004.00		20	97.200	1.0	R 683.10		20	97.200	1.0	R 683.10		30	3.000	1.0
5736	Sesamoidectomy	2004.00		20	97.800	1.0	R 687.30		20	97.800	1.0	R 687.30		30	3.000	1.0
5737	Repair major foot tendons e.g. Tib Post	2004.00		20	147.300	1.0	R 1 035.20		20	120.000	1.0	R 843.40		30	3.000	1.0
5738	Repair of dislocating peroneal tendons	2004.00		20	173.200	1.0	R 1 217.20		20	138.560	1.0	R 973.80		30	3.000	1.0
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot	2004.00		20	202.300	1.0	R 1 421.80		20	161.840	1.0	R 1 137.40		30	3.000	1.0
5740	Steindler strip - plantar fascia	2004.00		20	97.200	1.0	R 683.10		20	97.200	1.0	R 683.10		30	3.000	1.0
5741	Kelikian syndactilly (one web space)	2004.00		20	97.200	1.0	R 683.10		20	97.200	1.0	R 683.10		30	3.000	1.0
5742	Tendon transfer foot	2004.00		20	172.000	1.0	R 1 208.60		20	137.600	1.0	R 967.10		30	3.000	1.0
5743	Capsulotomy metatarsophalangeal joints: Foot	2004.00		20	86.800	1.0	R 610.00		20	86.800	1.0	R 610.00		30	3.000	1.0
3.8.2	Big toe (refer to section 3.8.1 for procedures on big toe)															
3.8.3	Special areas: Reimplantations															
0912	Replantation of amputated upper limb proximal to wrist joint	2004.00		20	730.000	1.0	R 5 130.40		20	584.000	1.0	R 4 104.40		30	3.000	1.0
0913	Replantation of thumb	2004.00		20	670.000	1.0	R 4 708.80		20	536.000	1.0	R 3 767.00		30	3.000	1.0
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	2004.00		20	580.000	1.0	R 4 076.20		20	464.000	1.0	R 3 261.00		30	3.000	1.0
0915	Replantation operation through the palm	2004.00		20	1270.000	1.0	R 8 925.60		20	########	1.0	R 7 140.40		30	3.000	1.0
3.8.4	Special areas: Hands: (Note: Skin: See Integumentary System)															
0919	Tumours: Epidermoid cysts	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	3.000	1.0
0920	Tumours: Ganglion or fibroma	2004.00		20	77.500	1.0	R 544.70		20	77.500	1.0	R 544.70		30	3.000	1.0
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)	2004.00		20	86.000	1.0	R 604.40		20	86.000	1.0	R 604.40		30	3.000	1.0
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	2004.00		20	19.000	1.0	R 133.50		20	19.000	1.0	R 133.50		30	3.000	1.0
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	2004.00		20	32.000	1.0	R 224.90		20	32.000	1.0	R 224.90		30	3.000	1.0
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum	2005.01		20	37.000	1.0	R 260.00		20	37.000	1.0	R 260.00		30	3.000	1.0
	Item 0924: The number of units chargeable under this item ranges from 37.00 to 110.00 for Specialists and General Practitioners.	2004.00														
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	2004.00		20	16.000	1.0	R 112.40		20	16.000	1.0	R 112.40		30	3.000	1.0
3.8.5	Special areas: Spine															

	Please note the following with regard to section 3.8.5: Spine□ □ a) Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together:□ □ 1. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis.□ □ 2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition.□ □ b) Modifier 0005 (multiple procedures/operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. Ostectomy, laminectomy.	2004.00															
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	2004.00		20	207.000	1.0	R 1 454.80		20	165.600	1.0	R 1 163.80		30	3.000	1.0
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	2004.00	+	20	42.000	1.0	R 295.20		20	42.000	1.0	R 295.20		30	3.000	1.0
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40		30	5.000	1.0
0930	Posterior osteotomy of spine: One vertebral segment	2004.00		20	339.000	1.0	R 2 382.50		20	271.200	1.0	R 1 906.00		30	3.000	1.0
0931	Posterior spinal fusion: One level	2004.00		20	385.000	1.0	R 2 705.80		20	308.000	1.0	R 2 164.60		30	3.000	1.0
0932	Posterior osteotomy of spine: Each additional vertebral segment	2004.00	+	20	103.000	1.0	R 723.90		20	103.000	1.0	R 723.90		30	3.000	1.0
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	2004.00		20	315.000	1.0	R 2 213.80		20	252.000	1.0	R 1 771.10		30	3.000	1.0
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	2004.00	+	20	103.000	1.0	R 723.90		20	103.000	1.0	R 723.90		30	3.000	1.0
0938	Anterior fusion base of skull to C2	2004.00		20	449.000	1.0	R 3 155.60		20	359.200	1.0	R 2 524.50		30	4.000	1.0
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	3.000	1.0
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	3.000	1.0
0941	Anterior interbody fusion: One level	2004.00		20	360.000	1.0	R 2 530.10		20	288.000	1.0	R 2 024.10		30	3.000	1.0
0942	Anterior interbody fusion: Each additional level	2004.00	+	20	102.000	1.0	R 716.90		20	102.000	1.0	R 716.90		30	3.000	1.0
0944	Posterior fusion: Occiput to C2	2004.00		20	390.000	1.0	R 2 740.90		20	312.000	1.0	R 2 192.70		30	4.000	1.0
0946	Posterior spinal fusion: Each additional level	2004.00	+	20	111.000	1.0	R 780.10		20	111.000	1.0	R 780.10		30	3.000	1.0
0948	Posterior interbody lumbar fusion: One level	2004.00		20	364.000	1.0	R 2 558.20		20	291.200	1.0	R 2 046.60		30	3.000	1.0
0950	Posterior interbody lumbar fusion: Each additional interspace	2004.00	+	20	95.000	1.0	R 667.70		20	95.000	1.0	R 667.70		30	3.000	1.0
0959	Excision of coccyx	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	3.000	1.0
0961	Costo-transversectomy	2004.00		20	198.000	1.0	R 1 391.50		20	158.400	1.0	R 1 113.20		30	3.000	1.0
0963	Antero-lateral decompression of spinal cord or anterior debridement	2004.00		20	326.000	1.0	R 2 291.10		20	260.800	1.0	R 1 832.90		30	3.000	1.0
	MODIFIER																
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed	2004.00															
3.8.6	Special areas: Spinal deformities																
	Please note : Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).	2004.00															
0952	Posterior fusion for spinal deformity: Up to 6 levels	2004.00		20	359.000	1.0	R 2 523.10		20	287.200	1.0	R 2 018.40		30	3.000	1.0
0954	Posterior fusion for spinal deformity: 7 to 12 levels	2004.00		20	547.000	1.0	R 3 844.30		20	437.600	1.0	R 3 075.50		30	3.000	1.0
0955	Posterior fusion for spinal deformity: 13 or more levels	2004.00		20	593.000	1.0	R 4 167.60		20	474.400	1.0	R 3 334.10		30	3.000	1.0
0956	Anterior fusion for spinal deformity: 2 or 3 levels	2004.00		20	410.000	1.0	R 2 881.50		20	328.000	1.0	R 2 305.20		30	3.000	1.0

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0957	Anterior fusion for spinal deformity: 4 to 7 levels	2004.00		20	444.000	1.0	R 3 120.40		20	355.200	1.0	R 2 496.30		30	3.000	1.0
0958	Anterior fusion for spinal deformity: 8 or more levels	2004.00		20	539.000	1.0	R 3 788.10		20	431.200	1.0	R 3 030.50		30	3.000	1.0
	MODIFIER																	
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere	2004.00																
3.8.7	Special areas: All spinal problems																	
0943	Laminectomy with decompression of nerve roots and disc removal: One level	2004.00		20	240.000	1.0	R 1 686.70		20	192.000	1.0	R 1 349.40		30	3.000	1.0
0960	Posterior non-segmental instrumentation	2004.00		20	167.000	1.0	R 1 173.70		20	133.600	1.0	R 938.90		30	5.000	1.0
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	2004.00		20	176.000	1.0	R 1 236.90		20	140.800	1.0	R 989.50		30	5.000	1.0
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	2004.00		20	201.000	1.0	R 1 412.60		20	160.800	1.0	R 1 130.10		30	5.000	1.0
0966	Posterior segmental instrumentation:13 or more vertebrae	2004.00		20	245.000	1.0	R 1 721.90		20	196.000	1.0	R 1 377.50		30	5.000	1.0
0968	Anterior instrumentation: 2 to 3 vertebrae	2004.00		20	159.000	1.0	R 1 117.50		20	127.200	1.0	R 894.00		30	5.000	1.0
0969	Skull or skull-femoral traction including two weeks after-care	2004.00		20	64.000	1.0	R 449.60		20	64.000	1.0	R 449.60				
0970	Anterior instrumentation: 4 to 7 vertebrae	2004.00		20	185.000	1.0	R 1 300.20		20	148.000	1.0	R 1 040.10		30	5.000	1.0
0971	Halo-splint and POP jacket including two weeks after-care	2004.00		20	116.000	1.0	R 815.20		20	116.000	1.0	R 815.20				
0972	Anterior instrumentation: 8 or more vertebrae	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	5.000	1.0
0974	Additional pelvic fixation of instrumentation other than sacrum	2004.00		20	108.000	1.0	R 759.00		20	108.000	1.0	R 759.00		30	5.000	1.0
5750	Reinsertion of instrumentation	2004.00		20	276.000	1.0	R 1 939.70		20	220.800	1.0	R 1 551.80		30	6.000	1.0
5751	Removal of posterior non-segmental instrumentation	2004.00		20	173.000	1.0	R 1 215.80		20	138.400	1.0	R 972.70		30	6.000	1.0
5752	Removal of posterior segmental instrumentation	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90		30	6.000	1.0
5753	Removal of anterior instrumentation	2004.00		20	204.000	1.0	R 1 433.70		20	163.200	1.0	R 1 147.00		30	6.000	1.0
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	2004.00		20	295.000	1.0	R 2 073.30		20	236.000	1.0	R 1 658.60		30	3.000	1.0
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	2004.00		20	304.000	1.0	R 2 136.50		20	243.200	1.0	R 1 709.20		30	3.000	1.0
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	2004.00		20	321.000	1.0	R 2 256.00		20	256.800	1.0	R 1 804.80		30	3.000	1.0
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	2004.00	+	20	63.000	1.0	R 442.80		20	63.000	1.0	R 442.80		30	3.000	1.0
5759	Laminectomy for decompression diskectomy, etc. revision operation	2004.00		20	352.000	1.0	R 2 473.90		20	281.600	1.0	R 1 979.10		30	4.000	1.0
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	2004.00		20	301.000	1.0	R 2 115.40		20	240.800	1.0	R 1 692.30		30	3.000	1.0
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	2004.00	+	20	68.000	1.0	R 477.90		20	68.000	1.0	R 477.90		30	3.000	1.0
5763	Anterior disc removal and spinal decompression cervical: One level	2004.00		20	344.000	1.0	R 2 417.60		20	275.200	1.0	R 1 934.10		30	3.000	1.0
5764	Anterior disc removal and spinal decompression cervical: Each additional level	2004.00	+	20	81.000	1.0	R 569.30		20	81.000	1.0	R 569.30		30	3.000	1.0
5765	Vertebral corpectomy for spinal decompression: One level	2004.00		20	466.000	1.0	R 3 275.00		20	372.800	1.0	R 2 620.00		30	3.000	1.0
5766	Vertebral corpectomy for spinal decompression: Each additional level	2004.00		20	88.000	1.0	R 618.50		20	88.000	1.0	R 618.50		30	3.000	1.0
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	2004.00		20	71.000	1.0	R 499.00		20	71.000	1.0	R 499.00				
3.9	Facial bone procedures																	
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9	2004.00																
0987	Repair of orbital floor (blowout fracture)	2004.00		20	184.600	1.0	R 1 297.40		20	147.680	1.0	R 1 037.90		30	4.000	1.0
0988	Genioplasty	2004.00		20	263.000	1.0	R 1 848.40		20	210.400	1.0	R 1 478.70		30	4.000	1.0
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	2004.00		20	202.200	1.0	R 1 421.10		20	161.760	1.0	R 1 136.80		30	4.000	1.0
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	2004.00		20	302.000	1.0	R 2 122.50		20	241.600	1.0	R 1 698.00		30	4.000	1.0
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	2004.00		20	433.000	1.0	R 3 043.10		20	346.400	1.0	R 2 434.50		30	4.000	1.0

0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	2004.00		20	970.000	1.0	R 6 817.20		20	776.000	1.0	R 5 453.70		30	4.000	1.0
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	2004.00		20	302.000	1.0	R 2 122.50		20	241.600	1.0	R 1 698.00		30	4.000	1.0
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	2004.00		20	1103.000	1.0	R 7 751.90		20	882.400	1.0	R 6 201.50		30	4.000	1.0
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	2004.00		20	1654.000	1.0	R 11 624.30		20	#######	1.0	R 9 299.40		30	4.000	1.0
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement	2004.00		20	-	1.0	R -	F	20	-	1.0	R -	F			
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation	2004.00		20	302.000	1.0	R 2 122.50		20	241.600	1.0	R 1 698.00		30	3.000	1.0
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	2004.00		20	184.000	1.0	R 1 293.20		20	147.200	1.0	R 1 034.50		30	3.000	1.0
1001	Temporo-mandibular joint: Reconstruction for dysfunction	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
1003	Manipulation: Immobilisation and follow-up of fractured nose	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	3.000	1.0
1005	Nasal fracture without manipulation	2004.00		20	-	1.0	R -	F	20	-	1.0	R -	F			
1007	Mandibulectomy	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	5.000	1.0
1009	Maxillectomy	2004.00		20	382.500	1.0	R 2 688.20		20	306.000	1.0	R 2 150.60		30	4.000	1.0
1011	Bone graft to mandible	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
1012	Adjustment of occlusion by ramisection	2004.00		20	227.000	1.0	R 1 595.40		20	181.600	1.0	R 1 276.30		30	4.000	1.0
1013	Fracture of arch of zygoma without displacement	2004.00		20	-	1.0	R -	F	20	-	1.0	R -	F			
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	2004.00		20	131.000	1.0	R 920.70		20	120.000	1.0	R 843.40		30	3.000	1.0
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	2004.00		20	262.000	1.0	R 1 841.30		20	209.600	1.0	R 1 473.10		30	3.000	1.0
4	Respiratory System															
4.1	Nose and sinuses															
1018	Flexible nasopharyngolaryngoscope examination	2004.00		20	51.940	1.0	R 365.00		20	51.940	1.0	R 365.00				
1019	ENT endoscopy in rooms with rigid endoscope	2004.00		20	12.000	1.0	R 84.30									
1020	Repair of perforated septum: Any method	2006.04		20	141.900	1.0	R 997.30		20	120.000	1.0	R 843.40		30	4.000	1.0
1022	Functional reconstruction of nasal septum	2004.00		20	121.200	1.0	R 851.80		20	120.000	1.0	R 843.40		30	4.000	1.0
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	2004.00		20	30.000	1.0	R 210.80		20	30.000	1.0	R 210.80		30	4.000	1.0
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	2006.04		20	64.600	1.0	R 454.00		20	64.600	1.0	R 454.00		30	4.000	1.0
1027	Dacrocystorhinostomy	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	5.000	1.0
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	2006.04		20	62.600	1.0	R 440.00		20	62.600	1.0	R 440.00		30	4.000	1.0
1030	Endoscopic turbinectomy: Laser or microdebrider	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	5.000	1.0
1031	Removal of single nasal polyp at rooms (at initial consultation only)	2004.00		20	25.400	1.0	R 178.50		20	25.400	1.0	R 178.50				
1033	Removal of multiple polyps in hospital under general anaesthetic	2004.00		20	81.800	1.0	R 574.90		20	81.800	1.0	R 574.90		30	4.000	1.0
1034	Autogenous nasal bone transplant: Bone removal included	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	4.000	1.0
1035	Functional endoscopic sinus surgery: Unilateral	2004.00		20	140.000	1.0	R 983.90		20	120.000	1.0	R 843.40		30	4.000	1.0
1036	Functional endoscopic sinus surgery: Bilateral	2004.00		20	245.000	1.0	R 1 721.90		20	196.000	1.0	R 1 377.50		30	4.000	1.0
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	2004.00		20	8.000	1.0	R 56.20		20	8.000	1.0	R 56.20				
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	4.000	1.0
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	2004.00		20	40.000	1.0	R 281.10		20	40.000	1.0	R 281.10		30	6.000	1.0

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1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	6.000	1.0
1045	Ligation anterior ethmoidal artery	2004.00		20	135.400	1.0	R 951.60		20	120.000	1.0	R 843.40		30	6.000	1.0
1047	Caldwell-Luc operation: Unilateral	2004.00		20	137.300	1.0	R 964.90		20	120.000	1.0	R 843.40		30	4.000	1.0
1049	Ligation internal maxillary artery	2004.00		20	196.000	1.0	R 1 377.50		20	156.800	1.0	R 1 102.00		30	6.000	1.0
1050	Vidian neurectomy (transantral or transnasal)	2004.00		20	113.000	1.0	R 794.20		20	113.000	1.0	R 794.20		30	4.000	1.0
1051	Removal nasopharyngeal fibroma	2004.00		20	285.000	1.0	R 2 003.00		20	228.000	1.0	R 1 602.40		30	6.000	1.0
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	4.000	1.0
1053	Frontal sinus drainage, trephine operation	2004.00		20	93.100	1.0	R 654.30		20	93.100	1.0	R 654.30		30	4.000	1.0
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	2006.04		20	37.300	1.0	R 262.10									
1055	External frontal ethmoidectomy	2004.00		20	190.700	1.0	R 1 340.20		20	152.560	1.0	R 1 072.20		30	4.000	1.0
1057	External ethmoidectomy and/or sphenoidectomy	2004.00		20	199.400	1.0	R 1 401.40		20	159.520	1.0	R 1 121.10		30	4.000	1.0
1058	Sublabial transseptal sphenoidotomy	2004.00		20	137.000	1.0	R 962.80		20	120.000	1.0	R 843.40		30	4.000	1.0
1059	Frontal osteomyelitis	2004.00		20	194.000	1.0	R 1 363.40		20	155.200	1.0	R 1 090.70		30	4.000	1.0
1060	Obliteration of frontal sinus	2004.00		20	291.100	1.0	R 2 045.90		20	232.880	1.0	R 1 636.70		30	4.000	1.0
1061	Lateral rhinotomy	2004.00		20	164.000	1.0	R 1 152.60		20	131.200	1.0	R 922.10		30	4.000	1.0
1062	Excision nasolabial cyst	2004.00		20	186.100	1.0	R 1 307.90		20	148.880	1.0	R 1 046.30		30	4.000	1.0
1063	Removal of foreign bodies from nose: At rooms	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
1065	Removal of foreign body from nose: Under general anaesthetic	2004.00		20	38.600	1.0	R 271.30		20	38.600	1.0	R 271.30		30	4.000	1.0
1067	Proof puncture at rooms: Unilateral	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30		30	4.000	1.0
1069	Proof puncture, uni- or bilateral under general anaesthetic	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	4.000	1.0
1071	Proetz treatment (consultation fee only to be charged for first treatment)	2004.00		20	4.000	1.0	R 28.10		20	4.000	1.0	R 28.10				
1077	Septum abscess: At rooms, including after-care	2004.00		20	8.000	1.0	R 56.20		20	8.000	1.0	R 56.20				
1079	Septum abscess: Under general anaesthetic	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	4.000	1.0
1081	Oro-antral fistula (without Caldwell-Luc)	2004.00		20	111.800	1.0	R 785.70		20	111.800	1.0	R 785.70		30	4.000	1.0
1083	Choanal atresia: Intranasal approach	2004.00		20	113.000	1.0	R 794.20		20	113.000	1.0	R 794.20		30	5.000	1.0
1084	Choanal atresia: Transpalatal approach	2004.00		20	194.000	1.0	R 1 363.40		20	155.200	1.0	R 1 090.70		30	7.000	1.0
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	5.000	1.0
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	5.000	1.0
1089	Forehead rhinoplasty (all stages): Total	2004.00		20	552.000	1.0	R 3 879.50		20	441.600	1.0	R 3 103.60		30	5.000	1.0
1091	Forehead rhinoplasty (all stages): Partial	2004.00		20	414.000	1.0	R 2 909.60		20	331.200	1.0	R 2 327.70		30	5.000	1.0
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	2004.00		20	138.000	1.0	R 969.90		20	120.000	1.0	R 843.40		30	5.000	1.0
1095	Full nasal reconstruction for secondary cleft lip deformity	2004.00		20	357.900	1.0	R 2 515.30		20	286.320	1.0	R 2 012.30		30	5.000	1.0
1097	Partial nasal reconstruction for cleft lip deformity	2004.00		20	199.700	1.0	R 1 403.50		20	159.760	1.0	R 1 122.80		30	5.000	1.0
1099	Columella reconstruction or lengthening	2004.00		20	138.000	1.0	R 969.90		20	120.000	1.0	R 843.40		30	5.000	1.0
	MODIFIERS GOVERNING NASAL OPERATIONS															
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083	2004.00														
4.2	Throat															
1101	Tonsillectomy (dissection of the tonsils)	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10		30	4.000	1.0
1102	Laser tonsillectomy	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10		30	6.000	1.0
1105	Removal of adenoids	2004.11		20	40.000	1.0	R 281.10		20	40.000	1.0	R 281.10		30	4.000	1.0

1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)	2004.00		20	168.300	1.0	R 1 182.80		20	134.640	1.0	R 946.20		30	5.000	1.0
1107	Opening of quinsy: At rooms	2004.00		20	12.000	1.0	R 84.30		20	12.000	1.0	R 84.30		30	6.000	1.0
1108	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser): Follow-up operation performed by the same surgeon	2004.00		20	85.000	1.0	R 597.40		20	85.000	1.0	R 597.40		30	5.000	1.0
1109	Opening of quinsy: Under general anaesthetic	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	6.000	1.0
1110	Ludwig's Angina: Drainage	2004.00		20	42.000	1.0	R 295.20		20	42.000	1.0	R 295.20		30	9.000	1.0
1111	Post tonsillectomy or adenoidectomy haemorrhage	2004.00		20	46.000	1.0	R 323.30		20	46.000	1.0	R 323.30		30	6.000	1.0
1112	Pharyngeal pouch operation	2004.11		20	231.800	1.0	R 1 629.10		20	185.440	1.0	R 1 303.30		30	5.000	1.0
1113	Retropharyngeal abscess: Internal approach	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	6.000	1.0
1115	Retropharyngeal abscess: External approach	2004.00		20	85.000	1.0	R 597.40		20	85.000	1.0	R 597.40		30	6.000	1.0
1116	Functional reconstruction of palate and uvula	2004.00		20	168.300	1.0	R 1 182.80		20	134.640	1.0	R 946.20		30	5.000	1.0
4.3	Larynx															
1117	Laryngeal intubation	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
1118	Laryngeal stroboscopy with video capture	2004.00		20	39.000	1.0	R 274.10		20	39.000	1.0	R 274.10		30	6.000	1.0
1119	Laryngectomy without block dissection of the neck	2004.00		20	430.000	1.0	R 3 022.00		20	344.000	1.0	R 2 417.60		30	7.000	1.0
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)	2004.00		20	35.000	1.0	R 246.00									
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	2004.00		20	81.100	1.0	R 570.00		20	81.100	1.0	R 570.00		30	6.000	1.0
1126	Post laryngectomy for voice restoration	2004.00		20	139.500	1.0	R 980.40		20	120.000	1.0	R 843.40		30	9.000	1.0
1127	Tracheotomy	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	9.000	1.0
1128	Endolaryngeal operations	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10		30	8.000	1.0
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	2004.00		20	294.400	1.0	R 2 069.00		20	235.520	1.0	R 1 655.20		30	8.000	1.0
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	2004.00		20	41.400	1.0	R 291.00		20	41.400	1.0	R 291.00		30	6.000	1.0
1131	Direct laryngoscopy plus foreign body removal	2004.00		20	64.600	1.0	R 454.00		20	64.600	1.0	R 454.00		30	6.000	1.0
	MODIFIERS															
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (ôFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhere in the Tariff)	2004.00														
4.4	Bronchial procedures															
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy	2004.00														
1132	Bronchoscopy: Diagnostic bronchoscopy	2004.00		20	65.000	1.0	R 456.80		20	65.000	1.0	R 456.80		30	6.000	1.0
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	2004.00		20	80.000	1.0	R 562.20		20	80.000	1.0	R 562.20		30	8.000	1.0
1134	Bronchoscopy: Bronchoscopy with laser	2004.00		20	75.000	1.0	R 527.10							30	8.000	1.0
1136	Nebulisation (in rooms)	2004.00		20	12.000	1.0	R 84.30		20	12.000	1.0	R 84.30		20	12.000	1.0
1137	Bronchial lavage	2004.00												30	8.000	1.0
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	12.000	1.0
4.5	Pleura															
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	3.000	1.0
1141	Insertion of intercostal catheter (under water drainage)	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	6.000	1.0
1142	Intra-pleural block	2004.00		20	36.000	1.0	R 253.00		20	36.000	1.0	R 253.00		20	36.000	1.0
1143	Paracentesis chest: Diagnostic	2004.00		20	8.000	1.0	R 56.20		20	8.000	1.0	R 56.20		30	3.000	1.0
1145	Paracentesis chest: Therapeutic	2004.00		20	13.000	1.0	R 91.40		20	13.000	1.0	R 91.40		30	3.000	1.0

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1147	Pneumothorax: Induction (diagnostic)	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70				
1149	Pleurectomy	2004.00		20	250.000	1.0	R	1 757.00		20	200.000	1.0	R	1 405.60		30	11.000	1.0
1151	Decortication of lung	2004.00		20	350.000	1.0	R	2 459.80		20	280.000	1.0	R	1 967.80		30	11.000	1.0
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	2004.00		20	55.000	1.0	R	386.50		20	55.000	1.0	R	386.50		30	3.000	1.0
4.6	Pulmonary procedures																	
4.6.1	Pulmonary procedures: Surgical																	
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90		30	5.000	1.0
1157	Pneumonectomy	2004.00		20	350.000	1.0	R	2 459.80		20	280.000	1.0	R	1 967.80		30	11.000	1.0
1159	Pulmonary lobectomy	2004.00		20	389.500	1.0	R	2 737.40		20	311.600	1.0	R	2 189.90		30	11.000	1.0
1161	Segmental lobectomy	2004.00		20	365.000	1.0	R	2 565.20		20	292.000	1.0	R	2 052.20		30	11.000	1.0
1163	Excision tracheal stenosis: Cervical	2004.00		20	375.000	1.0	R	2 635.50		20	300.000	1.0	R	2 108.40		30	8.000	1.0
1164	Excision tracheal stenosis: Intra thoracic	2004.00		20	350.000	1.0	R	2 459.80		20	280.000	1.0	R	1 967.80		30	12.000	1.0
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	2004.00		20	215.000	1.0	R	1 511.00		20	172.000	1.0	R	1 208.80		30	12.000	1.0
1168	Thoracoplasty: Complete	2004.00		20	250.000	1.0	R	1 757.00		20	200.000	1.0	R	1 405.60		30	11.000	1.0
1169	Thoracoplasty: Limited (osteoplastic)	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	11.000	1.0
1171	Drainage empyema (including six weeks after treatment)	2004.00		20	170.000	1.0	R	1 194.80		20	136.000	1.0	R	955.80		30	11.000	1.0
1173	Drainage of lung abscess (including six weeks after treatment)	2004.00		20	170.000	1.0	R	1 194.80		20	136.000	1.0	R	955.80		30	11.000	1.0
1175	Thoracotomy (limited): For lung or pleural biopsy	2004.00		20	115.000	1.0	R	808.20		20	115.000	1.0	R	808.20		30	11.000	1.0
1177	Major: Diagnostic, as for inoperable carcinoma	2004.00		20	215.000	1.0	R	1 511.00		20	172.000	1.0	R	1 208.80		30	11.000	1.0
1179	Thoracoscopy	2004.00		20	89.000	1.0	R	625.50		20	89.000	1.0	R	625.50		30	11.000	1.0
1181	Lung transplant: Unilateral	2004.00		20	600.000	1.0	R	4 216.80		20	480.000	1.0	R	3 373.40		30	15.000	1.0
1182	Harvesting donor lung: Unilateral	2004.00		20	120.000	1.0	R	843.40		20	120.000	1.0	R	843.40		30	5.000	1.0
1183	Excision or plication of emphysematous cyst: Unilateral	2004.00		20	250.000	1.0	R	1 757.00		20	200.000	1.0	R	1 405.60		30	11.000	1.0
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	2004.00		20	438.000	1.0	R	3 078.30		20	350.400	1.0	R	2 462.60		30	11.000	1.0
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	2004.00		20	100.000	1.0	R	702.80		20	100.000	1.0	R	702.80		30	11.000	1.0
4.6.2	Pulmonary function tests																	
1186	Flow volume test: Inspiration/expiration	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		20	30.000	1.0
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation - thereafter item 1186 applies)	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		20	50.000	1.0
1189	Forced expirogram only	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		20	10.000	1.0
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	2004.00		20	45.310	1.0	R	318.40										
1191	N2 single breath distribution	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		20	10.000	1.0
1192	Peak expiratory flow only	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10		20	5.000	1.0
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	2004.00		20	37.760	1.0	R	265.40										
1195	Thoracic gas volume	2004.00		20	37.930	1.0	R	266.60										
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	2004.00		20	45.310	1.0	R	318.40										
1197	Compliance and resistance, using oesophageal balloon	2004.00		20	24.000	1.0	R	168.70		20	24.000	1.0	R	168.70		20	24.000	1.0
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry	2004.00		20	55.890	1.0	R	392.80		20	55.890	1.0	R	392.80				
1199	Pulmonary stress testing: For determination of VO2 max	2004.00		20	96.500	1.0	R	678.20		20	96.500	1.0	R	678.20				
1200	Carbon monoxide diffusing capacity, any method	2004.00		20	38.060	1.0	R	267.50										
1201	Maximum inspiratory/expiratory pressure	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10		20	5.000	1.0
4.7	Intensive care																	

	RULES GOVERNING THIS SECTION																
Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily	2006.05															
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)	2004.00															
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.	2004.00															
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring	2004.00															
4.7.1	Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Neonatal procedures																
1202	Insertion of central venous catheter via peripheral vein in neonates	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		20	40.000	1.0
4.7.2	Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Tariff items for intensive care																
1204	Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per day	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		20	30.000	1.0
1205	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): First day	2004.00		20	100.000	1.0	R	702.80		20	100.000	1.0	R	702.80		20	100.000	1.0
1206	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): Subsequent days, per day	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		20	50.000	1.0
1207	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): After two weeks, per day	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		20	30.000	1.0
	Please Note: The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109	2004.00															
1208	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	2004.00		20	137.000	1.0	R	962.80		20	120.000	1.0	R	843.40		20	137.000	1.0

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1209	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	2004.00		20	58.000	1.0	R	407.60		20	58.000	1.0	R	407.60		20	58.000	1.0
1210	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		20	50.000	1.0
4.7.3	Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Procedures																	
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) - 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.	2004.00																
1212	Ventilation: First day	2004.00		20	75.000	1.0	R	527.10		20	75.000	1.0	R	527.10		20	75.000	1.0
1213	Ventilation: Subsequent days, per day	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		20	50.000	1.0
1214	Ventilation: After two weeks, per day	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		20	25.000	1.0
1215	Insertion of arterial pressure cannula	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		20	25.000	1.0
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	2004.11		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		20	50.000	1.0
1217	Insertion of central venous line via peripheral vein	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		20	10.000	1.0
1218	Insertion of central venous line via subclavian or jugular veins	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		20	25.000	1.0
1219	Hyperalimentation (daily tariff)	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		20	15.000	1.0
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		20	30.000	1.0
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		20	30.000	1.0
4.8	Hyperbaric Oxygen Therapy																	
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy:□ □ a. Arterial gas embolism (traumatic or iatrogenic).□ b. Decompression sickness ('the bends')□ c. Carbon monoxide poisoning□ d. Gas gangrene□ e. Crush injuries, compartment syndromes or acute traumatic ischaemias.□ f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union)□ g. Necrotising soft tissue infections (e.g. necrotising fasciitis)□ h. Refractory osteomyelitis.□ I. Bone and soft tissue radiation necrosis.□ j. Compromised skin grafts and flaps.□ k. Acute thermal burns.□ l. Acute bloodloss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia).□ m. Cerebral abscesses	2004.00																
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80				
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT	2005.03		20	101.130	1.0	R	710.70	Z	20	101.130	1.0	R	710.70	Z			

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4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Routine HBO table (2-2,5 ATA x 90-120 min): PROFESSIONAL COMPONENT	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70						
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT	2005.03		20	131.260	1.0	R 922.50	Z	20	131.260	1.0	R 922.50	Z					
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Emergency HBO table (2,5-3 ATA x 90-120 min): PROFESSIONAL COMPONENT	2004.00		20	80.000	1.0	R 562.20		20	80.000	1.0	R 562.20						
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT	2005.03		20	131.260	1.0	R 922.50	Z	20	131.260	1.0	R 922.50	Z					
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT5 (2,8 ATA x 135 min): PROFESSIONAL COMPONENT	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50						
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT	2005.03		20	214.180	1.0	R 1 505.30	Z	20	214.180	1.0	R 1 505.30	Z					
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6 (2,8 ATA x 285 min): PROFESSIONAL COMPONENT	2004.00		20	190.000	1.0	R 1 335.30		20	190.000	1.0	R 1 335.30						
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	2005.03		20	386.420	1.0	R 2 715.80	Z	20	386.420	1.0	R 2 715.80	Z					
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min): PROFESSIONAL COMPONENT	2004.00		20	327.000	1.0	R 2 298.20		20	327.000	1.0	R 2 298.20						
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	2005.03		20	680.850	1.0	R 4 785.00	Z	20	680.850	1.0	R 4 785.00	Z					
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	2005.03		20	678.280	1.0	R 4 767.00	Z	20	678.280	1.0	R 4 767.00	Z					
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	2005.03		20	671.850	1.0	R 4 721.80	Z	20	671.850	1.0	R 4 721.80	Z					
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour: Minimum 40,00 clinical procedure units; maximum 320,00 clinical procedure units	2004.00																
5	Mediastinal Procedures																	
1222	Mediastinal tumours	2004.00		20	285.000	1.0	R 2 003.00		20	228.000	1.0	R 1 602.40		30	11.000	1.0		
1223	Mediastinoscopy	2004.00		20	95.000	1.0	R 667.70		20	95.000	1.0	R 667.70		30	5.000	1.0		
1224	Mediastinotomy	2004.00		20	115.000	1.0	R 808.20		20	115.000	1.0	R 808.20		30	11.000	1.0		
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	11.000	1.0		
1226	Removal of single rib with a lesion	2004.00		20	282.000	1.0	R 1 981.90		20	225.600	1.0	R 1 585.50		30	11.000	1.0		
6	Cardiovascular System																	
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP																	
6.1	Cardiovascular system: General																	
1227	Prolonged neonatal resuscitation	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60		20	20.000	1.0		
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG	2004.00																
1228	General Practitioner's fee for the taking of an ECG only: Without effort: ½ (item 1232)	2004.00							20	4.500	1.0	R 31.60						
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: ½ (item 1233)	2004.00							20	6.500	1.0	R 45.70						
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added	2004.00																
1230	Physician's fee for interpreting an ECG: Without effort	2004.00		20	6.000	1.0	R 42.20											
1231	Physician's fee for interpreting an ECG: With and without effort	2006.04		20	10.000	1.0	R 70.30											

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	A specialist physician is entitled to the fees specified in item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation	2004.00															
1232	Electrocardiogram: Without effort	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30			
1233	Electrocardiogram: With and without effort	2006.04		20	13.000	1.0	R	91.40		20	13.000	1.0	R	91.40			
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10			
1235	Multi-stage treadmill test	2004.00		20	60.000	1.0	R	421.70		20	60.000	1.0	R	421.70			
1236	Electrocardiogram without effort: Under 4 years old	2006.04		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50			
1237	24 Hour ambulatory blood pressure: Hire fee	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80			
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee	2004.00		20	55.000	1.0	R	386.50		20	55.000	1.0	R	386.50			
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation	2004.00		20	27.000	1.0	R	189.80		20	27.000	1.0	R	189.80			
1240	Signal averaged electrocardiogram	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20			
1241	X-ray Screening: Chest	2004.00		20	4.000	1.0	R	28.10		20	4.000	1.0	R	28.10			
1242	X-ray screening: Prosthetic valves	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30			
1243	Two week event triggered ambulatory ECG monitoring: Hire fee	2004.00		20	55.000	1.0	R	386.50		20	55.000	1.0	R	386.50			
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70			
1245	Angiography cerebral: First two series	2004.00		20	34.300	1.0	R	241.10		20	34.300	1.0	R	241.10		30	4.000	1.0
1246	Angiography peripheral: Per limb	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	4.000	1.0
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	2004.00		20	65.000	1.0	R	456.80		20	65.000	1.0	R	456.80		30	6.000	1.0
1248	Paracentesis of pericardium	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	9.000	1.0
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	2004.00		20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40				
	MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER																
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%	2004.00															
6.2	Invasive Cardiology																
6.2.1	Invasive cardiology: Cardiac catheterisation																
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	2004.00		20	140.000	1.0	R	983.90								30	9.000	1.0
1250	Endomyocardial biopsy	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00		30	9.000	1.0
1251	Transeptal puncture	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00		30	9.000	1.0
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	2004.00		20	140.000	1.0	R	983.90								30	9.000	1.0
1253	Right heart catheterisation (with or without biopsy)	2004.00		20	70.000	1.0	R	492.00								30	9.000	1.0
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	9.000	1.0
1255	Tilt test	2004.00		20	31.300	1.0	R	220.00		20	31.300	1.0	R	220.00				
6.2.2	Invasive cardiology: Electrophysiological study																
1256	Ventricular stimulation study	2004.00		20	160.000	1.0	R	1 124.50								30	9.000	1.0
1257	Full electrophysiological study	2004.00		20	300.000	1.0	R	2 108.40								30	9.000	1.0
6.2.3	Invasive cardiology: Pacemakers																
1258	Pacemaker: Permanent - single chamber	2004.00		20	155.000	1.0	R	1 089.30		20	124.000	1.0	R	871.50		30	9.000	1.0
1259	Pacemaker: Permanent - dual chamber	2004.00		20	230.000	1.0	R	1 616.40		20	184.000	1.0	R	1 293.20		30	9.000	1.0
1260	AV nodal ablation	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	9.000	1.0
1261	Accessory pathway ablation	2004.00		20	600.000	1.0	R	4 216.80		20	480.000	1.0	R	3 373.40		30	9.000	1.0
1262	Electrophysiological mapping	2004.00		20	500.000	1.0	R	3 514.00		20	400.000	1.0	R	2 811.20				

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1263	Insertion transvenous implantable defibrillator	2004.00	20	212.000	1.0	R 1 489.90	20	169.600	1.0	R 1 191.90	30	15.000	1.0
1264	Test for implantable transvenous defibrillator	2004.00	20	120.000	1.0	R 843.40	20	120.000	1.0	R 843.40	30	15.000	1.0
1265	Renewal of pacemaker unit only, team fee	2004.00	20	125.000	1.0	R 878.50	20	120.000	1.0	R 843.40	30	9.000	1.0
1266	Resiting pacemaker generator	2004.00	20	80.000	1.0	R 562.20	20	80.000	1.0	R 562.20			
1267	Repositioning of catheter electrode	2004.00	20	50.000	1.0	R 351.40	20	50.000	1.0	R 351.40	30	9.000	1.0
1268	Threshold testing: Own equipment	2004.00	20	15.000	1.0	R 105.40							
1269	Threshold testing: Hospital equipment	2004.00	20	11.000	1.0	R 77.30							
1270	Programming of atrio-ventricular sequential pacemaker	2004.00	20	50.000	1.0	R 351.40	20	50.000	1.0	R 351.40			
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	2004.00	20	120.000	1.0	R 843.40	20	120.000	1.0	R 843.40	30	9.000	1.0
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer	2004.00	20	200.000	1.0	R 1 405.60	20	160.000	1.0	R 1 124.50	30	9.000	1.0
6.2.4	Invasive cardiology: Percutaneous translumical angioplasty												
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	2004.00	20	260.000	1.0	R 1 827.30	20	208.000	1.0	R 1 461.80	30	13.000	1.0
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	2004.00	20	140.000	1.0	R 983.90	20	120.000	1.0	R 843.40	30	13.000	1.0
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	2004.00	20	60.000	1.0	R 421.70	20	60.000	1.0	R 421.70	30	13.000	1.0
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	2004.00	20	40.000	1.0	R 281.10	20	40.000	1.0	R 281.10	30	13.000	1.0
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	2004.00	20	60.000	1.0	R 421.70	20	60.000	1.0	R 421.70	30	13.000	1.0
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	2004.00	20	40.000	1.0	R 281.10	20	40.000	1.0	R 281.10	30	13.000	1.0
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty	2004.00	20	260.000	1.0	R 1 827.30	20	208.000	1.0	R 1 461.80	30	15.000	1.0
1283	Use of balloon procedure as in item 1282: Second cardiologist	2004.00	20	140.000	1.0	R 983.90	20	120.000	1.0	R 843.40	30	15.000	1.0
1284	Atherectomy: Single lesion: First cardiologist	2004.00	20	300.000	1.0	R 2 108.40	20	240.000	1.0	R 1 686.70			
1285	Atherectomy: Single lesion: Second cardiologist	2004.00	20	180.000	1.0	R 1 265.00	20	144.000	1.0	R 1 012.00			
1286	Insertion of intravascular stent: First cardiologist	2004.00	20	100.000	1.0	R 702.80	20	100.000	1.0	R 702.80			
1287	Insertion of intravascular stent: Second cardiologist	2004.00	20	50.000	1.0	R 351.40	20	50.000	1.0	R 351.40			
1290	Use of balloon procedures including: First paediatric cardiologist (33): Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty; Closure atrial septal defect; Closure of patient ductus arteriosus	2004.00	20	300.000	1.0	R 2 108.40					30	15.000	1.0
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)	2004.00	20	160.000	1.0	R 1 124.50					30	15.000	1.0
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation												
1288	Cardiac catheterisation for congenital heart disease: All ages above 1 year old	2004.00	20	210.000	1.0	R 1 475.90	20	168.000	1.0	R 1 180.70	30	12.000	1.0
1289	Paediatric cardiac catheterisation: Infants below the age of one year	2004.00	20	263.000	1.0	R 1 848.40	20	210.400	1.0	R 1 478.70	30	12.000	1.0
6.3	Cardiac surgery												
1294	Patent ductus arteriosus	2004.00	20	320.000	1.0	R 2 249.00	20	256.000	1.0	R 1 799.20	30	13.000	1.0
1295	Pericardiectomy for constrictive pericarditis	2004.00	20	400.000	1.0	R 2 811.20	20	320.000	1.0	R 2 249.00	30	15.000	1.0
1297	Coarctation of aorta	2004.00	20	425.000	1.0	R 2 986.90	20	340.000	1.0	R 2 389.50	30	15.000	1.0
1299	Systemo-pulmonary anastomosis	2004.00	20	425.000	1.0	R 2 986.90	20	340.000	1.0	R 2 389.50	30	15.000	1.0
1301	Mitral valvotomy: Closed heart technique	2004.00	20	350.000	1.0	R 2 459.80	20	280.000	1.0	R 1 967.80	30	15.000	1.0
1302	Heart transplant	2004.00	20	875.000	1.0	R 6 149.50	20	700.000	1.0	R 4 919.60	30	15.000	1.0
1303	Harvesting donor heart	2004.00	20	75.000	1.0	R 527.10	20	75.000	1.0	R 527.10	30	5.000	1.0
1305	Operative implantation of cardiac pacemaker by thoracotomy	2004.00	20	220.000	1.0	R 1 546.20	20	176.000	1.0	R 1 236.90	30	15.000	1.0
1307	Re-exploration after cardiac surgery	2004.00	20	215.000	1.0	R 1 511.00	20	172.000	1.0	R 1 208.80	30	15.000	1.0
1308	Heart and lung transplant	2004.00	20	1000.000	1.0	R 7 028.00	20	800.000	1.0	R 5 622.40	30	15.000	1.0
1309	Harvesting donor heart and lungs	2004.00	20	120.000	1.0	R 843.40	20	120.000	1.0	R 843.40	30	5.000	1.0
1311	Pericardial drainage	2004.00	20	140.000	1.0	R 983.90	20	120.000	1.0	R 843.40	30	13.000	1.0

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6.3.1	Cardiac surgery: Open heart surgery																	
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	2004.00		20	25.000	1.0	R 175.70		20	200.000	1.0	R 1 405.60		30	15.000	1.0		
1320	Repeat open heart surgery (additional fee above procedure fee)	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	15.000	1.0		
1321	Stand-by fee for coronary angioplasty	2004.00		20	30.000	1.0	R 210.80		20	30.000	1.0	R 210.80		20	30.000	1.0		
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour	2004.00		20	20.000	1.0	R 140.60											
6.3.1.1	Cardiac surgery: Open heart surgery: Congenital conditions																	
1323	Atrial septal defect: Osteum secundum	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	15.000	1.0		
1325	Atrial septal defect: Sinus venosus or osteum primum	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1327	Atrial septal defect: Ventricular septal defect	2004.00		20	603.800	1.0	R 4 243.50		20	483.040	1.0	R 3 394.60		30	15.000	1.0		
1329	Atrial septal defect: Fallot's tetralogy	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1330	Atrial septal defect: Pulmonary stenosis	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	15.000	1.0		
1331	Transposition of large vessels (venous repair)	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1332	Transposition of great arteries (arterial repair)	2004.00		20	750.000	1.0	R 5 271.00		20	600.000	1.0	R 4 216.80		30	15.000	1.0		
1333	Ebstein's Anomaly	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	2004.00		20	548.800	1.0	R 3 857.00		20	439.040	1.0	R 3 085.60		30	20.000	1.0		
1335	Total anomalous venous drainage	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	2004.00		20	658.900	1.0	R 4 630.70		20	527.120	1.0	R 3 704.60		30	20.000	1.0		
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	15.000	1.0		
1338	Fontan type repair	2004.00		20	750.000	1.0	R 5 271.00		20	600.000	1.0	R 4 216.80		30	15.000	1.0		
6.3.1.2	Cardiac surgery: Open heart surgery: Acquired conditions																	
1339	Mitral valve replacement	2004.00		20	657.000	1.0	R 4 617.40		20	525.600	1.0	R 3 693.90		30	15.000	1.0		
1340	Mitral valvuloplasty	2004.00		20	688.000	1.0	R 4 835.30		20	550.400	1.0	R 3 868.20		30	15.000	1.0		
1341	Aortic valve replacement	2004.00		20	623.800	1.0	R 4 384.10		20	499.040	1.0	R 3 507.30		30	15.000	1.0		
1342	Tricuspid annulo plasty	2004.00		20	188.000	1.0	R 1 321.30		20	150.400	1.0	R 1 057.00		30	15.000	1.0		
1343	Double valve replacement	2004.00		20	968.900	1.0	R 6 809.40		20	775.120	1.0	R 5 447.50		30	15.000	1.0		
1344	Acute dissecting aneurysm repair	2004.00		20	750.000	1.0	R 5 271.00		20	600.000	1.0	R 4 216.80		30	15.000	1.0		
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	2004.00		20	1000.000	1.0	R 7 028.00		20	800.000	1.0	R 5 622.40		30	15.000	1.0		
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80						
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90						
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	2004.00		20	750.000	1.0	R 5 271.00		20	600.000	1.0	R 4 216.80		30	15.000	1.0		
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery	2004.00		20	781.000	1.0	R 5 488.90		20	624.800	1.0	R 4 391.10		30	15.000	1.0		
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery	2004.00		20	813.000	1.0	R 5 713.80		20	650.400	1.0	R 4 571.00		30	15.000	1.0		
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	2004.00		20	875.000	1.0	R 6 149.50		20	700.000	1.0	R 4 919.60		30	15.000	1.0		
1352	Cardiac aneurysm	2004.00		20	563.000	1.0	R 3 956.80		20	450.400	1.0	R 3 165.40		30	15.000	1.0		
1353	Ascending/descending thoracic aortic aneurysm repair	2004.00		20	625.000	1.0	R 4 392.50		20	500.000	1.0	R 3 514.00		30	15.000	1.0		
1354	Arrhythmia surgery	2004.00		20	688.000	1.0	R 4 835.30		20	550.400	1.0	R 3 868.20		30	15.000	1.0		
1355	Cardiac tumour	2004.00		20	625.000	1.0	R 4 392.50		20	500.000	1.0	R 3 514.00		30	15.000	1.0		

1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	2004.00		20	188.000	1.0	R 1 321.30		20	150.400	1.0	R 1 057.00		30	15.000	1.0
1358	Harvesting of radial artery	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90				
6.4	Peripheral vascular system															
	MODIFIER GOVERNING THIS SECTION															
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins	2004.00														
6.4.1	Peripheral vascular system: Investigations															
1357	Skin temperature test: Response to reflex heating	2004.00		20	15.000	1.0	R 105.40		20	15.000	1.0	R 105.40				
1359	Skin temperature test: Response to reflex cooling	2004.00		20	15.000	1.0	R 105.40		20	15.000	1.0	R 105.40				
1361	Cold sensitivity test	2004.00		20	17.000	1.0	R 119.50		20	17.000	1.0	R 119.50				
1363	Oscillometry test	2004.00		20	5.000	1.0	R 35.10		20	5.000	1.0	R 35.10				
1365	Sweating test	2004.00		20	17.000	1.0	R 119.50		20	17.000	1.0	R 119.50				
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	2004.00		20	26.300	1.0	R 184.80		20	26.300	1.0	R 184.80				
1367	Doppler blood tests	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20				
5369	Doppler arterial pressures	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20				
5371	Doppler arterial pressures with exercise	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
5373	Doppler segmental pressures and wave forms	2004.00		20	12.000	1.0	R 84.30		20	12.000	1.0	R 84.30				
5375	Venous doppler examination (both limbs)	2004.00		20	9.000	1.0	R 63.30		20	9.000	1.0	R 63.30				
5377	Venous plethysmography	2004.00		20	16.000	1.0	R 112.40		20	16.000	1.0	R 112.40				
5379	Supra-orbital doppler test	2004.00		20	5.000	1.0	R 35.10		20	5.000	1.0	R 35.10				
5381	Carotid non-invasive complex tests	2004.00		20	39.000	1.0	R 274.10		20	39.000	1.0	R 274.10				
6.4.2	Peripheral vascular system: Arterio-venous abnormalities															
1369	Fistula or aneurysm (as for grafting of various arteries)	2004.00														
6.4.3	Arteries															
6.4.3.1	Peripheral vascular system: Arteries: Aorta-iliac and major branches															
1372	Abdominal aorta and iliac artery: Unruptured	2004.00		20	540.000	1.0	R 3 795.10		20	432.000	1.0	R 3 036.10		30	15.000	1.0
1373	Abdominal aorta and iliac artery: Ruptured	2004.00		20	600.000	1.0	R 4 216.80		20	480.000	1.0	R 3 373.40		30	15.000	1.0
1375	Grafting and/or thrombo-endarterectomy for thrombosis	2004.00		20	444.000	1.0	R 3 120.40		20	355.200	1.0	R 2 496.30		30	15.000	1.0
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	2004.00		20	594.000	1.0	R 4 174.60		20	475.200	1.0	R 3 339.70		30	15.000	1.0
6.4.3.2	Peripheral vascular system: Arteries: Iliac artery															
1379	Prosthetic grafting and/or thrombo-endarterectomy	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	13.000	1.0
6.4.3.3	Peripheral vascular system: Arteries: Peripheral															
1385	Prosthetic grafting	2004.00		20	255.000	1.0	R 1 792.10		20	204.000	1.0	R 1 433.70		30	5.000	1.0
1387	Grafting vein: Vein grafting proximal to knee joint	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	5.000	1.0
1388	Grafting vein: Distal to knee joint	2004.00		20	444.000	1.0	R 3 120.40		20	355.200	1.0	R 2 496.30		30	5.000	1.0
1389	Grafting vein: Endarterectomy when not part of another specified procedure	2004.00		20	264.000	1.0	R 1 855.40		20	211.200	1.0	R 1 484.30		30	5.000	1.0
1390	Grafting vein: Carotid endarterectomy	2004.00		20	321.000	1.0	R 2 256.00		20	256.800	1.0	R 1 804.80		30	15.000	1.0
1393	Embolectomy: Peripheral embolectomy transfemoral	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	5.000	1.0
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	2004.00		20	125.000	1.0	R 878.50		20	100.000	1.0	R 702.80		30	5.000	1.0
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure	2004.00		20	264.000	1.0	R 1 855.40		20	211.200	1.0	R 1 484.30		30	15.000	1.0

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1397	Profundoplasty	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	5.000	1.0
1399	Distal tibial (ankle region)	2004.00		20	456.000	1.0	R 3 204.80		20	364.800	1.0	R 2 563.80		30	5.000	1.0
1401	Femoro-femoral	2004.00		20	254.000	1.0	R 1 785.10		20	203.200	1.0	R 1 428.10		30	5.000	1.0
1402	Carotid-subclavian	2004.00		20	288.000	1.0	R 2 024.10		20	230.400	1.0	R 1 619.30		30	8.000	1.0
1403	Axillo-femoral: (Bifemoral + 50%)	2004.00		20	288.000	1.0	R 2 024.10		20	230.400	1.0	R 1 619.30		30	8.000	1.0
6.4.4	Peripheral vascular system: Veins															
1407	Ligation of saphenous vein	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	3.000	1.0
1408	Placement of Hickman catheter or similar	2004.00		20	91.000	1.0	R 639.50		20	91.000	1.0	R 639.50		30	4.000	1.0
1410	Litigation of inferior vena cava: Abdominal	2004.00		20	180.000	1.0	R 1 265.00		20	144.000	1.0	R 1 012.00		30	8.000	1.0
1412	Umbrella operation on inferior vena cava: Abdominal	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	8.000	1.0
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral	2004.00		20	141.000	1.0	R 990.90		20	120.000	1.0	R 843.40		30	3.000	1.0
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral	2004.00		20	247.000	1.0	R 1 735.90		20	197.600	1.0	R 1 388.70		30	3.000	1.0
1417	Extensive sub-fascial ligation of perforating veins	2004.00		20	125.000	1.0	R 878.50		20	120.000	1.0	R 843.40		30	3.000	1.0
1419	Lesser varicose vein procedures	2004.00		20	31.000	1.0	R 217.90		20	31.000	1.0	R 217.90		30	3.000	1.0
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9) injections per leg (excluding cost of material)	2004.00		20	9.000	1.0	R 63.30		20	9.000	1.0	R 63.30				
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	2004.00		20	240.000	1.0	R 1 686.70		20	192.000	1.0	R 1 349.40		30	11.000	1.0
1427	Thrombectomy: Illio-femoral	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90		30	6.000	1.0
6.4.5	Peripheral vascular system: Portal hypertension															
1429	Porto-caval shunt	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	11.000	1.0
6.5	Cardiac rehabilitation															
1431	Cardiac rehabilitation: Phase II: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 5 patients per group	2004.00		20	12.000	1.0	R 84.30		20	12.000	1.0	R 84.30				
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20				
	Please note :□ a. A practitioner is only allowed to instruct one group at a time.□ b. Benefits are limited to 3 times per week for a period of 60 minutes with a maximum of 3 months.	2004.00														
7	Lympho Reticular System															
7.1	Spleen															
1435	Splenectomy (in all cases)	2004.00		20	221.300	1.0	R 1 555.30		20	177.040	1.0	R 1 244.20		30	9.000	1.0
1436	Splenorrhaphy	2004.00		20	231.800	1.0	R 1 629.10		20	185.440	1.0	R 1 303.30		30	9.000	1.0
7.2	Lymph nodes and lymphatic channels															
1439	Excision of lymph node for biopsy: Neck or axilla	2004.00		20	65.000	1.0	R 456.80		20	65.000	1.0	R 456.80		30	4.000	1.0
1441	Excision of lymph node for biopsy: Groin	2004.00		20	65.000	1.0	R 456.80		20	65.000	1.0	R 456.80		30	3.000	1.0
1443	Simple excision of lymph nodes for tuberculosis	2004.00		20	91.000	1.0	R 639.50		20	91.000	1.0	R 639.50		30	3.000	1.0
1445	Radical excision of lymph nodes of neck: Total: Unilateral	2004.00		20	315.000	1.0	R 2 213.80		20	252.000	1.0	R 1 771.10		30	5.000	1.0
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral	2004.00		20	235.000	1.0	R 1 651.60		20	188.000	1.0	R 1 321.30		30	5.000	1.0
1449	Radical excision of lymph nodes of axilla	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	4.000	1.0
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	2004.00		20	58.000	1.0	R 407.60		20	58.000	1.0	R 407.60		30	5.000	1.0
1451	Radical excision of lymph nodes of groin: Illo-inguinal	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90		30	4.000	1.0
1453	Radical excision of lymph nodes of groin: Inguinal	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	4.000	1.0

1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	2004.00		20	39.000	1.0	R	274.10		20	39.000	1.0	R	274.10		30	5.000	1.0
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	2004.00		20	275.000	1.0	R	1 932.70		20	220.000	1.0	R	1 546.20		30	6.000	1.0
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	2004.00		20	42.000	1.0	R	295.20		20	42.000	1.0	R	295.20		30	5.000	1.0
1457	Bone marrow biopsy: By trephine	2004.00		20	13.000	1.0	R	91.40		20	13.000	1.0	R	91.40		30	3.000	1.0
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	2004.00		20	8.000	1.0	R	56.20		20	8.000	1.0	R	56.20				
1459	Staging laparotomy for lymphoma (including splenectomy	2004.00		20	245.000	1.0	R	1 721.90		20	196.000	1.0	R	1 377.50		30	7.000	1.0
8	Digestive System																	
	MODIFIERS GOVERNING THIS SECTION																	
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.	2004.00																
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	2004.00		20	21.000	1.0	R	147.59		20	21.000	1.0	R	147.59				
8.1	Oral cavity																	
1461	All dental procedures	2004.00														30	4.000	1.0
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	2004.00		20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	4.000	1.0
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	4.000	1.0
1467	Drainage of intra-oral abscess	2004.00		20	31.000	1.0	R	217.90		20	31.000	1.0	R	217.90		30	4.000	1.0
1469	Local excision of mucosal lesion of oral cavity	2004.00		20	23.000	1.0	R	161.60		20	23.000	1.0	R	161.60		30	4.000	1.0
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	2004.00		20	549.000	1.0	R	3 858.40		20	439.200	1.0	R	3 086.70		30	7.000	1.0
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	2004.00		20	-	0.0	R	-	q	20	-	0.0	R	-	q	30	7.000	1.0
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	2004.00		20	215.000	1.0	R	1 511.00		20	172.000	1.0	R	1 208.80		30	6.000	1.0
1477	Cleft palate: Secondary repair	2004.00		20	174.200	1.0	R	1 224.30		20	139.360	1.0	R	979.40		30	6.000	1.0
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	2004.00		20	240.000	1.0	R	1 686.70		20	192.000	1.0	R	1 349.40		30	6.000	1.0
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	2004.00		20	227.000	1.0	R	1 595.40		20	181.600	1.0	R	1 276.30		30	6.000	1.0
1480	Repair of oronasal fistula (large) e.g. distant flap	2004.00		20	227.000	1.0	R	1 595.40		20	181.600	1.0	R	1 276.30		30	6.000	1.0
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	2004.00		20	138.000	1.0	R	969.90		20	120.000	1.0	R	843.40		30	5.000	1.0
1482	Repair of oronasal fistula (large): Second stage	2004.00		20	138.000	1.0	R	969.90		20	120.000	1.0	R	843.40		30	5.000	1.0
1483	Alveolar periosteal or other flaps for arch closure	2004.00		20	138.000	1.0	R	969.90		20	120.000	1.0	R	843.40		30	4.000	1.0
1486	Closure of anterior nasal floor	2004.00		20	138.000	1.0	R	969.90		20	120.000	1.0	R	843.40		30	5.000	1.0
8.2	Lips																	
1484	Cleft lip repair: Lip adhesion (cleft lip)	2004.00		20	95.000	1.0	R	667.70		20	95.000	1.0	R	667.70		30	5.000	1.0
1485	Local excision of benign lesion of lip	2004.00		20	27.000	1.0	R	189.80		20	27.000	1.0	R	189.80		30	4.000	1.0
1487	Resection for lip malignancy	2004.00		20	91.000	1.0	R	639.50		20	91.000	1.0	R	639.50		30	4.000	1.0
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	2004.00		20	227.000	1.0	R	1 595.40		20	181.600	1.0	R	1 276.30		30	5.000	1.0
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages	2004.00		20	251.600	1.0	R	1 768.20		20	201.280	1.0	R	1 414.60		30	5.000	1.0
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage	2004.00		20	329.900	1.0	R	2 318.50		20	263.920	1.0	R	1 854.80		30	5.000	1.0
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage	2004.00		20	227.000	1.0	R	1 595.40		20	181.600	1.0	R	1 276.30		30	5.000	1.0
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	2004.00		20	251.600	1.0	R	1 768.20		20	201.280	1.0	R	1 414.60		30	5.000	1.0

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1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	2004.00		20	91.000	1.0	R 639.50		20	91.000	1.0	R 639.50		30	5.000	1.0
1495	Abbé or Estlander type flap (all stages included)	2004.00		20	273.100	1.0	R 1 919.30		20	218.480	1.0	R 1 535.50		30	5.000	1.0
1497	Vermilionectomy	2004.00		20	94.900	1.0	R 667.00		20	94.900	1.0	R 667.00		30	4.000	1.0
1499	Lip reconstruction following an injury: Direct repair	2004.00		20	105.600	1.0	R 742.20		20	105.600	1.0	R 742.20		30	4.000	1.0
1501	Lip reconstruction following an injury or tumour removal: Flap repair	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	2004.00		20	206.000	1.0	R 1 447.80		20	164.800	1.0	R 1 158.20		30	4.000	1.0
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)	2004.00		20	104.000	1.0	R 730.90		20	104.000	1.0	R 730.90		30	4.000	1.0
8.3	Tongue															
1505	Partial glossectomy	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	6.000	1.0
1507	Local excision of lesion of tongue	2004.00		20	27.000	1.0	R 189.80		20	27.000	1.0	R 189.80		30	4.000	1.0
8.4	Palate, uvula and salivary glands															
1509	Wide excision of lesion of palate	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	5.000	1.0
1511	Radical resection of palate (including skin graft)	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	7.000	1.0
1513	Excision of ranula	2004.00		20	85.600	1.0	R 601.60		20	85.600	1.0	R 601.60		30	5.000	1.0
1515	Excision of sublingual salivary gland	2004.00		20	120.000	1.0	R 843.40		20	120.000	1.0	R 843.40		30	4.000	1.0
1517	Excision of submandibular salivary gland	2004.00		20	146.000	1.0	R 1 026.10		20	120.000	1.0	R 843.40		30	4.000	1.0
1519	Excision of submandibular salivary gland with suprahyoid dissection	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	5.000	1.0
1521	Excision of submandibular salivary gland: With radical neck dissection	2004.00		20	352.000	1.0	R 2 473.90		20	281.600	1.0	R 1 979.10		30	6.000	1.0
1523	Local resection of parotid tumour	2004.00		20	169.600	1.0	R 1 191.90		20	135.680	1.0	R 953.60		30	5.000	1.0
1525	Partial parotidectomy	2004.00		20	310.000	1.0	R 2 178.70		20	248.000	1.0	R 1 742.90		30	5.000	1.0
1526	Total parotidectomy with preservation of facial nerve	2004.00		20	358.500	1.0	R 2 519.50		20	286.800	1.0	R 2 015.60		30	5.000	1.0
1527	Total parotidectomy	2004.00		20	358.500	1.0	R 2 519.50		20	286.800	1.0	R 2 015.60		30	5.000	1.0
1529	Parotidectomy: Extracapsular	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	5.000	1.0
1531	Drainage of parotid abscess	2004.00		20	25.000	1.0	R 175.70		20	25.000	1.0	R 175.70		30	4.000	1.0
1533	Closure of salivary fistula	2004.00		20	91.000	1.0	R 639.50		20	91.000	1.0	R 639.50		30	4.000	1.0
1535	Dilatation of salivary duct	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30		30	4.000	1.0
1537	Operative removal of salivary calculus	2004.00		20	55.000	1.0	R 386.50		20	55.000	1.0	R 386.50		30	4.000	1.0
1539	Salivary duct: Meatotomy	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60		30	4.000	1.0
1541	Branchial cyst and/or fistula: Excision	2004.00		20	140.000	1.0	R 983.90		20	120.000	1.0	R 843.40		30	5.000	1.0
1543	Excision of cystic hygroma	2004.00		20	140.000	1.0	R 983.90		20	120.000	1.0	R 843.40		30	5.000	1.0
1544	Ludwig's Angina: Drainage	2004.00		20	42.000	1.0	R 295.20		20	42.000	1.0	R 295.20		30	9.000	1.0
8.5	Oesophagus															
1545	Oesophagoscopy with rigid instrument: First and subsequent	2004.00		20	47.000	1.0	R 330.30		20	47.000	1.0	R 330.30		30	4.000	1.0
1549	Oesophagoscopy with dilatation of stricture	2004.00		20	70.000	1.0	R 492.00		20	70.000	1.0	R 492.00		30	4.000	1.0
1550	Oesophagoscopy with removal of foreign body	2004.00		20	70.000	1.0	R 492.00		20	70.000	1.0	R 492.00		30	4.000	1.0
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	2004.00		20	80.000	1.0	R 562.20		20	80.000	1.0	R 562.20		30	4.000	1.0
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	2004.00		20	80.000	1.0	R 562.20		20	80.000	1.0	R 562.20		30	4.000	1.0
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	2004.00		20	65.000	1.0	R 456.80		20	65.000	1.0	R 456.80		30	4.000	1.0
1554	Per-oral small bowel biopsy	2004.00		20	25.000	1.0	R 175.70		20	25.000	1.0	R 175.70		30	4.000	1.0
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	2004.00		20	400.000	1.0	R 2 811.20		20	320.000	1.0	R 2 249.00		30	15.000	1.0
1557	Oesophageal dilatation	2004.00		20	40.000	1.0	R 281.10		20	40.000	1.0	R 281.10		30	4.000	1.0
1559	Oesophagectomy: Two stage	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	11.000	1.0
1560	Oesophagectomy: Three stage	2004.00		20	550.000	1.0	R 3 865.40		20	440.000	1.0	R 3 092.30		30	11.000	1.0
1561	Thoraco-abdominal oesophagogastrectomy	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	11.000	1.0
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	11.000	1.0

1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	11.000	1.0
1566	Private fee: Gastroplasty	2004.00		20	325.000	1.0	R 2 284.10		20	260.000	1.0	R 1 827.30		30	8.000	1.0
1567	Bochdalek hernia repair in newborn	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	14.000	1.0
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	11.000	1.0
1569	Heller's operation	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	14.000	1.0
1575	Insertion of indwelling oesophageal tube by laparotomy	2004.00		20	142.000	1.0	R 998.00		20	120.000	1.0	R 843.40		30	6.000	1.0
1578	Oesophageal motility (4 channel + pneumograph)	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	4.000	1.0
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	2004.00		20	400.000	1.0	R 2 811.20		20	320.000	1.0	R 2 249.00		30	11.000	1.0
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	2004.00		20	110.000	1.0	R 773.10		20	110.000	1.0	R 773.10		30	4.000	1.0
1581	Removal of benign oesophageal tumours	2004.00		20	285.000	1.0	R 2 003.00		20	228.000	1.0	R 1 602.40		30	11.000	1.0
1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	4.000	1.0
1583	Excision of intrathoracic oesophageal diverticulum	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	11.000	1.0
1584	24 Hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe: 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)	2004.00		20	55.000	1.0	R 386.50		20	55.000	1.0	R 386.50				
1585	24 Hour oesophageal pH studies: Interpretation	2004.00		20	27.000	1.0	R 189.80		20	27.000	1.0	R 189.80				
8.6	Stomach															
1587	Upper gastro-intestinal endoscopy: Hospital equipment	2004.00		20	48.750	1.0	R 342.60	Z	20	48.750	1.0	R 342.60	Z	30	4.000	1.0
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (item 1587)	2004.00	+	20	25.000	1.0	R 175.70	Z	20	25.000	1.0	R 175.70	Z	30	4.000	1.0
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (item 1587) or colonoscopy (item 1653)	2004.00	+	20	34.000	1.0	R 239.00		20	34.000	1.0	R 239.00		30	6.000	1.0
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (Item 1587)	2004.00	+	20	25.000	1.0	R 175.70	Z	20	25.000	1.0	R 175.70	Z	30	4.000	1.0
1593	Augmented histamine test: Gastric intubation with x-ray screening	2004.00		20	5.000	1.0	R 35.10		20	5.000	1.0	R 35.10				
1597	Gastrostomy or Gastrotomy	2004.00		20	147.500	1.0	R 1 036.60		20	120.000	1.0	R 843.40		30	6.000	1.0
1598	Gastrotomy with suture repair of bleeding ulcer	2005.03		20	251.200	1.0	R 1 765.40	Z	20	200.960	1.0	R 1 412.30	Z	30	6.000	1.0
1599	Pyloromyotomy (Rammstedt)	2004.00		20	116.000	1.0	R 815.20		20	116.000	1.0	R 815.20		30	6.000	1.0
1601	Local excision of ulcer or benign neoplasm	2004.00		20	195.600	1.0	R 1 374.70		20	156.480	1.0	R 1 099.70		30	6.000	1.0
1603	Vagotomy: Abdominal	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	6.000	1.0
1604	Vagotomy: Thoracic	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	11.000	1.0
1605	Truncal or selective with drainage procedures	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	6.000	1.0
1607	Vagotomy and antrectomy	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	6.000	1.0
1609	Highly selective vagotomy	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	6.000	1.0
1611	Pyloroplasty	2004.00		20	180.200	1.0	R 1 266.40		20	144.160	1.0	R 1 013.20		30	6.000	1.0
1613	Gastroenterostomy	2004.00		20	203.600	1.0	R 1 430.90		20	162.880	1.0	R 1 144.70		30	6.000	1.0
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	7.000	1.0
1617	Partial gastrectomy	2004.00		20	328.300	1.0	R 2 307.30		20	262.640	1.0	R 1 845.80		30	7.000	1.0
1619	Total gastrectomy	2004.00		20	384.430	1.0	R 2 701.80		20	307.540	1.0	R 2 161.40		30	7.000	1.0
1621	Revision of gastrectomy or gastro-enterostomy	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	7.000	1.0
1625	Gastro-esophageal operation for portal hypertension (Tanner)	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	11.000	1.0
8.7	Duodenum															
1626	Endoscopic examination of the small bowel beyond the duodenojejunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	2004.00		20	120.000	1.0	R 843.40		20	120.000	1.0	R 843.40		30	6.000	1.0
1627	Duodenal intubation (under X-ray screening)	2004.00		20	8.000	1.0	R 56.20									

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1629	Duodenal intubation with biliary drainage after gall bladder stimulation	2004.00		20	21.000	1.0	R	147.60										
1631	Duodenal intubation: Under 3 years of age	2006.04		20	15.000	1.0	R	105.40										
8.8	Intestines																	
1632	H2 breath test (intestines)	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30				
1633	Complete test using lactose or lactulose	2004.00		20	27.000	1.0	R	189.80		20	27.000	1.0	R	189.80				
1634	Enterotomy or Enterostomy	2004.11		20	202.600	1.0	R	1 423.90		20	162.080	1.0	R	1 139.10		30	6.000	1.0
1635	Intestinal obstruction of the newborn	2004.00		20	240.000	1.0	R	1 686.70		20	192.000	1.0	R	1 349.40		30	7.000	1.0
1637	Operation for relief of intestinal obstruction	2004.00		20	240.000	1.0	R	1 686.70		20	192.000	1.0	R	1 349.40		30	7.000	1.0
1639	Resection of small bowel with enterostomy or anastomosis	2004.00		20	244.900	1.0	R	1 721.20		20	195.920	1.0	R	1 376.90		30	6.000	1.0
1641	Entero-enterostomy or entero-colostomy for bypass	2004.00		20	213.100	1.0	R	1 497.70		20	170.480	1.0	R	1 198.10		30	6.000	1.0
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (item 0201 applicable for video capsule - disposable single patient use) (Please note: All patients should have had a normal gastroscopy and colonoscopy)	2005.03		20	150.000	1.0	R	1 054.20	Z	20	120.000	1.0	R	843.40	Z			
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	2005.03		20	90.000	1.0	R	632.50	Z	20	90.000	1.0	R	632.50	Z			
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	2004.00		20	185.200	1.0	R	1 301.60		20	148.160	1.0	R	1 041.30		30	6.000	1.0
1647	Closure of intestinal fistula	2004.00		20	258.000	1.0	R	1 813.20		20	206.400	1.0	R	1 450.60		30	6.000	1.0
1649	Excision of Meckel's diverticulum	2004.00		20	179.800	1.0	R	1 263.60		20	143.840	1.0	R	1 010.90		30	6.000	1.0
1651	Excision of lesion of mesentery	2004.00		20	171.600	1.0	R	1 206.00		20	137.280	1.0	R	964.80		30	4.000	1.0
1652	Laparotomy for mesenteric thrombosis	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	8.000	1.0
1653	Total colonoscopy: With hospital equipment (including biopsy)	2004.00		20	90.000	1.0	R	632.50	Z	20	90.000	1.0	R	632.50	Z	30	4.000	1.0
1654	Plus removal of polyps: ADD to colonoscopy (Item 1653)	2004.00	+	20	30.000	1.0	R	210.80	Z	20	30.000	1.0	R	210.80	Z	30	4.000	1.0
1656	Left-sided colonoscopy	2004.00		20	60.000	1.0	R	421.70	Z	20	60.000	1.0	R	421.70	Z	30	4.000	1.0
1657	Right or left hemicolectomy or segmental colectomy	2004.00		20	325.000	1.0	R	2 284.10		20	260.000	1.0	R	1 827.30		30	6.000	1.0
1658	Reconstruction of colon after Hartman's procedure	2004.00		20	359.400	1.0	R	2 525.90		20	287.520	1.0	R	2 020.70		30	6.000	1.0
1661	Colotomy: Including removal of tumour or foreign body	2004.00		20	205.700	1.0	R	1 445.70		20	164.560	1.0	R	1 156.50		30	6.000	1.0
1663	Total colectomy	2004.00		20	390.000	1.0	R	2 740.90		20	312.000	1.0	R	2 192.70		30	6.000	1.0
1665	Colostomy or ileostomy isolated procedure	2004.00		20	233.800	1.0	R	1 643.10		20	187.040	1.0	R	1 314.50		30	6.000	1.0
1666	Continent ileostomy pouch (all types)	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	6.000	1.0
1667	Colostomy: Closure	2004.00		20	179.100	1.0	R	1 258.70		20	143.280	1.0	R	1 007.00		30	5.000	1.0
1668	Revision of ileostomy pouch	2004.00		20	375.000	1.0	R	2 635.50		20	300.000	1.0	R	2 108.40		30	6.000	1.0
1669	Total proctocolectomy and ileostomy	2004.00		20	480.000	1.0	R	3 373.40		20	384.000	1.0	R	2 698.80		30	7.000	1.0
1670	Proctocolectomy, ileostomy and ileostomy pouch	2004.00		20	540.000	1.0	R	3 795.10		20	432.000	1.0	R	3 036.10		30	7.000	1.0
1671	Colomyotomy (Reilly operation)	2004.00		20	185.000	1.0	R	1 300.20		20	148.000	1.0	R	1 040.10		30	6.000	1.0
8.9	Appendix																	
1673	Drainage of appendix abscess	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	5.000	1.0
1675	Appendicectomy	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	4.000	1.0
8.10	Rectum and anus																	
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	2004.00		20	48.750	1.0	R	342.60	Z	20	48.750	1.0	R	342.60	Z	30	3.000	1.0
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	2004.00		20	13.000	1.0	R	91.40		20	13.000	1.0	R	91.40		30	3.000	1.0
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	2004.00	+	20	25.000	1.0	R	175.70	Z	20	25.000	1.0	R	175.70	Z	30	3.000	1.0
1679	Sigmoidoscopy with removal of polyps, first and subsequent	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	3.000	1.0
1681	Proctoscopy with removal of polyps: First time	2004.00		20	21.000	1.0	R	147.60		20	21.000	1.0	R	147.60		30	3.000	1.0
1683	Proctoscopy with removal of polyps: Subsequent times	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0
1685	Endoscopic fulguration of tumour	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0

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1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	2004.00		20	381.300	1.0	R	2 679.80		20	305.040	1.0	R	2 143.80		30	6.000	1.0
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	2004.00		20	445.000	1.0	R	3 127.50		20	356.000	1.0	R	2 502.00		30	8.000	1.0
1689	Perineal resection of rectum	2004.00		20	141.000	1.0	R	990.90		20	120.000	1.0	R	843.40		30	5.000	1.0
	Please note: Items 1691 and 1692: Abdominal and/or perineal assistant's fee to be charged additionally.	2004.00																
1691	Abdomino-perineal resection of rectum: Abdominal surgeon	2004.00		20	409.300	1.0	R	2 876.60		20	327.440	1.0	R	2 301.20		30	7.000	1.0
1692	Abdomino-perineal resection of rectum: Perineal surgeon	2004.00		20	158.500	1.0	R	1 113.90		20	126.800	1.0	R	891.20				
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	4.000	1.0
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	2004.00		20	400.000	1.0	R	2 811.20		20	320.000	1.0	R	2 249.00		30	7.000	1.0
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	6.000	1.0
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	6.000	1.0
1701	Repair of prolapsed rectum: Abdominal: Perineal	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	4.000	1.0
1703	Repair of prolapsed rectum: Abdominal: Thierisch suture	2004.00		20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	4.000	1.0
1705	Incision and drainage of peri-anal abscess	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	3.000	1.0
1707	Drainage of submucous abscess	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	3.000	1.0
1709	Drainage of ischio-rectal abscess	2004.00		20	87.000	1.0	R	611.40		20	87.000	1.0	R	611.40		30	3.000	1.0
1711	Excision of pelvi-rectal fistula	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	5.000	1.0
1713	Excision of fistula-in-ano	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	3.000	1.0
1715	Operation for fissure-in-ano	2004.00		20	66.800	1.0	R	469.50		20	66.800	1.0	R	469.50		30	3.000	1.0
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
1721	Sclerosing injection for haemorrhoids: Per injection	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10				
1723	Haemorrhoidectomy	2004.00		20	120.000	1.0	R	843.40		20	120.000	1.0	R	843.40		30	3.000	1.0
1725	Drainage of external thrombosed pile	2004.00		20	12.500	1.0	R	87.90		20	12.500	1.0	R	87.90		30	3.000	1.0
1727	Multiple procedures (haemorrhoids, fissure, etc.)	2004.00		20	90.000	1.0	R	632.50		20	90.000	1.0	R	632.50		30	3.000	1.0
1728	Biopsy of ano-rectal wall, for congenital megacolon	2005.03		20	60.600	1.0	R	425.90	Z	20	60.600	1.0	R	425.90	Z	30	5.000	1.0
1729	Excision of anal skin tags	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	3.000	1.0
1731	Operation for low imperforate anus	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
1733	Anoplasty: Y-V-plasty	2004.00		20	41.000	1.0	R	288.10		20	41.000	1.0	R	288.10		30	3.000	1.0
1735	Anal sphincteroplasty for incontinence	2004.00		20	120.000	1.0	R	843.40		20	120.000	1.0	R	843.40		30	3.000	1.0
1737	Dilation of ano-rectal stricture	2004.00		20	12.500	1.0	R	87.90		20	12.500	1.0	R	87.90		30	3.000	1.0
1739	Closure of recto-vesical fistula	2004.00		20	241.000	1.0	R	1 693.70		20	192.800	1.0	R	1 355.00		30	5.000	1.0
1741	Closure of recto-urethral fistula	2004.00		20	241.000	1.0	R	1 693.70		20	192.800	1.0	R	1 355.00		30	5.000	1.0
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	2004.00		20	27.000	1.0	R	189.80		20	27.000	1.0	R	189.80				
8.11	Liver																	
1743	Needle biopsy of liver	2004.00		20	30.300	1.0	R	212.90		20	30.300	1.0	R	212.90		30	3.000	1.0
1745	Biopsy of liver by laparotomy	2004.00		20	125.000	1.0	R	878.50		20	120.000	1.0	R	843.40		30	4.000	1.0
1747	Drainage of liver abscess or cyst	2004.00		20	179.100	1.0	R	1 258.70		20	143.280	1.0	R	1 007.00		30	7.000	1.0
1748	Body composition measured by bio-electrical impedance	2004.00		20	3.000	1.0	R	21.10		20	3.000	1.0	R	21.10				
1749	Hemi-hepatectomy: Right	2004.00		20	564.000	1.0	R	3 963.80		20	451.200	1.0	R	3 171.00		30	9.000	1.0
1751	Hemi-hepatectomy: Left	2004.00		20	521.100	1.0	R	3 662.30		20	416.880	1.0	R	2 929.80		30	9.000	1.0
1752	Extended right or left hepatectomy	2004.00		20	570.900	1.0	R	4 012.30		20	456.720	1.0	R	3 209.80		30	9.000	1.0
1753	Partial or segmental hepatectomy	2004.00		20	378.000	1.0	R	2 656.60		20	302.400	1.0	R	2 125.30		30	9.000	1.0

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1754	Hepatico-jejunostomy	2004.00		20	369.200	1.0	R 2 594.70		20	295.360	1.0	R 2 075.80		30	9.000	1.0
1755	Liver transplant	2004.00		20	1400.800	1.0	R 9 844.80		20	########	1.0	R 7 875.90		30	15.000	1.0
1756	Harvesting donor hepatectomy	2004.00		20	616.200	1.0	R 4 330.70		20	492.960	1.0	R 3 464.50		30	5.000	1.0
1757	Suture of liver wound or injury	2004.00		20	214.200	1.0	R 1 505.40		20	171.360	1.0	R 1 204.30		30	9.000	1.0
8.12	Biliary tract															
1759	Cholecystostomy	2004.00		20	171.600	1.0	R 1 206.00		20	137.280	1.0	R 964.80		30	6.000	1.0
1761	Cholecystectomy	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	6.000	1.0
1762	Cholecystectomy and operative cholangiogram	2004.00		20	255.000	1.0	R 1 792.10		20	204.000	1.0	R 1 433.70		30	6.000	1.0
1763	With exploration of common bile duct	2004.00		20	264.500	1.0	R 1 858.90		20	211.600	1.0	R 1 487.10		30	6.000	1.0
1765	Exploration of common bile duct: Secondary operation	2004.00		20	327.700	1.0	R 2 303.10		20	262.160	1.0	R 1 842.50		30	6.000	1.0
1767	Reconstruction of common bile duct	2004.00		20	371.700	1.0	R 2 612.30		20	297.360	1.0	R 2 089.80		30	6.000	1.0
1768	Resection bile duct tumour with reconstruction	2004.00		20	327.700	1.0	R 2 303.10		20	262.160	1.0	R 1 842.50		30	6.000	1.0
1769	Cholecysto-enterostomy or gastrostomy	2004.00		20	236.300	1.0	R 1 660.70		20	189.040	1.0	R 1 328.60		30	6.000	1.0
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	2006.04	+	20	25.600	1.0	R 179.90		20	25.600	1.0	R 179.90		30	6.000	1.0
1773	Transduodenal sphincteroplasty	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	6.000	1.0
1774	Balloon dilatation of common bile duct strictures	2004.00		20	125.000	1.0	R 878.50		20	100.000	1.0	R 702.80		30	6.000	1.0
1775	Excision choledochal cyst with reconstruction	2004.00		20	327.700	1.0	R 2 303.10		20	262.160	1.0	R 1 842.50		30	6.000	1.0
1777	Porto-enterostomy for biliary atresia	2004.00		20	400.000	1.0	R 2 811.20		20	320.000	1.0	R 2 249.00		30	11.000	1.0
8.13	Pancreas															
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	2004.00		20	105.900	1.0	R 744.30		20	105.900	1.0	R 744.30		30	4.000	1.0
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	2004.00	+	20	15.820	1.0	R 111.20		20	15.820	1.0	R 111.20		30	4.000	1.0
1780	Gastric and duodenal intubation	2004.00		20	8.000	1.0	R 56.20		20	8.000	1.0	R 56.20				
1781	Procedure (excluding laboratory tests)	2004.00		20	21.000	1.0	R 147.60		20	21.000	1.0	R 147.60				
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	2004.00	+	20	30.000	1.0	R 210.80		20	30.000	1.0	R 210.80		30	4.000	1.0
1783	Drainage of pancreatic abscess	2004.00		20	239.300	1.0	R 1 681.80		20	191.440	1.0	R 1 345.40		30	6.000	1.0
1784	Debridement pancreatic necrosis	2004.00		20	348.400	1.0	R 2 448.60		20	278.720	1.0	R 1 958.80		30	6.000	1.0
1785	Internal drainage of pancreatic cyst	2004.00		20	250.600	1.0	R 1 761.20		20	200.480	1.0	R 1 409.00		30	6.000	1.0
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	2004.00	+	20	30.000	1.0	R 210.80		20	30.000	1.0	R 210.80		30	6.000	1.0
1786	Internal drainage of pancreatic cyst with Roux-Y	2004.00		20	306.800	1.0	R 2 156.20		20	245.440	1.0	R 1 725.00		30	6.000	1.0
1787	Operative pancreatogram: ADD	2004.00	+	20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30				
1788	Biopsy of pancreas	2004.00		20	177.700	1.0	R 1 248.90		20	142.160	1.0	R 999.10		30	6.000	1.0
1789	Pancreatico-duodenectomy	2004.00		20	704.800	1.0	R 4 953.30		20	563.840	1.0	R 3 962.70		30	8.000	1.0
1791	Local, partial or subtotal pancreatectomy	2004.00		20	351.300	1.0	R 2 468.90		20	281.040	1.0	R 1 975.10		30	8.000	1.0
1793	Distal pancreatectomy with internal drainage	2004.00		20	377.400	1.0	R 2 652.40		20	301.920	1.0	R 2 121.90		30	8.000	1.0
8.14	Peritoneal cavity															
1797	Pneumo-peritoneum: First	2004.00		20	13.000	1.0	R 91.40		20	13.000	1.0	R 91.40		30	4.000	1.0
1799	Pneumo-peritoneum: Repeat	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20		30	4.000	1.0
1800	Peritoneal lavage	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60				
1801	Diagnostic paracentesis: Abdomen	2004.00		20	8.000	1.0	R 56.20		20	8.000	1.0	R 56.20				
1803	Therapeutic paracentesis: Abdomen	2004.00		20	13.000	1.0	R 91.40		20	13.000	1.0	R 91.40				
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	2004.00	+	20	45.000	1.0	R 316.30		20	45.000	1.0	R 316.30		30	5.000	1.0
1809	Laparotomy	2004.00		20	196.000	1.0	R 1 377.50		20	156.800	1.0	R 1 102.00		30	4.000	1.0

1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	7.000	1.0
1811	Suture of burst abdomen	2004.00		20	188.300	1.0	R 1 323.40		20	150.640	1.0	R 1 058.70		30	7.000	1.0
1812	Laparotomy for control of surgical haemorrhage	2004.00		20	105.000	1.0	R 737.90		20	105.000	1.0	R 737.90		30	9.000	1.0
1813	Drainage of sub-phrenic abscess	2004.00		20	180.000	1.0	R 1 265.00		20	144.000	1.0	R 1 012.00		30	7.000	1.0
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	2004.00		20	248.400	1.0	R 1 745.80		20	198.720	1.0	R 1 396.60		30	5.000	1.0
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10		30	4.000	1.0
9	Herniae															
1819	Inguinal or femoral hernia: Adult	2004.00		20	125.000	1.0	R 878.50		20	120.000	1.0	R 843.40		30	4.000	1.0
1821	Inguinal or femoral hernia: Child under 14 years	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	4.000	1.0
1823	Inguinal hernia: Infant under one year	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	4.000	1.0
1825	Recurrent inguinal or femoral hernia	2004.00		20	155.000	1.0	R 1 089.30		20	124.000	1.0	R 871.50		30	4.000	1.0
1827	Strangulated hernia or femoral hernia	2004.00		20	238.000	1.0	R 1 672.70		20	190.400	1.0	R 1 338.10		30	7.000	1.0
1829	Epigastric hernia	2004.00		20	93.300	1.0	R 655.70		20	93.300	1.0	R 655.70		30	4.000	1.0
1831	Umbilical hernia: Adult	2004.00		20	140.000	1.0	R 983.90		20	120.000	1.0	R 843.40		30	4.000	1.0
1833	Umbilical hernia: Child under 14 years	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	4.000	1.0
1835	Incisional hernia	2004.00		20	166.800	1.0	R 1 172.30		20	133.440	1.0	R 937.80		30	4.000	1.0
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to item for the incisional or ventral hernia repair)	2004.00	+	20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	4.000	1.0
1837	Repair of omphalocele in new-born (one or more procedures)	2004.00		20	275.000	1.0	R 1 932.70		20	220.000	1.0	R 1 546.20		30	7.000	1.0
10	Urinary System															
	RULES GOVERNING THE SECTION URINARY SYSTEM															
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.	2004.00														
10.1	Kidney															
1839	Renal biopsy: Per kidney: Open	2004.00		20	71.000	1.0	R 499.00		20	71.000	1.0	R 499.00		30	5.000	1.0
1841	Renal biopsy: Needle	2004.00		20	30.000	1.0	R 210.80		20	30.000	1.0	R 210.80		30	3.000	1.0
1843	Peritoneal dialysis: First day	2004.00		20	33.000	1.0	R 231.90		20	33.000	1.0	R 231.90				
1845	Peritoneal dialysis: Every subsequent day	2004.00		20	33.000	1.0	R 231.90		20	33.000	1.0	R 231.90				
1847	Haemodialysis: Per hour or part thereof	2004.00		20	21.000	1.0	R 147.60		20	21.000	1.0	R 147.60				
1849	Haemodialysis: Maximum: Eight hours	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60				
1851	Haemodialysis: Thereafter per week	2004.00		20	55.000	1.0	R 386.50		20	55.000	1.0	R 386.50				
1852	Continuous haemodiafiltration per day in intensive or high care unit	2004.00		20	33.000	1.0	R 231.90		20	33.000	1.0	R 231.90				
1853	Nephrectomy: Primary nephrectomy	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	5.000	1.0
1855	Nephrectomy: Secondary nephrectomy	2004.00		20	267.000	1.0	R 1 876.50		20	213.600	1.0	R 1 501.20		30	5.000	1.0
1857	Radical with regional lymph adenectomy for tumour	2004.11		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	6.000	1.0
1859	Nephrectomy: Partial	2004.00		20	267.000	1.0	R 1 876.50		20	213.600	1.0	R 1 501.20		30	5.000	1.0
1861	Symphysiotomy for horse-shoe kidney	2004.00		20	287.000	1.0	R 2 017.00		20	229.600	1.0	R 1 613.60		30	6.000	1.0
1863	Nephro-ureterectomy	2004.00		20	305.000	1.0	R 2 143.50		20	244.000	1.0	R 1 714.80		30	5.000	1.0
1865	Nephrotomy with drainage nephrostomy	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	6.000	1.0

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1869	Nephrolithotomy	2004.00		20	227.000	1.0	R 1 595.40		20	181.600	1.0	R 1 276.30		30	5.000	1.0
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	2004.00		20	284.000	1.0	R 1 996.00		20	227.200	1.0	R 1 596.80		30	5.000	1.0
1871	Staghorn stone: Surgical	2004.00		20	341.000	1.0	R 2 396.50		20	272.800	1.0	R 1 917.20		30	6.000	1.0
1873	Suture renal laceration (renorraphy)	2004.00		20	193.000	1.0	R 1 356.40		20	154.400	1.0	R 1 085.10		30	6.000	1.0
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	2004.00		20	34.000	1.0	R 239.00		20	34.000	1.0	R 239.00		30	3.000	1.0
1877	Operation for renal cyst: Marsupialisation or excision	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1879	Closure renal fistula	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1881	Pyeloplasty	2006.04		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	5.000	1.0
1883	Pyelostomy	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1885	Pyelolithotomy	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	2004.00		20	223.000	1.0	R 1 567.20		20	178.400	1.0	R 1 253.80		30	5.000	1.0
1889	Nephrectomy for Allograft: Living or dead	2004.00		20	255.000	1.0	R 1 792.10		20	204.000	1.0	R 1 433.70		30	5.000	1.0
1891	Perinephric abscess or renal abscess: Drainage	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	7.000	1.0
1893	Aberrant renal vessels: Repositioning with pyeloplasty	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	5.000	1.0
1894	Auto transplantation of kidney	2004.00		20	420.000	1.0	R 2 951.80		20	336.000	1.0	R 2 361.40		30	10.000	1.0
1895	Allo transplantation of kidney	2004.00		20	420.000	1.0	R 2 951.80		20	336.000	1.0	R 2 361.40		30	10.000	1.0
10.2	Ureter															
1897	Ureterorraphy: Suture of ureter	2004.11		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	5.000	1.0
1898	Ureterorraphy: Lumbar approach	2004.11		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1899	Ureteroplasty	2004.00		20	181.000	1.0	R 1 272.10		20	144.800	1.0	R 1 017.70		30	5.000	1.0
1901	Ureterolysis	2004.00		20	118.000	1.0	R 829.30		20	118.000	1.0	R 829.30		30	5.000	1.0
1902	Ureterolysis: Lumbar approach	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1903	Ureterectomy only	2004.00		20	137.000	1.0	R 962.80		20	120.000	1.0	R 843.40		30	5.000	1.0
1905	Ureterolithotomy	2004.00		20	265.800	1.0	R 1 868.00		20	212.640	1.0	R 1 494.40		30	5.000	1.0
1907	Cutaneous ureterostomy: Unilateral	2004.00		20	108.000	1.0	R 759.00		20	108.000	1.0	R 759.00		30	5.000	1.0
1909	Cutaneous ureterostomy: Bilateral	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
1911	Uretero-enterostomy: Unilateral	2004.00		20	137.000	1.0	R 962.80		20	120.000	1.0	R 843.40		30	5.000	1.0
1913	Uretero-enterostomy: Bilateral	2004.00		20	240.000	1.0	R 1 686.70		20	192.000	1.0	R 1 349.40		30	5.000	1.0
1915	Uretero-ureterostomy	2004.00		20	137.000	1.0	R 962.80		20	120.000	1.0	R 843.40		30	5.000	1.0
1917	Transuretero-ureterostomy	2004.00		20	155.000	1.0	R 1 089.30		20	124.000	1.0	R 871.50		30	5.000	1.0
1919	Closure of ureteric fistula	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	5.000	1.0
1921	Immediate deligation of ureter	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	5.000	1.0
1923	Ureterolysis for retrocaval ureter with anastomosis	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	5.000	1.0
1925	Uretero-pyelostomy	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	5.000	1.0
1927	Uretero-neo-cystostomy: Unilateral	2004.00		20	316.100	1.0	R 2 221.60		20	252.880	1.0	R 1 777.20		30	5.000	1.0
1929	Uretero-neo-cystostomy: Bilateral	2004.00		20	474.150	1.0	R 3 332.30		20	379.320	1.0	R 2 665.90		30	5.000	1.0
1931	Uretero-neo-cystostomy: With Boariplasty	2004.00		20	351.800	1.0	R 2 472.50		20	281.440	1.0	R 1 978.00		30	5.000	1.0
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	5.000	1.0
1935	Uretero-ileal conduit	2004.00		20	388.000	1.0	R 2 726.90		20	310.400	1.0	R 2 181.50		30	5.000	1.0
1937	Replacement of ureter by bowel segment: Unilateral	2004.00		20	277.000	1.0	R 1 946.80		20	221.600	1.0	R 1 557.40		30	5.000	1.0
1939	Replacement of ureter by bowel segment: Bilateral	2004.00		20	485.000	1.0	R 3 408.60		20	388.000	1.0	R 2 726.90		30	5.000	1.0
1941	Ureterostomy-in-situ: Unilateral	2004.00		20	100.000	1.0	R 702.80		20	100.000	1.0	R 702.80		30	5.000	1.0
1943	Ureterostomy-in-situ: Bilateral	2004.00		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90		30	5.000	1.0
10.3	Bladder															
1952	J J Stent catheter	2004.00	+	20	44.000	1.0	R 309.20		20	44.000	1.0	R 309.20		30	3.000	1.0

1953	With hydrodilatation of the bladder for interstitial cystitis	2004.00	+	20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10		30	3.000	1.0
1954	Uretroscopy	2004.00	+	20	35.000	1.0	R	246.00								30	3.000	1.0
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	2004.00	+	20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	3.000	1.0
1957	With dilatation of the ureter or ureters	2004.00	+	20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	3.000	1.0
1959	With manipulation of ureteral calculus	2004.00	+	20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0
1961	With removal of foreign body or calculus from urethra or bladder	2004.00	+	20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0
1963	With fulguration or treatment of minor lesions, with or without biopsy	2004.00	+	20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0
1964	And control of haemorrhage and blood clot evacuation	2004.00	+	20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0
1965	And catheterisation of the ejaculatory duct	2004.00	+	20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
1967	With ureteric meatotomy: Unilateral or bilateral	2004.00	+	20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0
1969	And cold biopsy	2004.00	+	20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	3.000	1.0
1971	With cryosurgery for bladder or prostatic disease	2004.00	+	20	55.000	1.0	R	386.50		20	55.000	1.0	R	386.50		30	3.000	1.0
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	2004.00	+	20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	3.000	1.0
1975	Ultraviolet cystoscopy for bladder tumour	2004.00		20	60.000	1.0	R	421.70		20	60.000	1.0	R	421.70		30	3.000	1.0
1976	Optic urethrotomy	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	3.000	1.0
1977	Transurethral resection of ejaculatory duct	2004.00		20	60.700	1.0	R	426.60		20	60.700	1.0	R	426.60		30	3.000	1.0
1979	Internal urethrotomy: Female	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	3.000	1.0
1981	Internal urethrotomy: Male	2004.00		20	76.200	1.0	R	535.50		20	76.200	1.0	R	535.50		30	3.000	1.0
1983	Transurethral resection of bladder tumour	2004.00		20	100.000	1.0	R	702.80		20	100.000	1.0	R	702.80		30	5.000	1.0
1984	Transurethral resection of bladder tumours: Large multiple tumours	2004.00		20	115.000	1.0	R	808.20		20	115.000	1.0	R	808.20		30	5.000	1.0
1985	Transurethral resection of bladder neck: Female or child	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	5.000	1.0
1986	Transurethral resection of bladder neck: Male	2004.00		20	125.000	1.0	R	878.50		20	120.000	1.0	R	843.40		30	5.000	1.0
1987	Litholapaxy	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	5.000	1.0
1989	Cystometrogram	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	3.000	1.0
1991	Flometric bladder, studies with videocystograph	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	3.000	1.0
1992	Without videocystograph	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	3.000	1.0
1993	Voiding cysto-urethrogram	2004.00		20	21.000	1.0	R	147.60		20	21.000	1.0	R	147.60		30	3.000	1.0
1994	Rigiscan examination	2004.00		20	66.000	1.0	R	463.80		20	66.000	1.0	R	463.80				
1995	Percutaneous aspiration of bladder	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
1996	Bladder catheterisation: Male (not at operation)	2004.00		20	6.000	1.0	R	42.20		20	6.000	1.0	R	42.20		30	3.000	1.0
1997	Bladder catheterisation: Female (not at operation)	2004.00		20	3.000	1.0	R	21.10		20	3.000	1.0	R	21.10				
1999	Percutaneous cystostomy	2004.00		20	24.000	1.0	R	168.70		20	24.000	1.0	R	168.70		30	3.000	1.0
1945	Instillation of radio-opaque material for cystography or urethrocystography	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10		30	3.000	1.0
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
1949	Cystoscopy: Hospital equipment	2004.00		20	44.000	1.0	R	309.20		20	44.000	1.0	R	309.20		30	3.000	1.0
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	2004.00	+	20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	3.000	1.0
2001	Total cystectomy: After previous urinary diversion	2004.00		20	294.000	1.0	R	2 066.20		20	235.200	1.0	R	1 653.00		30	8.000	1.0
2003	Total cystectomy: With conduit construction and ureteric anastomosis	2004.00		20	554.700	1.0	R	3 898.40		20	443.760	1.0	R	3 118.70		30	8.000	1.0
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	2004.00		20	650.000	1.0	R	4 568.20		20	520.000	1.0	R	3 654.60		30	8.000	1.0
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	2004.00		20	700.000	1.0	R	4 919.60		20	560.000	1.0	R	3 935.70		30	8.000	1.0
2007	Partial cystectomy	2004.00		20	147.000	1.0	R	1 033.10		20	120.000	1.0	R	843.40		30	6.000	1.0
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	2004.00		20	600.000	1.0	R	4 216.80		20	480.000	1.0	R	3 373.40		30	8.000	1.0

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2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	2004.00	20	462.000	1.0	R 3 246.90	20	369.600	1.0	R 2 597.50	30	8.000	1.0
2010	Reversion of temporary conduit	2004.00	20	360.000	1.0	R 2 530.10	20	288.000	1.0	R 2 024.10	30	8.000	1.0
2011	Partial cystectomy with uretero-neo-cystostomy	2004.00	20	202.000	1.0	R 1 419.70	20	161.600	1.0	R 1 135.70	30	6.000	1.0
2012	Reversion of conduit with major urinary tract reconstruction	2004.00	20	600.000	1.0	R 4 216.80	20	480.000	1.0	R 3 373.40	30	8.000	1.0
2013	Diverticulectomy (independent procedure): Multiple or single	2004.00	20	137.000	1.0	R 962.80	20	120.000	1.0	R 843.40	30	5.000	1.0
2015	Suprapubic cystostomy	2004.00	20	67.000	1.0	R 470.90	20	67.000	1.0	R 470.90	30	5.000	1.0
2016	Abdomino-neo-urethrostomy	2004.00	20	252.000	1.0	R 1 771.10	20	201.600	1.0	R 1 416.80	30	5.000	1.0
2017	Open loop fulguration or excision of bladder tumour	2004.00	20	101.000	1.0	R 709.80	20	101.000	1.0	R 709.80	30	5.000	1.0
2019	Operation for vesico-vaginal or urethra-vaginal fistula	2004.00	20	155.000	1.0	R 1 089.30	20	124.000	1.0	R 871.50	30	5.000	1.0
2020	Repair of vesico vaginal fistula: Abdominal approach	2004.00	20	255.000	1.0	R 1 792.10	20	204.000	1.0	R 1 433.70	30	5.000	1.0
2021	Vesico-plication (Hamilton Stewart)	2004.00	20	118.000	1.0	R 829.30	20	118.000	1.0	R 829.30	30	5.000	1.0
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	2004.11	20	195.000	1.0	R 1 370.50	20	156.000	1.0	R 1 096.40	30	5.000	1.0
2025	Vesico-urethropexy with rectus sling	2004.11	20	229.400	1.0	R 1 612.20	20	183.520	1.0	R 1 289.80	30	5.000	1.0
2027	Open operation for ureterocele: Unilateral	2004.00	20	118.000	1.0	R 829.30	20	118.000	1.0	R 829.30	30	5.000	1.0
2029	Open operation for ureterocele: Bilateral	2004.00	20	207.000	1.0	R 1 454.80	20	165.600	1.0	R 1 163.80	30	5.000	1.0
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	2004.00	20	264.000	1.0	R 1 855.40	20	211.200	1.0	R 1 484.30	30	8.000	1.0
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	2004.00	20	53.000	1.0	R 372.50	20	53.000	1.0	R 372.50	30	8.000	1.0
2035	Cutaneous vesicostomy	2004.00	20	118.000	1.0	R 829.30	20	118.000	1.0	R 829.30	30	5.000	1.0
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	2004.00	20	126.000	1.0	R 885.50	20	120.000	1.0	R 843.40	30	5.000	1.0
2039	Operation for ruptured bladder	2004.00	20	137.000	1.0	R 962.80	20	120.000	1.0	R 843.40	30	6.000	1.0
2042	Enterocystoplasty plus bowel anastomosis	2004.00	20	419.900	1.0	R 2 951.10	20	335.920	1.0	R 2 360.80	30	5.000	1.0
2043	Cysto-lithotomy	2004.00	20	132.000	1.0	R 927.70	20	120.000	1.0	R 843.40	30	5.000	1.0
2045	Excision of patent-urachus or urachal cyst	2004.00	20	112.000	1.0	R 787.10	20	112.000	1.0	R 787.10	30	5.000	1.0
2047	Drainage of perivesical or prevesical abscess	2004.00	20	105.000	1.0	R 737.90	20	105.000	1.0	R 737.90	30	5.000	1.0
2049	Evacuation of clots from bladder: Other than post-operative	2004.00	20	132.100	1.0	R 928.40	20	120.000	1.0	R 843.40	30	3.000	1.0
2050	Evacuation of clots from bladder: Post-operative	2004.00									30	4.000	1.0
2051	Simple bladder lavage: Including catheterisation	2004.00	20	12.000	1.0	R 84.30	20	12.000	1.0	R 84.30	30	3.000	1.0
2053	Bladder neck plasty: Male	2004.00	20	137.000	1.0	R 962.80	20	120.000	1.0	R 843.40	30	5.000	1.0
2057	Bladder neck plasty: Female	2004.00	20	137.000	1.0	R 962.80	20	120.000	1.0	R 843.40	30	5.000	1.0
10.4	Urethra												
2059	Open biopsy of urethra: Male	2004.00	20	45.000	1.0	R 316.30	20	45.000	1.0	R 316.30	30	3.000	1.0
2061	Open biopsy of urethra: Female	2004.00	20	45.000	1.0	R 316.30	20	45.000	1.0	R 316.30	30	3.000	1.0
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	2004.00	20	20.000	1.0	R 140.60	20	20.000	1.0	R 140.60	30	3.000	1.0
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	2004.00	20	10.000	1.0	R 70.30	20	10.000	1.0	R 70.30	30	3.000	1.0
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	2004.00	20	20.000	1.0	R 140.60	20	20.000	1.0	R 140.60	30	3.000	1.0
2069	Dilatation of female urethra	2004.00	20	5.000	1.0	R 35.10	20	5.000	1.0	R 35.10	30	3.000	1.0
2071	Urethrorraphy: Suture of urethral wound or injury	2004.00	20	139.000	1.0	R 976.90	20	120.000	1.0	R 843.40	30	4.000	1.0
2073	External urethrotomy: Pendulous urethra (anterior)	2004.00	20	67.000	1.0	R 470.90	20	67.000	1.0	R 470.90	30	3.000	1.0
2075	Urethraplasty: Pendulous urethra: First stage	2004.00	20	71.000	1.0	R 499.00	20	71.000	1.0	R 499.00	30	4.000	1.0
2077	Urethraplasty: Pendulous urethra: Second stage	2004.00	20	145.000	1.0	R 1 019.10	20	120.000	1.0	R 843.40	30	4.000	1.0
2079	Reconstruction of female urethra	2004.00	20	147.000	1.0	R 1 033.10	20	120.000	1.0	R 843.40	30	4.000	1.0
2081	Reconstruction or repair of male anterior urethra (one stage)	2004.00	20	261.600	1.0	R 1 838.50	20	209.280	1.0	R 1 470.80	30	4.000	1.0
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	2004.00	20	168.000	1.0	R 1 180.70	20	134.400	1.0	R 944.60	30	6.000	1.0
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	2004.00	20	168.000	1.0	R 1 180.70	20	134.400	1.0	R 944.60	30	6.000	1.0

2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	2004.00		20	294.000	1.0	R 2 066.20		20	235.200	1.0	R 1 653.00		30	6.000	1.0
2087	Urethral diverticulectomy: Male or female	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	4.000	1.0
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units	2004.00		20	86.000	1.0	R 604.40		20	86.000	1.0	R 604.40				
2089	Marsupialisation of urethral diverticula: Male or female	2004.00		20	115.100	1.0	R 808.90		20	115.100	1.0	R 808.90		30	4.000	1.0
2091	Total urethrectomy: Female	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	5.000	1.0
2093	Total urethrectomy: Male	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
2095	Drainage of simple localised perineal urinary extravasation	2004.00		20	128.800	1.0	R 905.20		20	120.000	1.0	R 843.40		30	5.000	1.0
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	2005.05		20	137.000	1.0	R 962.80		20	120.000	1.0	R 843.40		30	5.000	1.0
2099	Fulguration for urethral caruncle or polyp	2004.00		20	53.600	1.0	R 376.70		20	53.600	1.0	R 376.70		30	3.000	1.0
2101	Excision of urethral caruncle	2004.00		20	53.600	1.0	R 376.70		20	53.600	1.0	R 376.70		30	3.000	1.0
2103	Simple urethral meatotomy	2004.00		20	26.300	1.0	R 184.80		20	26.300	1.0	R 184.80		30	3.000	1.0
2105	Incision of deep peri-urethral abscess: Female	2004.00		20	123.100	1.0	R 865.10		20	120.000	1.0	R 843.40		30	3.000	1.0
2107	Incision of deep peri-urethral abscess: Male	2004.00		20	123.100	1.0	R 865.10		20	120.000	1.0	R 843.40		30	3.000	1.0
2109	Badenoch pull-through for intractable stricture or incontinence	2004.00		20	181.000	1.0	R 1 272.10		20	144.800	1.0	R 1 017.70		30	5.000	1.0
2111	External sphincterotomy	2006.04		20	108.000	1.0	R 759.00		20	108.000	1.0	R 759.00		30	5.000	1.0
2113	Drainage of Skene gland abscess or cyst	2004.00		20	42.300	1.0	R 297.30		20	42.300	1.0	R 297.30		30	3.000	1.0
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	5.000	1.0
2116	Urethral meatoplasty	2004.00		20	101.500	1.0	R 713.30		20	101.500	1.0	R 713.30		30	3.000	1.0
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	2004.00		20	150.300	1.0	R 1 056.30		20	120.240	1.0	R 845.00		30	3.000	1.0
2121	Closure of urethrovaginal fistula: Including diversionary procedures	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	5.000	1.0
11	Male Genital System															
11.1	Penis															
2123	Biopsy of penis (independent procedure)	2004.00		20	52.100	1.0	R 366.20		20	52.100	1.0	R 366.20		30	3.000	1.0
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)	2006.04		20	16.600	1.0	R 116.70		20	16.600	1.0	R 116.70		30	3.000	1.0
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	2006.04		20	41.600	1.0	R 292.40		20	41.600	1.0	R 292.40		30	3.000	1.0
2129	Electrodesiccation: Limited number	2004.00		20	20.800	1.0	R 146.20		20	20.800	1.0	R 146.20		30	3.000	1.0
2131	Electrodesiccation: Multiple extensive	2004.00		20	41.600	1.0	R 292.40		20	41.600	1.0	R 292.40		30	3.000	1.0
2132	Ligation of abnormal venous drainage	2004.00		20	106.100	1.0	R 745.70		20	106.100	1.0	R 745.70		30	3.000	1.0
2133	Circumcision: Clamp procedure	2004.00		20	42.300	1.0	R 297.30		20	42.300	1.0	R 297.30		30	3.000	1.0
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	2004.00		20	60.000	1.0	R 421.70		20	60.000	1.0	R 421.70		30	3.000	1.0
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	2004.00		20	36.800	1.0	R 258.60		20	36.800	1.0	R 258.60		30	3.000	1.0
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	2004.00		20	101.000	1.0	R 709.80		20	101.000	1.0	R 709.80		30	3.000	1.0
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	2004.00		20	188.600	1.0	R 1 325.50		20	150.880	1.0	R 1 060.40		30	3.000	1.0
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	2004.00		20	224.600	1.0	R 1 578.50		20	179.680	1.0	R 1 262.80		30	3.000	1.0
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	3.000	1.0
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	3.000	1.0
2153	Reconstructive operation for epispadias with incontinence	2004.00		20	168.000	1.0	R 1 180.70		20	134.400	1.0	R 944.60		30	3.000	1.0
2154	Induction of artificial erection	2004.00		20	16.000	1.0	R 112.40		20	16.000	1.0	R 112.40		30	3.000	1.0
2155	Hypospadias: Urethral reconstruction	2004.00		20	187.000	1.0	R 1 314.20		20	149.600	1.0	R 1 051.40		30	3.000	1.0
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	2004.00		20	84.000	1.0	R 590.40		20	84.000	1.0	R 590.40		30	3.000	1.0

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2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	3.000	1.0
2161	Total amputation of penis: Without gland dissection	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	4.000	1.0
2163	Total amputation of penis: With gland-dissection	2004.00		20	336.000	1.0	R 2 361.40		20	268.800	1.0	R 1 889.10		30	6.000	1.0
2165	Partial amputation of penis: With gland-dissection	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	6.000	1.0
2167	Partial amputation of penis: Without gland-dissection	2004.00		20	84.000	1.0	R 590.40		20	84.000	1.0	R 590.40		30	4.000	1.0
2169	Injection procedure for Peyronie's disease	2004.00		20	14.000	1.0	R 98.40		20	14.000	1.0	R 98.40		30	3.000	1.0
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	2004.00		20	42.000	1.0	R 295.20		20	42.000	1.0	R 295.20		30	3.000	1.0
2173	Priapism operation: Shunt procedure: Any type	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	4.000	1.0
2174	Priapism operation: Stab shunt	2004.00		20	114.400	1.0	R 804.00		20	114.400	1.0	R 804.00		30	4.000	1.0
11.2	Testis and epididymis															
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure	2004.00														
2175	Testis biopsy: Needle (independent procedure)	2004.00		20	18.500	1.0	R 130.00		20	18.500	1.0	R 130.00		30	3.000	1.0
2177	Testis biopsy: Incisional: Independent procedure: Unilateral	2004.00		20	58.900	1.0	R 413.90		20	58.900	1.0	R 413.90		30	3.000	1.0
2179	Testis biopsy: Incisional: Independent procedure: Bilateral	2004.00		20	58.900	1.0	R 413.90		20	58.900	1.0	R 413.90		30	3.000	1.0
2181	Epididymis biopsy: Needle	2004.00		20	86.100	1.0	R 605.10		20	86.100	1.0	R 605.10		30	3.000	1.0
2183	Puncture aspiration hydrocele with or without injection of medication	2004.00		20	10.000	1.0	R 70.30		20	10.000	1.0	R 70.30		30	3.000	1.0
2185	Operation for maldescended testicle: Including herniotomy	2004.00		20	135.000	1.0	R 948.80		20	120.000	1.0	R 843.40		30	4.000	1.0
2187	Operation for torsion appendix testis	2004.00		20	119.200	1.0	R 837.70		20	119.200	1.0	R 837.70		30	4.000	1.0
2189	Operation for torsion testis with fixation of contralateral testis	2004.00		20	119.200	1.0	R 837.70		20	119.200	1.0	R 837.70		30	4.000	1.0
2191	Orchidectomy (total or subcapsular): Unilateral	2004.00		20	98.000	1.0	R 688.70		20	98.000	1.0	R 688.70		30	3.000	1.0
2193	Orchidectomy (total or subcapsular): Bilateral	2004.00		20	147.000	1.0	R 1 033.10		20	120.000	1.0	R 843.40		30	3.000	1.0
2195	Radical operation for malignant testis: Excluding gland dissection	2004.00		20	155.300	1.0	R 1 091.40		20	124.240	1.0	R 873.20		30	6.000	1.0
2197	Operation for hydrocele or spermatocele	2004.00		20	99.800	1.0	R 701.40		20	99.800	1.0	R 701.40		30	4.000	1.0
2199	Varicocelectomy	2004.00		20	106.100	1.0	R 745.70		20	106.100	1.0	R 745.70		30	4.000	1.0
2201	Abdominal ligation of spermatic vein for varicocele	2004.00		20	112.800	1.0	R 792.80		20	112.800	1.0	R 792.80		30	4.000	1.0
2203	Epididymectomy: Unilateral	2004.00		20	114.400	1.0	R 804.00		20	114.400	1.0	R 804.00		30	3.000	1.0
2205	Epididymectomy: Bilateral	2004.00		20	158.200	1.0	R 1 111.80		20	126.560	1.0	R 889.50		30	3.000	1.0
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	2004.00		20	55.900	1.0	R 392.90		20	55.900	1.0	R 392.90		30	3.000	1.0
2209	Vasotomy: Unilateral or bilateral	2004.00		20	70.400	1.0	R 494.80		20	70.400	1.0	R 494.80		30	3.000	1.0
2210	Vasogram, seminal vesiculogram: Unilateral	2004.00		20	58.100	1.0	R 408.30		20	58.100	1.0	R 408.30		30	3.000	1.0
2211	Vasogram, seminal vesiculogram: Bilateral	2004.00		20	58.100	1.0	R 408.30		20	58.100	1.0	R 408.30		30	3.000	1.0
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	2004.00		20	91.200	1.0	R 641.00		20	91.200	1.0	R 641.00		30	4.000	1.0
2213	Suture or repair of testicular injury	2004.00		20	110.300	1.0	R 775.20		20	110.300	1.0	R 775.20		30	4.000	1.0
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	2004.00		20	90.000	1.0	R 632.50		20	90.000	1.0	R 632.50		30	4.000	1.0
2217	Excision of local lesion of testis or epididymis	2004.00		20	90.800	1.0	R 638.10		20	90.800	1.0	R 638.10		30	4.000	1.0
2219	Vaso-vasostomy: Unilateral	2004.00		20	67.000	1.0	R 470.90		20	67.000	1.0	R 470.90		30	3.000	1.0
2221	Vaso-vasostomy: Bilateral	2004.00		20	117.000	1.0	R 822.30		20	117.000	1.0	R 822.30		30	3.000	1.0
2223	Epididymo-vasostomy: Unilateral	2004.00		20	67.000	1.0	R 470.90		20	67.000	1.0	R 470.90		30	3.000	1.0
2225	Epididymo-vasostomy: Bilateral	2004.00		20	117.000	1.0	R 822.30		20	117.000	1.0	R 822.30		30	3.000	1.0
2227	Incision and drainage of scrotal wall abscess	2004.00		20	42.700	1.0	R 300.10		20	42.700	1.0	R 300.10		30	3.000	1.0
2229	Excision of Mullerian duct cyst	2004.00		20	189.000	1.0	R 1 328.30		20	151.200	1.0	R 1 062.60		30	4.000	1.0
2231	Excision of lesion of spermatic cord	2004.00		20	84.000	1.0	R 590.40		20	84.000	1.0	R 590.40		30	3.000	1.0
2233	Seminal Vesiculectomy	2004.00		20	220.000	1.0	R 1 546.20		20	176.000	1.0	R 1 236.90		30	5.000	1.0

11.3	Prostate																
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	2004.00		20	23.300	1.0	R 163.80		20	23.300	1.0	R 163.80		30	3.000	1.0
2237	Biopsy prostate: Incisional, any approach	2004.00		20	105.000	1.0	R 737.90		20	105.000	1.0	R 737.90		30	4.000	1.0
2239	Transurethral drainage of prostatic abscess	2004.00		20	117.400	1.0	R 825.10		20	117.400	1.0	R 825.10		30	4.000	1.0
2241	Perineal drainage of prostatic abscess	2004.00		20	77.000	1.0	R 541.20		20	77.000	1.0	R 541.20		30	4.000	1.0
2243	Trans-urethral cryo-surgical removal of prostate	2004.00		20	126.000	1.0	R 885.50		20	120.000	1.0	R 843.40		30	6.000	1.0
2245	Trans-urethral resection of prostate	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	6.000	1.0
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	2004.00		20	126.000	1.0	R 885.50		20	120.000	1.0	R 843.40		30	6.000	1.0
2249	Trans-urethral resection of post-operative bladder neck contracture	2004.00		20	126.000	1.0	R 885.50		20	120.000	1.0	R 843.40		30	5.000	1.0
2251	Prostatectomy: Perineal: Sub-total	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	6.000	1.0
2253	Prostatectomy: Perineal: Radical	2004.00		20	336.000	1.0	R 2 361.40		20	268.800	1.0	R 1 889.10		30	8.000	1.0
2254	Pelvic lymph adenectomy	2004.11		20	175.000	1.0	R 1 229.90		20	140.000	1.0	R 983.90		30	8.000	1.0
2255	Supra-pelvic, transversical	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	6.000	1.0
2257	Retropubic: Sub-total	2004.00		20	252.000	1.0	R 1 771.10		20	201.600	1.0	R 1 416.80		30	6.000	1.0
2259	Retropubic: Radical	2004.00		20	336.000	1.0	R 2 361.40		20	268.800	1.0	R 1 889.10		30	8.000	1.0
2260	Prostate brachytherapy	2004.00		20	230.000	1.0	R 1 616.40		20	184.000	1.0	R 1 293.20		30	8.000	1.0
12	Female Genital System																
12.1	Vulva and introitus																
2271	Removal of tag or polyp	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20		30	3.000	1.0
2272	Removal of small superficial benign lesions	2004.00		20	23.000	1.0	R 161.60		20	23.000	1.0	R 161.60		30	3.000	1.0
2273	Biopsy with suture in theatre (excluding after-care)	2004.00		20	27.000	1.0	R 189.80		20	27.000	1.0	R 189.80		30	3.000	1.0
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	2004.00		20	71.000	1.0	R 499.00		20	71.000	1.0	R 499.00		30	3.000	1.0
2275	Reduction labial hypertrophy	2004.00		20	67.000	1.0	R 470.90		20	67.000	1.0	R 470.90		30	4.000	1.0
2277	Removal of extensive benign vulva tumour	2004.00		20	67.000	1.0	R 470.90		20	67.000	1.0	R 470.90		30	4.000	1.0
2279	Secondary perineal repair: Repair second degree tear	2004.00		20	45.000	1.0	R 316.30		20	45.000	1.0	R 316.30		30	6.000	1.0
2280	Secondary perineal repair: Repair third degree tear	2004.00		20	96.000	1.0	R 674.70		20	96.000	1.0	R 674.70		30	6.000	1.0
2281	Excision of inclusion cyst	2004.00		20	43.000	1.0	R 302.20		20	43.000	1.0	R 302.20		30	4.000	1.0
2283	Hymenectomy	2004.00		20	43.000	1.0	R 302.20		20	43.000	1.0	R 302.20		30	4.000	1.0
2285	Drainage haematocolpos	2004.00		20	54.000	1.0	R 379.50		20	54.000	1.0	R 379.50		30	4.000	1.0
2287	Clitoris repair for injury: Including skin graft, if required	2004.00		20	67.000	1.0	R 470.90		20	67.000	1.0	R 470.90		30	4.000	1.0
2288	Clitoral reduction	2004.00		20	160.000	1.0	R 1 124.50		20	128.000	1.0	R 899.60		30	4.000	1.0
2289	Denervation or alcohol infiltration vulva (Woodruff)	2004.00		20	54.000	1.0	R 379.50		20	54.000	1.0	R 379.50		30	4.000	1.0
2291	Vulva: Undercutting skin (ball)	2004.00		20	58.000	1.0	R 407.60		20	58.000	1.0	R 407.60		30	4.000	1.0
2293	Vulva and introitus: Drainage of abscess	2004.00		20	27.000	1.0	R 189.80		20	27.000	1.0	R 189.80		30	3.000	1.0
2295	Bartholin gland: Bartholin abscess marsupialisation	2004.00		20	36.000	1.0	R 253.00		20	36.000	1.0	R 253.00		30	3.000	1.0
2297	Bartholin gland: Bartholin gland excision	2004.00		20	45.000	1.0	R 316.30		20	45.000	1.0	R 316.30		30	3.000	1.0
2299	Bartholin gland: Bartholin radical excision for malignant lesion	2004.00		20	357.000	1.0	R 2 509.00		20	285.600	1.0	R 2 007.20		30	6.000	1.0
2301	Operation for enlarging introitus: Fenton plasty	2004.00		20	50.000	1.0	R 351.40		20	50.000	1.0	R 351.40		30	4.000	1.0
2303	Operation for enlarging introitus: Bilateral Z-plastic	2004.00		20	88.000	1.0	R 618.50		20	88.000	1.0	R 618.50		30	4.000	1.0
2305	Vulvectomy: Partial	2004.00		20	161.000	1.0	R 1 131.50		20	128.800	1.0	R 905.20		30	4.000	1.0
2307	Vulvectomy	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	6.000	1.0
2309	Radical vulvectomy with bilateral lymphdenectomy	2004.00		20	357.000	1.0	R 2 509.00		20	285.600	1.0	R 2 007.20		30	6.000	1.0
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	2004.00		20	402.000	1.0	R 2 825.30		20	321.600	1.0	R 2 260.20		30	6.000	1.0
12.2	Vaginal procedures and operations																
2312	Artificial insemination	2004.00		20	13.000	1.0	R 91.40		20	13.000	1.0	R 91.40				

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2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure	2004.00		20	25.500	1.0	R	179.20		20	25.500	1.0	R	179.20		30	3.000	1.0
2314	Intra uterine insemination	2004.00		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50				
2315	Simms Hühner test plus wet smear	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10				
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40		30	3.000	1.0
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20		30	3.000	1.0
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	2004.00		20	56.000	1.0	R	393.60		20	56.000	1.0	R	393.60		30	3.000	1.0
2319	Excision of cysts or tumours	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	3.000	1.0
2321	Drainage of vaginal abscess	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	3.000	1.0
2322	Pudendal nerve block	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40				
2323	Reconstruction of vagina after atresia	2004.00		20	107.000	1.0	R	752.00		20	107.000	1.0	R	752.00		30	5.000	1.0
2325	Construction of artificial vagina: Labial fusion	2004.00		20	179.000	1.0	R	1 258.00		20	143.200	1.0	R	1 006.40		30	4.000	1.0
2327	Construction of artificial vagina: Macindoe type	2004.00		20	196.000	1.0	R	1 377.50		20	156.800	1.0	R	1 102.00		30	5.000	1.0
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each	2004.11		20	241.000	1.0	R	1 693.70		20	192.800	1.0	R	1 355.00		30	6.000	1.0
2331	Vaginal septum removal	2004.00		20	107.000	1.0	R	752.00		20	107.000	1.0	R	752.00		30	4.000	1.0
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	2004.00		20	243.300	1.0	R	1 709.90		20	194.640	1.0	R	1 367.90		30	6.000	1.0
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	2004.00		20	243.300	1.0	R	1 709.90		20	194.640	1.0	R	1 367.90		30	6.000	1.0
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	2004.00		20	166.900	1.0	R	1 173.00		20	133.520	1.0	R	938.40		30	6.000	1.0
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	2004.00		20	166.900	1.0	R	1 173.00		20	133.520	1.0	R	938.40		30	6.000	1.0
2339	Colpotomy: Diagnostic (excluding after-care)	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	4.000	1.0
2341	Colpotomy: Therapeutic, with or without sterilisation	2004.00		20	103.000	1.0	R	723.90		20	103.000	1.0	R	723.90		30	4.000	1.0
2343	Vaginal hysterectomy: Without repair	2004.00		20	210.500	1.0	R	1 479.40		20	168.400	1.0	R	1 183.50		30	6.000	1.0
2345	Vaginal hysterectomy: With repair	2004.00		20	231.700	1.0	R	1 628.40		20	185.360	1.0	R	1 302.70		30	6.000	1.0
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	2004.00		20	320.000	1.0	R	2 249.00		20	256.000	1.0	R	1 799.20		30	6.000	1.0
2361	Vaginal hysterectomy and repair for total prolapse	2004.00		20	320.000	1.0	R	2 249.00		20	256.000	1.0	R	1 799.20		30	6.000	1.0
2363	Fothergill or Manchester repair operation	2004.00		20	196.000	1.0	R	1 377.50		20	156.800	1.0	R	1 102.00		30	5.000	1.0
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	2004.00		20	232.000	1.0	R	1 630.50		20	185.600	1.0	R	1 304.40		30	5.000	1.0
2366	Posterior repair alone	2004.00		20	107.000	1.0	R	752.00		20	107.000	1.0	R	752.00		30	5.000	1.0
2367	Other operations for prolapse: Anterior repair - with or without posterior repair	2004.00		20	161.000	1.0	R	1 131.50		20	128.800	1.0	R	905.20		30	5.000	1.0
2368	Uterovesical fistula	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	5.000	1.0
2369	Repair of Vesico- or urethro-vaginal fistula	2004.00		20	179.000	1.0	R	1 258.00		20	143.200	1.0	R	1 006.40		30	5.000	1.0
2370	Repair of VVF - Obstetric or radiation	2004.00		20	232.000	1.0	R	1 630.50		20	185.600	1.0	R	1 304.40		30	5.000	1.0
2371	Closure of uretero-vaginal fistula	2004.00		20	250.000	1.0	R	1 757.00		20	200.000	1.0	R	1 405.60		30	5.000	1.0
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	2004.00		20	250.000	1.0	R	1 757.00		20	200.000	1.0	R	1 405.60		30	5.000	1.0
2373	Closure of recto-vaginal fistula	2004.00		20	134.000	1.0	R	941.80		20	120.000	1.0	R	843.40		30	5.000	1.0
2374	Closure of recto-vaginal fistula: Obstetric or radiation	2004.00		20	151.000	1.0	R	1 061.20		20	120.800	1.0	R	849.00		30	5.000	1.0
2375	Colpocleisis	2004.00		20	129.000	1.0	R	906.60		20	120.000	1.0	R	843.40		30	4.000	1.0
2377	Le Fort operation	2004.00		20	129.000	1.0	R	906.60		20	120.000	1.0	R	843.40		30	4.000	1.0
2379	Schauta operation	2004.00		20	357.000	1.0	R	2 509.00		20	285.600	1.0	R	2 007.20		30	8.000	1.0
2381	Vaginectomy	2004.00		20	268.000	1.0	R	1 883.50		20	214.400	1.0	R	1 506.80		30	8.000	1.0
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee	2004.00		20	429.000	1.0	R	3 015.00		20	343.200	1.0	R	2 412.00		30	8.000	1.0
2385	Vaginal laceration or trauma: Repair	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0

12.3	Cervix																	
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)	2006.05		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60				
2391	Cervix: Canal reconstruction	2004.00		20	147.000	1.0	R	1 033.10		20	120.000	1.0	R	843.40		30	3.000	1.0
2392	Cryo- or electro-cauterisation, or Lietz of cervix (excluding cost of disposable loop electrode): In consulting room	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40				
2395	Cryo- or electro-cauterisation, or Lietz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	2004.00		20	22.000	1.0	R	154.60		20	22.000	1.0	R	154.60		30	3.000	1.0
2396	Laser or harmonic scalpel treatment of the cervix	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	3.000	1.0
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	2004.00		20	31.000	1.0	R	217.90		20	31.000	1.0	R	217.90		30	3.000	1.0
2399	Punch biopsy (excluding after-care)	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30		30	3.000	1.0
2400	Biopsy during pregnancy (excluding after-care)	2004.00		20	13.000	1.0	R	91.40		20	13.000	1.0	R	91.40		30	3.000	1.0
2403	Wedge biopsy: Cervix (excluding after-care)	2004.00		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	3.000	1.0
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	2004.00		20	24.000	1.0	R	168.70		20	24.000	1.0	R	168.70		30	3.000	1.0
2405	Cone biopsy: Cervix (excluding after-care)	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	3.000	1.0
2407	Amputation: Cervix	2004.00		20	67.000	1.0	R	470.90		20	67.000	1.0	R	470.90		30	3.000	1.0
2409	Cervix encirclage: McDonald stitch	2004.00		20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	3.000	1.0
2411	Cervix encirclage: Shirodkar suture	2004.00		20	60.000	1.0	R	421.70		20	60.000	1.0	R	421.70		30	3.000	1.0
2413	Cervix encirclage: Lash	2004.00		20	49.000	1.0	R	344.40		20	49.000	1.0	R	344.40		30	3.000	1.0
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10				
2416	Cervix: Removal items 2409 and 2411: With anaesthetic in theatre	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	3.000	1.0
2417	Repair of tears: Emmet repair of tears	2004.00		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30		30	3.000	1.0
2418	Repair of tears: Sturmdorff repair of tears	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	3.000	1.0
2421	Extirpation of cervical stump: Vaginal	2004.00		20	134.000	1.0	R	941.80		20	120.000	1.0	R	843.40		30	5.000	1.0
2423	Extirpation of cervical stump: Abdominal	2004.00		20	134.000	1.0	R	941.80		20	120.000	1.0	R	843.40		30	5.000	1.0
2425	Removal of cervical polyps (excluding after-care)	2004.00		20	13.000	1.0	R	91.40		20	13.000	1.0	R	91.40		30	3.000	1.0
2427	Removal of cervical myomata	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	3.000	1.0
2429	Colposcopy (excluding after-care)	2004.00		20	27.000	1.0	R	189.80		20	27.000	1.0	R	189.80		30	3.000	1.0
12.4	Uterus																	
2433	Embryo transfer	2004.00		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30		30	4.000	1.0
2434	Endometrial biopsy (excluding after-care)	2004.00		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	3.000	1.0
2435	Hysterosalpingogram (excluding after-care)	2004.00		20	22.000	1.0	R	154.60		20	22.000	1.0	R	154.60		30	3.000	1.0
2436	Hysteroscopy (excluding after-care)	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	3.000	1.0
2437	Hysteroscopy and D&C (excluding after-care)	2004.00		20	58.000	1.0	R	407.60		20	58.000	1.0	R	407.60		30	3.000	1.0
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	3.000	1.0
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	2004.00		20	63.000	1.0	R	442.80		20	63.000	1.0	R	442.80		30	3.000	1.0
2440	Hysteroscopy and polypectomy (excluding after-care)	2004.00		20	75.000	1.0	R	527.10		20	75.000	1.0	R	527.10		30	3.000	1.0
2441	Hysteroscopy and myomectomy (excluding after-care)	2004.00		20	130.000	1.0	R	913.60		20	120.000	1.0	R	843.40		30	3.000	1.0
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	2006.04		20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	3.000	1.0
2443	Dilatation and curettage (D&C) (excluding after-care)	2006.04		20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	3.000	1.0
2444	Fractional dilatation and curettage (D&C) (excluding after-care)	2006.04		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30		30	3.000	1.0
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	2004.00		20	71.000	1.0	R	499.00		20	71.000	1.0	R	499.00		30	4.000	1.0
2448	Termination of pregnancy before 12 weeks	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0
2449	Evacuation: Missed abortion: Before 12 weeks gestation	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0
2451	Evacuation: Missed abortion: After 12 weeks gestation	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	4.000	1.0

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2452	Termination of pregnancy after 12 weeks - administration of intra/extra amniotic prostaglandin	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	4.000	1.0
2453	Evacuation hydatidiform mole	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	5.000	1.0
2455	Evacuation uterus post-partum	2004.00		20	54.000	1.0	R	379.50		20	54.000	1.0	R	379.50		30	6.000	1.0
2461	Ventrosuspension	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	4.000	1.0
2463	Uteroplasty: Strassman	2004.00		20	143.000	1.0	R	1 005.00		20	120.000	1.0	R	843.40		30	6.000	1.0
2465	Uteroplasty: Tompkins	2004.00		20	143.000	1.0	R	1 005.00		20	120.000	1.0	R	843.40		30	6.000	1.0
2467	Myomectomy	2004.00		20	143.000	1.0	R	1 005.00		20	120.000	1.0	R	843.40		30	6.000	1.0
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	2004.00		20	254.100	1.0	R	1 785.80		20	203.280	1.0	R	1 428.70		30	6.000	1.0
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy - uncomplicated	2004.00		20	252.200	1.0	R	1 772.50		20	201.760	1.0	R	1 418.00		30	6.000	1.0
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	2004.00		20	355.000	1.0	R	2 494.90		20	284.000	1.0	R	1 996.00		30	6.000	1.0
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	2004.00		20	472.800	1.0	R	3 322.80		20	378.240	1.0	R	2 658.30		30	8.000	1.0
2477	Abdominal hysterotomy with or without sterilisation	2004.00		20	188.000	1.0	R	1 321.30		20	150.400	1.0	R	1 057.00		30	6.000	1.0
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	6.000	1.0
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	2004.00		20	225.000	1.0	R	1 581.30		20	180.000	1.0	R	1 265.00		30	6.000	1.0
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)	2004.00		20	120.000	1.0	R	843.40										
12.5	Fallopian tubes																	
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee	2004.00																
2481	Insufflation Fallopian tubes (excluding after-care)	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40		30	3.000	1.0
2483	Salpingolysis	2004.00		20	125.000	1.0	R	878.50		20	120.000	1.0	R	843.40		30	4.000	1.0
2485	Salpingostomy	2004.00		20	161.000	1.0	R	1 131.50		20	128.800	1.0	R	905.20		30	4.000	1.0
2487	Tuboplasty tubal anastomosis or re-implantation	2004.00		20	196.000	1.0	R	1 377.50		20	156.800	1.0	R	1 102.00		30	4.000	1.0
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	2004.00		20	125.000	1.0	R	878.50		20	120.000	1.0	R	843.40		30	6.000	1.0
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	2004.00		20	161.000	1.0	R	1 131.50		20	128.800	1.0	R	905.20		30	6.000	1.0
2491	Ectopic pregnancy - after 12 weeks	2004.00		20	225.000	1.0	R	1 581.30		20	180.000	1.0	R	1 265.00		30	6.000	1.0
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	2004.00		20	94.000	1.0	R	660.60		20	94.000	1.0	R	660.60		30	5.000	1.0
	Note: Use item 1807 for open procedures performed with a laparoscope instead of item 2493. Item 1807 may only be added once, and may not be charged together with item 2493 for more than one procedure performed laparoscopically	2004.00																
2493	Diagnostic laparoscopy (excluding after-care)	2004.00		20	94.400	1.0	R	663.40		20	94.400	1.0	R	663.40		30	5.000	1.0
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	2004.00	+	20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	5.000	1.0
2497	Laparoscopy: Plus sterilisation	2004.00	+	20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	5.000	1.0
2499	Laparoscopy: Plus biopsy (excluding after-care)	2004.00	+	20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	5.000	1.0
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	2004.00	+	20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40		30	5.000	1.0
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	2004.00	+	20	18.000	1.0	R	126.50		20	18.000	1.0	R	126.50		30	5.000	1.0
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	2004.00	+	20	52.000	1.0	R	365.50		20	52.000	1.0	R	365.50		30	5.000	1.0
2503	Laparoscopy: Plus ovarian drilling	2004.00	+	20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	5.000	1.0
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	2004.00	+	20	107.000	1.0	R	752.00		20	107.000	1.0	R	752.00		30	5.000	1.0
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	2004.00	+	20	52.000	1.0	R	365.50		20	52.000	1.0	R	365.50		30	5.000	1.0
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	2004.00		20	58.000	1.0	R	407.60		20	58.000	1.0	R	407.60				
12.6	Ovaries																	

2525	Wedge resection of ovaries, unilateral or bilateral	2004.00		20	105.000	1.0	R 737.90		20	105.000	1.0	R 737.90		30	4.000	1.0
2527	Removal of ovarian tumour or cyst	2004.00		20	187.000	1.0	R 1 314.20		20	149.600	1.0	R 1 051.40		30	4.000	1.0
2529	Oophorectomy: Uni- or bilateral	2004.00		20	134.500	1.0	R 945.30		20	120.000	1.0	R 843.40		30	4.000	1.0
2531	Ovarian carcinoma debulking and omentectomy	2004.00		20	357.000	1.0	R 2 509.00		20	285.600	1.0	R 2 007.20		30	6.000	1.0
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	2004.00		20	469.000	1.0	R 3 296.10		20	375.200	1.0	R 2 636.90		30	6.000	1.0
12.7	Miscellaneous procedures															
2535	Exenteration: Anterior Exenteration	2004.00		20	402.000	1.0	R 2 825.30		20	321.600	1.0	R 2 260.20		30	8.000	1.0
2537	Exenteration: Posterior Exenteration	2004.00		20	402.000	1.0	R 2 825.30		20	321.600	1.0	R 2 260.20		30	8.000	1.0
2539	Exenteration: Total	2004.00		20	625.000	1.0	R 4 392.50		20	500.000	1.0	R 3 514.00		30	8.000	1.0
2541	Presacral neurectomy	2004.00		20	98.000	1.0	R 688.70		20	98.000	1.0	R 688.70		30	5.000	1.0
2543	Moschowitz operation	2004.00		20	120.000	1.0	R 843.40		20	120.000	1.0	R 843.40		30	5.000	1.0
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be used together with this item)	2004.00		20	193.100	1.0	R 1 357.10		20	154.480	1.0	R 1 085.70		30	5.000	1.0
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	2004.00		20	195.000	1.0	R 1 370.50		20	156.000	1.0	R 1 096.40		30	5.000	1.0
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach	2004.00		20	149.000	1.0	R 1 047.20		20	120.000	1.0	R 843.40		30	6.000	1.0
2547	Operations for stress incontinence: Burch colposuspension	2004.00		20	161.000	1.0	R 1 131.50		20	128.800	1.0	R 905.20		30	5.000	1.0
2548	Operation for stress incontinence: Use of tape	2004.00		20	229.400	1.0	R 1 612.20		20	183.520	1.0	R 1 289.80		30	5.000	1.0
2550	Operations for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach	2004.00		20	196.000	1.0	R 1 377.50		20	156.800	1.0	R 1 102.00		30	5.000	1.0
2551	Laparotomy	2004.00		20	196.000	1.0	R 1 377.50		20	156.800	1.0	R 1 102.00		30	4.000	1.0
2552	Removal benign retroperitoneal tumour	2004.00		20	223.000	1.0	R 1 567.20		20	178.400	1.0	R 1 253.80		30	6.000	1.0
2553	Radical removal of malignant retroperitoneal tumour	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	8.000	1.0
2554	Drainage of pelvic abscess per abdomen	2004.00		20	180.000	1.0	R 1 265.00		20	144.000	1.0	R 1 012.00		30	6.000	1.0
2556	Drainage of pelvic abscess per vagina (refer to item 2341)	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10		30	5.000	1.0
2558	Drainage intra-abdominal abscess: Delayed closure	2004.00		20	268.000	1.0	R 1 883.50		20	214.400	1.0	R 1 506.80		30	6.000	1.0
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	6.000	1.0
2561	Surgery for severe endometriosis (AFS stage 4 - retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	2004.00		20	210.000	1.0	R 1 475.90		20	168.000	1.0	R 1 180.70		30	6.000	1.0
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	2004.00		20	51.000	1.0	R 358.40		20	51.000	1.0	R 358.40		30	6.000	1.0
2565	Implantation hormone pellets (excluding after-care)	2004.00		20	3.000	1.0	R 21.10		20	3.000	1.0	R 21.10				
2570	Ligation of internal iliac vessels (when not part of another procedure)	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	8.000	1.0
13	Obstetric Procedures															
	RULES GOVERNING THIS SECTION															

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U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the	2004.00														
13.1	Pre-natal care and procedures															
2603	External cephalic version (excluding after-care)	2004.00		20	22.000	1.0	R 154.60		20	22.000	1.0	R 154.60				
2605	Amniocentesis (excluding after-care)	2004.00		20	36.000	1.0	R 253.00		20	36.000	1.0	R 253.00				
2607	Amnioscopy (excluding after-care)	2004.00		20	18.000	1.0	R 126.50		20	18.000	1.0	R 126.50				
2609	Intra-uterine transfusion of foetus or cordocentesis	2004.00		20	134.000	1.0	R 941.80		20	120.000	1.0	R 843.40				
2610	Tococardiography - pre-natal and intrapartum (including stress and non-stress test: Own machine) (excluding after-care)	2004.00		20	16.000	1.0	R 112.40		20	16.000	1.0	R 112.40				
2611	Chorion villus sampling (excluding after-care)	2004.00		20	54.000	1.0	R 379.50		20	54.000	1.0	R 379.50				
13.2	Confinements															
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding Caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit)	2004.11		20	282.000	1.0	R 1 981.90		20	225.600	1.0	R 1 585.50		30	6.000	1.0
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit). See modifier 0011 for emergency caesarean section (all hours)	2004.00		20	267.000	1.0	R 1 876.50		20	213.600	1.0	R 1 501.20		30	6.000	1.0
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	2004.00		20	190.000	1.0	R 1 335.30		20	152.000	1.0	R 1 068.30				
	Global obstetric care includes□ o All modes of delivery (including Caesarean)□ o All inductions of labour (medical or surgical)□ o Intrapartum paracervical and pudential blocks□ o Intrapartum amnioscopy□ o Foetal blood sampling□ o Application of scalp leads□ o Symphysiotomy□ o Manual removal of placenta□ o Repair cervical tears□ o Correction of uterine inversion□ o Drainage of vulval haematoma□ o Repair third degree tear□ o Repair second degree tear□ o Repair episiotomy□ o Resuscitation of newborn by obstetrician□ o Tracheal intubation□ o Missed confinement	2004.00															

	Global obstetric care excludes□ o Prenatal consultations□ o Prenatal procedures (Items 2603 - 2611)□ o Emergency hysterectomy for obstetrical reasons□ o Abdominal operation for repair of ruptured gravid uterus□ o Intensive care for obstetrical emergencies□ o Tubal ligation performed as a post-partum procedure□ o Post-partum complications occurring after discharge from the hospital	2004.00															
13.3	Operative procedures (excluding antenatal care)																
2653	Caesarean-hysterectomy	2004.00		20	335.000	1.0	R 2 354.40		20	268.000	1.0	R 1 883.50		30	9.000	1.0	
2657	Post-partum hysterectomy	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	8.000	1.0	
2669	Abdominal operation for ruptured gravid uterus: Repair	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	9.000	1.0	
14	Nervous System																
14.1	Diagnostic procedures																
2681	Visual evoked potentials (VEP): Unilateral	2004.00		20	50.000	1.0	R 351.40										
2682	Visual evoked potentials (VEP): Bilateral	2004.00		20	88.000	1.0	R 618.50										
2683	Electro-retinography (Ganzfeld method): Unilateral	2004.00		20	60.000	1.0	R 421.70										
2684	Electro-retinography (Ganzfeld method): Bilateral	2004.00		20	105.000	1.0	R 737.90										
2685	Electro-oculography: Unilateral	2004.00		20	30.000	1.0	R 210.80										
2686	Electro-oculography: Bilateral	2004.00		20	53.000	1.0	R 372.50										
2687	VEP stable condition (photic drive): Unilateral	2004.00		20	50.000	1.0	R 351.40										
2689	VEP stable condition (photic drive): Bilateral	2004.00		20	88.000	1.0	R 618.50										
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	2004.00		20	150.000	1.0	R 1 054.20										
	Note: See items 2691 to 2702 under section 17.5.1: Audiometry	2004.00															
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex	2004.00		20	48.000	1.0	R 337.30										
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	2004.00		20	6.000	1.0	R 42.20		20	6.000	1.0	R 42.20					
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation	2004.00		20	220.000	1.0	R 1 546.20										
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	2004.00		20	80.000	1.0	R 562.20										
2709	Full spinogram including bilateral median and posterior-tibial studies	2004.00		20	140.000	1.0	R 983.90										
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)	2004.00															
2711	Electro-encephalography: Taking of record	2004.00		20	36.100	1.0	R 253.70		20	36.100	1.0	R 253.70					
2712	Electro-encephalography: Interpretation	2004.00		20	24.000	1.0	R 168.70		20	24.000	1.0	R 168.70					
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	2006.02		20	18.400	1.0	R 129.30		20	18.400	1.0	R 129.30	Z				
2714	Cisternal puncture and/or intrathecal injections	2004.00		20	15.000	1.0	R 105.40		20	15.000	1.0	R 105.40					
2715	8 Hour ambulatory EEG monitoring (Holter): Hire	2004.00		20	136.000	1.0	R 955.80										
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation	2004.00		20	30.000	1.0	R 210.80										
2717	Electromyography: First	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10					
2718	Electromyography: Subsequent	2004.00		20	75.000	1.0	R 527.10		20	75.000	1.0	R 527.10					
2719	Overnight polysomnogram and sleep staging: Hire	2004.00		20	125.000	1.0	R 878.50										
2720	Overnight polysomnogram and sleep staging: Interpretation	2004.00		20	23.000	1.0	R 161.60										

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2721	Daytime polysomnogram: Hire	2004.00		20	125.000	1.0	R	878.50												
2722	Daytime polysomnogram: Interpretation	2004.00		20	17.000	1.0	R	119.50												
2723	Multiple sleep latency test: Interpretation	2004.00		20	125.000	1.0	R	878.50												
2724	Overnight continuous positive airways pressure (CPAP) titration	2004.00		20	155.000	1.0	R	1 089.30		20	124.000	1.0	R	871.50						
2725	Angiography carotis: Unilateral	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		30	4.000	1.0		
2726	Angiography carotis: Bilateral	2004.00		20	44.000	1.0	R	309.20		20	44.000	1.0	R	309.20		30	4.000	1.0		
2727	Vertebral artery: Direct needling	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0		
2729	Vertebral catheterisation	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0		
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with Item 0714)	2006.02		20	60.000	1.0	R	421.70	Z											
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	2004.00		20	14.500	1.0	R	101.90								30	4.000	1.0		
2733	Cortical Stimulation	2004.00		20	58.900	1.0	R	413.90		20	58.900	1.0	R	413.90						
2734	Sodium Amytal Testing (WADA test)	2004.00		20	88.700	1.0	R	623.40		20	88.700	1.0	R	623.40		30	13.000	1.0		
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	2004.00		20	31.500	1.0	R	221.40		20	-	1.0	R	-	v					
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20						
2739	Ventricular needling without burring: Tapping only	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40		30	4.000	1.0		
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	2004.00		20	43.000	1.0	R	302.20		20	43.000	1.0	R	302.20		30	4.000	1.0		
2743	Subdural tapping: First sitting	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40		30	4.000	1.0		
2745	Subdural tapping: Subsequent	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	4.000	1.0		
6001	Sleep electro-encephalography: Infants that fit into a perambulator: Taking of record	2004.00		20	36.100	1.0	R	253.70		20	36.100	1.0	R	253.70						
6002	Sleep electro-encephalography: Infants that fit into a perambulator: Interpretation	2004.00		20	24.500	1.0	R	172.20		20	24.500	1.0	R	172.20						
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record	2004.00		20	36.100	1.0	R	253.70		20	36.100	1.0	R	253.70						
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation	2004.00		20	24.500	1.0	R	172.20		20	24.500	1.0	R	172.20						
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised sixteen or more channel EEG, which may include video recording (e.g. for pre-operative localisation): Each full 24 hour period	2004.00		20	294.600	1.0	R	2 070.40		20	235.680	1.0	R	1 656.40						
6011	Interpretation of item 6010: Electro-encephalogram monitoring: To be charged once only for each full 24 hour period of monitoring	2004.00		20	128.600	1.0	R	903.80		20	120.000	1.0	R	843.40						
14.2	Introduction of burr holes for																			
2747	Ventriculography	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
2749	Catheterisation for ventriculography and/or drainage	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
2751	Biopsy of brain tumour	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
2753	Subdural haematoma or hygroma	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
2755	Subdural empyema	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
2757	Brain abscess	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	8.000	1.0		
14.3	Nerve procedures																			
2759	Nerve biopsy: Peripheral	2004.00		20	37.000	1.0	R	260.00		20	37.000	1.0	R	260.00		30	4.000	1.0		
2763	Nerve biopsy: Cranial nerves: Extra-cranial	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	4.000	1.0		
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)	2004.00		20	26.000	1.0	R	182.70		20	26.000	1.0	R	182.70		30	4.000	1.0		
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)	2004.00		20	25.000	1.0	R	175.70												
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)	2004.00		20	30.000	1.0	R	210.80												
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)	2004.00		20	35.000	1.0	R	246.00												

6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)	2004.00		20	35.000	1.0	R	246.00									
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)	2004.00		20	50.000	1.0	R	351.40									
14.3.1	Nerve procedures: Nerve repair or suture																
2767	Suture brachial plexus (see also items 2837 and 2839)	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	6.000	1.0
2769	Suture: Large nerve: Primary	2004.00		20	134.000	1.0	R	941.80		20	120.000	1.0	R	843.40		30	5.000	1.0
2771	Suture: Large nerve: Secondary	2004.00		20	202.000	1.0	R	1 419.70		20	161.600	1.0	R	1 135.70		30	5.000	1.0
2773	Digital nerve: Primary	2004.00		20	65.000	1.0	R	456.80		20	65.000	1.0	R	456.80		30	3.000	1.0
2775	Digital nerve: Secondary	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
2777	Nerve graft: Simple	2004.00		20	202.000	1.0	R	1 419.70		20	161.600	1.0	R	1 135.70		30	4.000	1.0
2779	Fascicular: First fasciculus	2004.00		20	202.000	1.0	R	1 419.70		20	161.600	1.0	R	1 135.70		30	4.000	1.0
2781	Fascicular: Each additional fasciculus	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40		30	4.000	1.0
2783	Fascicular: Nerve flap: To include all stages	2004.00		20	224.000	1.0	R	1 574.30		20	179.200	1.0	R	1 259.40		30	4.000	1.0
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	2004.00		20	124.000	1.0	R	871.50		20	120.000	1.0	R	843.40		30	6.000	1.0
2787	Fascicular: Grafting of facial nerve	2004.00		20	215.000	1.0	R	1 511.00		20	172.000	1.0	R	1 208.80		30	5.000	1.0
14.3.2	Nerve procedures: Neurectomy																
2789	Trigeminal ganglion: Injection of alcohol	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	4.000	1.0
2791	Trigeminal ganglion: Injection of cortisone	2004.00		20	65.000	1.0	R	456.80		20	65.000	1.0	R	456.80		30	3.000	1.0
2793	Trigeminal ganglion: Coagulation through high frequency	2004.00		20	170.000	1.0	R	1 194.80		20	136.000	1.0	R	955.80		30	3.000	1.0
2799	Procedures for pain relief: Intrathecal injections for pain	2004.00		20	36.000	1.0	R	253.00		20	36.000	1.0	R	253.00		30	4.000	1.0
2800	Procedures for pain relief: Plexus nerve block	2004.00		20	36.000	1.0	R	253.00		20	36.000	1.0	R	253.00		20	36.000	1.0
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) (refer to modifier 0021 for epidural anaesthetic)	2004.00		20	36.000	1.0	R	253.00		20	36.000	1.0	R	253.00				
2802	Procedures for pain relief: Peripheral nerve block	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70		20	25.000	1.0
2803	Alcohol injection in peripheral nerves for pain: Unilateral	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	3.000	1.0
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique)	2004.00	+	20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		20	10.000	1.0
2805	Alcohol injection in peripheral nerves for pain: Bilateral	2004.00		20	35.000	1.0	R	246.00		20	35.000	1.0	R	246.00		30	3.000	1.0
2809	Peripheral nerve section for pain	2004.00		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30		30	3.000	1.0
2811	Pudendal neurectomy: Bilateral	2004.00		20	116.000	1.0	R	815.20		20	116.000	1.0	R	815.20		30	3.000	1.0
2813	Obturator or Stoffels	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
2815	Interdigital	2004.00		20	82.300	1.0	R	578.40		20	82.300	1.0	R	578.40		30	3.000	1.0
2825	Excision: Neuroma: Peripheral	2004.00		20	109.500	1.0	R	769.60		20	109.500	1.0	R	769.60		30	3.000	1.0
14.3.3	Nerve procedures: Other nerve procedures																
2827	Transposition of ulnar nerve	2004.00		20	100.000	1.0	R	702.80		20	100.000	1.0	R	702.80		30	3.000	1.0
2829	Neurolysis: Minor	2004.00		20	51.000	1.0	R	358.40		20	51.000	1.0	R	358.40		30	3.000	1.0
2831	Neurolysis: Major	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	3.000	1.0
2833	Neurolysis: Digital	2004.00		20	96.000	1.0	R	674.70		20	96.000	1.0	R	674.70		30	3.000	1.0
2835	Scalenotomy	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	6.000	1.0
2837	Brachial plexus, suture or neurolysis (item 2767)	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	6.000	1.0
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	2004.00		20	895.200	1.0	R	6 291.50		20	716.160	1.0	R	5 033.20		30	6.000	1.0
2841	Carpal Tunnel	2004.00		20	64.000	1.0	R	449.80		20	64.000	1.0	R	449.80		30	3.000	1.0
2843	Lumbar sympathectomy: Unilateral	2004.00		20	153.000	1.0	R	1 075.30		20	122.400	1.0	R	860.20		30	4.000	1.0
2845	Lumbar sympathectomy: Bilateral	2004.00		20	268.000	1.0	R	1 883.50		20	214.400	1.0	R	1 506.80		30	6.000	1.0
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)	2004.00														30	11.000	1.0

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2847	Cervical sympathectomy: Unilateral	2004.00		20	153.000	1.0	R 1 075.30		20	122.400	1.0	R 860.20		30	4.000	1.0
2848	Cervical sympathectomy: Bilateral	2004.00		20	268.000	1.0	R 1 883.50		20	214.400	1.0	R 1 506.80		30	6.000	1.0
2849	Sympathetic block: Other levels: Unilateral	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60		30	3.000	1.0
2851	Sympathetic block: Other levels: Bilateral	2004.00		20	35.000	1.0	R 246.00		20	35.000	1.0	R 246.00		30	3.000	1.0
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60		30	4.000	1.0
14.4	Skull procedures															
2855	Removal of skull tumour: With or without plastic repair: Small	2004.00		20	170.000	1.0	R 1 194.80		20	136.000	1.0	R 955.80		30	5.000	1.0
2857	Removal of skull tumour: With or without plastic repair: Major	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	8.000	1.0
2859	Repair of depressed fracture of skull: Without brain laceration: Major	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	8.000	1.0
2860	Repair of depressed fracture of skull: Without brain laceration: Small	2004.00		20	170.000	1.0	R 1 194.80		20	136.000	1.0	R 955.80		30	8.000	1.0
2861	Repair of depressed fracture of skull: With brain lacerations: Small	2004.00		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	8.000	1.0
2862	Repair of depressed fracture of skull: With brain lacerations: Major	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	8.000	1.0
2863	Cranioplasty	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	8.000	1.0
2864	Encephalocele (excluding frontal)	2004.11		20	200.000	1.0	R 1 405.60		20	160.000	1.0	R 1 124.50		30	8.000	1.0
2865	Craniostenosis: Few suturae	2004.00		20	213.000	1.0	R 1 497.00		20	170.400	1.0	R 1 197.60		30	9.000	1.0
2867	Craniostenosis: Multiple suturae	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	9.000	1.0
14.5	Shunt procedures															
2869	Ventriculo-cisternostomy	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	8.000	1.0
2871	Ventriculo-caval shunt	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	11.000	1.0
2873	Ventriculo-peritoneal shunt	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	8.000	1.0
2875	Theco-peritoneal C.S.F. shunt	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	8.000	1.0
14.6	Aneurysm repair															
2876	Repair of aneurysms or arteriovenous anomalies (Intracranial)	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	15.000	1.0
2877	Extracranial to intracranial vascular	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	15.000	1.0
2878	Posterior fossa arteriovenous anomalies	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	15.000	1.0
14.7	Posterior fossa surgery															
2879	Glosso pharyngeal nerve	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	6.000	1.0
2881	Eighth nerve: Intracranial	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	8.000	1.0
2883	Eighth nerve: Extracranial	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	4.000	1.0
2884	Sub-temporal section of the trigeminal nerve	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	9.000	1.0
2885	Trigeminal tractotomy	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	9.000	1.0
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	9.000	1.0
2887	Vestibular nerve	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	9.000	1.0
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	2006.04		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	11.000	1.0
2891	Posterior fossa tumour removal: Glioma, secondary deposits	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2893	Posterior fossa tumour removal: Abscess	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2895	Excision of tumour of glomus jugulare: Intracranial	2004.00		20	420.000	1.0	R 2 951.80		20	336.000	1.0	R 2 361.40		30	11.000	1.0
2897	Excision of tumour of glomus jugulare: Extracranial	2004.00		20	420.000	1.0	R 2 951.80		20	336.000	1.0	R 2 361.40		30	9.000	1.0
2898	Excision of tumour of glomus jugulare: Hemispherectomy	2004.00		20	500.000	1.0	R 3 514.00		20	400.000	1.0	R 2 811.20		30	15.000	1.0
14.7.1	Posterior fossa surgery: Supratentorial procedures															
2899	Craniectomy for extra-dural haematoma or empyema	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	11.000	1.0
14.8	Craniotomy for															

2900	Craniotomy for Extra-dural orbital decompression or excision of orbital tumour	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	11.000	1.0
2901	Craniotomy for Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	11.000	1.0
2903	Craniotomy for Abscess, Glioma	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2905	Craniotomy for Focal epilepsy: Excision of cortical scar	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	2004.11		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	11.000	1.0
2907	Craniotomy for Temporal lobectomy	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2908	Craniotomy for Torkildsen anastomosis	2004.00		20	375.000	1.0	R 2 635.50		20	300.000	1.0	R 2 108.40		30	11.000	1.0
2909	Craniotomy for CSF-leaks	2004.00		20	450.000	1.0	R 3 162.60		20	360.000	1.0	R 2 530.10		30	11.000	1.0
2910	Craniotomy for removal of arteriovenous malformation	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	11.000	1.0
14.8.1	Craniotomy for Stereo-tactic cerebral and spinal cord procedures															
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	2004.00		20	280.000	1.0	R 1 967.80		20	224.000	1.0	R 1 574.30		30	4.000	1.0
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	2004.00		20	196.000	1.0	R 1 377.50		20	156.800	1.0	R 1 102.00		30	4.000	1.0
2915	Transnasal hypophysectomy	2004.00		20	300.000	1.0	R 2 108.40		20	240.000	1.0	R 1 686.70		30	11.000	1.0
2916	Transfrontal hypophysectomy	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	11.000	1.0
2917	Transnasal hypophyseal implants	2004.00		20	172.000	1.0	R 1 208.80		20	137.600	1.0	R 967.10		30	11.000	1.0
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)	2004.00		20	-	0.0	R -		20	-	0.0	R -				
14.9	Spinal operations															
	See section 3.8.7 for laminectomy procedures	2004.00														
2923	Chordotomy: Unilateral	2004.00		20	178.000	1.0	R 1 251.00		20	142.400	1.0	R 1 000.80		30	3.000	1.0
2925	Chordotomy: Open	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	3.000	1.0
2927	Rhizotomy: Extradural, but intraspinal	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	3.000	1.0
2928	Rhizotomy: Intradural	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	3.000	1.0
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	8.000	1.0
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	8.000	1.0
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	3.000	1.0
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach	2004.00		20	350.000	1.0	R 2 459.80		20	280.000	1.0	R 1 967.80		30	8.000	1.0
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach	2004.00		20	320.000	1.0	R 2 249.00		20	256.000	1.0	R 1 799.20		30	7.000	1.0
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy	2004.00		20	225.000	1.0	R 1 581.30		20	180.000	1.0	R 1 265.00		30	3.000	1.0
2937	Repair of meningocele, involving nerve tissue	2004.00		20	250.000	1.0	R 1 757.00		20	200.000	1.0	R 1 405.60		30	9.000	1.0
2938	Simple	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	9.000	1.0
2939	Excision of arterial vascular malformations and cysts of the spinal cord	2004.00		20	700.000	1.0	R 4 919.60		20	560.000	1.0	R 3 935.70		30	9.000	1.0
2940	Lumbar osteophyte removal	2004.00		20	187.000	1.0	R 1 314.20		20	149.600	1.0	R 1 051.40		30	3.000	1.0
2941	Cervical or thoracic osteophyte removal	2004.00		20	285.000	1.0	R 2 003.00		20	228.000	1.0	R 1 602.40		30	3.000	1.0
14.10	Arterial ligations															
2951	Carotis: Trauma	2004.00		20	120.000	1.0	R 843.40		20	120.000	1.0	R 843.40		30	8.000	1.0
2953	Carotis: For aneurysm (AV anomaly)	2004.00		20	150.000	1.0	R 1 054.20		20	120.000	1.0	R 843.40		30	8.000	1.0
2955	Removal of carotid body tumour (without vascular reconstruction)	2004.00		20	335.600	1.0	R 2 358.60		20	268.480	1.0	R 1 886.90		30	8.000	1.0
14.11	Medical psychotherapy															
2957	Individual psychotherapy (specify type): Including play therapy for children: Per short session (20 minutes)	2004.00							20	16.000	1.0	R 112.40				

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2958	Psychoanalytic therapy: Per 60-minute session	2004.00							20	48.000	1.0	R	337.30						
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session	2004.00							20	16.000	1.0	R	112.40						
2963	Pairs, marriage or sex therapy: Per 20-minute session	2004.00							20	16.000	1.0	R	112.40						
2968	Group therapy: Adults (specify number): Tariff per person per 80-minute session; Children (specify number): Tariff per person per 80-minute session	2004.00							20	8.000	1.0	R	56.20						
2974	Individual psychotherapy (specify type): Including play therapy for children: Per intermediate session (40 minutes)	2004.00							20	32.000	1.0	R	224.90						
2975	Individual psychotherapy (specify type): Including play therapy for children: Per extended session (60 minutes or longer)	2004.00							20	48.000	1.0	R	337.30						
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session	2004.00							20	32.000	1.0	R	224.90						
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session	2004.00							20	48.000	1.0	R	337.30						
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY																		
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods	2004.00																	
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)	2004.00																	
14.12	Physical treatment methods																		
2970	Electro-convulsive treatment (ECT): Each time (See rule Va)	2004.00							20	17.000	1.0	R	119.50		30	3.000	1.0		
14.13	Psychiatric examination methods																		
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per 60 min session	2006.05							20	16.000	1.0	R	112.40						
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)	2004.00							20	16.000	1.0	R	112.40						
15	Endocrine System																		
15.1	Thyroid																		
2983	Lobectomy: Partial	2004.00		20	198.100	1.0	R	1 392.20	20	158.480	1.0	R	1 113.80		30	5.000	1.0		
2985	Lobectomy: Total	2004.00		20	200.000	1.0	R	1 405.60	20	160.000	1.0	R	1 124.50		30	5.000	1.0		
2987	Thyroidectomy: Subtotal	2004.00		20	266.000	1.0	R	1 869.40	20	212.800	1.0	R	1 495.60		30	5.000	1.0		
2989	Thyroidectomy: Total	2004.00		20	279.000	1.0	R	1 960.80	20	223.200	1.0	R	1 568.60		30	5.000	1.0		
2991	Thyroglossal cyst or fistula excision	2004.00		20	126.200	1.0	R	886.90	20	120.000	1.0	R	843.40		30	5.000	1.0		
15.2	Parathyroid																		
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	2004.00		20	275.000	1.0	R	1 932.70	20	220.000	1.0	R	1 546.20		30	5.000	1.0		
15.3	Adrenals																		
2995	Adrenalectomy: Unilateral	2004.00		20	225.000	1.0	R	1 581.30	20	180.000	1.0	R	1 265.00		30	9.000	1.0		
2997	Bilateral exploration of adrenal glands: Including removal	2004.00		20	394.000	1.0	R	2 769.00	20	315.200	1.0	R	2 215.20		30	11.000	1.0		
15.4	Hypophysis																		
2999	Transethmoidal hypophysectomy	2004.00		20	300.000	1.0	R	2 108.40	20	240.000	1.0	R	1 686.70		30	11.000	1.0		
3000	Transnasal hypophysectomy (see also item 2915)	2004.00		20	300.000	1.0	R	2 108.40	20	240.000	1.0	R	1 686.70		30	11.000	1.0		
15.5	Endocrine system: General																		
3001	Implantation of pellets (excluding cost of material) (excluding after-care)	2004.00		20	3.000	1.0	R	21.10	20	3.000	1.0	R	21.10						
16	Eye																		
16.1	Eye: Procedures performed in rooms																		

	(a) Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions□ (b) Material used is excluded□ (c) The fee for photography is not related to the number of photographs taken	2004.00																	
16.1.1	Eye investigations																		
3002	Gonioscopy	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3006	Keratometry	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	2004.00	+	20	11.680	1.0	R	82.10											
3012	Pre-surgical retinal examination before retinal surgery	2004.00		20	32.000	1.0	R	224.90		20	32.000	1.0	R	224.90					
3013	Ocular motility assessment: Comprehensive examination	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30					
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30					
16.1.2	Special eye investigations																		
3005	Endothelial cell count	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3007	Potential acuity measurement	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3008	Contrast sensitivity test	2004.00		20	7.000	1.0	R	49.20		20	7.000	1.0	R	49.20					
3010	Orthoptics consultation	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30					
3011	Orthoptic subsequent sessions	2004.00		20	5.000	1.0	R	35.10		20	5.000	1.0	R	35.10					
3015	Charting of visual field with manual perimeter	2004.00		20	28.000	1.0	R	196.80		20	28.000	1.0	R	196.80					
3016	Retinal threshold test without storage facilities	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80					
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	2004.00		20	74.000	1.0	R	520.10		20	74.000	1.0	R	520.10					
3018	Retinal threshold trend evaluation (additional to item 3017)	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40					
3019	Ocular muscle function with Hess screen or perimeter	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40					
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	2004.00		20	46.000	1.0	R	323.30		20	46.000	1.0	R	323.30					
3022	Digital fluorescein video angiography	2004.00		20	68.000	1.0	R	477.90		20	68.000	1.0	R	477.90		30	9.000	1.0	
3023	Digital indocyanine video angiography	2004.00		20	110.000	1.0	R	773.10		20	110.000	1.0	R	773.10		30	9.000	1.0	
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30					
3025	Electronic tonography	2004.00		20	19.000	1.0	R	133.50		20	19.000	1.0	R	133.50					
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	2004.00		20	19.300	1.0	R	135.60		20	19.300	1.0	R	135.60					
3027	Fundus photography	2004.00		20	21.000	1.0	R	147.60		20	21.000	1.0	R	147.60					
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	2004.00		20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10					
3029	Anterior segment microphotography	2004.00		20	21.000	1.0	R	147.60		20	21.000	1.0	R	147.60					
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)	2004.00		20	45.000	1.0	R	316.30		20	45.000	1.0	R	316.30					
3032	Eyelid and orbit photography	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30					
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40					
3034	Determination of lens implant power per eye	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40					

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3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged	2004.00		20	22.000	1.0	R	154.60		20	22.000	1.0	R	154.60			
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	2004.00		20	36.000	1.0	R	253.00		20	36.000	1.0	R	253.00			
16.2	Retina																
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	2004.00		20	306.900	1.0	R	2 158.90		20	245.520	1.0	R	1 725.50		30	6.000	1.0
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
3041	Pan retinal photocoagulation (per eye): Done in one sitting	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	6.000	1.0
3044	Removal of encircling band and/or buckling material	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
16.3	Cataract																
3045	Cataract: Intra-capsular	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	7.000	1.0
3047	Cataract: Extra-capsular (including capsulotomy)	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	7.000	1.0
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	2004.00		20	57.000	1.0	R	400.60		20	57.000	1.0	R	400.60		30	7.000	1.0
3050	Repositioning of intra ocular lens	2004.00		20	171.100	1.0	R	1 202.50		20	136.880	1.0	R	962.00		30	7.000	1.0
3051	Needling or capsulotomy	2004.00		20	130.000	1.0	R	913.60		20	120.000	1.0	R	843.40		30	4.000	1.0
3052	Laser capsulotomy	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	4.000	1.0
3057	Removal of lenticulus	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	7.000	1.0
3058	Exchange of intra ocular lens	2004.00		20	236.000	1.0	R	1 658.60		20	188.800	1.0	R	1 326.90		30	7.000	1.0
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	7.000	1.0
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)	2004.00		20	4.000	1.0	R	28.10										
16.4	Glaucoma																
3061	Drainage operation	2004.00		20	247.600	1.0	R	1 740.10		20	198.080	1.0	R	1 392.10		30	6.000	1.0
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	2004.00		20	60.000	1.0	R	421.70		20	60.000	1.0	R	421.70		30	6.000	1.0
3063	Cyclocryotherapy or cyclodiathermy	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
3064	Laser trabeculoplasty	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
3065	Removal of blood from anterior chamber	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	4.000	1.0
3067	Goniotomy	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	7.000	1.0
16.5	Intra-ocular foreign body																
3071	Intra-ocular foreign body: Anterior to iris	2004.00		20	127.000	1.0	R	892.60		20	120.000	1.0	R	843.40		30	4.000	1.0
3073	Intra-ocular foreign body: Posterior to iris (including prophylactic thermal treatment to retina)	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	6.000	1.0
16.6	Strabismus																
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to item 0202)	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60			
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	2004.00		20	175.600	1.0	R	1 234.10		20	140.480	1.0	R	987.30		30	5.000	1.0
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50		30	5.000	1.0
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	2004.00		20	120.000	1.0	R	843.40		20	120.000	1.0	R	843.40		30	5.000	1.0

3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	5.000	1.0
16.7	Globe																		
3079	Transcleral biopsy	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3080	Examination of eyes under general anaesthetic where no surgery is done	2004.00		20	80.000	1.0	R	562.20		20	80.000	1.0	R	562.20		30	4.000	1.0
3081	Treatment of minor perforating injury	2004.00		20	161.600	1.0	R	1 135.70		20	129.280	1.0	R	908.60		30	6.000	1.0
3083	Treatment of major perforating injury	2004.00		20	267.500	1.0	R	1 880.00		20	214.000	1.0	R	1 504.00		30	6.000	1.0
3085	Enucleation or Evisceration	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	5.000	1.0
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	2004.00		20	160.000	1.0	R	1 124.50		20	128.000	1.0	R	899.60		30	5.000	1.0
3088	Hydroxyapetite insertion (additional to item 3087)	2004.00	+	20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10		30	5.000	1.0
3089	Subconjunctival injection if not done at time of operation	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	5.000	1.0
3090	Intra vitreal injection drug	2005.08		20	47.600	1.0	R	334.50		20	47.600	1.0	R	334.50		30	4.000	1.0
3091	Retrobulbar injection (if not done at time of operation)	2004.00		20	16.000	1.0	R	112.40		20	16.000	1.0	R	112.40		30	4.000	1.0
3092	External laser treatment for superficial lesions	2004.00		20	53.000	1.0	R	372.50		20	53.000	1.0	R	372.50				
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	2004.00		20	209.000	1.0	R	1 468.90		20	167.200	1.0	R	1 175.10		30	6.000	1.0
3094	Implantation of intra vitreal drug delivery system	2004.00		20	247.600	1.0	R	1 740.10		20	198.080	1.0	R	1 392.10		30	4.000	1.0
3095	Biopsy of vitreous body or anterior chamber contents	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	6.000	1.0
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	2004.00		20	130.000	1.0	R	913.60		20	120.000	1.0	R	843.40		30	7.000	1.0
3097	Anterior vitrectomy	2004.00		20	280.000	1.0	R	1 967.80		20	224.000	1.0	R	1 574.30		30	6.000	1.0
3098	Removal of silicon from globe	2004.00		20	280.000	1.0	R	1 967.80		20	224.000	1.0	R	1 574.30		30	6.000	1.0
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	2004.00		20	419.000	1.0	R	2 944.70		20	335.200	1.0	R	2 355.80		30	6.000	1.0
3100	Lensectomy done at time of posterior vitrectomy	2004.00		20	30.000	1.0	R	210.80		20	30.000	1.0	R	210.80		30	7.000	1.0
16.8	Orbit																		
3101	Drainage of orbital abscess	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	5.000	1.0
3103	Orbit: Removal of tumour	2004.00		20	240.000	1.0	R	1 686.70		20	192.000	1.0	R	1 349.40		30	5.000	1.0
3104	Removal orbital prosthesis	2004.00		20	212.700	1.0	R	1 494.90		20	170.160	1.0	R	1 195.90		30	5.000	1.0
3105	Orbit: Exenteration	2004.00		20	275.000	1.0	R	1 932.70		20	220.000	1.0	R	1 546.20		30	5.000	1.0
3107	Orbitotomy requiring bone flap	2004.00		20	393.000	1.0	R	2 762.00		20	314.400	1.0	R	2 209.60		30	5.000	1.0
3108	Eye socket reconstruction	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	5.000	1.0
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	2004.00		20	300.000	1.0	R	2 108.40		20	240.000	1.0	R	1 686.70		30	5.000	1.0
3110	Second stage hydroxyapetite implantation	2004.00		20	110.000	1.0	R	773.10		20	110.000	1.0	R	773.10		30	5.000	1.0
16.9	Cornea																		
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	2004.00		20	-	0.0	R	-	F	20	-	0.0	R	-	F				
3112	Fitting of contact lens for treatment of disease including supply of lens	2004.00		20	12.200	1.0	R	85.70		20	12.200	1.0	R	85.70					
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one (1) year	2004.00		20	200.000	1.0	R	1 405.60		20	160.000	1.0	R	1 124.50					
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only	2004.00		20	78.850	1.0	R	554.20											
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	2004.00		20	166.000	1.0	R	1 166.60		20	132.800	1.0	R	933.30					
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	2004.00		20	135.200	1.0	R	950.20		20	120.000	1.0	R	843.40		30	6.000	1.0

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3117	Removal of foreign body: On the basis of fee per consultation	2004.00		20	-	0.0	R	-	F	20	-	0.0	R	-	F	30	4.000	1.0
3118	Curettage of cornea after removal of foreign body (after-care excluded)	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30				
3119	Tattooing	2004.00		20	26.000	1.0	R	182.70		20	26.000	1.0	R	182.70		30	4.000	1.0
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	6.000	1.0
3121	Corneal graft (Lamellar or full thickness)	2004.00		20	289.000	1.0	R	2 031.10		20	231.200	1.0	R	1 624.90		30	6.000	1.0
3122	Epikeratophakia	2004.00		20	289.000	1.0	R	2 031.10		20	231.200	1.0	R	1 624.90				
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	2004.00		20	254.000	1.0	R	1 785.10		20	203.200	1.0	R	1 428.10		30	6.000	1.0
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see item 0202)	2004.00		20	9.000	1.0	R	63.30		20	9.000	1.0	R	63.30				
3125	Keratectomy	2004.00		20	127.000	1.0	R	892.60		20	120.000	1.0	R	843.40		30	6.000	1.0
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	2004.00	+	20	52.180	1.0	R	366.70		20	52.180	1.0	R	366.70				
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	4.000	1.0
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	6.000	1.0
3129	Additional to item 3128 for the use of own diamond knives	2004.00	+	20	40.000	1.0	R	281.10		20	40.000	1.0	R	281.10				
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	2004.00		20	96.900	1.0	R	681.00		20	96.900	1.0	R	681.00		30	4.000	1.0
3131	Cornea: Paracentesis	2004.00		20	53.000	1.0	R	372.50		20	53.000	1.0	R	372.50		30	4.000	1.0
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	2004.00		20	150.000	1.0	R	1 054.20		20	120.000	1.0	R	843.40		30	6.000	1.0
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure	2004.00		20	116.300	1.0	R	817.40		20	116.300	1.0	R	817.40		30	4.000	1.0
3136	Conjunctival flap or graft (not for use with pterigium surgery)	2004.00		20	95.700	1.0	R	672.60		20	95.700	1.0	R	672.60		30	6.000	1.0
3138	Removal corneal epithelium and chelating agent for band keratopathy	2004.00		20	69.500	1.0	R	488.40		20	69.500	1.0	R	488.40		30	4.000	1.0
16.10	Ducts																	
3133	Probing and/or syringing, per duct	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	4.000	1.0
3135	Insert polythene tubes	2004.00		20	51.800	1.0	R	364.10		20	51.800	1.0	R	364.10		30	4.000	1.0
3137	Excision of lacrimal sac: Unilateral	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3139	Dacrocystorhinostomy (Single) with or without polythene tube	2004.00		20	210.000	1.0	R	1 475.90		20	168.000	1.0	R	1 180.70		30	5.000	1.0
3141	Sealing Punctum surgical or by cautery: Per eye	2004.00		20	24.900	1.0	R	175.00		20	24.900	1.0	R	175.00		30	4.000	1.0
3142	Sealing Punctum with plugs: Per eye	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60		30	4.000	1.0
3143	Three-snip operation	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	4.000	1.0
3145	Repair of canaliculus: Primary procedure	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3147	Repair of canaliculus: Secondary procedure	2004.00		20	175.000	1.0	R	1 229.90		20	140.000	1.0	R	983.90		30	4.000	1.0
16.11	Iris																	
3149	Iridectomy or iridotomy by open operation as isolated procedure	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3151	Excision of iris tumour	2004.00		20	185.000	1.0	R	1 300.20		20	148.000	1.0	R	1 040.10		30	6.000	1.0
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	2004.00		20	105.000	1.0	R	737.90		20	105.000	1.0	R	737.90		30	4.000	1.0
3155	Iridocyclectomy for tumour	2004.00		20	266.000	1.0	R	1 869.40		20	212.800	1.0	R	1 495.60		30	6.000	1.0
3157	Division of anterior synechiae as isolated procedure	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3158	Repair iris as in dialysis: Anterior chamber reconstruction	2004.00		20	142.400	1.0	R	1 000.80		20	120.000	1.0	R	843.40		30	4.000	1.0
16.12	Lids																	
3161	Tarsorrhaphy	2004.00		20	47.000	1.0	R	330.30		20	47.000	1.0	R	330.30		30	4.000	1.0
3163	Excision of superficial lid tumour	2004.00		20	47.000	1.0	R	330.30		20	47.000	1.0	R	330.30		30	4.000	1.0
3165	Repair of skin laceration lid: Simple	2004.00		20	27.300	1.0	R	191.90		20	27.300	1.0	R	191.90		30	4.000	1.0

3167	Diathermy to wart on lid margin	2004.00		20	12.000	1.0	R	84.30		20	12.000	1.0	R	84.30		30	4.000	1.0
3169	Electrolysis of any number of eyelashes: Per eye	2004.00		20	15.000	1.0	R	105.40		20	15.000	1.0	R	105.40				
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see item 0202)	2004.00		20	20.400	1.0	R	143.40		20	20.400	1.0	R	143.40		30	4.000	1.0
3173	Epicanthal folds	2004.00		20	128.700	1.0	R	904.50		20	120.000	1.0	R	843.40		30	4.000	1.0
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)	2004.00		20	25.000	1.0	R	175.70										
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)	2004.00		20	35.000	1.0	R	246.00										
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	2004.00		20	187.000	1.0	R	1 314.20		20	149.600	1.0	R	1 051.40		30	4.000	1.0
16.12.1	Lids: Entropion or ectropion by																	
3177	Entropion or ectropion by Cautery	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30		30	4.000	1.0
3179	Entropion or ectropion by Suture	2004.00		20	49.400	1.0	R	347.20		20	49.400	1.0	R	347.20		30	4.000	1.0
3181	Entropion or ectropion by Open operation	2004.00		20	111.500	1.0	R	783.60		20	111.500	1.0	R	783.60		30	4.000	1.0
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	2004.00		20	122.600	1.0	R	861.60		20	122.600	1.0	R	861.60		30	4.000	1.0
16.12.2	Lids: Reconstruction of eyelid																	
3185	Staged procedure for partial or total loss of eyelid: First stage	2004.00		20	259.000	1.0	R	1 820.30		20	207.200	1.0	R	1 456.20		30	4.000	1.0
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	2004.00		20	206.000	1.0	R	1 447.80		20	164.800	1.0	R	1 158.20		30	4.000	1.0
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	2004.00		20	136.500	1.0	R	959.30		20	120.000	1.0	R	843.40		30	4.000	1.0
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	2004.00		20	150.200	1.0	R	1 055.60		20	120.160	1.0	R	844.50		30	4.000	1.0
3172	Blepharoplasty lower eyelid plus fat pad	2004.00		20	125.800	1.0	R	884.10		20	120.000	1.0	R	843.40		30	4.000	1.0
16.12.3	Lids: Ptosis																	
3193	Repair by superior rectus, levator or frontalis muscle operation	2004.00		20	190.000	1.0	R	1 335.30		20	152.000	1.0	R	1 068.30		30	4.000	1.0
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	2004.00		20	137.600	1.0	R	967.10		20	120.000	1.0	R	843.40		30	4.000	1.0
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	2004.00		20	166.000	1.0	R	1 166.60		20	132.800	1.0	R	933.30		30	4.000	1.0
16.13	Conjunctiva																	
3199	Repair of conjunctiva by grafting	2004.00		20	132.000	1.0	R	927.70		20	120.000	1.0	R	843.40		30	4.000	1.0
3200	Repair of lacerated conjunctiva	2004.00		20	47.000	1.0	R	330.30		20	47.000	1.0	R	330.30		30	4.000	1.0
16.14	Eye: General																	
	OWN EQUIPMENT USED IN TREATMENT:□ Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.	2004.00																
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting	2004.00		20	109.000	1.0	R	766.10										
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of R15,00 per minute may be charged	2004.00																
3196	Diamond knife: Use of own diamond knife during intraocular surgery	2004.00		20	12.000	1.0	R	84.30										
3198	Excimer laser: Hire fee (per eye)	2004.00		20	284.130	1.0	R	1 996.90										
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting (Not to be used with IOL Master)	2004.00		20	109.000	1.0	R	766.10										
3202	Phako emulsification apparatus: Hire fee	2004.00		20	109.000	1.0	R	766.10										
3203	Vitrectomy apparatus: Hire fee	2004.00		20	120.000	1.0	R	843.40										
17	Ear																	
17.1	External ear (Pinna)																	
3267	Major congenital deformity reconstruction of external ear: Unilateral	2004.00		20	138.000	1.0	R	969.90		20	120.000	1.0	R	843.40		30	5.000	1.0
3269	Major congenital deformity reconstruction of external ear: Bilateral	2004.00		20	242.000	1.0	R	1 700.80		20	193.600	1.0	R	1 360.60		30	5.000	1.0
3270	Excision of superficial pre-auricular fistula	2004.00		20	55.000	1.0	R	386.50		20	55.000	1.0	R	386.50		30	4.000	1.0

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3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear	2004.00		20	-	0.0	R -	f											
3272	Excision of complicated pre-auricular fistula	2004.00		20	140.000	1.0	R 983.90			20	120.000	1.0	R 843.40			30	4.000	1.0	
17.2	External ear canal																		
3204	External ear canal: Removal of foreign body: At rooms	2004.00		20	-	0.0	R -	F		20	-	0.0	R -	F					
3205	External ear canal: Removal of foreign body: Under general anaesthetic	2004.00		20	21.000	1.0	R 147.60			20	21.000	1.0	R 147.60			30	4.000	1.0	
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	2004.00		20	164.000	1.0	R 1 152.60			20	131.200	1.0	R 922.10			30	4.000	1.0	
3217	Meatus atresia: Congenital	2004.00		20	277.000	1.0	R 1 946.80			20	221.600	1.0	R 1 557.40			30	4.000	1.0	
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	2004.00		20	77.000	1.0	R 541.20			20	77.000	1.0	R 541.20			30	4.000	1.0	
3221	Meatus atresia: Removal of osteoma from meatus: Multiple	2004.00		20	215.000	1.0	R 1 511.00			20	172.000	1.0	R 1 208.80			30	4.000	1.0	
17.3	Middle ear																		
3206	Microscopic examination of tympanic membrane including microsuction	2004.00		20	8.000	1.0	R 56.20			20	8.000	1.0	R 56.20						
3207	Myringotomy: Unilateral	2004.00		20	28.000	1.0	R 196.80			20	28.000	1.0	R 196.80			30	4.000	1.0	
3209	Myringotomy: Bilateral	2004.00		20	46.000	1.0	R 323.30			20	46.000	1.0	R 323.30			30	4.000	1.0	
3211	Unilateral myringotomy with insertion of ventilation tube	2004.00		20	38.000	1.0	R 267.10			20	38.000	1.0	R 267.10			30	4.000	1.0	
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	2004.00		20	57.000	1.0	R 400.60			20	57.000	1.0	R 400.60			30	4.000	1.0	
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	2004.00		20	65.000	1.0	R 456.80			20	65.000	1.0	R 456.80			30	4.000	1.0	
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	2004.00		20	255.000	1.0	R 1 792.10			20	204.000	1.0	R 1 433.70			30	5.000	1.0	
3237	Exploratory tympanotomy	2004.00		20	158.900	1.0	R 1 116.70			20	127.120	1.0	R 893.40			30	5.000	1.0	
3243	Myringoplasty	2004.00		20	138.000	1.0	R 969.90			20	120.000	1.0	R 843.40			30	5.000	1.0	
3245	Functional reconstruction of tympanic membrane	2004.00		20	277.000	1.0	R 1 946.80			20	221.600	1.0	R 1 557.40			30	5.000	1.0	
3249	Stapedotomy and stapedectomy	2004.00		20	277.000	1.0	R 1 946.80			20	221.600	1.0	R 1 557.40			30	5.000	1.0	
3257	Cortical mastoidectomy	2004.00		20	188.500	1.0	R 1 324.80			20	150.800	1.0	R 1 059.80			30	5.000	1.0	
3259	Radical mastoidectomy (excluding minor procedures)	2004.00		20	277.400	1.0	R 1 949.60			20	221.920	1.0	R 1 559.70			30	5.000	1.0	
3261	Muscle grafting to mastoid cavity without tympanoplasty	2004.00		20	180.000	1.0	R 1 265.00			20	144.000	1.0	R 1 012.00			30	5.000	1.0	
3263	Autogenous bone graft to mastoid cavity	2004.00		20	180.000	1.0	R 1 265.00			20	144.000	1.0	R 1 012.00			30	5.000	1.0	
3264	Tympanomastoidectomy	2004.00		20	375.000	1.0	R 2 635.50			20	300.000	1.0	R 2 108.40			30	5.000	1.0	
3265	Reconstruction of posterior canal wall, following radical mastoid	2004.00		20	320.000	1.0	R 2 249.00			20	256.000	1.0	R 1 799.20			30	5.000	1.0	
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	2004.00		20	30.000	1.0	R 210.80			20	30.000	1.0	R 210.80			30	5.000	1.0	
17.4	Facial nerve																		
17.4.1	Facial nerve: Facial nerve tests																		
3223	Percutaneous stimulation of the facial nerve	2004.00		20	9.000	1.0	R 63.30			20	9.000	1.0	R 63.30			30	4.000	1.0	
3224	Electroneurography (ENOG)	2004.00		20	75.000	1.0	R 527.10			20	75.000	1.0	R 527.10			30	4.000	1.0	
17.4.2	Facial nerve: Facial nerve surgery																		
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	2004.00		20	297.000	1.0	R 2 087.30			20	237.600	1.0	R 1 669.90			30	5.000	1.0	
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)	2004.00		20	436.000	1.0	R 3 064.20			20	348.800	1.0	R 2 451.40			30	5.000	1.0	
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	2004.00		20	436.000	1.0	R 3 064.20			20	348.800	1.0	R 2 451.40			30	5.000	1.0	
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	2004.00		20	124.000	1.0	R 871.50			20	120.000	1.0	R 843.40			30	6.000	1.0	
17.5	Inner ear																		
17.5.1	Inner ear: Audiometry																		
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	2004.00		20	50.000	1.0	R 351.40												
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	2004.00		20	88.000	1.0	R 618.50												

2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels	2004.00		20	60.000	1.0	R	421.70											
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels	2004.00		20	105.000	1.0	R	737.90											
2695	Audiology 40Hz response: Unilateral	2004.00		20	30.000	1.0	R	210.80											
2696	Audiology 40Hz response: Bilateral	2004.00		20	53.000	1.0	R	372.50											
2697	Mid- and long latency auditory evoked potentials: Unilateral	2004.00		20	30.000	1.0	R	210.80											
2698	Mid- and long latency auditory evoked potentials: Bilateral	2004.00		20	53.000	1.0	R	372.50											
2699	Electro-cochleography: Unilateral	2004.00		20	50.000	1.0	R	351.40											
2700	Electro-cochleography: Bilateral	2004.00		20	88.000	1.0	R	618.50											
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	2004.00		20	140.000	1.0	R	983.90									30	4.000	1.0
3248	Otoacoustic emission performed as a screening test	2005.03		20	33.240	1.0	R	233.60	Z	20	33.240	1.0	R	233.60	Z				
3250	Otoacoustic emission (high risk patients only)	2004.00		20	66.480	1.0	R	467.20		20	66.480	1.0	R	467.20					
3273	Pure tone audiometry (air conduction)	2004.00		20	6.500	1.0	R	45.70		20	6.500	1.0	R	45.70					
3274	Pure tone audiometry (bone conduction with masking)	2004.00		20	6.500	1.0	R	45.70		20	6.500	1.0	R	45.70					
3275	Impedance audiometry (tympanometry)	2004.00		20	6.500	1.0	R	45.70		20	6.500	1.0	R	45.70					
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.	2004.00		20	6.500	1.0	R	45.70		20	6.500	1.0	R	45.70					
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	2006.04		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30					
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	2004.00		20	6.500	1.0	R	45.70		20	6.500	1.0	R	45.70					
17.5.2	Inner ear: Balance tests																		
3251	Minimal caloric test (excluding consultation fee)	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30					
3252	Bithermal Halpike caloric test (excluding consultation fee)	2004.00		20	20.000	1.0	R	140.60		20	20.000	1.0	R	140.60					
3253	Electro-nystagmography for spontaneous and positional nystagmus	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70					
3254	Video nystagmoscopy (monocular)	2004.00		20	25.000	1.0	R	175.70		20	25.000	1.0	R	175.70					
3255	Caloric test done with electronystamography	2004.00		20	70.000	1.0	R	492.00		20	70.000	1.0	R	492.00					
3256	Video nystagmoscopy (binocular)	2004.00		20	50.000	1.0	R	351.40		20	50.000	1.0	R	351.40					
3258	Otolith repositioning manoeuvre	2004.00		20	14.000	1.0	R	98.40		20	14.000	1.0	R	98.40			30	4.000	1.0
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	2004.00		20	71.480	1.0	R	502.40	Z	20	71.480	1.0	R	502.40	Z				
17.5.3	Inner ear surgery																		
3233	Labyrinthectomy via the middle ear or mastoid	2004.00		20	277.000	1.0	R	1 946.80		20	221.600	1.0	R	1 557.40			30	5.000	1.0
3240	Endolymphatic sac surgery	2004.00		20	277.000	1.0	R	1 946.80		20	221.600	1.0	R	1 557.40			30	4.000	1.0
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	2004.00		20	310.000	1.0	R	2 178.70		20	248.000	1.0	R	1 742.90			30	5.000	1.0
3246	Cochlear implant surgery	2004.00		20	340.500	1.0	R	2 393.00		20	272.400	1.0	R	1 914.40			30	5.000	1.0
17.6	Microsurgery of the skull base																		
17.6.1	Microsurgery of the skull base: Middel fossa approach (i.e transtemporal or supralabyrinthine)																		
3229	Facial nerve: Exploration of the labyrinthine segment	2004.00		20	420.000	1.0	R	2 951.80		20	336.000	1.0	R	2 361.40			30	5.000	1.0
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	2006.04		20	510.000	1.0	R	3 584.30		20	408.000	1.0	R	2 867.40			30	11.000	1.0
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	2006.04		20	620.000	1.0	R	4 357.40		20	496.000	1.0	R	3 485.90			30	11.000	1.0
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	2004.00		20	530.000	1.0	R	3 724.80		20	424.000	1.0	R	2 979.90			30	11.000	1.0
5224	Removal of acoustic neuroma via the middle fossa approach	2004.00		20	660.000	1.0	R	4 638.50		20	528.000	1.0	R	3 710.80			30	11.000	1.0
17.6.2	Microsurgery of the skull base: Translabyrinthe approach																		
3239	Acoustic neuroma removal translabyrinthine	2004.00		20	660.000	1.0	R	4 638.50		20	528.000	1.0	R	3 710.80			30	5.000	1.0

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5227	Cochleo-vestibular neurectomy	2004.00		20	530.000	1.0	R 3 724.80		20	424.000	1.0	R 2 979.90		30	11.000	1.0
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)	2006.04		20	660.000	1.0	R 4 638.50		20	528.000	1.0	R 3 710.80		30	11.000	1.0
17.6.3	Microsurgery of the skull base: Transotic approach to the cerebellopontime angle															
5232	Removal of acoustic neuroma or cyst of the internal auditory canal	2004.00		20	660.000	1.0	R 4 638.50		20	528.000	1.0	R 3 710.80		30	11.000	1.0
17.6.4	Microsurgery of the skull base: Intratemporal fossa approach type A															
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours	2004.00		20	710.000	1.0	R 4 989.90		20	568.000	1.0	R 3 991.90		30	11.000	1.0
17.6.5	Microsurgery of the skull base: Intratemporal fossa approach type B															
5238	Removal of tumour of the petrous apex	2004.00		20	620.000	1.0	R 4 357.40		20	496.000	1.0	R 3 485.90		30	11.000	1.0
5239	Removal of tumour of the clivus	2004.00		20	620.000	1.0	R 4 357.40		20	496.000	1.0	R 3 485.90		30	11.000	1.0
17.6.6	Microsurgery of the skull base: Intrafemoral approach type C															
5242	Removal of nasopharyngeal angiofibroma or carcinoma	2004.00		20	520.000	1.0	R 3 654.60		20	416.000	1.0	R 2 923.60		30	8.000	1.0
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	2004.00		20	520.000	1.0	R 3 654.60		20	416.000	1.0	R 2 923.60		30	11.000	1.0
17.6.7	Microsurgery of the skull base: Subtotal petrosectomy															
5246	Subtotal petrosectomy for removal of temporal bone tumour	2004.00		20	600.000	1.0	R 4 216.80		20	480.000	1.0	R 3 373.40		30	11.000	1.0
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	2004.00		20	480.000	1.0	R 3 373.40		20	384.000	1.0	R 2 698.80		30	11.000	1.0
17.6.8	Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa															
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland	2004.00		20	520.000	1.0	R 3 654.60		20	416.000	1.0	R 2 923.60		30	11.000	1.0
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	2004.00		20	600.000	1.0	R 4 216.80		20	480.000	1.0	R 3 373.40		30	8.000	1.0
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	2004.00		20	660.000	1.0	R 4 638.50		20	528.000	1.0	R 3 710.80		30	8.000	1.0
18	Physical Treatment															
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	2004.00	+	20	0.750	1.0	R 5.27									
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	2004.00		20	13.500	1.0	R 94.90									
3281	Ultrasonic therapy	2004.00		20	10.000	1.0	R 70.30									
3282	Shortwave diathermy	2004.00		20	10.000	1.0	R 70.30									
3284	Sensory nerve conduction studies	2004.00		20	31.000	1.0	R 217.90									
3285	Motor nerve conduction studies	2004.00		20	26.000	1.0	R 182.70									
3287	Spinal joint and ligament injection	2004.00		20	20.000	1.0	R 140.60		20	20.000	1.0	R 140.60				
3288	Epidural injection	2004.00		20	36.000	1.0	R 253.00									
3289	Multiple injections: First joint	2004.00		20	7.500	1.0	R 52.70									
3290	Multiple injections: Each additional joint	2004.00		20	4.500	1.0	R 31.60									
3291	Tendon or ligament injection	2004.00		20	9.000	1.0	R 63.30									
3292	Aspiration of joint or inter-articular injection	2004.00		20	9.000	1.0	R 63.30									
3293	Aspiration or injection of bursa or ganglion	2004.00		20	9.000	1.0	R 63.30									
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389)	2006.05		20	20.000	1.0	R 140.60									
3295	Paravertebral root block: Unilateral	2004.00		20	20.000	1.0	R 140.60									
3296	Paravertebral root block: Bilateral	2004.00		20	30.000	1.0	R 210.80									
3297	Manipulation of spine performed by a specialist in Physical Medicine	2004.00		20	14.000	1.0	R 98.40									
3298	Spinal traction	2004.00		20	6.000	1.0	R 42.20									
3299	Manipulation of large joints: Under general anaesthesia	2004.00		20	14.000	1.0	R 98.40							30	3.000	1.0
3299a	Manipulation of large joints: Under general anaesthesia	2005.01		20	14.000	1.0	R 98.40							30	4.000	1.0

3300	Manipulation of large joints: Without anaesthetic	2004.00		20	-	0.0	R	-	F	20	-	0.0	R	-	F				
3301	Muscle fatigue studies	2004.00		20	20.000	1.0	R	140.60											
3302	Strength duration curve per session	2004.00		20	10.500	1.0	R	73.80											
3303	Electromyography	2004.00		20	75.000	1.0	R	527.10											
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (For subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment: A fee for the treatment only, is applicable: See general rules L and M)	2004.00		20	10.000	1.0	R	70.30		20	10.000	1.0	R	70.30					
	SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT																		
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)	2004.00																	
19	Radiology																		
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values	2004.00																	
	RULES GOVERNING THE SECTION RADIOLOGY																		
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used	2004.00																	
Z.	No fee is subject to more than one reduction	2004.00																	
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years	2004.00																	
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").	2004.00																	
	MODIFIERS GOVERNING THE SECTION																		
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere	2004.00																	
0080	Multiple examinations: Full Fee	2004.00																	
0081	Repeat examinations: No reduction	2004.00																	
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction	2004.00																	
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used	2004.00																	
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)	2004.00																	
19.1	Skeleton																		

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19.1.1	Skeleton: Limbs																		
3305	Finger, toe	2004.00							40	6.300	1.0	R	62.70						
3309	Smith-Petersen or equivalent control, in theatre	2004.00							40	38.700	1.0	R	385.30						
3311	Stress studies, e.g. joint	2004.00							40	7.700	1.0	R	76.70						
3313	Full length study, both legs	2004.00							40	15.500	1.0	R	154.30						
3315	Skeletal survey under 5 years	2004.00							40	19.900	1.0	R	198.10						
3317	Skeletal survey over 5 years	2004.00							40	28.000	1.0	R	278.80						
3319	Arthrography per joint	2004.00							40	15.400	1.0	R	153.30						
3320	Introduction of contrast medium or air: ADD	2004.00	+						40	13.800	1.0	R	137.40						
6500	Hand	2004.00							40	7.700	1.0	R	76.70						
6501	Wrist (specify region)	2004.00							40	7.700	1.0	R	76.70						
6503	Scaphoid	2004.00							40	7.700	1.0	R	76.70						
6504	Radius and ulna	2004.00							40	7.700	1.0	R	76.70						
6505	Elbow	2004.00							40	7.700	1.0	R	76.70						
6506	Humerus	2004.00							40	7.700	1.0	R	76.70						
6507	Shoulder	2004.00							40	7.700	1.0	R	76.70						
6508	Acromio-Clavicula joint	2004.00							40	7.700	1.0	R	76.70						
6509	Clavicle	2004.00							40	7.700	1.0	R	76.70						
6510	Scapula	2004.00							40	7.700	1.0	R	76.70						
6511	Foot	2004.00							40	7.700	1.0	R	76.70						
6512	Ankle	2004.00							40	7.700	1.0	R	76.70						
6513	Calcaneus	2004.00							40	7.700	1.0	R	76.70						
6514	Tibia and fibula	2004.00							40	7.700	1.0	R	76.70						
6515	Knee	2004.00							40	7.700	1.0	R	76.70						
6516	Patella	2004.00							40	7.700	1.0	R	76.70						
6517	Femur	2004.00							40	7.700	1.0	R	76.70						
6518	Hip	2004.00							40	7.700	1.0	R	76.70						
6519	Sesamoid Bone	2004.00							40	7.700	1.0	R	76.70						
19.1.2	Skeleton: Spinal column																		
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic	2004.00							40	11.000	1.0	R	109.50						
3325	Stress studies	2004.00							40	11.000	1.0	R	109.50						
3329	Scoliosis studies	2004.00							40	21.000	1.0	R	209.10						
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)	2004.00							40	11.000	1.0	R	109.50						
3333	Myelography: Lumbar	2004.00							40	28.900	1.0	R	287.70		30	4.000	1.0		
3334	Myelography: Thoracic	2004.00							40	22.200	1.0	R	221.00		30	4.000	1.0		
3335	Myelography: Cervical	2004.00							40	35.500	1.0	R	353.40		30	4.000	1.0		
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	2004.00													30	4.000	1.0		
3344	Introduction of contrast medium	2004.00	+						40	18.700	1.0	R	186.20						
3345	Discography	2004.00							40	34.600	1.0	R	344.50		30	4.000	1.0		
3347	Introduction of contrast medium per disc level: ADD	2004.00	+						40	28.200	1.0	R	280.80						
19.1.3	Skeleton: Skull																		
3349	Skull studies	2004.00							40	15.700	1.0	R	156.30						
3351	Paranasal sinuses	2004.00							40	11.000	1.0	R	109.50						
3353	Facial bones and/or orbits	2004.00							40	12.600	1.0	R	125.40						

3355	Mandible	2004.00							40	9.400	1.0	R	93.60						
3357	Nasal bone	2004.00							40	7.800	1.0	R	77.70						
3359	Mastoid: Bilateral	2004.00							40	18.000	1.0	R	179.20						
3361	Teeth: One quadrant	2004.00							40	3.700	1.0	R	36.80						
3363	Teeth: Two quadrants	2004.00							40	6.300	1.0	R	62.70						
3365	Teeth: Full mouth	2004.00							40	11.000	1.0	R	109.50						
3366	Teeth: Rotation tomography of the teeth and jaws	2004.00							40	13.300	1.0	R	132.40						
3367	Teeth: Tempero-mandibular joints: Per side	2004.00							40	11.000	1.0	R	109.50						
3369	Teeth: Tomography: Per side	2004.00							40	11.000	1.0	R	109.50						
3371	Localisation of foreign body in the eye	2004.00							40	15.700	1.0	R	156.30						
3381	Ventriculography	2004.00							40	27.300	1.0	R	271.80		30	4.000	1.0		
3385	Post-nasal studies: Lateral neck	2004.00							40	6.300	1.0	R	62.70						
3387	Maxillo-facial cephalometry	2004.00							40	8.800	1.0	R	87.60						
3389	Dacrocystography	2004.00							40	11.000	1.0	R	109.50		30	4.000	1.0		
3391	For introduction of contrast medium: ADD	2004.00	+						40	11.000	1.0	R	109.50						
19.2	Alimentary tract																		
3393	Bowel washout: ADD	2004.00	+						40	4.800	1.0	R	47.80						
3395	Sialography (plus 80% for each additional gland)	2004.00							40	12.700	1.0	R	126.40		30	4.000	1.0		
3397	Introduction of contrast medium (plus 80% for each additional gland: ADD)	2004.00	+						40	11.000	1.0	R	109.50						
3399	Pharynx and oesophagus	2004.00							40	12.700	1.0	R	126.40						
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	2004.00							40	20.000	1.0	R	199.10						
3405	Double contrast: ADD	2004.00	+						40	7.300	1.0	R	72.70						
3406	Small bowel meal (control film of abdomen included except when part of item 3408)	2004.00							40	20.000	1.0	R	199.10						
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	2004.00							40	28.900	1.0	R	287.70						
3409	Barium enema (control film of abdomen included)	2004.00							40	18.300	1.0	R	182.20						
3411	Air contrast study: ADD	2004.00	+						40	19.300	1.0	R	192.20						
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included	2004.00							40	23.300	1.0	R	232.00		30	4.000	1.0		
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included	2004.00							40	15.500	1.0	R	154.30		30	4.000	1.0		
	Note: For items 3415 and 3416: Endoscopy (see item 1778)	2004.00																	
3417	Gastric/oesophageal/duodenal intubation control	2004.00							40	5.900	1.0	R	58.70						
3419	Gastric/oesophageal intubation insertion of tube: ADD	2004.00	+						40	5.600	1.0	R	55.80						
3421	Duodenal intubation: Insertion of tube: ADD	2004.00	+						40	11.000	1.0	R	109.50						
3423	Hypotonic duodenography (item 3403 and item 3405 included)	2004.00	+						40	29.300	1.0	R	291.70						
19.3	Biliary tract																		
3425	Oral cholecystography	2004.00							40	15.700	1.0	R	156.30						
3427	Cholangiography: Intravenous	2004.00							40	22.000	1.0	R	219.00						
3431	Operative cholangiography: First series: ADD item 3607 only when the Radiologist attends personally in theatre	2004.00							40	21.000	1.0	R	209.10						
3433	Post operative: T-tube	2004.00							40	16.700	1.0	R	166.30						
3435	Introduction of contrast medium: ADD	2004.00	+						40	5.600	1.0	R	55.80						
3437	Trans hepatic, percutaneous	2004.00							40	18.300	1.0	R	182.20						
3439	Introduction of contrast medium: ADD	2004.00	+						40	33.100	1.0	R	329.50						
3441	Tomography of biliary tract: ADD	2004.00	+						40	9.400	1.0	R	93.60						

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19.4	Chest																		
3443	Larynx (Tomography included)	2004.00							40	12.500	1.0	R	124.50						
3445	Chest (item 3601 included)	2004.00							40	9.400	1.0	R	93.60						
3447	Chest and cardiac studies (item 3601)	2004.00							40	12.600	1.0	R	125.40						
3449	Ribs	2004.00							40	12.300	1.0	R	122.50						
3451	Sternum or sterno-clavicular joints	2004.00							40	12.600	1.0	R	125.40						
3453	Bronchography: Unilateral	2004.00							40	12.600	1.0	R	125.40		30	8.000	1.0		
3455	Bronchography: Bilateral	2004.00							40	22.100	1.0	R	220.00		30	8.000	1.0		
3457	Introduction of contrast medium included	2004.00							40	35.700	1.0	R	355.40						
3461	Pleurography	2004.00							40	12.600	1.0	R	125.40		30	3.000	1.0		
3463	For introduction of contrast medium: ADD	2004.00	+						40	2.800	1.0	R	27.90						
3465	Laryngography	2004.00							40	11.000	1.0	R	109.50						
3467	For introduction of contrast medium: ADD	2004.00	+						40	10.000	1.0	R	99.60						
3468	Thoracic inlet	2004.00							40	6.300	1.0	R	62.70						
19.5	Abdomen																		
3477	Control films of the Abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)	2004.00							40	9.400	1.0	R	93.60						
3479	Acute abdomen or equivalent studies	2004.00							40	15.700	1.0	R	156.30						
19.6	Urinary tract																		
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)	2004.00							40	25.100	1.0	R	249.90						
3493	Waterload test: ADD	2004.00	+						40	12.200	1.0	R	121.50						
3497	Cystography only or urethrography only (retrograde)	2004.00							40	19.300	1.0	R	192.20						
3499	Cysto-urethrography: Retrograde	2004.00							40	31.900	1.0	R	317.60						
3503	Cysto-urethrography: Introduction of contrast medium	2004.00	+						40	3.700	1.0	R	36.80						
3505	Retrograde-prograde pyelography	2004.00							40	18.300	1.0	R	182.20		30	3.000	1.0		
3511	Aspiration renal cyst	2004.00							40	18.400	1.0	R	183.20						
3513	Tomography of renal tract: ADD	2004.00	+						40	9.400	1.0	R	93.60						
19.7	Gynaecology and obstetrics																		
3515	Pregnancy	2004.00							40	9.400	1.0	R	93.60						
3517	Pelvimetry	2004.00							40	17.400	1.0	R	173.20						
3519	Hystero-salpingography	2004.00							40	12.500	1.0	R	124.50		30	3.000	1.0		
3521	Introduction of contrast medium: ADD	2004.00	+						40	15.300	1.0	R	152.30						
19.8	Vascular studies																		

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	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures):□ □ a. The machine fee (items 3536 to 3550 includes the cost of the following:□ □ i. All runs (runs may not be billed for separately).□ ii. All film costs (modifier 0084 is not applicable).□ iii All fluoroscopy (item 3601 does not apply).□ iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media).□ □ b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices.□ □ c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items.□ □ d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies.□	2004.00																
	MODIFIER GOVERNING VASCULAR STUDIES																	
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations	2004.00																
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)	2004.00																
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00																
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00																
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure	2004.00																
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value	2004.00																
19.8.1	Vascular studies: Film Series																	
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.	2004.00																
3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment	2004.00																
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment	2004.00																
3538	Analogue monoplane table with DSA attachment	2004.00																

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3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment	2004.00																	
3540	Radiography fee for coronary catheterisation laboratory, per radiographer, per half hour or part thereof	2004.00																	
3545	Venography: Per limb	2004.00								40	16.500	1.0	R	164.30					
3548	Analogue monoplane screening table	2004.00																	
3550	Digital monoplane screening table	2004.00																	
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)	2004.00								40	166.800	1.0	R	1 660.70					
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	2004.00								40	48.600	1.0	R	483.90		30	4.000	1.0	
3558	Translumbar aortic puncture, with full study	2004.00								40	69.600	1.0	R	692.90		30	5.000	1.0	
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram	2004.00								40	57.000	1.0	R	567.50		30	4.000	1.0	
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram	2006.04								40	65.400	1.0	R	651.10		30	4.000	1.0	
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	2004.00								40	73.200	1.0	R	728.80		30	4.000	1.0	
3564	Direct femoral arterial or venous or jugular venous puncture	2004.00								40	37.200	1.0	R	370.40					
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	2004.00								40	85.800	1.0	R	854.20		30	5.000	1.0	
3569	Intravascular pressure studies, arterial or venous, once off per case	2004.00								40	19.800	1.0	R	197.10					
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	2004.00								40	130.800	1.0	R	1 302.20		30	5.000	1.0	
3572	Transcatheter selective blood sampling, arterial or venous	2004.00								40	32.400	1.0	R	322.60					
3574	Spinal angiogram (global fee) including all selective catheterisations	2004.00								40	480.000	1.0	R	4 778.90		30	5.000	1.0	
19.8.2	Vascular studies: Introduction of contrast medium																		
3563	Direct intravenous for limb	2004.00	+							40	7.400	1.0	R	73.70					
3575	Cut-downs for venography: ADD	2004.00	+							40	11.000	1.0	R	109.50					
19.9	Tomography and cinematography																		
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values	2004.00																	
3577	Tomography (conventional except where otherwise specified): ADD 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations	2004.00																	
3579	Tomography (multi-dimensional in motion): ADD 150%	2004.00																	
3581	Cinematography: For first series: ADD 100%	2004.00																	
3583	Cinematography: For each series after the first: ADD 80% of the primary fee	2004.00																	
19.9.1	Tomography and cinematography: Computed Tomography																		
3592	Where a fully digital C-arm portable x-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour	2004.00																	
3597	Contrast media: General Rule Y applies (Please note: Item 0201 is not applicable for contrast media)	2004.00																	
3598	Electron beam computed tomography (EBCT) for assessment of coronary artery calcification (complete fee - no additions)	2004.00								70	-	1.0	R	-					
3599	Electron beam computed tomography (EBCT) of the heart. Total fee for contract examination excluding cost of contrast medium (not to be used for coronary artery calcium assessment or scoring - see item 3598)	2004.00								70	-	1.0	R	-					
6400	Plus spiral CT	2004.00																	

6401	Plus 3D reconstruction	2004.00															
6402	Plus high resolution study	2004.00															
6403	CT limb uncontrasted	2004.00													30	5.000	1.0
6404	CT limb with contrast only	2004.00													30	5.000	1.0
6405	CT limb pre- AND post contrast	2004.00													30	5.000	1.0
6406	CT joint uncontrasted	2004.00													30	5.000	1.0
6407	CT joint with contrast only	2004.00													30	5.000	1.0
6408	CT joint pre AND post contrast	2004.00													30	5.000	1.0
6409	CT brain uncontrasted (including posterior fossa)	2004.00													30	5.000	1.0
6410	CT brain with contrast only (including posterior fossa)	2004.00													30	5.000	1.0
6411	CT brain pre AND post contrast (including posterior fossa)	2004.00													30	5.000	1.0
6412	CT orbits complete study, axial OR coronal, uncontrasted	2004.00													30	5.000	1.0
6413	CT orbits complete study, axial AND coronal, uncontrasted	2004.00													30	5.000	1.0
6414	CT orbits complete study, axial OR coronal pre AND post contrast	2004.00													30	5.000	1.0
6415	CT orbits complete study, axial AND coronal pre AND post contrast	2004.00													30	5.000	1.0
6416	CT paranasal sinuses limited study axial OR coronal	2004.00													30	5.000	1.0
6417	CT paranasal sinuses limited study axial AND coronal	2004.00													30	5.000	1.0
6418	CT paranasal sinuses complete study, axial or coronal, uncontrasted	2004.00													30	5.000	1.0
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	2004.00													30	5.000	1.0
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	2004.00													30	5.000	1.0
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	2004.00													30	5.000	1.0
6422	CT pituitary fossa, uncontrasted	2004.00													30	5.000	1.0
6423	CT pituitary fossa, pre AND post contrast	2004.00													30	5.000	1.0
6424	CT internal auditory meati, uncontrasted	2004.00													30	5.000	1.0
6425	CT internal audiory meati, pre AND post contrast	2004.00													30	5.000	1.0
6426	CT mastoids	2004.00													30	5.000	1.0
6427	CT ear structures, limited study	2004.00													30	5.000	1.0
6428	CT middle AND inner ear, complete study including reconstructions	2004.00													30	5.000	1.0
6429	CT facial bones	2004.00													30	5.000	1.0
6430	CT neck soft tissue, uncontrasted	2004.00													30	5.000	1.0
6431	CT neck soft tissue with contrast only	2004.00													30	5.000	1.0
6432	CT neck pre AND post contrast	2004.00													30	5.000	1.0
6433	CT cervical spine uncontrasted	2004.00													30	5.000	1.0
6434	CT cervical spine pre AND post contrast	2004.00													30	5.000	1.0
6435	CT cervical spine post myelogram	2004.00													30	5.000	1.0
6436	CT dorsal spine uncontrasted	2004.00													30	5.000	1.0
6437	CT dorsal spine pre AND post contrast	2004.00													30	5.000	1.0
6438	CT dorsal spine post myelogram	2004.00													30	5.000	1.0
6439	CT lumbar spine uncontrasted	2004.00													30	5.000	1.0
6440	CT lumbar spine pre AND post contrast	2004.00													30	5.000	1.0
6441	CT lumbar spine post myelogram	2004.00													30	5.000	1.0
6442	CT pelvimetry (topogram only)	2004.00													30	5.000	1.0
6443	CT chest uncontrasted	2004.00													30	5.000	1.0
6444	CT chest with contrast	2004.00													30	5.000	1.0
6445	CT chest pre AND post contrast	2004.00													30	5.000	1.0

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6446	CT chest high resolution lungs, limited study	2004.00													30	5.000	1.0
6447	CT high resolution lungs, complete study	2004.00													30	5.000	1.0
6448	CT abdomen uncontrasted	2004.00													30	5.000	1.0
6449	CT abdomen with contrast	2004.00													30	5.000	1.0
6450	CT abdomen pre AND post contrast	2004.00													30	5.000	1.0
6451	CT abdomen triphasic study	2004.00													30	5.000	1.0
6452	CT pelvis uncontrasted	2004.00													30	5.000	1.0
6453	CT pelvis with contrast	2004.00													30	5.000	1.0
6454	CT pelvis pre AND post contrast	2004.00													30	5.000	1.0
6455	CT abdomen AND pelvis uncontrasted	2004.00													30	5.000	1.0
6456	CT abdomen AND pelvis with contrast	2004.00													30	5.000	1.0
6457	CT abdomen AND pelvis pre AND post contrast	2004.00													30	5.000	1.0
6458	CT chest, abdomen AND pelvis with contrast	2004.00													30	5.000	1.0
6459	CT base of skull to symphysis pubis with contrast	2004.00													30	5.000	1.0
6460	CT for dental implants maxilla OR mandible	2004.00															
6461	CT for dental implants maxilla AND mandible	2004.00															
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)	2004.00													30	5.000	1.0
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	2004.00													30	5.000	1.0
6464	CT limited study, any region. Region to be identified on the account	2004.00													30	5.000	1.0
6465	CT guidance for aspiration, biopsy or drainage	2004.00													30	11.000	1.0
6466	CT guidance for aspiration at time of CT diagnostic study	2004.00															
6467	CT stereotactic localisation for biopsy	2004.00													30	11.000	1.0
6468	CT for radiotherapy planning (not to be used as an add-on)	2004.00															
6469	Quantitative CT for bone mineral density	2004.00															
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast	2004.00													30	5.000	1.0
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast	2004.00													30	5.000	1.0
6472	Computer Aided Diagnosis for Mammography	2004.00															
19.10	Radiology: Miscellaneous																
3594	Mammogram of surgically removed breast biopsy specimen	2004.00															
3600	Peripheral bone densitometry utilizing ionizing radiation	2004.00		40	13.000	1.0	R	129.40		40	13.000	1.0	R	129.40			
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445 and 3447)	2004.00	+							40	7.700	1.0	R	76.70			
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD	2004.00								40	10.700	1.0	R	106.50			
3603	Sinography	2004.00								40	18.400	1.0	R	183.20			
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	2004.00		40	77.000	1.0	R	766.60		40	77.000	1.0	R	766.60			
3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This item may not be used together with an item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, item 3629 is used	2004.00								40	33.000	1.0	R	328.50			
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour	2004.00								40	21.000	1.0	R	209.10			
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except item 3309): Per half hour: Plus fee or examination performed (Only to be used by radiological technical staff)	2004.00								40	5.800	1.0	R	55.80			

3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position	2004.00								40	40.000	1.0	R	398.20		30	3.000	1.0
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done	2004.00								40	-	1.0	R	-				
3611	Foreign body localisation: Introduction of sterile needle markers: ADD	2004.00	+							40	11.000	1.0	R	109.50				
3613	Setting of sterile trays	2004.00								40	3.300	1.0	R	32.90				
5029	Mammotome - stereotaxis: Hand held	2004.00																
5034	Fine needle aspiration or biopsy or core biopsy of mamma	2004.00								40	25.000	1.0	R	248.90		30	6.000	1.0
19.11	Ultrasound investigations																	
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values	2004.00																
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.	2004.00																
3596	Intravascular ultrasound per case, arterial or venous, for intervention	2004.00		60	30.000	1.0	R	201.00		60	30.000	1.0	R	201.00				
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	2004.00		60	110.000	1.0	R	736.90		60	110.000	1.0	R	736.90		30	5.000	1.0
3612	Ultrasonic bone densitometry	2004.00		60	19.000	1.0	R	127.30		60	19.000	1.0	R	127.30				
3614	Transvaginal aspiration of ova	2004.00		60	110.000	1.0	R	736.90		60	110.000	1.0	R	736.90				
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3616	Contrast media: General Rule Y applies	2004.00																
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)	2004.00		60	40.000	1.0	R	268.00		60	40.000	1.0	R	268.00				
3619	Intravascular ultrasound imaging assesses the atheroschlerotic process to guide the placement of an intracoronary stent. This item may be applied once per vessel (left anterior descending territory, circumflex territory and/or right coronary territory) in which a stent or multiple stents are deployed	2004.00		60	30.000	1.0	R	201.00		60	30.000	1.0	R	201.00		30	9.000	1.0
3620	Cardiac examination plus Doppler colour mapping	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3621	Cardiac examination (MMode)	2004.00		60	25.000	1.0	R	167.50		60	25.000	1.0	R	167.50				
3622	Cardiac examination: 2 Dimensional	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3623	Cardiac examination + effort	2004.00	+	60	10.000	1.0	R	67.00		60	10.000	1.0	R	67.00				
3624	Cardiac examinations + contrast	2004.00	+	60	10.000	1.0	R	67.00		60	10.000	1.0	R	67.00				
3625	Cardiac examinations + doppler	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3626	Cardiac examination + phonocardiography	2004.00	+	60	10.000	1.0	R	67.00		60	10.000	1.0	R	67.00				
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)	2004.00		60	60.000	1.0	R	401.90		60	60.000	1.0	R	401.90				
3628	Renal tract	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3631	Ophthalmic examination	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				
3633	Neonatal head scan	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00				

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3634	Peripheral vascular study, B mode only	2004.00		60	39.000	1.0	R	261.30		60	39.000	1.0	R	261.30					
3635	+ Doppler	2004.00		60	39.000	1.0	R	261.30		60	39.000	1.0	R	261.30					
3636	Trans-oesophageal echocardiography including passing the device	2004.00		60	100.000	1.0	R	669.90		60	100.000	1.0	R	669.90					
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)	2004.00		60	78.000	1.0	R	522.50		60	78.000	1.0	R	522.50					
5026	Ultrasound guided amniocentesis	2004.00		60	39.000	1.0	R	261.30								30	6.000	1.0	
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00					
5101	Pleural space ultrasound	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00					
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00					
5103	Ultrasound soft tissue, any region	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00					
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy	2004.00		60	25.000	1.0	R	167.50		60	25.000	1.0	R	167.50					
5107	Ultrasound after 24 weeks - motivation required	2004.00		60	25.000	1.0	R	167.50		60	25.000	1.0	R	167.50					
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00					
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy	2004.00		60	128.000	1.0	R	857.50		60	120.000	1.0	R	803.90					
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with items 5110, 5112, 5113 or 5114)	2004.00		60	206.000	1.0	R	1 380.00		60	164.800	1.0	R	1 104.00					
5112	Peripheral arterial ultrasound vascular study: B mode, pulsed and colour Doppler; per limb; to include waveforms at minimum of three levels, pressure studies at two levels and full interpretation of results	2004.00		60	117.000	1.0	R	783.80		60	117.000	1.0	R	783.80					
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis	2004.00		60	117.000	1.0	R	783.80		60	117.000	1.0	R	783.80					
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally	2004.00		60	178.000	1.0	R	1 192.40		60	142.400	1.0	R	953.90					
5115	Intra-operative ultrasound study	2004.00		60	50.000	1.0	R	335.00		60	50.000	1.0	R	335.00		30	3.000	1.0	
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure	2004.00		60	88.000	1.0	R	589.50		60	88.000	1.0	R	589.50					
5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery [LAD (left anterior desending), Circumflex or Right coronary artery]). May be used a maximum of twice per angiographic procedure	2004.00		60	44.000	1.0	R	294.80		60	44.000	1.0	R	294.80					
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS																		
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units	2004.00																	
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	2004.00		60	6.000	1.0	R	40.19		60	6.000	1.0	R	40.19					
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%	2004.00																	
	GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY																		

EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter	2004.00																
19.12	Portable unit examinations																	
3639	Where portable X-ray unit is used in the hospital or theatre: ADD	2004.00	+							40	7.000	1.0	R	69.70				
3640	Theatre investigations with fixed installation	2004.00	+							40	3.000	1.0	R	29.90				
19.13	Diagnostic procedures requiring the use of radio-isotopes																	
AA.	Procedures to exclude cost of isotope	2004.00																
3641	Tracer test	2004.00		40	33.200	1.0	R	330.50		40	22.100	1.0	R	220.00				
3642	Repeat of further tracer tests for same investigation: Half of above fee	2004.00		40	16.600	1.0	R	165.30		40	11.100	1.0	R	110.50				
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee	2004.00																
3644	Tracer test of complete body or brain tumour location	2004.00		40	82.200	1.0	R	818.40		40	54.800	1.0	R	545.60				
3645	Other organ scanning with use of relevant radio isotopes	2004.00		40	82.200	1.0	R	818.40		40	54.800	1.0	R	545.60				
3646	Thyroid scanning	2004.00		40	28.800	1.0	R	286.70		40	19.200	1.0	R	191.20				
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera	2004.00																
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera	2004.00																
19.14	Interventional radiological procedures																	

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	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures):□ □ a. The machine fee (items 3536 to 3550 includes the cost of the following:□ □ i. All runs (runs may not be billed for separately).□ ii. All film costs (modifier 0084 is not applicable).□ iii All fluoroscopy (item 3601 does not apply).□ iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media).□ □ b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices.□ □ c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items.□ □ d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies.□	2004.00																
	Note: In regard to multiple examinations see modifier 0080	2004.00																
5002	Percutaneous transluminal angioplasty: Aortic/IVC	2004.00							40	102.600	1.0	R	1 021.50		30	13.000	1.0
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel	2004.00							40	102.600	1.0	R	1 021.50		30	13.000	1.0
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial	2004.00							40	102.600	1.0	R	1 021.50		30	13.000	1.0
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial	2004.00							40	139.200	1.0	R	1 385.90		30	13.000	1.0
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic	2004.00							40	139.200	1.0	R	1 385.90		30	13.000	1.0
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral - stand alone procedure	2004.00							40	172.200	1.0	R	1 714.40		30	13.000	1.0
5014	Atherectomy (per vessel)	2004.00							40	204.600	1.0	R	2 037.00				
5016	Aspiration thrombectomy (per vessel)	2004.00							40	131.400	1.0	R	1 308.20				
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite	2004.00							40	106.800	1.0	R	1 063.30		30	5.000	1.0
5022	Embolisation non-intracranial, per vessel	2004.00							40	106.800	1.0	R	1 063.30		30	9.000	1.0
5030	Percutaneous nephrostomy for further procedure or drainage	2004.00							40	73.800	1.0	R	734.80		30	6.000	1.0
5031	Antegrade ureteric stent insertion	2004.00							40	69.600	1.0	R	692.90		30	6.000	1.0
5033	Percutaneous cystostomy in radiology suite	2004.00							40	30.000	1.0	R	298.70				
5035	Urethral balloon dilatation in radiology suite	2004.00							40	22.800	1.0	R	227.00				
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality	2004.00							40	34.200	1.0	R	340.50				
5037	Urethral stenting in radiology suite	2004.00							40	102.600	1.0	R	1 021.50				
5038	Intracranial/spinal AVM embolisation (per session)	2004.00							40	335.400	1.0	R	3 339.20		30	13.000	1.0
5039	Intracranial thrombolysis (on-table) per session	2004.00							40	139.200	1.0	R	1 385.90		30	13.000	1.0
5040	Intracranial aneurysm occlusion	2004.00							40	286.800	1.0	R	2 855.40		30	13.000	1.0
5041	Balloon occlusion/Wada test	2004.00							40	106.800	1.0	R	1 063.30		30	9.000	1.0
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation	2006.04							40	286.800	1.0	R	2 855.40		30	13.000	1.0
5043	Intracranial angioplasty	2004.00							40	204.600	1.0	R	2 037.00		30	13.000	1.0
5044	Transhepatic portogram	2004.00							40	139.200	1.0	R	1 385.90		30	9.000	1.0
5045	Hepatic arterial infusion catheter insertion	2004.00							40	156.000	1.0	R	1 553.10		30	6.000	1.0

5046	Percutaneous biliary drainage (external)	2004.00							40	102.600	1.0	R 1 021.50		30	9.000	1.0
5047	Combined internal/external biliary drainage	2004.00							40	102.600	1.0	R 1 021.50		30	9.000	1.0
5048	Biliary stent insertion	2004.00							40	139.200	1.0	R 1 385.90		30	9.000	1.0
5049	Percutaneous gall bladder drainage	2004.00							40	69.600	1.0	R 692.90		30	9.000	1.0
5050	Percutaneous or renal gall bladder stone removal	2004.00							40	172.200	1.0	R 1 714.40		30	5.000	1.0
5058	Stent insertion: Aortic/IVC - including percutaneous transluminal angioplasty (PTA)	2004.00							40	139.200	1.0	R 1 385.90		30	13.000	1.0
5060	Stent insertion: Iliac/subclavian/AV fistula - including percutaneous transluminal angioplasty (PTA)	2004.00							40	139.200	1.0	R 1 385.90		30	13.000	1.0
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial - including percutaneous transluminal angioplasty (PTA)	2004.00							40	139.200	1.0	R 1 385.90		30	13.000	1.0
5064	Stent insertion: Sub-popliteal - including percutaneous transluminal angioplasty (PTA)	2004.00							40	172.200	1.0	R 1 714.40		30	13.000	1.0
5066	Stent insertion: Renal/visceral/brachiocephalic - including percutaneous transluminal angioplasty (PTA)	2004.00							40	204.600	1.0	R 2 037.00		30	13.000	1.0
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure	2004.00							40	204.600	1.0	R 2 037.00				
5070	Stent insertion: Aorto-iliac stent graft - including percutaneous transluminal angioplasty (PTA)	2004.00							40	311.400	1.0	R 3 100.30		30	13.000	1.0
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite	2004.00							40	82.200	1.0	R 818.40		30	5.000	1.0
5074	IVC filter insertion jugular or femoral route	2004.00							40	156.000	1.0	R 1 553.10		30	9.000	1.0
5076	Intravascular foreign body removal, arterial or venous, any route	2004.00							40	204.600	1.0	R 2 037.00		30	9.000	1.0
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)	2004.00							40	70.200	1.0	R 698.90		30	5.000	1.0
5080	Transjugular intrahepatic porto-systemic shunt	2004.00							40	335.400	1.0	R 3 339.20		30	13.000	1.0
5082	Transjugular liver biopsy	2004.00							40	69.600	1.0	R 692.90		30	9.000	1.0
5084	Endoluminal fallopian tube recanalisation	2004.00							40	172.200	1.0	R 1 714.40		30	6.000	1.0
5086	Renal cyst aspiration/ablation	2004.00							40	22.800	1.0	R 227.00				
5088	Oesophageal stent insertion in radiology suite	2004.00							40	102.600	1.0	R 1 021.50		30	6.000	1.0
5090	Tracheal stent insertion	2004.00							40	102.600	1.0	R 1 021.50		30	6.000	1.0
5091	GIT balloon dilatation under fluoroscopy	2004.00							40	66.600	1.0	R 663.10		30	6.000	1.0
5092	Other GIT stent insertion	2004.00							40	102.600	1.0	R 1 021.50		30	6.000	1.0
5093	Percutaneous gastrostomy in radiology suite	2004.00							40	85.800	1.0	R 854.20				
5094	Cutting needle biopsy with image guidance	2004.00							40	22.800	1.0	R 227.00				
5095	Chest drain insertion in radiology suite	2004.00							40	32.400	1.0	R 322.60				
5096	Percutaneous cyst or tumour ablation (non aspiration)	2004.00							40	54.600	1.0	R 543.60				
5097	Vertebroplasty - introduction of stabilising material under screening or CT control - per level	2004.00												30	13.000	1.0
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES															
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)	2004.00														
19.15	Magnetic Resonance Imaging (MRI)															
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes	2004.00														
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region	2004.00														

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6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee	2004.00																
6103	Post-contrast study: Bone tumour: 100% of the fee	2004.00																
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable	2004.00																
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items	2004.00																
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00																
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00																
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"	2004.00																
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain	2004.00																
6110	MRI spectroscopy: 50% of fee	2004.00																
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.	2004.00																
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.	2004.00																
6200	Magnetic Resonance Imaging: Per anatomical region: Brain	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6201	Magnetic Resonance Imaging: Per anatomical region: Orbitae	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6202	Magnetic Resonance Imaging: Per anatomical region: Paranasal sinuses	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6203	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Face/skull	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6204	Magnetic Resonance Imaging: Per anatomical region: Skull basis/cranio-cervical joint	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6205	Magnetic Resonance Imaging: Per anatomical region: Middle and internal ears	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6206	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Neck	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6207	Magnetic Resonance Imaging: Per anatomical region: Thyroid/para-thyroid	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6208	Magnetic Resonance Imaging: Per anatomical region: Hypophysis (see modifiers 6104 and 6105 for limited examinations)	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6209	Magnetic Resonance Imaging: Per anatomical region: Bone tumour (see modifier 6103)	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6210	Magnetic Resonance Imaging: Per anatomical region: Cervical vertebrae	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6211	Magnetic Resonance Imaging: Per anatomical region: Thoracic vertebrae	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6212	Magnetic Resonance Imaging: Per anatomical region: Lumbar vertebrae	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6213	Magnetic Resonance Imaging: Per anatomical region: Sacrum	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6214	Magnetic Resonance Imaging: Per anatomical region: Pelvis	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6215	Magnetic Resonance Imaging: Per anatomical region: Pelvic organs	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6216	Magnetic Resonance Imaging: Per anatomical region: Abdomen	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	
6217	Magnetic Resonance Imaging: Per anatomical region: Thorax wall	2004.00								75	400.000	1.0	R 3 030.80		30	5.000	1.0	

6218	Magnetic Resonance Imaging: Per anatomical region: Mediastinum	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6219	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Back	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6220	Magnetic Resonance Imaging: Per anatomical region: Left shoulder	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6221	Magnetic Resonance Imaging: Per anatomical region: Right shoulder	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6222	Magnetic Resonance Imaging: Per anatomical region: Both hips	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6223	Magnetic Resonance Imaging: Per anatomical region: Left hip	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6224	Magnetic Resonance Imaging: Per anatomical region: Right hip	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6225	Magnetic Resonance Imaging: Per anatomical region: Left upper-arm	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6226	Magnetic Resonance Imaging: Per anatomical region: Right upper-arm	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6227	Magnetic Resonance Imaging: Per anatomical region: Left elbow	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6228	Magnetic Resonance Imaging: Per anatomical region: Right elbow	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6229	Magnetic Resonance Imaging: Per anatomical region: Left fore-arm	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6230	Magnetic Resonance Imaging: Per anatomical region: Right fore-arm	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6231	Magnetic Resonance Imaging: Per anatomical region: Left wrist and hand	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6232	Magnetic Resonance Imaging: Per anatomical region: Right wrist and hand	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6233	Magnetic Resonance Imaging: Per anatomical region: Left upper-leg	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6234	Magnetic Resonance Imaging: Per anatomical region: Right upper-leg	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6235	Magnetic Resonance Imaging: Per anatomical region: Left knee	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6236	Magnetic Resonance Imaging: Per anatomical region: Right knee	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6237	Magnetic Resonance Imaging: Per anatomical region: Left lower-leg	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6238	Magnetic Resonance Imaging: Per anatomical region: Right lower-leg	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6239	Magnetic Resonance Imaging: Per anatomical region: Left ankle	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6240	Magnetic Resonance Imaging: Per anatomical region: Right ankle	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6241	Magnetic Resonance Imaging: Per anatomical region: Left foot	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6242	Magnetic Resonance Imaging: Per anatomical region: Right foot	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6250	Magnetic Resonance angiography (See modifiers 6106 to 6108): Brain	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6251	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Neck	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6252	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Chest	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6253	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Abdomen	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6254	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Legs	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6255	Magnetic Resonance angiography (See modifiers 6106 to 6108): Heart	2004.00								75	400.000	1.0	R	3 030.80		30	5.000	1.0
6260	Contrast medium: Current price according the regular price list published by the Radiology Society of SA	2004.00																
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations	2004.00								75	70.000	1.0	R	530.40		30	5.000	1.0
20	Radiation Oncology																	
	GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST□ □ (a) Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services.□ □ (b) The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.	2004.00																

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BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes	2004.00																
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values	2004.00																
20.1	Kilovolt therapy																	
20.2	Radium therapy																	
20.3	Isotope therapy																	
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope	2004.00																
20.4	Megavolt therapy																	
20.5	Beta-ray therapy with strontium-90-applicator																	
20.6	Planning of therapy																	
20.7	Technical aids																	
5141	Radiation materials (see modifier 0095)	2005.03																
20.8	Oncological surgical procedures																	
20.9	Special procedures																	
20.10	Chemotherapy																	
	Where patients are not treated in chemotherapy facilities, items 0213, 0214 and 0215 are used instead of items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.	2004.11																
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities	2004.11																
5790	Non infusional Chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day - for exclusive use by doctors with appropriate oncology training (consultations to be charged separately) - (not applicable to oral hormonal therapy)	2004.11		20	42.950	1.0	R	301.90	Z	20	42.950	1.0	R	301.90	Z			
5791	Non infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured or scripted for oral chemotherapy, intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	2005.03		20	24.490	1.0	R	172.10	Z	20	24.490	1.0	R	172.10	Z			
5792	Non infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	2005.03		20	30.610	1.0	R	215.10	Z	20	30.610	1.0	R	215.10	Z			
	Non-infusional chemotherapy: Consultations are charged separately.	2005.05																

	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.	2004.11																
5793	Infusional Chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day - for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities(consultations to be charged separately)	2004.11		20	159.470	1.0	R	1 120.80	Z	20	127.580	1.0	R	896.60	Z			
5794	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured, stored, admixed and administered, and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee	2005.03		20	90.030	1.0	R	632.70	Z	20	90.030	1.0	R	632.70	Z			
5795	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee	2004.11		20	112.540	1.0	R	790.90	Z	20	112.540	1.0	R	790.90	Z			
	Item 5795 is chargeable in addition to item 5793 by the Oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to item 5793 if own or rented facility is used).	2004.11																
20.11	Radiation Therapy Planning																	
20.11.1	Manual Radiotherapy Planning Procedures																	
5801	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	2005.03		50	42.560	1.0	R	363.50	Z									
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest -TECHNICAL COMPONENT	2005.01		50	99.320	1.0	R	848.40	Z									
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	2005.03		50	56.180	1.0	R	479.90	Z									
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	2005.01		50	131.100	1.0	R	1 119.90	Z									
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	2005.03		50	76.620	1.0	R	654.50	Z									
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	2005.01		50	178.770	1.0	R	1 527.10	Z									
20.11.2	Conventional Radiotherapy Planning Procedures																	
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	2005.03		50	170.260	1.0	R	1 454.40	Z									
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	2005.01		50	397.270	1.0	R	3 393.50	Z									

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5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	2005.03		50	238.360	1.0	R 2 036.10	Z										
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	2005.01		50	556.180	1.0	R 4 750.90	Z										
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	2005.03		50	297.950	1.0	R 2 545.10	Z										
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	2005.01		50	695.220	1.0	R 5 938.60	Z										
20.11.3	Three Dimensional Radiotherapy Planning Procedures																	
5820	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	240.230	1.0	R 2 052.00	Z										
5620	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	977.200	1.0	R 8 347.20	Z										
5821	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	407.750	1.0	R 3 483.00	Z										
5621	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	1368.070	1.0	R 11 686.10	Z										
5822	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	554.330	1.0	R 4 735.10	Z										
5622	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	1710.090	1.0	R 14 607.60	Z										
20.11.4	Intensity Modulated Radiotherapy Planning Procedures																	
5823	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	642.920	1.0	R 5 491.80	Z										
5623	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	1916.810	1.0	R 16 373.40	Z										
5825	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	232.180	1.0	R 1 983.30	Z										
5625	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	958.400	1.0	R 8 186.70	Z										
5826	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	753.350	1.0	R 6 435.10	Z										

5626	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2006.02		50	2174.480	1.0	R 18 574.40	Z										
20.11.9	Kilovolt Radiation Treatment																	
5834	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT	2005.03		50	49.080	1.0	R 419.20	Z										
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT	2005.01		50	114.520	1.0	R 978.20	Z										
20.11.6	Short Course Radiation Treatment																	
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	2005.03		50	105.740	1.0	R 903.20	Z										
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	2005.01		50	246.730	1.0	R 2 107.60	Z										
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	2005.03		50	148.040	1.0	R 1 264.60	Z										
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	2005.01		50	345.410	1.0	R 2 950.50	Z										
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	2005.03		50	190.330	1.0	R 1 625.80	Z										
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	2005.01		50	444.110	1.0	R 3 793.60	Z										
20.11.7	Weekly Radiation Treatment Sessions																	
20.11.7	Weekly Radiation Treatment Sessions - Conventional Techniques																	
5839	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	2005.03		50	193.860	1.0	R 1 656.00	Z										
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	2005.01		50	452.330	1.0	R 3 863.80	Z										
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	2005.03		50	246.730	1.0	R 2 107.60	Z										
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	2005.01		50	575.690	1.0	R 4 917.50	Z										
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	2005.03		50	317.220	1.0	R 2 709.70	Z										
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	2005.01		50	740.180	1.0	R 6 322.60	Z										
20.11.7	Weekly Radiation Treatment Sessions - Advanced Techniques																	
5849	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - PROFESSIONAL COMPONENT	2005.03		50	236.240	1.0	R 2 018.00	Z										
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	2005.01		50	551.210	1.0	R 4 708.40	Z										
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	2005.03		50	330.730	1.0	R 2 825.10	Z										
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	2005.01		50	771.710	1.0	R 6 591.90	Z										

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5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	2005.03		50	425.230	1.0	R 3 632.30	Z										
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	2005.01		50	992.190	1.0	R 8 475.30	Z										
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	2005.03		50	348.870	1.0	R 2 980.00	Z										
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	2005.01		50	814.030	1.0	R 6 953.40	Z										
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	2005.03		50	826.830	1.0	R 7 062.80	Z										
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	2005.01		50	1929.260	1.0	R 16 479.70	Z										
20.11.8	Stereotactic Radiation																	
5860	Stereotactic Radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee - PROFESSIONAL COMPONENT	2005.03		50	3719.340	1.0	R 31 770.60	Z										
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT	2005.01		50	8678.460	1.0	R 74 131.40	Z										
5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT	2005.03		50	4277.240	1.0	R 36 536.20	Z										
5661	Stereotactic Radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee - TECHNICAL COMPONENT	2005.01		50	9980.230	1.0	R 85 251.10	Z										
20.12	Brachytherapy																	
20.12.1	Isotope/Applicator Therapy																	
5870	Isotope/Applicator Therapy: Isotopes - Low Complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included	2005.03		50	108.400	1.0	R 926.00	Z										
5872	Isotope/Applicator Therapy: Isotopes - Intermediate Complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included	2005.03		50	216.800	1.0	R 1 851.90	Z										
5873	Isotope/Applicator Therapy: Isotopes - High Complexity, surface application of seed arrays requiring dosimetric assessment and/or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included	2005.03		50	601.160	1.0	R 5 135.10	Z										
20.12.2	Brachytherapy Implants																	
5882	Brachytherapy Implants: Implants - Low Complexity, placement of a single guide tube for the administration of brachytherapy requiring <8 dwell points. The cost of materials are not included	2005.03		50	216.800	1.0	R 1 851.90	Z										
5883	Brachytherapy Implants: Implants - Intermediate Complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included	2005.03		50	786.800	1.0	R 6 720.80	Z										
5885	Brachytherapy Implants: Implants - High Complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included	2005.03		50	1049.070	1.0	R 8 961.20	Z										

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20.12.3	Brachytherapy Treatment																	
5890	Brachytherapy Treatment: Global fee for manual afterloading - includes storage, handling, calibration, planning (manual or computerized), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included	2005.03		50	613.040	1.0	R	5 236.60	Z									
5892	Brachytherapy Treatment: Global fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - PROFESSIONAL COMPONENT	2005.03		50	415.960	1.0	R	3 553.10	Z									
5893	Global Fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - TECHNICAL COMPONENT	2005.03		50	970.560	1.0	R	8 290.50	Z									
20.12.4	Brachytherapy Imaging																	
5895	Brachytherapy Imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than items 5883 or 5885	2005.03		50	156.770	1.0	R	1 339.10	Z									
21	Clinical Pathology																	
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee	2004.00																
	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values.□ Note: For fees for Histology and Cytology refer to items 4561-4593 under Section 22: Anatomical Pathology.	2004.00																
21.1	Haematology																	
3705	Alkali resistant haemoglobin	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	2004.00		80	3.650	1.0	R	29.70		80	2.450	1.0	R	19.90				
3710	Antibody titration	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00				
3711	Arneth count	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3712	Antibody identification	2004.00		80	8.450	1.0	R	68.70		80	5.650	1.0	R	45.90				
3713	Bleeding time (does not include the cost of the simplate device)	2004.00		80	6.940	1.0	R	56.40		80	4.630	1.0	R	37.60				
3714	Blood volume, dye method	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00				
3715	Buffy layer examination	2004.00		80	19.900	1.0	R	161.70		80	13.270	1.0	R	107.80				
3716	Mean Cell Volume	2004.00		80	2.250	0.0	R	-		80	1.500	0.0	R	-				
3717	Bone marrow cytological examination only	2004.00		80	19.900	1.0	R	161.70		80	13.270	1.0	R	107.80				
3719	Bone marrow: Aspiration	2004.00		80	8.400	1.0	R	68.30		80	5.600	1.0	R	45.50				
3720	Bone marrow trephine biopsy	2004.00		80	32.600	1.0	R	264.90		80	21.700	1.0	R	176.30				
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	2004.00		80	36.800	1.0	R	299.00		80	24.500	1.0	R	199.10				
3722	Capillary fragility: Hess	2004.00		80	2.020	1.0	R	16.40		80	1.350	1.0	R	11.00				
3723	Circulating anticoagulants	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3724	Coagulation factor inhibitor assay	2004.00		80	57.560	1.0	R	467.70		80	38.370	1.0	R	311.80				
3726	Activated protein C resistance	2004.00		80	26.000	1.0	R	211.30		80	17.300	1.0	R	140.60				
3727	Coagulation time	2004.00		80	3.160	1.0	R	25.70		80	2.110	1.0	R	17.10				
3728	Anti-factor Xa Activity	2004.00		80	53.600	1.0	R	435.50		80	35.730	1.0	R	290.30				
3729	Cold agglutinins	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				
3730	Protein S: Functional	2004.00		80	37.500	1.0	R	304.70		80	25.000	1.0	R	203.10				
3731	Compatibility for blood transfusion	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				
3732	Cryoglobulin	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				

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3734	Protein C (chromogenic)	2004.00		80	30.290	1.0	R	246.10		80	20.190	1.0	R	164.00					
3735	Anti-thrombin III (chromogenic)	2004.00		80	22.000	1.0	R	178.80		80	14.700	1.0	R	119.40					
3736	Plasminogen (chromogenic)	2004.00		80	61.650	1.0	R	500.90		80	41.100	1.0	R	333.90					
3737	Lupus Russel Viper method	2004.00		80	17.000	1.0	R	138.10		80	11.300	1.0	R	91.80					
3738	Lupus Kaolin Exner method	2004.00		80	25.000	1.0	R	203.10		80	16.700	1.0	R	135.70					
3739	Erythrocyte count	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
3740	Factors V and VII: Qualitative	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
3741	Coagulation factor assay: Functional	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
3742	Coagulation factor assay: Immunological	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3743	Erythrocyte sedimentation rate	2004.00		80	3.000	1.0	R	24.40		80	2.000	1.0	R	16.30					
3744	Fibrin stabilizing factor (urea test)	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3746	Fibrin monomers	2004.00		80	2.700	1.0	R	21.90		80	1.800	1.0	R	14.60					
3748	Plasminogen activator inhibitor (PAI-I)	2004.00		80	65.950	1.0	R	535.80		80	43.970	1.0	R	357.30					
3750	Tissue plasminogen Activator (tPA)	2004.00		80	67.790	1.0	R	550.80		80	45.190	1.0	R	367.20					
3751	Osmotic fragility (screen)	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
3752	Osmotic fragility test: Quantitative	2004.00		80	10.000	1.0	R	81.30		80	6.650	1.0	R	54.00					
3753	Osmotic fragility (before and after incubation)	2004.00		80	18.000	1.0	R	146.30		80	12.000	1.0	R	97.50					
3754	ABO Reverse Group	2004.00		80	5.500	0.0	R	-		80	3.670	0.0	R	-					
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	2004.00		80	10.500	1.0	R	85.30		80	7.000	1.0	R	56.90					
3756	Full cross match	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
3757	Coagulation factors: Quantitative	2004.00		80	32.200	1.0	R	261.60		80	21.470	1.0	R	174.40					
3758	Factor VIII related antigen	2004.00		80	60.460	1.0	R	491.20		80	40.310	1.0	R	327.50					
3759	Coagulation factor correction study	2004.00		80	11.720	1.0	R	95.20		80	7.810	1.0	R	63.50					
3761	Factor XIII related antigen	2004.00		80	61.110	1.0	R	496.50		80	40.740	1.0	R	331.00					
3762	Haemoglobin estimation	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75					
3763	Contact activated product assay	2004.00		80	16.200	1.0	R	131.60		80	10.800	1.0	R	87.80					
3764	Grouping: A B and O antigens	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
3765	Grouping: Rh antigen	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
3766	PIVKA	2004.00		80	43.490	1.0	R	353.40		80	28.990	1.0	R	235.50					
3767	Euglobulin Lysis time	2004.00		80	25.580	1.0	R	207.80		80	17.050	1.0	R	138.50					
3768	Haemoglobin A2 (column chromatography)	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
3769	Haemoglobin electrophoresis	2004.00		80	26.820	1.0	R	217.90		80	17.880	1.0	R	145.30					
3770	Haemoglobin-S (solubility test)	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
3771	Factor III-availability test	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70					
3772	Haptoglobin: Quantitative	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
3773	Ham's acidified serum test	2004.00		80	8.000	1.0	R	65.00		80	5.330	1.0	R	43.30					
3775	Heinz bodies	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
3776	Haemosiderin in urinary sediment	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
3781	Heparin tolerance	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
3783	Leucocyte differential count	2004.00		80	6.200	1.0	R	50.40		80	4.150	1.0	R	33.70					
3785	Leucocytes: Total count	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75					
3786	QBC malaria concentration and fluorescent staining	2004.00		80	25.000	1.0	R	203.10		80	16.700	1.0	R	135.70					
3787	LE-cells	2004.00		80	8.300	1.0	R	67.40		80	5.550	1.0	R	45.10					
3789	Neutrophil alkaline phosphatase	2004.00		80	28.000	1.0	R	227.50		80	18.700	1.0	R	151.90					
3791	Packed cell volume: Haematocrit	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75					

3792	Plasmodium falciparum: Monoclonal immunological identification	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80				
3793	Plasma haemoglobin	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60				
3794	Platelet sensitivities	2004.00		80	18.640	1.0	R	151.50		80	12.430	1.0	R	101.00				
3795	Platelet aggregation per aggregant	2004.00		80	12.140	1.0	R	98.60		80	8.090	1.0	R	65.70				
3796	Platelet antibodies: Agglutination	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30				
3797	Platelet count	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3799	Platelet adhesiveness	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3801	Prothrombin consumption	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3803	Prothrombin determination (two stages)	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3805	Prothrombin index	2004.00		80	6.000	1.0	R	48.80		80	4.000	1.0	R	32.50				
3806	Therapeutic drug level: Dosage	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3807	Recalcification time	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3809	Reticulocyte count	2004.00		80	3.000	1.0	R	24.40		80	2.000	1.0	R	16.30				
3810	Schumm's test	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				
3811	Sickling test	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3814	Sucrose lysis test for PNH	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	2004.00		80	21.100	1.0	R	171.40		80	14.070	1.0	R	114.30				
3820	Thrombo - Elastogram	2004.00		80	26.000	1.0	R	211.30		80	17.330	1.0	R	140.80				
3825	Fibrinogen titre	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50				
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	2004.00		80	8.000	1.0	R	65.00		80	5.330	1.0	R	43.30				
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	2004.00		80	16.000	1.0	R	130.00		80	10.700	1.0	R	86.90				
3832	Red cell pyruvate kinase: Quantitative	2004.00		80	16.000	1.0	R	130.00		80	10.700	1.0	R	86.90				
3834	Red cell Rhesus phenotype	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3835	Haemoglobin F in blood smear	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3837	Partial thromboplastin time	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3841	Thrombin time (screen)	2004.00		80	7.160	1.0	R	58.20		80	4.770	1.0	R	38.80				
3843	Thrombin time (serial)	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40				
3847	Haemoglobin H	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3851	Fibrin degeneration products (diffusion plate)	2004.00		80	10.350	1.0	R	84.10		80	6.900	1.0	R	56.10				
3853	Fibrin degeneration products (latex slide)	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3854	XDP (Dimer test or equivalent latex slide test)	2004.00		80	8.500	1.0	R	69.10		80	5.670	1.0	R	46.10				
3855	Haemagglutination inhibition	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3856	D-Dimer (quantitative)	2004.00		80	27.520	1.0	R	223.60		80	18.350	1.0	R	149.10				
3857	Ristocetin Cofactor	2004.00		80	35.530	1.0	R	288.70		80	23.690	1.0	R	192.50				
3858	Heparin removal	2004.00		80	28.880	1.0	R	234.70		80	19.250	1.0	R	156.40				
21.2	Microscopic and miscellaneous tests																	
3863	Autogenous vaccine	2004.00		80	12.600	1.0	R	102.40		80	8.400	1.0	R	68.30				
3864	Entomological examination	2004.00		80	20.700	1.0	R	168.20		80	13.800	1.0	R	112.10				
3865	Parasites in blood smear	2004.00		80	5.600	1.0	R	45.50		80	3.730	1.0	R	30.30				
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	2004.00		80	4.900	1.0	R	39.80		80	3.300	1.0	R	26.80				
3868	Fungus identification	2004.00		80	8.300	1.0	R	67.40		80	5.500	1.0	R	44.70				
3869	Faeces (including parasites)	2004.00		80	4.900	1.0	R	39.80		80	3.270	1.0	R	26.60				
3873	Transmission electron microscopy	2004.00		80	85.000	1.0	R	690.60		80	57.000	1.0	R	463.10				
3874	Scanning electron microscopy	2004.00		80	100.000	1.0	R	812.50		80	67.000	1.0	R	544.40				
3875	Inclusion bodies	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				

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3878	Crystal identification polarized light microscopy	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3879	Campylobacter in stool: Fastidious culture	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3880	Antigen detection with polyclonal antibodies	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3881	Mycobacteria	2004.00		80	3.000	1.0	R	24.40		80	2.000	1.0	R	16.30				
3882	Antigen detection with monoclonal antibodies	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50				
3883	Concentration techniques for parasites	2004.00		80	3.000	1.0	R	24.40		80	2.000	1.0	R	16.30				
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	2004.00		80	6.300	1.0	R	51.20		80	4.200	1.0	R	34.10				
3885	Cytochemical stain	2004.00		80	5.450	1.0	R	44.30		80	3.650	1.0	R	29.70				
21.3	Bacteriology																	
3887	Antibiotic susceptibility test: Per organism	2004.00		80	8.000	1.0	R	65.00		80	5.330	1.0	R	43.30				
3888	Adhesive tape preparation	2004.00		80	2.700	1.0	R	21.90		80	1.800	1.0	R	14.60				
3889	Clostridium difficile toxin: Monoclonal immunological	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20				
3890	Antibiotic assay of tissues and fluids	2004.00		80	13.900	1.0	R	112.90		80	9.270	1.0	R	75.30				
3891	Blood culture: Aerobic	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3892	Blood culture: Anaerobic	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70				
3893	Bacteriological culture: Miscellaneous	2004.00		80	6.300	1.0	R	51.20		80	4.200	1.0	R	34.10				
3894	Radiometric blood culture	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50				
3895	Bacteriological culture: Fastidious organisms	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3896	In vivo culture: Bacteria	2004.00		80	16.000	1.0	R	130.00		80	10.650	1.0	R	86.50				
3897	In vivo culture: Virus	2004.00		80	16.000	1.0	R	130.00		80	10.650	1.0	R	86.50				
3898	Bacterial exotoxin production (in vitro assay)	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3899	Bacterial exotoxin production (in vivo assay)	2004.00		80	20.700	1.0	R	168.20		80	13.800	1.0	R	112.10				
3901	Fungal culture	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3902	Clostridium difficile (cytotoxicity neutralisation)	2004.00		80	30.000	1.0	R	243.80		80	20.000	1.0	R	162.50				
3903	Antibiotic level: Biological fluids	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40				
3904	Rotavirus latex slide test	2004.00		80	5.620	1.0	R	45.70		80	3.750	1.0	R	30.50				
3905	Identification of virus or rickettsia	2004.00		80	20.700	1.0	R	168.20		80	13.800	1.0	R	112.10				
3906	Identification: Chlamydia	2004.00		80	16.000	1.0	R	130.00		80	10.650	1.0	R	86.50				
3907	Culture for staphylococcus aureus	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3908	Anaerobe culture: Comprehensive	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3909	Anaerobe culture: Limited procedure	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3911	Beta-lactamase assay	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3914	Sterility control test: Biological method	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3915	Mycobacterium culture	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40				
3916	Radiometric tuberculosis culture	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50				
3917	Mycoplasma culture: Limited	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20				
3918	Mycoplasma culture: Comprehensive	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3919	Identification of mycobacterium	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3920	Mycobacterium: Antibiotic sensitivity	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60				
3921	Antibiotic synergistic study	2004.00		80	20.700	1.0	R	168.20		80	13.800	1.0	R	112.10				
3922	Viable cell count	2004.00		80	1.350	1.0	R	11.00		80	0.900	1.0	R	7.31				
3923	Biochemical identification of bacterium: Abridged	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10				
3924	Biochemical identification of bacterium: Extended	2004.00		80	12.500	1.0	R	101.60		80	8.330	1.0	R	67.70				
3925	Serological identification of bacterium: Abridged	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10				
3926	Serological identification of bacterium: Extended	2004.00		80	10.200	1.0	R	82.90		80	6.800	1.0	R	55.30				

3927	Grouping for streptococci	2004.00		80	7.300	1.0	R	59.30		80	4.850	1.0	R	39.40					
3928	Antimicrobic substances	2004.00		80	3.800	1.0	R	30.90		80	2.500	1.0	R	20.30					
3929	Radiometric mycobacterium identification	2004.00		80	14.000	1.0	R	113.80		80	9.300	1.0	R	75.60					
3930	Radiometric mycobacterium antibiotic sensitivity	2004.00		80	25.000	1.0	R	203.10		80	16.700	1.0	R	135.70					
3931	Helicobacter: Monoclonal immunological	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
4650	Antibiotic MIC per organism per antibiotic	2004.00		80	8.000	1.0	R	65.00		80	5.330	1.0	R	43.30					
4651	Non-radiometric automated blood cultures	2004.00		80	13.900	1.0	R	112.90		80	9.270	1.0	R	75.30					
4652	Rapid automated bacterial identification per organism	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
4653	Rapid automated antibiotic susceptibility per organism	2004.00		80	17.000	1.0	R	138.10		80	11.330	1.0	R	92.10					
4654	Rapid automated MIC per organism per antibiotic	2004.00		80	17.000	1.0	R	138.10		80	11.330	1.0	R	92.10					
4655	Mycobacteria: MIC determination - E Test	2005.03		80	16.500	1.0	R	134.10	Z	80	11.000	1.0	R	89.40	Z				
4656	Mycobacteria: Identification HPLC	2005.03		80	35.000	1.0	R	284.40	Z	80	23.330	1.0	R	189.60	Z				
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	2005.03		80	9.900	1.0	R	80.40	Z	80	6.600	1.0	R	53.60	Z				
21.4	Serology																		
3958	Anti Gad/la2 Ab	2004.00		80	67.950	1.0	R	552.10		80	45.300	1.0	R	368.10					
3959	Rose Waaler agglutination test	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3960	Gonococcal, listeria or echinococcus agglutination	2004.00		80	9.500	1.0	R	77.20		80	6.300	1.0	R	51.20					
3961	Slide agglutination test	2004.00		80	2.630	1.0	R	21.40		80	1.750	1.0	R	14.20					
3962	Rebuck skin window	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
3963	Serum complement level; Each component	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
3965	Anti la2 Antibodies	2004.00		80	36.000	1.0	R	292.50		80	24.000	1.0	R	195.00					
3966	Anti Gad Antibodies	2004.00		80	36.000	1.0	R	292.50		80	24.000	1.0	R	195.00					
3967	Auto-antibody: Sensitized erythrocytes	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3968	Herpes virus typing: Monoclonal immunological	2004.00		80	20.690	1.0	R	168.10		80	13.790	1.0	R	112.00					
3969	Western blot technique	2004.00		80	74.000	1.0	R	601.30		80	49.000	1.0	R	398.10					
3970	Epstein-Barr virus antibody titer	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	2004.00		80	14.100	1.0	R	114.60		80	9.400	1.0	R	76.40					
3933	IgE: Total: EMIT or ELISA	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40					
3934	Auto antibodies by labelled antibodies	2004.00		80	16.000	1.0	R	130.00		80	10.650	1.0	R	86.50					
3935	Sperm antibodies	2004.00		80	16.000	1.0	R	130.00		80	10.650	1.0	R	86.50					
3936	Virus neutralisation test: First antibody	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30					
3937	Virus neutralisation test: Each additional antibody	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
3938	Precipitation test per antigen	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3939	Agglutination test per antigen	2004.00		80	5.500	1.0	R	44.70		80	3.670	1.0	R	29.80					
3940	Haemagglutination test: Per antigen	2004.00		80	9.900	1.0	R	80.40		80	6.600	1.0	R	53.60					
3941	Modified Coombs' test for brucellosis	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
3942	Hepatitis Rapid Viral Ab	2004.00		80	12.240	1.0	R	99.50		80	8.160	1.0	R	66.30					
3943	Antibody titer to bacterial exotoxin	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
3945	Complement fixation test	2004.00		80	5.850	1.0	R	47.50		80	3.900	1.0	R	31.70					
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	2004.00		80	14.050	1.0	R	114.20		80	9.370	1.0	R	76.10					
3947	C-reactive protein	2004.00		80	10.840	1.0	R	88.10		80	7.227	1.0	R	58.70					
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	2004.00		80	12.950	1.0	R	105.20		80	8.630	1.0	R	70.10					
3949	Qualitative Kahn, VDRL or other flocculation	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
3950	Neutrophil phagocytosis	2004.00		80	25.200	1.0	R	204.80		80	16.800	1.0	R	136.50					

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3951	Quantitative Kahn, VDRL or other flocculation	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50						
3952	Neutrophil chemotaxis	2004.00		80	67.950	1.0	R	552.10		80	45.300	1.0	R	368.10						
3953	Tube agglutination test	2004.00		80	4.150	1.0	R	33.70		80	2.760	1.0	R	22.40						
3955	Paul Bunnell: Presumptive	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20						
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	2004.00		80	8.500	1.0	R	69.10		80	5.670	1.0	R	46.10						
3957	Paul Bunnell: Absorption	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40						
3971	Immuno-diffusion test: Per antigen	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10						
3972	Respiratory syncytial virus (ELISA technique)	2004.00		80	35.000	1.0	R	284.40		80	23.000	1.0	R	186.90						
3973	Immuno electrophoresis: Per immune serum	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20						
3974	Polymerase chain reaction	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30						
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	2004.00		80	12.000	1.0	R	97.50		80	8.000	1.0	R	65.00						
3977	Counter immuno-electrophoresis	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60						
3978	Lymphocyte transformation	2004.00		80	51.700	1.0	R	420.10		80	34.500	1.0	R	280.30						
3980	Bilharzia Ag Serum/Urine	2004.00		80	14.500	1.0	R	117.80		80	9.670	1.0	R	78.60						
3982	Histone Ab	2004.00		80	16.000	1.0	R	130.00		80	10.670	1.0	R	86.70						
4600	Anti-CCP	2005.03		80	17.460	1.0	R	141.90	Z	80	11.640	1.0	R	94.60	Z					
4601	Panel typing: Antibody detection: Class I	2004.00		80	36.000	1.0	R	292.50		80	24.000	1.0	R	195.00						
4602	Panel typing: Antibody detection: Class II	2004.00		80	44.000	1.0	R	357.50		80	29.300	1.0	R	238.10						
4603	HLA test for specific locus/antigen - serology	2004.00		80	27.000	1.0	R	219.40		80	18.000	1.0	R	146.30						
4604	HLA typing: Class I - serology	2004.00		80	52.000	1.0	R	422.50		80	34.700	1.0	R	281.90						
4605	HLA typing: Class II - serology	2004.00		80	52.000	1.0	R	422.50		80	34.700	1.0	R	281.90						
4606	HLA typing: Class I & II - serology	2004.00		80	90.000	1.0	R	731.30		80	60.000	1.0	R	487.50						
4607	Cross matching T-cells (per tray)	2004.00		80	18.000	1.0	R	146.30		80	12.000	1.0	R	97.50						
4608	Cross matching B-cells	2004.00		80	38.000	1.0	R	308.80		80	25.300	1.0	R	205.60						
4609	Cross matching T- & B-cells	2004.00		80	48.000	1.0	R	390.00		80	32.000	1.0	R	260.00						
4610	Helicobacter: Pylori antigen test	2004.00		80	34.600	1.0	R	281.10		80	23.070	1.0	R	187.40						
4611	Erythropoietin	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30						
4612	HTLV I/II	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30						
4613	Anti-Gm1 Antibody Assay	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30						
4614	HIV Ab - Rapid Test	2004.00		80	12.000	1.0	R	97.50		80	8.000	1.0	R	65.00						
21.5	Skin tests																			
	For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section	2004.00																		
21.6	Biochemical tests: Blood																			
3991	Abnormal pigments: Qualitative	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40						
3993	Abnormal pigments: Quantitative	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80						
3995	Acid phosphate	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00						
3996	Serum Amyloid A	2004.00		80	8.280	1.0	R	67.30		80	5.520	1.0	R	44.90						
3997	Acid phosphatase fractionation	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75						
3998	Amino acids Quantitative (Post derivatisation HPLC)	2004.00		80	78.120	1.0	R	634.70		80	52.080	1.0	R	423.20						
3999	Albumin	2004.00		80	4.800	1.0	R	39.00		80	3.200	1.0	R	26.00						
4000	Alcohol	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20						
4001	Alkaline phosphatase	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00						
4002	Alkaline phosphatase-iso-enzymes	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40						
4003	Ammonia: Enzymatic	2004.00		80	7.710	1.0	R	62.60		80	5.140	1.0	R	41.80						

4004	Ammonia: Monitor	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4005	Alpha-1-antitrypsin: Total	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
4006	Amylase	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4007	Arsenic in blood, hair or nails	2004.00		80	36.250	1.0	R	294.50		80	24.170	1.0	R	196.40					
4008	Bilirubin - Reflectance	2004.00		80	4.770	1.0	R	38.80		80	3.180	1.0	R	25.80					
4009	Bilirubin: Total	2004.00		80	4.770	1.0	R	38.80		80	3.180	1.0	R	25.80					
4010	Bilirubin: Conjugated	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4011	Breath Hydrogen Test	2004.00		80	21.560	1.0	R	175.20		80	14.370	1.0	R	116.80					
4012	CSF Nicotinic Acid	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4013	CSF Glutamine	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4014	Cadmium: Atomic absorption	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4016	Calcium: Ionized	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4017	Calcium: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4018	Calcium: Atomic absorption	2004.00		80	7.250	1.0	R	58.90		80	4.830	1.0	R	39.30					
4019	Carotene	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4020	Carnitine (Total or free) in biological fluid: Each	2004.00		80	11.690	1.0	R	95.00		80	7.790	1.0	R	63.30					
4021	Carnitine (Total or free) in muscle: Each	2004.00		80	23.380	1.0	R	190.00		80	15.590	1.0	R	126.70					
4022	Acyl Carnitine	2004.00		80	23.380	1.0	R	190.00		80	15.590	1.0	R	126.70					
4023	Chloride	2004.00		80	2.590	1.0	R	21.00		80	1.730	1.0	R	14.10					
4025	Chol/HDL/LDL/Trig	2004.00		80	27.070	1.0	R	219.90		80	18.050	1.0	R	146.70					
4026	LDL cholesterol (chemical determination)	2004.00		80	6.900	1.0	R	56.10		80	4.600	1.0	R	37.40					
4027	Cholesterol total	2004.00		80	5.340	1.0	R	43.40		80	3.560	1.0	R	28.90					
4028	HDL cholesterol	2004.00		80	6.900	1.0	R	56.10		80	4.600	1.0	R	37.40					
4029	Cholinesterase: Serum or erythrocyte: Each	2004.00		80	7.480	1.0	R	60.80		80	4.990	1.0	R	40.50					
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80					
4031	Total CO2	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4032	Creatinine	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4033	CSF-Immunoglobulin G	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4034	C1-Esterase Inhibitor	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4035	CSF-Albumin	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4036	CSF-IgG Index	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
4038	Glutamic acid	2004.00		80	29.060	1.0	R	236.10		80	19.370	1.0	R	157.40					
4040	Homocysteine (random)	2004.00		80	15.300	1.0	R	124.30		80	10.200	1.0	R	82.90					
4041	Homocysteine (after Methionine load)	2004.00		80	18.100	1.0	R	147.10		80	12.060	1.0	R	98.00					
4042	D-Xylose absorption test: Two hours	2004.00		80	13.150	1.0	R	106.80		80	8.750	1.0	R	71.10					
4045	Fibrinogen: Quantitative	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
4047	Hollander test	2004.00		80	24.750	1.0	R	201.10		80	16.500	1.0	R	134.10					
4049	Glucose tolerance test (2 specimens)	2004.00		80	8.970	1.0	R	72.90		80	5.980	1.0	R	48.60					
4050	Glucose strip-test with photometric reading	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75					
4051	Galactose	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4052	Glucose tolerance test (3 specimens)	2004.00		80	13.170	1.0	R	107.00		80	8.780	1.0	R	71.30					
4053	Glucose tolerance test (4 specimens)	2004.00		80	17.370	1.0	R	141.10		80	11.580	1.0	R	94.10					
4057	Glucose: Quantitative	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4061	Glucose tolerance test (5 specimens)	2004.00		80	21.560	1.0	R	175.20		80	14.370	1.0	R	116.80					
4062	Galactose-1-phosphate uridyl transferase	2004.00		80	16.000	1.0	R	130.00		80	10.700	1.0	R	86.90					

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4063	Fructosamine	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
4064	HbA1C	2006.04		80	14.250	1.0	R	115.80		80	9.500	1.0	R	77.20					
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	2004.00		80	46.880	1.0	R	380.90		80	31.250	1.0	R	253.90					
4067	Lithium: Flame ionisation	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4068	Lithium: Atomic absorption	2004.00		80	7.480	1.0	R	60.80		80	4.990	1.0	R	40.50					
4071	Iron	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4073	Iron-binding capacity	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4076	Blood gases: Astrup/pO2 and ancillary tests - can only be charged to a maximum of 6 times per patient per day	2004.00		80	19.100	1.0	R	155.20		80	12.730	1.0	R	103.40					
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	2004.11		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4079	Ketones in plasma: Qualitative	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4081	Drug level-biological fluid: Quantitative	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4082	Tacrolimus assay	2004.00		80	20.100	1.0	R	163.30		80	13.400	1.0	R	108.90					
4083	Lysosomal enzyme assay	2004.00		80	36.560	1.0	R	297.10		80	24.370	1.0	R	198.00					
4084	Thymidine kinase	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4085	Lipase	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4086	Lactate	2004.00		80	16.000	1.0	R	130.00		80	10.670	1.0	R	86.70					
4091	Lipoprotein electrophoresis	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80					
4092	Orosmucoid	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4093	Osmolality: Serum or urine	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4094	Magnesium: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4095	Magnesium: Atomic absorption	2004.00		80	7.250	1.0	R	58.90		80	4.830	1.0	R	39.20					
4096	Mercury: Atomic absorption	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4098	Copper: Atomic absorption	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4105	Protein electrophoresis	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80					
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	2004.00		80	20.000	1.0	R	162.50		80	13.200	1.0	R	107.30					
4109	Phosphate	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4111	Phospholipids	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
4113	Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4114	Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4117	Protein: Total	2004.00		80	3.110	1.0	R	25.30		80	2.070	1.0	R	16.80					
4121	pH, pCO2 or pO2: Each	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4123	Pyruvic acid	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4125	Salicylates	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4126	Secretin-pancreozymin response	2004.00		80	26.100	1.0	R	212.10		80	17.400	1.0	R	141.40					
4127	Caeruloplasmin	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4128	Phenylalanine: Quantitative	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4129	Glutamate dehydrogenase (GDH)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4130	Aspartate aminotransferase (AST)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4131	Alanine aminotransferase (ALT)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4132	Creatine kinase (CK)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4133	Lactate dehidrogenase (LD)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4134	Gamma glutamyl transferase (GGT)	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4135	Aldolase	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4136	Anglotensin converting enzyme (ACE)	2004.00		80	9.000	1.0	R	73.10		80	6.000	1.0	R	48.80					

4137	Lactate dehydrogenase isoenzyme	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4138	CK-MB: Immunoinhibition/precipitation	2004.11		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4139	Adenosine deaminase	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4142	Red cell enzymes: Each	2004.00		80	7.800	1.0	R	63.40		80	5.200	1.0	R	42.30					
4143	Serum/plasma enzymes	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4144	Transferrin	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40					
4146	Lead: Atomic absorption	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
4147	Triglyceride	2004.00		80	7.930	1.0	R	64.40		80	5.290	1.0	R	43.00					
4148	Tay - Sachs Study	2004.00		80	36.560	1.0	R	297.10		80	24.370	1.0	R	198.00					
4149	Red cell magnesium	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40					
4151	Urea	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4152	CK-MB: Mass determination: Quantitative (Automated)	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
4153	CK-MB: Mass determination: Quantitative (Not automated)	2004.00		80	17.470	1.0	R	141.90		80	11.650	1.0	R	94.70					
4154	Myoglobin quantitative: Monoclonal immunological	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
4155	Uric acid	2004.00		80	3.780	1.0	R	30.70		80	2.520	1.0	R	20.50					
4156	Vitamin D3	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4157	Vitamin A-saturation test	2004.00		80	15.300	1.0	R	124.30		80	10.200	1.0	R	82.90					
4158	Vitamin E (tocopherol)	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
4159	Vitamin A	2004.00		80	6.300	1.0	R	51.20		80	4.200	1.0	R	34.10					
4160	Vitamin C (ascorbic acid)	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4161	Troponin isoforms: Each	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4163	Apoprotein AI: Turbidometric method	2004.00		80	8.280	1.0	R	67.30		80	5.520	1.0	R	44.90					
4165	Apoprotein AII: Turbidometric method	2004.00		80	8.280	1.0	R	67.30		80	5.520	1.0	R	44.90					
4167	Apoprotein B: Turbidometric method	2004.00		80	8.280	1.0	R	67.30		80	5.520	1.0	R	44.90					
4170	Lipoprotein (a)(Lp(a)) assay	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4171	Sodium + potassium + chloride + CO2 + urea	2004.00		80	15.840	1.0	R	128.70		80	10.560	1.0	R	85.80					
4172	ELISA/EMIT technique	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4173	Sirolimus Assay	2004.00		80	78.000	1.0	R	633.80		80	52.000	1.0	R	422.50					
4181	Quantitative protein estimation: Mancini method	2004.00		80	7.760	1.0	R	63.10		80	5.170	1.0	R	42.00					
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	2004.00		80	8.280	1.0	R	67.30		80	5.520	1.0	R	44.90					
4183	Quantitative protein estimation: Labelled antibody	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4184	C-reactive protein (Ultra sensitive)	2004.00		80	11.680	1.0	R	94.90		80	7.790	1.0	R	63.30					
4185	Lactose	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4186	Vitamin B6	2004.00		80	15.300	1.0	R	124.30		80	10.200	1.0	R	82.90					
4187	Zinc: Atomic absorption	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
21.7	Biochemical tests: Urine																		
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	2004.00		80	1.500	1.0	R	12.20		80	1.000	1.0	R	8.13					
4189	Abnormal pigments	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4193	Alkapton test: Homogentisic acid	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4194	Amino acids: Quantitative (Post derivatisation HPLC)	2004.00		80	78.120	1.0	R	634.70		80	52.080	1.0	R	423.20					
4195	Amino laevulinic acid	2004.00		80	18.000	1.0	R	146.30		80	12.000	1.0	R	97.50					
4197	Amylase	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4198	Arsenic	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4199	Ascorbic acid	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4201	Bence-Jones protein	2004.00		80	2.700	1.0	R	21.90		80	1.800	1.0	R	14.60					

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4203	Phenol	2004.00		80	3.600	1.0	R	26.30		80	2.400	1.0	R	19.50					
4204	Calcium: Atomic absorption	2004.00		80	7.250	1.0	R	58.90		80	4.830	1.0	R	39.20					
4205	Calcium: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4206	Calcium: Absorption and excretion studies	2004.00		80	25.000	1.0	R	203.10		80	16.700	1.0	R	135.70					
4209	Lead: Atomic absorption	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
4210	Urine collagen telopeptides	2004.00		80	36.500	1.0	R	296.60		80	24.330	1.0	R	197.70					
4211	Bile pigments: Qualitative	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4213	Protein: Quantitative	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4216	Mucopolysaccharides: Qualitative	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
4217	Oxalate	2004.00		80	9.380	1.0	R	76.20		80	6.250	1.0	R	50.80					
4218	Glucose: Quantitative	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4219	Steroids: Chromatography (each)	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
4220	Klinolab Newborn Screen	2004.00		80	36.560	1.0	R	297.10		80	24.370	1.0	R	198.00					
4221	Creatinine	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4223	Creatinine clearance	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4227	Electrophoresis: Qualitative	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4228	Fetal Lung Maturity	2004.00		80	36.560	1.0	R	297.10		80	24.370	1.0	R	198.00					
4229	Uric acid clearance	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4230	Urine/Fluid - Specific Gravity	2004.00		80	0.900	1.0	R	7.31		80	0.600	1.0	R	4.88					
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	2005.03		80	37.500	1.0	R	304.70	Z	80	25.000	1.0	R	203.10	Z				
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	2005.03		80	46.800	1.0	R	380.30	Z	80	31.200	1.0	R	253.50	Z				
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	2005.03		80	37.500	1.0	R	304.70	Z	80	25.000	1.0	R	203.10	Z				
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	2005.03		80	46.800	1.0	R	380.30	Z	80	31.200	1.0	R	253.50	Z				
4237	5-Hydroxy-indole-acetic acid: Screen test	2004.00		80	2.700	1.0	R	21.90		80	1.800	1.0	R	14.60					
4238	5HIAA (Hplc)	2004.00		80	78.120	1.0	R	634.70		80	52.080	1.0	R	423.20					
4239	5-Hydroxy-indole-acetic acid: Quantitative	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4247	Ketones: Excluding dip-stick method	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4248	Reducing substances	2004.00		80	1.800	1.0	R	14.60		80	1.200	1.0	R	9.75					
4251	Metanephrines: Column chromatography	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
4252	Metanephrine (Hplc)	2004.00		80	78.120	1.0	R	634.70		80	52.080	1.0	R	423.20					
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	2004.00		80	27.000	1.0	R	219.40		80	18.000	1.0	R	146.30					
4254	Nitrosonaphtol test for tyrosine	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4255	Orotic Acid - Urine	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4256	Very long Chain Fatty Acids	2004.00		80	129.380	1.0	R	1 051.20		80	86.250	1.0	R	700.80					
4261	Micro Albumin: Quantitative	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4262	Micro Albumin: Qualitative	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4263	pH: Excluding dip-stick method	2004.00		80	0.900	1.0	R	7.31		80	0.600	1.0	R	4.88					
4265	Thin layer chromatography: One way	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4266	Thin layer chromatography: Two way	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4267	Total organic matter screen: Infrared	2004.00		80	31.250	1.0	R	253.90		80	20.830	1.0	R	169.20					
4268	Organic acids: Quantitative: GCMS	2004.00		80	109.380	1.0	R	888.70		80	72.920	1.0	R	592.50					
4269	Phenylpyruvic acid: Ferric chloride	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4270	Chromium Total Urine	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4271	Phosphate excretion index	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
4272	Porphobilinogen qualitative screen: Urine	2004.00		80	5.000	1.0	R	40.60		80	3.330	1.0	R	27.10					

4273	Porphobilinogen/ALA: Quantitative each	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
4283	Magnesium: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4284	Magnesium: Atomic absorption	2004.00		80	7.250	1.0	R	58.90		80	4.830	1.0	R	39.20					
4285	Identification of carbohydrate	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4287	Identification of drug: Qualitative	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4288	Identification of drug: Quantitative	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4293	Urea clearance	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4297	Copper: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4298	Copper: Atomic absorption	2004.00		80	18.120	1.0	R	147.20		80	12.080	1.0	R	98.20					
4300	Indican or indole: Qualitative	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
4301	Chloride	2004.00		80	2.590	1.0	R	21.00		80	1.730	1.0	R	14.10					
4307	Ammonium chloride loading test	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
4309	Urobilinogen: Quantitative	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4313	Phosphates	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4315	Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4316	Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4319	Urea	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4321	Uric acid	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4322	Fluoride	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4323	Total protein and protein electrophoresis	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4325	VMA: Quantitative	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4326	Catecholamines (HPLC)	2004.00		80	78.120	1.0	R	634.70		80	52.080	1.0	R	423.20					
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	2004.11		80	46.680	1.0	R	380.90		80	31.250	1.0	R	253.90					
4328	Immunoglobulin D	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4335	Cystine: Quantitative	2004.00		80	12.600	1.0	R	102.40		80	8.400	1.0	R	68.30					
4336	Dinitrophenol hydrazine test: Ketoacids	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4337	Hydroxyproline: Quantitative	2004.00		80	18.900	1.0	R	153.60		80	12.600	1.0	R	102.40					
21.8	Biochemical tests: Faeces																		
4339	Chloride	2004.00		80	2.590	1.0	R	21.00		80	1.730	1.0	R	14.10					
4343	Fat: Qualitative	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
4345	Fat: Quantitative	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
4347	Ph	2004.00		80	0.900	1.0	R	7.31		80	0.600	1.0	R	4.88					
4351	Occult blood: Chemical test	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4352	Occult blood: Monoclonal antibodies	2004.00		80	10.000	1.0	R	81.30		80	6.670	1.0	R	54.20					
4357	Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4358	Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4359	Secretory IgA	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4361	Stercobilin	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4362	Elastase quantitative ELISA	2004.00		80	47.000	1.0	R	381.90		80	31.330	1.0	R	254.60					
4363	Stercobilinogen: Quantitative	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4364	Chymotrypsin determination: Enzymatic	2004.00		80	7.470	1.0	R	60.70		80	4.980	1.0	R	40.50					
21.9	Biochemical tests: Miscellaneous																		
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	2004.00		80	5.000	1.0	R	40.60		80	3.330	1.0	R	27.10					
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					

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4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	2004.00		80	30.000	1.0	R	243.80		80	20.000	1.0	R	162.50					
4370	Drug level in biological fluid: Monoclonal immunological	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
4371	Amylase in exudate	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
4372	Fluoride in biological fluids and water	2004.00		80	15.620	1.0	R	126.90		80	10.410	1.0	R	84.60					
4373	Breast milk analysis	2004.00		80	6.750	1.0	R	54.80		80	4.500	1.0	R	36.60					
4374	Trace metals in biological fluid: Atomic absorption	2004.00		80	18.130	1.0	R	147.30		80	12.090	1.0	R	98.20					
4375	Calcium in fluid: Spectrophotometric	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4376	Calcium in fluid: Atomic absorption	2004.00		80	7.250	1.0	R	58.90		80	4.830	1.0	R	39.20					
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	2004.11		80	21.880	1.0	R	177.80		80	14.590	1.0	R	118.50					
4378	Urea breath test	2004.00		80	58.000	1.0	R	471.30		80	38.670	1.0	R	314.20					
4380	Lecithin in amniotic fluid: L/S ratio	2004.00		80	27.000	1.0	R	219.40		80	18.000	1.0	R	146.30					
4381	Lamellar body count in amniotic fluid	2004.00		80	10.000	1.0	R	81.30		80	6.700	1.0	R	54.40					
4382	Bilirubin in amniotic fluid: Spectrophotometric essay	2004.00		80	9.450	1.0	R	76.80		80	6.300	1.0	R	51.20					
4386	Oestrogen/Progesterone receptors: Fluorescent method	2004.00		80	20.700	1.0	R	168.20		80	13.800	1.0	R	112.10					
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique	2004.00		80	230.000	1.0	R	1 868.80		80	153.000	1.0	R	1 243.10					
4388	Gastric contents: Maximal stimulation test	2004.00		80	27.000	1.0	R	219.40		80	18.000	1.0	R	146.30					
4389	Gastric fluid: Total acid per specimen	2004.00		80	2.250	1.0	R	18.30		80	1.500	1.0	R	12.20					
4390	Foam test: Amniotic fluid	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
4391	Renal calculus: Chemistry	2004.00		80	5.400	1.0	R	43.90		80	3.600	1.0	R	29.30					
4392	Renal calculus: Crystallography	2004.00		80	16.250	1.0	R	132.00		80	10.800	1.0	R	87.80					
4393	Saliva: Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4394	Saliva: Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4395	Sweat: Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4396	Sweat: Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4397	Sweat: Chloride	2004.00		80	2.590	1.0	R	21.00		80	1.730	1.0	R	14.10					
4399	Sweat collection by iontophoresis (excluding collection material)	2004.00		80	4.500	1.0	R	36.60		80	3.000	1.0	R	24.40					
4400	Tryptophane loading test	2004.00		80	22.050	1.0	R	179.20		80	14.700	1.0	R	119.40					
21.10	Cerebrospinal fluid																		
4401	Cell count	2004.00		80	3.450	1.0	R	28.00		80	2.300	1.0	R	18.70					
4407	Cell count, protein, glucose and chloride	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4409	Chloride	2004.00		80	2.590	1.0	R	21.00		80	1.730	1.0	R	14.10					
4415	Potassium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4416	Sodium	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4417	Protein: Qualitative	2004.00		80	0.900	1.0	R	7.31		80	0.600	1.0	R	4.88					
4419	Protein: Quantitative	2004.00		80	3.110	1.0	R	25.30		80	2.070	1.0	R	16.80					
4421	Glucose	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4423	Urea	2004.00		80	3.620	1.0	R	29.40		80	2.410	1.0	R	19.60					
4425	Protein electrophoresis	2004.00		80	12.600	1.0	R	102.40		80	8.400	1.0	R	68.30					
21.11	RNA/DNA based tests and andrology																		
21.11.1	RNA/DNA based tests and andrology: RNA/DNA based tests																		
4424	HLA test for specific allele DNA-PCR	2004.00		80	36.000	1.0	R	292.50		80	24.000	1.0	R	195.00					
4426	HLA typing low resolution Class I DNA-PCR per locus	2004.00		80	100.000	1.0	R	812.50		80	67.000	1.0	R	544.40					
4427	HLA typing low resolution Class II DNA-PCR per locus	2004.00		80	74.000	1.0	R	601.30		80	49.300	1.0	R	400.60					
4428	HLA typing high resolution Class I or II DNA-PCR per locus	2004.00		80	66.000	1.0	R	536.30		80	44.000	1.0	R	357.50					
4429	Quantitative PCR (DNA/RNA)	2004.00		80	84.300	1.0	R	684.90		80	56.200	1.0	R	456.60					

4430	Recombinant DNA technique	2004.00		80	25.000	1.0	R	203.10		80	16.670	1.0	R	135.40					
4431	Ribosomal RNA targeting for bacteriological identification	2004.00		80	35.000	1.0	R	284.40		80	23.330	1.0	R	189.60					
4432	Ribosomal RNA amplification for bacteriological identification	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30					
4433	Bacteriological DNA identification (LCR)	2004.00		80	25.000	1.0	R	203.10		80	16.670	1.0	R	135.40					
4434	Bacteriological DNA identification (PCR)	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30					
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	2005.03		80	150.000	1.0	R	1 218.80	Z	80	100.000	1.0	R	812.50	Z				
21.11.2	RNA/DNA based tests and andrology: Andrology																		
4435	Mixed antiglobulin reaction: Semen	2004.00		80	6.600	1.0	R	53.60		80	4.400	1.0	R	35.80					
4436	Friberg test: Semen	2004.00		80	14.500	1.0	R	117.80		80	9.670	1.0	R	78.60					
4437	Kremer test: Semen	2004.00		80	3.600	1.0	R	29.30		80	2.400	1.0	R	19.50					
4440	Semen analysis: Cell count	2004.00		80	7.650	1.0	R	62.20		80	5.100	1.0	R	41.40					
4441	Semen analysis: Cytology	2004.00		80	7.200	1.0	R	58.50		80	4.800	1.0	R	39.00					
4442	Semen analysis: Viability + motility - 6 hours	2004.00		80	6.000	1.0	R	48.80		80	4.000	1.0	R	32.50					
4443	Semen analysis: Supravital stain	2004.00		80	5.440	1.0	R	44.20		80	3.630	1.0	R	29.50					
4445	Seminal fluid: Alpha glucosidase	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4446	Seminal fluid fructose	2004.00		80	3.150	1.0	R	25.60		80	2.100	1.0	R	17.10					
4447	Seminal fluid: Acid phosphatase	2004.00		80	5.180	1.0	R	42.10		80	3.450	1.0	R	28.00					
21.12	Immunology																		
4448	HCG: Latex agglutination: Qualitative (side room)	2004.00		80	4.000	1.0	R	32.50		80	2.670	1.0	R	21.70					
4449	HCG: Latex agglutination: Semi-quantitative (side room)	2004.00		80	9.310	1.0	R	75.60		80	6.210	1.0	R	50.50					
4450	HCG: Monoclonal immunological: Qualitative	2004.00		80	10.000	1.0	R	81.30		80	6.670	1.0	R	54.20					
4451	HCG: Monoclonal immunological: Quantitative	2004.00		80	12.400	1.0	R	100.80		80	8.270	1.0	R	67.20					
4452	Bone Specific Alk Phosphatase	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4455	Anti IgE receptor antibody test (10 samples and dilution)	2004.00		80	161.560	1.0	R	1 312.70		80	107.710	1.0	R	875.10					
4456	Eosinophil cationic protein	2004.00		80	27.810	1.0	R	226.00		80	18.540	1.0	R	150.60					
4457	Mast cell tryptase	2004.00		80	96.870	1.0	R	787.10		80	64.580	1.0	R	524.70					
4458	Micro-albuminuria: Radio-isotope method	2004.00		80	12.420	1.0	R	100.90		80	8.300	1.0	R	67.40					
4459	Acetyl choline receptor antibody	2004.00		80	158.120	1.0	R	1 284.70		80	105.410	1.0	R	856.50					
4460	CA-199 tumour marker	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4461	Nuclear Matrix Protein 22	2004.00		80	35.000	1.0	R	284.40		80	23.330	1.0	R	189.60					
4462	CA-125 tumour marker	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4463	C6 complement functional essay	2004.00		80	45.000	1.0	R	365.60		80	30.000	1.0	R	243.80					
4464	House dust mite antigen ELIZA	2004.00		80	20.310	1.0	R	165.00		80	13.540	1.0	R	110.00					
4466	Beta-2-microglobulin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4467	Chromograqnin A	2004.00		80	47.000	1.0	R	381.90		80	31.330	1.0	R	254.60					
4468	CA-549	2004.00		80	20.000	1.0	R	162.50		80	13.300	1.0	R	108.10					
4469	Tumour markers: Monoclonal immunological (each)	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4470	CA-195 tumour marker	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4471	Carcino-embryonic antigen	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4472	MCA antigen tumour marker	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4473	TSH Receptor Ab	2004.00		80	17.460	1.0	R	142.00		80	11.650	1.0	R	94.70					
4474	Cast Per Allergen	2004.00		80	27.810	1.0	R	226.00		80	18.540	1.0	R	150.60					
4475	CA-724	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4476	Neopterin	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4477	Neuron specific enolase	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					

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4478	Osteocalcin	2004.00		80	31.400	1.0	R	255.10		80	20.930	1.0	R	170.10					
4479	Vitamin B12-absorption: Shilling test	2004.00		80	11.700	1.0	R	95.10		80	7.800	1.0	R	63.40					
4480	Serotonin	2004.00		80	18.750	1.0	R	152.30		80	12.500	1.0	R	101.60					
4482	Free thyroxine (FT4)	2004.00		80	17.480	1.0	R	142.00		80	11.650	1.0	R	94.70					
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	2004.00		80	37.080	1.0	R	301.30		80	24.720	1.0	R	200.90					
4485	Insulin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4486	C-Peptide	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4487	Calcitonin	2004.00		80	18.900	1.0	R	153.60		80	12.600	1.0	R	102.40					
4488	B-Type Natriuretic Peptide	2004.00		80	47.040	1.0	R	382.20		80	31.360	1.0	R	254.80					
4490	Releasing hormone response	2004.00		80	50.000	1.0	R	406.30		80	33.350	1.0	R	271.00					
4491	Vitamin B12	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4492	Vitamin D3: Calcitroil (RIA)	2004.00		80	75.000	1.0	R	609.40		80	50.000	1.0	R	406.30					
4493	Drug concentration: Quantitative	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4494	Free hormone assay	2004.00		80	17.480	1.0	R	142.00		80	11.650	1.0	R	94.70					
4495	Growth hormone	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4496	Hormone concentration: Quantitative	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4497	Carbohydrate deficient transferrin	2004.00		80	29.060	1.0	R	236.10		80	19.370	1.0	R	157.40					
4499	Cortisol	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4500	DHEA sulphate	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4501	Testosterone	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4502	Free testosterone	2004.00		80	17.480	1.0	R	142.00		80	11.650	1.0	R	94.70					
4503	Oestradiol	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4505	Oestriol	2004.00		80	10.800	1.0	R	87.80		80	7.200	1.0	R	58.50					
4506	Multiple antigen specific IgE screening test for Atopy	2004.00		80	37.260	1.0	R	302.70		80	24.800	1.0	R	201.50					
4507	Thyrotropin (TSH)	2004.00		80	19.600	1.0	R	159.30		80	13.070	1.0	R	106.20					
4508	Combined antigen specific IgE	2004.00		80	24.480	1.0	R	198.90		80	16.600	1.0	R	134.90					
4509	Free tri-iodothyronine (FT3)	2004.00		80	17.480	1.0	R	142.00		80	11.650	1.0	R	94.70					
4511	Renin activity	2004.00		80	18.900	1.0	R	153.60		80	12.600	1.0	R	102.40					
4512	Parathormone	2004.00		80	17.080	1.0	R	138.80		80	11.390	1.0	R	92.50					
4513	IgE: Total	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4514	Antigen specific IgE	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4515	Aldosterone	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4516	Follitropin (FSH)	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4517	Lutropin (LH)	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4518	Soluble transferrin receptor	2004.00		80	11.250	1.0	R	91.40		80	7.500	1.0	R	60.90					
4519	Prostate specific antigen	2004.00		80	14.490	1.0	R	117.70		80	9.660	1.0	R	78.50					
4520	17 Hydroxy progesterone	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4521	Progesterone	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4522	Alpha-feto protein	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4523	ACTH	2004.00		80	21.740	1.0	R	176.60		80	14.490	1.0	R	117.70					
4524	Free PSA	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4526	Sex hormone binding globulin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4527	Gastrin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4528	Ferritin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4529	Anti-DNA antibodies	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					

4530	Antiplatelet antibodies	2004.00		80	15.300	1.0	R	124.30		80	10.200	1.0	R	82.90					
4531	Hepatitis: Per antigen or antibody	2004.00		80	14.490	1.0	R	117.70		80	9.660	1.0	R	78.50					
4532	Transcobalamine	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4533	Folic acid	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4534	Prostatic acid phosphatase	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4536	Erythrocyte folate	2004.00		80	17.480	1.0	R	142.00		80	11.650	1.0	R	94.70					
4537	Prolactin	2004.00		80	12.420	1.0	R	100.90		80	8.280	1.0	R	67.30					
4538	Procalcitonin: Semi-quantitative	2004.00		80	32.000	1.0	R	260.00		80	21.330	1.0	R	173.30					
4539	Procalcitonin: Quantitative	2004.00		80	46.000	1.0	R	373.80		80	30.670	1.0	R	249.20					
4540	HCG: Quantitative as used for Down's screen	2004.00		80	15.000	1.0	R	121.90		80	10.000	1.0	R	81.30					
4546	First trimester Downs screen	2004.00		80	53.500	1.0	R	434.70		80	35.670	1.0	R	289.80					
4552	Second Trimester Down's screen	2004.00		80	33.620	1.0	R	273.20		80	22.410	1.0	R	182.10					
4553	Thyroglubulin	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
4554	SCC marker	2004.00		80	20.000	1.0	R	162.50		80	13.330	1.0	R	108.30					
21.13	Clinical pathology: Miscellaneous																		
4544	Attendance in theatre	2004.00		80	27.000	1.0	R	219.40											
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays - Refer to General Rule B.	2004.00																	
4551	Unlisted pathology service: Fees for items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the fee for a comparable service in the coding structure. New items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note General Rule C and item 6999 are not applicable to pathology services (sections 21, 22 and 23)	2004.00																	
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be charged separately	2004.00																	
22	Anatomical Pathology																		
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values	2004.00																	
22.1	Exfoliative cytology																		
4561	Sputum, all body fluids and tumour aspirates: First unit	2004.00		90	13.400	1.0	R	125.60		90	8.900	1.0	R	83.40					
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	2004.00		90	7.800	1.0	R	73.10		90	5.200	1.0	R	48.70					
4564	Performance of fine-needle aspiration for cytology	2004.00		90	15.000	1.0	R	140.60											
4565	Examination of fine needle aspiration in theatre	2004.00		90	90.000	1.0	R	843.30		90	60.000	1.0	R	562.20					
4566	Vaginal or cervical smears, each	2004.00		90	11.000	1.0	R	103.10		90	7.000	1.0	R	65.60					
22.2	Histology																		
4567	Histology per sample	2004.00		95	20.000	1.0	R	177.40		95	13.300	1.0	R	118.00					
4571	Histology per additional block, each	2004.00		95	11.600	1.0	R	102.90		95	7.700	1.0	R	68.30					
4575	Histology and frozen section in laboratory	2004.00		95	22.700	1.0	R	201.30		95	15.100	1.0	R	133.90					
4577	Histology and frozen section in theatre	2004.00		95	90.000	1.0	R	798.30		95	60.000	1.0	R	532.20					
4578	Second and subsequent frozen sections, each	2004.00		95	20.000	1.0	R	177.40		95	13.400	1.0	R	118.90					
4579	Attendance in theatre - no frozen section performed	2004.00		95	45.000	1.0	R	399.20		95	30.000	1.0	R	266.10					
4582	Serial step sections (including item 4567)	2004.00		95	23.300	1.0	R	206.70		95	15.600	1.0	R	138.40					

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4584	Serial step sections per additional block, each	2004.00		95	13.500	1.0	R	119.70		95	9.000	1.0	R	79.80					
4587	Histology consultation	2004.00		95	10.100	1.0	R	89.60		95	6.700	1.0	R	59.40					
4589	Special stains	2004.00		95	6.700	1.0	R	59.40		95	4.500	1.0	R	39.90					
4591	Immunofluorescence studies	2004.00		95	20.700	1.0	R	183.60		95	13.800	1.0	R	122.40					
4592	Immunoperoxidase studies	2004.00		95	40.000	1.0	R	354.80		95	26.670	1.0	R	236.60					
4593	Electron microscopy	2004.00		95	94.000	1.0	R	833.80		95	63.000	1.0	R	558.80					
4595	Foetal autopsy excluding histology	2004.00		95	73.000	1.0	R	647.50		95	48.670	1.0	R	431.70					
23	Human Genetics																		
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values	2004.00																	
23.1	Cytogenitc																		
4750	Cell culture: Lymphocytes, cord blood	2004.00		100	15.000	1.0	R	124.80		100	15.000	1.0	R	124.80					
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	2004.00		100	45.000	1.0	R	374.50		100	45.000	1.0	R	374.50					
4752	Cell culture: Chorionic villi	2004.00		100	60.000	1.0	R	499.30		100	60.000	1.0	R	499.30					
4754	Cytogenetic analysis: Lymphocytes: idiograms, karyotyping, one staining technique	2004.00		100	135.000	1.0	R	1 123.50		100	135.000	1.0	R	1 123.50					
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: idiograms, karyotyping, one straining technique	2004.00		100	270.000	1.0	R	2 246.90		100	270.000	1.0	R	2 246.90					
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	2004.00		100	70.000	1.0	R	582.50		100	70.000	1.0	R	582.50					
4760	FISH procedure, including cell culture	2004.00		100	115.000	1.0	R	957.00		100	115.000	1.0	R	957.00					
4761	FISH analysis per probe system	2004.00		100	35.000	1.0	R	291.30		100	35.000	1.0	R	291.30					
23.2	DNA-testing																		
4763	Blood: DNA extraction	2004.00		100	45.000	1.0	R	374.50		100	45.000	1.0	R	374.50					
4764	Blood: Genotype per person: Southern blotting	2004.00		100	89.000	1.0	R	740.70		100	89.000	1.0	R	740.70					
4765	Blood: Genotype per person: PCR	2004.00		100	60.000	1.0	R	499.30		100	60.000	1.0	R	499.30					
4766	HIV Drug Resistance Testing	2004.00		100	513.000	1.0	R	4 269.20		100	342.000	1.0	R	2 846.10					
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	2004.00		100	90.000	1.0	R	749.00		100	90.000	1.0	R	749.00					
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	2004.00		100	188.000	1.0	R	1 564.50		100	188.000	1.0	R	1 564.50					
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	2004.00		100	120.000	1.0	R	998.60		100	120.000	1.0	R	998.60					
IV.	Travelling Expenses																		
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner	2004.00																	
5003	R6,67 for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16=3 X R6,67 = R20,01	2004.00																	

5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof	2004.00		20	18.000	1.0	R	126.50										
5007	Normal hours: General practitioner: 18,00 clinical procedure units per hour or part thereof	2004.00								20	18.000	1.0	R	126.50				
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them	2004.00																
V.	LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED																	
	Modifier 0004 is not applicable to the following sections:□ □ All anaesthetic services□ Section 19: Radiology □ Section 20: Radiation Oncology□ Section 21: Clinical Pathology (except for items 3719, 3720 and 3721 where modifier 0004 may be applied)□ Section 22: Anatomical Pathology□ Section 23: Human Genetic□ □ Please note : This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures.	2004.00																

Medical Practitioners 2008

Code	Description	
10000	Specialists	
10008	Specialist Radiologist/Nuclear Physicians	
10099	General Practitioners / non-designated Specialists	
11000	Anaesthesiology	
11200	Dermatology	
11400	General Medical Practice	
11600	Obstetrics and Gynaecology	
11700	Pulmonology	
11800	Medicine (Specialist Physician)	
11900	Gastroenterology	
12000	Neurology	
12100	Cardiology	
12200	Psychiatry	
12300	Medical Oncology	
12400	Neurosurgery	
12500	Nuclear Medicine	
12600	Opthalmology	
12800	Orthopaedics	
13000	Otorhinolaryngology	
13100	Rheumatology	
13200	Paediatrics	
13300	Paediatric Cardiology	
13400	Physical Medicine	
13600	Plastic and Reconstructive Surgery	
13800	Radiology	
14000	Radiation Oncology	
14200	Surgery	
14400	Cardiothoracic Surgery	
14600	Urology	
15200	Pathology (Clinical)	
15300	Pathology (Anatomical)	

Medical Practitioners 2008

Code	Description	RCF	
10	Consultative Services	11.349	
11	Psychiatrists	13.535	
12	Consultative Services (Paediatrics and Paediatric Cardiologists)	11.349	
20	Clinical Procedures	7.028	
30	Anaesthesiologists	44.110	
40	Radiology	9.956	
50	Radiation Oncology	8.542	
60	Ultrasound	6.699	
70	Computed Tomography	7.906	
75	Magnetic Resonance Imaging	7.577	
80	Clinical Pathology	8.125	
90	Anatomical Pathology - Cytology	9.370	
95	Anatomical Pathology - Histology	8.870	
100	Human Genetics	8.322	
130	GP Consultative Services (Items 0190 - 0192, 0173-0175)	12.723	