GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. 1236 **3 October 2008**

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

REGULATIONS RELATING TO THE OBTAINMENT OF INFORMATION AND THE PROCESS OF DETERMINATION AND PUBLICATION OF REFERENCE PRICE LISTS

DRAFT REFERENCE PRICE LISTS

The Director-General of the National Department of Health hereby, in terms of regulation 8(1) of the Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of Reference Price Lists (GN R.681 of 23 July 2007), publishes the draft reference price lists for public comment.

Interested persons are requested to submit comments on the draft reference price lists within four weeks of publication of this notice to the Director-General: Health (for the attention of the Director: Health, Financial Planning and Economics) Private Bag X828 Pretoria 0001.

DIRECTOR-GENERAL: HEALTH

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DRAFT SCHEDULES FOR RPL 2009

ACUPUNCTURE AND CHINESE MEDICINE

Acupuncture & Chinese Medicine 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY ACUPUNCTURE & CHINESE MEDICINE PRACTITIONERS WITH EFFECT FROM 1 JANUARY 2009

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 the practitioner - qualifications of the practitioner - 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	09.00
02	When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately.	09.00
03	Not more than two separate techniques may be charged for at each session.	09.00
04	The maximum number of acupuncture treatments per course to be charged for is limited to ten. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient.	09.00

ITEMS

1.	**Consultations**					
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or diagnosis					09.00
Code	**Description**	**Ver**	**Add**	**Chinese Medicine & Acupuncture**		
				RVU	**Fee**	
1100	Consultation (up to 15 mins)	09.00		10.000	93.20 (81.80)	
1101	Consultation (16-30 mins)	09.00		22.500	209.70 (183.90)	
1102	Consultation (31-45 min)	09.00		37.500	349.40 (306.50)	
1103	Consultation (46-60 min)	09.00		52.500	489.20 (429.10)	
1110	Consultation, each additional full 15 mins beyond 60 mins	09.00		15.000	139.80 (122.60)	
2.	**Treatments**					
3100	First treatment (needles, plus maximum of two speciality therapy techniques)	09.00		39.524	368.30 (323.10)	
3200	Follow-up treatment (needles, plus maximum of two speciality therapy techniques)	09.00		36.145	336.80 (295.40)	
3.	**Speciality Therapy Techniques**					
4010	Moxibustion	09.00		22.770	212.20 (186.10)	
4020	Cupping	09.00		19.493	181.60 (159.30)	
4030	Dermal needle therapy (plum-blossom or seven-star)	09.00		18.184	169.40 (148.60)	
4040	Auricular therapy (micro acupuncture)	09.00		32.146	299.50 (262.70)	
4050	Scalp acupuncture	09.00		27.308	254.50 (223.20)	
4060	Shilao (diet therapy)	09.00		23.712	220.90 (193.80)	
4070	Tui-Na (massage/pressure)	09.00		34.226	318.90 (279.70)	

AMBULANCES

Ambulance Services 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR AMBULANCE SERVICES, EFFECTIVE FROM 1 JANUARY 2009		
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.								
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.								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
	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.								
1	**BASIC LIFE SUPPORT**								
Metropolitan area									
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**
100	Up to 45 minutes	05.04		171.276	832.80	171.276	832.80	171.276	832.80
102	Up to 60 minutes	05.04		228.156	1109.40	228.156	1109.40	228.156	1109.40
103	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		57.084	277.60	57.084	277.60	57.084	277.60
Long distance									
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		2.843	13.80	2.843	13.80	2.843	13.80
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	1.000	4.86	1.000	4.86
2	**INTERMEDIATE LIFE SUPPORT**								
Metropolitan area									
125	Up to 45 minutes	05.04		231.226	1124.30	231.226	1124.30	-	-
127	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		77.075	374.80	77.075	374.80	-	-
Long distance									
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		3.850	18.70	3.850	18.70	-	-
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	1.000	4.86	-	-
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**								
Metropolitan area									
131	Up to 60 minutes	05.04		406.641	1977.20	-	-	-	-
133	Every 15 minutes thereafter or part thereof, where specially motivated.	05.04		101.660	494.30	-	-	-	-
Long distance									
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		5.072	24.70	-	-	-	-

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
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.86	-	-	-	-
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	2207.50	454.000	2207.50	-	-
153	Doctor per hour	04.00		130.000	632.10	130.000	632.10	-	-
	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
	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								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							

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
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							
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							

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
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				

BIOKINETICS

Biokinetics 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF BIOKINETICS WITH EFFECT FROM 1 JANUARY 2009

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 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 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	**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	69.80 (61.20)
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.	06.01		11.700	48.90 (42.90)
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	69.80 (61.20)
922	Patient education (based upon the evaluation outcomes)	06.01		16.300	68.10 (59.70)
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	41.80 (36.70)
909	Complex evaluation at the first visit only (to be fully documented).	06.01		16.700	69.80 (61.20)
912	Anthropometric/body composition assessment	06.01		10.000	41.80 (36.70)
913	Ergological testing evaluation of body segment, limb or joint	06.01		28.500	119.10 (104.50)

Code	Description	Ver	Add	Biokinetics	
				RVU	Fee
914	Neurological patients: Ergological evaluation	06.01		16.700	69.80 (61.20)
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	06.01		16.700	69.80 (61.20)
916	Perceptual motor evaluation (perception and gross motor function)	06.01		16.700	69.80 (61.20)
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	06.01		28.500	119.10 (104.50)
918	Physical work capacity with full ECG	06.01		28.500	119.10 (104.50)
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	06.01		28.500	119.10 (104.50)
921	Isokinetic testing by means of specialised electronic equipment	06.01		28.500	119.10 (104.50)
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	68.10 (59.70)
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	06.01		16.300	68.10 (59.70)
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	06.01		16.300	68.10 (59.70)
927	Posture, gait and activities of daily living (ADL), with/without equipment use	06.01		16.300	68.10 (59.70)
928	A rehabilitative exercise prescription	06.01		16.300	68.10 (59.70)
929	Callisthenics exercises	06.01		16.300	68.10 (59.70)
930	Group session with high risk patients, per patient (maximum 10 patients)	06.01		8.800	36.80 (32.30)
931	Passive and active range of motion exercise therapy	06.01		16.300	68.10 (59.70)
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	36.80 (32.30)

CHIROPRACTORS

Chiropractors 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2009

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	106.10 (93.10)
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	106.10 (93.10)
312	Two diagnostic procedures	05.03		37.500	159.20 (139.60)
313	Three diagnostic procedures	05.05		50.000	212.30 (186.20)
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	42.50 (37.30)
322	Two instances of immobilization or therapeutic exercises	05.03		15.000	63.70 (55.90)
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	42.50 (37.30)
332	Two treatment procedures	05.03		15.000	63.70 (55.90)
333	Three treatment procedures	05.03		20.000	84.90 (74.50)
334	Four treatment procedures	05.03		25.000	106.10 (93.10)
335	Five treatment procedures	05.03		30.000	127.40 (111.80)
336	Six treatment procedures	05.03		35.000	148.60 (130.40)
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		-	-

CLINICAL TECHNOLOGISTS

Clinical Technologists 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2009

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	1812.50 (1589.90)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1622.80 (1423.50)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1812.50 (1589.90)
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	167.50 (146.90)
014	Radiofrequency Catheter Ablations	04.00		219.700	1812.50 (1589.90)
	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	160.10 (140.40)
	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	485.10 (425.50)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	160.10 (140.40)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	485.10 (425.50)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	04.00		10.000	82.50 (72.40)
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	1622.80 (1423.50)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	160.10 (140.40)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	636.10 (558.00)
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	509.00 (446.50)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	120.50 (105.70)
034	Lymph compression treatment.	04.00		22.500	185.60 (162.80)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1812.50 (1589.90)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	275.60 (241.80)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	04.00		26.300	217.00 (190.40)

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	101.50 (89.00)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	199.70 (175.20)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
039	Flow-volume determinations.	04.00		30.600	252.50 (221.50)
041	Flow-volume (Pre-post B-D).	04.00		50.800	419.10 (367.60)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	199.70 (175.20)
045	Gas distribution measurements.	04.00		24.200	199.70 (175.20)
047	Diffusion determinations.	04.00		24.200	199.70 (175.20)
049	Exercise testing (EIA).	04.00		17.100	141.10 (123.80)
050	ECMO change-out and re-establishment.	04.00		46.300	382.00 (335.10)
051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	04.00		24.200	199.70 (175.20)
053	Allergy tests.	04.00		11.400	94.10 (82.50)
055	If RAST included add (per allergen).	04.00	+	11.400	94.10 (82.50)
057	Bronchial provocation testing.	04.00		40.800	336.60 (295.30)
059	Compliance measurements.	04.00		24.200	199.70 (175.20)
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	04.00		6.000	49.50 (43.40)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	246.70 (216.40)
063	Cardiac catheterisation for the first hour.	04.00		40.300	332.50 (291.70)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	82.50 (72.40)
064	Intravascular Ultrasound (IVUS)	04.00		25.700	212.00 (186.00)
	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	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	82.50 (72.40)
066	Cardiac Cath Right Heart Studies	04.00		56.000	462.00 (405.30)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	560.20 (491.40)
069	Temporary and single Pacemaker procedures.	04.00		40.300	332.50 (291.70)
070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	04.00		46.300	382.00 (335.10)
	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	82.50 (72.40)
072	Multisite Pacing (Bi-ventricular pacing)	04.00		46.300	382.00 (335.10)
073	Dilatation procedures and stents.	04.00		55.400	457.10 (401.00)
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	04.00		10.000	82.50 (72.40)
075	Pacemaker checking and/or reprogramming.	04.00		14.000	115.50 (101.30)
077	24 Hour Holter ambulatory monitoring.	04.00		55.400	457.10 (401.00)
079	Cardiac exercise stress testing.	04.00		29.100	240.10 (210.60)
081	Recording of twelve lead ECG.	04.00		7.700	63.50 (55.70)
087	M Mode echocardiogram.	04.00		16.600	137.00 (120.20)
089	2D echocardiogram.	04.00		29.400	242.60 (212.80)
091	Doppler flow.	04.00		32.300	266.50 (233.80)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
093	Colour imaging.	04.00		32.300	266.50 (233.80)
095	ECG signal averaging (Hi-Res).	04.00		53.700	443.00 (388.60)
097	Ambulatory bloodpressure monitoring.	04.00		18.600	153.50 (134.60)
099	Vector cardiogram.	04.00		55.400	457.10 (401.00)
111	Transoesophageal echocardiogram.	04.00		43.100	355.60 (311.90)
Neurology					
	Preparation, recording and analyses/technical report of:				04.00
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	05.03		74.100	611.30 (536.20)
179	Auditory evoked potentials, full audiological examination, bilateral	05.03		74.100	611.30 (536.20)
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	05.03		37.110	306.20 (268.60)
181	Somatosensory evoked potentials, unilateral, upper limb	05.03		37.110	306.20 (268.60)
182	Somatosensory evoked potentials, unilateral, lower limb	05.03		37.110	306.20 (268.60)
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	122.90 (107.80)
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	04.00		43.100	355.60 (311.90)
183	Electronystagmography for spontaneous and positional nystagmus (3253)	05.03		24.150	199.20 (174.70)
184	Caloric test done with electronystagmography (3255)	05.03		67.570	557.50 (489.00)
119	Sleep EEG.	04.00		31.400	259.10 (227.30)
185	Overnight polysomnography	05.03		264.830	2184.80 (1916.50)
186	Obstructive sleep apnea screening	05.03		137.170	1131.70 (992.70)
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	1137.60 (997.90)
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	2184.80 (1916.50)
125	Multiple sleep latency test (MSLT)	04.00		111.100	916.60 (804.00)
127	Overnight CPAP titration.	04.00		104.200	859.70 (754.10)
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	05.02	+	17.420	143.70 (126.10)
133	EEG with special activation.	04.00		49.400	407.60 (357.50)
135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	04.00		14.900	122.90 (107.80)
137	Intra-operative evoked potentials for the 1st hour	04.00		55.400	457.10 (401.00)
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	04.00		37.100	306.10 (268.50)
141	Intra-operative EEG (carotid endarterectomy).	04.00		26.300	217.00 (190.40)
143	Transcranial or Carotid Doppler (bilateral).	04.00		39.400	325.10 (285.20)
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	382.00 (335.10)
146	Chronic haemodialysis (acetate dialysate)	04.00		149.400	1232.60 (1081.20)
148	Chronic haemodialysis (bicarbonate dialysate)	04.00		159.600	1316.70 (1155.00)
	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	05.03			

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
147	Peritoneal dialysis, per day	04.00		16.800	138.60 (121.60)
	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	14025.00 (12302.60)
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	05.03		2360.000	19470.00 (17078.90)
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	04.00		33.400	275.60 (241.80)
150	Acute haemodialysis	04.00		317.200	2616.90 (2295.50)
	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	204.60 (179.50)
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	410.00 (359.60)
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	614.60 (539.10)
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	819.20 (718.60)
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	04.00		16.600	137.00 (120.20)
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	240.10 (210.60)
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	82.50 (72.40)
161	Complete semen analysis.	04.00		31.700	261.50 (229.40)
163	Semen wash for A I.	04.00		30.300	250.00 (219.30)
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	04.00		368.700	3041.80 (2668.20)
	Cannot be used with items 161, 163, 167 and 169	05.03			
167	Ovum and embryo freezing.	04.00		131.300	1083.20 (950.20)
169	Semen freezing.	04.00		30.300	250.00 (219.30)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	5.57 (4.89)
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			

DENTAL PRACTITIONERS

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2009		
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

STAATSKOERANT, 3 OKTOBER 2008 No. 31469 27

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 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.										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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	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

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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	141.73 (124.32)	141.73 (124.32)		141.73 (124.32)					
	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	220.05 (193.03)	220.05 (193.03)		220.05 (193.03)					
	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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	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

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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
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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.										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	124.40 (109.10)								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	201.00 (176.30)								B

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	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	60.30 (52.90)								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	60.30 (52.90)								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	104.80 (91.90)								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	124.40 (109.10)								B

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	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		158.50 (139.00)							S
8902	Consultation - MFOS (detailed)	06.03		414.90 (363.90)							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	358.00 (314.00)	537.00 (471.10)	537.00 (471.10)					+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			158.50 (139.00)						A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	04.00			92.30 (81.00)						A
8837	Diagnosis and treatment planning - Orthodontist	04.00			73.60 (64.60)						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				158.50 (139.00)					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				414.90 (363.90)					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				124.00 (108.80)					A

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8707	Periodontal screening - Periodontist	06.03				124.00 (108.80)					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				124.00 (108.80)					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				218.20 (191.40)					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				92.30 (81.00)					S
	Subsequent consultation for same disease/condition.										
Prosthodontist											
8501	Consultation - Prosthodontis	04.00					158.50 (139.00)				A
8507	Comprehensive consultation - Prosthodontist	06.03					254.50 (223.20)				A
	Examination, diagnosis and treatment planning.										
8506	Detailed consultation - Prosthodontist	06.03					414.90 (363.90)				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						158.50 (139.00)			
9205	Consultation - oral pathologist (subsequent)	04.00						92.30 (81.00)			

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	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)				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	389.80 (341.90)	389.80 (341.90)	389.80 (341.90)	389.80 (341.90)	389.80 (341.90)				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	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)	50.40 (44.20)				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.										
8113	Intraoral radiograph - occlusal	04.00	86.70 (76.10)	86.70 (76.10)	86.70 (76.10)	86.70 (76.10)	86.70 (76.10)				B
8114	Extraoral radiograph - hand-wrist	06.03	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)				B
	Use to report extraoral radiographs such as hand-wrist radiographs.										
8115	Extraoral radiograph - panoramic	04.00	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)				B
8116	Extraoral radiograph - cephalometric	05.02	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)				B
8118	Extraoral radiograph - skull/facial bone	05.02	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)	201.30 (176.60)				B
8121	Oral and/or facial image (digital/conventional)	06.03	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)				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	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)	54.10 (47.50)			+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	136.10 (119.40)	136.10 (119.40)	136.10 (119.40)	136.10 (119.40)	136.10 (119.40)			+L	B
	See code 8117. Report this code when models are mounted on a movable condyle articulator.										
8122	Microbiological studies	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
	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	56.20 (49.30)								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	14.90 (13.10)								
	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	169.60 (148.80)				254.50 (223.20)				A
8505	Pantographic recording	04.00	246.20 (216.00)				369.20 (323.90)				A
8508	Electrognathographic recording	04.00	263.50 (231.10)				395.40 (346.80)				A
8509	Electrognathographic recording with computer analysis	04.00	437.50 (383.80)				656.40 (575.80)				A
8811	Tracing and analysis of extra-oral film	04.00	23.30 (20.40)	23.30 (20.40)	23.30 (20.40)	23.30 (20.40)	23.30 (20.40)				B
8839	Diagnostic setup (orthodontics)	04.00	103.90 (91.10)		155.70 (136.60)						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	76.40 (67.00)			105.30 (92.40)	76.40 (67.00)				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	150.10 (131.70)			211.70 (185.70)	150.10 (131.70)				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	87.70 (76.90)								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
	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	163.10 (143.10)								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	76.40 (67.00)			76.40 (67.00)	76.40 (67.00)				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	76.40 (67.00)			76.40 (67.00)	76.40 (67.00)				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	141.80 (124.40)						T	+L	B
8175	Space maintainer - removable	04.00	182.80 (160.40)							+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	76.40 (67.00)			152.90 (134.10)	152.90 (134.10)				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	56.00 (49.10)			73.60 (64.60)	73.60 (64.60)				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	50.40 (44.20)				50.40 (44.20)		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	293.70 (257.60)							+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	88.90 (78.00)							+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	115.70 (101.50)								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	62.50 (54.80)								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	152.00 (133.30)						T		B
8342	Amalgam - two surfaces	04.00	187.40 (164.40)						T		B
8343	Amalgam - three surfaces	04.00	228.40 (200.40)						T		B
8344	Amalgam - four or more surfaces	04.00	254.50 (223.20)						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	331.60 (290.90)						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	166.90 (146.40)						T		B
8352	Resin - two surfaces, anterior	04.00	209.80 (184.00)						T		B

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	250.80 (220.00)						T		B
8354	Resin - four or more surfaces, anterior	06.03	279.70 (245.40)						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	180.90 (158.70)						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	223.70 (196.20)						T		B
8369	Resin - three surfaces, posterior	04.00	270.40 (237.20)						T		B
8370	Resin - four or more surfaces, posterior	04.00	290.90 (255.20)						T		B
GOLD FOIL RESTORATIONS											
8561	Gold foil class I or IV	04.00	442.60 (388.20)				663.80 (582.30)		T		A
8563	Gold foil class V	04.00	517.80 (454.20)				776.70 (681.30)		T		A
8565	Gold foil class III	04.00	651.40 (571.40)				977.10 (857.10)		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	232.10 (203.60)				457.80 (401.60)		T	+L	A
8362	Inlay/onlay - metal - two surfaces	04.00	339.40 (297.70)				663.80 (582.30)		T	+L	A
8363	Inlay/onlay - metal - three surfaces	04.00	565.90 (496.40)				1029.40 (903.00)		T	+L	A
8364	Inlay/onlay - metal - four or more surfaces	04.00	684.40 (600.40)				1029.40 (903.00)		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

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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
8371	Inlay - porcelain - one surface	05.02	279.70 (245.40)				552.90 (485.00)		T	(+L)	A
8372	Inlay/onlay - porcelain - two surfaces	05.02	413.00 (362.30)				796.30 (698.50)		T	(+L)	A
8373	Inlay/onlay - porcelain - three surfaces	05.02	680.70 (597.10)				1237.30 (1085.40)		T	(+L)	A
8374	Inlay/onlay - porcelain - four or more surfaces	05.02	824.30 (723.10)				1237.30 (1085.40)		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	279.70 (245.40)				552.90 (485.00)		T	(+L)	A
8382	Inlay/onlay - resin - two surfaces	05.02	413.00 (362.30)				796.30 (698.50)		T	(+L)	A
8383	Inlay/onlay - resin - three surfaces	05.02	680.70 (597.10)				1237.30 (1085.40)		T	(+L)	A
8384	Inlay/onlay - resin - four or more surfaces	05.02	824.30 (723.10)				1237.30 (1085.40)		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	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8403	Crown - 3/4 cast metal	04.00	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8404	Crown - 3/4 porcelain/ceramic	05.02	824.20 (723.00)				1237.30 (1085.40)		T	+L	A
8405	Crown - resin laboratory	06.03	824.20 (723.00)				1237.30 (1085.40)		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.										

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	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8409	Crown - porcelain/ceramic	04.00	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8411	Crown - porcelain with metal	04.00	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8410	Provisional crown	06.03	169.60 (148.80)			169.60 (148.80)	254.50 (223.20)		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	264.90 (232.40)				264.90 (232.40)		T		B
	Involves direct layering of material over tooth. No laboratory processing.										
8552	Veneer - porcelain (laboratory)	06.03	586.10 (514.10)				879.20 (771.20)		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	586.10 (514.10)				879.20 (771.20)		T	+L	A
	Involves an impression being taken and laboratory processing.										
TEMPORARY RESTORATIONS											
8137	Emergency crown (chair-side)	06.03	261.90 (229.70)				261.90 (229.70)		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	155.70 (136.60)				155.70 (136.60)		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	155.70 (136.60)				155.70 (136.60)		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	150.10 (131.70)						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
	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	75.50 (66.20)						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	69.90 (61.30)						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	112.90 (99.00)				152.90 (134.10)		T	+L	A
8376	Core build-up with prefabricated posts	06.03	415.80 (364.70)				415.80 (364.70)		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	175.30 (153.80)						T	+L	A
	Report in addition to crown.										
8392	Cast post (each additional)	06.03	104.40 (91.60)						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	279.70 (245.40)				363.70 (319.00)		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	339.40 (297.70)				339.40 (297.70)		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					259.20 (227.40)		T	+L	A
	See also GDP code 8391										
8582	Cast core with double post	06.03					369.20 (323.90)		T	+L	A
	See also GDP code 8392										
8583	Cast core with triple post	06.03					457.80 (401.60)		T	+L	A
	See also GDP code 8392										

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	76.40 (67.00)				97.00 (85.10)		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	152.00 (133.30)				152.00 (133.30)		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	99.70 (87.50)						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	76.40 (67.00)								B
	Not applicable to restorations recently done.										
8349	Carve restoration to accommodate existing removable prosthesis	04.00	30.80 (27.00)						T		B
8413	Repair crown (permanent or provisional)	06.03	169.60 (148.80)				169.60 (148.80)		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	50.40 (44.20)						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	101.60 (89.10)						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	101.60 (89.10)						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	99.70 (87.50)						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	124.90 (109.60)						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	76.40 (67.00)						T		B
	Limitation: A maximum of four visits per tooth may be charged.										
8333	Root canal preparatory visit - multi canal tooth	06.03	107.20 (94.00)						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	346.80 (304.20)						T		B
8328	Root canal obturation - anteriors and premolars - each additional canal	04.00	141.80 (124.40)						T		B
8336	Root canal obturation - posteriors - first canal	04.00	477.30 (418.70)						T		B
8337	Root canal obturation - posteriors - each additional canal	04.00	141.80 (124.40)						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	530.50 (465.40)						T		B
8329	Root canal therapy - anteriors and premolars - each additional canal	04.00	177.20 (155.40)						T		B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8339	Root canal therapy - posteriors - first canal	04.00	729.10 (639.60)						T		B
8340	Root canal therapy - posteriors - each additional canal	04.00	177.20 (155.40)						T		B
8631	Root canal therapy - first canal	06.03					900.70 (790.10)		T		B
	Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.										
8633	Root canal therapy - each additional canal	06.03					226.50 (198.70)		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	112.90 (99.00)				136.10 (119.40)		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	101.60 (89.10)				150.10 (131.70)		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	376.70 (330.40)	499.80 (438.40)		499.80 (438.40)	499.80 (438.40)		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	664.50 (582.90)	996.70 (874.30)		996.70 (874.30)	996.70 (874.30)		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	99.70 (87.50)						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
	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	68.00 (59.60)						T		B
8640	Removal of fractured post or instrument from root canal	06.03					264.90 (232.40)		T		B
	See also GDP Code 8330.										
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	06.03	333.20 (292.30)			499.80 (438.40)	499.80 (438.40)		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	399.10 (350.10)			547.40 (480.20)			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	318.80 (279.60)			434.50 (381.10)			Q		A
	See code 8741 for descriptor										
8749	Flap procedure, root planing and one to three surgical services - per quadrant	06.03	828.50 (726.80)			1242.90 (1090.30)			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	686.20 (601.90)			1029.40 (903.00)			S		A
	See code 8749, per sextant.										

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	1027.00 (900.90)			1540.40 (1351.20)			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	832.30 (730.10)			1248.50 (1095.20)			S		A
	See code 8753, per sextant.										
8756	Clinical crown lengthening (isolated procedure)	06.03	504.70 (442.70)			757.10 (664.10)			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	379.20 (332.60)			568.70 (498.90)			M		A
	E.g. lateral sliding double papilla, rotated and similar.										
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	05.02	412.10 (361.50)	618.20 (542.30)		618.20 (542.30)			M	+L	A
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	05.02	619.10 (543.10)	928.70 (814.60)		928.70 (814.60)			M	+L	A
8763	Wedge resection (isolated procedure)	06.03	242.50 (212.70)			363.70 (319.00)			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	198.30 (173.90)			297.50 (261.00)					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	514.10 (451.00)	771.10 (676.40)		771.10 (676.40)					A
	Excluding cost of regenerative material - See code 8770										
8769	Membrane removal (used for guided tissue regeneration)	06.03	242.50 (212.70)	363.70 (319.00)		363.70 (319.00)					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										

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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
8772	Submucosal connective tissue autograft (isolated procedure)	05.02	416.50 (365.40)	624.70 (548.00)		624.70 (548.00)					A
8995	Gingivectomy - per jaw	06.03	591.10 (518.50)	886.80 (777.90)					M	+L	S
	See also codes 8741 and 8743.										
NON-SURGICAL PERIODONTAL SERVICES											
8723	Provisional splinting - extracoronal (wire) - per sextant	05.02	141.80 (124.40)			212.60 (186.50)	212.60 (186.50)		M	+L	A
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	05.02	205.70 (180.40)			308.60 (270.70)	308.60 (270.70)		M	+L	A
8727	Provisional splinting - intracoronal - per tooth	06.03	64.60 (56.70)			97.00 (85.10)	97.00 (85.10)		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	305.80 (268.20)			414.90 (363.90)			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	243.40 (213.50)			331.00 (290.40)			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	242.50 (212.70)			363.70 (319.00)			T		A
8787	Unlisted oral medicine procedure	04.00	87.00 (76.30)			130.50 (114.50)					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	1232.60 (1081.20)				2573.40 (2257.40)		M	+L	B
	Inclusive of soft bases or metal bases, where applicable.										
8232	Complete denture - maxillary or mandibular	06.03	759.90 (666.60)				1800.50 (1579.40)		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	759.90 (666.60)				1139.90 (999.90)			+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	759.90 (666.60)				1139.90 (999.90)			+L	
	See 8244 descriptor.										
8643	Complete dentures - maxillary and mandibular (with complications)	04.00					3339.80 (2929.60)			+L	B
8645	Complete dentures - maxillary and mandibular (with major complications)	04.00					4108.10 (3603.60)			+L	B
8649	Complete denture - maxillary or mandibular (with complications)	05.02					2055.00 (1802.60)		M	+L	B
8651	Complete denture - maxillary or mandibular (with major complications)	05.02					2311.40 (2027.50)		M	+L	B
PARTIAL DENTURES											
8233	Partial denture - resin base - one tooth	05.02	353.30 (309.90)						M	+L	B
8234	Partial denture - resin base - two teeth	05.02	353.30 (309.90)						M	+L	B
8235	Partial denture - resin base - three teeth	05.02	528.70 (463.80)						M	+L	B
8236	Partial denture - resin base - four teeth	05.02	528.70 (463.80)						M	+L	B
8237	Partial denture - resin base - five teeth	05.02	528.70 (463.80)						M	+L	B
8238	Partial denture - resin base - six teeth	05.02	701.20 (615.10)						M	+L	B
8239	Partial denture - resin base - seven teeth	05.02	701.20 (615.10)						M	+L	B
8240	Partial denture - resin base - eight teeth	05.02	701.20 (615.10)						M	+L	B
8241	Partial denture - resin base - nine or more teeth	05.02	701.20 (615.10)						M	+L	B
8281	Partial denture - cast metal framework only	06.03	824.30 (723.10)						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					2055.00 (1802.60)		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	56.00 (49.10)				56.00 (49.10)				B
	After six months or for patient of another practitioner.										
8662	Adjust complete or partial dentures (remounting)	04.00	197.80 (173.50)				296.60 (260.20)			+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	97.00 (85.10)				104.40 (91.60)		M	+L	B
	See code 8273 (Impression to repair/modify a denture)										
8270	Add clasp to existing partial denture	06.03	69.90 (61.30)						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	69.90 (61.30)						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	56.00 (49.10)				56.00 (49.10)			+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	288.10 (252.70)				415.80 (364.70)		M	+L	B
8261	Remodel complete or partial denture	05.02	462.50 (405.70)						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	182.80 (160.40)				228.40 (200.40)		M		B
8267	Reline complete or partial denture (laboratory)	06.03	420.60 (368.90)				420.60 (368.90)		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	759.90 (666.60)				1139.80 (999.80)		M	+L	B
	See code 8659 for descriptor.										
8659	Interim partial denture	06.03	607.90 (533.20)				911.80 (799.80)		M	+L	B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	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					2055.00 (1802.60)			+L	A
	See also codes 8658, 8659 and 8265.										
OTHER REMOVABLE PROSTHETIC PROCEDURES											
8251	Clasp or rest - cast gold	06.03	69.90 (61.30)							+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	69.90 (61.30)							+L	B
	See code 8251 descriptor.										
8255	Clasp or rest - stainless steel	06.03	73.60 (64.60)							+L	B
	See code 8251 descriptor.										
8257	Bar - lingual or palatal	06.03	86.70 (76.10)						M	+L	B
	See code 8251 descriptor.										
8265	Tissues conditioning per arch (including soft self-cure reline)	05.02	119.40 (104.70)				152.90 (134.10)		M		B
8277	Inlay in denture	06.03								+L	A
	Limitation: Benefits by arrangement.										
8597	Locks and milled rests	04.00	69.60 (61.10)				104.40 (91.60)		T	+L	A
8599	Precision attachment (removable denture)	06.03	169.60 (148.80)				254.50 (223.20)		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	1369.90 (1201.70)				2055.00 (1802.60)		M	+L	B
	Other separate procedures may be required concurrent to 8652.										
8653	Overdenture - partial	06.04	1095.90 (961.30)				1644.00 (1442.10)		M	+L	B
	Other separate procedures may be required concurrent to 8653.										
8657	Replacement of precision attachment	06.03	97.00 (85.10)				104.40 (91.60)		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	412.70 (362.00)				619.10 (543.10)		M	+L	A
	E.g. chrome cobalt, gold, etc.										
8664	Remount crown or bridge for prosthetics	04.00	197.80 (173.50)				309.80 (271.80)				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	412.70 (362.00)				619.10 (543.10)		M	+L	B
8672	Altered cast technique (in addition to partial denture)	05.02	52.90 (46.40)				79.30 (69.60)		M	+L	B
8674	Additive partial denture	05.02	621.60 (545.30)				932.40 (817.90)		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	102.00 (89.50)				152.90 (134.10)			+L	
9102	Obturator prosthesis, surgical - continuous base	04.00	276.50 (242.50)				414.90 (363.90)			+L	
9103	Obturator prosthesis, surgical - split base	04.00	412.10 (361.50)				618.20 (542.30)			+L	
9104	Obturator prosthesis, interim - on existing denture	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9105	Obturator prosthesis, interim - on new denture	04.00	1919.60 (1683.90)				2879.30 (2525.70)			+L	
9106	Obturator prosthesis, definitive - open/hollow box	04.00	621.60 (545.30)				932.40 (817.90)			+D	
9107	Obturator prosthesis, definitive - silicone glove	04.00	1200.30 (1052.90)				1800.50 (1579.40)			+D	
MANDIBULAR RESECTION PROSTHESES											
9108	Mandibular resection prosthesis w/ guide flange	04.00	1474.50 (1293.40)				2211.60 (1940.00)			+L	
9109	Mandibular resection prosthesis w/o guide flange	04.00	1369.90 (1201.70)				2055.00 (1802.60)			+L	
9110	Mandibular resection prosthesis, palatal augmentation	04.00	276.50 (242.50)				414.90 (363.90)			+D	
GLOSSAL RESECTION PROSTHESES											
9111	Glossal resection prosthesis - simple	04.00	576.80 (506.00)				865.30 (759.00)			+D	
9112	Glossal resection prosthesis - complex	04.00	864.10 (758.00)				1296.10 (1136.90)			+D	
RADIOTHERAPY APPLIANCES											
9113	Radiation carrier - simple	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9114	Radiation carrier - complex	04.00	1715.60 (1504.90)				2573.50 (2257.50)			+L	
9115	Radiation shield - simple	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9116	Radiation shield - complex	04.00	1715.60 (1504.90)				2573.50 (2257.50)			+L	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9117	Radiation cone locator	04.00	621.60 (545.30)				932.40 (817.90)			+L	
CHEMOTHERAPY APPLIANCES											
9118	Chemotherapeutic agent carrier	04.00	621.60 (545.30)				932.40 (817.90)			+L	
CLEFT PALATE PROSTHESES											
8855	Consultation - cleft palate therapy (house or hospital)	04.00	141.80 (124.40)		212.60 (186.50)		212.60 (186.50)				S
8856	Consultation - cleft palate (subsequent)	04.00	69.60 (61.10)		104.40 (91.60)		104.40 (91.60)				S
8857	Consultation - cleft palate (maximum)	04.00	484.20 (424.70)		726.30 (637.10)		726.30 (637.10)				S
NEONATAL PROSTHESES											
9119	Feeding aid prosthesis, neonatal	04.00	550.20 (482.60)		825.20 (723.90)		825.20 (723.90)			+L	S
9120	Orthopaedic appliance, active presurgical - minor	04.00	550.20 (482.60)		825.20 (723.90)		825.20 (723.90)			+L	S
9121	Orthopaedic appliance, active presurgical - moderate	04.00	814.20 (714.20)		1221.40 (1071.40)		1221.40 (1071.40)			+L	S
9122	Orthopaedic appliance, active presurgical - severe	04.00	1369.90 (1201.70)		2055.00 (1802.60)		2055.00 (1802.60)			+L	S
9123	Orthopaedic appliance, active presurgical - modification	04.00	69.60 (61.10)		104.40 (91.60)		104.40 (91.60)				S
INTERMEDIATE/DEFINITIVE PROSTHESES											
9125	Speech aid/obturator prosthesis - palatal alteration	04.00	277.20 (243.20)				415.80 (364.70)			+D	
9126	Speech aid/obturator prosthesis - velar alteration	04.00	621.60 (545.30)				932.40 (817.90)			+D	
9127	Speech aid/obturator prosthesis - pharyngeal alteration	04.00	1369.90 (1201.70)				2055.00 (1802.60)			+D	
9128	Speech aid/obturator prosthesis - modification	04.00	69.60 (61.10)				104.40 (91.60)				
9129	Speech aid/obturator prosthesis - surgical	04.00	550.20 (482.60)				825.20 (723.90)			+L	
SPEACH APPLIANCES											
9130	Speech aid appliance - palatal lift	04.00	276.50 (242.50)				414.90 (363.90)			+D	
9131	Speech aid appliance - palatal stimulating	04.00	621.60 (545.30)				932.40 (817.90)			+D	
9132	Speech aid appliance - bulb	04.00	1369.90 (1201.70)				2055.00 (1802.60)			+D	
9133	Speech aid appliance - modification	04.00	69.60 (61.10)				104.40 (91.60)				
9134	Unspecified speech aid appliance	04.00	-				-			+L	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
EXTRA-ORAL APPLIANCES											
9135	Auricular prosthesis - simple	04.00	1715.60 (1504.90)				2573.50 (2257.50)			+L	
9136	Auricular prosthesis - complex	04.00	2238.40 (1963.50)				3339.80 (2929.60)			+L	
9137	Nasal prosthesis - simple	04.00	1715.60 (1504.90)				2573.50 (2257.50)			+L	
9138	Nasal prosthesis - complex	04.00	2238.40 (1963.50)				3339.80 (2929.60)			+L	
9139	Ocular prosthesis - interim	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9140	Ocular prosthesis - modified stock appliance	04.00	1542.10 (1352.70)				2313.20 (2029.10)			+L	
9141	Ocular prosthesis - custom appliance	04.00	2238.40 (1963.50)				3339.80 (2929.60)			+L	
9142	Orbital prosthesis - simple	04.00	1542.10 (1352.70)				2313.20 (2029.10)			+L	
9143	Orbital prosthesis - complex	04.00	2238.40 (1963.50)				3339.80 (2929.60)			+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	1542.10 (1352.70)				2313.20 (2029.10)			+L	
9149	Unspecified body prosthesis - complex	04.00	2238.40 (1963.50)				3339.80 (2929.60)			+L	
9150	Facial prosthesis, surgical - simple	04.00	1200.30 (1052.90)				1800.50 (1579.40)			+L	
9151	Facial prosthesis, surgical - complex	04.00	1542.10 (1352.70)				2313.20 (2029.10)			+L	
9152	Extraoral appliance - additional prosthesis	04.00								+L	
9153	Extraoral appliance - replacement prosthesis	04.00								+L	
9155	Cranial prosthesis	04.00	621.60 (545.30)				932.40 (817.90)			+L	
CUSTOM IMPLANTS											
9156	Cranial implant prosthesis, custom made	04.00	750.30 (658.20)				1125.40 (987.20)			+L	
9157	Facial implant prosthesis, custom made - simple	04.00	374.80 (328.80)				562.20 (493.20)			+L	
9158	Facial implant prosthesis, custom made - complex	04.00	750.30 (658.20)				1125.40 (987.20)			+L	
9159	Ocular implant prosthesis, custom made	04.00	374.80 (328.80)				562.20 (493.20)			+L	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9160	Body implant prosthesis - custom made	04.00	1668.40 (1463.50)				2502.60 (2195.30)			+L	
SURGICAL APPLIANCES											
9161	Surgical splint - simple	04.00	169.60 (148.80)				254.50 (223.20)			+L	
9162	Surgical splint - complex	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9163	Surgical template - simple	04.00	169.60 (148.80)				254.50 (223.20)			+L	
9164	Surgical template - complex	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9165	Surgical conformer - simple	04.00	169.60 (148.80)				254.50 (223.20)			+L	
9166	Surgical conformer - complex	04.00	621.60 (545.30)				932.40 (817.90)			+L	
TRISMUS APPLIANCES											
9167	Trismus appliance (simple)	04.00	69.60 (61.10)				104.40 (91.60)			+L	
9168	Trismus appliance (complex)	04.00	621.60 (545.30)				932.40 (817.90)			+L	
9169	Orthoses appliance	04.00	1369.90 (1201.70)				2055.00 (1802.60)			+L	
9170	Facial palsy appliance	04.00	412.10 (361.50)				618.20 (542.30)			+D	
9171	Commissure splint	04.00	169.60 (148.80)				254.50 (223.20)			+L	
9172	Oral retractor, dynamic - per arm	04.00	169.60 (148.80)				254.50 (223.20)			+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	229.30 (201.10)				344.00 (301.80)				
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	1005.70 (882.20)	1508.70 (1323.40)					M		S
9181	Surgical placement of sub-periosteal implant - placement stage	05.02	1005.70 (882.20)	1508.70 (1323.40)					M	+L	S
9182	Surgical placement of endosteal implant plate	04.00	503.50 (441.70)	755.20 (662.50)		755.20 (662.50)				+L	S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9183	Surgical placement of endosteal implant - first per jaw	06.03	708.70 (621.70)	963.20 (844.90)		963.20 (844.90)			T	+M	S
	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	530.50 (465.40)	722.60 (633.90)		722.60 (633.90)			T	+M	S
9185	Surgical placement of endosteal implant - third and subsequent per jaw	05.02	355.20 (311.60)	484.00 (424.60)		484.00 (424.60)			T	+M	S
9190	Surgical placement of abutment - first per jaw	06.03	262.90 (230.60)	356.10 (312.40)		356.10 (312.40)	356.10 (312.40)		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	197.60 (173.30)	267.70 (234.80)		267.70 (234.80)	267.70 (234.80)		T	+M	S
9192	Surgical placement of abutment - third and subsequent per jaw	05.02	132.40 (116.10)	180.00 (157.90)		180.00 (157.90)	180.00 (157.90)		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	1369.90 (1201.70)				2055.00 (1802.60)				

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	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.										
8578	Prefabricated abutment	06.03	141.80 (124.40)				212.60 (186.50)				
	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	646.40 (567.00)				969.70 (850.60)				
	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	1369.90 (1201.70)				2055.00 (1802.60)		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	1095.90 (961.30)				1644.00 (1442.10)		M	+L	B
	See code 8533 for descriptor.										
Fixed-detachable Dentures											
8654	Implant supported fixed-detachable complete overdenture	06.03	1540.90 (1351.70)				2311.40 (2027.50)		M	+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 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	1232.70 (1081.30)				1583.90 (1389.40)		M	+L	A
	See code 8654 for descriptor.										
8660	Additional fee to implant supported fixed-detachable denture - per implant	06.03	212.60 (186.50)				212.60 (186.50)		T		A
	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	1132.80 (993.70)				1498.30 (1314.30)		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	1132.80 (993.70)				1498.30 (1314.30)		T	+L	A
8538	Crown - implant/abutment supported - cast metal	05.02	1132.80 (993.70)				1498.30 (1314.30)		T	+L	A
8592	Crown - implant/abutment supported	06.03					1498.30 (1314.30)		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	1132.80 (993.70)				1498.30 (1314.30)		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	1132.80 (993.70)				1498.30 (1314.30)		T	+L	A
8548	Crown retainer - implant/abutment supported - cast metal	05.02	1132.80 (993.70)				1498.30 (1314.30)		T	+L	A
OTHER IMPLANT SERVICES											
8590	Implant maintenance procedures - per implant	06.03	62.70 (55.00)				94.20 (82.60)		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 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, rnay 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	69.60 (61.10)				104.40 (91.60)				
	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	69.60 (61.10)				104.40 (91.60)				
	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	327.60 (287.40)	491.40 (431.10)		491.40 (431.10)			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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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	712.40 (624.90)						T	+L	A
8416	Pontic - cast metal	05.03	565.90 (496.40)						T	+L	A
8417	Pontic - resin with metal	05.03	712.40 (624.90)						T	+L	A
8418	Pontic - porcelain fused to metal	05.03	712.40 (624.90)						T	+L	A
8419	Provisional pontic	06.03	169.60 (148.80)				254.50 (223.20)		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)										
8611	Pontic - sanitary	06.03					776.70 (681.30)		T	+L	A
	See GDP codes 8415 to 8418.										
8613	Pontic - posterior	06.03					950.20 (833.50)		T	+L	A
	See GDP codes 8415 to 8418.										
8615	Pontic - anterior/premolar	06.03					1026.60 (900.50)		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	339.40 (297.70)				663.80 (582.30)		T	+L	A
8433	Inlay/onlay retainer - metal - three surfaces	05.02	565.90 (496.40)				1029.40 (903.00)		T	+L	A
8434	Inlay/onlay retainer - metal - four or more surfaces	05.02	684.40 (600.40)				1029.40 (903.00)		T	+L	A
8436	Inlay/onlay retainer - porcelain - two surfaces	05.02	413.00 (362.30)				796.30 (698.50)		T	+L	A
8437	Inlay/onlay retainer - porcelain - three surfaces	05.02	680.70 (597.10)				1237.30 (1085.40)		T	+L	A
8438	Inlay/onlay retainer - porcelain - four or more surfaces	05.02	824.30 (723.10)				1237.30 (1085.40)		T	+L	A
8617	Retainer cast metal (Maryland type retainer)	06.03	339.40 (297.70)				663.80 (582.30)		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
	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	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8442	Crown retainer - 3/4 cast metal	05.02	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8443	Crown retainer - porcelain/ceramic	05.02	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8444	Crown retainer - 3/4 porcelain/ceramic	05.02	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8445	Crown retainer - porcelain with metal	05.02	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8446	Crown retainer - resin with metal	05.02	872.70 (765.50)				1284.80 (1127.00)		T	+L	A
8447	Provisional crown retainer	06.03	169.60 (148.80)				254.50 (223.20)		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	76.40 (67.00)				97.00 (85.10)		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	152.00 (133.30)				152.00 (133.30)		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	169.60 (148.80)				169.60 (148.80)		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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8585	Connector bar	06.03	1369.90 (1201.70)				2055.00 (1802.60)		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	511.00 (448.20)				766.50 (672.40)		M	+L	A
	A non-ridgid connector.										
8587	Coping metal	06.03	113.80 (99.80)				212.60 (186.50)		T	+L	A
	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	76.40 (67.00)	114.60 (100.50)					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	30.80 (27.00)	46.20 (40.50)					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	330.10 (289.60)						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	254.50 (223.20)						T		S
8937	Surgical removal of tooth	06.03	330.10 (289.60)	445.60 (390.90)					T		S

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 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	547.40 (480.20)	719.80 (631.40)					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	293.70 (257.60)	387.80 (340.20)					T		S
8945	Surgical removal of impacted tooth - third and subsequent teeth	04.00	166.90 (146.40)	220.00 (193.00)					T		S
8953	Surgical removal of residual roots, first tooth - per tooth	06.03		445.60 (390.90)					T		S
	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	176.50 (154.80)				264.90 (232.40)		T	+L	S
8909	Oral antral fistula closure	04.00	773.90 (678.90)	1160.80 (1018.20)							S
8911	Caldwell-Luc procedure	04.00	302.80 (265.60)	454.10 (398.30)							S
8917	Biopsy of oral tissue - soft	06.03	193.00 (169.30)	257.30 (225.70)		257.30 (225.70)			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	297.10 (260.60)	445.60 (390.90)					M		S
8921	Biopsy – extra-oral bone/soft tissue	05.02	486.10 (426.40)	729.10 (639.60)					M		S
8961	Tooth transplantation	06.03	664.50 (582.90)	996.70 (874.30)					T	+L	S
	See Surgery Guidelines, Notes 2 and 3.										
8965	Peripheral neurectomy	04.00	664.50 (582.90)	996.70 (874.30)							S
8966	Repair of oronasal fistula (local flaps)	04.00	924.30 (810.80)	1386.50 (1216.20)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	06.03	609.80 (534.90)	830.80 (728.80)		830.80 (728.80)			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	441.30 (387.10)	662.00 (580.70)					T		S
8984	Corticotomy - each additional tooth	04.00	223.70 (196.20)	335.70 (294.50)					T		S
ALVEOLOPLASTY											
8957	Alveolotomy or alveolectomy (including extractions)	06.03	405.30 (355.50)	608.00 (533.30)					M		S
	Report per jaw.										
9003	Reposition mental foramen and nerve - per side	05.02	923.10 (809.70)	1384.70 (1214.60)					M	+L	S
9004	Lateralization of inferior dental nerve	05.02	1487.50 (1304.80)	2231.30 (1957.30)							S
VESTIBULOPLASTY											
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.										06.03
8997	Sulcoplasty / Vestibuloplasty	05.02	1523.50 (1336.40)	2285.40 (2004.70)		2285.40 (2004.70)			M	+L	S
SURGICAL EXCISION OF SOFT TISSUE LESIONS											
8971	Excision of tumour of the soft tissue	04.00	297.10 (260.60)	445.60 (390.90)		445.60 (390.90)					S
SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS											
8967	Surgical removal of jaw cyst - intra-oral approach	05.02	923.10 (809.70)	1384.70 (1214.60)					M		S
8969	Surgical removal of jaw cyst - extra-oral approach	05.02	1478.70 (1297.10)	2218.10 (1945.70)					M		S
8973	Surgical excision of tumours of the jaw	05.02	1478.70 (1297.10)	2218.10 (1945.70)					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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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	1553.40 (1362.60)	2330.10 (2043.90)					M		S
	Include splintage of segments.										
8987	Reduction of mylohyoid ridges - per side	04.00	664.50 (582.90)	996.70 (874.30)						+L	S
8989	Removal torus mandibularis	04.00	664.50 (582.90)	996.70 (874.30)						+L	S
8991	Removal of torus palatinus	04.00	664.50 (582.90)	996.70 (874.30)						+L	S
8993	Surgical reduction of osseous tuberosity - per side	06.03	297.10 (260.60)	445.60 (390.90)					M	+L	S
	See procedure code 8971 for excision of denture granuloma.										
SURGICAL INCISION											
8731	Incision & drainage of abscess - intra-oral	06.03	121.90 (106.90)			182.80 (160.40)					A
	Periodontal abscess - treatment of acute phase (with or without flap procedure).										
8908	Surgical removal of roots from maxillary antrum	06.03	1009.50 (885.50)	1514.30 (1328.30)							S
	Involves Caldwell-Luc and closure of oral antral communication.										
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	189.00 (165.80)	283.40 (248.60)					M		S
9013	Incision & drainage of abscess - extra-oral (pyogenic)	06.03	258.50 (226.80)	387.80 (340.20)					M		S
	E.g., Ludwig's angina.										
9017	Decortication, saucerisation and sequestrectomy	06.03	1368.10 (1200.10)	2052.20 (1800.20)							S
	For osteomyelitis of the mandible.										
9019	Sequestrectomy - intra oral per sextant and or ramus	05.02	297.10 (260.60)	445.60 (390.90)					M		S
TREATMENT OF FRACTURES											
Alveolus Fractures											
9024	Dento-alveolar fracture - per sextant	04.00	333.20 (292.30)	499.80 (438.40)						+L	S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
Mandibular Fractures											
9025	Mandible fracture - closed reduction	06.03	737.80 (647.20)	1106.80 (970.90)							S
	Includes intermaxillary fixation.										
9027	Mandible fracture - compound, with eyelet wiring	04.00	1036.30 (909.00)	1554.30 (1363.40)							S
9029	Mandible fracture - splints	06.03	1147.40 (1006.50)	1721.20 (1509.80)						+L	S
	Metal cap splintage or Gunning's splints.										
9031	Mandible fracture - open reduction	06.03	1700.70 (1491.80)	2551.00 (2237.70)						+L	S
	Includes restoration of occlusion by splintage.										
Maxilliary Fractures											
9035	Maxilla fracture - Le Fort I or Guerin	06.03	1038.10 (910.60)	1557.10 (1365.90)						+L	S
	When open reduction is required for Codes 9035 and 9037, Modifier 8010 may be applied.										
9037	Maxilla fracture - Le Fort II or middle third face	06.03	1700.70 (1491.80)	2551.00 (2237.70)						+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	2439.20 (2139.60)	3658.80 (3209.50)						+L	S
	Includes comminuted mid-facial fractures requiring open reduction and splintage.										
Zygoma/Orbital/Antral Fractures											
9041	Zygomatic arch fracture - closed reduction	06.03	737.80 (647.20)	1106.80 (970.90)							S
	Gillies or temporal elevation.										
9043	Zygomatic arch fracture - open reduction	06.03	1478.70 (1297.10)	2218.10 (1945.70)							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	2215.30 (1943.20)	3323.10 (2915.00)							S
9046	Placement of Zygomaticus fixture, per fixture	05.02	1463.30 (1283.60)	2194.90 (1925.40)							S
Nasal Fractures											
9280	Open reduction and fixation of nasal fractures	04.00									
9282	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	-	-	-	-	-				

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Comment: Applicable to pre-fabricated devices. See Rule 002 and Modifier 8025 for direct material costs.										
8850	Treatment of MPDS - first visit	04.00	116.80 (102.50)		175.30 (153.80)		175.30 (153.80)				A
8851	Treatment of MPDS - subsequent visit	04.00	61.50 (53.90)		92.30 (81.00)		92.30 (81.00)				A
8852	Occlusal orthotic appliance	06.03	293.70 (257.60)	386.90 (339.40)	386.90 (339.40)	386.90 (339.40)	386.90 (339.40)			+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	922.50 (809.20)	1383.70 (1213.80)							S
9074	Tmj arthroscopy diagnostic	04.00	734.10 (643.90)	1101.10 (965.90)							S
9075	Condylectomy, coronoidectomy or both	04.00	1844.20 (1617.70)	2766.40 (2426.70)							S
9076	TMJ artrocentesis	04.00	405.30 (355.50)	608.00 (533.30)							S
9077	TMJ intra-articular injection	04.00	110.60 (97.00)	165.90 (145.50)							S
9079	Trigger point injection	04.00	86.30 (75.70)	129.60 (113.70)							S
9081	Condylectomy (Ward/Kostecka)	06.03	737.80 (647.20)	1106.80 (970.90)							S
	For Codes 9081, 9083 and 9092 the full fee may be charged per side.										
9083	TMJ srthroplasty	06.03	1844.20 (1617.70)	2766.40 (2426.70)							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	146.70 (128.70)	220.00 (193.00)							S
9087	Reduction of TMJ disloc w/ anaesthetic	04.00	297.10 (260.60)	445.60 (390.90)							S
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	04.00	737.80 (647.20)	1106.80 (970.90)							S
9091	Reduction of TMJ dislocation - open reduction	04.00	1844.20 (1617.70)	2766.40 (2426.70)							S
9092	Joint reconstruction	06.03	4923.80 (4319.10)	7385.60 (6478.60)						+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	376.70 (330.40)								S
	Use to report the suturing of recent small wounds. Excludes the closure of surgical incisions.										

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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
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	376.70 (330.40)	499.80 (438.40)							S
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	04.00	701.20 (615.10)	1051.80 (922.60)							S
OTHER REPAIR PROCEDURES											
8958	Emergency tracheotomy	04.00	340.60 (298.80)	510.90 (448.20)							
8959	Pharyngostomy	04.00	340.60 (298.80)	510.90 (448.20)							
8962	Harvest iliac crest graft	04.00	245.00 (214.90)	301.10 (264.10)							S
8963	Harvest rib graft	04.00	281.00 (246.50)	421.50 (369.70)							S
8964	Harvest cranium graft	04.00	220.00 (193.00)	330.10 (289.60)							S
8977	Surgical repair of maxilla or mandible - major	06.03	1552.20 (1361.60)	2328.20 (2042.30)							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	128.00 (112.30)	192.00 (168.40)		192.00 (168.40)					S
8985	Frenulectomy/frenulotomy	04.00	405.30 (355.50)	608.00 (533.30)		608.00 (533.30)					S
9005	Alveolar ridge augmentation - total (by bone graft)	05.02	1553.40 (1362.60)	2330.10 (2043.90)		2330.10 (2043.90)			M	+L	S
9007	Alveolar ridge augmentation - total (by alloplastic material)	05.02	977.80 (857.70)	1466.60 (1286.50)					M	+L	S
9008	Alveolar ridge augmentation - one to two tooth sites	05.02	302.30 (265.20)	552.90 (485.00)		552.90 (485.00)			M	+L	S
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	05.02	671.90 (589.40)	1007.90 (884.10)		1007.90 (884.10)			M	+L	S
9010	Sinus lift procedure	05.02	1009.50 (885.50)	1514.30 (1328.30)		1514.30 (1328.30)			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	264.10 (249.20)	426.10 (373.80)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
Functional Correction of Malocclusion											
	For Codes 9047 to 9072 the full fee may be charged.										06.03
9047	Osteotomy - open with stabilisation	06.03	3100.50 (2719.70)	4650.90 (4079.70)						+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	2584.10 (2266.80)	3876.00 (3400.00)						+L	S
	E.g. Köle										
9050	Osteotomy - total subapical	04.00	4726.70 (4146.20)	7090.00 (6219.30)							S
9051	Genioplasty	04.00	1478.70 (1297.10)	2218.10 (1945.70)							S
9052	Midfacial exposure	06.03	2340.90 (2053.40)	3511.40 (3080.20)							S
	For maxillary and nasal augmentation or pyramidal Le Fort II osteotomy.										
9055	Osteotomy - segmented, posterior	06.03	2584.10 (2266.80)	3876.00 (3400.00)					M	+L	S
	Maxillary posterior segment osteotomy (Schukardt) - 1 or 2 stage procedure.										
9057	Osteotomy - segmented, anterior	06.03	2584.10 (2266.80)	3876.00 (3400.00)					M	+L	S
	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure.										
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	04.00	4862.30 (4265.20)	7293.30 (6397.60)						+L	S
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	05.02	5458.30 (4788.00)	8187.30 (7181.80)						+L	S
9061	Palatal osteotomy	04.00	1700.70 (1491.80)	2551.00 (2237.70)							S
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	04.00	6206.80 (5444.60)	9310.10 (8166.80)						+L	S
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and post-traumatic deformities)	04.00	6209.80 (5447.20)	9314.70 (8170.80)						+L	S
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	06.03	9306.60 (8163.70)	13959.90 (12245.50)						+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	1478.70 (1297.10)	2218.10 (1945.70)					M		S
	This procedure is to expand the maxilla or mandible to facilitate orthodontic aligning of constricted dental arches.										
9069	Glossectomy - partial	04.00	1107.60 (971.60)	1661.50 (1457.50)							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
9071	Geniohyoidotomy	04.00	664.50 (582.90)	996.70 (874.30)							S
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	04.00	4862.30 (4265.20)	7293.30 (6397.60)						+L	S
Salivary Glands											
9093	Removal of salivary stone (Sialolithotomy)	04.00	333.20 (292.30)	499.80 (438.40)							S
9095	Excision of sublinglual salivary gland	04.00	821.10 (720.30)	1231.70 (1080.40)							S
9096	Excision of salivary gland - extra oral approach	04.00	1216.50 (1067.10)	1824.70 (1600.60)							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.										06.03
9284	Musculofascial flap	04.00									
9286	Musculocranial flap	04.00									
9288	Buccal fat pad (major repair)	04.00									
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	2715.80 (2382.30)	4073.60 (3573.30)							S
9222	Repair cleft hard palate - bilateral (one procedure)	04.00	3447.40 (3024.00)	5171.00 (4536.00)							S
9224	Repair cleft hard palate - bilateral (two procedures)	04.00	5137.00 (4506.10)	7704.60 (6758.40)							S
9226	Repair cleft soft palate - w/o muscle reconstruction	04.00	2275.70 (1996.20)	3413.50 (2994.30)							S
9228	Repair cleft soft palate - w/ muscle reconstruction	04.00	3304.40 (2898.60)	4956.60 (4347.90)							S
9230	Repair submucosal cleft and/or bifid uvula - w/ muscle reconstruction	04.00	2460.30 (2158.20)	3690.50 (3237.30)							S
9232	Velopharyngeal reconstruction - uncomplicated	04.00	2531.80 (2220.90)	3797.60 (3331.20)							S
9234	Velopharyngeal reconstruction - complicated	04.00	2707.10 (2374.60)	4060.60 (3561.90)							S
9238	Repair oronasal fistula (one procedure)	04.00	1548.50 (1358.30)	2322.60 (2037.40)							S
9240	Repair oronasal fistula (two procedures)	04.00	2701.40 (2369.60)	4052.20 (3554.60)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
9246	Secondary periosteal flaps	04.00	1350.10 (1184.30)	2025.20 (1776.50)							S
9248	Lipadhesion	04.00	504.70 (442.70)	757.10 (664.10)							S
9250	Repair cleft lip - unilateral w/o muscle reconstruction	04.00	888.90 (779.70)	1333.30 (1169.60)							S
9252	Repair cleft lip - unilateral w/ muscle reconstruction	04.00	1205.20 (1057.20)	1807.90 (1585.90)							S
9254	Repair cleft lip - bilateral w/o muscle reconstruction	04.00	1241.30 (1088.90)	1862.00 (1633.30)							S
9256	Repair cleft lip - bilateral w/ muscle reconstruction	04.00	1917.70 (1682.20)	2876.50 (2523.20)							S
9258	Repair anterior nasal floor	04.00	484.20 (424.70)	726.30 (637.10)							S
9260	Revision of secondary cleft lip deformity - partial	04.00	484.20 (424.70)	726.30 (637.10)							S
9262	Revision of secondary cleft lip deformity - total w/ muscle reconstruction	04.00	1094.10 (959.70)	1641.10 (1439.60)							S
9264	Abbe-flap - two stages	04.00	1238.90 (1086.80)	1858.30 (1630.10)							S
9266	Reconstruct columella	04.00	732.30 (642.40)	1098.30 (963.40)							S
9268	Reconstruct nose due to cleft deformity - partial	04.00	930.50 (816.20)	1395.80 (1224.40)							S
9270	Reconstruct nose due to cleft deformity - complete	04.00	1470.70 (1290.10)	2206.10 (1935.20)							S
9272	Paranasal augmentation for nasal base deviation	04.00	732.30 (642.40)	1098.30 (963.40)							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	857.20 (751.90)		1285.70 (1127.80)					+L	A
8863	Ortho Tx - each additional removable appliance	06.03	430.80 (377.90)		646.20 (566.80)					+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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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	1544.10 (1354.50)		2316.10 (2031.70)					+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	1027.00 (900.90)		1540.40 (1351.20)						A
8865	Ortho Tx - partial fixed appliance - one arch	04.00	2739.40 (2403.00)		4109.10 (3604.50)						A
8866	Ortho Tx - partial fixed appliance - both arches	04.00	3767.50 (3304.80)		5651.30 (4957.30)						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.										06.03
8867	Ortho Tx - fixed appliance - one arch	04.00	2944.60 (2583.00)		4416.80 (3874.40)						A
8868	Ortho Tx - fixed appliance - one arch, modeate	04.00	3632.00 (3186.00)		5448.00 (4778.90)						A
8869	Ortho Tx - fixed appliance - one arch, severe	04.00	4248.10 (3726.40)		6372.00 (5589.50)						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.										06.03
8873	Ortho Tx - fixed appliance - both arches, Class 1 mild	04.00	5388.70 (4726.90)		8083.00 (7090.40)						A
8875	Ortho Tx - fixed appliance - both arches, Class 1 moderate	04.00	6615.10 (5802.70)		9922.60 (8704.00)						A
8877	Ortho Tx - fixed appliance - both arches, Class 1 severe	04.00	7711.60 (6764.60)		11567.30 (10146.80)						A
8879	Ortho Tx - fixed appliance - both arches, Class 1 severe w/ complications	04.00	8666.40 (7602.10)		12999.50 (11403.10)						A
8881	Ortho Tx - fixed appliance - both arches, Class 2/3 mild	04.00	7711.60 (6764.60)		11567.30 (10146.80)						A
8883	Ortho Tx - fixed appliance - both arches, Class 2/3 moderate	04.00	8666.40 (7602.10)		12999.50 (11403.10)						A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8885	Ortho Tx - fixed appliance - both arches, Class 2/3 severe	04.00	9728.80 (8534.00)		14593.10 (12801.00)						A
8887	Ortho Tx - fixed appliance - both arches, Class 2/3 severe w/ complications	04.00	10961.30 (9615.20)		16441.90 (14422.70)						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.										06.03
8841	Ortho Tx - fixed lingual appliance - one arch	04.00	5534.20 (4854.60)		8301.10 (7281.70)						A
8842	Ortho Tx - fixed lingual appliance - one arch, modeate	04.00	6503.90 (5705.20)		9755.70 (8557.60)						A
8843	Ortho Tx - fixed lingual appliance - one arch, severe	04.00	7410.10 (6500.10)		11115.20 (9750.20)						A
Lingual Orthodontics - Comprehensive: Both Arches											
8874	Ortho Tx - fixed lingual appliance - both arches, Class 1 mild	04.00	10557.30 (9260.80)		15835.90 (13891.10)						A
8876	Ortho Tx - fixed lingual appliance - both arches, Class 1 moderate	04.00	12360.60 (10842.60)		18540.80 (16263.90)						A
8878	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe	04.00	14027.80 (12305.10)		21041.50 (18457.50)						A
8880	Ortho Tx - fixed lingual appliance - both arches, Class 1 severe w/ complications	04.00	15565.00 (13653.50)		23347.30 (20480.10)						A
8882	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 mild	04.00	12885.80 (11303.30)		19328.70 (16955.00)						A
8884	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 moderate	04.00	14415.10 (12644.80)		21622.40 (18967.00)						A
8886	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe	04.00	16054.80 (14083.20)		24082.00 (21124.60)						A
8888	Ortho Tx - fixed lingual appliance - both arches, Class 2/3 severe w/ complications	04.00	17864.30 (15670.40)		26796.20 (23505.40)						A
OTHER ORTHODONTIC SERVICES											
8846	Repair orthodontic appliance - removable	04.00	70.20 (61.60)		105.30 (92.40)					+L	A
8847	Replace orthodontic appliance - removable	04.00	242.50 (212.70)		363.70 (319.00)					+L	A
8848	Repair orthodontic appliance - fixed	06.03	103.90 (91.10)		155.70 (136.60)					+L	A
	As a result of the patient's negligence. Report per retainer.										
8849	Retainer (orthodontic)	04.00	242.50 (212.70)		363.70 (319.00)					+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.										

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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
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	56.00 (49.10)								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	28.90 (25.40)								B
	See 8141 descriptor.										
8144	Intravenous sedation	04.00	33.60 (29.50)								B
8145	Local anaesthetic - per visit	06.03	48.60 (42.60)								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.										
8147	Monitoring equipment for intravenous sedation	06.03	119.40 (104.70)								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	187.40 (164.40)								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	124.00 (108.80)			124.00 (108.80)					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		138.90 (121.80)							S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	06.03		92.30 (81.00)							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		203.30 (178.30)							S

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	06.03		231.20 (202.80)							S
	See Code 8904 descriptor.										
9203	House/Hosp/Nursing home consultation - Oral pathologist	04.00						138.90 (121.80)			
9207	After hours visit - Oral pathologist	04.00						203.30 (178.30)			
DRUGS, MEDICAMENTS AND MATERIALS											
8109	Infection control/barrier techniques	06.03	11.20 (9.82)								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	28.90 (25.40)								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	33.60 (29.50)								B
	Not applicable to local anaesthetic.										
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.										
8304	Rubber dam per arch	06.03	59.70 (52.40)								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	127.70 (112.00)	127.70 (112.00)	127.70 (112.00)	127.70 (112.00)	127.70 (112.00)				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

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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: By arrangement with patient										
MISCELLANEOUS SERVICES											
Palliative Treatment											
8131	Emergency dental treatment	06.03	76.40 (67.00)				155.70 (136.60)		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	50.40 (44.20)						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	58.80 (51.60)								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	76.40 (67.00)						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.										
Post Surgical Complications											
8931	Treatment of post-extraction haemorrhage	06.03	56.00 (49.10)	335.70 (294.50)							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	773.90 (678.90)	1160.80 (1018.20)							S
8935	Treatment of septic socket	06.03	56.00 (49.10)	87.70 (76.90)							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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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	180.90 (158.70)				271.40 (238.10)		T		A
	Report code 8304 (application of a rubber dam) in addition to this code.										
8327	Internal bleaching - each additional visit	06.03	86.70 (76.10)				130.10 (114.10)		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	69.90 (61.30)								
	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
	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	483.60 (424.20)		725.40 (636.30)		725.40 (636.30)				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	168.70 (148.00)		231.20 (202.80)	231.20 (202.80)	231.20 (202.80)				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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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	141.73 (124.32)	141.73 (124.32)		141.73 (124.32)					
	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	220.05 (193.03)	220.05 (193.03)		220.05 (193.03)					
	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
	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.										

DENTAL TECHNICIANS

Dental Technicians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR DENTAL TECHNICIANS, EFFECTIVE FROM 1 JANUARY 2009

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.

1	**Preparatory Work**				
The following section includes comsumables, however it excludes materials					
Code	**Description**	**Ver**	**Add**	**Dental Technology**	
				RVU	**Fee**
9301	Casting and trimming of model in plaster (yellow/white), per model	09.00		2.714	21.80 (19.10)
9303	Casting and trimming of model in super-hard stone (die-stone) per model	09.00		3.857	30.90 (27.10)
9305	Casting and trimming of study model, per model	09.00		7.143	57.30 (50.30)
9307	Casting and trimming of gnathostatic model, per model.	09.00		9.286	74.50 (65.40)
9309	New trimmed base to supplied model, per model	09.00		3.286	26.40 (23.20)
9311	Trimming of supplied model, per model	09.00		2.000	16.00 (14.00)
9312	Gingival tissue mask per implant	09.00		15.429	123.80 (108.60)
9313	Duplicating model, per model	09.00		8.286	66.50 (58.30)
9314	Refractory model, per unit	09.00		8.143	65.30 (57.30)
9315	Models and duplicate models (virgin model) for crown and bridge, work inclusive of one removable die	09.00		11.286	90.50 (79.40)
9317	Sectional models for crown and bridge, work inclusive of one removable die	09.00		10.000	80.20 (70.40)
9319	Each additional removable die for items 9315 and 9317 per die	09.00	+	2.571	20.60 (18.10)
9320	Indexed or model tray per die (not more than 9319)	09.00		2.571	20.60 (18.10)
9321	Occlusion block, per block	09.00		9.857	79.10 (69.40)
9323	Occlusion block on baseplate, per block	09.00		12.429	99.70 (87.50)
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	09.00		1.857	14.90 (13.10)
9329	Fit and supply of disposable articulator	09.00		4.857	39.00 (34.20)
9330	Delivery / Collection fee per completed procedure (maximum 4)	09.00		5.143	41.30 (36.20)
	The tariff under all sections excludes the fees for models - occlusion blocks and delivery charge.	09.00			
2	**Prosthetic Services Using Acrylic**				
	The tariff under this section excludes the fees for models and occlusion blocks.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Full Dentures**				
9331	Full upper and lower dentures	09.00		132.571	1063.40 (932.80)
9333	Full upper or lower denture	09.00		77.571	622.20 (545.80)
9335	Set-up and waxing of full upper and lower dentures	09.00		45.714	366.70 (321.70)
9337	Set-up and waxing of full upper or lower denture	09.00		30.571	245.20 (215.10)
9339	Waxing and finishing of full upper and lower dentures	09.00		81.286	652.00 (571.90)
9341	Waxing and finishing of full upper or lower denture	09.00		45.429	364.40 (319.60)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9343	Additional fee for dentures on fully adjustable articulator at request of dentist	09.00	+	129.429	1038.20 (910.70)
9345	Additional fee for immediate dentures, or tooth socketed	09.00	+	1.857	14.90 (13.10)
9346	Additional fee for immediate dentures, per tooth not socketed.	09.00	+	1.000	8.02 (7.04)
9347	Additional fee for each retry from the third and upwards at an agreed quantum of time to be calculated at hourly rate	09.00	+	29.429	236.10 (207.10)
B	**Partial Dentures**				
9351	Set-up and finish of one-tooth denture	09.00		35.571	285.30 (250.30)
9352	Set-up and finish of two-tooth denture	09.00		37.857	303.70 (266.40)
9353	Set-up and finish of three-tooth denture	09.00		40.571	325.40 (285.40)
9354	Set-up and finish of four-tooth denture	09.00		42.857	343.80 (301.60)
9355	Set-up and finish of five-tooth denture	09.00		46.286	371.30 (325.70)
9356	Set-up and finish of six-tooth denture	09.00		55.286	443.40 (388.90)
9357	Set-up and finish of seven-tooth denture	09.00		65.714	527.10 (462.40)
9358	Set-up and finish of eight-tooth denture	09.00		69.714	559.20 (490.50)
9359	Set-up and finish nine or more tooth denture	09.00		71.429	572.90 (502.50)
9361	Set-up and waxing of one-tooth denture	09.00		10.143	81.40 (71.40)
9362	Set-up and waxing of two-tooth denture	09.00		12.286	98.50 (86.40)
9363	Set-up and waxing of three-tooth denture	09.00		14.000	112.30 (98.50)
9364	Set-up and waxing of four-tooth denture	09.00		16.286	130.60 (114.60)
9365	Set-up and waxing of five-tooth denture	09.00		18.000	144.40 (126.70)
9366	Set-up and waxing of six-tooth denture	09.00		21.286	170.70 (149.70)
9367	Set-up and waxing of seven-tooth denture	09.00		23.429	187.90 (164.80)
9368	Set-up and waxing of eight-tooth denture	09.00		25.143	201.70 (176.90)
9369	Set-up and waxing of nine or more tooth denture	09.00		26.857	215.40 (188.90)
9371	Waxing and finishing of one-tooth denture	09.00		27.857	223.40 (196.00)
9372	Waxing and finishing of two-tooth denture	09.00		28.429	228.00 (200.00)
9373	Waxing and finishing of three-tooth denture	09.00		28.857	231.50 (203.10)
9374	Waxing and finishing of four-tooth denture	09.00		29.429	236.10 (207.10)
9375	Waxing and finishing of five-tooth denture	09.00		30.571	245.20 (215.10)
9376	Waxing and finishing of six-tooth denture	09.00		31.714	254.40 (223.20)
9377	Waxing and finishing of seven-tooth denture	09.00		39.571	317.40 (278.40)
9378	Waxing and finishing of eighth-tooth denture	09.00		41.143	330.00 (289.50)
9379	Waxing and finishing of nine or more tooth denture	09.00		43.429	348.30 (305.50)
9383	Additional fee for finishing denture in tooth colour material, per tooth	09.00	+	6.857	55.00 (48.20)
9385	Additional fee for supplying finished denture on duplicate model	09.00	+	13.000	104.30 (91.50)
C	**Repair Service**				
9391	Basic charge which includes repair of one fracture, or addition of one tooth, or addition of one clasp	09.00		22.571	181.00 (158.80)
9393	Additional charge for each additional fracture, or tooth, or clasp	09.00	+	7.000	56.10 (49.20)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9395	Additional fee for using wire strengthener	09.00	+	8.000	64.20 (56.30)
9397	Additional fee for using pre-formed strengthener	09.00	+	8.571	68.70 (60.30)
9398	Additional fee for using mesh strengthener in repair procedure	09.00	+	13.571	108.90 (95.50)
D	**Additional Services**				
9401	Clear base	09.00		10.000	80.20 (70.40)
9403	Dox grinding of upper and lower dentures	09.00		12.714	102.00 (89.50)
9405	Inlay to artificial tooth, one surface only, per inlay	09.00		21.857	175.30 (153.80)
9406	Inlay to artificial tooth, multi-surfaces e.g. horseshoe or L-type inlay, per inlay	09.00		28.000	224.60 (197.00)
9407	Heka base technique per upper or lower denture	09.00		30.000	240.60 (211.10)
9409	Frego frame	09.00		13.000	104.30 (91.50)
9410	Bleaching tray	09.00		14.429	115.70 (101.50)
9411	Template per upper or lower denture	09.00		35.857	287.60 (252.30)
9413	Reline/rebase of single denture	09.00		45.143	362.10 (317.60)
9415	Remodel of single denture	09.00		69.429	556.90 (488.50)
9417	Soft base reline per denture	09.00		114.000	914.40 (802.10)
9419	Soft base to new denture, per denture	09.00		114.000	914.40 (802.10)
9421	Gum tinting per denture	09.00		21.143	169.60 (148.80)
9423	Lingual or palatal bar	09.00		17.000	136.40 (119.60)
9425	Cleaning and polishing of existing denture, per denture	09.00		13.857	111.10 (97.50)
9427	Mesh strengthener	09.00		11.857	95.10 (83.40)
9429	Theatre/ Consultation out of Laboratory per hour or part thereof	09.00		29.429	236.10 (207.10)
9431	Special Tray, acrylic, each	09.00		11.143	89.40 (78.40)
9432	Special Tray Light Cure, each	09.00		12.143	97.40 (85.40)
9433	Special Tray in base plate material, each	09.00		11.429	91.70 (80.40)
9435	Provision of single arm clasp, to partial denture	09.00		5.857	47.00 (41.20)
9437	Provision of double arm clasp, to partial denture	09.00		10.143	81.40 (71.40)
9439	Provision of single arm clasp with rest, to partial denture	09.00		13.143	105.40 (92.50)
9441	Provision of double arm clasp with rest, to partial denture	09.00		17.714	142.10 (124.60)
9443	Provision of preformed Roach clasp, to partial denture	09.00		7.571	60.70 (53.20)
9445	Provision of rest only to partial denture	09.00		7.571	60.70 (53.20)
9447	Cast Clasp	09.00		26.571	213.10 (186.90)
9448	Casting and trimming of Model from impression inside occlusion block or wax try in	09.00		4.857	39.00 (34.20)
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	09.00		10.143	81.40 (71.40)
3	**Cobalt Chrome / Gold Prosthetic Services**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
A	**Full Metal Dentures**				
9451	Metal base for full upper or full lower denture each	09.00		91.000	729.90 (640.30)
B	**Partial Metal Dentures**				
9453	Basic charge - which excludes models and any special trays which may be required by the dentist, but includes refractory model	09.00		79.571	638.20 (559.80)
9455	Additional charge for each one arm clasp	09.00	+	3.286	26.40 (23.20)
9457	Additional charge for each Roach clasp	09.00	+	5.571	44.70 (39.20)
9459	Additional charge for each rest	09.00	+	3.000	24.10 (21.10)
9461	Additional charge for continuous clasp, per tooth	09.00	+	3.286	26.40 (23.20)
9463	Additional charge for lingual bar, per tooth passed	09.00	+	7.714	61.90 (54.30)
9465	Additional charge for palatal bar	09.00	+	12.286	98.50 (86.40)
9467	Additional charge for onlay	09.00	+	32.714	262.40 (230.20)
9469	Additional charge for saddle with finishing line, per tooth	09.00		5.429	43.50 (38.20)
9471	Additional charge for saddle without finishing line, per tooth	09.00		3.143	25.20 (22.10)
9473	Additional charge for horseshoe saddle, per tooth	09.00		5.429	43.50 (38.20)
9475	Additional charge for fitting of tooth to metal backing, per tooth	09.00		3.714	29.80 (26.10)
9479	Additional charge for fitting one distal-extension hinge	09.00	+	11.000	88.20 (77.40)
9480	Additional charge per milled edge per tooth	09.00	+	9.571	76.80 (67.40)
9481	Additional charge for each soldering joint	09.00	+	13.429	107.70 (94.50)
9483	Additional charge for soldering retention	09.00	+	16.286	130.60 (114.60)
9485	Additional charge for each additional retention soldering joint	09.00	+	5.000	40.10 (35.20)
9487	Additional charge for each welding joint	09.00	+	16.429	131.80 (115.60)
9489	Additional charge for fitting swing lock	09.00	+	13.429	107.70 (94.50)
9491	Additional charge for each backing cast	09.00	+	13.143	105.40 (92.50)
9493	Additional charge for each Steels backing or pontic cast (Plastic work to be charged in addition)	09.00	+	14.286	114.60 (100.50)
C	**Chrome Cobalt and Repairs**				
9495	Basic fee for the repairing of or addition to any appliance necessitating the casting of a model (9301)	09.00		20.714	166.10 (145.70)
9497	Basic fee if a new section is to be fabricated and where item 9495 does not apply (9301)	09.00		23.571	189.10 (165.90)
4	**Crown and Bridge Prosthetic Services**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Porcelain (Ceramic) Services**				
9501	Ceramic jacket crown/Ceromer crown or pontic	09.00		90.429	725.30 (636.20)
9502	Ceramic metal substitute coping	09.00		73.000	585.50 (513.60)
9505	Ceramic Bonded crown or pontic	09.00		119.429	957.90 (840.30)
9507	Post-solder invested joint, per joint	09.00		24.429	195.90 (171.80)
9511	Inlay in porcelain veneer crown	09.00		39.429	316.30 (277.50)
9512	Ceramic, inlay/onlay, bridge retainer	09.00		92.714	743.70 (652.40)
9515	Porcelain shoulder per unit (not applicable to pontics)	09.00		8.000	64.20 (56.30)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9520	Additional fee for crown- & bridge work performed on a movable condyle articulator per unit	09.00	+	3.857	30.90 (27.10)
B	**Gold and Acrylic Veneer Services**				
9521	Full metal crown, MOD, three-quarter crown	09.00		73.857	592.40 (519.60)
9524	Indirect Composite Resin inlay	09.00		20.000	160.40 (140.70)
9525	Class IV, MO, DO, cervical/occlusal inlay	09.00		60.857	488.10 (428.20)
9526	Additional fee for one piece casting of crown or inlay on post	09.00	+	18.571	149.00 (130.70)
9531	Pin-ledge inlay	09.00		69.000	553.40 (485.40)
9533	Full metal pontic	09.00		54.571	437.70 (383.90)
9535	Abutment thimble cast	09.00		51.143	410.20 (359.80)
9537	Precision lock and rest cast	09.00		72.571	582.10 (510.60)
9538	Lock and rest cast	09.00		34.714	278.40 (244.20)
9539	Casting of rest only	09.00		20.714	166.10 (145.70)
9541	Metal inlay or post, cast direct	09.00		22.000	176.50 (154.80)
9543	Gold/pre-solder invested joint	09.00		21.857	175.30 (153.80)
9545	Cast post with thimble, indirect	09.00		36.429	292.20 (256.30)
9546	Multiple Post	09.00		60.286	483.60 (424.20)
9547	Manufacture cast post and core to existing crown	09.00		47.571	381.60 (334.70)
9549	C.S.P. attachment (Steiger)	09.00		160.571	1287.90 (1129.70)
9550	Milling milled edge per unit	09.00		51.143	410.20 (359.80)
9551	Telescope crown	09.00		126.000	1010.60 (886.50)
9553	Composite/acrylic veneer crown/pontic, indirect	09.00		100.714	807.80 (708.60)
9557	Composite/acrylic jacket crown, indirect	09.00		71.143	570.60 (500.50)
9559	Composite/acrylic veneer post crown	09.00		99.571	798.70 (700.60)
9560	Indirect Composite Resin Veneer	09.00		42.143	338.00 (296.50)
9561	Composite/acrylic jacket crown, direct	09.00		48.571	389.60 (341.80)
9563	Temporary acrylic/composite crown per unit	09.00		34.714	278.40 (244.20)
9564	Heat formed template supplied to dentist for the manufacture of temporary restorations	09.00		17.429	139.80 (122.60)
9565	Composite/acrylic-facing replaced	09.00		40.429	324.30 (284.50)
9566	Porcelain/ Cerorner facing replaced	09.00		73.286	587.80 (515.60)
9569	Waxing of crown to existing denture	09.00		28.571	229.20 (201.10)
9570	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	09.00	+	29.429	236.10 (207.10)
5	**Orthodontic Appliances**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Orthodontic Services**				
9571	Basic charge which includes acrylic base	09.00		36.143	289.90 (254.30)
9572	Basic charge non acrylic base	09.00		17.429	139.80 (122.60)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9573	Additional charge for fitting first expansion screw	09.00	+	6.857	55.00 (48.20)
9575	Additional fee for fitting subsequent expansion screws	09.00	+	5.857	47.00 (41.20)
9576	Additional fee for full aclusal bite plate	09.00	+	20.286	162.70 (142.70)
9577	Additional fee for bite plate anterior	09.00	+	6.857	55.00 (48.20)
9578	Additional fee for bite plate posterior	09.00	+	6.857	55.00 (48.20)
9579	Additional fee for fitting tongue guard	09.00	+	8.571	68.70 (60.30)
9581	Additional fee for flat or inclined plane	09.00	+	5.286	42.40 (37.20)
9583	Additional fee for Adams Crib	09.00	+	6.286	50.40 (44.20)
9585	Additional fee for Jackson Crib	09.00	+	6.571	52.70 (46.20)
9587	Additional fee for ball clasp	09.00	+	7.429	59.60 (52.30)
9589	Additional fee for single arm clasp	09.00	+	5.714	45.80 (40.20)
9591	Additional fee for double arm clasp	09.00	+	10.000	80.20 (70.40)
A.1	**Springs**				
9593	Additional fee for fitting single loop finger spring	09.00	+	4.714	37.80 (33.20)
9595	Additional fee for fitting double loop finger spring	09.00	+	5.571	44.70 (39.20)
9597	Additional fee for fitting Buccal retraction spring	09.00	+	4.143	33.20 (29.10)
9599	Additional fee for fitting apron spring	09.00	+	10.714	85.90 (75.40)
9603	Additional fee for fitting coffin spring	09.00	+	10.286	82.50 (72.40)
9605	Additional fee for fitting Quad Helix	09.00	+	11.429	91.70 (80.40)
9607	Additional fee for fitting flapper or "T"-spring	09.00	+	8.571	68.70 (60.30)
9609	Additional fee for fitting all springs with tubing, each	09.00	+	9.571	76.80 (67.40)
A.2	**Arches**				
9611	Additional fee for fitting labial arch	09.00	+	5.429	43.50 (38.20)
9613	Additional fee for fitting buccal arch	09.00	+	6.429	51.60 (45.30)
9615	Additional fee for fitting Roberts retractor	09.00	+	12.000	96.30 (84.50)
9617	Invisible Retainer	09.00		15.857	127.20 (111.60)
9619	Additional fee for fitting twin wire arch extra-oral arch	09.00	+	15.000	120.30 (105.50)
9620	Additional fee Lip bumper	09.00	+	6.286	50.40 (44.20)
9621	Additional fee for fitting extra-oral arch	09.00	+	14.286	114.60 (100.50)
9622	Additional fee for fitting space maintainer arch	09.00	+	6.286	50.40 (44.20)
A.3	**Welding And Soldering**				
9623	Additional fee for each spot-welding joint	09.00	+	2.857	22.90 (20.10)
9625	Additional fee for each soldering joint	09.00	+	4.571	36.70 (32.20)
9627	Additional fee for each invested soldering joint	09.00	+	12.714	102.00 (89.50)
9629	Additional fee for each hook for elastic traction	09.00	+	4.143	33.20 (29.10)
B	**Mouth Protectors and MYO Functional Appliances**				
9631	Mouth protector (gum guard)	09.00		26.857	215.40 (188.90)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9633	Oral Screen	09.00		33.000	264.70 (232.20)
9635	Andresen or Norwegian appliance	09.00		59.000	473.20 (415.10)
9637	Tooth positioner	09.00		68.000	545.40 (478.40)
9639	Gunning splint	09.00		90.571	726.50 (637.30)
9641	Frankel appliance	09.00		87.429	701.30 (615.20)
9643	Chin cap	09.00		29.000	232.60 (204.00)
9645	Bionator	09.00		59.143	474.40 (416.10)
9646	Diagnostic set-up	09.00		56.857	456.10 (400.10)
9647	Snoring Appliance	09.00		53.714	430.80 (377.90)
C	**Fixed Appliances**				
9651	Pinched or swaged band with welded attachment (excluding cost of attachment)	09.00		17.429	139.80 (122.60)
9653	Pinched or swaged band with soldered attachment	09.00		22.857	183.30 (160.80)
D	**Additional Services**				
9662	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	09.00	+	29.429	236.10 (207.10)
6	**Materials**				
A	**Prosthetic/Restorative Services**				
9700	Diatorics 1 X 6/8	09.00		-	-
9702	Diatorics, odds, anterior	09.00		-	-
9704	Diatorics, odds, posterior	09.00		-	-
9706	Cost of Bleaching tray material	09.00		-	-
9720	Soft base material per denture	09.00		-	-
9722	Acrylic per denture	09.00		-	-
9724	Cost of precision attachment, per attachment	09.00		-	-
9726	Preformed Ball or Roach Clasp	09.00		-	-
9728	Cost of lingual / palatal bar	09.00		-	-
9729	Cost of mesh strengthener	09.00		-	-
9730	Cost of pre-fabricated burn-out component, per component	09.00		-	-
9732	Cost of other attachment components e.g. Nylon caps, sleeves etc	09.00		-	-
9734	Cost of dolder bar and clips, per gram or per clip	09.00		-	-
9736	Cost of implant components	09.00		-	-
9738	Cost of preformed strengthener	09.00		-	-
9739	Additional Charge Gold plating	09.00	+	-	-
B	**Metal**				
9740	Cost of gold wire, per gram	09.00		-	-
9741	Cost of Cobalt Chrome casting alloy	09.00		-	-
9742	Cost of specialised Cobalt Chrome casting metal e g Vitallium, Titanium	09.00		-	-
9744	Cost of precious casting alloy	09.00		-	-
9746	Cost of semi-precious casting alloy	09.00		-	-
9748	Cost of non-precious casting alloy	09.00		-	-
9752	Cost of platinum foil	09.00		-	-
9754	Cost of gold solder, per gram	09.00		-	-
9755	Etching For bonding (metal or Ceramic)	09.00		-	-
9756	Cost of silver solder, per gram	09.00		-	-
9757	Ceromer material - per unit	09.00		-	-
9758	Fiber re-enforced material per unit	09.00		-	-
9760	Composite restoration material	09.00		-	-
9761	Ceramic material	09.00		-	-
C	**Orthodontic Services**				
9762	Cost of anterior orthodontic attachment, per attachment	09.00		-	-
9763	Orthodontic material	09.00		-	-
9764	Cost of posterior orthodontic attachment, per attachment	09.00		-	-
9765	Preformed components	09.00		-	-
9766	Cost of expansion screw, per screw	09.00		-	-
9767	Soldering material	09.00		-	-
9768	Cost of buccal tube/transfer tube, per tube	09.00		-	-

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9770	Cost of J-hook, per hook	09.00		-	-
9772	Cost of lingual buttons, per button	09.00		-	-
9774	Cost of invisible retainer material	09.00		-	-
9775	R/A case	09.00		-	-
9776	Cost of mouth protector material	09.00		-	-
9778	Cost of arch wire	09.00		-	-
9779	Dual laminate material	09.00		-	-
7	**Precision Attachments and Implant Services**				
	The following section includes consumables, however it excludes materials				09.00
9780	Positioning and finishing of complete (male and female) pre-fabricated burn-out attachment	09.00		45.000	360.90 (316.60)
9782	Positioning and soldering of complete (male and female) precision attachment	09.00		37.571	301.40 (264.40)
9783	Implant stent per unit	09.00		34.714	278.40 (244.20)
9784	Alignment of dolder bar and clips	09.00		47.429	380.40 (333.70)
9786	Trimming, waxing and finishing of implant abutment - crown and bridge work only, per abutment	09.00		20.429	163.90 (143.80)
9787	Waxing, milling and finishing of a custom abutment	09.00		39.857	319.70 (280.40)
9788	Implant superstructure (edentulous cases) including placing of preformed parts, per section cast	09.00		217.857	1747.40 (1532.80)
9789	Finishing of prosthesis on implant structure per arch	09.00		79.571	638.20 (559.80)

DENTAL THERAPY

Dental Therapy 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2009

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	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	MP	Lab	TC
8139	Appointment not kept /30min	06.03	-			B
	Comment: By arrangement with patient					
8109	Infection control/barrier techniques	06.03	11.20 (9.82)			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	28.90 (25.40)			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	64.70 (56.80)			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	104.50 (91.70)			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	50.40 (44.20)			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	50.40 (44.20)			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	155.40 (136.30)			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	102.80 (90.20)			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	48.60 (42.60)			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	389.70 (341.80)			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	48.60 (42.60)			B

Code	Description	Ver	Dental Therapy	MP	Lab	TC
	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	83.50 (73.20)			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	194.20 (170.40)			B
8116	Extraoral radiograph - cephalometric	05.02	194.20 (170.40)			B
8118	Extraoral radiograph - skull/facial bone	05.02	-			B
8121	Oral and/or facial image (digital/conventional)	06.03	52.10 (45.70)			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.					
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	50.80 (44.60)			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	37.20 (32.60)			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					
8155	Polishing - complete dentition	06.03	62.20 (54.60)			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	113.20 (99.30)			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	62.20 (54.60)			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	62.20 (54.60)			B
	See code 8161.					
8163	Dental sealant	06.03	46.00 (40.40)	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	72.50 (63.60)	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	28.00 (24.60)	T		B
	To be reported for an additional extraction in the same quadrant at the same visit.					
8145	Local anaesthetic - per visit	06.03	11.00 (9.65)			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	47.30 (41.50)			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	47.30 (41.50)			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	89.30 (78.30)	M		S
8303	Pulp cap - indirect	06.03	91.90 (80.60)	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	132.70 (116.40)	T		B
8342	Amalgam - two surfaces	04.00	163.60 (143.50)	T		B
8343	Amalgam - three surfaces	04.00	199.40 (174.90)	T		B
8344	Amalgam - four or more surfaces	04.00	222.10 (194.80)	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	160.50 (140.80)	T		B
8352	Resin - two surfaces, anterior	04.00	201.80 (177.00)	T		B
8367	Resin - one surface, posterior	06.03	174.00 (152.60)	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	260.00 (228.10)	T		B
8370	Resin - four or more surfaces, posterior	04.00	279.70 (245.40)	T		B
8368	Resin - two surfaces, posterior	04.00	215.30 (188.90)	T		B
8353	Resin - three surfaces, anterior	04.00	241.10 (211.50)	T		B
8354	Resin - four or more surfaces, anterior	06.03	269.10 (236.10)	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	289.30 (253.80)	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	64.70 (56.80)	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	64.70 (56.80)	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	42.70 (37.50)	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	49.80 (43.70)			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.					

DIETICIANS

Dieticians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2009

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	26.30 (23.10)
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	05.03		1.500	78.80 (69.10)
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	05.03		2.500	131.40 (115.30)
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	05.03		3.500	183.90 (161.30)
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	05.03		4.500	236.40 (207.40)
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	05.03		5.500	289.00 (253.50)
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	05.03		6.500	341.50 (299.60)
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	05.03		7.500	394.10 (345.70)
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	05.03		8.500	446.60 (391.80)
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	05.03		9.500	499.10 (437.80)
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	05.03		10.500	551.70 (483.90)
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	05.03		11.500	604.20 (530.00)
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	5.25 (4.61)
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	05.03		0.300	15.80 (13.90)
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	05.03		0.500	26.30 (23.10)

Code	Description	Ver	Add	Dietetics	
				RVU	Fee
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	05.03		0.700	36.80 (32.30)
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	05.03		0.900	47.30 (41.50)
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	05.03		1.100	57.80 (50.70)
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	05.03		1.300	68.30 (59.90)
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	05.03		1.500	78.80 (69.10)
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	05.03		1.700	89.30 (78.30)
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	05.03		1.900	99.80 (87.50)
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	05.03		2.100	110.30 (96.80)
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	05.03		2.300	120.80 (106.00)

HEARING AID ACOUSTICIANS

Hearing Aid Acousticians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HEARING AID ACOUSTICIANS EFFECTIVE FROM 1 JANUARY 2009

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	81.40 (71.40)
003	Consultation (screening interview)	04.00		10.000	51.90 (45.50)
021	Test - air conduction	04.00		10.000	51.90 (45.50)
023	Test - bone conduction	04.00		10.000	51.90 (45.50)
025	Test - speech hearing tests	04.00		14.000	72.60 (63.70)
027	Test - free field	04.00		12.800	66.40 (58.20)
029	Test - insertion gain (per ear)	04.00		10.900	56.50 (49.60)
031	Test - binaural loudness balance test, per ear	04.00		12.800	66.40 (58.20)
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	66.40 (58.20)
055	Technical adjustment or replacement of earmolds	04.00		21.100	109.40 (96.00)
057	Repairs/service per instrument (3 X services/4 year cycle)	04.00		-	-
059	Tympanogram	04.00		10.000	51.90 (45.50)
061	Reflex test (stapedial reflex)	04.00		10.000	51.90 (45.50)
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		-	-

HOMOEOPATHS

Homoeopaths 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY HOMOEOPATHS EFFECTIVE FROM 1 JANUARY 2009

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 of 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, eardrops, 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 medicine: These are registered medicines (consonant with the homoeopathic scope of practice) 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 (consonant with the homoeopathic scope of practice) 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. Dispense/Dispensing: in terms of Act 101 of 1965 means in the case of a medical practitioner, dentist, practitioner, nurse or any prescriber authorised to dispense medicines. i. the interpretation and evaluation of a prescription; ii. the selection, reconstitution, dilution, labelling, recording and supply of the medicine in an appropriate container; or iii. the provision of information and instructions to ensure safe and effective use of a medicine by a patient. Compound/Compounding: means to prepare, mix, combine, package and label a medicine for dispensing as a result of a prescription for an individual patient by a pharmacist or a person authorised in terms of Act 101 of 1965. Proprietary Materials: To be used for all material and/or unregistered/unscheduled products used in treatment. The appropriate NAPPI code(s), where applicable, must be provided.	09.00

Code	Description	Ver	Add	Homoeopathy	
				RVU	Fee
General Rules on Medicines, supplies, material and use of own equipment in treatment and procedures					
	MEDICINE CODE USAGE: Licensed Practitioners 201: as medicine dispensed to patients may only be used by a practitioner licensed to dispense medicine. 202-204: as compounded medicines which are dispensed to patients may only be used by a practitioner licensed to compound and dispense medicine 221-224: may be used by a licensed practitioner in the administration or usage of a medicine or material during the consultation. Items 222-224 specifically require a compounding license. 209: the use or administration of proprietary materials during a consultation. Unlicensed Practitioners: 221: administered proprietary medicine (consonant with the homoeopathic scope of practice) to patients during the consultation as administration does not warrant a dispensing license as per Regulation 18, Act 101 of 1965, which states: Regulation 18, Act 101 (8) For the purposes of this regulation, "compounding and dispensing" does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation. 209: the use or administration of proprietary materials during a consultation 400: a dispensing code allowing the dispensing of proprietary Homoeopathic medicine to a patient for an emergency medical condition on a once-off basis by an unlicensed practitioner. This should only be used bearing in mind the understanding of the term "emergency medical condition" where failure to such an act would prove a danger to the patient or community or as defined by the Regulations to the Medical Schemes Act, 1998 (Act 131 of 1998): "Emergency Medical Condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment 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. Reflection of NAPPI/NHRPL codes on electronic and paper claims: 1. NAPPI Codes are only relevant for Items 201, 221 and, if applicable, 209 2. Due to the nature of non-proprietary medicine, no NAPPI codes exist for items 202-204 and 222-224 and the inclusion of the NHRPL codes should be regarded as sufficient 3. For electronic claims each NHRPL and/or NAPPI code should be reflected on its own line followed by consecutive columns: the Single Exit Price (SEP) or NHRPL value (VAT inclusive) of the specific medicine and the total amount reflecting a VAT inclusive amount.				09.00
	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 5 - 15 mins	09.00		10.000	53.60 (47.00)
302	Consultation (initial or follow up). Duration 16 - 30 mins	06.04		22.500	120.50 (105.70)
303	Consultation (initial or follow up). Duration 31 - 45 mins	06.04		37.500	200.80 (176.10)
304	Consultation (initial or follow up). Duration 46 - 60 mins	06.04		52.500	281.10 (246.60)
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	06.04		15.000	80.30 (70.40)
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		-	-

Code	Description	Ver	Add	Homoeopathy	
				RVU	Fee
2.	**Medicines and Materials**				
2.1	**Licensed practitioner in licensed area:**				
Dispensed Medicine:					
	Codes 201 - 204 are to allow for the dispensing of medicine - either proprietary or non-proprietary. Code 201 requires only a Dispensing License Codes 202 - 204 require a combined Compounding and Dispensing license				09.00
201	Proprietary (dispensed) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00		-	-
202	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Tablets & Capsules (each)	09.00		0.100	1.09 (0.96)
203	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Liquid drops (per ml)	09.00		0.230	2.52 (2.21)
204	Non-proprietary (compounded and dispensed) Homoeopathic Medicine - Pillules & granules (per ml)	09.00		0.230	2.52 (2.21)
Administered Medicine/Materials:					
221	Proprietary (administered) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00			
222	Non-proprietary (compounded and administered) Homoeopathic Medicine - Tablets & Capsules (each)	09.00		0.100	1.09 (0.96)
223	Non-proprietary (compounded and administered) Homoeopathic Medicine - Liquid drops (per ml)	09.00		0.230	2.52 (2.21)
224	Non-proprietary (compounded and administered) Homoeopathic Medicine - Pillules & granules (per ml)	09.00		0.230	2.52 (2.21)
209	Proprietary Materials (administered)	09.00			
2.2	**Unlicensed practitioner OR licensed practitioner in unlicensed area:**				
Dispensed Medicine:					
400	Once off dispensing: Once off dispensing of proprietary homeopathic medicine, all forms, by unlicensed Homoeopathic practitioners or licensed homoeopathic practitioner in an unlicensed area. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code. To be used as emergency only.	09.00		-	-
Administered Medicine:					
221	Proprietary (administered) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.	09.00			
209	Proprietary Materials (administered)	09.00			

HOSPICES

Hospices 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79" WITH EFFECT FROM 1 JANUARY 2009

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	729.50 (639.90)
955	Home health care, per visit	04.00		10.000	238.80 (209.50)
960	Global fee for a terminally ill patient - By arrangement with medical scheme/patient	05.02		-	-

MEDICAL PRACTITIONERS

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2009

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

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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	114.60 (100.53)	15.000	114.60 (100.53)		
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	92.53 (81.17)	7.500	103.73 (90.99)		
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. Neonates requiring intensive care: per fee for intensive care +50% for neonatologists and paediatricians								09.01
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	206.28 (180.95)	27.000	206.28 (180.95)		
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	588.28 (516.04)	77.000	588.28 (516.04)		

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				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	882.42 (774.05)	115.500	882.42 (774.05)		
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	588.28 (516.04)	77.000	588.28 (516.04)		
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	244.48 (214.46)	32.000	244.48 (214.46)		
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	588.28 (516.04)	77.000	588.28 (516.04)		
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	343.80 (301.58)	45.000	343.80 (301.58)		
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	160.44 (140.74)	21.000	160.44 (140.74)		
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

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				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	43.69 (38.32)	6.000	43.69 (38.32)			
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	220.70 (193.60)				
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	404.60 (354.90)				
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	588.60 (516.30)				
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	772.50 (677.60)				
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	220.70 (193.60)				
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	404.60 (354.90)				
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	588.60 (516.30)				
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	772.50 (677.60)				
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 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							09.01	+
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	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)								
Cardiology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								
Cardiothoracic Surgery	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								
Dermatology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)								
Gastroenterology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								
General Medical Practice	207.50 (182.00)	207.50 (182.00)	207.50 (182.00)	207.50 (182.00)	207.50 (182.00)	207.50 (182.00)	207.50 (182.00)		207.50 (182.00)	83.00 (72.80)	110.60 (97.00)	193.60 (169.80)		
Medical Oncology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								
Medicine (Specialist Physician)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								
Neurology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)								

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Code	Description							Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
										RVU	Fee	RVU	Fee	RVU	Fee
Neurosurgery	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)									
Nuclear Medicine	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)									
Obstetrics and Gynaecology	222.10 (194.80)	222.10 (194.80)	222.10 (194.80)	222.10 (194.80)	222.10 (194.80)	222.10 (194.80)									
Opthalmology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Orthopaedics	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Otorhinolaryngology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Paediatric Cardiology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)		277.60 (243.50)							
Paediatrics	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)		277.60 (243.50)							
Pathology (Anatomical)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Pathology (Clinical)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Physical Medicine	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)									
Plastic and Reconstructive Surgery	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Psychiatry							220.70 (193.60)			220.70 (193.60)	88.30 (77.50)	117.70 (103.20)	206.00 (180.70)	-	-
Pulmonology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)									
Radiation Oncology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Radiology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Rheumatology	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)	320.80 (281.40)									
Specialists							185.10 (162.40)			185.10 (162.40)	74.00 (64.90)	98.70 (86.60)	172.70 (151.50)	-	-
Surgery	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
Urology	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)	209.70 (183.90)									
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	221.30 (194.10)	16.000	197.40 (173.20)

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	221.30 (194.10)	16.000	197.40 (173.20)
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	221.30 (194.10)	16.000	197.40 (173.20)
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	407.10 (357.10)	33.000	456.40 (400.40)		
	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	555.20 (487.00)	45.000	622.40 (546.00)		
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	148.00 (129.80)			
Cardiology	222.10 (194.80)			
Cardiothoracic Surgery	209.70 (183.90)			
Dermatology	148.00 (129.80)			
Gastroenterology	222.10 (194.80)			
General Medical Practice	166.00 (145.60)	69.20 (60.70)	124.50 (109.20)	296.40 (260.00)
Medical Oncology	222.10 (194.80)			
Medicine (Specialist Physician)	222.10 (194.80)			
Neurology	222.10 (194.80)			
Neurosurgery	222.10 (194.80)			
Nuclear Medicine	222.10 (194.80)			
Obstetrics and Gynaecology	148.00 (129.80)			
Opthalmology	148.00 (129.80)			
Orthopaedics	148.00 (129.80)			
Otorhinolaryngology	148.00 (129.80)			
Paediatric Cardiology	222.10 (194.80)			
Paediatrics	222.10 (194.80)			
Pathology (Anatomical)	148.00 (129.80)			
Pathology (Clinical)	148.00 (129.80)			
Physical Medicine	222.10 (194.80)			
Plastic and Reconstructive Surgery	148.00 (129.80)			
Psychiatry	176.60 (154.90)	73.60 (64.60)	147.10 (129.00)	

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
Pulmonology	222.10 (194.80)								
Radiation Oncology	148.00 (129.80)								
Radiology	148.00 (129.80)								
Rheumatology	222.10 (194.80)								
Specialists	61.70 (54.10)				111.00 (97.40)				264.40 (231.90)
Surgery	148.00 (129.80)								
Urology	148.00 (129.80)								
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	76.40 (67.00)	10.000	76.40 (67.00)		

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	832.80 (730.50)	109.000	832.80 (730.50)		
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	92.53 (81.17)	7.500	103.73 (90.99)		
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	45.80 (40.20)	6.000	45.80 (40.20)		
0204	Inhalation sedation: Per additional quarter-hour or part thereof	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)		
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	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)		
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)		
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	61.10 (53.60)	8.000	61.10 (53.60)		
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)		
0209	Umbilical artery cannulation at birth	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)		
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	04.00		3.250	24.80 (21.80)	3.250	24.80 (21.80)		
0211	Exchange transfusion: First and subsequent (including after-care)	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)		

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	38.20 (33.50)	5.000	38.20 (33.50)			
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	68.80 (60.40)	9.000	68.80 (60.40)			
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	107.00 (93.90)	14.000	107.00 (93.90)			
1.3	**Oncology related services in non-oncology facilities**									
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	3016.70 (2646.20) Z	315.890	2413.40 (2117.00) 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	2004.80 (1756.60) Z	209.930	1603.90 (1406.90) 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	594.50 (521.50) Z	77.810	594.50 (521.50) 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	325.80 (285.80) Z	42.650	325.80 (285.80) 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	143.86 (126.19)
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	143.86 (126.19)
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	06.04						3.000	143.86 (126.19)
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	143.86 (126.19)
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	143.86 (126.19)
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	47.95 (42.06)
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	95.90 (84.12)
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	06.04						3.000	143.86 (126.19)
5444	Shaft of femur: Add four (4,00) anaesthetic units	06.04						4.000	191.81 (168.25)

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				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	239.76 (210.32)
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	383.62 (336.51)
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	30.60 (26.80)	4.000	30.60 (26.80)		
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	04.00		2.800	21.40 (18.80)	2.800	21.40 (18.80)		
0219	Allergy: Patch tests: Each additional patch	04.00		2.000	15.30 (13.40)	2.000	15.30 (13.40)		
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	04.00		1.900	14.50 (12.70)	1.900	14.50 (12.70)		
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	04.00		2.800	21.40 (18.80)	2.800	21.40 (18.80)		
2.2	**Skin (general)**								
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	04.00		4.000	30.60 (26.80)	4.000	30.60 (26.80)		
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
0225	Epilation: Per session	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
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	61.10 (53.60)	8.000	61.10 (53.60)	4.000	191.80 (168.20) T
0228	PUVA Treatment: Maximum of 21 treatments	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
0229	PUVA: Follow-up or maintenance therapy once a week	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
0230	UVR-Treatment	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
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	42.00 (36.80)	5.500	42.00 (36.80)		
0233	Biopsy without suturing: First lesion	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)	3.000	143.90 (126.20) T
0234	Biopsy without suturing: Subsequent lesions (each)	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)	3.000	143.90 (126.20) T
0235	Biopsy without suturing: Maximum for multiple additional lesions	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)	3.000	143.90 (126.20) T
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	3.000	143.90 (126.20) 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	45.80 (40.20)	6.000	45.80 (40.20)	3.000	143.90 (126.20) T
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)	3.000	143.90 (126.20) T
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	3.000	143.90 (126.20) T
0244	Repair of nail bed	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	3.000	143.90 (126.20) 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	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) 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	53.50 (46.90)	7.000	53.50 (46.90)	3.000	143.90 (126.20) T
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	3.000	143.90 (126.20) T
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) 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	664.70 (583.10)	87.000	664.70 (583.10)	3.000	143.90 (126.20) T
0259	Removal of foreign body superficial to deep fascia (except hands)	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
0261	Removal of foreign body deep to deep fascia (except hands)	04.00		31.000	236.80 (207.70)	31.000	236.80 (207.70)	3.000	143.90 (126.20) T
0271	Kurtin planing for acne scarring: Whole face	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0273	Kurtin planing for acne scarring: Extensive	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	4.000	191.80 (168.20) T
0275	Kurtin planing for acne scarring: Limited	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	4.000	191.80 (168.20) T
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	04.00		103.000	786.90 (690.30)	103.000	786.90 (690.30)	4.000	191.80 (168.20) T
0279	Surgical treatment for axillary hyperhidrosis	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	4.000	191.80 (168.20) T
0280	Laser treatment for small skin lesions: First lesion	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)	3.000	143.90 (126.20) T
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	04.00		56.000	427.80 (375.30)	56.000	427.80 (375.30)	3.000	143.90 (126.20) T
0283	Laser treatment for large skin lesions: Limited area	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	4.000	191.80 (168.20) T
0284	Laser treatment for large skin lesions: Extensive area	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	4.000	191.80 (168.20) T

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	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	04.00		56.630	432.70 (379.60) Z	56.630	432.70 (379.60) Z		
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	04.00		43.440	331.90 (291.10) Z	43.440	331.90 (291.10) Z		
2.3	**Major plastic repair**								
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	04.00		234.000	1787.80 (1568.20)	187.200	1430.20 (1254.60)	4.000	191.80 (168.20) T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	04.00		410.000	3132.40 (2747.70)	328.000	2505.90 (2198.20)	4.000	191.80 (168.20) T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	04.00		800.000	6112.00 (5361.40)	640.000	4889.60 (4289.10)	4.000	191.80 (168.20) T
0292	Distant flaps: First stage	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0293	Contour grafts (excluding cost of material)	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	04.11		1200.000	9168.00 (8042.10)	960.000	7334.40 (6433.70)	6.000	287.70 (252.40) T
0295	Local skin flaps (large, complicated)	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0296	Other procedures of major technical nature	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
0297	Subsequent major procedures for repair of same lesion	04.00		104.000	794.60 (697.00)	104.000	794.60 (697.00)	4.000	191.80 (168.20) T
0298	Lower abdominal dermo-lipectomy	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	5.000	239.80 (210.40) T
0299	Major abdominal lipectomy with repositioning of umbilicus	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	5.000	239.80 (210.40) 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	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)	3.000	143.90 (126.20) T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	4.000	191.80 (168.20) T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
0304	Major debridement of wound, sloughectomy or secondary suture	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) T
0305	Needle biopsy - soft tissue	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	3.000	143.90 (126.20) T
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	3.000	143.90 (126.20) 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	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
0310	Radical excision of nailbed	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	3.000	143.90 (126.20) T
0311	Excision of large benign tumour (more than 5 cm)	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)	3.000	143.90 (126.20) T
0313	Extensive resection for malignant soft tissue tumour including muscle	04.00		283.900	2169.00 (1902.60)	227.120	1735.20 (1522.10)	4.000	191.80 (168.20) T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	04.00		104.000	794.60 (697.00)	104.000	794.60 (697.00)	4.000	191.80 (168.20) T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)	3.000	143.90 (126.20) T
2.5	**Breasts**								
0316	Fine needle aspiration for soft tissue (all areas)	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
0317	Aspiration of cyst or tumour	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) T
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	3.000	143.90 (126.20) T
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	04.00		94.200	719.70 (631.30)	94.200	719.70 (631.30)	3.000	143.90 (126.20) T
0323	Subareolar cone excision of ducts of wedge excision of breast	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) T
0324	Wedge excision of breast and axillary dissection	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	5.000	239.80 (210.40) T
0325	Total mastectomy	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)	5.000	239.80 (210.40) T
0327	Total mastectomy with axillary gland biopsy	04.00		185.000	1413.40 (1239.80)	148.000	1130.70 (991.80)	5.000	239.80 (210.40) T
0329	Total mastectomy with axillary gland dissection	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	5.000	239.80 (210.40) T
0330	Nipple and areola reconstruction	04.00		95.000	725.80 (636.70)	95.000	725.80 (636.70)	4.000	191.80 (168.20) T
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	04.00		234.000	1787.80 (1568.20)	187.200	1430.20 (1254.60)	4.000	191.80 (168.20) T
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	04.00		410.000	3132.40 (2747.70)	328.000	2505.90 (2198.20)	4.000	191.80 (168.20) T
0334	Removal of breast implant by means of capsulectomy: Per breast	04.00		234.000	1787.80 (1568.20)	187.200	1430.20 (1254.60)	4.000	191.80 (168.20) T
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	04.00		234.000	1787.80 (1568.20)	187.200	1430.20 (1254.60)	5.000	239.80 (210.40) T
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	04.00		410.000	3132.40 (2747.70)	328.000	2505.90 (2198.20)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0341	Gynaecomastia: Unilateral	04.00		92.000	702.90 (616.60)	92.000	702.90 (616.60)	3.000	143.90 (126.20) T
0343	Gynaecomastia: Bilateral	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	3.000	143.90 (126.20) T
2.6	**Burns**								
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	04.00		276.000	2108.60 (1849.60)	220.800	1686.90 (1479.70)	5.000	239.80 (210.40) T
0353	Tangential excision and grafting: Small	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	5.000	239.80 (210.40) T
0354	Tangential excision and grafting: Large	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	5.000	239.80 (210.40) 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	1126.10 (987.80)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
0357	Small skin graft in acute hand injury	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
0361	Z-plasty	04.00		220.100	1681.60 (1475.10)	176.080	1345.30 (1180.10)	3.000	143.90 (126.20) T
0363	Local flap and skin graft	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0365	Cross finger flap (all stages)	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
0367	Palmar flap (all stages)	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
0369	Distant flap: First stage	04.00		158.000	1207.10 (1058.90)	126.400	965.70 (847.10)	3.000	143.90 (126.20) T
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) T
0373	Transfer neurovascular island flap	04.00		230.500	1761.00 (1544.70)	184.400	1408.80 (1235.80)	3.000	143.90 (126.20) T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	04.00		242.400	1851.90 (1624.50)	193.920	1481.50 (1299.60)	3.000	143.90 (126.20) T
0375	Dupuytren's contracture: Fasciotomy	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) T
0376	Dupuytren's contracture: Fasciectomy	04.00		218.000	1665.50 (1461.00)	174.400	1332.40 (1168.80)	3.000	143.90 (126.20) 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	76.40 (67.00)	10.000	76.40 (67.00)		
0378	Laser acupuncture using more than 6 points	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0379	Electro-acupuncture	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)		
0380	Scalp acupuncture	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
0381	Micro-acupuncture (ear, hand)	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
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	206.28 (180.95)	27.000	206.28 (180.95)		
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	588.28 (516.04)	77.000	588.28 (516.04)		
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	882.42 (774.05)	115.500	882.42 (774.05)		
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	588.28 (516.04)	77.000	588.28 (516.04)		
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	244.48 (214.46)	32.000	244.48 (214.46)		
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	588.28 (516.04)	77.000	588.28 (516.04)		
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	143.90 (126.20) TM
0387	Fracture (reduction under general anaesthetic): Clavicle	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	04.00		175.700	1342.30 (1177.50)	140.560	1073.90 (942.00)	3.000	143.90 (126.20) TM
0389	Fracture (reduction under general anaesthetic): Humerus	04.00		111.600	852.60 (747.90)	111.600	852.60 (747.90)	3.000	143.90 (126.20) TM
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	3.000	143.90 (126.20) TM
0402	Fracture (reduction under general anaesthetic): Carpal bone	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) TM
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	04.00		118.300	903.80 (792.80)	118.300	903.80 (792.80)	3.000	143.90 (126.20) TM
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) TM
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	04.00		52.000	397.30 (348.50)	52.000	397.30 (348.50)	3.000	143.90 (126.20) TM
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	04.00		48.000	366.70 (321.70)	48.000	366.70 (321.70)	3.000	143.90 (126.20) T
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	04.00		102.000	779.30 (683.60)	102.000	779.30 (683.60)	3.000	143.90 (126.20) TM
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) T
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	04.00		237.000	1810.70 (1588.30)	189.600	1448.50 (1270.60)	3.000	143.90 (126.20) TM
0425	Fracture (reduction under general anaesthetic): Patella	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0433	Fracture (reduction under general anaesthetic): Fibula shaft	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) TM
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	04.00		58.000	443.10 (388.70)	58.000	443.10 (388.70)	3.000	143.90 (126.20) TM
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	04.00		198.700	1518.10 (1331.70)	158.960	1214.50 (1065.40)	3.000	143.90 (126.20) TM
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) TM
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	04.00		403.500	3082.70 (2704.10)	322.500	2463.90 (2161.30)	3.000	143.90 (126.20) TM
0441	Fracture (reduction under general anaesthetic): Metatarsal	04.00		41.800	319.40 (280.20)	41.800	319.40 (280.20)	3.000	143.90 (126.20) TM
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal Simple	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) T
0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0447	Fracture (reduction under general anaesthetic): Other: Simple	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)	3.000	143.90 (126.20) T
0449	Fracture (reduction under general anaesthetic): Other: Compound	04.00		52.000	397.30 (348.50)	52.000	397.30 (348.50)	3.000	143.90 (126.20) TM
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) 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	1757.20 (1541.40)	184.000	1405.80 (1233.20)	3.000	143.90 (126.20) TM
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) TM
0456	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Rest	04.00		-	- ß	-	- ß	3.000	143.90 (126.20) TM
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical	04.00		-	- v	-	- v	3.000	143.90 (126.20) TM
0462	Fracture (reduction under general anaesthetic): Compression fracture: Rest	04.00		-	- v	-	- v	3.000	143.90 (126.20) TM
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical	04.00		-	- v	-	- v	3.000	143.90 (126.20) TM
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest	04.00		-	- v	-	- v	3.000	143.90 (126.20) 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	2200.30 (1930.10)	230.400	1760.30 (1544.10)	3.000	143.90 (126.20) TM
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	04.00		43.000	328.50 (288.20)	43.000	328.50 (288.20)	3.000	143.90 (126.20) T
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	04.00		282.000	2154.50 (1889.90)	225.600	1723.60 (1511.90)	3.000	143.90 (126.20) TM
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	04.00		154.000	1176.60 (1032.10)	123.200	941.20 (825.60)	3.000	143.90 (126.20) 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	2154.50 (1889.90)	225.600	1723.60 (1511.90)	3.000	143.90 (126.20) TM
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits	04.00		340.000	2597.60 (2278.60)	272.000	2078.10 (1822.90)	3.000	143.90 (126.20) TM
0499	Grafts to cysts: Large bones	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) TM
0501	Grafts to cysts: Small bones	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0503	Grafts to cysts: Cartilage graft	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	3.000	143.90 (126.20) TM
0505	Grafts to cysts: Inter-metacarpal bone graft	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) TM
3.1.2.2	**Bony operations: Acute or chronic osteomyelitis**								
0509	Acute or chronic osteomyelitis: Conservative treatment	04.00		-	- v	-	- 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	04.00							
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including six weeks after-care	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
3.1.2.3	**Bony operations: Osteotomy**								
0514	Osteotomy: Sternum: Repair of pectus excavatum	04.00		330.000	2521.20 (2211.60)	264.000	2017.00 (1769.30)	3.000	143.90 (126.20) TM
0515	Osteotomy: Sternum: Repair of pectus carinatum	04.00		330.000	2521.20 (2211.60)	264.000	2017.00 (1769.30)	3.000	143.90 (126.20) TM
0516	Osteotomy: Pelvic	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0521	Osteotomy: Femoral: Proximal	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0527	Osteotomy: Knee region	04.11		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0528	Osteotomy: Os Calcis (Dwyer operation)	04.00		115.000	878.60 (770.70)	115.000	878.60 (770.70)	3.000	143.90 (126.20) TM
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0531	Rotational osteotomy of tibia and fibula - stand alone procedure	04.00		278.900	2130.80 (1869.10)	223.120	1704.60 (1495.30)	3.000	143.90 (126.20) TM
0532	Osteotomy: Rotation osteotomy of the Radius, Ulna or Humerus	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0533	Osteotomy: Single metatarsal	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) TM
0534	Osteotomy: Multiple metatarsal osteotomies	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
3.1.2.4	**Bony operations: Exostosis**								
0535	Exostosis: Excision: Readily accessible sites	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) TM
0537	Exostosis: Excision: Less accessible sites	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
3.1.2.5	**Bony operations: Biopsy**								
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)	4.000	191.80 (168.20) T
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)		
3.2	**Joints**								
3.2.1	**Joints: Dislocations**								
0547	Joint: Dislocation: Clavicle either end	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	3.000	143.90 (126.20) TM
0549	Joint: Dislocation: Shoulder	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM
0551	Joint: Dislocation: Elbow	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM
0552	Joint: Dislocation: Wrist	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation	04.00		130.000	993.20 (871.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0555	Joint: Dislocation: Lunate	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM
0556	Joint: Dislocation: Carpo-metacarpo dislocation	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)	3.000	143.90 (126.20) TM
0559	Joint: Dislocation: Hip	04.00		109.000	832.80 (730.50)	109.000	832.80 (730.50)	3.000	143.90 (126.20) TM
0561	Joint: Dislocation: Knee	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0563	Joint: Dislocation: Patella	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)	3.000	143.90 (126.20) TM
0565	Joint: Dislocation: Ankle	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) TM
0567	Joint: Dislocation: Sub-Talar dislocation	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) TM
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) 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	1528.00 (1340.40)	160.000	1222.40 (1072.30)	3.000	143.90 (126.20) TM
0579	Operations for dislocations: Recurrent dislocation of all other joints	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	3.000	143.90 (126.20) 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	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) TM

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				RVU	Fee	RVU	Fee	RVU	Fee
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0585	Capsulectomy digital joint	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) TM
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) TM
0587	Release of digital joint contracture	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
3.2.4	**Joints: Synovectomy**								
0589	Synovectomy: Digital joint	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) TM
0592	Synovectomy: Large joint	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0593	Tendon synovectomy	04.00		203.700	1556.30 (1365.20)	162.960	1245.00 (1092.10)	3.000	143.90 (126.20) TM
3.2.5	**Joints: Arthrodesis**								
0597	Arthrodesis: Shoulder	04.00		224.000	1711.40 (1501.20)	179.200	1369.10 (1201.00)	3.000	143.90 (126.20) TM
0598	Arthrodesis: Elbow	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
0599	Arthrodesis: Wrist	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
0600	Arthrodesis: Digital joint	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0601	Arthrodesis: Hip	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0602	Arthrodesis: Knee	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
0603	Arthrodesis: Ankle	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
0604	Arthrodesis: Sub-talar	04.00		130.000	993.20 (871.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
0607	Arthrodesis: Mid-tarsal wedge resection	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	3.000	143.90 (126.20) TM
3.2.6	**Joints: Arthroplasty**								
0614	Arthroplasty: Debridement large joints	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0615	Arthroplasty: Excision medial or lateral end of clavicle	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	3.000	143.90 (126.20) TM
0617	Shoulder: Acromioplasty	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0619	Shoulder: Partial replacement	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	5.000	239.80 (210.40) TM
0620	Shoulder: Total replacement	04.00		416.000	3178.20 (2787.90)	332.800	2542.60 (2230.40)	5.000	239.80 (210.40) TM
0621	Elbow: Excision head of radius	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0622	Elbow: Excision	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) TM
0623	Elbow: Partial replacement	04.00		188.000	1436.30 (1259.90)	150.400	1149.10 (1008.00)	3.000	143.90 (126.20) TM
0624	Elbow: Total replacement	04.00		282.000	2154.50 (1889.90)	225.600	1723.60 (1511.90)	3.000	143.90 (126.20) TM
0625	Wrist: Excision distal end of ulna	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0626	Wrist: Excision single bone	04.00		110.000	840.40 (737.20)	110.000	840.40 (737.20)	3.000	143.90 (126.20) TM
0627	Wrist: Excision proximal row	04.00		166.000	1268.20 (1112.50)	132.800	1014.60 (890.00)	3.000	143.90 (126.20) TM
0631	Wrist: Total replacement	04.00		249.000	1902.40 (1668.80)	199.200	1521.90 (1335.00)	3.000	143.90 (126.20) TM
0635	Digital Joint: Total replacement	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) TM
0637	Hip: Total replacement	04.00		416.000	3178.20 (2787.90)	332.800	2542.60 (2230.40)	3.000	143.90 (126.20) TM
0641	Hip: Prosthetic replacement of femoral head	04.00		288.000	2200.30 (1930.10)	230.400	1760.30 (1544.10)	3.000	143.90 (126.20) TM
0643	Hip: Girdlestone	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
0645	Knee: Partial replacement	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	3.000	143.90 (126.20) TM
0646	Knee: Total replacement	04.00		416.000	3178.20 (2787.90)	332.800	2542.60 (2230.40)	3.000	143.90 (126.20) TM
0649	Ankle: Total replacement	04.00		290.400	2218.70 (1946.20)	232.320	1774.90 (1556.90)	3.000	143.90 (126.20) TM
0650	Ankle: Astragalectomy	04.00		154.000	1176.60 (1032.10)	123.200	941.20 (825.60)	3.000	143.90 (126.20) 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	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) T
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint	04.00		7.500	57.30 (50.30)	7.500	57.30 (50.30)	3.000	143.90 (126.20) T
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	04.00		4.000	30.60 (26.80)	4.000	30.60 (26.80)	3.000	143.90 (126.20) T
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0669	Manipulation knee or shoulder joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	09.01		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
0669A	Manipulation hip joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	09.01		14.000	107.00 (93.90)	14.000	107.00 (93.90)	4.000	191.80 (168.20) T
	Only the consultation fee should be charged when manipulation of a large joint is performed without general anaesthetic	09.01							
0673	Meniscectomy or operation for other internal derangement of knee	04.00		109.000	832.80 (730.50)	109.000	832.80 (730.50)	3.000	143.90 (126.20) TM
3.2.8	**Joints: Joint ligament reconstruction or suture**								
0675	Joint ligament reconstruction or suture: Ankle: Collateral	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0677	Joint ligament reconstruction or suture: Knee: Collateral	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0678	Joint ligament reconstruction or suture: Knee: Cruciate	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	3.000	143.90 (126.20) TM
0680	Joint ligament reconstruction or suture: Digital joint ligament	04.00		165.000	1260.60 (1105.80)	132.000	1008.50 (884.60)	3.000	143.90 (126.20) TM
3.3	**Amputations**								
3.3.1	**Amputations: Specific Amputations**								
0682	Amputation: Fore-quarter amputation	04.00		294.000	2246.20 (1970.40)	235.200	1796.90 (1576.20)	9.000	431.60 (378.60) TM
0683	Amputation: Through shoulder	04.00		148.000	1130.70 (991.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) TM
0685	Amputation: Upper arm or fore-arm	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	3.000	143.90 (126.20) TM
0687	Partial amputation of the hand: One ray	04.00		102.000	779.30 (683.60)	102.000	779.30 (683.60)	3.000	143.90 (126.20) TM
0691	Amputation: Whole or part of finger	06.04		116.800	892.40 (782.80)	116.800	892.40 (782.80)	3.000	143.90 (126.20) TM
0693	Hindquarter amputation	04.00		420.000	3208.80 (2814.70)	336.000	2567.00 (2251.80)	6.000	287.70 (252.40) TM
0695	Amputation: Through hip joint region	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	6.000	287.70 (252.40) TM
0697	Amputation: Through thigh	04.00		205.000	1566.20 (1373.90)	164.000	1253.00 (1099.10)	6.000	287.70 (252.40) TM
0699	Amputation: Below knee, through knee or Syme	04.00		194.000	1482.20 (1300.20)	155.200	1185.70 (1040.10)	5.000	239.80 (210.40) TM
0701	Amputation: Trans-metatarsal or trans-tarsal	04.00		142.000	1084.90 (951.70)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0703	Amputation: Foot: One ray	04.00		97.000	741.10 (650.10)	97.000	741.10 (650.10)	3.000	143.90 (126.20) TM
0705	Amputation: Toe	04.00		66.000	504.20 (442.30)	66.000	504.20 (442.30)	3.000	143.90 (126.20) TM

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				RVU	Fee	RVU	Fee	RVU	Fee
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	573.00 (502.60)	75.000	573.00 (502.60)	3.000	143.90 (126.20) TM
0707	Post-amputation reconstruction: Krukenberg reconstruction	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	3.000	143.90 (126.20) TM
0709	Post-amputation reconstruction: Metacarpal transfer	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) TM
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	04.00		282.000	2154.50 (1889.90)	225.600	1723.60 (1511.90)	3.000	143.90 (126.20) TM
0712	Post-amputation reconstruction: Toe to thumb transfer	04.00		800.000	6112.00 (5361.40)	640.000	4889.60 (4289.10)	3.000	143.90 (126.20) TM
3.4	**Muscles, tendons and fasciae**								
3.4.1	**Muscles, tendons and fasciae: Investigations**								
0713	Electromyography	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	3.000	143.90 (126.20) T
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)	06.04		57.000	435.50 (382.00)	57.000	435.50 (382.00)	3.000	143.90 (126.20) T
0715	Strength duration curve per session	04.00		10.500	80.20 (70.40)	10.500	80.20 (70.40)	3.000	143.90 (126.20) T
0717	Electrical examination of single nerve or muscle	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) T
0718	Oxidative study for mitochondrial function	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)		
0721	Voltage integration during isometric contraction	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	3.000	143.90 (126.20) T
0723	Tonometry with edrophonium	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)	3.000	143.90 (126.20) T
0725	Isometric tension studies with edrophonium	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)	3.000	143.90 (126.20) T
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
0729	Tendon reflex time	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)	3.000	143.90 (126.20) T
0730	Limb brain somatosensory studies (per limb)	04.00		49.000	374.40 (328.40)	49.000	374.40 (328.40)		
0731	Vision and audio-sensory studies	04.00		49.000	374.40 (328.40)	49.000	374.40 (328.40)		
0733	Motor nerve conduction studies (single nerve)	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)		
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	04.00		31.000	236.80 (207.70)	31.000	236.80 (207.70)	3.000	143.90 (126.20) T

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				RVU	Fee	RVU	Fee	RVU	Fee
0737	Biopsy for motor nerve terminals and end plates	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	04.00		34.000	259.80 (227.90)	34.000	259.80 (227.90)	8.000	383.60 (336.50) T
0740	Muscle fatigue studies	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
0741	Muscle biopsy	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	8.000	383.60 (336.50) T
0742	Global fee for all muscle studies, including histochemical studies	04.00		262.000	2001.70 (1755.90)				
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	04.00		20.250	154.70 (135.70)				
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	04.00		33.300	254.40 (223.20)				
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	04.00		5.700	43.50 (38.20)				
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	04.00		1.600	12.20 (10.70)				
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	04.00		9.900	75.60 (66.30)				
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	04.00		13.700	104.70 (91.80)				
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	04.00		25.900	197.90 (173.60)				
4715	Biochemical estimations on muscle biopsy specimens: Enolase	04.00		32.700	249.80 (219.10)				
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	04.00		37.700	288.00 (252.60)				
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	04.00		15.750	120.30 (105.50)				
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	04.00		11.060	84.50 (74.10)				
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	04.00		34.700	265.10 (232.50)				
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	04.00		40.300	307.90 (270.10)				
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose isomerase	04.00		28.800	220.00 (193.00)				
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	04.00		43.000	328.50 (288.20)				
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	04.00		14.000	107.00 (93.90)				
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	04.00		20.000	152.80 (134.00)				
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	04.00		71.000	542.40 (475.80)				
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	04.00		69.000	527.20 (462.50)				

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	626.50 (549.60)				
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	04.00		143.000	1092.50 (958.30)				
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	04.00		75.000	573.00 (502.60)				
3.4.2	**Muscles, tendons and fasciae: Decompression Operations**								
0743	Major compartmental decompression	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0744	Decompression operation: Fasciotomy only	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) T
3.4.3	**Muscles, tendons and fasciae: Muscle and tendon repair**								
0745	Muscle and tendon repair: Biceps humeri	04.00		109.000	832.80 (730.50)	109.000	832.80 (730.50)	3.000	143.90 (126.20) T
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0747	Muscle and tendon repair: Rotator cuff	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
0748	Muscle and tendon repair: Debridement rotator cuff	04.00		139.700	1067.30 (936.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	04.00		271.900	2077.30 (1822.20)	217.520	1661.90 (1457.80)	4.000	191.80 (168.20) T
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0757	Muscle and tendon repair: Achilles tendon repair	04.00		197.600	1509.70 (1324.30)	158.080	1207.70 (1059.40)	4.000	191.80 (168.20) T
0759	Muscle and tendon repair: Other single tendon	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	3.000	143.90 (126.20) T
0763	Muscle and tendon repair: Tendon or ligament injection	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) T
0767	Hand: Flexor tendon suture: Primary (per tendon)	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0769	Hand: Flexor tendon suture: Secondary (per tendon)	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) T
0771	Extensor tendon suture: Primary (per tendon)	04.00		129.700	990.90 (869.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0773	Extensor tendon suture: Secondary (per tendon)	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	3.000	143.90 (126.20) T
0774	Repair of Boutonniere deformity or Mallet finger with graft	04.00		183.700	1403.50 (1231.10)	146.960	1122.80 (984.90)	3.000	143.90 (126.20) T
3.4.4	**Muscles, tendons and fasciae: Tendon graft**								
0775	Free tendon graft	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) 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	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) T
0777	Tendon graft: Finger: Flexor	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
0779	Tendon graft: Finger: Extensor	04.00		122.000	932.10 (817.60)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0780	Two stage flexor tendon graft using silastic rod	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	3.000	143.90 (126.20) T
3.4.5	**Muscles, tendons and fasciae: Tendolysis**								
0781	Tendon freeing operation, except where specified elsewhere	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) T
0782	Carpal tunnel syndrome	04.00		98.700	754.10 (661.50)	98.700	754.10 (661.50)	3.000	143.90 (126.20) T
0783	Tenolysis: De Quervain	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	3.000	143.90 (126.20) T
0784	Trigger finger	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	3.000	143.90 (126.20) T
0785	Flexor tendon freeing operation following free tendon graft or suture	04.00		186.800	1427.20 (1251.90)	149.440	1141.70 (1001.50)	3.000	143.90 (126.20) T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	04.00		180.900	1382.10 (1212.40)	144.720	1105.70 (969.90)	3.000	143.90 (126.20) T
0788	Intrinsic tendon release per finger	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) T
0789	Central tendon tenotomy for Boutonniere deformity	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) T
3.4.6	**Muscles, tendons and fasciae: Tenodesis**								
0790	Tenodesis: Digital joint	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) T
3.4.7	**Muscles, tendons and fasciae: Muscle tendon and facia transfer**								
0791	Single tendon transfer	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T
0792	Multiple tendon transfer	04.00		128.000	977.90 (857.60)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0793	Hamstring to quadriceps transfer	04.00		141.000	1077.20 (944.90)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	5.000	239.80 (210.40) T
0795	Tendon transfer at elbow	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	3.000	143.90 (126.20) T
0802	Radial club hand repair - stand alone procedure	04.00		360.300	2752.70 (2414.60)	288.240	2202.20 (1931.80)	3.000	143.90 (126.20) T
0803	Hand tendons: Single tendon transfer (first)	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T

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				RVU	Fee	RVU	Fee	RVU	Fee
0809	Hand tendons: Substitution for intrinsic paralysis of hand	04.00		224.000	1711.40 (1501.20)	179.200	1369.10 (1201.00)	3.000	143.90 (126.20) T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	04.00		220.600	1685.40 (1478.40)	176.480	1348.30 (1182.70)	3.000	143.90 (126.20) T
3.4.8	**Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening**								
0812	Percutaneous Tenotomy: All sites	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	3.000	143.90 (126.20) T
0813	Torticollis	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	5.000	239.80 (210.40) T
0815	Scalenotomy	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
0817	Scalenotomy with excision of first rib	04.00		190.000	1451.60 (1273.30)	152.000	1161.30 (1018.70)	3.000	143.90 (126.20) TM
0821	Tennis elbow	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T
0822	Open release elbow (Mitals) - stand alone procedure	04.00		278.200	2125.40 (1864.40)	222.560	1700.40 (1491.60)	3.000	143.90 (126.20) TM
0823	Excision or slide for Volkmann's Contracture	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
0825	Hip: Open muscle release	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	7.000	335.70 (294.50) T
0829	Knee: Quadriceps plasty	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) T
0831	Knee: Open tenotomy	04.00		141.000	1077.20 (944.90)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
0835	Calf	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	4.000	191.80 (168.20) T
0837	Open elongation tendon Achilles	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	4.000	191.80 (168.20) T
0838	Percutaneous "Hoke" elongation tendo Achilles	04.00		79.300	605.90 (531.50)	79.300	605.90 (531.50)	4.000	191.80 (168.20) T
0845	Foot: Plantar fasciotomy	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	3.000	143.90 (126.20) T
0846	Foot: Postero-medial release for club-foot	04.00		192.000	1466.90 (1286.80)	153.600	1173.50 (1029.40)	3.000	143.90 (126.20) T
3.5	**Bursae and ganglia**								
0847	Excision: Semimembranosus	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	4.000	191.80 (168.20) T
0849	Excision: Prepatellar	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
0851	Excision: Olecranon	04.00		81.800	625.00 (548.20)	81.800	625.00 (548.20)	3.000	143.90 (126.20) T
0853	Excision: Small bursa or ganglion	04.00		80.900	618.10 (542.20)	80.900	618.10 (542.20)	3.000	143.90 (126.20) 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	977.90 (857.80)	128.000	977.90 (857.80)	3.000	143.90 (126.20) T
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) 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	2154.50 (1889.90)	225.600	1723.60 (1511.90)	3.000	143.90 (126.20) TM
0861	Leg equalisation and congenital hips and feet: Leg lengthening	04.00		416.000	3178.20 (2787.90)	332.800	2542.60 (2230.40)	3.000	143.90 (126.20) TM
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	3.000	143.90 (126.20) TM
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip	04.00		109.000	832.80 (730.50)	109.000	832.80 (730.50)	3.000	143.90 (126.20) TM
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips	06.04		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0868	Open reduction of congenital dislocation of the hip	04.00		186.000	1421.00 (1246.50)	148.800	1136.80 (997.20)	3.000	143.90 (126.20) TM
0869	Subsequent plasters	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)		
0873	Congenital club foot: Manipulation and plaster: One foot	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)	3.000	143.90 (126.20) T
0874	Ponseti technique assistant (medical practitioner)	05.03		13.000	99.30 (87.10) Z	13.000	99.30 (87.10) 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	279.60 (245.30)	36.600	279.60 (245.30)	3.000	143.90 (126.20)
0884	Removal of internal fixatives: Less accessible	04.00		75.500	576.80 (506.00)	75.500	576.80 (506.00)	3.000	143.90 (126.20)
0885	Removal of prosthesis for infection soon after operation	04.00		128.000	977.90 (857.80)	120.000	916.80 (804.20)	6.000	287.70 (252.40)
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	04.00	+	64.000	489.00 (428.90)	64.000	489.00 (428.90)	6.000	287.70 (252.40) TM
3.7	**Plasters (exclusive of after-care)**								
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)	04.00		13.000	99.30 (87.10) ò	13.000	99.30 (87.10) ò	3.000	143.90 (126.20) T
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)	4.000	191.80 (168.20) T
0891	Turnbuckle cast for scoliosis (excluding after-care)	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	5.000	239.80 (210.40) T
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	04.00		19.000	145.20 (127.40)	19.000	145.20 (127.40)	5.000	239.80 (210.40) 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	2312.60 (2028.60)	242.160	1850.10 (1622.90)	3.000	143.90 (126.20) TM
0896	Club foot: Posterior release only - stand alone procedure	04.00		159.300	1217.10 (1067.60)	127.440	973.60 (854.00)	3.000	143.90 (126.20) TM
0900	Excision tarsal coalition - stand alone procedure	04.00		141.500	1081.10 (948.30)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0901	Tenotomy: Single tendon	04.00		63.300	483.60 (424.20)	63.300	483.60 (424.20)	3.000	143.90 (126.20) TM
0903	Hammer toe: One toe	04.00		99.500	760.20 (666.80)	99.500	760.20 (666.80)	3.000	143.90 (126.20) TM
0905	Filleting of toe or Ruiz-Mora procedure	04.00		99.500	760.20 (666.80)	99.500	760.20 (666.80)	3.000	143.90 (126.20) TM
0906	Arthrodesis Hallux	04.00		148.000	1130.70 (991.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0907	Silver bunionectomy or similar for Hallux Valgus	04.00		126.200	964.20 (845.80)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
	Not to be charged with item 0911	09.01							
0909	Excision arthroplasty	04.00		145.200	1109.30 (973.10)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
0910	Cheilectomy or metatarsophangeal implant Hallux	04.00		183.000	1398.10 (1226.40)	146.400	1118.50 (981.10)	3.000	143.90 (126.20) TM
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	04.00		189.200	1445.50 (1268.00)	151.360	1156.40 (1014.40)	3.000	143.90 (126.20) TM
	Not to be charged with item 0907	09.01							
5730	Hallux Valgus double osteotomy etc.	04.00		182.600	1395.10 (1223.80)	146.080	1116.10 (979.00)	3.000	143.90 (126.20) TM
5731	Distal soft tissue procedure for Hallux Valgus	04.00		173.600	1326.30 (1163.40)	138.880	1061.00 (930.70)	3.000	143.90 (126.20) TM
5732	Aitkin procedure or similar	04.00		166.800	1274.40 (1117.90)	133.440	1019.50 (894.30)	3.000	143.90 (126.20) T
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	3.000	143.90 (126.20) TM
5735	Repair angular deformity toe (lesser toes)	04.00		97.200	742.60 (651.40)	97.200	742.60 (651.40)	3.000	143.90 (126.20) TM
5736	Sesamoidectomy	04.00		97.800	747.20 (655.40)	97.800	747.20 (655.40)	3.000	143.90 (126.20) TM
5737	Repair major foot tendons e.g. Tib Post	04.00		147.300	1125.40 (987.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
5738	Repair of dislocating peroneal tendons	04.00		173.200	1323.20 (1160.70)	138.560	1058.60 (928.60)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot	04.00		202.300	1545.60 (1355.80)	161.840	1236.50 (1084.60)	3.000	143.90 (126.20) TM
5740	Steindler strip - plantar fascia	04.00		97.200	742.60 (651.40)	97.200	742.60 (651.40)	3.000	143.90 (126.20) T
5741	Kelikian syndactilly (one web space)	04.00		97.200	742.60 (651.40)	97.200	742.60 (651.40)	3.000	143.90 (126.20) T
5742	Tendon transfer foot	04.00		172.000	1314.10 (1152.70)	137.600	1051.30 (922.20)	3.000	143.90 (126.20) T
5743	Capsulotomy metatarsophalangeal joints: Foot	04.00		86.800	663.20 (581.80)	86.800	663.20 (581.80)	3.000	143.90 (126.20) 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	5577.20 (4892.30)	584.000	4461.80 (3913.90)	3.000	143.90 (126.20) TM
0913	Replantation of thumb	04.00		670.000	5118.80 (4490.20)	536.000	4095.00 (3592.10)	3.000	143.90 (126.20) TM
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	04.00		580.000	4431.20 (3887.00)	464.000	3545.00 (3109.60)	3.000	143.90 (126.20) TM
0915	Replantation operation through the palm	04.00		1270.000	9702.80 (8511.20)	1016.000	7762.20 (6808.90)	3.000	143.90 (126.20) TM
3.8.4	**Special areas: Hands: (Note: Skin: See Integumentary System)**								
0919	Tumours: Epidermoid cysts	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) TM
0920	Tumours: Ganglion or fibroma	04.00		77.500	592.10 (519.40)	77.500	592.10 (519.40)	3.000	143.90 (126.20) TM
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)	04.00		86.000	657.00 (576.30)	86.000	657.00 (576.30)	3.000	143.90 (126.20) TM
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	04.00		19.000	145.20 (127.40)	19.000	145.20 (127.40)	3.000	143.90 (126.20) TM
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)	3.000	143.90 (126.20) TM
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum	05.01		37.000	282.70 (248.00)	37.000	282.70 (248.00)	3.000	143.90 (126.20) 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	122.20 (107.20)	16.000	122.20 (107.20)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	1581.50 (1387.30)	165.600	1265.20 (1109.80)	3.000	143.90 (126.20) TM
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	04.00	+	42.000	320.90 (281.50)	42.000	320.90 (281.50)	3.000	143.90 (126.20) TM
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	5.000	239.80 (210.40) TM
0930	Posterior osteotomy of spine: One vertebral segment	04.00		339.000	2590.00 (2271.90)	271.200	2072.00 (1817.50)	3.000	143.90 (126.20) TM
0931	Posterior spinal fusion: One level	04.00		385.000	2941.40 (2580.20)	308.000	2353.10 (2064.10)	3.000	143.90 (126.20) TM
0932	Posterior osteotomy of spine: Each additional vertebral segment	04.00	+	103.000	786.90 (690.30)	103.000	786.90 (690.30)	3.000	143.90 (126.20) TM
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	04.00		315.000	2406.60 (2111.10)	252.000	1925.30 (1688.90)	3.000	143.90 (126.20) TM
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	04.00	+	103.000	786.90 (690.30)	103.000	786.90 (690.30)	3.000	143.90 (126.20) TM
0938	Anterior fusion base of skull to C2	04.00		449.000	3430.40 (3009.10)	359.200	2744.30 (2407.30)	4.000	191.80 (168.20) TM
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	3.000	143.90 (126.20) TM
0941	Anterior interbody fusion: One level	04.00		360.000	2750.40 (2412.60)	288.000	2200.30 (1930.10)	3.000	143.90 (126.20) TM
0942	Anterior interbody fusion: Each additional level	04.00	+	102.000	779.30 (683.60)	102.000	779.30 (683.60)	3.000	143.90 (126.20) TM
0944	Posterior fusion: Occiput to C2	04.00		390.000	2979.60 (2613.70)	312.000	2383.70 (2091.00)	4.000	191.80 (168.20) TM
0946	Posterior spinal fusion: Each additional level	04.00	+	111.000	848.00 (743.90)	111.000	848.00 (743.90)	3.000	143.90 (126.20) TM
0948	Posterior interbody lumbar fusion: One level	04.00		364.000	2781.00 (2439.50)	291.200	2224.80 (1951.60)	3.000	143.90 (126.20) TM
0950	Posterior interbody lumbar fusion: Each additional interspace	04.00	+	95.000	725.80 (636.70)	95.000	725.80 (636.70)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0959	Excision of coccyx	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) TM
0961	Costo-transversectomy	04.00		198.000	1512.70 (1326.90)	158.400	1210.20 (1061.60)	3.000	143.90 (126.20) TM
0963	Antero-lateral decompression of spinal cord or anterior debridement	04.00		326.000	2490.60 (2184.70)	260.800	1992.50 (1747.80)	3.000	143.90 (126.20) T
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								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
0952	Posterior fusion for spinal deformity: Up to 6 levels	04.00		359.000	2742.80 (2406.00)	287.200	2194.20 (1924.70)	3.000	143.90 (126.20) TM
0954	Posterior fusion for spinal deformity: 7 to 12 levels	04.00		547.000	4179.10 (3665.90)	437.600	3343.30 (2932.70)	3.000	143.90 (126.20) TM
0955	Posterior fusion for spinal deformity: 13 or more levels	04.00		593.000	4530.50 (3974.10)	474.400	3624.40 (3179.30)	3.000	143.90 (126.20) TM
0956	Anterior fusion for spinal deformity: 2 or 3 levels	04.00		410.000	3132.40 (2747.70)	328.000	2505.90 (2198.20)	3.000	143.90 (126.20) TM
0957	Anterior fusion for spinal deformity: 4 to 7 levels	04.00		444.000	3392.20 (2975.60)	355.200	2713.70 (2380.40)	3.000	143.90 (126.20) TM
0958	Anterior fusion for spinal deformity: 8 or more levels	04.00		539.000	4118.00 (3612.30)	431.200	3294.40 (2889.80)	3.000	143.90 (126.20) 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	1833.60 (1608.40)	192.000	1466.90 (1286.80)	3.000	143.90 (126.20) TM
0960	Posterior non-segmental instrumentation	04.00		167.000	1275.90 (1119.20)	133.600	1020.70 (895.40)	5.000	239.80 (210.40) TM
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	04.00		176.000	1344.60 (1179.50)	140.800	1075.70 (943.60)	5.000	239.80 (210.40) TM
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	04.00		201.000	1535.60 (1347.00)	160.800	1228.50 (1077.60)	5.000	239.80 (210.40) TM
0966	Posterior segmental instrumentation:13 or more vertebrae	04.00		245.000	1871.80 (1641.90)	196.000	1497.40 (1313.50)	5.000	239.80 (210.40) TM
0968	Anterior instrumentation: 2 to 3 vertebrae	04.00		159.000	1214.80 (1065.60)	127.200	971.80 (852.50)	5.000	239.80 (210.40) TM
0969	Skull or skull-femoral traction including two weeks after-care	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)		
0970	Anterior instrumentation: 4 to 7 vertebrae	04.00		185.000	1413.40 (1239.80)	148.000	1130.70 (991.80)	5.000	239.80 (210.40) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0971	Halo-splint and POP jacket including two weeks after-care	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)		
0972	Anterior instrumentation: 8 or more vertebrae	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	5.000	239.80 (210.40) TM
0974	Additional pelvic fixation of instrumentation other than sacrum	04.00		108.000	825.10 (723.80)	108.000	825.10 (723.80)	5.000	239.80 (210.40) TM
5750	Reinsertion of instrumentation	04.00		276.000	2108.60 (1849.60)	220.800	1686.90 (1479.70)	6.000	287.70 (252.40) TM
5751	Removal of posterior non-segmental instrumentation	04.00		173.000	1321.70 (1159.40)	138.400	1057.40 (927.50)	6.000	287.70 (252.40) TM
5752	Removal of posterior segmental instrumentation	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	6.000	287.70 (252.40) TM
5753	Removal of anterior instrumentation	04.00		204.000	1558.60 (1367.20)	163.200	1246.80 (1093.70)	6.000	287.70 (252.40) TM
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	04.00		295.000	2253.80 (1977.00)	236.000	1803.00 (1581.60)	3.000	143.90 (126.20) TM
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	04.00		304.000	2322.60 (2037.40)	243.200	1858.00 (1629.80)	3.000	143.90 (126.20) TM
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	04.00		321.000	2452.40 (2151.20)	256.800	1962.00 (1721.10)	3.000	143.90 (126.20) TM
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	04.00	+	63.000	481.30 (422.20)	63.000	481.30 (422.20)	3.000	143.90 (126.20) TM
5759	Laminectomy for decompression diskectomy, etc. revision operation	04.00		352.000	2689.30 (2359.00)	281.600	2151.40 (1887.20)	4.000	191.80 (168.20) TM
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	04.00		301.000	2299.60 (2017.20)	240.800	1839.70 (1613.80)	3.000	143.90 (126.20) TM
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	04.00	+	68.000	519.50 (455.70)	68.000	519.50 (455.70)	3.000	143.90 (126.20) TM
5763	Anterior disc removal and spinal decompression cervical: One level	04.00		344.000	2628.20 (2305.40)	275.200	2102.50 (1844.30)	3.000	143.90 (126.20) TM
5764	Anterior disc removal and spinal decompression cervical: Each additional level	04.00	+	81.000	618.80 (542.80)	81.000	618.80 (542.80)	3.000	143.90 (126.20) TM
5765	Vertebral corpectomy for spinal decompression: One level	04.00		466.000	3560.20 (3123.00)	372.800	2848.20 (2498.40)	3.000	143.90 (126.20) TM
5766	Vertebral corpectomy for spinal decompression: Each additional level	04.00		88.000	672.30 (589.70)	88.000	672.30 (589.70)	3.000	143.90 (126.20) TM
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	04.00		71.000	542.40 (475.80)	71.000	542.40 (475.80)		
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	1410.30 (1237.10)	147.680	1128.30 (989.70)	4.000	191.80 (168.20) TM
0988	Genioplasty	04.00		263.000	2009.30 (1762.50)	210.400	1607.50 (1410.10)	4.000	191.80 (168.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	04.00		202.200	1544.80 (1355.10)	161.760	1235.80 (1084.00)	4.000	191.80 (168.20) TM
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	04.00		302.000	2307.30 (2023.90)	241.600	1845.80 (1619.10)	4.000	191.80 (168.20) TM
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	04.00		433.000	3308.10 (2901.80)	346.400	2646.50 (2321.50)	4.000	191.80 (168.20) TM
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	04.00		970.000	7410.80 (6500.70)	776.000	5926.60 (5200.50)	4.000	191.80 (168.20) TM
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	04.00		302.000	2307.30 (2023.90)	241.600	1845.80 (1619.10)	4.000	191.80 (168.20) TM
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	04.00		1103.000	8426.90 (7392.00)	882.400	6741.50 (5913.60)	4.000	191.80 (168.20) TM
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	04.00		1654.000	12636.60 (11084.70)	1323.200	10109.20 (8867.70)	4.000	191.80 (168.20) 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	2307.30 (2023.90)	241.600	1845.80 (1619.10)	3.000	143.90 (126.20) TM
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	04.00		184.000	1405.80 (1233.20)	147.200	1124.60 (986.50)	3.000	143.90 (126.20) TM
1001	Temporo-mandibular joint: Reconstruction for dysfunction	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) TM
1003	Manipulation: Immobilisation and follow-up of fractured nose	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) TM
1005	Nasal fracture without manipulation	04.00		-	- F	-	- F		
1007	Mandibulectomy	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	5.000	239.80 (210.40) TM
1009	Maxillectomy	04.00		382.500	2922.30 (2563.40)	306.000	2337.80 (2050.70)	4.000	191.80 (168.20) TM
1011	Bone graft to mandible	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) TM
1012	Adjustment of occlusion by ramisection	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	4.000	191.80 (168.20) 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	1000.80 (877.90)	120.000	916.80 (804.20)	3.000	143.90 (126.20) TM
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	04.00		262.000	2001.70 (1755.90)	209.600	1601.30 (1404.60)	3.000	143.90 (126.20) TM
4	**Respiratory System**								
4.1	**Nose and sinuses**								
1018	Flexible nasopharyngolaryngoscope examination	04.00		51.940	396.80 (348.10)	51.940	396.80 (348.10)		
1019	ENT endoscopy in rooms with rigid endoscope	04.00		12.000	91.70 (80.40)				
1020	Repair of perforated septum: Any method	06.04		141.900	1084.10 (951.00)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1022	Functional reconstruction of nasal septum	04.00		121.200	926.00 (812.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	4.000	191.80 (168.20) T
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	06.04		64.600	493.50 (432.90)	64.600	493.50 (432.90)	4.000	191.80 (168.20) T
1027	Dacrocystorhinostomy	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	06.04		62.600	478.30 (419.60)	62.600	478.30 (419.60)	4.000	191.80 (168.20) T
1030	Endoscopic turbinectomy: Laser or microdebrider	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	5.000	239.80 (210.40) T
1031	Removal of single nasal polyp at rooms (at initial consultation only)	04.00		25.400	194.10 (170.30)	25.400	194.10 (170.30)		
1033	Removal of multiple polyps in hospital under general anaesthetic	04.00		81.800	625.00 (548.20)	81.800	625.00 (548.20)	4.000	191.80 (168.20) T
1034	Autogenous nasal bone transplant: Bone removal included	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	4.000	191.80 (168.20) T
1035	Functional endoscopic sinus surgery: Unilateral	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1036	Functional endoscopic sinus surgery: Bilateral	04.00		245.000	1871.80 (1641.90)	196.000	1497.40 (1313.50)	4.000	191.80 (168.20) T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	4.000	191.80 (168.20) T
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	6.000	287.70 (252.40) T
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	6.000	287.70 (252.40) T
1045	Ligation anterior ethmoidal artery	04.00		135.400	1034.50 (907.50)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
1047	Caldwell-Luc operation: Unilateral	04.00		137.300	1049.00 (920.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1049	Ligation internal maxillary artery	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	6.000	287.70 (252.40) T
1050	Vidian neurectomy (transantral or transnasal)	04.00		113.000	863.30 (757.30)	113.000	863.30 (757.30)	4.000	191.80 (168.20) T
1051	Removal nasopharyngeal fibroma	04.00		285.000	2177.40 (1910.00)	228.000	1741.90 (1528.00)	6.000	287.70 (252.40) T
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
1053	Frontal sinus drainage, trephine operation	04.00		93.100	711.30 (623.90)	93.100	711.30 (623.90)	4.000	191.80 (168.20) T
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	06.04		37.300	285.00 (250.00)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1055	External frontal ethmoidectomy	04.00		190.700	1456.90 (1278.00)	152.560	1165.60 (1022.50)	4.000	191.80 (168.20) T
1057	External ethmoidectomy and/or sphenoidectomy	04.00		199.400	1523.40 (1336.30)	159.520	1218.70 (1069.00)	4.000	191.80 (168.20) T
1058	Sublabial transseptal sphenoidotomy	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1059	Frontal osteomyelitis	04.00		194.000	1482.20 (1300.20)	155.200	1185.70 (1040.10)	4.000	191.80 (168.20) T
1060	Obliteration of frontal sinus	04.00		291.100	2224.00 (1950.90)	232.880	1779.20 (1560.70)	4.000	191.80 (168.20) T
1061	Lateral rhinotomy	04.00		164.000	1253.00 (1099.10)	131.200	1002.40 (879.30)	4.000	191.80 (168.20) T
1062	Excision nasolabial cyst	04.00		186.100	1421.80 (1247.20)	148.880	1137.40 (997.70)	4.000	191.80 (168.20) T
1063	Removal of foreign bodies from nose: At rooms	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
1065	Removal of foreign body from nose: Under general anaesthetic	04.00		38.600	294.90 (258.70)	38.600	294.90 (258.70)	4.000	191.80 (168.20) T
1067	Proof puncture at rooms: Unilateral	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
1069	Proof puncture, uni- or bilateral under general anaesthetic	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	4.000	191.80 (168.20) T
1071	Proetz treatment (consultation fee only to be charged for first treatment)	04.00		4.000	30.60 (26.80)	4.000	30.60 (26.80)		
1077	Septum abscess: At rooms, including after-care	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
1079	Septum abscess: Under general anaesthetic	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	4.000	191.80 (168.20) T
1081	Oro-antral fistula (without Caldwell-Luc)	04.00		111.800	854.20 (749.30)	111.800	854.20 (749.30)	4.000	191.80 (168.20) T
1083	Choanal atresia: Intranasal approach	04.00		113.000	863.30 (757.30)	113.000	863.30 (757.30)	5.000	239.80 (210.40) T
1084	Choanal atresia: Transpalatal approach	04.00		194.000	1482.20 (1300.20)	155.200	1185.70 (1040.10)	7.000	335.70 (294.50) T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	5.000	239.80 (210.40) T
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
1089	Forehead rhinoplasty (all stages): Total	04.00		552.000	4217.30 (3699.40)	441.600	3373.80 (2959.50)	5.000	239.80 (210.40) T
1091	Forehead rhinoplasty (all stages): Partial	04.00		414.000	3163.00 (2774.60)	331.200	2530.40 (2219.60)	5.000	239.80 (210.40) T
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1095	Full nasal reconstruction for secondary cleft lip deformity	04.00		357.900	2734.40 (2398.60)	286.320	2187.50 (1918.90)	5.000	239.80 (210.40) T
1097	Partial nasal reconstruction for cleft lip deformity	04.00		199.700	1525.70 (1338.30)	159.760	1220.60 (1070.70)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1099	Columella reconstruction or lengthening	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) 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	573.00 (502.60)	75.000	573.00 (502.60)	4.000	191.80 (168.20) T
1102	Laser tonsillectomy	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	6.000	287.70 (252.40) T
1105	Removal of adenoids	04.11		40.000	305.60 (268.10)	40.000	305.60 (268.10)	4.000	191.80 (168.20) T
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)	04.00		168.300	1285.80 (1127.90)	134.640	1028.60 (902.30)	5.000	239.80 (210.40) T
1107	Opening of quinsy: At rooms	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	6.000	287.70 (252.40) 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	649.40 (569.60)	85.000	649.40 (569.60)	5.000	239.80 (210.40) T
1109	Opening of quinsy: Under general anaesthetic	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	6.000	287.70 (252.40) T
1110	Ludwig's Angina: Drainage	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	9.000	431.60 (378.60) T
1111	Post tonsillectomy or adenoidectomy haemorrhage	04.00		46.000	351.40 (308.20)	46.000	351.40 (308.20)	6.000	287.70 (252.40) T
1112	Pharyngeal pouch operation	04.11		231.800	1771.00 (1553.50)	185.440	1416.80 (1242.80)	5.000	239.80 (210.40) T
1113	Retropharyngeal abscess: Internal approach	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	6.000	287.70 (252.40) T
1115	Retropharyngeal abscess: External approach	04.00		85.000	649.40 (569.60)	85.000	649.40 (569.60)	6.000	287.70 (252.40) T
1116	Functional reconstruction of palate and uvula	04.00		168.300	1285.80 (1127.90)	134.640	1028.60 (902.30)	5.000	239.80 (210.40) T
4.3	**Larynx**								
1117	Laryngeal intubation	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
1118	Laryngeal stroboscopy with video capture	04.00		39.000	298.00 (261.40)	39.000	298.00 (261.40)	6.000	287.70 (252.40) T
1119	Laryngectomy without block dissection of the neck	04.00		430.000	3285.20 (2881.80)	344.000	2628.20 (2305.40)	7.000	335.70 (294.50) T
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)	04.00		35.000	267.40 (234.60)				
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	04.00		81.100	619.60 (543.50)	81.100	619.60 (543.50)	6.000	287.70 (252.40) T
1126	Post laryngectomy for voice restoration	04.00		139.500	1065.80 (934.90)	120.000	916.80 (804.20)	9.000	431.60 (378.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1127	Tracheotomy	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	9.000	431.60 (378.60) T
1128	Endolaryngeal operations	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	8.000	383.60 (336.50) T
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	04.00		294.400	2249.20 (1973.00)	235.520	1799.40 (1578.40)	8.000	383.60 (336.50) T
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	04.00		41.400	316.30 (277.50)	41.400	316.30 (277.50)	6.000	287.70 (252.40) T
1131	Direct laryngoscopy plus foreign body removal	04.00		64.600	493.50 (432.90)	64.600	493.50 (432.90)	6.000	287.70 (252.40) T
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 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	496.60 (435.60)	65.000	496.60 (435.60)	6.000	287.70 (252.40) T
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	8.000	383.60 (336.50) T
1134	Bronchoscopy: Bronchoscopy with laser	04.00		75.000	573.00 (502.60)			8.000	383.60 (336.50) T
1136	Nebulisation (in rooms)	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	12.000	91.70 (80.40) ç
1137	Bronchial lavage	04.00						8.000	383.60 (336.50) T
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	12.000	575.40 (504.70) T
4.5	**Pleura**								
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) T
1141	Insertion of intercostal catheter (under water drainage)	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	6.000	287.70 (252.40) T
1142	Intra-pleural block	04.00		36.000	275.00 (241.20)	36.000	275.00 (241.20)	36.000	275.00 (241.20) ç
1143	Paracentesis chest: Diagnostic	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)	3.000	143.90 (126.20) T
1145	Paracentesis chest: Therapeutic	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	3.000	143.90 (126.20) T
1147	Pneumothorax: Induction (diagnostic)	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)		
1149	Pleurectomy	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	11.000	527.50 (462.70) T
1151	Decortication of lung	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)	3.000	143.90 (126.20) 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	244.50 (214.50)	32.000	244.50 (214.50)	5.000	239.80 (210.40) T
1157	Pneumonectomy	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	11.000	527.50 (462.70) T
1159	Pulmonary lobectomy	04.00		389.500	2975.80 (2610.40)	311.600	2380.60 (2088.20)	11.000	527.50 (462.70) T
1161	Segmental lobectomy	04.00		365.000	2788.60 (2446.10)	292.000	2230.90 (1956.90)	11.000	527.50 (462.70) T
1163	Excision tracheal stenosis: Cervical	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	8.000	383.60 (336.50) T
1164	Excision tracheal stenosis: Intra thoracic	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	12.000	575.40 (504.70) T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	12.000	575.40 (504.70) T
1168	Thoracoplasty: Complete	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	11.000	527.50 (462.70) T
1169	Thoracoplasty: Limited (osteoplastic)	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	11.000	527.50 (462.70) T
1171	Drainage empyema (including six weeks after treatment)	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	11.000	527.50 (462.70) T
1173	Drainage of lung abscess (including six weeks after treatment)	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	11.000	527.50 (462.70) T
1175	Thoracotomy (limited): For lung or pleural biopsy	04.00		115.000	878.60 (770.70)	115.000	878.60 (770.70)	11.000	527.50 (462.70) T
1177	Major: Diagnostic, as for inoperable carcinoma	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	11.000	527.50 (462.70) T
1179	Thoracoscopy	04.00		89.000	680.00 (596.50)	89.000	680.00 (596.50)	11.000	527.50 (462.70) T
1181	Lung transplant: Unilateral	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	15.000	719.30 (631.00) T
1182	Harvesting donor lung: Unilateral	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1183	Excision or plication of emphysematous cyst: Unilateral	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	11.000	527.50 (462.70) T
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	04.00		438.000	3346.30 (2935.40)	350.400	2677.10 (2348.30)	11.000	527.50 (462.70) T
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4.6.2	**Pulmonary function tests**								
	When these procedures are performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.								09.01
1186	Flow volume test: Inspiration/expiration	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) 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	382.00 (335.10)	50.000	382.00 (335.10)	50.000	382.00 (335.10) ç
1189	Forced expirogram only	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	10.000	76.40 (67.00) ç
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	04.00		45.310	346.20 (303.70)				
1191	N2 single breath distribution	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	10.000	76.40 (67.00) ç
1192	Peak expiratory flow only	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)	5.000	38.20 (33.50) ç
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	04.00		37.760	288.50 (253.10)				
1195	Thoracic gas volume	04.00		37.930	289.80 (254.20)				
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	04.00		45.310	346.20 (303.70)				
1197	Compliance and resistance, using oesophageal balloon	04.00		24.000	183.40 (160.90)	24.000	183.40 (160.90)	24.000	183.40 (160.90) 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	427.00 (374.60)	55.890	427.00 (374.60)		
1199	Pulmonary stress testing: For determination of VO2 max	04.00		96.500	737.30 (646.80)	96.500	737.30 (646.80)		
1200	Carbon monoxide diffusing capacity, any method	04.00		38.060	290.80 (255.10)				
1201	Maximum inspiratory/expiratory pressure	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)	5.000	38.20 (33.50) 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

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	305.60 (268.10)	40.000	305.60 (268.10)	40.000	305.60 (268.10) 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 (High Care) : Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per day	09.01		30.000	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) ç
	(i) Only one practitioner may charge category 1: Intensive monitoring of patient in high care unit. (ii) Item 1204 may not be charged by the surgeon who performed a surgical procedure. Intensive monitoring is regarded as normal postoperative care, which is included in the global fee attached to that surgical procedure. (iii) Practitioners involved in treating a patient in a high care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.	09.01							
1205	Intensive care: Category 2 (ICU): 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	09.01		100.000	764.00 (670.20)	100.000	764.00 (670.20)	100.000	764.00 (670.20) ç
1206	Intensive care: Category 2 (ICU): 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	09.01		50.000	382.00 (335.10)	50.000	382.00 (335.10)	50.000	382.00 (335.10) ç
1207	Intensive care: Category 2(ICU): 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	09.01		30.000	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) ç
	Please Note: (i) The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109 (ii) Only one practitioner may charge category 2: Intensive monitoring of patient in intensive care unit. (ii) Should a patient during the post-operative care period require active system support, the person who is responsible for the active systems support, may use items 1205-1207 (as appropriate). (iii) It would be acceptable for the surgeon who performed a surgical procedure of which the after-care is included, to charge fees according to the appropriate hospital follow-up visit (item 0109) (iv) Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.	09.01							
1208	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	09.01		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	137.000	1046.70 (918.20) ç
1209	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	09.01		58.000	443.10 (388.70)	58.000	443.10 (388.70)	58.000	443.10 (388.70) ç
1210	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	09.01		50.000	382.00 (335.10)	50.000	382.00 (335.10)	50.000	382.00 (335.10) ç
	Please note: (i) Items 1208-1210 are used if more than one practitioner is involved in active system support on a category 2 patient in the intensive care unit. (ii) Items 1208-1210 are used for category 3 patients with multiple organ failure. (iv) Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.	09.01							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4.7.3	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Procedures**								
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.								09.01
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	573.00 (502.60)	75.000	573.00 (502.60)	75.000	573.00 (502.60) ç
1213	Ventilation: Subsequent days, per day	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	50.000	382.00 (335.10) ç
1214	Ventilation: After two weeks, per day	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	25.000	191.00 (167.50) ç
1215	Insertion of arterial pressure cannula	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	25.000	191.00 (167.50) ç
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	04.11		50.000	382.00 (335.10)	50.000	382.00 (335.10)	50.000	382.00 (335.10) ç
1217	Insertion of central venous line via peripheral vein	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	10.000	76.40 (67.00) ç
1218	Insertion of central venous line via subclavian or jugular veins	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	25.000	191.00 (167.50) ç
1219	Hyperalimentation (daily tariff)	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)	15.000	114.60 (100.50) 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	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) 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	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) ç
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	229.20 (201.10)	30.000	229.20 (201.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT	05.03		101.130	772.60 (677.70) Z	101.130	772.60 (677.70) 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	458.40 (402.10)	60.000	458.40 (402.10)		
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT	05.03		131.260	1002.80 (879.60) Z	131.260	1002.80 (879.60) 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	611.20 (536.10)	80.000	611.20 (536.10)		
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT	05.03		131.260	1002.80 (879.60) Z	131.260	1002.80 (879.60) 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	687.60 (603.20)	90.000	687.60 (603.20)		
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT	05.03		214.180	1636.30 (1435.40) Z	214.180	1636.30 (1435.40) 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	1451.60 (1273.30)	190.000	1451.60 (1273.30)		
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	05.03		386.420	2952.20 (2589.60) Z	386.420	2952.20 (2589.60) 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	2498.30 (2191.50)	327.000	2498.30 (2191.50)		
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		680.850	5201.70 (4562.90) Z	680.850	5201.70 (4562.90) Z		
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		678.280	5182.10 (4545.70) Z	678.280	5182.10 (4545.70) Z		
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	05.03		671.850	5132.90 (4502.50) Z	671.850	5132.90 (4502.50) 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							
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.	09.01							
5	**Mediastinal Procedures**								
1222	Mediastinal tumours	04.00		285.000	2177.40 (1910.00)	228.000	1741.90 (1528.00)	11.000	527.50 (462.70) T
1223	Mediastinoscopy	04.00		95.000	725.80 (636.70)	95.000	725.80 (636.70)	5.000	239.80 (210.40) T
1224	Mediastinotomy	04.00		115.000	878.60 (770.70)	115.000	878.60 (770.70)	11.000	527.50 (462.70) T
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1226	Removal of single rib with a lesion	04.00		282.000	2154.50 (1889.90)	225.600	1723.60 (1511.90)	11.000	527.50 (462.70) 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	152.80 (134.00)	20.000	152.80 (134.00)	20.000	152.80 (134.00) 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	34.40 (30.20)		
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: ½ (item 1233)	04.00				6.500	49.70 (43.60)		
	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	45.80 (40.20)				
1231	Physician's fee for interpreting an ECG: With and without effort	06.04		10.000	76.40 (67.00)				
	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	68.80 (60.40)	9.000	68.80 (60.40)		
1233	Electrocardiogram: With and without effort	06.04		13.000	99.30 (87.10)	13.000	99.30 (87.10)		
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)		
1235	Multi-stage treadmill test	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)		
1236	Electrocardiogram without effort: Under 4 years old	06.04		18.000	137.50 (120.60)	18.000	137.50 (120.60)		
1237	24 Hour ambulatory blood pressure: Hire fee	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)		
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)		
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)		
1240	Signal averaged electrocardiogram	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)		
1241	X-ray Screening: Chest	04.00		4.000	30.60 (26.80)	4.000	30.60 (26.80)		
1242	X-ray screening: Prosthetic valves	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
1243	Two week event triggered ambulatory ECG monitoring: Hire fee	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)		
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)		
1245	Angiography cerebral: First two series	04.00		34.300	262.10 (229.90)	34.300	262.10 (229.90)	4.000	191.80 (168.20) T
1246	Angiography peripheral: Per limb	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	6.000	287.70 (252.40) T
1248	Paracentesis of pericardium	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	9.000	431.60 (378.60) T
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)		
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%	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	1069.60 (938.20)			9.000	431.60 (378.60) T
1250	Endomyocardial biopsy	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	9.000	431.60 (378.60) T
1251	Transeptal puncture	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	9.000	431.60 (378.60) T
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	04.00		140.000	1069.60 (938.20)			9.000	431.60 (378.60) T
1253	Right heart catheterisation (with or without biopsy)	04.00		70.000	534.80 (469.10)			9.000	431.60 (378.60) T
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	9.000	431.60 (378.60) T
1255	Tilt test	04.00		31.300	239.10 (209.70)	31.300	239.10 (209.70)		
6.2.2	**Invasive cardiology: Electrophysiological study**								
1256	Ventricular stimulation study	04.00		160.000	1222.40 (1072.30)			9.000	431.60 (378.60) T
1257	Full electrophysiological study	04.00		300.000	2292.00 (2010.50)			9.000	431.60 (378.60) T
6.2.3	**Invasive cardiology: Pacemakers**								
1258	Pacemaker: Permanent - single chamber	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)	9.000	431.60 (378.60) T
1259	Pacemaker: Permanent - dual chamber	04.00		230.000	1757.20 (1541.40)	184.000	1405.80 (1233.20)	9.000	431.60 (378.60) T
1260	AV nodal ablation	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	9.000	431.60 (378.60) T
1261	Accessory pathway ablation	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	9.000	431.60 (378.60) T
1262	Electrophysiological mapping	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)		
1263	Insertion transvenous implantable defibrillator	04.00		212.000	1619.70 (1420.80)	169.600	1295.70 (1136.60)	15.000	719.30 (631.00) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1264	Test for implantable transvenous defibrillator	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	15.000	719.30 (631.00) T
1265	Renewal of pacemaker unit only, team fee	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	9.000	431.60 (378.60) T
1266	Resiting pacemaker generator	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)		
1267	Repositioning of catheter electrode	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	9.000	431.60 (378.60) T
1268	Threshold testing: Own equipment	04.00		15.000	114.60 (100.50)				
1269	Threshold testing: Hospital equipment	04.00		11.000	84.00 (73.70)				
1270	Programming of atrio-ventricular sequential pacemaker	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)		
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	9.000	431.60 (378.60) T
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	9.000	431.60 (378.60) T
6.2.4	**Invasive cardiology: Percutaneous transluminal angioplasty**								
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	04.00		260.000	1986.40 (1742.50)	208.000	1589.10 (1393.90)	13.000	623.40 (546.80) T
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	13.000	623.40 (546.80) T
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	13.000	623.40 (546.80) T
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	13.000	623.40 (546.80) T
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	13.000	623.40 (546.80) T
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	13.000	623.40 (546.80) 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	1986.40 (1742.50)	208.000	1589.10 (1393.90)	15.000	719.30 (631.00) T
1283	Use of balloon procedure as in item 1282: Second cardiologist	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	15.000	719.30 (631.00) T
1284	Atherectomy: Single lesion: First cardiologist	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)		
1285	Atherectomy: Single lesion: Second cardiologist	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)		
1286	Insertion of intravascular stent: First cardiologist	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)		
1287	Insertion of intravascular stent: Second cardiologist	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)		
	The insertion of a stent(s) (item 1286 & 1267) may only be charged once per vessel regardless of the number of stents inserted in this vessel.	09.01							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	2292.00 (2010.50)			15.000	719.30 (631.00) T
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)	04.00		160.000	1222.40 (1072.30)			15.000	719.30 (631.00) 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	1604.40 (1407.40)	168.000	1283.50 (1125.90)	12.000	575.40 (504.70) T
1289	Paediatric cardiac catheterisation: Infants below the age of one year	04.00		263.000	2009.30 (1762.50)	210.400	1607.50 (1410.10)	12.000	575.40 (504.70) T
6.3	**Cardiac surgery**								
1294	Patent ductus arteriosus	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	13.000	623.40 (546.80) T
1295	Pericardiectomy for constrictive pericarditis	04.00		400.000	3056.00 (2680.70)	320.000	2444.80 (2144.60)	15.000	719.30 (631.00) T
1297	Coarctation of aorta	04.00		425.000	3247.00 (2848.20)	340.000	2597.60 (2278.60)	15.000	719.30 (631.00) T
1299	Systemo-pulmonary anastomosis	04.00		425.000	3247.00 (2848.20)	340.000	2597.60 (2278.60)	15.000	719.30 (631.00) T
1301	Mitral valvotomy: Closed heart technique	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	15.000	719.30 (631.00) T
1302	Heart transplant	04.00		875.000	6685.00 (5864.00)	700.000	5348.00 (4691.20)	15.000	719.30 (631.00) T
1303	Harvesting donor heart	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	5.000	239.80 (210.40) T
1305	Operative implantation of cardiac pacemaker by thoracotomy	04.00		220.000	1680.80 (1474.40)	176.000	1344.60 (1179.50)	15.000	719.30 (631.00) T
1307	Re-exploration after cardiac surgery	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	15.000	719.30 (631.00) T
1308	Heart and lung transplant	04.00		1000.000	7640.00 (6701.80)	800.000	6112.00 (5361.40)	15.000	719.30 (631.00) T
1309	Harvesting donor heart and lungs	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1311	Pericardial drainage	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	13.000	623.40 (546.80) T
6.3.1	**Cardiac surgery: Open heart surgery**								
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	04.00		25.000	191.00 (167.50)				
1320	Repeat open heart surgery (additional fee above procedure fee)	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	15.000	719.30 (631.00) T
1321	Stand-by fee for coronary angioplasty	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	30.000	229.20 (201.10) ç
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour	04.00		20.000	152.80 (134.00)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6.3.1.1	**Cardiac surgery: Open heart surgery: Congenital conditions**								
1323	Atrial septal defect: Osteum secundum	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	15.000	719.30 (631.00) T
1325	Atrial septal defect: Sinus venosus or osteum primum	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1327	Atrial septal defect: Ventricular septal defect	04.00		603.800	4613.00 (4046.50)	483.040	3690.40 (3237.20)	15.000	719.30 (631.00) T
1329	Atrial septal defect: Fallot's tetralogy	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1330	Atrial septal defect: Pulmonary stenosis	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	15.000	719.30 (631.00) T
1331	Transposition of large vessels (venous repair)	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1332	Transposition of great arteries (arterial repair)	04.00		750.000	5730.00 (5026.30)	600.000	4584.00 (4021.10)	15.000	719.30 (631.00) T
1333	Ebstein's Anomaly	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	04.00		548.800	4192.80 (3677.90)	439.040	3354.30 (2942.40)	20.000	959.00 (841.20) T
1335	Total anomalous venous drainage	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	04.00		658.900	5034.00 (4415.80)	527.120	4027.20 (3532.60)	20.000	959.00 (841.20) T
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	15.000	719.30 (631.00) T
1338	Fontan type repair	04.00		750.000	5730.00 (5026.30)	600.000	4584.00 (4021.10)	15.000	719.30 (631.00) T
6.3.1.2	**Cardiac surgery: Open heart surgery: Acquired conditions**								
1339	Mitral valve replacement	04.00		657.000	5019.50 (4403.10)	525.600	4015.60 (3522.50)	15.000	719.30 (631.00) T
1340	Mitral valvuloplasty	04.00		688.000	5256.30 (4610.80)	550.400	4205.10 (3688.70)	15.000	719.30 (631.00) T
1341	Aortic valve replacement	04.00		623.800	4765.80 (4180.50)	499.040	3812.70 (3344.50)	15.000	719.30 (631.00) T
1342	Tricuspid annulo plasty	04.00		188.000	1436.30 (1259.90)	150.400	1149.10 (1008.00)	15.000	719.30 (631.00) T
1343	Double valve replacement	04.00		968.900	7402.40 (6493.30)	775.120	5921.90 (5194.60)	15.000	719.30 (631.00) T
1344	Acute dissecting aneurysm repair	04.00		750.000	5730.00 (5026.30)	600.000	4584.00 (4021.10)	15.000	719.30 (631.00) T
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	04.00		1000.000	7640.00 (6701.80)	800.000	6112.00 (5361.40)	15.000	719.30 (631.00) T
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)		
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	04.00		750.000	5730.00 (5026.30)	600.000	4584.00 (4021.10)	15.000	719.30 (631.00) T
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery	04.00		781.000	5966.80 (5234.00)	624.800	4773.50 (4187.30)	15.000	719.30 (631.00) T
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery	04.00		813.000	6211.30 (5448.50)	650.400	4969.10 (4358.90)	15.000	719.30 (631.00) T
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	04.00		875.000	6685.00 (5864.00)	700.000	5348.00 (4691.20)	15.000	719.30 (631.00) T
1352	Cardiac aneurysm	04.00		563.000	4301.30 (3773.10)	450.400	3441.10 (3018.50)	15.000	719.30 (631.00) T
1353	Ascending/descending thoracic aortic aneurysm repair	04.00		625.000	4775.00 (4188.60)	500.000	3820.00 (3350.90)	15.000	719.30 (631.00) T
1354	Arrhythmia surgery	04.00		688.000	5256.30 (4610.80)	550.400	4205.10 (3688.70)	15.000	719.30 (631.00) T
1355	Cardiac tumour	04.00		625.000	4775.00 (4188.60)	500.000	3820.00 (3350.90)	15.000	719.30 (631.00) T
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	04.00		188.000	1436.30 (1259.90)	150.400	1149.10 (1008.00)	15.000	719.30 (631.00) T
1358	Harvesting of radial artery	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)		
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	114.60 (100.50)	15.000	114.60 (100.50)		
1359	Skin temperature test: Response to reflex cooling	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
1361	Cold sensitivity test	04.00		17.000	129.90 (113.90)	17.000	129.90 (113.90)		
1363	Oscillometry test	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
1365	Sweating test	04.00		17.000	129.90 (113.90)	17.000	129.90 (113.90)		
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	04.00		26.300	200.90 (176.20)	26.300	200.90 (176.20)		
1367	Doppler blood tests	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)		
5369	Doppler arterial pressures	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)		
5371	Doppler arterial pressures with exercise	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
5373	Doppler segmental pressures and wave forms	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)		
5375	Venous doppler examination (both limbs)	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)		
5377	Venous plethysmography	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)		

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				RVU	Fee	RVU	Fee	RVU	Fee
5379	Supra-orbital doppler test	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
5381	Carotid non-invasive complex tests	04.00		39.000	298.00 (261.40)	39.000	298.00 (261.40)		
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	4125.60 (3618.90)	432.000	3300.50 (2895.20)	15.000	719.30 (631.00) T
1373	Abdominal aorta and iliac artery: Ruptured	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	15.000	719.30 (631.00) T
1375	Grafting and/or thrombo-endarterectomy for thrombosis	04.00		444.000	3392.20 (2975.60)	355.200	2713.70 (2380.40)	15.000	719.30 (631.00) T
1376	Aorta bi-femoral graft, *including* proximal and distal endarterectomy and preparation for anastomosis	04.00		594.000	4538.20 (3980.90)	475.200	3630.50 (3184.60)	15.000	719.30 (631.00) T
6.4.3.2	**Peripheral vascular system: Arteries: Iliac artery**								
1379	Prosthetic grafting and/or thrombo-endarterectomy	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	13.000	623.40 (546.80) T
6.4.3.3	**Peripheral vascular system: Arteries: Peripheral**								
1385	Prosthetic grafting	04.00		255.000	1948.20 (1708.90)	204.000	1558.60 (1367.20)	5.000	239.80 (210.40) T
1387	Grafting vein: Vein grafting proximal to knee joint	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	5.000	239.80 (210.40) T
1388	Grafting vein: Distal to knee joint	04.00		444.000	3392.20 (2975.60)	355.200	2713.70 (2380.40)	5.000	239.80 (210.40) T
1389	Grafting vein: Endarterectomy when not part of another specified procedure	04.00		264.000	2017.00 (1769.30)	211.200	1613.60 (1415.40)	5.000	239.80 (210.40) T
1390	Grafting vein: Carotid endarterectomy	04.00		321.000	2452.40 (2151.20)	256.800	1962.00 (1721.10)	15.000	719.30 (631.00) T
1393	Embolectomy: Peripheral embolectomy transfemoral	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	5.000	239.80 (210.40) T
1395	Miscellaneous arterial procedures: Arterial suture: *Trauma*	04.00		125.000	955.00 (837.70)	100.000	764.00 (670.20)	5.000	239.80 (210.40) 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	2017.00 (1769.30)	211.200	1613.60 (1415.40)	15.000	719.30 (631.00) T
1397	Profundoplasty	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
1399	Distal tibial (ankle region)	04.00		456.000	3483.80 (3056.00)	364.800	2787.10 (2444.80)	5.000	239.80 (210.40) T
1401	Femoro-femoral	04.00		254.000	1940.60 (1702.30)	203.200	1552.40 (1361.80)	5.000	239.80 (210.40) T

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				RVU	Fee	RVU	Fee	RVU	Fee
1402	Carotid-subclavian	04.00		288.000	2200.30 (1930.10)	230.400	1760.30 (1544.10)	8.000	383.60 (336.50) T
1403	Axillo-femoral: (Bifemoral + 50%)	04.00		288.000	2200.30 (1930.10)	230.400	1760.30 (1544.10)	8.000	383.60 (336.50) T
6.4.4	**Peripheral vascular system: Veins**								
1407	Ligation of saphenous vein	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) T
1408	Placement of Hickman catheter or similar	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	4.000	191.80 (168.20) T
1410	Litigation of inferior vena cava: Abdominal	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	8.000	383.60 (336.50) T
1412	Umbrella operation on inferior vena cava: Abdominal	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	8.000	383.60 (336.50) 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	1077.20 (944.90)	120.000	916.80 (804.20)	3.000	143.90 (126.20) 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	1887.10 (1655.40)	197.600	1509.70 (1324.30)	3.000	143.90 (126.20) T
1417	Extensive sub-fascial ligation of perforating veins	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
1419	Lesser varicose vein procedures	04.00		31.000	236.80 (207.70)	31.000	236.80 (207.70)	3.000	143.90 (126.20) 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	68.80 (60.40)	9.000	68.80 (60.40)		
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	11.000	527.50 (462.70) T
1427	Thrombectomy: Illio-femoral	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	6.000	287.70 (252.40) T
6.4.5	**Peripheral vascular system: Portal hypertension**								
1429	Porto-caval shunt	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	11.000	527.50 (462.70) T
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	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)		
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	45.80 (40.20)	6.000	45.80 (40.20)		
	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.	04.00							
7	**Lympho Reticular System**								
7.1	**Spleen**								
1435	Splenectomy (in all cases)	04.00		221.300	1690.70 (1483.10)	177.040	1352.60 (1186.50)	9.000	431.60 (378.60) T
1436	Splenorrhaphy	04.00		231.800	1771.00 (1553.50)	185.440	1416.80 (1242.80)	9.000	431.60 (378.60) T

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				RVU	Fee	RVU	Fee	RVU	Fee
7.2	**Lymph nodes and lymphatic channels**								
1439	Excision of lymph node for biopsy: Neck or axilla	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	4.000	191.80 (168.20) T
1441	Excision of lymph node for biopsy: Groin	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	3.000	143.90 (126.20) T
1443	Simple excision of lymph nodes for tuberculosis	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	3.000	143.90 (126.20) T
1445	Radical excision of lymph nodes of neck: Total: Unilateral	04.00		315.000	2406.60 (2111.10)	252.000	1925.30 (1688.90)	5.000	239.80 (210.40) T
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral	04.00		235.000	1795.40 (1574.90)	188.000	1436.30 (1259.90)	5.000	239.80 (210.40) T
1449	Radical excision of lymph nodes of axilla	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	4.000	191.80 (168.20) T
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	04.00		58.000	443.10 (388.70)	58.000	443.10 (388.70)	5.000	239.80 (210.40) T
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	4.000	191.80 (168.20) T
1453	Radical excision of lymph nodes of groin: Inguinal	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	04.00		39.000	298.00 (261.40)	39.000	298.00 (261.40)	5.000	239.80 (210.40) T
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	6.000	287.70 (252.40) T
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	5.000	239.80 (210.40) T
1457	Bone marrow biopsy: By trephine	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	3.000	143.90 (126.20) T
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
1459	Staging laparotomy for lymphoma (including splenectomy	04.00		245.000	1871.80 (1641.90)	196.000	1497.40 (1313.50)	7.000	335.70 (294.50) T
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	160.44 (140.74)	21.000	160.44 (140.74)		
8.1	**Oral cavity**								
1461	All dental procedures	04.00						4.000	191.80 (168.20) T
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	4.000	191.80 (168.20) T

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				RVU	Fee	RVU	Fee	RVU	Fee
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)	4.000	191.80 (168.20) T
1467	Drainage of intra-oral abscess	04.00		31.000	236.80 (207.70)	31.000	236.80 (207.70)	4.000	191.80 (168.20) T
1469	Local excision of mucosal lesion of oral cavity	04.00		23.000	175.70 (154.10)	23.000	175.70 (154.10)	4.000	191.80 (168.20) 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	4194.40 (3679.30)	439.200	3355.50 (2943.40)	7.000	335.70 (294.50) T
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	04.00		-	- q	-	- q	7.000	335.70 (294.50) T
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	6.000	287.70 (252.40) T
1477	Cleft palate: Secondary repair	04.00		174.200	1330.90 (1167.50)	139.360	1064.70 (933.90)	6.000	287.70 (252.40) T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	6.000	287.70 (252.40) T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	6.000	287.70 (252.40) T
1480	Repair of oronasal fistula (large) e.g. distant flap	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	6.000	287.70 (252.40) T
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1482	Repair of oronasal fistula (large): Second stage	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1483	Alveolar periosteal or other flaps for arch closure	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1486	Closure of anterior nasal floor	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
8.2	**Lips**								
1484	Cleft lip repair: Lip adhesion (cleft lip)	04.00		95.000	725.80 (636.70)	95.000	725.80 (636.70)	5.000	239.80 (210.40) T
1485	Local excision of benign lesion of lip	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	4.000	191.80 (168.20) T
1487	Resection for lip malignancy	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	4.000	191.80 (168.20) T
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	5.000	239.80 (210.40) T
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages	04.00		251.600	1922.20 (1686.10)	201.280	1537.80 (1348.90)	5.000	239.80 (210.40) T
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage	04.00		329.900	2520.40 (2210.90)	263.920	2016.30 (1768.70)	5.000	239.80 (210.40) T
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	5.000	239.80 (210.40) T
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	04.00		251.600	1922.20 (1686.10)	201.280	1537.80 (1348.90)	5.000	239.80 (210.40) T

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1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	5.000	239.80 (210.40) T
1495	Abbé or Estlander type flap (all stages included)	04.00		273.100	2086.50 (1830.30)	218.480	1669.20 (1464.20)	5.000	239.80 (210.40) T
1497	Vermilionectomy	04.00		94.900	725.00 (636.00)	94.900	725.00 (636.00)	4.000	191.80 (168.20) T
1499	Lip reconstruction following an injury: Direct repair	04.00		105.600	806.80 (707.70)	105.600	806.80 (707.70)	4.000	191.80 (168.20) T
1501	Lip reconstruction following an injury or tumour removal: Flap repair	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)	04.00		104.000	794.60 (697.00)	104.000	794.60 (697.00)	4.000	191.80 (168.20) T
8.3	**Tongue**								
1505	Partial glossectomy	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
1507	Local excision of lesion of tongue	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	4.000	191.80 (168.20) T
8.4	**Palate, uvula and salivary glands**								
1509	Wide excision of lesion of palate	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	5.000	239.80 (210.40) T
1511	Radical resection of palate (including skin graft)	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	7.000	335.70 (294.50) T
1513	Excision of ranula	04.00		85.600	654.00 (573.70)	85.600	654.00 (573.70)	5.000	239.80 (210.40) T
1515	Excision of sublingual salivary gland	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1517	Excision of submandibular salivary gland	04.00		146.000	1115.40 (978.40)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1519	Excision of submandibular salivary gland with suprahyoid dissection	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1521	Excision of submandibular salivary gland: With radical neck dissection	04.00		352.000	2689.30 (2359.00)	281.600	2151.40 (1887.20)	6.000	287.70 (252.40) T
1523	Local resection of parotid tumour	04.00		169.600	1295.70 (1136.60)	135.680	1036.60 (909.30)	5.000	239.80 (210.40) T
1525	Partial parotidectomy	04.00		310.000	2368.40 (2077.50)	248.000	1894.70 (1662.00)	5.000	239.80 (210.40) T
1526	Total parotidectomy with preservation of facial nerve	04.00		358.500	2738.90 (2402.50)	286.800	2191.20 (1922.10)	5.000	239.80 (210.40) T
1527	Total parotidectomy	04.00		358.500	2738.90 (2402.50)	286.800	2191.20 (1922.10)	5.000	239.80 (210.40) T
1529	Parotidectomy: Extracapsular	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1531	Drainage of parotid abscess	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	4.000	191.80 (168.20) T
1533	Closure of salivary fistula	04.00		91.000	695.20 (609.80)	91.000	695.20 (609.80)	4.000	191.80 (168.20) T
1535	Dilatation of salivary duct	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
1537	Operative removal of salivary calculus	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)	4.000	191.80 (168.20) T
1539	Salivary duct: Meatotomy	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	4.000	191.80 (168.20) T
1541	Branchial cyst and/or fistula: Excision	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1543	Excision of cystic hygroma	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1544	Ludwig's Angina: Drainage	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	9.000	431.60 (378.60) T
8.5	**Oesophagus**								
1545	Oesophagoscopy with rigid instrument: First and subsequent	04.00		47.000	359.10 (315.00)	47.000	359.10 (315.00)	4.000	191.80 (168.20) T
1549	Oesophagoscopy with dilatation of stricture	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	4.000	191.80 (168.20) T
1550	Oesophagoscopy with removal of foreign body	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)	4.000	191.80 (168.20) T
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	4.000	191.80 (168.20) T
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	4.000	191.80 (168.20) T
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	4.000	191.80 (168.20) T
1554	Per-oral small bowel biopsy	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	4.000	191.80 (168.20) T
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	04.00		400.000	3056.00 (2680.70)	320.000	2444.80 (2144.60)	15.000	719.30 (631.00) T
1557	Oesophageal dilatation	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	4.000	191.80 (168.20) T
1559	Oesophagectomy: Two stage	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	11.000	527.50 (462.70) T
1560	Oesophagectomy: Three stage	04.00		550.000	4202.00 (3686.00)	440.000	3361.60 (2948.80)	11.000	527.50 (462.70) T
1561	Thoraco-abdominal oesophagogastrectomy	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	11.000	527.50 (462.70) T
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	11.000	527.50 (462.70) T
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1566	Private fee: Gastroplasty	04.00		325.000	2483.00 (2178.10)	260.000	1986.40 (1742.50)	8.000	383.60 (336.50) T
1567	Bochdalek hernia repair in newborn	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	14.000	671.30 (588.90) T
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	11.000	527.50 (462.70) T
1569	Heller's operation	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	14.000	671.30 (588.90) T
1575	Insertion of indwelling oesophageal tube by laparotomy	04.00		142.000	1084.90 (951.70)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
1578	Oesophageal motility (4 channel + pneumograph)	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	4.000	191.80 (168.20) T
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	04.00		400.000	3056.00 (2680.70)	320.000	2444.80 (2144.60)	11.000	527.50 (462.70) T
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	04.00		110.000	840.40 (737.20)	110.000	840.40 (737.20)	4.000	191.80 (168.20) T
1581	Removal of benign oesophageal tumours	04.00		285.000	2177.40 (1910.00)	228.000	1741.90 (1528.00)	11.000	527.50 (462.70) T
1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1583	Excision of intrathoracic oesophageal diverticulum	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	11.000	527.50 (462.70) 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	420.20 (368.60)	55.000	420.20 (368.60)		
1585	24 Hour oesophageal pH studies: Interpretation	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)		
8.6	**Stomach**								
1587	Upper gastro-intestinal endoscopy: Hospital equipment	04.00		48.750	372.50 (326.80) Z	48.750	372.50 (326.80) Z	4.000	191.80 (168.20) T
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587)	04.00	+	25.000	191.00 (167.50) Z	25.000	191.00 (167.50) Z	4.000	191.80 (168.20) T
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	259.80 (227.90)	34.000	259.80 (227.90)	6.000	287.70 (252.40) T
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (Item 1587)	04.00	+	25.000	191.00 (167.50) Z	25.000	191.00 (167.50) Z	4.000	191.80 (168.20) T
1593	Augmented histamine test: Gastric intubation with x-ray screening	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
1597	Gastrostomy or Gastrotomy	04.00		147.500	1126.90 (988.50)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
1598	Gastrotomy with suture repair of bleeding ulcer	05.03		251.200	1919.20 (1683.50) Z	200.960	1535.30 (1346.80) Z	6.000	287.70 (252.40) T
1599	Pyloromyotomy (Rammstedt)	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	6.000	287.70 (252.40) T
1601	Local excision of ulcer or benign neoplasm	04.00		195.600	1494.40 (1310.90)	156.480	1195.50 (1048.70)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1603	Vagotomy: Abdominal	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
1604	Vagotomy: Thoracic	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	11.000	527.50 (462.70) T
1605	Truncal or selective with drainage procedures	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	6.000	287.70 (252.40) T
1607	Vagotomy and antrectomy	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	6.000	287.70 (252.40) T
1609	Highly selective vagotomy	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	6.000	287.70 (252.40) T
1611	Pyloroplasty	04.00		180.200	1376.70 (1207.60)	144.160	1101.40 (966.10)	6.000	287.70 (252.40) T
1613	Gastroenterostomy	04.00		203.600	1555.50 (1364.50)	162.880	1244.40 (1091.60)	6.000	287.70 (252.40) T
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	7.000	335.70 (294.50) T
1617	Partial gastrectomy	04.00		328.300	2508.20 (2200.20)	262.640	2006.60 (1760.20)	7.000	335.70 (294.50) T
1619	Total gastrectomy	04.00		384.430	2937.00 (2576.30)	307.540	2349.60 (2061.10)	7.000	335.70 (294.50) T
1621	Revision of gastrectomy or gastro-enterostomy	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	7.000	335.70 (294.50) T
1625	Gastro-esophageal operation for portal hypertension (Tanner)	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	11.000	527.50 (462.70) T
8.7	**Duodenum**								
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
1627	Duodenal intubation (under X-ray screening)	04.00		8.000	61.10 (53.60)				
1629	Duodenal intubation with biliary drainage after gall bladder stimulation	04.00		21.000	160.40 (140.70)				
1631	Duodenal intubation: Under 3 years of age	06.04		15.000	114.60 (100.50)				
8.8	**Intestines**								
1632	H2 breath test (intestines)	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)		
1633	Complete test using lactose or lactulose	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)		
1634	Enterotomy or Enterostomy	04.11		202.600	1547.90 (1357.80)	162.080	1238.30 (1086.20)	6.000	287.70 (252.40) T
1635	Intestinal obstruction of the newborn	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	7.000	335.70 (294.50) T
1637	Operation for relief of intestinal obstruction	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	7.000	335.70 (294.50) T
1639	Resection of small bowel with enterostomy or anastomosis	04.00		244.900	1871.00 (1641.20)	195.920	1496.80 (1313.00)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1641	Entero-enterostomy or entero-colostomy for bypass	04.00		213.100	1628.10 (1428.20)	170.480	1302.50 (1142.50)	6.000	287.70 (252.40) 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	1146.00 (1005.30) Z	120.000	916.80 (804.20) Z		
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	05.03		90.000	687.60 (603.20) Z	90.000	687.60 (603.20) Z		
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	04.00		185.200	1414.90 (1241.10)	148.160	1131.90 (992.90)	6.000	287.70 (252.40) T
1647	Closure of intestinal fistula	04.00		258.000	1971.10 (1729.00)	206.400	1576.90 (1383.20)	6.000	287.70 (252.40) T
1649	Excision of Meckel's diverticulum	04.00		179.800	1373.70 (1205.00)	143.840	1098.90 (963.90)	6.000	287.70 (252.40) T
1651	Excision of lesion of mesentery	04.00		171.600	1311.00 (1150.00)	137.280	1048.80 (920.00)	4.000	191.80 (168.20) T
1652	Laparotomy for mesenteric thrombosis	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	8.000	383.60 (336.50) T
1653	Total colonoscopy: With hospital equipment (including biopsy)	04.00		90.000	687.60 (603.20) Z	90.000	687.60 (603.20) Z	4.000	191.80 (168.20) T
1654	Plus removal of polyps: ADD to colonoscopy (item 1653)	04.00	+	30.000	229.20 (201.10) Z	30.000	229.20 (201.10) Z	4.000	191.80 (168.20) T
1656	Left-sided colonoscopy	04.00		60.000	458.40 (402.10) Z	60.000	458.40 (402.10) Z	4.000	191.80 (168.20) T
1657	Right or left hemicolectomy or segmental colectomy	04.00		325.000	2483.00 (2178.10)	260.000	1986.40 (1742.50)	6.000	287.70 (252.40) T
1658	Reconstruction of colon after Hartman's procedure	04.00		359.400	2745.80 (2408.60)	287.520	2196.70 (1926.90)	6.000	287.70 (252.40) T
1661	Colotomy: Including removal of tumour or foreign body	04.00		205.700	1571.50 (1378.50)	164.560	1257.20 (1102.80)	6.000	287.70 (252.40) T
1663	Total colectomy	04.00		390.000	2979.60 (2613.70)	312.000	2383.70 (2091.00)	6.000	287.70 (252.40) T
1665	Colostomy or ileostomy isolated procedure	04.00		233.800	1786.20 (1566.80)	187.040	1429.00 (1253.50)	6.000	287.70 (252.40) T
1666	Continent ileostomy pouch (all types)	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	6.000	287.70 (252.40) T
1667	Colostomy: Closure	04.00		179.100	1368.30 (1200.30)	143.280	1094.70 (960.30)	5.000	239.80 (210.40) T
1668	Revision of ileostomy pouch	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	6.000	287.70 (252.40) T
1669	Total proctocolectomy and ileostomy	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	7.000	335.70 (294.50) T
1670	Proctocolectomy, ileostomy and ileostomy pouch	04.00		540.000	4125.60 (3618.90)	432.000	3300.50 (2895.20)	7.000	335.70 (294.50) T
1671	Colomyotomy (Reilly operation)	04.00		185.000	1413.40 (1239.80)	148.000	1130.70 (991.80)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
8.9	**Appendix**								
1673	Drainage of appendix abscess	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1675	Appendicectomy	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	4.000	191.80 (168.20) T
8.10	**Rectum and anus**								
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	04.00		48.750	372.50 (326.80) Z	48.750	372.50 (326.80) Z	3.000	143.90 (126.20) T
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	3.000	143.90 (126.20) T
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	04.00	+	25.000	191.00 (167.50) Z	25.000	191.00 (167.50) Z	3.000	143.90 (126.20) T
1679	Sigmoidoscopy with removal of polyps, first and subsequent	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	3.000	143.90 (126.20) T
1681	Proctoscopy with removal of polyps: First time	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)	3.000	143.90 (126.20) T
1683	Proctoscopy with removal of polyps: Subsequent times	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
1685	Endoscopic fulguration of tumour	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	04.00		381.300	2913.10 (2555.40)	305.040	2330.50 (2044.30)	6.000	287.70 (252.40) T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	04.00		445.000	3399.80 (2982.30)	356.000	2719.80 (2385.80)	8.000	383.60 (336.50) T
1689	Perineal resection of rectum	04.00		141.000	1077.20 (944.90)	120.000	916.80 (804.20)	5.000	239.80 (210.40) 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	3127.10 (2743.10)	327.440	2501.60 (2194.40)	7.000	335.70 (294.50) T
1692	Abdomino-perineal resection of rectum: Perineal surgeon	04.00		158.500	1210.90 (1062.20)	126.800	968.80 (849.80)		
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	4.000	191.80 (168.20) 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	3056.00 (2680.70)	320.000	2444.80 (2144.60)	7.000	335.70 (294.50) T
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	6.000	287.70 (252.40) T
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	6.000	287.70 (252.40) T
1701	Repair of prolapsed rectum: Abdominal: Perineal	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1703	Repair of prolapsed rectum: Abdominal: Thierisch suture	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1705	Incision and drainage of peri-anal abscess	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	3.000	143.90 (126.20) T
1707	Drainage of submucous abscess	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	3.000	143.90 (126.20) T
1709	Drainage of ischio-rectal abscess	04.00		87.000	664.70 (583.10)	87.000	664.70 (583.10)	3.000	143.90 (126.20) T
1711	Excision of pelvi-rectal fistula	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	5.000	239.80 (210.40) T
1713	Excision of fistula-in-ano	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	3.000	143.90 (126.20) T
1715	Operation for fissure-in-ano	04.00		66.800	510.40 (447.70)	66.800	510.40 (447.70)	3.000	143.90 (126.20) T
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
1721	Sclerosing injection for haemorrhoids: Per injection	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
1723	Haemorrhoidectomy	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
1725	Drainage of external thrombosed pile	04.00		12.500	95.50 (83.80)	12.500	95.50 (83.80)	3.000	143.90 (126.20) T
1727	Multiple procedures (haemorrhoids, fissure, etc.)	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	3.000	143.90 (126.20) T
1728	Biopsy of ano-rectal wall, for congenital megacolon	05.03		60.600	463.00 (406.10) Z	60.600	463.00 (406.10) Z	5.000	239.80 (210.40) T
1729	Excision of anal skin tags	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	3.000	143.90 (126.20) T
1731	Operation for low imperforate anus	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
1733	Anoplasty: Y-V-plasty	04.00		41.000	313.20 (274.70)	41.000	313.20 (274.70)	3.000	143.90 (126.20) T
1735	Anal sphincteroplasty for incontinence	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
1737	Dilation of ano-rectal stricture	04.00		12.500	95.50 (83.80)	12.500	95.50 (83.80)	3.000	143.90 (126.20) T
1739	Closure of recto-vesical fistula	04.00		241.000	1841.20 (1615.10)	192.800	1473.00 (1292.10)	5.000	239.80 (210.40) T
1741	Closure of recto-urethral fistula	04.00		241.000	1841.20 (1615.10)	192.800	1473.00 (1292.10)	5.000	239.80 (210.40) T
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)		
8.11	**Liver**								
1743	Needle biopsy of liver	04.00		30.300	231.50 (203.10)	30.300	231.50 (203.10)	3.000	143.90 (126.20) T
1745	Biopsy of liver by laparotomy	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1747	Drainage of liver abscess or cyst	04.00		179.100	1368.30 (1200.30)	143.280	1094.70 (960.30)	7.000	335.70 (294.50) T
1748	Body composition measured by bio-electrical impedance	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)		
1749	Hemi-hepatectomy: Right	04.00		564.000	4309.00 (3779.80)	451.200	3447.20 (3023.90)	9.000	431.60 (378.60) T
1751	Hemi-hepatectomy: Left	04.00		521.100	3981.20 (3492.30)	416.880	3185.00 (2793.90)	9.000	431.60 (378.60) T
1752	Extended right or left hepatectomy	04.00		570.900	4361.70 (3826.10)	456.720	3489.30 (3060.80)	9.000	431.60 (378.60) T
1753	Partial or segmental hepatectomy	04.00		378.000	2887.90 (2533.20)	302.400	2310.30 (2026.60)	9.000	431.60 (378.60) T
1754	Hepatico-jejunostomy	04.00		369.200	2820.70 (2474.30)	295.360	2256.60 (1979.50)	9.000	431.60 (378.60) T
1755	Liver transplant	04.00		1400.800	10702.10 (9387.80)	1120.640	8561.70 (7510.30)	15.000	719.30 (631.00) T
1756	Harvesting donor hepatectomy	04.00		616.200	4707.80 (4129.60)	492.960	3766.20 (3303.70)	5.000	239.80 (210.40) T
1757	Suture of liver wound or injury	04.00		214.200	1636.50 (1435.50)	171.360	1309.20 (1148.40)	9.000	431.60 (378.60) T
8.12	**Biliary tract**								
1759	Cholecystostomy	04.00		171.600	1311.00 (1150.00)	137.280	1048.80 (920.00)	6.000	287.70 (252.40) T
1761	Cholecystectomy	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
1762	Cholecystectomy and operative cholangiogram	04.00		255.000	1948.20 (1708.90)	204.000	1558.60 (1367.20)	6.000	287.70 (252.40) T
1763	With exploration of common bile duct	04.00		264.500	2020.80 (1772.60)	211.600	1616.60 (1418.10)	6.000	287.70 (252.40) T
1765	Exploration of common bile duct: Secondary operation	04.00		327.700	2503.60 (2196.10)	262.160	2002.90 (1756.90)	6.000	287.70 (252.40) T
1767	Reconstruction of common bile duct	04.00		371.700	2839.80 (2491.10)	297.360	2271.80 (1992.80)	6.000	287.70 (252.40) T
1768	Resection bile duct tumour with reconstruction	04.00		327.700	2503.60 (2196.10)	262.160	2002.90 (1756.90)	6.000	287.70 (252.40) T
1769	Cholecysto-enterostomy or gastrostomy	04.00		236.300	1805.30 (1583.60)	189.040	1444.30 (1266.90)	6.000	287.70 (252.40) T
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	06.04	+	25.600	195.60 (171.60)	25.600	195.60 (171.60)	6.000	287.70 (252.40) T
1773	Transduodenal sphincteroplasty	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
1774	Balloon dilatation of common bile duct strictures	04.00		125.000	955.00 (837.70)	100.000	764.00 (670.20)	6.000	287.70 (252.40) T
1775	Excision choledochal cyst with reconstruction	04.00		327.700	2503.60 (2196.10)	262.160	2002.90 (1756.90)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1777	Porto-enterostomy for biliary atresia	04.00		400.000	3056.00 (2680.70)	320.000	2444.80 (2144.60)	11.000	527.50 (462.70) T
8.13	**Pancreas**								
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	04.00		105.900	809.10 (709.70)	105.900	809.10 (709.70)	4.000	191.80 (168.20) T
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	04.00	+	15.820	120.90 (106.10)	15.820	120.90 (106.10)	4.000	191.80 (168.20) T
1780	Gastric and duodenal intubation	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
1781	Procedure (excluding laboratory tests)	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)		
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	04.00	+	30.000	229.20 (201.10)	30.000	229.20 (201.10)	4.000	191.80 (168.20) T
1783	Drainage of pancreatic abscess	04.00		239.300	1828.30 (1603.80)	191.440	1462.60 (1283.00)	6.000	287.70 (252.40) T
1784	Debridement pancreatic necrosis	04.00		348.400	2661.80 (2334.90)	278.720	2129.40 (1867.90)	6.000	287.70 (252.40) T
1785	Internal drainage of pancreatic cyst	04.00		250.600	1914.60 (1679.50)	200.480	1531.70 (1343.60)	6.000	287.70 (252.40) T
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	04.00	+	30.000	229.20 (201.10)	30.000	229.20 (201.10)	6.000	287.70 (252.40) T
1786	Internal drainage of pancreatic cyst with Roux-Y	04.00		306.800	2344.00 (2056.10)	245.440	1875.20 (1644.90)	6.000	287.70 (252.40) T
1787	Operative pancreatogram: ADD	04.00	+	10.000	76.40 (67.00)	10.000	76.40 (67.00)		
1788	Biopsy of pancreas	04.00		177.700	1357.60 (1190.90)	142.160	1086.10 (952.70)	6.000	287.70 (252.40) T
1789	Pancreatico-duodenectomy	04.00		704.800	5384.70 (4723.40)	563.840	4307.70 (3778.70)	8.000	383.60 (336.50) T
1791	Local, partial or subtotal pancreatectomy	04.00		351.300	2683.90 (2354.30)	281.040	2147.10 (1883.40)	8.000	383.60 (336.50) T
1793	Distal pancreatectomy with internal drainage	04.00		377.400	2883.30 (2529.20)	301.920	2306.70 (2023.40)	8.000	383.60 (336.50) T
8.14	**Peritoneal cavity**								
1797	Pneumo-peritoneum: First	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	4.000	191.80 (168.20) T
1799	Pneumo-peritoneum: Repeat	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)	4.000	191.80 (168.20) T
1800	Peritoneal lavage	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
1801	Diagnostic paracentesis: Abdomen	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
1803	Therapeutic paracentesis: Abdomen	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)		
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	04.00	+	45.000	343.80 (301.60)	45.000	343.80 (301.60)	5.000	239.80 (210.40) T
1809	Laparotomy	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	7.000	335.70 (294.50) T
1811	Suture of burst abdomen	04.00		188.300	1438.60 (1261.90)	150.640	1150.90 (1009.60)	7.000	335.70 (294.50) T
1812	Laparotomy for control of surgical haemorrhage	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	9.000	431.60 (378.60) T
1813	Drainage of sub-phrenic abscess	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	7.000	335.70 (294.50) T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	04.00		248.400	1897.80 (1664.70)	198.720	1518.20 (1331.80)	5.000	239.80 (210.40) T
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	4.000	191.80 (168.20) T
9	**Herniae**								
1819	Inguinal or femoral hernia: Adult	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1821	Inguinal or femoral hernia: Child under 14 years	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	4.000	191.80 (168.20) T
1823	Inguinal hernia: Infant under one year	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	4.000	191.80 (168.20) T
1825	Recurrent inguinal or femoral hernia	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)	4.000	191.80 (168.20) T
1827	Strangulated hernia or femoral hernia	04.00		238.000	1818.30 (1595.00)	190.400	1454.70 (1276.10)	7.000	335.70 (294.50) T
1829	Epigastric hernia	04.00		93.300	712.80 (625.30)	93.300	712.80 (625.30)	4.000	191.80 (168.20) T
1831	Umbilical hernia: Adult	04.00		140.000	1069.60 (938.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
1833	Umbilical hernia: Child under 14 years	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	4.000	191.80 (168.20) T
1835	Incisional hernia	04.00		166.800	1274.40 (1117.90)	133.440	1019.50 (894.30)	4.000	191.80 (168.20) 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	588.30 (516.10)	77.000	588.30 (516.10)	4.000	191.80 (168.20) T
1837	Repair of omphalocele in new-born (one or more procedures)	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	7.000	335.70 (294.50) 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	542.40 (475.80)	71.000	542.40 (475.80)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1841	Renal biopsy: Needle	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	3.000	143.90 (126.20) T
1843	Peritoneal dialysis: First day	04.00		33.000	252.10 (221.10)	33.000	252.10 (221.10)		
1845	Peritoneal dialysis: Every subsequent day	04.00		33.000	252.10 (221.10)	33.000	252.10 (221.10)		
1847	Haemodialysis: Per hour or part thereof	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)		
1849	Haemodialysis: Maximum: Eight hours	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)		
1851	Haemodialysis: Thereafter per week	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)		
1852	Continuous haemodiafiltration per day in intensive or high care unit	04.00		33.000	252.10 (221.10)	33.000	252.10 (221.10)		
1853	Nephrectomy: Primary nephrectomy	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	5.000	239.80 (210.40) T
1855	Nephrectomy: Secondary nephrectomy	04.00		267.000	2039.90 (1789.40)	213.600	1631.90 (1431.50)	5.000	239.80 (210.40) T
1857	Radical with regional lymph adenectomy for tumour	04.11		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	6.000	287.70 (252.40) T
1859	Nephrectomy: Partial	04.00		267.000	2039.90 (1789.40)	213.600	1631.90 (1431.50)	5.000	239.80 (210.40) T
1861	Symphysiotomy for horse-shoe kidney	04.00		287.000	2192.70 (1923.40)	229.600	1754.10 (1538.70)	6.000	287.70 (252.40) T
1863	Nephro-ureterectomy	04.00		305.000	2330.20 (2044.00)	244.000	1864.20 (1635.30)	5.000	239.80 (210.40) T
1865	Nephrotomy with drainage nephrostomy	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	6.000	287.70 (252.40) T
1869	Nephrolithotomy	04.00		227.000	1734.30 (1521.30)	181.600	1387.40 (1217.00)	5.000	239.80 (210.40) T
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	04.00		284.000	2169.80 (1903.30)	227.200	1735.80 (1522.60)	5.000	239.80 (210.40) T
1871	Staghorn stone: Surgical	04.00		341.000	2605.20 (2285.30)	272.800	2084.20 (1828.20)	6.000	287.70 (252.40) T
1873	Suture renal laceration (renorraphy)	04.00		193.000	1474.50 (1293.40)	154.400	1179.60 (1034.70)	6.000	287.70 (252.40) T
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	04.00		34.000	259.80 (227.90)	34.000	259.80 (227.90)	3.000	143.90 (126.20) T
1877	Operation for renal cyst: Marsupialisation or excision	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1879	Closure renal fistula	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1881	Pyeloplasty	06.04		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1883	Pyelostomy	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1885	Pyelolithotomy	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	04.00		223.000	1703.70 (1494.50)	178.400	1363.00 (1195.60)	5.000	239.80 (210.40) T
1889	Nephrectomy for Allograft: Living or dead	04.00		255.000	1948.20 (1708.90)	204.000	1558.60 (1367.20)	5.000	239.80 (210.40) T
1891	Perinephric abscess or renal abscess: Drainage	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	7.000	335.70 (294.50) T
1893	Aberrant renal vessels: Repositioning with pyeloplasty	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
1894	Auto transplantation of kidney	04.00		420.000	3208.80 (2814.70)	336.000	2567.00 (2251.80)	10.000	479.50 (420.60) T
1895	Allo transplantation of kidney	04.00		420.000	3208.80 (2814.70)	336.000	2567.00 (2251.80)	10.000	479.50 (420.60) T
10.2	**Ureter**								
1897	Ureterorraphy: Suture of ureter	04.11		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1898	Ureterorraphy: Lumbar approach	04.11		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1899	Ureteroplasty	04.00		181.000	1382.80 (1213.00)	144.800	1106.30 (970.40)	5.000	239.80 (210.40) T
1901	Ureterolysis	04.00		118.000	901.50 (790.80)	118.000	901.50 (790.80)	5.000	239.80 (210.40) T
1902	Ureterolysis: Lumbar approach	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1903	Ureterectomy only	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1905	Ureterolithotomy	04.00		265.800	2030.70 (1781.30)	212.640	1624.60 (1425.10)	5.000	239.80 (210.40) T
1907	Cutaneous ureterostomy: Unilateral	04.00		108.000	825.10 (723.80)	108.000	825.10 (723.80)	5.000	239.80 (210.40) T
1909	Cutaneous ureterostomy: Bilateral	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
1911	Uretero-enterostomy: Unilateral	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1913	Uretero-enterostomy: Bilateral	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	5.000	239.80 (210.40) T
1915	Uretero-ureterostomy	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1917	Transuretero-ureterostomy	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)	5.000	239.80 (210.40) T
1919	Closure of ureteric fistula	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1921	Immediate deligation of ureter	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1923	Ureterolysis for retrocaval ureter with anastomosis	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	5.000	239.80 (210.40) T
1925	Uretero-pyelostomy	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	5.000	239.80 (210.40) T
1927	Uretero-neo-cystostomy: Unilateral	04.00		316.100	2415.00 (2118.40)	252.880	1932.00 (1694.70)	5.000	239.80 (210.40) T
1929	Uretero-neo-cystostomy: Bilateral	04.00		474.150	3622.50 (3177.60)	379.320	2898.00 (2542.10)	5.000	239.80 (210.40) T
1931	Uretero-neo-cystostomy: With Boariplasty	04.00		351.800	2687.80 (2357.70)	281.440	2150.20 (1886.10)	5.000	239.80 (210.40) T
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	5.000	239.80 (210.40) T
1935	Uretero-ileal conduit	04.00		388.000	2964.30 (2600.30)	310.400	2371.50 (2080.30)	5.000	239.80 (210.40) T
1937	Replacement of ureter by bowel segment: Unilateral	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	5.000	239.80 (210.40) T
1939	Replacement of ureter by bowel segment: Bilateral	04.00		485.000	3705.40 (3250.40)	388.000	2964.30 (2600.30)	5.000	239.80 (210.40) T
1941	Ureterostomy-in-situ: Unilateral	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	5.000	239.80 (210.40) T
1943	Ureterostomy-in-situ: Bilateral	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	5.000	239.80 (210.40) T
10.3	**Bladder**								
1952	J J Stent catheter	04.00	+	44.000	336.20 (294.90)	44.000	336.20 (294.90)	3.000	143.90 (126.20) T
1953	With hydrodilatation of the bladder for interstitial cystitis	04.00	+	5.000	38.20 (33.50)	5.000	38.20 (33.50)	3.000	143.90 (126.20) T
1954	Uretroscopy	04.00	+	35.000	267.40 (234.60)			3.000	143.90 (126.20) T
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	04.00	+	35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) T
1957	With dilatation of the ureter or ureters	04.00	+	25.000	191.00 (167.50)	25.000	191.00 (167.50)	3.000	143.90 (126.20) T
1959	With manipulation of ureteral calculus	04.00	+	20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
1961	With removal of foreign body or calculus from urethra or bladder	04.00	+	20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
1963	With fulguration or treatment of minor lesions, with or without biopsy	04.00	+	15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
1964	And control of haemorrhage and blood clot evacuation	04.00	+	15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
1965	And catheterisation of the ejaculatory duct	04.00	+	10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1967	With ureteric meatotomy: Unilateral or bilateral	04.00	+	15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
1969	And cold biopsy	04.00	+	15.000	114.60 (100.50)	15.000	114.60 (100.50)	3.000	143.90 (126.20) T
1971	With cryosurgery for bladder or prostatic disease	04.00	+	55.000	420.20 (368.60)	55.000	420.20 (368.60)	3.000	143.90 (126.20) 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	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) T
1975	Ultraviolet cystoscopy for bladder tumour	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) T
1976	Optic urethrotomy	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	3.000	143.90 (126.20) T
1977	Transurethral resection of ejaculatory duct	04.00		60.700	463.70 (406.80)	60.700	463.70 (406.80)	3.000	143.90 (126.20) T
1979	Internal urethrotomy: Female	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	3.000	143.90 (126.20) T
1981	Internal urethrotomy: Male	04.00		76.200	582.20 (510.70)	76.200	582.20 (510.70)	3.000	143.90 (126.20) T
1983	Transurethral resection of bladder tumour	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	5.000	239.80 (210.40) T
1984	Transurethral resection of bladder tumours: Large multiple tumours	04.00		115.000	878.60 (770.70)	115.000	878.60 (770.70)	5.000	239.80 (210.40) T
1985	Transurethral resection of bladder neck: Female or child	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	5.000	239.80 (210.40) T
1986	Transurethral resection of bladder neck: Male	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
1987	Litholapaxy	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	5.000	239.80 (210.40) T
1989	Cystometrogram	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	3.000	143.90 (126.20) T
1991	Flometric bladder, studies with videocystograph	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	3.000	143.90 (126.20) T
1992	Without videocystograph	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	3.000	143.90 (126.20) T
1993	Voiding cysto-urethrogram	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)	3.000	143.90 (126.20) T
1994	Rigiscan examination	04.00		66.000	504.20 (442.30)	66.000	504.20 (442.30)		
1995	Percutaneous aspiration of bladder	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
1996	Bladder catheterisation: Male (not at operation)	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)	3.000	143.90 (126.20) T
1997	Bladder catheterisation: Female (not at operation)	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)		
1999	Percutaneous cystostomy	04.00		24.000	183.40 (160.90)	24.000	183.40 (160.90)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
1945	Instillation of radio-opaque material for cystography or urethrocystography	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)	3.000	143.90 (126.20) T
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
1949	Cystoscopy: Hospital equipment	04.00		44.000	336.20 (294.90)	44.000	336.20 (294.90)	3.000	143.90 (126.20) T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	04.00	+	10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
2001	Total cystectomy: After previous urinary diversion	04.00		294.000	2246.20 (1970.40)	235.200	1796.90 (1576.20)	8.000	383.60 (336.50) T
2003	Total cystectomy: With conduit construction and ureteric anastomosis	04.00		554.700	4237.90 (3717.50)	443.760	3390.30 (2973.90)	8.000	383.60 (336.50) T
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	04.00		650.000	4966.00 (4356.10)	520.000	3972.80 (3484.90)	8.000	383.60 (336.50) T
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	8.000	383.60 (336.50) T
2007	Partial cystectomy	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	8.000	383.60 (336.50) T
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	04.00		462.000	3529.70 (3096.20)	369.600	2823.70 (2476.90)	8.000	383.60 (336.50) T
2010	Reversion of temporary conduit	04.00		360.000	2750.40 (2412.60)	288.000	2200.30 (1930.10)	8.000	383.60 (336.50) T
2011	Partial cystectomy with uretero-neo-cystostomy	04.00		202.000	1543.30 (1353.80)	161.600	1234.60 (1083.00)	6.000	287.70 (252.40) T
2012	Reversion of conduit with major urinary tract reconstruction	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	8.000	383.60 (336.50) T
2013	Diverticulectomy (independent procedure): Multiple or single	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2015	Suprapubic cystostomy	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	5.000	239.80 (210.40) T
2016	Abdomino-neo-urethrostomy	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	5.000	239.80 (210.40) T
2017	Open loop fulguration or excision of bladder tumour	04.00		101.000	771.60 (676.80)	101.000	771.60 (676.80)	5.000	239.80 (210.40) T
2019	Operation for vesico-vaginal or urethra-vaginal fistula	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)	5.000	239.80 (210.40) T
2020	Repair of vesico vaginal fistula: Abdominal approach	04.00		255.000	1948.20 (1708.90)	204.000	1558.60 (1367.20)	5.000	239.80 (210.40) T
2021	Vesico-plication (Hamilton Stewart)	04.00		118.000	901.50 (790.80)	118.000	901.50 (790.80)	5.000	239.80 (210.40) T
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	04.11		195.000	1489.80 (1306.80)	156.000	1191.80 (1045.40)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2025	Vesico-urethropexy with rectus sling	04.11		229.400	1752.60 (1537.40)	183.520	1402.10 (1229.90)	5.000	239.80 (210.40) T
2027	Open operation for ureterocele: Unilateral	04.00		118.000	901.50 (790.80)	118.000	901.50 (790.80)	5.000	239.80 (210.40) T
2029	Open operation for ureterocele: Bilateral	04.00		207.000	1581.50 (1387.30)	165.600	1265.20 (1109.80)	5.000	239.80 (210.40) T
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	04.00		264.000	2017.00 (1769.30)	211.200	1613.60 (1415.40)	8.000	383.60 (336.50) T
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	04.00		53.000	404.90 (355.20)	53.000	404.90 (355.20)	8.000	383.60 (336.50) T
2035	Cutaneous vesicostomy	04.00		118.000	901.50 (790.80)	118.000	901.50 (790.80)	5.000	239.80 (210.40) T
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	04.00		126.000	962.60 (844.40)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2039	Operation for ruptured bladder	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2042	Enterocystoplasty plus bowel anastomosis	04.00		419.900	3208.00 (2814.00)	335.920	2566.40 (2251.20)	5.000	239.80 (210.40) T
2043	Cysto-lithotomy	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2045	Excision of patent-urachus or urachal cyst	04.00		112.000	855.70 (750.60)	112.000	855.70 (750.60)	5.000	239.80 (210.40) T
2047	Drainage of perivesical or prevesical abscess	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	5.000	239.80 (210.40) T
2049	Evacuation of clots from bladder: Other than post-operative	04.00		132.100	1009.20 (885.30)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
2050	Evacuation of clots from bladder: Post-operative	04.00						4.000	191.80 (168.20) T
2051	Simple bladder lavage: Including catheterisation	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	3.000	143.90 (126.20) T
2053	Bladder neck plasty: Male	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2057	Bladder neck plasty: Female	04.00		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
10.4	**Urethra**								
2059	Open biopsy of urethra: Male	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2061	Open biopsy of urethra: Female	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2069	Dilatation of female urethra	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)	3.000	143.90 (126.20) T
2071	Urethrorraphy: Suture of urethral wound or injury	04.00		139.000	1062.00 (931.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2073	External urethrotomy: Pendulous urethra (anterior)	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	3.000	143.90 (126.20) T
2075	Urethraplasty: Pendulous urethra: First stage	04.00		71.000	542.40 (475.80)	71.000	542.40 (475.80)	4.000	191.80 (168.20) T
2077	Urethraplasty: Pendulous urethra: Second stage	04.00		145.000	1107.80 (971.80)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2079	Reconstruction of female urethra	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2081	Reconstruction or repair of male anterior urethra (one stage)	04.00		261.600	1998.60 (1753.20)	209.280	1598.90 (1402.50)	4.000	191.80 (168.20) T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	6.000	287.70 (252.40) T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	6.000	287.70 (252.40) T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	04.00		294.000	2246.20 (1970.40)	235.200	1796.90 (1576.20)	6.000	287.70 (252.40) T
2087	Urethral diverticulectomy: Male or female	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) 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	657.00 (576.30)	86.000	657.00 (576.30)		
2089	Marsupialisation of urethral diverticula: Male or female	04.00		115.100	879.40 (771.40)	115.100	879.40 (771.40)	4.000	191.80 (168.20) T
2091	Total urethrectomy: Female	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2093	Total urethrectomy: Male	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
2095	Drainage of simple localised perineal urinary extravasation	04.00		128.800	984.00 (863.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	05.05		137.000	1046.70 (918.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2099	Fulguration for urethral caruncle or polyp	04.00		53.600	409.50 (359.20)	53.600	409.50 (359.20)	3.000	143.90 (126.20) T
2101	Excision of urethral caruncle	04.00		53.600	409.50 (359.20)	53.600	409.50 (359.20)	3.000	143.90 (126.20) T
2103	Simple urethral meatotomy	04.00		26.300	200.90 (176.20)	26.300	200.90 (176.20)	3.000	143.90 (126.20) T
2105	Incision of deep peri-urethral abscess: Female	04.00		123.100	940.50 (825.00)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
2107	Incision of deep peri-urethral abscess: Male	04.00		123.100	940.50 (825.00)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2109	Badenoch pull-through for intractable stricture or incontinence	04.00		181.000	1382.80 (1213.00)	144.800	1106.30 (970.40)	5.000	239.80 (210.40) T
2111	External sphincterotomy	06.04		108.000	825.10 (723.80)	108.000	825.10 (723.80)	5.000	239.80 (210.40) T
2113	Drainage of Skene gland abscess or cyst	04.00		42.300	323.20 (283.50)	42.300	323.20 (283.50)	3.000	143.90 (126.20) T
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	5.000	239.80 (210.40) T
2116	Urethral meatoplasty	04.00		101.500	775.50 (680.30)	101.500	775.50 (680.30)	3.000	143.90 (126.20) T
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	04.00		150.300	1148.30 (1007.30)	120.240	918.60 (805.80)	3.000	143.90 (126.20) T
2121	Closure of urethrovaginal fistula: Including diversionary procedures	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	5.000	239.80 (210.40) T
11	**Male Genital System**								
11.1	**Penis**								
2123	Biopsy of penis (independent procedure)	04.00		52.100	398.00 (349.10)	52.100	398.00 (349.10)	3.000	143.90 (126.20) T
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)	06.04		16.600	126.80 (111.20)	16.600	126.80 (111.20)	3.000	143.90 (126.20) T
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	06.04		41.600	317.80 (278.80)	41.600	317.80 (278.80)	3.000	143.90 (126.20) T
2129	Electrodesiccation: Limited number	04.00		20.800	158.90 (139.40)	20.800	158.90 (139.40)	3.000	143.90 (126.20) T
2131	Electrodesiccation: Multiple extensive	04.00		41.600	317.80 (278.80)	41.600	317.80 (278.80)	3.000	143.90 (126.20) T
2132	Ligation of abnormal venous drainage	04.00		106.100	810.60 (711.10)	106.100	810.60 (711.10)	3.000	143.90 (126.20) T
2133	Circumcision: Clamp procedure	04.00		42.300	323.20 (283.50)	42.300	323.20 (283.50)	3.000	143.90 (126.20) T
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) T
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	04.00		36.800	281.20 (246.70)	36.800	281.20 (246.70)	3.000	143.90 (126.20) T
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	04.00		101.000	771.60 (676.80)	101.000	771.60 (676.80)	3.000	143.90 (126.20) T
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	04.00		188.600	1440.90 (1263.90)	150.880	1152.70 (1011.10)	3.000	143.90 (126.20) T
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	04.00		224.600	1715.90 (1505.20)	179.680	1372.80 (1204.20)	3.000	143.90 (126.20) T
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	3.000	143.90 (126.20) T
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2153	Reconstructive operation for epispadias with incontinence	04.00		168.000	1283.50 (1125.90)	134.400	1026.80 (900.70)	3.000	143.90 (126.20) T
2154	Induction of artificial erection	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)	3.000	143.90 (126.20) T
2155	Hypospadias: Urethral reconstruction	04.00		187.000	1428.70 (1253.20)	149.600	1142.90 (1002.50)	3.000	143.90 (126.20) T
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	04.00		84.000	641.80 (563.00)	84.000	641.80 (563.00)	3.000	143.90 (126.20) T
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	3.000	143.90 (126.20) T
2161	Total amputation of penis: Without gland dissection	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	4.000	191.80 (168.20) T
2163	Total amputation of penis: With gland-dissection	04.00		336.000	2567.00 (2251.80)	268.800	2053.60 (1801.40)	6.000	287.70 (252.40) T
2165	Partial amputation of penis: With gland-dissection	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	6.000	287.70 (252.40) T
2167	Partial amputation of penis: Without gland-dissection	04.00		84.000	641.80 (563.00)	84.000	641.80 (563.00)	4.000	191.80 (168.20) T
2169	Injection procedure for Peyronie's disease	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	04.00		42.000	320.90 (281.50)	42.000	320.90 (281.50)	3.000	143.90 (126.20) T
2173	Priapism operation: Shunt procedure: Any type	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	4.000	191.80 (168.20) T
2174	Priapism operation: Stab shunt	04.00		114.400	874.00 (766.70)	114.400	874.00 (766.70)	4.000	191.80 (168.20) 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	141.30 (123.90)	18.500	141.30 (123.90)	3.000	143.90 (126.20) T
2177	Testis biopsy: Incisional: Independent procedure: Unilateral	04.00		58.900	450.00 (394.70)	58.900	450.00 (394.70)	3.000	143.90 (126.20) T
2179	Testis biopsy: Incisional: Independent procedure: Bilateral	04.00		58.900	450.00 (394.70)	58.900	450.00 (394.70)	3.000	143.90 (126.20) T
2181	Epididymis biopsy: Needle	04.00		86.100	657.80 (577.00)	86.100	657.80 (577.00)	3.000	143.90 (126.20) T
2183	Puncture aspiration hydrocele with or without injection of medication	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	3.000	143.90 (126.20) T
2185	Operation for maldescended testicle: Including herniotomy	04.00		135.000	1031.40 (904.70)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2187	Operation for torsion appendix testis	04.00		119.200	910.70 (798.90)	119.200	910.70 (798.90)	4.000	191.80 (168.20) T
2189	Operation for torsion testis with fixation of contralateral testis	04.00		119.200	910.70 (798.90)	119.200	910.70 (798.90)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2191	Orchidectomy (total or subcapsular): Unilateral	04.00		98.000	748.70 (656.80)	98.000	748.70 (656.80)	3.000	143.90 (126.20) T
2193	Orchidectomy (total or subcapsular): Bilateral	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
2195	Radical operation for malignant testis: Excluding gland dissection	04.00		155.300	1186.50 (1040.80)	124.240	949.20 (832.60)	6.000	287.70 (252.40) T
2197	Operation for hydrocele or spermatocele	04.00		99.800	762.50 (668.90)	99.800	762.50 (668.90)	4.000	191.80 (168.20) T
2199	Varicocelectomy	04.00		106.100	810.60 (711.10)	106.100	810.60 (711.10)	4.000	191.80 (168.20) T
2201	Abdominal ligation of spermatic vein for varicocele	04.00		112.800	861.80 (756.00)	112.800	861.80 (756.00)	4.000	191.80 (168.20) T
2203	Epididymectomy: Unilateral	04.00		114.400	874.00 (766.70)	114.400	874.00 (766.70)	3.000	143.90 (126.20) T
2205	Epididymectomy: Bilateral	04.00		158.200	1208.60 (1060.20)	126.560	966.90 (848.20)	3.000	143.90 (126.20) T
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	04.00		55.900	427.10 (374.60)	55.900	427.10 (374.60)	3.000	143.90 (126.20) T
2209	Vasotomy: Unilateral or bilateral	04.00		70.400	537.90 (471.80)	70.400	537.90 (471.80)	3.000	143.90 (126.20) T
2210	Vasogram, seminal vesiculogram: Unilateral	04.00		58.100	443.90 (389.40)	58.100	443.90 (389.40)	3.000	143.90 (126.20) T
2211	Vasogram, seminal vesiculogram: Bilateral	04.00		58.100	443.90 (389.40)	58.100	443.90 (389.40)	3.000	143.90 (126.20) T
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	04.00		91.200	696.80 (611.20)	91.200	696.80 (611.20)	4.000	191.80 (168.20) T
2213	Suture or repair of testicular injury	04.00		110.300	842.70 (739.20)	110.300	842.70 (739.20)	4.000	191.80 (168.20) T
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	04.00		90.000	687.60 (603.20)	90.000	687.60 (603.20)	4.000	191.80 (168.20) T
2217	Excision of local lesion of testis or epididymis	04.00		90.800	693.70 (608.50)	90.800	693.70 (608.50)	4.000	191.80 (168.20) T
2219	Vaso-vasostomy: Unilateral	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	3.000	143.90 (126.20) T
2221	Vaso-vasostomy: Bilateral	04.00		117.000	893.90 (784.10)	117.000	893.90 (784.10)	3.000	143.90 (126.20) T
2223	Epididymo-vasostomy: Unilateral	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	3.000	143.90 (126.20) T
2225	Epididymo-vasostomy: Bilateral	04.00		117.000	893.90 (784.10)	117.000	893.90 (784.10)	3.000	143.90 (126.20) T
2227	Incision and drainage of scrotal wall abscess	04.00		42.700	326.20 (286.10)	42.700	326.20 (286.10)	3.000	143.90 (126.20) T
2229	Excision of Mullerian duct cyst	04.00		189.000	1444.00 (1266.70)	151.200	1155.20 (1013.30)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2231	Excision of lesion of spermatic cord	04.00		84.000	641.80 (563.00)	84.000	641.80 (563.00)	3.000	143.90 (126.20) T
2233	Seminal Vesiculectomy	04.00		220.000	1680.80 (1474.40)	176.000	1344.60 (1179.50)	5.000	239.80 (210.40) T
11.3	**Prostate**								
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	04.00		23.300	178.00 (156.10)	23.300	178.00 (156.10)	3.000	143.90 (126.20) T
2237	Biopsy prostate: Incisional, any approach	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	4.000	191.80 (168.20) T
2239	Transurethral drainage of prostatic abscess	04.00		117.400	896.90 (786.80)	117.400	896.90 (786.80)	4.000	191.80 (168.20) T
2241	Perineal drainage of prostatic abscess	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	4.000	191.80 (168.20) T
2243	Trans-urethral cryo-surgical removal of prostate	04.00		126.000	962.60 (844.40)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2245	Trans-urethral resection of prostate	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	6.000	287.70 (252.40) T
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	04.00		126.000	962.60 (844.40)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2249	Trans-urethral resection of post-operative bladder neck contracture	04.00		126.000	962.60 (844.40)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2251	Prostatectomy: Perineal: Sub-total	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	6.000	287.70 (252.40) T
2253	Prostatectomy: Perineal: Radical	04.00		336.000	2567.00 (2251.80)	268.800	2053.60 (1801.40)	8.000	383.60 (336.50) T
2254	Pelvic lymph adenectomy	04.11		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	8.000	383.60 (336.50) T
2255	Supra-pelvic, transversical	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	6.000	287.70 (252.40) T
2257	Retropubic: Sub-total	04.00		252.000	1925.30 (1688.90)	201.600	1540.20 (1351.10)	6.000	287.70 (252.40) T
2259	Retropubic: Radical	04.00		336.000	2567.00 (2251.80)	268.800	2053.60 (1801.40)	8.000	383.60 (336.50) T
2260	Prostate brachytherapy	04.00		230.000	1757.20 (1541.40)	184.000	1405.80 (1233.20)	8.000	383.60 (336.50) T
12	**Female Genital System**								
12.1	**Vulva and introitus**								
2271	Removal of tag or polyp	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)	3.000	143.90 (126.20) T
2272	Removal of small superficial benign lesions	04.00		23.000	175.70 (154.10)	23.000	175.70 (154.10)	3.000	143.90 (126.20) T
2273	Biopsy with suture in theatre (excluding after-care)	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	04.00		71.000	542.40 (475.80)	71.000	542.40 (475.80)	3.000	143.90 (126.20) T
2275	Reduction labial hypertrophy	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	4.000	191.80 (168.20) T
2277	Removal of extensive benign vulva tumour	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	4.000	191.80 (168.20) T
2279	Secondary perineal repair: Repair second degree tear	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	6.000	287.70 (252.40) T
2280	Secondary perineal repair: Repair third degree tear	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	6.000	287.70 (252.40) T
2281	Excision of inclusion cyst	04.00		43.000	328.50 (288.20)	43.000	328.50 (288.20)	4.000	191.80 (168.20) T
2283	Hymenectomy	04.00		43.000	328.50 (288.20)	43.000	328.50 (288.20)	4.000	191.80 (168.20) T
2285	Drainage haematocolpos	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	4.000	191.80 (168.20) T
2287	Clitoris repair for injury: Including skin graft, if required	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	4.000	191.80 (168.20) T
2288	Clitoral reduction	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	4.000	191.80 (168.20) T
2289	Denervation or alcohol infiltration vulva (Woodruff)	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	4.000	191.80 (168.20) T
2291	Vulva: Undercutting skin (ball)	04.00		58.000	443.10 (388.70)	58.000	443.10 (388.70)	4.000	191.80 (168.20) T
2293	Vulva and introitus: Drainage of abscess	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	3.000	143.90 (126.20) T
2295	Bartholin gland: Bartholin abscess marsupialisation	04.00		36.000	275.00 (241.20)	36.000	275.00 (241.20)	3.000	143.90 (126.20) T
2297	Bartholin gland: Bartholin gland excision	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2299	Bartholin gland: Bartholin radical excision for malignant lesion	04.00		357.000	2727.50 (2392.50)	285.600	2182.00 (1914.00)	6.000	287.70 (252.40) T
2301	Operation for enlarging introitus: Fenton plasty	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2303	Operation for enlarging introitus: Bilateral Z-plastic	04.00		88.000	672.30 (589.70)	88.000	672.30 (589.70)	4.000	191.80 (168.20) T
2305	Vulvectomy: Partial	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	4.000	191.80 (168.20) T
2307	Vulvectomy	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
2309	Radical vulvectomy with bilateral lymphdenectomy	04.00		357.000	2727.50 (2392.50)	285.600	2182.00 (1914.00)	6.000	287.70 (252.40) T
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	04.00		402.000	3071.30 (2694.10)	321.600	2457.00 (2155.30)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
12.2	**Vaginal procedures and operations**								
2312	Artificial insemination	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)		
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure	04.00		25.500	194.80 (170.90)	25.500	194.80 (170.90)	3.000	143.90 (126.20) T
2314	Intra uterine insemination	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)		
2315	Simms Hühner test plus wet smear	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	3.000	143.90 (126.20) T
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)	3.000	143.90 (126.20) T
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	04.00		56.000	427.80 (375.30)	56.000	427.80 (375.30)	3.000	143.90 (126.20) T
2319	Excision of cysts or tumours	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	3.000	143.90 (126.20) T
2321	Drainage of vaginal abscess	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	3.000	143.90 (126.20) T
2322	Pudendal nerve block	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
2323	Reconstruction of vagina after atresia	04.00		107.000	817.50 (717.10)	107.000	817.50 (717.10)	5.000	239.80 (210.40) T
2325	Construction of artificial vagina: Labial fusion	04.00		179.000	1367.60 (1199.60)	143.200	1094.00 (959.60)	4.000	191.80 (168.20) T
2327	Construction of artificial vagina: Macindoe type	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	5.000	239.80 (210.40) T
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each	04.11		241.000	1841.20 (1615.10)	192.800	1473.00 (1292.10)	6.000	287.70 (252.40) T
2331	Vaginal septum removal	04.00		107.000	817.50 (717.10)	107.000	817.50 (717.10)	4.000	191.80 (168.20) T
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	04.00		243.300	1858.80 (1630.50)	194.640	1487.00 (1304.40)	6.000	287.70 (252.40) T
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	04.00		243.300	1858.80 (1630.50)	194.640	1487.00 (1304.40)	6.000	287.70 (252.40) T
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	04.00		166.900	1275.10 (1118.50)	133.520	1020.10 (894.80)	6.000	287.70 (252.40) T
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	04.00		166.900	1275.10 (1118.50)	133.520	1020.10 (894.80)	6.000	287.70 (252.40) T
2339	Colpotomy: Diagnostic (excluding after-care)	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	4.000	191.80 (168.20) T
2341	Colpotomy: Therapeutic, with or without sterilisation	04.00		103.000	786.90 (690.30)	103.000	786.90 (690.30)	4.000	191.80 (168.20) T
2343	Vaginal hysterectomy: Without repair	04.00		210.500	1608.20 (1410.70)	168.400	1286.60 (1128.60)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2345	Vaginal hysterectomy: With repair	04.00		231.700	1770.20 (1552.80)	185.360	1416.20 (1242.30)	6.000	287.70 (252.40) T
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	6.000	287.70 (252.40) T
2361	Vaginal hysterectomy and repair for total prolapse	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	6.000	287.70 (252.40) T
2363	Fothergill or Manchester repair operation	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	5.000	239.80 (210.40) T
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	04.00		232.000	1772.50 (1554.80)	185.600	1418.00 (1243.90)	5.000	239.80 (210.40) T
2366	Posterior repair alone	04.00		107.000	817.50 (717.10)	107.000	817.50 (717.10)	5.000	239.80 (210.40) T
2367	Other operations for prolapse: Anterior repair - with or without posterior repair	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	5.000	239.80 (210.40) T
2368	Uterovesical fistula	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
2369	Repair of Vesico- or urethro-vaginal fistula	04.00		179.000	1367.60 (1199.60)	143.200	1094.00 (959.60)	5.000	239.80 (210.40) T
2370	Repair of VVF - Obstetric or radiation	04.00		232.000	1772.50 (1554.80)	185.600	1418.00 (1243.90)	5.000	239.80 (210.40) T
2371	Closure of uretero-vaginal fistula	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	5.000	239.80 (210.40) T
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	5.000	239.80 (210.40) T
2373	Closure of recto-vaginal fistula	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2374	Closure of recto-vaginal fistula: Obstetric or radiation	04.00		151.000	1153.60 (1011.90)	120.800	922.90 (809.60)	5.000	239.80 (210.40) T
2375	Colpocleisis	04.00		129.000	985.60 (864.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2377	Le Fort operation	04.00		129.000	985.60 (864.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2379	Schauta operation	04.00		357.000	2727.50 (2392.50)	285.600	2182.00 (1914.00)	8.000	383.60 (336.50) T
2381	Vaginectomy	04.00		268.000	2047.50 (1796.10)	214.400	1638.00 (1436.80)	8.000	383.60 (336.50) T
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee	04.00		429.000	3277.60 (2875.10)	343.200	2622.00 (2300.00)	8.000	383.60 (336.50) T
2385	Vaginal laceration or trauma: Repair	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
12.3	**Cervix**								
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)	06.05		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
2391	Cervix: Canal reconstruction	04.00		147.000	1123.10 (985.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T

Code	Description	Var	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)		
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	04.00		22.000	168.10 (147.50)	22.000	168.10 (147.50)	3.000	143.90 (126.20) T
2396	Laser or harmonic scalpel treatment of the cervix	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	3.000	143.90 (126.20) T
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	04.00		31.000	236.80 (207.70)	31.000	236.80 (207.70)	3.000	143.90 (126.20) T
2399	Punch biopsy (excluding after-care)	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	3.000	143.90 (126.20) T
2400	Biopsy during pregnancy (excluding after-care)	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	3.000	143.90 (126.20) T
2403	Wedge biopsy: Cervix (excluding after-care)	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)	3.000	143.90 (126.20) T
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	04.00		24.000	183.40 (160.90)	24.000	183.40 (160.90)	3.000	143.90 (126.20) T
2405	Cone biopsy: Cervix (excluding after-care)	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	3.000	143.90 (126.20) T
2407	Amputation: Cervix	04.00		67.000	511.90 (449.00)	67.000	511.90 (449.00)	3.000	143.90 (126.20) T
2409	Cervix encirclage: McDonald stitch	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) T
2411	Cervix encirclage: Shirodkar suture	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	3.000	143.90 (126.20) T
2413	Cervix encirclage: Lash	04.00		49.000	374.40 (328.40)	49.000	374.40 (328.40)	3.000	143.90 (126.20) T
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
2416	Cervix: Removal items 2409 and 2411: With anaesthetic in theatre	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	3.000	143.90 (126.20) T
2417	Repair of tears: Emmet repair of tears	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2418	Repair of tears: Sturmdorff repair of tears	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	3.000	143.90 (126.20) T
2421	Extirpation of cervical stump: Vaginal	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2423	Extirpation of cervical stump: Abdominal	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2425	Removal of cervical polyps (excluding after-care)	04.00		13.000	99.30 (87.10)	13.000	99.30 (87.10)	3.000	143.90 (126.20) T
2427	Removal of cervical myomata	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	3.000	143.90 (126.20) T
2429	Colposcopy (excluding after-care)	04.00		27.000	206.30 (181.00)	27.000	206.30 (181.00)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
12.4	**Uterus**								
2433	Embryo transfer	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	4.000	191.80 (168.20) T
2434	Endometrial biopsy (excluding after-care)	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)	3.000	143.90 (126.20) T
2435	Hysterosalpingogram (excluding after-care)	04.00		22.000	168.10 (147.50)	22.000	168.10 (147.50)	3.000	143.90 (126.20) T
2436	Hysteroscopy (excluding after-care)	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)	3.000	143.90 (126.20) T
2437	Hysteroscopy and D&C (excluding after-care)	04.00		58.000	443.10 (388.70)	58.000	443.10 (388.70)	3.000	143.90 (126.20) T
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	3.000	143.90 (126.20) T
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	04.00		63.000	481.30 (422.20)	63.000	481.30 (422.20)	3.000	143.90 (126.20) T
2440	Hysteroscopy and polypectomy (excluding after-care)	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	3.000	143.90 (126.20) T
2441	Hysteroscopy and myomectomy (excluding after-care)	04.00		130.000	993.20 (871.20)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	06.04		18.000	137.50 (120.60)	18.000	137.50 (120.60)	3.000	143.90 (126.20) T
2443	Dilatation and curettage (D&C) (excluding after-care)	06.04		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) T
2444	Fractional dilatation and curettage (D&C) (excluding after-care)	06.04		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	04.00		71.000	542.40 (475.80)	71.000	542.40 (475.80)	4.000	191.80 (168.20) T
2448	Termination of pregnancy before 12 weeks	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2449	Evacuation: Missed abortion: Before 12 weeks gestation	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2451	Evacuation: Missed abortion: After 12 weeks gestation	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	4.000	191.80 (168.20) T
2452	Termination of pregnancy after 12 weeks - administration of intra/extra amniotic prostaglandin	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	4.000	191.80 (168.20) T
2453	Evacuation hydatidiform mole	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	5.000	239.80 (210.40) T
2455	Evacuation uterus post-partum	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)	6.000	287.70 (252.40) T
2461	Ventrosuspension	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	4.000	191.80 (168.20) T
2463	Uteroplasty: Strassman	04.00		143.000	1092.50 (958.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2465	Uteroplasty: Tompkins	04.00		143.000	1092.50 (958.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2467	Myomectomy	04.00		143.000	1092.50 (958.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	04.00		254.100	1941.30 (1702.90)	203.280	1553.10 (1362.40)	6.000	287.70 (252.40) T
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy - uncomplicated	04.00		252.200	1926.80 (1690.20)	201.760	1541.40 (1352.10)	6.000	287.70 (252.40) T
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	04.00		355.000	2712.20 (2379.10)	284.000	2169.80 (1903.30)	6.000	287.70 (252.40) T
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	04.00		472.800	3612.20 (3168.60)	378.240	2889.80 (2534.90)	8.000	383.60 (336.50) T
2477	Abdominal hysterotomy with or without sterilisation	04.00		188.000	1436.30 (1259.90)	150.400	1149.10 (1008.00)	6.000	287.70 (252.40) T
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	6.000	287.70 (252.40) T
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)	04.00		120.000	916.80 (804.20)				
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	122.20 (107.20)	16.000	122.20 (107.20)	3.000	143.90 (126.20) T
2483	Salpingolysis	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2485	Salpingostomy	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	4.000	191.80 (168.20) T
2487	Tuboplasty tubal anastomosis or re-implantation	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	4.000	191.80 (168.20) T
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	04.00		125.000	955.00 (837.70)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	6.000	287.70 (252.40) T
2491	Ectopic pregnancy - after 12 weeks	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	6.000	287.70 (252.40) T
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	04.00		94.000	718.20 (630.00)	94.000	718.20 (630.00)	5.000	239.80 (210.40) 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	721.20 (632.60)	94.400	721.20 (632.60)	5.000	239.80 (210.40) T
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	04.00	+	18.000	137.50 (120.60)	18.000	137.50 (120.60)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2497	Laparoscopy: Plus sterilisation	04.00	+	40.000	305.60 (268.10)	40.000	305.60 (268.10)	5.000	239.80 (210.40) T
2499	Laparoscopy: Plus biopsy (excluding after-care)	04.00	+	18.000	137.50 (120.60)	18.000	137.50 (120.60)	5.000	239.80 (210.40) T
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	04.00	+	51.000	389.60 (341.80)	51.000	389.60 (341.80)	5.000	239.80 (210.40) T
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	04.00	+	18.000	137.50 (120.60)	18.000	137.50 (120.60)	5.000	239.80 (210.40) T
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	04.00	+	52.000	397.30 (348.50)	52.000	397.30 (348.50)	5.000	239.80 (210.40) T
2503	Laparoscopy: Plus ovarian drilling	04.00	+	40.000	305.60 (268.10)	40.000	305.60 (268.10)	5.000	239.80 (210.40) T
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	04.00	+	107.000	817.50 (717.10)	107.000	817.50 (717.10)	5.000	239.80 (210.40) T
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	04.00	+	52.000	397.30 (348.50)	52.000	397.30 (348.50)	5.000	239.80 (210.40) T
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	04.00		58.000	443.10 (388.70)	58.000	443.10 (388.70)		
12.6	**Ovaries**								
2525	Wedge resection of ovaries, unilateral or bilateral	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	4.000	191.80 (168.20) T
2527	Removal of ovarian tumour or cyst	04.00		187.000	1428.70 (1253.20)	149.600	1142.90 (1002.50)	4.000	191.80 (168.20) T
2529	Oophorectomy: Uni- or bilateral	04.00		134.500	1027.60 (901.40)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2531	Ovarian carcinoma debulking and omentectomy	04.00		357.000	2727.50 (2392.50)	285.600	2182.00 (1914.00)	6.000	287.70 (252.40) T
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	04.00		469.000	3583.20 (3143.20)	375.200	2866.50 (2514.50)	6.000	287.70 (252.40) T
12.7	**Miscellaneous procedures**								
2535	Exenteration: Anterior Exenteration	04.00		402.000	3071.30 (2694.10)	321.600	2457.00 (2155.30)	8.000	383.60 (336.50) T
2537	Exenteration: Posterior Exenteration	04.00		402.000	3071.30 (2694.10)	321.600	2457.00 (2155.30)	8.000	383.60 (336.50) T
2539	Exenteration: Total	04.00		625.000	4775.00 (4188.60)	500.000	3820.00 (3350.90)	8.000	383.60 (336.50) T
2541	Presacral neurectomy	04.00		98.000	748.70 (656.80)	98.000	748.70 (656.80)	5.000	239.80 (210.40) T
2543	Moschowitz operation	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be used together with this item)	04.00		193.100	1475.30 (1294.10)	154.480	1180.20 (1035.30)	5.000	239.80 (210.40) T
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	04.00		195.000	1489.80 (1306.80)	156.000	1191.80 (1045.40)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach	04.00		149.000	1138.40 (998.60)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2547	Operations for stress incontinence: Burch colposuspension	04.00		161.000	1230.00 (1078.90)	128.800	984.00 (863.20)	5.000	239.80 (210.40) T
2548	Operation for stress incontinence: Use of tape	04.00		229.400	1752.60 (1537.40)	183.520	1402.10 (1229.90)	5.000	239.80 (210.40) T
2550	Operations for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	5.000	239.80 (210.40) T
2551	Laparotomy	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	4.000	191.80 (168.20) T
2552	Removal benign retroperitoneal tumour	04.00		223.000	1703.70 (1494.50)	178.400	1363.00 (1195.60)	6.000	287.70 (252.40) T
2553	Radical removal of malignant retroperitoneal tumour	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	8.000	383.60 (336.50) T
2554	Drainage of pelvic abscess per abdomen	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	6.000	287.70 (252.40) T
2556	Drainage of pelvic abscess per vagina (refer to item 2341)	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	5.000	239.80 (210.40) T
2558	Drainage intra-abdominal abscess: Delayed closure	04.00		268.000	2047.50 (1796.10)	214.400	1638.00 (1436.80)	6.000	287.70 (252.40) T
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) 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	1604.40 (1407.40)	168.000	1283.50 (1125.90)	6.000	287.70 (252.40) T
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	6.000	287.70 (252.40) T
2565	Implantation hormone pellets (excluding after-care)	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)		
2570	Ligation of internal iliac vessels (when not part of another procedure)	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	8.000	383.60 (336.50) T
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	168.10 (147.50)	22.000	168.10 (147.50)		
2605	Amniocentesis (excluding after-care)	04.00		36.000	275.00 (241.20)	36.000	275.00 (241.20)		
2607	Amnioscopy (excluding after-care)	04.00		18.000	137.50 (120.60)	18.000	137.50 (120.60)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2609	Intra-uterine transfusion of foetus or cordocentesis	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)		
2610	Tococardiography - pre-natal and intrapartum (including stress and non-stress test: Own machine) (excluding after-care)	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)		
2611	Chorion villus sampling (excluding after-care)	04.00		54.000	412.60 (361.90)	54.000	412.60 (361.90)		
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	2154.50 (1889.90)	225.600	1723.60 (1511.90)	6.000	287.70 (252.40) 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	2039.90 (1789.40)	213.600	1631.90 (1431.50)	6.000	287.70 (252.40) T
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	04.00		190.000	1451.60 (1273.30)	152.000	1161.30 (1018.70)		
	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	2559.40 (2245.10)	268.000	2047.50 (1796.10)	9.000	431.60 (378.60) T
2657	Post-partum hysterectomy	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	8.000	383.60 (336.50) T
2669	Abdominal operation for ruptured gravid uterus: Repair	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	9.000	431.60 (378.60) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
14	**Nervous System**								
14.1	**Diagnostic procedures**								
2681	Visual evoked potentials (VEP): Unilateral	04.00		50.000	382.00 (335.10)				
2682	Visual evoked potentials (VEP): Bilateral	04.00		88.000	672.30 (589.70)				
2683	Electro-retinography (Ganzfeld method): Unilateral	04.00		60.000	458.40 (402.10)				
2684	Electro-retinography (Ganzfeld method): Bilateral	04.00		105.000	802.20 (703.70)				
2685	Electro-oculography: Unilateral	04.00		30.000	229.20 (201.10)				
2686	Electro-oculography: Bilateral	04.00		53.000	404.90 (355.20)				
2687	VEP stable condition (photic drive): Unilateral	04.00		50.000	382.00 (335.10)				
2689	VEP stable condition (photic drive): Bilateral	04.00		88.000	672.30 (589.70)				
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	04.00		150.000	1146.00 (1005.30)				
	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	366.70 (321.70)				
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	04.00		6.000	45.80 (40.20)	6.000	45.80 (40.20)		
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	1680.80 (1474.40)				
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	04.00		80.000	611.20 (536.10)				
2709	Full spinogram including bilateral median and posterior-tibial studies	04.00		140.000	1069.60 (938.20)				
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	275.80 (241.90)	36.100	275.80 (241.90)		
2712	Electro-encephalography: Interpretation	04.00		24.000	183.40 (160.90)	24.000	183.40 (160.90)		
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	06.02		18.400	140.60 (123.30)	18.400	140.60 (123.30) Z		
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.	09.01							
2714	Cisternal puncture and/or intrathecal injections	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
2715	8 Hour ambulatory EEG monitoring (Holter): Hire	04.00		136.000	1039.00 (911.40)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation	04.00		30.000	229.20 (201.10)				
2717	Electromyography: First	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)		
2718	Electromyography: Subsequent	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)		
2719	Overnight polysomnogram and sleep staging: Hire	04.00		125.000	955.00 (837.70)				
2720	Overnight polysomnogram and sleep staging: Interpretation	04.00		23.000	175.70 (154.10)				
2721	Daytime polysomnogram: Hire	04.00		125.000	955.00 (837.70)				
2722	Daytime polysomnogram: Interpretation	04.00		17.000	129.90 (113.90)				
2723	Multiple sleep latency test: Interpretation	04.00		125.000	955.00 (837.70)				
2724	Overnight continuous positive airways pressure (CPAP) titration	04.00		155.000	1184.20 (1038.80)	124.000	947.40 (831.10)		
2725	Angiography carotis: Unilateral	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	4.000	191.80 (168.20) T
2726	Angiography carotis: Bilateral	04.00		44.000	336.20 (294.90)	44.000	336.20 (294.90)	4.000	191.80 (168.20) T
2727	Vertebral artery: Direct needling	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2729	Vertebral catheterisation	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) 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	458.40 (402.10) Z				
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	04.00		14.500	110.80 (97.20)			4.000	191.80 (168.20) T
2733	Cortical Stimulation	04.00		58.900	450.00 (394.70)	58.900	450.00 (394.70)		
2734	Sodium Amytal Testing (WADA test)	04.00		88.700	677.70 (594.50)	88.700	677.70 (594.50)	13.000	623.40 (546.80) T
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	04.00		31.500	240.70 (211.10)	-	- v		
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
2739	Ventricular needling without burring: Tapping only	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)	4.000	191.80 (168.20) T
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	04.00		43.000	328.50 (288.20)	43.000	328.50 (288.20)	4.000	191.80 (168.20) T
2743	Subdural tapping: First sitting	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)	4.000	191.80 (168.20) T
2745	Subdural tapping: Subsequent	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6001	Sleep electro-encephalography: Infants that fit into a perambulator: Taking of record	04.00		36.100	275.80 (241.90)	36.100	275.80 (241.90)		
6002	Sleep electro-encephalography: Infants that fit into a perambulator: Interpretation	04.00		24.500	187.20 (164.20)	24.500	187.20 (164.20)		
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record	04.00		36.100	275.80 (241.90)	36.100	275.80 (241.90)		
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation	04.00		24.500	187.20 (164.20)	24.500	187.20 (164.20)		
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	04.00		294.600	2250.70 (1974.30)	235.680	1800.60 (1579.50)		
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	982.50 (861.80)	120.000	916.80 (804.20)		
14.2	**Introduction of burr holes for**								
2747	Ventriculography	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2749	Catheterisation for ventriculography and/or drainage	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2751	Biopsy of brain tumour	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2753	Subdural haematoma or hygroma	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2755	Subdural empyema	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2757	Brain abscess	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
14.3	**Nerve procedures**								
2759	Nerve biopsy: Peripheral	04.00		37.000	282.70 (248.00)	37.000	282.70 (248.00)	4.000	191.80 (168.20) T
2763	Nerve biopsy: Cranial nerves: Extra-cranial	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	4.000	191.80 (168.20) T
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)	4.000	191.80 (168.20) T
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)	04.00		25.000	191.00 (167.50)				
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)	04.00		30.000	229.20 (201.10)				
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)	04.00		35.000	267.40 (234.60)				
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)	04.00		35.000	267.40 (234.60)				
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	382.00 (335.10)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
14.3.1	**Nerve procedures: Nerve repair or suture**								
2767	Suture brachial plexus (see also items 2837 and 2839)	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	6.000	287.70 (252.40) T
2769	Suture: Large nerve: Primary	04.00		134.000	1023.80 (898.10)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
2771	Suture: Large nerve: Secondary	04.00		202.000	1543.30 (1353.80)	161.600	1234.60 (1083.00)	5.000	239.80 (210.40) T
2773	Digital nerve: Primary	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	3.000	143.90 (126.20) T
2775	Digital nerve: Secondary	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T
2777	Nerve graft: Simple	04.00		202.000	1543.30 (1353.80)	161.600	1234.60 (1083.00)	4.000	191.80 (168.20) T
2779	Fascicular: First fasciculus	04.00		202.000	1543.30 (1353.80)	161.600	1234.60 (1083.00)	4.000	191.80 (168.20) T
2781	Fascicular: Each additional fasciculus	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)	4.000	191.80 (168.20) T
2783	Fascicular: Nerve flap: To include all stages	04.00		224.000	1711.40 (1501.20)	179.200	1369.10 (1201.00)	4.000	191.80 (168.20) T
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	04.00		124.000	947.40 (831.10)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2787	Fascicular: Grafting of facial nerve	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	5.000	239.80 (210.40) T
14.3.2	**Nerve procedures: Neurectomy**								
2789	Trigeminal ganglion: Injection of alcohol	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
2791	Trigeminal ganglion: Injection of cortisone	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	3.000	143.90 (126.20) T
2793	Trigeminal ganglion: Coagulation through high frequency	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	3.000	143.90 (126.20) T
2799	Procedures for pain relief: Intrathecal injections for pain	04.00		36.000	275.00 (241.20)	36.000	275.00 (241.20)	4.000	191.80 (168.20) T
2800	Procedures for pain relief: Plexus nerve block	04.00		36.000	275.00 (241.20)	36.000	275.00 (241.20)	36.000	275.00 (241.20) 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	275.00 (241.20)	36.000	275.00 (241.20)		
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.	09.01							
2802	Procedures for pain relief: Peripheral nerve block	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)	25.000	191.00 (167.50) ç
2803	Alcohol injection in peripheral nerves for pain: Unilateral	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique)	04.00	+	10.000	76.40 (67.00)	10.000	76.40 (67.00)	10.000	76.40 (67.00) ç

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2805	Alcohol injection in peripheral nerves for pain: Bilateral	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) T
2809	Peripheral nerve section for pain	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)	3.000	143.90 (126.20) T
2811	Pudendal neurectomy: Bilateral	04.00		116.000	886.20 (777.40)	116.000	886.20 (777.40)	3.000	143.90 (126.20) T
2813	Obturator or Stoffels	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T
2815	Interdigital	04.00		82.300	628.80 (551.60)	82.300	628.80 (551.60)	3.000	143.90 (126.20) T
2825	Excision: Neuroma: Peripheral	04.00		109.500	836.60 (733.90)	109.500	836.60 (733.90)	3.000	143.90 (126.20) T
14.3.3	**Nerve procedures: Other nerve procedures**								
2827	Transposition of ulnar nerve	04.00		100.000	764.00 (670.20)	100.000	764.00 (670.20)	3.000	143.90 (126.20) T
2829	Neurolysis: Minor	04.00		51.000	389.60 (341.80)	51.000	389.60 (341.80)	3.000	143.90 (126.20) T
2831	Neurolysis: Major	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	3.000	143.90 (126.20) T
2833	Neurolysis: Digital	04.00		96.000	733.40 (643.30)	96.000	733.40 (643.30)	3.000	143.90 (126.20) T
2835	Scalenotomy	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
2837	Brachial plexus, suture or neurolysis (item 2767)	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	6.000	287.70 (252.40) T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	04.00		895.200	6839.30 (5999.40)	716.160	5471.50 (4799.60)	6.000	287.70 (252.40) T
2841	Carpal Tunnel	04.00		64.000	489.00 (428.90)	64.000	489.00 (428.90)	3.000	143.90 (126.20) T
2843	Lumbar sympathectomy: Unilateral	04.00		153.000	1168.90 (1025.40)	122.400	935.10 (820.30)	4.000	191.80 (168.20) T
2845	Lumbar sympathectomy: Bilateral	04.00		268.000	2047.50 (1796.10)	214.400	1638.00 (1436.80)	6.000	287.70 (252.40) T
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)	04.00						11.000	527.50 (462.70) T
2847	Cervical sympathectomy: Unilateral	04.00		153.000	1168.90 (1025.40)	122.400	935.10 (820.30)	4.000	191.80 (168.20) T
2848	Cervical sympathectomy: Bilateral	04.00		268.000	2047.50 (1796.10)	214.400	1638.00 (1436.80)	6.000	287.70 (252.40) T
2849	Sympathetic block: Other levels: Unilateral	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	3.000	143.90 (126.20) T
2851	Sympathetic block: Other levels: Bilateral	04.00		35.000	267.40 (234.60)	35.000	267.40 (234.60)	3.000	143.90 (126.20) 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	152.80 (134.00)	20.000	152.80 (134.00)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
14.4	**Skull procedures**								
2855	Removal of skull tumour: With or without plastic repair: Small	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	5.000	239.80 (210.40) T
2857	Removal of skull tumour: With or without plastic repair: Major	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	8.000	383.60 (336.50) T
2859	Repair of depressed fracture of skull: Without brain laceration: Major	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	8.000	383.60 (336.50) T
2860	Repair of depressed fracture of skull: Without brain laceration: Small	04.00		170.000	1298.80 (1139.30)	136.000	1039.00 (911.40)	8.000	383.60 (336.50) T
2861	Repair of depressed fracture of skull: With brain lacerations: Small	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	8.000	383.60 (336.50) T
2862	Repair of depressed fracture of skull: With brain lacerations: Major	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	8.000	383.60 (336.50) T
2863	Cranioplasty	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	8.000	383.60 (336.50) T
2864	Encephalocele (excluding frontal)	04.11		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	8.000	383.60 (336.50) T
2865	Craniostenosis: Few suturae	04.00		213.000	1627.30 (1427.50)	170.400	1301.90 (1142.00)	9.000	431.60 (378.60) T
2867	Craniostenosis: Multiple suturae	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	9.000	431.60 (378.60) T
14.5	**Shunt procedures**								
2869	Ventriculo-cisternostomy	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	8.000	383.60 (336.50) T
2871	Ventriculo-caval shunt	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	11.000	527.50 (462.70) T
2873	Ventriculo-peritoneal shunt	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	8.000	383.60 (336.50) T
2875	Theco-peritoneal C.S.F. shunt	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	8.000	383.60 (336.50) T
14.6	**Aneurysm repair**								
2876	Repair of aneurysms or arteriovenous anomalies (Intracranial)	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	15.000	719.30 (631.00) T
2877	Extracranial to intracranial vascular	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	15.000	719.30 (631.00) T
2878	Posterior fossa arteriovenous anomalies	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	15.000	719.30 (631.00) T
14.7	**Posterior fossa surgery**								
2879	Glosso pharyngeal nerve	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	6.000	287.70 (252.40) T
2881	Eighth nerve: Intracranial	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	8.000	383.60 (336.50) T
2883	Eighth nerve: Extracranial	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2884	Sub-temporal section of the trigeminal nerve	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	9.000	431.60 (378.60) T
2885	Trigeminal tractotomy	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	9.000	431.60 (378.60) 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	3438.00 (3015.80)	360.000	2750.40 (2412.60)	9.000	431.60 (378.60) T
2887	Vestibular nerve	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	9.000	431.60 (378.60) T
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	06.04		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	11.000	527.50 (462.70) T
2891	Posterior fossa tumour removal: Glioma, secondary deposits	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2893	Posterior fossa tumour removal: Abscess	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2895	Excision of tumour of glomus jugulare: Intracranial	04.00		420.000	3208.80 (2814.70)	336.000	2567.00 (2251.80)	11.000	527.50 (462.70) T
2897	Excision of tumour of glomus jugulare: Extracranial	04.00		420.000	3208.80 (2814.70)	336.000	2567.00 (2251.80)	9.000	431.60 (378.60) T
2898	Excision of tumour of glomus jugulare: Hemispherectomy	04.00		500.000	3820.00 (3350.90)	400.000	3056.00 (2680.70)	15.000	719.30 (631.00) T
14.7.1	**Posterior fossa surgery: Supratentorial procedures**								
2899	Craniectomy for extra-dural haematoma or empyema	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	11.000	527.50 (462.70) T
14.8	**Craniotomy for**								
2900	Craniotomy for Extra-dural orbital decompression or excision of orbital tumour	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	11.000	527.50 (462.70) 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	5348.00 (4691.20)	560.000	4278.40 (3753.00)	11.000	527.50 (462.70) T
2903	Craniotomy for Abscess, Glioma	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2905	Craniotomy for Focal epilepsy: Excision of cortical scar	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	04.11		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	11.000	527.50 (462.70) T
2907	Craniotomy for Temporal lobectomy	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2908	Craniotomy for Torkildsen anastomosis	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	11.000	527.50 (462.70) T
2909	Craniotomy for CSF-leaks	04.00		450.000	3438.00 (3015.80)	360.000	2750.40 (2412.60)	11.000	527.50 (462.70) T
2910	Craniotomy for removal of arteriovenous malformation	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	2139.20 (1876.50)	224.000	1711.40 (1501.20)	4.000	191.80 (168.20) T
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	04.00		196.000	1497.40 (1313.50)	156.800	1198.00 (1050.90)	4.000	191.80 (168.20) T
2915	Transnasal hypophysectomy	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	11.000	527.50 (462.70) T
2916	Transfrontal hypophysectomy	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	11.000	527.50 (462.70) T
2917	Transnasal hypophyseal implants	04.00		172.000	1314.10 (1152.70)	137.600	1051.30 (922.20)	11.000	527.50 (462.70) 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
2923	Chordotomy: Unilateral	04.00		178.000	1359.90 (1192.90)	142.400	1087.90 (954.30)	3.000	143.90 (126.20) TM
2925	Chordotomy: Open	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	3.000	143.90 (126.20) TM
2927	Rhizotomy: Extradural, but intraspinal	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	3.000	143.90 (126.20) TM
2928	Rhizotomy: Intradural	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	3.000	143.90 (126.20) TM
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	8.000	383.60 (336.50) T
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	8.000	383.60 (336.50) T
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	3.000	143.90 (126.20) TM
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach	04.00		350.000	2674.00 (2345.60)	280.000	2139.20 (1876.50)	8.000	383.60 (336.50) T
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	7.000	335.70 (294.50) T
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	3.000	143.90 (126.20) T
2937	Repair of meningocele, involving nerve tissue	04.00		250.000	1910.00 (1675.40)	200.000	1528.00 (1340.40)	9.000	431.60 (378.60) T
2938	Simple	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	9.000	431.60 (378.60) T
2939	Excision of arterial vascular malformations and cysts of the spinal cord	04.00		700.000	5348.00 (4691.20)	560.000	4278.40 (3753.00)	9.000	431.60 (378.60) T
2940	Lumbar osteophyte removal	04.00		187.000	1428.70 (1253.20)	149.600	1142.90 (1002.50)	3.000	143.90 (126.20) TM
2941	Cervical or thoracic osteophyte removal	04.00		285.000	2177.40 (1910.00)	228.000	1741.90 (1528.00)	3.000	143.90 (126.20) TM

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
14.10	**Arterial ligations**								
2951	Carotis: Trauma	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2953	Carotis: For aneurysm (AV anomaly)	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	8.000	383.60 (336.50) T
2955	Removal of carotid body tumour (without vascular reconstruction)	04.00		335.600	2564.00 (2249.10)	268.480	2051.20 (1799.30)	8.000	383.60 (336.50) T
14.11	**Medical psychotherapy**								
2957	Individual psychotherapy (specify type): Including play therapy for children: Per short session (20 minutes)	04.00		20.000	294.30 (258.20)	16.000	122.20 (107.20)		
2958	Psychoanalytic therapy: Per 60-minute session	04.00		60.000	882.80 (774.40)	48.000	366.70 (321.70)		
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session	04.00		20.000	294.30 (258.20)	16.000	122.20 (107.20)		
2963	Pairs, marriage or sex therapy: Per 20-minute session	04.00		20.000	294.30 (258.20)	16.000	122.20 (107.20)		
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	382.60 (335.60)	8.000	61.10 (53.60)		
2974	Individual psychotherapy (specify type): Including play therapy for children: Per intermediate session (40 minutes)	04.00		40.000	588.60 (516.30)	32.000	244.50 (214.50)		
2975	Individual psychotherapy (specify type): Including play therapy for children: Per extended session (60 minutes or longer)	04.00		60.000	882.80 (774.40)	48.000	366.70 (321.70)		
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session	04.00		40.000	588.60 (516.30)	32.000	244.50 (214.50)		
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session	04.00		60.000	882.80 (774.40)	48.000	366.70 (321.70)		
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	220.70 (193.60)	17.000	129.90 (113.90)	3.000	143.90 (126.20) T
14.13	**Psychiatric examination methods**								
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per 60 min session	06.05		60.000	882.80 (774.40)	16.000	122.20 (107.20)		
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)	04.00		20.000	294.30 (258.20)	16.000	122.20 (107.20)		
15	**Endocrine System**								
15.1	**Thyroid**								
2983	Lobectomy: Partial	04.00		198.100	1513.50 (1327.60)	158.480	1210.80 (1062.10)	5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
2985	Lobectomy: Total	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	5.000	239.80 (210.40) T
2987	Thyroidectomy: Subtotal	04.00		266.000	2032.20 (1782.60)	212.800	1625.80 (1426.10)	5.000	239.80 (210.40) T
2989	Thyroidectomy: Total	04.00		279.000	2131.60 (1869.80)	223.200	1705.20 (1495.80)	5.000	239.80 (210.40) T
2991	Thyroglossal cyst or fistula excision	04.00		126.200	964.20 (845.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
15.2	**Parathyroid**								
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	5.000	239.80 (210.40) T
15.3	**Adrenals**								
2995	Adrenalectomy: Unilateral	04.00		225.000	1719.00 (1507.90)	180.000	1375.20 (1206.30)	9.000	431.60 (378.60) T
2997	Bilateral exploration of adrenal glands: Including removal	04.00		394.000	3010.20 (2640.50)	315.200	2408.10 (2112.40)	11.000	527.50 (462.70) T
15.4	**Hypophysis**								
2999	Transethmoidal hypophysectomy	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	11.000	527.50 (462.70) T
3000	Transnasal hypophysectomy (see also item 2915)	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	11.000	527.50 (462.70) T
15.5	**Endocrine system: General**								
3001	Implantation of pellets (excluding cost of material) (excluding after-care)	04.00		3.000	22.90 (20.10)	3.000	22.90 (20.10)		
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								04.00
16.1.1	**Eye investigations**								
3002	Gonioscopy	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3006	Keratometry	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
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	89.20 (78.20)				
3012	Pre-surgical retinal examination before retinal surgery	04.00		32.000	244.50 (214.50)	32.000	244.50 (214.50)		
3013	Ocular motility assessment: Comprehensive examination	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)		
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)		
16.1.2	**Special eye investigations**								
3005	Endothelial cell count	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3007	Potential acuity measurement	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3008	Contrast sensitivity test	04.00		7.000	53.50 (46.90)	7.000	53.50 (46.90)		
3010	Orthoptics consultation	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
3011	Orthoptic subsequent sessions	04.00		5.000	38.20 (33.50)	5.000	38.20 (33.50)		
3015	Charting of visual field with manual perimeter	04.00		28.000	213.90 (187.60)	28.000	213.90 (187.60)		
3016	Retinal threshold test without storage facilities	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)		
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	04.00		74.000	565.40 (496.00)	74.000	565.40 (496.00)		
3018	Retinal threshold trend evaluation (additional to item 3017)	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)		
3019	Ocular muscle function with Hess screen or perimeter	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)		
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	04.00		46.000	351.40 (308.20)	46.000	351.40 (308.20)		
3022	Digital fluorescein video angiography	04.00		68.000	519.50 (455.70)	68.000	519.50 (455.70)	9.000	431.60 (378.60) T
3023	Digital indocyanine video angiography	04.00		110.000	840.40 (737.20)	110.000	840.40 (737.20)	9.000	431.60 (378.60) 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	91.70 (80.40)	12.000	91.70 (80.40)		
3025	Electronic tonography	04.00		19.000	145.20 (127.40)	19.000	145.20 (127.40)		
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	04.00		19.300	147.50 (129.40)	19.300	147.50 (129.40)		
3027	Fundus photography	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)		
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	04.00		40.000	305.60 (268.10)	40.000	305.60 (268.10)		
3029	Anterior segment microphotography	04.00		21.000	160.40 (140.70)	21.000	160.40 (140.70)		
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)	04.00		45.000	343.80 (301.60)	45.000	343.80 (301.60)		
3032	Eyelid and orbit photography	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)		
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)		
3034	Determination of lens implant power per eye	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
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	168.10 (147.50)	22.000	168.10 (147.50)		
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	275.00 (241.20)	36.000	275.00 (241.20)		

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				RVU	Fee	RVU	Fee	RVU	Fee
16.2	**Retina**								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	04.00		306.900	2344.70 (2056.80)	245.520	1875.80 (1645.40)	6.000	287.70 (252.40) 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	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
3041	Pan retinal photocoagulation (per eye): Done in one sitting	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3044	Removal of encircling band and/or buckling material	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
16.3	**Cataract**								
3045	Cataract: Intra-capsular	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	7.000	335.70 (294.50) T
3047	Cataract: Extra-capsular (including capsulotomy)	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	7.000	335.70 (294.50) T
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	04.00		57.000	435.50 (382.00)	57.000	435.50 (382.00)	7.000	335.70 (294.50) T
3050	Repositioning of intra ocular lens	04.00		171.100	1307.20 (1146.70)	136.880	1045.80 (917.40)	7.000	335.70 (294.50) T
3051	Needling or capsulotomy	04.00		130.000	993.20 (871.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3052	Laser capsulotomy	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	4.000	191.80 (168.20) T
3057	Removal of lenticulus	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	7.000	335.70 (294.50) T
3058	Exchange of intra ocular lens	04.00		236.000	1803.00 (1581.60)	188.800	1442.40 (1265.30)	7.000	335.70 (294.50) T
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	7.000	335.70 (294.50) 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	30.60 (26.80)				
16.4	**Glaucoma**								
3061	Drainage operation	04.00		247.600	1891.70 (1659.40)	198.080	1513.30 (1327.50)	6.000	287.70 (252.40) T
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	04.00		60.000	458.40 (402.10)	60.000	458.40 (402.10)	6.000	287.70 (252.40) T
3063	Cyclocryotherapy or cyclodiathermy	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
3064	Laser trabeculoplasty	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
3065	Removal of blood from anterior chamber	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	4.000	191.80 (168.20) T
3067	Goniotomy	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	7.000	335.70 (294.50) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
16.5	**Intra-ocular foreign body**								
3071	Intra-ocular foreign body: Anterior to Iris	04.00		127.000	970.30 (851.10)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	6.000	287.70 (252.40) 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	152.80 (134.00)	20.000	152.80 (134.00)		
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	04.00		175.600	1341.60 (1176.80)	140.480	1073.30 (941.50)	5.000	239.80 (210.40) T
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	04.00		200.000	1528.00 (1340.40)	160.000	1222.40 (1072.30)	5.000	239.80 (210.40) T
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	04.00		120.000	916.80 (804.20)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
16.7	**Globe**								
3079	Transcleral biopsy	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3080	Examination of eyes under general anaesthetic where no surgery is done	04.00		80.000	611.20 (536.10)	80.000	611.20 (536.10)	4.000	191.80 (168.20) T
3081	Treatment of minor perforating injury	04.00		161.600	1234.60 (1083.00)	129.280	987.70 (866.40)	6.000	287.70 (252.40) T
3083	Treatment of major perforating injury	04.00		267.500	2043.70 (1792.70)	214.000	1635.00 (1434.20)	6.000	287.70 (252.40) T
3085	Enucleation or Evisceration	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	5.000	239.80 (210.40) T
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	04.00		160.000	1222.40 (1072.30)	128.000	977.90 (857.80)	5.000	239.80 (210.40) T
3088	Hydroxyapetite insertion (additional to item 3087)	04.00	+	40.000	305.60 (268.10)	40.000	305.60 (268.10)	5.000	239.80 (210.40) T
3089	Subconjunctival injection if not done at time of operation	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	5.000	239.80 (210.40) T
3090	Intra vitreal injection drug	05.06		47.600	363.70 (319.00)	47.600	363.70 (319.00)	4.000	191.80 (168.20) T
3091	Retrobulbar injection (if not done at time of operation)	04.00		16.000	122.20 (107.20)	16.000	122.20 (107.20)	4.000	191.80 (168.20) T
3092	External laser treatment for superficial lesions	04.00		53.000	404.90 (355.20)	53.000	404.90 (355.20)		
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	1596.80 (1400.70)	167.200	1277.40 (1120.50)	6.000	287.70 (252.40) T
3094	Implantation of intra vitreal drug delivery system	04.00		247.600	1891.70 (1659.40)	198.080	1513.30 (1327.50)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3095	Biopsy of vitreous body or anterior chamber contents	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	6.000	287.70 (252.40) T
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	04.00		130.000	993.20 (871.20)	120.000	916.80 (804.20)	7.000	335.70 (294.50) T
3097	Anterior vitrectomy	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	6.000	287.70 (252.40) T
3098	Removal of silicon from globe	04.00		280.000	2139.20 (1876.50)	224.000	1711.40 (1501.20)	6.000	287.70 (252.40) T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	04.00		419.000	3201.20 (2808.10)	335.200	2560.90 (2246.40)	6.000	287.70 (252.40) T
3100	Lensectomy done at time of posterior vitrectomy	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	7.000	335.70 (294.50) T
16.8	**Orbit**								
3101	Drainage of orbital abscess	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	5.000	239.80 (210.40) T
3103	Orbit: Removal of tumour	04.00		240.000	1833.60 (1608.40)	192.000	1466.90 (1286.80)	5.000	239.80 (210.40) T
3104	Removal orbital prosthesis	04.00		212.700	1625.00 (1425.40)	170.160	1300.00 (1140.40)	5.000	239.80 (210.40) T
3105	Orbit: Exenteration	04.00		275.000	2101.00 (1843.00)	220.000	1680.80 (1474.40)	5.000	239.80 (210.40) T
3107	Orbitotomy requiring bone flap	04.00		393.000	3002.50 (2633.80)	314.400	2402.00 (2107.00)	5.000	239.80 (210.40) T
3108	Eye socket reconstruction	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	5.000	239.80 (210.40) T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	04.00		300.000	2292.00 (2010.50)	240.000	1833.60 (1608.40)	5.000	239.80 (210.40) T
3110	Second stage hydroxyapetite implantation	04.00		110.000	840.40 (737.20)	110.000	840.40 (737.20)	5.000	239.80 (210.40) 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. Bandage contact lens as for corneal erosion, ulcer, abrasion or corneal wound.	09.01		12.200	93.20 (81.80)	12.200	93.20 (81.80)		
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	1528.00 (1340.40)	160.000	1222.40 (1072.30)		
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only	04.00		78.850	602.40 (528.40)				
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	1268.20 (1112.50)	132.800	1014.60 (890.00)		
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	1032.90 (906.10)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3117	Removal of foreign body: On the basis of fee per consultation	04.00		-	- F	-	- F	4.000	191.80 (168.20) T
3118	Curettage of cornea after removal of foreign body (after-care excluded)	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		

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				RVU	Fee	RVU	Fee	RVU	Fee
3119	Tattooing	04.00		26.000	198.60 (174.20)	26.000	198.60 (174.20)	4.000	191.80 (168.20) 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	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3121	Corneal graft (Lamellar or full thickness)	04.00		289.000	2208.00 (1936.80)	231.200	1766.40 (1549.50)	6.000	287.70 (252.40) T
3122	Epikeratophakia	04.00		289.000	2208.00 (1936.80)	231.200	1766.40 (1549.50)		
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	04.00		254.000	1940.60 (1702.30)	203.200	1552.40 (1361.80)	6.000	287.70 (252.40) T
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see item 0202)	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)		
3125	Keratectomy	04.00		127.000	970.30 (851.10)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	04.00	+	52.180	398.70 (349.70)	52.180	398.70 (349.70)		
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3129	Additional to item 3128 for the use of own diamond knives	04.00	+	40.000	305.60 (268.10)	40.000	305.60 (268.10)		
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	04.00		96.900	740.30 (649.40)	96.900	740.30 (649.40)	4.000	191.80 (168.20) T
3131	Cornea: Paracentesis	04.00		53.000	404.90 (355.20)	53.000	404.90 (355.20)	4.000	191.80 (168.20) T
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	04.00		150.000	1146.00 (1005.30)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure	04.00		116.300	888.50 (779.40)	116.300	888.50 (779.40)	4.000	191.80 (168.20) T
3136	Conjunctival flap or graft (not for use with pterigium surgery)	04.00		95.700	731.10 (641.30)	95.700	731.10 (641.30)	6.000	287.70 (252.40) T
3138	Removal corneal epithelium and chelating agent for band keratopathy	04.00		69.500	531.00 (465.80)	69.500	531.00 (465.80)	4.000	191.80 (168.20) T
16.10	**Ducts**								
3133	Probing and/or syringing, per duct	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
3135	Insert polythene tubes	04.00		51.800	395.80 (347.20)	51.800	395.80 (347.20)	4.000	191.80 (168.20) T
3137	Excision of lacrimal sac: Unilateral	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3139	Dacrocystorhinostomy (Single) with or without polythene tube	04.00		210.000	1604.40 (1407.40)	168.000	1283.50 (1125.90)	5.000	239.80 (210.40) T
3141	Sealing Punctum surgical or by cautery: Per eye	04.00		24.900	190.20 (166.80)	24.900	190.20 (166.80)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3142	Sealing Punctum with plugs: Per eye	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)	4.000	191.80 (168.20) T
3143	Three-snip operation	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
3145	Repair of caniculus: Primary procedure	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3147	Repair of caniculus: Secondary procedure	04.00		175.000	1337.00 (1172.80)	140.000	1069.60 (938.20)	4.000	191.80 (168.20) T
16.11	**Iris**								
3149	Iridectomy or iridotomy by open operation as isolated procedure	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3151	Excision of iris tumour	04.00		185.000	1413.40 (1239.80)	148.000	1130.70 (991.80)	6.000	287.70 (252.40) T
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	04.00		105.000	802.20 (703.70)	105.000	802.20 (703.70)	4.000	191.80 (168.20) T
3155	Iridocyclectomy for tumour	04.00		266.000	2032.20 (1782.60)	212.800	1625.80 (1426.10)	6.000	287.70 (252.40) T
3157	Division of anterior synechiae as isolated procedure	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3158	Repair iris as in dialysis: Anterior chamber reconstruction	04.00		142.400	1087.90 (954.30)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
16.12	**Lids**								
3161	Tarsorrhaphy	04.00		47.000	359.10 (315.00)	47.000	359.10 (315.00)	4.000	191.80 (168.20) T
3163	Excision of superficial lid tumour	04.00		47.000	359.10 (315.00)	47.000	359.10 (315.00)	4.000	191.80 (168.20) T
3165	Repair of skin laceration lid: Simple	04.00		27.300	208.60 (183.00)	27.300	208.60 (183.00)	4.000	191.80 (168.20) T
3167	Diathermy to wart on lid margin	04.00		12.000	91.70 (80.40)	12.000	91.70 (80.40)	4.000	191.80 (168.20) T
3169	Electrolysis of any number of eyelashes: Per eye	04.00		15.000	114.60 (100.50)	15.000	114.60 (100.50)		
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see item 0202)	04.00		20.400	155.90 (136.80)	20.400	155.90 (136.80)	4.000	191.80 (168.20) T
3173	Epicanthal folds	04.00		128.700	983.30 (862.50)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)	04.00		25.000	191.00 (167.50)				
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)	04.00		35.000	267.40 (234.60)				
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	04.00		187.000	1428.70 (1253.20)	149.600	1142.90 (1002.50)	4.000	191.80 (168.20) T

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				RVU	Fee	RVU	Fee	RVU	Fee
16.12.1	**Lids: Entropion or ectropion by**								
3177	Entropion or ectropion by Cautery	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)	4.000	191.80 (168.20) T
3179	Entropion or ectropion by Suture	04.00		49.400	377.40 (331.10)	49.400	377.40 (331.10)	4.000	191.80 (168.20) T
3181	Entropion or ectropion by Open operation	04.00		111.500	851.90 (747.30)	111.500	851.90 (747.30)	4.000	191.80 (168.20) T
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	04.00		122.600	936.70 (821.70)	122.600	936.70 (821.70)	4.000	191.80 (168.20) T
16.12.2	**Lids: Reconstruction of eyelid**								
3185	Staged procedure for partial or total loss of eyelid: First stage	04.00		259.000	1978.80 (1735.80)	207.200	1583.00 (1388.60)	4.000	191.80 (168.20) T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	04.00		206.000	1573.80 (1380.50)	164.800	1259.10 (1104.50)	4.000	191.80 (168.20) T
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	04.00		136.500	1042.90 (914.80)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	04.00		150.200	1147.50 (1006.60)	120.160	918.00 (805.30)	4.000	191.80 (168.20) T
3172	Blepharoplasty lower eyelid plus fat pad	04.00		125.800	961.10 (843.10)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
16.12.3	**Lids: Ptosis**								
3193	Repair by superior rectus, levator or frontalis muscle operation	04.00		190.000	1451.60 (1273.30)	152.000	1161.30 (1018.70)	4.000	191.80 (168.20) T
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	04.00		137.600	1051.30 (922.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	04.00		166.000	1268.20 (1112.50)	132.800	1014.60 (890.00)	4.000	191.80 (168.20) T
16.13	**Conjunctiva**								
3199	Repair of conjunctiva by grafting	04.00		132.000	1008.50 (884.60)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
3200	Repair of lacerated conjunctiva	04.00		47.000	359.10 (315.00)	47.000	359.10 (315.00)	4.000	191.80 (168.20) 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	832.80 (730.50)				
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 the indicated amount per minute may be charged	09.00		2.250	17.20 (15.10)	2.250	17.20 (15.10)		
3196	Diamond knife: Use of own diamond knife during intraocular surgery	04.00		12.000	91.70 (80.40)				
3198	Excimer laser: Hire fee (per eye)	04.00		284.130	2170.80 (1904.20)				
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	832.80 (730.50)				

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3202	Phako emulsification apparatus: Hire fee	04.00		109.000	832.80 (730.50)				
3203	Vitrectomy apparatus: Hire fee	04.00		120.000	916.80 (804.20)				
17	**Ear**								
	Fitting / orientation / checking of a hearing aid: report this service using the appropriate consultation code								09.01
	Repair / modification of hearing aid: report this service using item 0201 and supply invoice								09.01
17.1	**External ear (Pinna)**								
	Fitting / orientation / checking of a hearing aid: report this service using the appropriate consultation code								09.01
	Repair / modification of hearing aid: report this service using 0201 and supply invoice								09.01
3267	Major congenital deformity reconstruction of external ear: Unilateral	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
3269	Major congenital deformity reconstruction of external ear: Bilateral	04.00		242.000	1848.90 (1621.80)	193.600	1479.10 (1297.50)	5.000	239.80 (210.40) T
3270	Excision of superficial pre-auricular fistula	04.00		55.000	420.20 (368.60)	55.000	420.20 (368.60)	4.000	191.80 (168.20) 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	1069.60 (938.20)	120.000	916.80 (804.20)	4.000	191.80 (168.20) T
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	160.40 (140.70)	21.000	160.40 (140.70)	4.000	191.80 (168.20) T
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	04.00		164.000	1253.00 (1099.10)	131.200	1002.40 (879.30)	4.000	191.80 (168.20) T
3217	Meatus atresia: Congenital	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	4.000	191.80 (168.20) T
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	04.00		77.000	588.30 (516.10)	77.000	588.30 (516.10)	4.000	191.80 (168.20) T
3221	Meatus atresia: Removal of osteoma from meatus: Multiple	04.00		215.000	1642.60 (1440.90)	172.000	1314.10 (1152.70)	4.000	191.80 (168.20) T
17.3	**Middle ear**								
3206	Microscopic examination of tympanic membrane including microsuction	04.00		8.000	61.10 (53.60)	8.000	61.10 (53.60)		
3207	Myringotomy: Unilateral	04.00		28.000	213.90 (187.60)	28.000	213.90 (187.60)	4.000	191.80 (168.20) T
3209	Myringotomy: Bilateral	04.00		46.000	351.40 (308.20)	46.000	351.40 (308.20)	4.000	191.80 (168.20) T
3211	Unilateral myringotomy with insertion of ventilation tube	04.00		38.000	290.30 (254.60)	38.000	290.30 (254.60)	4.000	191.80 (168.20) T
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	04.00		57.000	435.50 (382.00)	57.000	435.50 (382.00)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	04.00		65.000	496.60 (435.60)	65.000	496.60 (435.60)	4.000	191.80 (168.20) T
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	04.00		255.000	1948.20 (1708.90)	204.000	1558.60 (1367.20)	5.000	239.80 (210.40) T
3237	Exploratory tympanotomy	04.00		158.900	1214.00 (1064.90)	127.120	971.20 (851.90)	5.000	239.80 (210.40) T
3243	Myringoplasty	04.00		138.000	1054.30 (924.80)	120.000	916.80 (804.20)	5.000	239.80 (210.40) T
3245	Functional reconstruction of tympanic membrane	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	5.000	239.80 (210.40) T
3249	Stapedotomy and stapedectomy	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	5.000	239.80 (210.40) T
3257	Cortical mastoidectomy	04.00		188.500	1440.10 (1263.20)	150.800	1152.10 (1010.60)	5.000	239.80 (210.40) T
3259	Radical mastoidectomy (excluding minor procedures)	04.00		277.400	2119.30 (1859.00)	221.920	1695.50 (1487.30)	5.000	239.80 (210.40) T
3261	Muscle grafting to mastoid cavity without tympanoplasty	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	5.000	239.80 (210.40) T
3263	Autogenous bone graft to mastoid cavity	04.00		180.000	1375.20 (1206.30)	144.000	1100.20 (965.10)	5.000	239.80 (210.40) T
3264	Tympanomastoidectomy	04.00		375.000	2865.00 (2513.20)	300.000	2292.00 (2010.50)	5.000	239.80 (210.40) T
3265	Reconstruction of posterior canal wall, following radical mastoid	04.00		320.000	2444.80 (2144.60)	256.000	1955.80 (1715.60)	5.000	239.80 (210.40) T
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	04.00		30.000	229.20 (201.10)	30.000	229.20 (201.10)	5.000	239.80 (210.40) T
17.4	**Facial nerve**								
17.4.1	**Facial nerve: Facial nerve tests**								
3223	Percutaneous stimulation of the facial nerve	04.00		9.000	68.80 (60.40)	9.000	68.80 (60.40)	4.000	191.80 (168.20) T
3224	Electroneurography (ENOG)	04.00		75.000	573.00 (502.60)	75.000	573.00 (502.60)	4.000	191.80 (168.20) T
17.4.2	**Facial nerve: Facial nerve surgery**								
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	04.00		297.000	2269.10 (1990.40)	237.600	1815.30 (1592.40)	5.000	239.80 (210.40) T
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)	04.00		436.000	3331.00 (2921.90)	348.800	2664.80 (2337.50)	5.000	239.80 (210.40) T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	04.00		436.000	3331.00 (2921.90)	348.800	2664.80 (2337.50)	5.000	239.80 (210.40) T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	04.00		124.000	947.40 (831.10)	120.000	916.80 (804.20)	6.000	287.70 (252.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	382.00 (335.10)				
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	04.00		88.000	672.30 (589.70)				
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels	04.00		60.000	458.40 (402.10)				
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels	04.00		105.000	802.20 (703.70)				
2695	Audiology 40Hz response: Unilateral	04.00		30.000	229.20 (201.10)				
2696	Audiology 40Hz response: Bilateral	04.00		53.000	404.90 (355.20)				
2697	Mid- and long latency auditory evoked potentials: Unilateral	04.00		30.000	229.20 (201.10)				
2698	Mid- and long latency auditory evoked potentials: Bilateral	04.00		53.000	404.90 (355.20)				
2699	Electro-cochleography: Unilateral	04.00		50.000	382.00 (335.10)				
2700	Electro-cochleography: Bilateral	04.00		88.000	672.30 (589.70)				
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	04.00		140.000	1069.60 (938.20)			4.000	191.80 (168.20) T
3248	Otoacoustic emission performed as a screening test	05.03		33.240	254.00 (222.80) Z	33.240	254.00 (222.80) Z		
3250	Otoacoustic emission (high risk patients only)	04.00		66.480	507.90 (445.50)	66.480	507.90 (445.50)		
3273	Pure tone audiometry (air conduction)	04.00		6.500	49.70 (43.60)	6.500	49.70 (43.60)		
3274	Pure tone audiometry (bone conduction with masking)	04.00		6.500	49.70 (43.60)	6.500	49.70 (43.60)		
3275	Impedance audiometry (tympanometry)	04.00		6.500	49.70 (43.60)	6.500	49.70 (43.60)		
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.	04.00		6.500	49.70 (43.60)	6.500	49.70 (43.60)		
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	06.04		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	04.00		6.500	49.70 (43.60)	6.500	49.70 (43.60)		
17.5.2	**Inner ear: Balance tests**								
3251	Minimal caloric test (excluding consultation fee)	04.00		10.000	76.40 (67.00)	10.000	76.40 (67.00)		
3252	Bithermal Halpike caloric test (excluding consultation fee)	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
3253	Electro-nystagmography for spontaneous and positional nystagmus	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)		
3254	Video nystagmoscopy (monocular)	04.00		25.000	191.00 (167.50)	25.000	191.00 (167.50)		
3255	Caloric test done with electronystamography	04.00		70.000	534.80 (469.10)	70.000	534.80 (469.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3256	Video nystagmoscopy (binocular)	04.00		50.000	382.00 (335.10)	50.000	382.00 (335.10)		
3258	Otolith repositioning manoeuvre	04.00		14.000	107.00 (93.90)	14.000	107.00 (93.90)	4.000	191.80 (168.20) 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	546.10 (479.00) Z	71.480	546.10 (479.00) Z		
17.5.3	**Inner ear surgery**								
3233	Labyrinthectomy via the middle ear or mastoid	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	5.000	239.80 (210.40) T
3240	Endolymphatic sac surgery	04.00		277.000	2116.30 (1856.40)	221.600	1693.00 (1485.10)	4.000	191.80 (168.20) T
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	04.00		310.000	2368.40 (2077.50)	248.000	1894.70 (1662.00)	5.000	239.80 (210.40) T
3246	Cochlear implant surgery	04.00		340.500	2601.40 (2281.90)	272.400	2081.10 (1825.50)	5.000	239.80 (210.40) 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	3208.80 (2814.70)	336.000	2567.00 (2251.80)	5.000	239.80 (210.40) T
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	06.04		510.000	3896.40 (3417.90)	408.000	3117.10 (2734.30)	11.000	527.50 (462.70) 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	4736.80 (4155.10)	496.000	3789.40 (3324.00)	11.000	527.50 (462.70) T
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	04.00		530.000	4049.20 (3551.90)	424.000	3239.40 (2841.60)	11.000	527.50 (462.70) T
5224	Removal of acoustic neuroma via the middle fossa approach	04.00		660.000	5042.40 (4423.20)	528.000	4033.90 (3538.50)	11.000	527.50 (462.70) T
17.6.2	**Microsurgery of the skull base: Translabyrinthe approach**								
3239	Acoustic neuroma removal translabyrinthine	04.00		660.000	5042.40 (4423.20)	528.000	4033.90 (3538.50)	5.000	239.80 (210.40) T
5227	Cochleo-vestibular neurectomy	04.00		530.000	4049.20 (3551.90)	424.000	3239.40 (2841.60)	11.000	527.50 (462.70) 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	5042.40 (4423.20)	528.000	4033.90 (3538.50)	11.000	527.50 (462.70) 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	5042.40 (4423.20)	528.000	4033.90 (3538.50)	11.000	527.50 (462.70) 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	5424.40 (4758.20)	568.000	4339.50 (3806.60)	11.000	527.50 (462.70) 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	4736.80 (4155.10)	496.000	3789.40 (3324.00)	11.000	527.50 (462.70) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
5239	Removal of tumour of the clivus	04.00		620.000	4736.80 (4155.10)	496.000	3789.40 (3324.00)	11.000	527.50 (462.70) T
17.6.6	**Microsurgery of the skull base: Intrafemoral approach type C**								
5242	Removal of nasopharyngeal angiofibroma or carcinoma	04.00		520.000	3972.80 (3484.90)	416.000	3178.20 (2787.90)	8.000	383.60 (336.50) T
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	04.00		520.000	3972.80 (3484.90)	416.000	3178.20 (2787.90)	11.000	527.50 (462.70) T
17.6.7	**Microsurgery of the skull base: Subtotal petrosectomy**								
5246	Subtotal petrosectomy for removal of temporal bone tumour	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	11.000	527.50 (462.70) T
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	04.00		480.000	3667.20 (3216.80)	384.000	2933.80 (2573.50)	11.000	527.50 (462.70) 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	3972.80 (3484.90)	416.000	3178.20 (2787.90)	11.000	527.50 (462.70) T
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	04.00		600.000	4584.00 (4021.10)	480.000	3667.20 (3216.80)	8.000	383.60 (336.50) T
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	04.00		660.000	5042.40 (4423.20)	528.000	4033.90 (3538.50)	8.000	383.60 (336.50) 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	5.73 (5.03)				
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	04.00		13.500	103.10 (90.40)				
3281	Ultrasonic therapy	04.00		10.000	76.40 (67.00)				
3282	Shortwave diathermy	04.00		10.000	76.40 (67.00)				
3284	Sensory nerve conduction studies	04.00		31.000	236.80 (207.70)				
3285	Motor nerve conduction studies	04.00		26.000	198.60 (174.20)				
3287	Spinal joint and ligament injection	04.00		20.000	152.80 (134.00)	20.000	152.80 (134.00)		
3288	Epidural injection	04.00		36.000	275.00 (241.20)				
3289	Multiple injections: First joint	04.00		7.500	57.30 (50.30)				
3290	Multiple injections: Each additional joint	04.00		4.500	34.40 (30.20)				
3291	Tendon or ligament injection	04.00		9.000	68.80 (60.40)				
3292	Aspiration of joint or inter-articular injection	04.00		9.000	68.80 (60.40)				
3293	Aspiration or injection of bursa or ganglion	04.00		9.000	68.80 (60.40)				
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389)	06.05		20.000	152.80 (134.00)				
3295	Paravertebral root block: Unilateral	04.00		20.000	152.80 (134.00)				

Code	Description	Var	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3296	Paravertebral root block: Bilateral	04.00		30.000	229.20 (201.10)				
3297	Manipulation of spine performed by a specialist in Physical Medicine	04.00		14.000	107.00 (93.90)				
3298	Spinal traction	04.00		6.000	45.80 (40.20)				
3299	Manipulation of large joints: Under general anaesthesia	04.00		14.000	107.00 (93.90)			3.000	143.90 (126.20) T
3299a	Manipulation of large joints: Under general anaesthesia	05.01		14.000	107.00 (93.90)			4.000	191.80 (168.20) T
3300	Manipulation of large joints: Without anaesthetic	04.00		-	- F	-	- F		
3301	Muscle fatigue studies	04.00		20.000	152.80 (134.00)				
3302	Strength duration curve per session	04.00		10.500	80.20 (70.40)				
3303	Electromyography	04.00		75.000	573.00 (502.60)				
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	76.40 (67.00)	10.000	76.40 (67.00)		
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
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	68.20 (59.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3309	Smith-Petersen or equivalent control, in theatre	04.00				38.700	418.90 (367.50)		
3311	Stress studies, e.g. joint	04.00				7.700	83.30 (73.10)		
3313	Full length study, both legs	04.00				15.500	167.80 (147.20)		
3315	Skeletal survey under 5 years	04.00				19.900	215.40 (188.90)		
3317	Skeletal survey over 5 years	04.00				28.000	303.00 (265.80)		
3319	Arthrography per joint	04.00				15.400	166.70 (146.20)		
3320	Introduction of contrast medium or air: ADD	04.00	+			13.800	149.40 (131.10)		
6500	Hand	04.00				7.700	83.30 (73.10)		
6501	Wrist (specify region)	04.00				7.700	83.30 (73.10)		
6503	Scaphoid	04.00				7.700	83.30 (73.10)		
6504	Radius and ulna	04.00				7.700	83.30 (73.10)		
6505	Elbow	04.00				7.700	83.30 (73.10)		
6506	Humerus	04.00				7.700	83.30 (73.10)		
6507	Shoulder	04.00				7.700	83.30 (73.10)		
6508	Acromio-Clavicula joint	04.00				7.700	83.30 (73.10)		
6509	Clavicle	04.00				7.700	83.30 (73.10)		
6510	Scapula	04.00				7.700	83.30 (73.10)		
6511	Foot	04.00				7.700	83.30 (73.10)		
6512	Ankle	04.00				7.700	83.30 (73.10)		
6513	Calcaneus	04.00				7.700	83.30 (73.10)		
6514	Tibia and fibula	04.00				7.700	83.30 (73.10)		
6515	Knee	04.00				7.700	83.30 (73.10)		
6516	Patella	04.00				7.700	83.30 (73.10)		
6517	Femur	04.00				7.700	83.30 (73.10)		
6518	Hip	04.00				7.700	83.30 (73.10)		
6519	Sesamoid Bone	04.00				7.700	83.30 (73.10)		
19.1.2	**Skeleton: Spinal column**								
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic	04.00				11.000	119.10 (104.50)		
3325	Stress studies	04.00				11.000	119.10 (104.50)		
3329	Scoliosis studies	04.00				21.000	227.30 (199.40)		
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)	04.00				11.000	119.10 (104.50)		
3333	Myelography: Lumbar	04.00				28.900	312.80 (274.40)	4.000	191.80 (168.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3334	Myelography: Thoracic	04.00				22.200	240.30 (210.80)	4.000	191.80 (168.20) T
3335	Myelography: Cervical	04.00				35.500	384.20 (337.00)	4.000	191.80 (168.20) T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast nm of contrast medium)	04.00						4.000	191.80 (168.20) T
3344	Introduction of contrast medium	04.00	+			18.700	202.40 (177.50)		
3345	Discography	04.00				34.600	374.50 (328.50)	4.000	191.80 (168.20) T
3347	Introduction of contrast medium per disc level: ADD	04.00	+			28.200	305.20 (267.70)		
19.1.3	**Skeleton: Skull**								
3349	Skull studies	04.00				15.700	169.90 (149.00)		
3351	Paranasal sinuses	04.00				11.000	119.10 (104.50)		
3353	Facial bones and/or orbits	04.00				12.600	136.40 (119.60)		
3355	Mandible	04.00				9.400	101.70 (89.20)		
3357	Nasal bone	04.00				7.800	84.40 (74.00)		
3359	Mastoid: Bilateral	04.00				18.000	194.80 (170.90)		
3361	Teeth: One quadrant	04.00				3.700	40.00 (35.10)		
3363	Teeth: Two quadrants	04.00				6.300	68.20 (59.80)		
3365	Teeth: Full mouth	04.00				11.000	119.10 (104.50)		
3366	Teeth: Rotation tomography of the teeth and jaws	04.00				13.300	143.90 (126.20)		
3367	Teeth: Tempero-mandibular joints: Per side	04.00				11.000	119.10 (104.50)		
3369	Teeth: Tomography: Per side	04.00				11.000	119.10 (104.50)		
3371	Localisation of foreign body in the eye	04.00				15.700	169.90 (149.00)		
3381	Ventriculography	04.00				27.300	295.50 (259.20)	4.000	191.80 (168.20) T
3385	Post-nasal studies: Lateral neck	04.00				6.300	68.20 (59.80)		
3387	Maxillo-facial cephalometry	04.00				8.800	95.20 (83.50)		
3389	Dacrocystography	04.00				11.000	119.10 (104.50)	4.000	191.80 (168.20) T
3391	For introduction of contrast medium: ADD	04.00	+			11.000	119.10 (104.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
19.2	**Alimentary tract**								
3393	Bowel washout: ADD	04.00	+			4.800	52.00 (45.60)		
3395	Sialography (plus 80% for each additional gland)	04.00				12.700	137.50 (120.60)	4.000	191.80 (168.20) T
3397	Introduction of contrast medium (plus 80% for each additional gland: ADD)	04.00	+			11.000	119.10 (104.50)		
3399	Pharynx and oesophagus	04.00				12.700	137.50 (120.60)		
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	04.00				20.000	216.50 (189.90)		
3405	Double contrast: ADD	04.00	+			7.300	79.00 (69.30)		
3406	Small bowel meal (control film of abdomen included except when part of item 3408)	04.00				20.000	216.50 (189.90)		
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	312.80 (274.40)		
3409	Barium enema (control film of abdomen included)	04.00				18.300	198.10 (173.80)		
3411	Air contrast study: ADD	04.00	+			19.300	208.90 (183.20)		
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included	04.00				23.300	252.20 (221.20)	4.000	191.80 (168.20) T
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included	04.00				15.500	167.80 (147.20)	4.000	191.80 (168.20) T
	Note: For items 3415 and 3416: Endoscopy (see item 1778)	04.00							
3417	Gastric/oesophageal/duodenal intubation control	04.00				5.900	63.90 (56.10)		
3419	Gastric/oesophageal intubation insertion of tube: ADD	04.00	+			5.600	60.60 (53.20)		
3421	Duodenal intubation: Insertion of tube: ADD	04.00	+			11.000	119.10 (104.50)		
3423	Hypotonic duodenography (item 3403 and item 3405 included)	04.00	+			29.300	317.10 (278.20)		
19.3	**Biliary tract**								
3425	Oral cholecystography	04.00				15.700	169.90 (149.00)		
3427	Cholangiography: Intravenous	04.00				22.000	238.10 (208.90)		
3431	Operative cholangiography: First series: ADD item 3607 only when the Radiologist attends personally in theatre	04.00				21.000	227.30 (199.40)		
3433	Post operative: T-tube	04.00				16.700	180.70 (158.50)		
3435	Introduction of contrast medium: ADD	04.00	+			5.600	60.60 (53.20)		
3437	Trans hepatic, percutaneous	04.00				18.300	198.10 (173.80)		
3439	Introduction of contrast medium: ADD	04.00	+			33.100	358.20 (314.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3441	Tomography of biliary tract: ADD	04.00	+			9.400	101.70 (89.20)		
19.4	**Chest**								
3443	Larynx (Tomography included)	04.00				12.500	135.30 (118.70)		
3445	Chest (item 3601 included)	04.00				9.400	101.70 (89.20)		
3447	Chest and cardiac studies (item 3601)	04.00				12.600	136.40 (119.60)		
3449	Ribs	04.00				12.300	133.10 (116.80)		
3451	Sternum or sterno-clavicular joints	04.00				12.600	136.40 (119.60)		
3453	Bronchography: Unilateral	04.00				12.600	136.40 (119.60)	8.000	383.60 (336.50) T
3455	Bronchography: Bilateral	04.00				22.100	239.20 (209.80)	8.000	383.60 (336.50) T
3457	Introduction of contrast medium included	04.00				35.700	386.40 (338.90)		
3461	Pleurography	04.00				12.600	136.40 (119.60)	3.000	143.90 (126.20) T
3463	For introduction of contrast medium: ADD	04.00	+			2.800	30.30 (26.60)		
3465	Laryngography	04.00				11.000	119.10 (104.50)		
3467	For introduction of contrast medium: ADD	04.00	+			10.000	108.20 (94.90)		
3468	Thoracic inlet	04.00				6.300	68.20 (59.80)		
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	101.70 (89.20)		
3479	Acute abdomen or equivalent studies	04.00				15.700	169.90 (149.00)		
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	271.70 (238.30)		
3493	Waterload test: ADD	04.00	+			12.200	132.00 (115.80)		
3497	Cystography only or urethrography only (retrograde)	04.00				19.300	208.90 (183.20)		
3499	Cysto-urethrography: Retrograde	04.00				31.900	345.30 (302.90)		
3503	Cysto-urethrography: Introduction of contrast medium	04.00	+			3.700	40.00 (35.10)		
3505	Retrograde-prograde pyelography	04.00				18.300	198.10 (173.80)	3.000	143.90 (126.20) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3511	Aspiration renal cyst	04.00				18.400	199.10 (174.60)		
3513	Tomography of renal tract: ADD	04.00	+			9.400	101.70 (89.20)		
19.7	**Gynaecology and obstetrics**								
3515	Pregnancy	04.00				9.400	101.70 (89.20)		
3517	Pelvimetry	04.00				17.400	188.30 (165.20)		
3519	Hystero-salpingography	04.00				12.500	135.30 (118.70)	3.000	143.90 (126.20) T
3521	Introduction of contrast medium: ADD	04.00	+			15.300	165.60 (145.30)		
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
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							

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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							
3545	Venography: Per limb	04.00				16.500	178.60 (156.70)		
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	1805.30 (1583.60)		
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	04.00				48.600	526.00 (461.40)	4.000	191.80 (168.20) T
3558	Translumbar aortic puncture, with full study	04.00				69.600	753.30 (660.80)	5.000	239.80 (210.40) T
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram	04.00				57.000	616.90 (541.10)	4.000	191.80 (168.20) T
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram	06.04				65.400	707.80 (620.90)	4.000	191.80 (168.20) T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	04.00				73.200	792.20 (694.90)	4.000	191.80 (168.20) T
3564	Direct femoral arterial or venous or jugular venous puncture	04.00				37.200	402.60 (353.20)		
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	04.00				85.800	928.60 (814.60)	5.000	239.80 (210.40) T
3569	Intravascular pressure studies, arterial or venous, once off per case	04.00				19.800	214.30 (188.00)		
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	04.00				130.800	1415.60 (1241.80)	5.000	239.80 (210.40) T
3572	Transcatheter selective blood sampling, arterial or venous	04.00				32.400	350.70 (307.60)		
3574	Spinal angiogram (global fee) including all selective catheterisations	04.00				480.000	5195.00 (4557.00)	5.000	239.80 (210.40) T
19.8.2	**Vascular studies: Introduction of contrast medium**								
3563	Direct intravenous for limb	04.00	+			7.400	80.10 (70.30)		
3575	Cut-downs for venography: ADD	04.00	+			11.000	119.10 (104.50)		
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							

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	239.80 (210.40) T
6404	CT limb with contrast only	04.00						5.000	239.80 (210.40) T
6405	CT limb pre- AND post contrast	04.00						5.000	239.80 (210.40) T
6406	CT joint uncontrasted	04.00						5.000	239.80 (210.40) T
6407	CT joint with contrast only	04.00						5.000	239.80 (210.40) T
6408	CT joint pre AND post contrast	04.00						5.000	239.80 (210.40) T
6409	CT brain uncontrasted (including posterior fossa)	04.00						5.000	239.80 (210.40) T
6410	CT brain with contrast only (including posterior fossa)	04.00						5.000	239.80 (210.40) T
6411	CT brain pre AND post contrast (including posterior fossa)	04.00						5.000	239.80 (210.40) T
6412	CT orbits complete study, axial OR coronal, uncontrasted	04.00						5.000	239.80 (210.40) T
6413	CT orbits complete study, axial AND coronal, uncontrasted	04.00						5.000	239.80 (210.40) T
6414	CT orbits complete study, axial OR coronal pre AND post contrast	04.00						5.000	239.80 (210.40) T
6415	CT orbits complete study, axial AND coronal pre AND post contrast	04.00						5.000	239.80 (210.40) T
6416	CT paranasal sinuses limited study axial OR coronal	04.00						5.000	239.80 (210.40) T
6417	CT paranasal sinuses limited study axial AND coronal	04.00						5.000	239.80 (210.40) T
6418	CT paranasal sinuses complete study, axial or coronal, uncontrasted	04.00						5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	04.00						5.000	239.80 (210.40) T
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	04.00						5.000	239.80 (210.40) T
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	04.00						5.000	239.80 (210.40) T
6422	CT pituitary fossa, uncontrasted	04.00						5.000	239.80 (210.40) T
6423	CT pituitary fossa, pre AND post contrast	04.00						5.000	239.80 (210.40) T
6424	CT internal auditory meati, uncontrasted	04.00						5.000	239.80 (210.40) T
6425	CT internal audiory meati, pre AND post contrast	04.00						5.000	239.80 (210.40) T
6426	CT mastoids	04.00						5.000	239.80 (210.40) T
6427	CT ear structures, limited study	04.00						5.000	239.80 (210.40) T
6428	CT middle AND inner ear, complete study including reconstructions	04.00						5.000	239.80 (210.40) T
6429	CT facial bones	04.00						5.000	239.80 (210.40) T
6430	CT neck soft tissue, uncontrasted	04.00						5.000	239.80 (210.40) T
6431	CT neck soft tissue with contrast only	04.00						5.000	239.80 (210.40) T
6432	CT neck pre AND post contrast	04.00						5.000	239.80 (210.40) T
6433	CT cervical spine uncontrasted	04.00						5.000	239.80 (210.40) T
6434	CT cervical spine pre AND post contrast	04.00						5.000	239.80 (210.40) T
6435	CT cervical spine post myelogram	04.00						5.000	239.80 (210.40) T
6436	CT dorsal spine uncontrasted	04.00						5.000	239.80 (210.40) T
6437	CT dorsal spine pre AND post contrast	04.00						5.000	239.80 (210.40) T
6438	CT dorsal spine post myelogram	04.00						5.000	239.80 (210.40) T
6439	CT lumbar spine uncontrasted	04.00						5.000	239.80 (210.40) T
6440	CT lumbar spine pre AND post contrast	04.00						5.000	239.80 (210.40) T

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
6441	CT lumbar spine post myelogram	04.00						5.000	239.80 (210.40) T
6442	CT pelvimetry (topogram only)	04.00						5.000	239.80 (210.40) T
6443	CT chest uncontrasted	04.00						5.000	239.80 (210.40) T
6444	CT chest with contrast	04.00						5.000	239.80 (210.40) T
6445	CT chest pre AND post contrast	04.00						5.000	239.80 (210.40) T
6446	CT chest high resolution lungs, limited study	04.00						5.000	239.80 (210.40) T
6447	CT high resolution lungs, complete study	04.00						5.000	239.80 (210.40) T
6448	CT abdomen uncontrasted	04.00						5.000	239.80 (210.40) T
6449	CT abdomen with contrast	04.00						5.000	239.80 (210.40) T
6450	CT abdomen pre AND post contrast	04.00						5.000	239.80 (210.40) T
6451	CT abdomen triphasic study	04.00						5.000	239.80 (210.40) T
6452	CT pelvis uncontrasted	04.00						5.000	239.80 (210.40) T
6453	CT pelvis with contrast	04.00						5.000	239.80 (210.40) T
6454	CT pelvis pre AND post contrast	04.00						5.000	239.80 (210.40) T
6455	CT abdomen AND pelvis uncontrasted	04.00						5.000	239.80 (210.40) T
6456	CT abdomen AND pelvis with contrast	04.00						5.000	239.80 (210.40) T
6457	CT abdomen AND pelvis pre AND post contrast	04.00						5.000	239.80 (210.40) T
6458	CT chest, abdomen AND pelvis with contrast	04.00						5.000	239.80 (210.40) T
6459	CT base of skull to symphysis pubis with contrast	04.00						5.000	239.80 (210.40) 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	239.80 (210.40) T
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	04.00						5.000	239.80 (210.40) T

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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	218.50 (191.70)	30.000	218.50 (191.70)		
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	04.00		110.000	801.00 (702.60)	110.000	801.00 (702.60)	5.000	239.80 (210.40) T
3612	Ultrasonic bone densitometry	04.00		19.000	138.40 (121.40)	19.000	138.40 (121.40)		
3614	Transvaginal aspiration of ova	04.00		110.000	801.00 (702.60)	110.000	801.00 (702.60)		
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	364.10 (319.40)	50.000	364.10 (319.40)		
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	364.10 (319.40)	50.000	364.10 (319.40)		
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)	04.00		40.000	291.30 (255.50)	40.000	291.30 (255.50)		
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	218.50 (191.70)	30.000	218.50 (191.70)	9.000	431.60 (378.60) T
3620	Cardiac examination plus Doppler colour mapping	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3621	Cardiac examination (MMode)	04.00		25.000	182.10 (159.70)	25.000	182.10 (159.70)		
3622	Cardiac examination: 2 Dimensional	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3623	Cardiac examination + effort	04.00	+	10.000	72.80 (63.90)	10.000	72.80 (63.90)		
3624	Cardiac examinations + contrast	04.00	+	10.000	72.80 (63.90)	10.000	72.80 (63.90)		
3625	Cardiac examinations + doppler	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3626	Cardiac examination + phonocardiography	04.00	+	10.000	72.80 (63.90)	10.000	72.80 (63.90)		
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	436.90 (383.20)	60.000	436.90 (383.20)		
3628	Renal tract	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3631	Ophthalmic examination	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3633	Neonatal head scan	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
3634	Peripheral vascular study, B mode only	04.00		39.000	284.00 (249.10)	39.000	284.00 (249.10)		
3635	+ Doppler	04.00		39.000	284.00 (249.10)	39.000	284.00 (249.10)		
3636	Trans-oesophageal echocardiography including passing the device	04.00		100.000	728.20 (638.80)	100.000	728.20 (638.80)		
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	568.00 (498.20)	78.000	568.00 (498.20)		
5026	Ultrasound guided amniocentesis	04.00		39.000	284.00 (249.10)			6.000	287.70 (252.40) T
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
5101	Pleural space ultrasound	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
5103	Ultrasound soft tissue, any region	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)		
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	182.10 (159.70)	25.000	182.10 (159.70)		
5107	Ultrasound after 24 weeks - motivation required	04.00		25.000	182.10 (159.70)	25.000	182.10 (159.70)		
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	364.10 (319.40)	50.000	364.10 (319.40)		
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	932.10 (817.60)	120.000	873.80 (766.50)		
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	1500.10 (1315.90)	164.800	1200.10 (1052.70)		
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	852.00 (747.40)	117.000	852.00 (747.40)		
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis	04.00		117.000	852.00 (747.40)	117.000	852.00 (747.40)		
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	1296.20 (1137.00)	142.400	1037.00 (909.60)		
5115	Intra-operative ultrasound study	04.00		50.000	364.10 (319.40)	50.000	364.10 (319.40)	3.000	143.90 (126.20) 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	640.80 (562.10)	88.000	640.80 (562.10)		
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	320.40 (281.10)	44.000	320.40 (281.10)		
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

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	04.00		6.000	43.69 (38.32)	6.000	43.69 (38.32)		
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	75.80 (66.50)		
3640	Theatre investigations with fixed installation	04.00	+			3.000	32.50 (28.50)		
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	359.30 (315.20)	22.100	239.20 (209.80)		
3642	Repeat of further tracer tests for same investigation: Half of above fee	04.00		16.600	179.70 (157.60)	11.100	120.10 (105.40)		
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	889.70 (780.40)	54.800	593.10 (520.30)		
3645	Other organ scanning with use of relevant radio isotopes	04.00		82.200	889.70 (780.40)	54.800	593.10 (520.30)		
3646	Thyroid scanning	04.00		28.800	311.70 (273.40)	19.200	207.80 (182.30)		
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	1110.40 (974.00)	13.000	623.40 (546.80) T
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel	04.00				102.600	1110.40 (974.00)	13.000	623.40 (546.80) T
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial	04.00				102.600	1110.40 (974.00)	13.000	623.40 (546.80) T
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral - stand alone procedure	04.00				172.200	1863.70 (1634.80)	13.000	623.40 (546.80) T
5014	Atherectomy (per vessel)	04.00				204.600	2214.40 (1942.50)		
5016	Aspiration thrombectomy (per vessel)	04.00				131.400	1422.10 (1247.50)		
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite	04.00				106.800	1155.90 (1013.90)	5.000	239.80 (210.40) T
5022	Embolisation non-intracranial, per vessel	04.00				106.800	1155.90 (1013.90)	9.000	431.60 (378.60) T
5030	Percutaneous nephrostomy for further procedure or drainage	04.00				73.800	798.70 (700.60)	6.000	287.70 (252.40) T
5031	Antegrade ureteric stent insertion	04.00				69.600	753.30 (660.80)	6.000	287.70 (252.40) T
5033	Percutaneous cystostomy in radiology suite	04.00				30.000	324.70 (284.80)		

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	246.80 (216.50)		
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality	04.00				34.200	370.10 (324.60)		
5037	Urethral stenting in radiology suite	04.00				102.600	1110.40 (974.00)		
5038	Intracranial/spinal AVM embolisation (per session)	04.00				335.400	3630.00 (3184.20)	13.000	623.40 (546.80) T
5039	Intracranial thrombolysis (on-table) per session	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5040	Intracranial aneurysm occlusion	04.00				286.800	3104.00 (2722.80)	13.000	623.40 (546.80) T
5041	Balloon occlusion/Wada test	04.00				106.800	1155.90 (1013.90)	9.000	431.60 (378.60) T
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation	06.04				286.800	3104.00 (2722.80)	13.000	623.40 (546.80) T
5043	Intracranial angioplasty	04.00				204.600	2214.40 (1942.50)	13.000	623.40 (546.80) T
5044	Transhepatic portogram	04.00				139.200	1506.60 (1321.60)	9.000	431.60 (378.60) T
5045	Hepatic arterial infusion catheter insertion	04.00				156.000	1688.40 (1481.10)	6.000	287.70 (252.40) T
5046	Percutaneous biliary drainage (external)	04.00				102.600	1110.40 (974.00)	9.000	431.60 (378.60) T
5047	Combined internal/external biliary drainage	04.00				102.600	1110.40 (974.00)	9.000	431.60 (378.60) T
5048	Biliary stent insertion	04.00				139.200	1506.60 (1321.60)	9.000	431.60 (378.60) T
5049	Percutaneous gall bladder drainage	04.00				69.600	753.30 (660.80)	9.000	431.60 (378.60) T
5050	Percutaneous or renal gall bladder stone removal	04.00				172.200	1863.70 (1634.80)	5.000	239.80 (210.40) T
5058	Stent insertion: Aortic/IVC - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5060	Stent insertion: Iliac/subclavian/AV fistula - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial - including percutaneous transluminal angioplasty (PTA)	04.00				139.200	1506.60 (1321.60)	13.000	623.40 (546.80) T
5064	Stent insertion: Sub-popliteal - including percutaneous transluminal angioplasty (PTA)	04.00				172.200	1863.70 (1634.80)	13.000	623.40 (546.80) T
5066	Stent insertion: Renal/visceral/brachiocephalic - including percutaneous transluminal angioplasty (PTA)	04.00				204.600	2214.40 (1942.50)	13.000	623.40 (546.80) T
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure	04.00				204.600	2214.40 (1942.50)	13.000	623.40 (546.80)

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	246.80 (216.50)		
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality	04.00				34.200	370.10 (324.60)		

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	3370.30 (2956.40)	13.000	623.40 (546.80) T
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite	04.00				82.200	889.70 (780.40)	5.000	239.80 (210.40) T
5074	IVC filter insertion jugular or femoral route	04.00				156.000	1688.40 (1481.10)	9.000	431.60 (378.60) T
5076	Intravascular foreign body removal, arterial or venous, any route	04.00				204.600	2214.40 (1942.50)	9.000	431.60 (378.60) T
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)	04.00				70.200	759.80 (666.50)	5.000	239.80 (210.40) T
5080	Transjugular intrahepatic porto-systemic shunt	04.00				335.400	3630.00 (3184.20)	13.000	623.40 (546.80) T
5082	Transjugular liver biopsy	04.00				69.600	753.30 (660.80)	9.000	431.60 (378.60) T
5084	Endoluminal fallopian tube recanalisation	04.00				172.200	1863.70 (1634.80)	6.000	287.70 (252.40) T
5086	Renal cyst aspiration/ablation	04.00				22.800	246.80 (216.50)		
5088	Oesophageal stent insertion in radiology suite	04.00				102.600	1110.40 (974.00)	6.000	287.70 (252.40) T
5090	Tracheal stent insertion	04.00				102.600	1110.40 (974.00)	6.000	287.70 (252.40) T
5091	GIT balloon dilatation under fluoroscopy	04.00				66.600	720.80 (632.30)	6.000	287.70 (252.40) T
5092	Other GIT stent insertion	04.00				102.600	1110.40 (974.00)	6.000	287.70 (252.40) T
5093	Percutaneous gastrostomy in radiology suite	04.00				85.800	928.60 (814.60)		
5094	Cutting needle biopsy with image guidance	04.00				22.800	246.80 (216.50)		
5095	Chest drain insertion in radiology suite	04.00				32.400	350.70 (307.60)		
5096	Percutaneous cyst or tumour ablation (non aspiration)	04.00				54.600	590.90 (518.30)		
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level	04.00						13.000	623.40 (546.80) 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	3294.80 (2890.20)	5.000	239.80 (210.40) T
6201	Magnetic Resonance Imaging: Per anatomical region: Orbitae	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6202	Magnetic Resonance Imaging: Per anatomical region: Paranasal sinuses	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6203	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Face/skull	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6204	Magnetic Resonance Imaging: Per anatomical region: Skull basis/cranio-cervical joint	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6205	Magnetic Resonance Imaging: Per anatomical region: Middle and internal ears	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6206	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Neck	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6207	Magnetic Resonance Imaging: Per anatomical region: Thyroid/para-thyroid	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6208	Magnetic Resonance Imaging: Per anatomical region: Hypophysis (see modifiers 6104 and 6105 for limited examinations)	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6209	Magnetic Resonance Imaging: Per anatomical region: Bone tumour (see modifier 6103)	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6210	Magnetic Resonance Imaging: Per anatomical region: Cervical vertebrae	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6211	Magnetic Resonance Imaging: Per anatomical region: Thoracic vertebrae	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6212	Magnetic Resonance Imaging: Per anatomical region: Lumbar vertebrae	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6213	Magnetic Resonance Imaging: Per anatomical region: Sacrum	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) 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	3294.80 (2890.20)	5.000	239.80 (210.40) T
6215	Magnetic Resonance Imaging: Per anatomical region: Pelvic organs	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6216	Magnetic Resonance Imaging: Per anatomical region: Abdomen	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6217	Magnetic Resonance Imaging: Per anatomical region: Thorax wall	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6218	Magnetic Resonance Imaging: Per anatomical region: Mediastinum	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6219	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Back	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6220	Magnetic Resonance Imaging: Per anatomical region: Left shoulder	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6221	Magnetic Resonance Imaging: Per anatomical region: Right shoulder	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6222	Magnetic Resonance Imaging: Per anatomical region: Both hips	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6223	Magnetic Resonance Imaging: Per anatomical region: Left hip	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6224	Magnetic Resonance Imaging: Per anatomical region: Right hip	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6225	Magnetic Resonance Imaging: Per anatomical region: Left upper-arm	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6226	Magnetic Resonance Imaging: Per anatomical region: Right upper-arm	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6227	Magnetic Resonance Imaging: Per anatomical region: Left elbow	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6228	Magnetic Resonance Imaging: Per anatomical region: Right elbow	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6229	Magnetic Resonance Imaging: Per anatomical region: Left fore-arm	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6230	Magnetic Resonance Imaging: Per anatomical region: Right fore-arm	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6231	Magnetic Resonance Imaging: Per anatomical region: Left wrist and hand	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6232	Magnetic Resonance Imaging: Per anatomical region: Right wrist and hand	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6233	Magnetic Resonance Imaging: Per anatomical region: Left upper-leg	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6234	Magnetic Resonance Imaging: Per anatomical region: Right upper-leg	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6235	Magnetic Resonance Imaging: Per anatomical region: Left knee	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) 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	3294.80 (2890.20)	5.000	239.80 (210.40) T
6237	Magnetic Resonance Imaging: Per anatomical region: Left lower-leg	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6238	Magnetic Resonance Imaging: Per anatomical region: Right lower-leg	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6239	Magnetic Resonance Imaging: Per anatomical region: Left ankle	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6240	Magnetic Resonance Imaging: Per anatomical region: Right ankle	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6241	Magnetic Resonance Imaging: Per anatomical region: Left foot	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6242	Magnetic Resonance Imaging: Per anatomical region: Right foot	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6250	Magnetic Resonance angiography (See modifiers 6106 to 6108): Brain	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6251	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Neck	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6252	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Chest	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6253	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Abdomen	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6254	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Legs	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) T
6255	Magnetic Resonance angiography (See modifiers 6106 to 6108): Heart	04.00				400.000	3294.80 (2890.20)	5.000	239.80 (210.40) 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	576.60 (505.80)	5.000	239.80 (210.40) 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	328.10 (287.80) Z	42.950	328.10 (287.80) 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	187.10 (164.10) Z	24.490	187.10 (164.10) 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	05.03		30.610	233.90 (205.20) Z	30.610	233.90 (205.20) 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	1218.40 (1068.80) Z	127.580	974.70 (855.00) 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	687.80 (603.30) Z	90.030	687.80 (603.30) Z		

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	859.80 (754.20) Z	112.540	859.80 (754.20) 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	395.20 (346.70) Z				
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	05.01		99.320	922.30 (809.00) Z				
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		56.180	521.70 (457.60) Z				
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		131.100	1217.40 (1067.90) Z				
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	05.03		76.620	711.50 (624.10) Z				
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	05.01		178.770	1660.10 (1456.20) 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	1581.00 (1386.80) Z				
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	05.01		397.270	3689.00 (3236.00) Z				
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		238.360	2213.40 (1941.60) Z				
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		556.180	5164.70 (4530.40) Z				
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	05.03		297.950	2766.80 (2427.00) Z				
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	05.01		695.220	6455.80 (5663.00) 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	2230.60 (1956.80) 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	9074.30 (7959.90) 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	3786.40 (3321.40) Z				

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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	12703.90 (11143.80) Z				
5822	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	5147.50 (4515.40) 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	15879.90 (13929.70) 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	5970.20 (5237.00) 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	17799.50 (15613.60) 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	2156.00 (1891.20) 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	8899.70 (7806.80) 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	6995.60 (6136.50) 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	20192.20 (17712.50) Z				
20.11.5	**Kilovolt Radiation Treatment**								
5834	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT	05.03		49.080	455.80 (399.80) Z				
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT	05.01		114.520	1063.40 (932.80) Z				
20.11.6	**Short Course Radiation Treatment**								
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	05.03		105.740	981.90 (861.30) Z				
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	05.01		246.730	2291.10 (2009.70) Z				
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		148.040	1374.70 (1205.90) Z				
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		345.410	3207.50 (2813.60) Z				
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	05.03		190.330	1767.40 (1550.40) Z				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	05.01		444.110	4124.00 (3617.50) Z				

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	1800.20 (1579.10) Z				
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	05.01		452.330	4200.30 (3684.50) Z				
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		246.730	2291.10 (2009.70) Z				
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		575.690	5345.90 (4689.40) Z				
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	05.03		317.220	2945.70 (2583.90) Z				
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	05.01		740.180	6873.30 (6029.20) 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	2193.70 (1924.30) Z				
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	05.01		551.210	5118.50 (4489.90) Z				
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	05.03		330.730	3071.20 (2694.00) Z				
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	05.01		771.710	7166.10 (6286.10) Z				
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	05.03		425.230	3948.70 (3463.80) Z				
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	05.01		992.190	9213.50 (8082.00) Z				
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	05.03		348.870	3239.60 (2841.80) Z				
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	05.01		814.030	7559.10 (6630.80) Z				
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	05.03		826.830	7677.90 (6735.00) Z				
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	05.01		1929.260	17915.10 (15715.00) 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	34537.80 (30296.30) Z				
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT	05.01		8678.460	80588.20 (70691.40) Z				
5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT	05.03		4277.240	39718.50 (34840.80) 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	92676.40 (81295.10) 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	05.03		108.400	1006.60 (883.00) 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	05.03		216.800	2013.20 (1766.00) 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	5582.40 (4896.80) 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	2013.20 (1766.00) 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	7306.20 (6408.90) 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	9741.70 (8545.40) 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	5692.70 (4993.60) 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	05.03		415.960	3862.60 (3388.20) 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	9012.60 (7905.80) 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	1455.80 (1277.00) 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	39.70 (34.80)	3.000	26.50 (23.20)		
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	04.00		3.650	32.20 (28.20)	2.450	21.60 (18.90)		
3710	Antibody titration	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
3712	Antibody identification	04.00		8.450	74.60 (65.40)	5.650	49.90 (43.80)		
3713	Bleeding time (does not include the cost of the simplate device)	04.00		6.940	61.30 (53.80)	4.630	40.90 (35.90)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3714	Blood volume, dye method	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
3715	Buffy layer examination	04.00		19.900	175.80 (154.20)	13.270	117.20 (102.80)		
3716	Mean Cell Volume	04.00		2.250	-	1.500	-		
3717	Bone marrow cytological examination only	04.00		19.900	175.80 (154.20)	13.270	117.20 (102.80)		
3719	Bone marrow: Aspiration	04.00		8.400	74.20 (65.10)	5.600	49.50 (43.40)		
3720	Bone marrow trephine biopsy	04.00		32.600	288.00 (252.60)	21.700	191.70 (168.20)		
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	04.00		36.800	325.10 (285.20)	24.500	216.40 (189.80)		
3722	Capillary fragility: Hess	04.00		2.020	17.80 (15.60)	1.350	11.90 (10.40)		
3723	Circulating anticoagulants	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3724	Coagulation factor inhibitor assay	04.00		57.560	508.40 (446.00)	38.370	338.90 (297.30)		
3726	Activated protein C resistance	04.00		26.000	229.70 (201.50)	17.300	152.80 (134.00)		
3727	Coagulation time	04.00		3.160	27.90 (24.50)	2.110	18.60 (16.30)		
3728	Anti-factor Xa Activity	04.00		53.600	473.40 (415.30)	35.730	315.60 (276.80)		
3729	Cold agglutinins	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3730	Protein S: Functional	04.00		37.500	331.20 (290.50)	25.000	220.80 (193.70)		
3731	Compatibility for blood transfusion	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3732	Cryoglobulin	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3734	Protein C (chromogenic)	04.00		30.290	267.60 (234.70)	20.190	178.30 (156.40)		
3735	Anti-thrombin III (chromogenic)	04.00		22.000	194.30 (170.40)	14.700	129.80 (113.90)		
3736	Plasminogen (chromogenic)	04.00		61.650	544.60 (477.70)	41.100	363.00 (318.40)		
3737	Lupus Russel Viper method	04.00		17.000	150.20 (131.80)	11.300	99.80 (87.50)		
3738	Lupus Kaolin Exner method	04.00		25.000	220.80 (193.70)	16.700	147.50 (129.40)		
3739	Erythrocyte count	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3740	Factors V and VII: Qualitative	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
3741	Coagulation factor assay: Functional	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
3743	Erythrocyte sedimentation rate	04.00		3.000	26.50 (23.20)	2.000	17.70 (15.50)		
3744	Fibrin stabilizing factor (urea test)	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3746	Fibrin monomers	04.00		2.700	23.80 (20.90)	1.800	15.90 (13.90)		
3748	Plasminogen activator inhibitor (PAI-I)	04.00		65.950	582.50 (511.00)	43.970	388.40 (340.70)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3750	Tissue plasminogen Activator (tPA)	04.00		67.790	598.80 (525.30)	45.190	399.20 (350.20)		
3753	Osmotic fragility (before and after incubation)	04.00		18.000	159.00 (139.50)	12.000	106.00 (93.00)		
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	92.70 (81.30)	7.000	61.80 (54.20)		
3756	Full cross match	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
3757	Coagulation factors: Quantitative	04.00		32.200	284.40 (249.50)	21.470	189.60 (166.30)		
3758	Factor VIII related antigen	04.00		60.460	534.00 (468.40)	40.310	356.10 (312.40)		
3759	Coagulation factor correction study	04.00		11.720	103.50 (90.80)	7.810	69.00 (60.50)		
3761	Factor XIII related antigen	04.00		61.110	539.80 (473.50)	40.740	359.90 (315.70)		
3762	Haemoglobin estimation	04.00		1.800	15.90 (13.90)	1.200	10.60 (9.30)		
3763	Contact activated product assay	04.00		16.200	143.10 (125.50)	10.800	95.40 (83.70)		
3764	Grouping: A B and O antigens	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3765	Grouping: Rh antigen	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3766	PIVKA	04.00		43.490	384.10 (336.90)	28.990	256.10 (224.60)		
3767	Euglobulin Lysis time	04.00		25.580	225.90 (198.20)	17.050	150.60 (132.10)		
3768	Haemoglobin A2 (column chromatography)	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
3769	Haemoglobin electrophoresis	04.00		26.820	236.90 (207.80)	17.880	157.90 (138.50)		
3770	Haemoglobin-S (solubility test)	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3772	Haptoglobin: Quantitative	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
3773	Ham's acidified serum test	04.00		8.000	70.70 (62.00)	5.330	47.10 (41.30)		
3775	Heinz bodies	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3776	Haemosiderin in urinary sediment	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3783	Leucocyte differential count	04.00		6.200	54.80 (48.10)	4.150	36.70 (32.20)		
3785	Leucocytes: Total count	04.00		1.800	15.90 (13.90)	1.200	10.60 (9.30)		
3786	QBC malaria concentration and fluorescent staining	04.00		25.000	220.80 (193.70)	16.700	147.50 (129.40)		
3787	LE-cells	04.00		8.300	73.30 (64.30)	5.550	49.00 (43.00)		
3789	Neutrophil alkaline phosphatase	04.00		28.000	247.30 (216.90)	18.700	165.20 (144.90)		
3791	Packed cell volume: Haematocrit	04.00		1.800	15.90 (13.90)	1.200	10.60 (9.30)		
3792	Plasmodium falciparum: Monoclonal immunological identification	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
3793	Plasma haemoglobin	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3794	Platelet sensitivities	04.00		18.640	164.60 (144.40)	12.430	109.80 (96.30)		
3795	Platelet aggregation per aggregant	04.00		12.140	107.20 (94.00)	8.090	71.50 (62.70)		
3797	Platelet count	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3799	Platelet adhesiveness	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3801	Prothrombin consumption	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3803	Prothrombin determination (two stages)	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3805	Prothrombin index	04.00		6.000	53.00 (46.50)	4.000	35.30 (31.00)		
3806	Therapeutic drug level: Dosage	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3809	Reticulocyte count	04.00		3.000	26.50 (23.20)	2.000	17.70 (15.50)		
3810	Schumm's test	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3811	Sickling test	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3814	Sucrose lysis test for PNH	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	04.00		21.100	186.40 (163.50)	14.070	124.30 (109.00)		
3820	Thrombo - Elastogram	04.00		26.000	229.70 (201.50)	17.330	153.10 (134.30)		
3825	Fibrinogen titre	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	04.00		8.000	70.70 (62.00)	5.330	47.10 (41.30)		
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	04.00		16.000	141.30 (123.90)	10.700	94.50 (82.90)		
3832	Red cell pyruvate kinase: Quantitative	04.00		16.000	141.30 (123.90)	10.700	94.50 (82.90)		
3834	Red cell Rhesus phenotype	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3835	Haemoglobin F in blood smear	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3837	Partial thromboplastin time	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3841	Thrombin time (screen)	04.00		7.160	63.20 (55.40)	4.770	42.10 (36.90)		
3843	Thrombin time (serial)	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
3847	Haemoglobin H	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3851	Fibrin degeneration products (diffusion plate)	04.00		10.350	91.40 (80.20)	6.900	60.90 (53.40)		
3853	Fibrin degeneration products (latex slide)	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3854	XDP (Dimer test or equivalent latex slide test)	04.00		8.500	75.10 (65.90)	5.670	50.10 (43.90)		
3855	Haemagglutination inhibition	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3856	D-Dimer (quantitative)	04.00		27.520	243.10 (213.20)	18.350	162.10 (142.20)		
3857	Ristocetin Cofactor	04.00		35.530	313.80 (275.30)	23.690	209.30 (183.60)		
3858	Heparin removal	04.00		28.880	255.10 (223.80)	19.250	170.00 (149.10)		
21.2	**Microscopic and miscellaneous tests**								
3863	Autogenous vaccine	04.00		12.600	111.30 (97.60)	8.400	74.20 (65.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3864	Entomological examination	04.00		20.700	182.80 (160.40)	13.800	121.90 (106.90)		
3865	Parasites in blood smear	04.00		5.600	49.50 (43.40)	3.730	32.90 (28.90)		
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	04.00		4.900	43.30 (38.00)	3.300	29.10 (25.50)		
3868	Fungus identification	04.00		8.300	73.30 (64.30)	5.500	48.60 (42.60)		
3869	Faeces (including parasites)	04.00		4.900	43.30 (38.00)	3.270	28.90 (25.40)		
3873	Transmission electron microscopy	04.00		85.000	750.80 (658.60)	57.000	503.50 (441.70)		
3874	Scanning electron microscopy	04.00		100.000	883.30 (774.80)	67.000	591.80 (519.10)		
3875	Inclusion bodies	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3878	Crystal identification polarized light microscopy	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3879	Campylobacter in stool: Fastidious culture	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3880	Antigen detection with polyclonal antibodies	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3881	Mycobacteria	04.00		3.000	26.50 (23.20)	2.000	17.70 (15.50)		
3882	Antigen detection with monoclonal antibodies	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
3883	Concentration techniques for parasites	04.00		3.000	26.50 (23.20)	2.000	17.70 (15.50)		
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	04.00		6.300	55.60 (48.80)	4.200	37.10 (32.50)		
3885	Cytochemical stain	04.00		5.450	48.10 (42.20)	3.650	32.20 (28.20)		
21.3	**Bacteriology**								
3887	Antibiotic susceptibility test: Per organism	04.00		8.000	70.70 (62.00)	5.330	47.10 (41.30)		
3888	Adhesive tape preparation	04.00		2.700	23.80 (20.90)	1.800	15.90 (13.90)		
3889	Clostridium difficile toxin: Monoclonal immunological	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
3890	Antibiotic assay of tissues and fluids	04.00		13.900	122.80 (107.70)	9.270	81.90 (71.80)		
3891	Blood culture: Aerobic	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3892	Blood culture: Anaerobic	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3893	Bacteriological culture: Miscellaneous	04.00		6.300	55.60 (48.80)	4.200	37.10 (32.50)		
3894	Radiometric blood culture	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
3895	Bacteriological culture: Fastidious organisms	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3896	In vivo culture: Bacteria	04.00		16.000	141.30 (123.90)	10.650	94.10 (82.50)		
3897	In vivo culture: Virus	04.00		16.000	141.30 (123.90)	10.650	94.10 (82.50)		
3899	Bacterial exotoxin production (in vivo assay)	04.00		20.700	182.80 (160.40)	13.800	121.90 (106.90)		
3901	Fungal culture	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3902	Clostridium difficile (cytotoxicity neutralisation)	04.00		30.000	265.00 (232.50)	20.000	176.70 (155.00)		
3903	Antibiotic level: Biological fluids	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
3904	Rotavirus latex slide test	04.00		5.620	49.60 (43.50)	3.750	33.10 (29.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3905	Identification of virus or rickettsia	04.00		20.700	182.80 (160.40)	13.800	121.90 (106.90)		
3906	identification: Chlamydia	04.00		16.000	141.30 (123.90)	10.650	94.10 (82.50)		
3907	Culture for staphylococcus aureus	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3908	Anaerobe culture: Comprehensive	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3909	Anaerobe culture: Limited procedure	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3911	Beta-lactamase assay	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3914	Sterility control test: Biological method	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3915	Mycobacterium culture	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3916	Radiometric tuberculosis culture	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
3918	Mycoplasma culture: Comprehensive	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3919	Identification of mycobacterium	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3920	Mycobacterium: Antibiotic sensitivity	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3921	Antibiotic synergistic study	04.00		20.700	182.80 (160.40)	13.800	121.90 (106.90)		
3922	Viable cell count	04.00		1.350	11.90 (10.40)	0.900	7.95 (6.97)		
3923	Biochemical identification of bacterium: Abridged	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
3924	Biochemical identification of bacterium: Extended	04.00		12.500	110.40 (96.80)	8.330	73.60 (64.60)		
3925	Serological identification of bacterium: Abridged	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
3926	Serological identification of bacterium: Extended	04.00		10.200	90.10 (79.00)	6.800	60.10 (52.70)		
3927	Grouping for streptococci	04.00		7.300	64.50 (56.60)	4.850	42.80 (37.50)		
3928	Antimicrobic substances	04.00		3.800	33.60 (29.50)	2.500	22.10 (19.40)		
3929	Radiometric mycobacterium identification	04.00		14.000	123.70 (108.50)	9.300	82.10 (72.00)		
3930	Radiometric mycobacterium antibiotic sensitivity	04.00		25.000	220.80 (193.70)	16.700	147.50 (129.40)		
3931	Helicobacter: Monoclonal immunological	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4650	Antibiotic MIC per organism per antibiotic	04.00		8.000	70.70 (62.00)	5.330	47.10 (41.30)		
4651	Non-radiometric automated blood cultures	04.00		13.900	122.80 (107.70)	9.270	81.90 (71.80)		
4652	Rapid automated bacterial identification per organism	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
4653	Rapid automated antibiotic susceptibility per organism	04.00		17.000	150.20 (131.80)	11.330	100.10 (87.80)		
4654	Rapid automated MIC per organism per antibiotic	04.00		17.000	150.20 (131.80)	11.330	100.10 (87.80)		
4655	Mycobacteria: MIC determination - E Test	05.03		16.500	145.70 (127.80) Z	11.000	97.20 (85.30) Z		
4656	Mycobacteria: Identification HPLC	05.03		35.000	309.20 (271.20) Z	23.330	206.10 (180.80) Z		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	05.03		9.900	87.40 (76.70) Z	6.600	58.30 (51.10) Z		
21.4	**Serology**								
3958	Anti Gad/Ia2 Ab	04.00		67.950	600.20 (526.50)	45.300	400.10 (351.00)		
3959	Rose Waaler agglutination test	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3960	Gonococcal, listeria or echinococcus agglutination	04.00		9.500	83.90 (73.60)	6.300	55.60 (48.80)		
3961	Slide agglutination test	04.00		2.630	23.20 (20.40)	1.750	15.50 (13.60)		
3963	Serum complement level: Each component	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
3965	Anti Ia2 Antibodies	04.00		36.000	318.00 (278.90)	24.000	212.00 (186.00)		
3966	Anti Gad Antibodies	04.00		36.000	318.00 (278.90)	24.000	212.00 (186.00)		
3967	Auto-antibody: Sensitized erythrocytes	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3968	Herpes virus typing: Monoclonal immunological	04.00		20.690	182.80 (160.40)	13.790	121.80 (106.80)		
3969	Western blot technique	04.00		74.000	653.60 (573.30)	49.000	432.80 (379.60)		
3970	Epstein-Barr virus antibody titer	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	04.00		14.100	124.50 (109.20)	9.400	83.00 (72.80)		
3933	IgE: Total: EMIT or ELISA	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
3934	Auto antibodies by labelled antibodies	04.00		16.000	141.30 (123.90)	10.650	94.10 (82.50)		
3935	Sperm antibodies	04.00		16.000	141.30 (123.90)	10.650	94.10 (82.50)		
3936	Virus neutralisation test: First antibody	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
3937	Virus neutralisation test: Each additional antibody	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
3938	Precipitation test per antigen	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3939	Agglutination test per antigen	04.00		5.500	48.60 (42.60)	3.670	32.40 (28.40)		
3940	Haemagglutination test: Per antigen	04.00		9.900	87.40 (76.70)	6.600	58.30 (51.10)		
3941	Modified Coombs' test for brucellosis	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
3942	Hepatitis Rapid Viral Ab	04.00		12.240	108.10 (94.80)	8.160	72.10 (63.20)		
3943	Antibody titer to bacterial exotoxin	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
3945	Complement fixation test	04.00		5.850	51.70 (45.40)	3.900	34.40 (30.20)		
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	04.00		14.050	124.10 (108.90)	9.370	82.80 (72.60)		
3947	C-reactive protein	04.00		10.840	95.70 (83.90)	7.227	63.80 (56.00)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.950	114.40 (100.40)	8.630	76.20 (66.80)		
3949	Qualitative Kahn, VDRL or other flocculation	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3950	Neutrophil phagocytosis	04.00		25.200	222.60 (195.30)	16.800	148.40 (130.20)		
3951	Quantitative Kahn, VDRL or other flocculation	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
3952	Neutrophil chemotaxis	04.00		67.950	600.20 (526.50)	45.300	400.10 (351.00)		
3953	Tube agglutination test	04.00		4.150	36.70 (32.20)	2.760	24.40 (21.40)		
3955	Paul Bunnell: Presumptive	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	04.00		8.500	75.10 (65.90)	5.670	50.10 (43.90)		
3971	Immuno-diffusion test: Per antigen	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
3972	Respiratory syncytial virus (ELISA technique)	04.00		35.000	309.20 (271.20)	23.000	203.20 (178.20)		
3973	Immuno electrophoresis: Per immune serum	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
3974	Polymerase chain reaction	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	04.00		12.000	106.00 (93.00)	8.000	70.70 (62.00)		
3978	Lymphocyte transformation	04.00		51.700	456.70 (400.60)	34.500	304.70 (267.30)		
3980	Bilharzia Ag Serum/Urine	04.00		14.500	128.10 (112.40)	9.670	85.40 (74.90)		
3982	Histone Ab	04.00		16.000	141.30 (123.90)	10.670	94.20 (82.60)		
4600	Anti-CCP	05.03		17.460	154.20 (135.30) Z	11.640	102.80 (90.20) Z		
4601	Panel typing: Antibody detection: Class I	04.00		36.000	318.00 (278.90)	24.000	212.00 (186.00)		
4602	Panel typing: Antibody detection: Class II	04.00		44.000	388.70 (341.00)	29.300	258.80 (227.00)		
4603	HLA test for specific locus/antigen - serology	04.00		27.000	238.50 (209.20)	18.000	159.00 (139.50)		
4604	HLA typing: Class I - serology	04.00		52.000	459.30 (402.90)	34.700	306.50 (268.90)		
4605	HLA typing: Class II - serology	04.00		52.000	459.30 (402.90)	34.700	306.50 (268.90)		
4606	HLA typing: Class I & II - serology	04.00		90.000	795.00 (697.40)	60.000	530.00 (464.90)		
4607	Cross matching T-cells (per tray)	04.00		18.000	159.00 (139.50)	12.000	106.00 (93.00)		
4608	Cross matching B-cells	04.00		38.000	335.70 (294.50)	25.300	223.50 (196.10)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4609	Cross matching T- & B-cells	04.00		48.000	424.00 (371.90)	32.000	282.70 (248.00)		
4610	Helicobacter: Pylori antigen test	04.00		34.600	305.60 (268.10)	23.070	203.80 (178.80)		
4611	Erythropoietin	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4612	HTLV I/II	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4613	Anti-Gm1 Antibody Assay	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
4614	HIV Ab - Rapid Test	04.00		12.000	106.00 (93.00)	8.000	70.70 (62.00)		
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	39.70 (34.80)	3.000	26.50 (23.20)		
3993	Abnormal pigments: Quantitative	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
3995	Acid phosphate	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
3998	Amino acids Quantitative (Post derivatisation HPLC)	04.00		78.120	690.00 (605.30)	52.080	460.00 (403.50)		
3999	Albumin	04.00		4.800	42.40 (37.20)	3.200	28.30 (24.80)		
4000	Alcohol	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4001	Alkaline phosphatase	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4002	Alkaline phosphatase-iso-enzymes	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
4003	Ammonia: Enzymatic	04.00		7.710	68.10 (59.70)	5.140	45.40 (39.80)		
4004	Ammonia: Monitor	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4005	Alpha-1-antitrypsin: Total	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
4006	Amylase	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4007	Arsenic in blood, hair or nails	04.00		36.250	320.20 (280.90)	24.170	213.50 (187.30)		
4008	Bilirubin - Reflectance	04.00		4.770	42.10 (36.90)	3.180	28.10 (24.60)		
4009	Bilirubin: Total	04.00		4.770	42.10 (36.90)	3.180	28.10 (24.60)		
4010	Bilirubin: Conjugated	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4011	Breath Hydrogen Test	04.00		21.560	190.40 (167.00)	14.370	126.90 (111.30)		
4012	CSF Nicotinic Acid	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4013	CSF Glutamine	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4014	Cadmium: Atomic absorption	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4016	Calcium: Ionized	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4017	Calcium: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4018	Calcium: Atomic absorption	04.00		7.250	64.00 (56.10)	4.830	42.70 (37.50)		
4019	Carotene	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4020	Carnitine (Total or free) in biological fluid: Each	04.00		11.690	103.30 (90.60)	7.790	68.80 (60.40)		
4021	Carnitine (Total or free) in muscle: Each	04.00		23.380	206.50 (181.10)	15.590	137.70 (120.80)		
4022	Acyl Carnitine	04.00		23.380	206.50 (181.10)	15.590	137.70 (120.80)		
4023	Chloride	04.00		2.590	22.90 (20.10)	1.730	15.30 (13.40)		
4025	Chol/HDL/LDL/Trig	04.00		27.070	239.10 (209.70)	18.050	159.40 (139.80)		
4026	LDL cholesterol (chemical determination)	04.00		6.900	60.90 (53.40)	4.600	40.60 (35.60)		
4027	Cholesterol total	04.00		5.340	47.20 (41.40)	3.560	31.40 (27.50)		
4028	HDL cholesterol	04.00		6.900	60.90 (53.40)	4.600	40.60 (35.60)		
4029	Cholinesterase: Serum or erythrocyte: Each	04.00		7.480	66.10 (58.00)	4.990	44.10 (38.70)		
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
4031	Total CO2	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4032	Creatinine	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4033	CSF-Immunoglobulin G	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4034	C1-Esterase Inhibitor	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4035	CSF-Albumin	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4036	CSF-IgG Index	04.00		22.050	194.80 (170.90)	14.700	129.80 (113.90)		
4038	Glutamic acid	04.00		29.060	256.70 (225.20)	19.370	171.10 (150.10)		
4040	Homocysteine (random)	04.00		15.300	135.10 (118.50)	10.200	90.10 (79.00)		
4041	Homocysteine (after Methionine load)	04.00		18.100	159.90 (140.30)	12.060	106.50 (93.40)		
4042	D-Xylose absorption test: Two hours	04.00		13.150	116.20 (101.90)	8.750	77.30 (67.80)		
4045	Fibrinogen: Quantitative	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
4049	Glucose tolerance test (2 specimens)	04.00		8.970	79.20 (69.50)	5.980	52.80 (46.30)		
4050	Glucose strip-test with photometric reading	04.00		1.800	15.90 (13.90)	1.200	10.60 (9.30)		
4051	Galactose	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4052	Glucose tolerance test (3 specimens)	04.00		13.170	116.30 (102.00)	8.780	77.60 (68.10)		
4053	Glucose tolerance test (4 specimens)	04.00		17.370	153.40 (134.60)	11.580	102.30 (89.70)		
4057	Glucose: Quantitative	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4061	Glucose tolerance test (5 specimens)	04.00		21.560	190.40 (167.00)	14.370	126.90 (111.30)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4062	Galactose-1-phosphate uridyl transferase	04.00		16.000	141.30 (123.90)	10.700	94.50 (82.90)		
4063	Fructosamine	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
4064	HbA1C	06.04		14.250	125.90 (110.40)	9.500	83.90 (73.60)		
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.00		46.880	414.10 (363.20)	31.250	276.00 (242.10)		
4067	Lithium: Flame ionisation	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4068	Lithium: Atomic absorption	04.00		7.480	66.10 (58.00)	4.990	44.10 (38.70)		
4071	Iron	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4073	Iron-binding capacity	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
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	168.70 (148.00)	12.730	112.40 (98.60)		
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	04.11		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4079	Ketones in plasma: Qualitative	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4081	Drug level-biological fluid: Quantitative	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4082	Tacrolimus assay	04.00		20.100	177.50 (155.70)	13.400	118.40 (103.90)		
4083	Lysosomal enzyme assay	04.00		36.560	322.90 (283.20)	24.370	215.30 (188.90)		
4084	Thymidine kinase	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4085	Lipase	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4086	Lactate	04.00		16.000	141.30 (123.90)	10.670	94.20 (82.60)		
4091	Lipoprotein electrophoresis	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
4092	Orosmucoid	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4093	Osmolality: Serum or urine	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4094	Magnesium: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4095	Magnesium: Atomic absorption	04.00		7.250	64.00 (56.10)	4.830	42.70 (37.50)		
4096	Mercury: Atomic absorption	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4098	Copper: Atomic absorption	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4105	Protein electrophoresis	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	04.00		20.000	176.70 (155.00)	13.200	116.60 (102.30)		
4109	Phosphate	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4113	Potassium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4114	Sodium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4117	Protein: Total	04.00		3.110	27.50 (24.10)	2.070	18.30 (16.10)		
4121	pH, pCO2 or pO2: Each	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4123	Pyruvic acid	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4125	Salicylates	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4127	Caeruloplasmin	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4128	Phenylalanine: Quantitative	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4130	Aspartate aminotransferase (AST)	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4131	Alanine aminotransferase (ALT)	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4132	Creatine kinase (CK)	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4133	Lactate dehidrogenase (LD)	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4134	Gamma glutamyl transferase (GGT)	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4135	Aldolase	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4136	Angiotensin converting enzyme (ACE)	04.00		9.000	79.50 (69.70)	6.000	53.00 (46.50)		
4137	Lactate dehydrogenase isoenzyme	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4138	CK-MB: Immunoinhibition/precipitation	04.11		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4139	Adenosine deaminase	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4143	Serum/plasma enzymes	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4144	Transferrin	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
4146	Lead: Atomic absorption	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
4147	Triglyceride	04.00		7.930	70.00 (61.40)	5.290	46.70 (41.00)		
4148	Tay - Sachs Study	04.00		36.560	322.90 (283.20)	24.370	215.30 (188.90)		
4149	Red cell magnesium	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
4151	Urea	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4152	CK-MB: Mass determination: Quantitative (Automated)	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4153	CK-MB: Mass determination: Quantitative (Not automated)	04.00		17.470	154.30 (135.40)	11.650	102.90 (90.30)		
4154	Myoglobin quantitative: Monoclonal immunological	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4155	Uric acid	04.00		3.780	33.40 (29.30)	2.520	22.30 (19.60)		
4156	Vitamin D3	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4157	Vitamin A-saturation test	04.00		15.300	135.10 (118.50)	10.200	90.10 (79.00)		
4158	Vitamin E (tocopherol)	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
4159	Vitamin A	04.00		6.300	55.60 (48.80)	4.200	37.10 (32.50)		
4161	Troponin isoforms: Each	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4163	Apoprotein AI: Turbidometric method	04.00		8.280	73.10 (64.10)	5.520	48.80 (42.80)		
4165	Apoprotein AII: Turbidometric method	04.00		8.280	73.10 (64.10)	5.520	48.80 (42.80)		
4167	Apoprotein B: Turbidometric method	04.00		8.280	73.10 (64.10)	5.520	48.80 (42.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4170	Lipoprotein (a)(Lp(a)) assay	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4171	Sodium + potassium + chloride + CO2 + urea	04.00		15.840	139.90 (122.70)	10.560	93.30 (81.80)		
4172	ELISA/EMIT technique	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4173	Sirolimus Assay	04.00		78.000	689.00 (604.40)	52.000	459.30 (402.90)		
4181	Quantitative protein estimation: Mancini method	04.00		7.760	68.50 (60.10)	5.170	45.70 (40.10)		
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	04.00		8.280	73.10 (64.10)	5.520	48.80 (42.80)		
4183	Quantitative protein estimation: Labelled antibody	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4184	C-reactive protein (Ultra sensitive)	04.00		11.680	103.20 (90.50)	7.790	68.80 (60.40)		
4185	Lactose	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4186	Vitamin B6	04.00		15.300	135.10 (118.50)	10.200	90.10 (79.00)		
4187	Zinc: Atomic absorption	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
21.7	**Biochemical tests: Urine**								
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	04.00		1.500	13.20 (11.60)	1.000	8.83 (7.75)		
4189	Abnormal pigments	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4193	Alkapton test: Homogentisic acid	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4194	Amino acids: Quantitative (Post derivatisation HPLC)	04.00		78.120	690.00 (605.30)	52.080	460.00 (403.50)		
4195	Amino laevulinic acid	04.00		18.000	159.00 (139.50)	12.000	106.00 (93.00)		
4197	Amylase	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4198	Arsenic	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4199	Ascorbic acid	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4201	Bence-Jones protein	04.00		2.700	23.80 (20.90)	1.800	15.90 (13.90)		
4204	Calcium: Atomic absorption	04.00		7.250	64.00 (56.10)	4.830	42.70 (37.50)		
4205	Calcium: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4209	Lead: Atomic absorption	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
4210	Urine collagen telopeptides	04.00		36.500	322.40 (282.80)	24.330	214.90 (188.50)		
4211	Bile pigments: Qualitative	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4213	Protein: Quantitative	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4216	Mucopolysaccharides: Qualitative	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
4217	Oxalate	04.00		9.380	82.90 (72.70)	6.250	55.20 (48.40)		
4218	Glucose: Quantitative	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4219	Steroids: Chromatography (each)	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
4221	Creatinine	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4223	Creatinine clearance	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
4227	Electrophoresis: Qualitative	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4228	Fetal Lung Maturity	04.00		36.560	322.90 (283.20)	24.370	215.30 (188.90)		
4230	Urine/Fluid - Specific Gravity	04.00		0.900	7.95 (6.97)	0.600	5.30 (4.65)		
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	05.03		37.500	331.20 (290.50) Z	25.000	220.80 (193.70) Z		
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	05.03		46.800	413.40 (362.60) Z	31.200	275.60 (241.80) Z		
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	05.03		37.500	331.20 (290.50) Z	25.000	220.80 (193.70) Z		
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	05.03		46.800	413.40 (362.60) Z	31.200	275.60 (241.80) Z		
4237	5-Hydroxy-indole-acetic acid: Screen test	04.00		2.700	23.80 (20.90)	1.800	15.90 (13.90)		
4238	5HIAA (Hplc)	04.00		78.120	690.00 (605.30)	52.080	460.00 (403.50)		
4247	Ketones: Excluding dip-stick method	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4248	Reducing substances	04.00		1.800	15.90 (13.90)	1.200	10.60 (9.30)		
4251	Metanephrines: Column chromatography	04.00		22.050	194.80 (170.90)	14.700	129.80 (113.90)		
4252	Metanephrine (Hplc)	04.00		78.120	690.00 (605.30)	52.080	460.00 (403.50)		
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	04.00		27.000	238.50 (209.20)	18.000	159.00 (139.50)		
4254	Nitrosonaphtol test for tyrosine	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4255	Orotic Acid - Urine	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4256	Very long Chain Fatty Acids	04.00		129.380	1142.80 (1002.50)	86.250	761.80 (668.20)		
4261	Micro Albumin: Quantitative	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4262	Micro Albumin: Qualitative	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4263	pH: Excluding dip-stick method	04.00		0.900	7.95 (6.97)	0.600	5.30 (4.65)		
4265	Thin layer chromatography: One way	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4266	Thin layer chromatography: Two way	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4268	Organic acids: Quantitative: GCMS	04.00		109.380	966.20 (847.50)	72.920	644.10 (565.00)		
4269	Phenylpyruvic acid: Ferric chloride	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4270	Chromium Total Urine	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4271	Phosphate excretion index	04.00		22.050	194.80 (170.90)	14.700	129.80 (113.90)		

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4272	Porphobilinogen qualitative screen: Urine	04.00		5.000	44.20 (38.80)	3.330	29.40 (25.80)		
4273	Porphobilinogen/ALA: Quantitative each	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
4283	Magnesium: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4284	Magnesium: Atomic absorption	04.00		7.250	64.00 (56.10)	4.830	42.70 (37.50)		
4285	Identification of carbohydrate	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
4287	Identification of drug: Qualitative	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4288	Identification of drug: Quantitative	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4293	Urea clearance	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4297	Copper: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4298	Copper: Atomic absorption	04.00		18.120	160.10 (140.40)	12.080	106.70 (93.60)		
4301	Chloride	04.00		2.590	22.90 (20.10)	1.730	15.30 (13.40)		
4309	Urobilinogen: Quantitative	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
4313	Phosphates	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4315	Potassium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4316	Sodium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4319	Urea	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4321	Uric acid	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4323	Total protein and protein electrophoresis	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4325	VMA: Quantitative	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4326	Catecholamines (HPLC)	04.00		78.120	690.00 (605.30)	52.080	460.00 (403.50)		
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.11		46.880	414.10 (363.20)	31.250	276.00 (242.10)		
4328	Immunoglobulin D	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4335	Cystine: Quantitative	04.00		12.600	111.30 (97.60)	8.400	74.20 (65.10)		
4336	Dinitrophenol hydrazine test: Ketoacids	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
21.8	**Biochemical tests: Faeces**								
4339	Chloride	04.00		2.590	22.90 (20.10)	1.730	15.30 (13.40)		
4343	Fat: Qualitative	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
4345	Fat: Quantitative	04.00		22.050	194.80 (170.90)	14.700	129.80 (113.90)		
4347	Ph	04.00		0.900	7.95 (6.97)	0.600	5.30 (4.65)		
4351	Occult blood: Chemical test	04.00		2.250	19.90 (17.50)	1.500	13.20 (11.60)		
4352	Occult blood: Monoclonal antibodies	04.00		10.000	88.30 (77.50)	6.670	58.90 (51.70)		
4357	Potassium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4358	Sodium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4359	Secretory IgA	04.00		9.450	83.50 (73.20)	6.300	55.60 (48.80)		
4362	Elastase quantitative ELISA	04.00		47.000	415.20 (364.20)	31.330	276.70 (242.70)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4363	Stercobilinogen: Quantitative	04.00		6.750	59.60 (52.30)	4.500	39.70 (34.80)		
21.9	**Biochemical tests: Miscellaneous**								
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	04.00		5.000	44.20 (38.80)	3.330	29.40 (25.80)		
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	04.00		30.000	265.00 (232.50)	20.000	176.70 (155.00)		
4370	Drug level in biological fluid: Monoclonal immunological	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4371	Amylase in exudate	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
4372	Fluoride in biological fluids and water	04.00		15.620	138.00 (121.10)	10.410	92.00 (80.70)		
4374	Trace metals in biological fluid: Atomic absorption	04.00		18.130	160.10 (140.40)	12.090	106.80 (93.70)		
4375	Calcium in fluid: Spectrophotometric	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4376	Calcium in fluid: Atomic absorption	04.00		7.250	64.00 (56.10)	4.830	42.70 (37.50)		
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	04.11		21.880	193.30 (169.60)	14.590	128.90 (113.10)		
4378	Urea breath test	04.00		58.000	512.30 (449.40)	38.670	341.60 (299.60)		
4380	Lecithin in amniotic fluid: L/S ratio	04.00		27.000	238.50 (209.20)	18.000	159.00 (139.50)		
4381	Lamellar body count in amniotic fluid	04.00		10.000	88.30 (77.50)	6.700	59.20 (51.90)		
4390	Foam test: Amniotic fluid	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
4391	Renal calculus: Chemistry	04.00		5.400	47.70 (41.80)	3.600	31.80 (27.90)		
4392	Renal calculus: Crystallography	04.00		16.250	143.50 (125.90)	10.800	95.40 (83.70)		
4395	Sweat: Sodium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4396	Sweat: Potassium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4397	Sweat: Chloride	04.00		2.590	22.90 (20.10)	1.730	15.30 (13.40)		
4399	Sweat collection by iontophoresis (excluding collection material)	04.00		4.500	39.70 (34.80)	3.000	26.50 (23.20)		
4400	Tryptophane loading test	04.00		22.050	194.80 (170.90)	14.700	129.80 (113.90)		
21.10	**Cerebrospinal fluid**								
4401	Cell count	04.00		3.450	30.50 (26.80)	2.300	20.30 (17.80)		
4407	Cell count, protein, glucose and chloride	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
4409	Chloride	04.00		2.590	22.90 (20.10)	1.730	15.30 (13.40)		
4416	Sodium	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4417	Protein: Qualitative	04.00		0.900	7.95 (6.97)	0.600	5.30 (4.65)		
4419	Protein: Quantitative	04.00		3.110	27.50 (24.10)	2.070	18.30 (16.10)		
4421	Glucose	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4423	Urea	04.00		3.620	32.00 (28.10)	2.410	21.30 (18.70)		
4425	Protein electrophoresis	04.00		12.600	111.30 (97.60)	8.400	74.20 (65.10)		
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	318.00 (278.90)	24.000	212.00 (186.00)		
4426	HLA typing low resolution Class I DNA-PCR per locus	04.00		100.000	883.30 (774.80)	67.000	591.80 (519.10)		
4427	HLA typing low resolution Class II DNA-PCR per locus	04.00		74.000	653.60 (573.30)	49.300	435.50 (382.00)		
4428	HLA typing high resolution Class I or II DNA-PCR per locus	04.00		66.000	583.00 (511.40)	44.000	388.70 (341.00)		
4429	Quantitative PCR (DNA/RNA)	04.00		84.300	744.60 (653.20)	56.200	496.40 (435.40)		
4430	Recombinant DNA technique	04.00		25.000	220.80 (193.70)	16.670	147.20 (129.10)		
4431	Ribosomal RNA targeting for bacteriological identification	04.00		35.000	309.20 (271.20)	23.330	206.10 (180.80)		
4432	Ribosomal RNA amplification for bacteriological identification	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
4433	Bacteriological DNA identification (LCR)	04.00		25.000	220.80 (193.70)	16.670	147.20 (129.10)		
4434	Bacteriological DNA identification (PCR)	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	05.03		150.000	1325.00 (1162.30) Z	100.000	883.30 (774.80) Z		
21.11.2	**RNA/DNA based tests and andrology: Andrology**								
4435	Mixed antiglobulin reaction: Semen	04.00		6.600	58.30 (51.10)	4.400	38.90 (34.10)		
4436	Friberg test: Semen	04.00		14.500	128.10 (112.40)	9.670	85.40 (74.90)		
4437	Kremer test: Semen	04.00		3.600	31.80 (27.90)	2.400	21.20 (18.60)		
4440	Semen analysis: Cell count	04.00		7.650	67.60 (59.30)	5.100	45.00 (39.50)		
4441	Semen analysis: Cytology	04.00		7.200	63.60 (55.80)	4.800	42.40 (37.20)		
4442	Semen analysis: Viability + motility - 6 hours	04.00		6.000	53.00 (46.50)	4.000	35.30 (31.00)		
4443	Semen analysis: Supravital stain	04.00		5.440	48.10 (42.20)	3.630	32.10 (28.20)		
4445	Seminal fluid: Alpha glucosidase	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4446	Seminal fluid fructose	04.00		3.150	27.80 (24.40)	2.100	18.50 (16.20)		
4447	Seminal fluid: Acid phosphatase	04.00		5.180	45.80 (40.20)	3.450	30.50 (26.80)		
21.12	**Immunology**								
4448	HCG: Latex agglutination: Qualitative (side room)	04.00		4.000	35.30 (31.00)	2.670	23.60 (20.70)		
4449	HCG: Latex agglutination: Semi-quantitative (side room)	04.00		9.310	82.20 (72.10)	6.210	54.90 (48.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4450	HCG: Monoclonal immunological: Qualitative	04.00		10.000	88.30 (77.50)	6.670	58.90 (51.70)		
4451	HCG: Monoclonal immunological: Quantitative	04.00		12.400	109.50 (96.10)	8.270	73.00 (64.00)		
4452	Bone Specific Alk Phosphatase	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4455	Anti IgE receptor antibody test (10 samples and dilution)	04.00		161.560	1427.10 (1251.80)	107.710	951.40 (834.60)		
4456	Eosinophil cationic protein	04.00		27.810	245.60 (215.40)	18.540	163.80 (143.70)		
4457	Mast cell tryptase	04.00		96.870	855.70 (750.60)	64.580	570.40 (500.40)		
4458	Micro-albuminuria: Radio-isotope method	04.00		12.420	109.70 (96.20)	8.300	73.30 (64.30)		
4459	Acetyl choline receptor antibody	04.00		158.120	1396.70 (1225.20)	105.410	931.10 (816.80)		
4460	CA-199 tumour marker	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4461	Nuclear Matrix Protein 22	04.00		35.000	309.20 (271.20)	23.330	206.10 (180.80)		
4462	CA-125 tumour marker	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4463	C6 complement functional essay	04.00		45.000	397.50 (348.70)	30.000	265.00 (232.50)		
4466	Beta-2-microglobulin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4467	Chromograqnin A	04.00		47.000	415.20 (364.20)	31.330	276.70 (242.70)		
4468	CA-549	04.00		20.000	176.70 (155.00)	13.300	117.50 (103.10)		
4469	Tumour markers: Monoclonal immunological (each)	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4470	CA-195 tumour marker	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4471	Carcino-embryonic antigen	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4473	TSH Receptor Ab	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4474	Cast Per Allergen	04.00		27.810	245.60 (215.40)	18.540	163.80 (143.70)		
4475	CA-724	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4477	Neuron specific enolase	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4478	Osteocalcin	04.00		31.400	277.40 (243.30)	20.930	184.90 (162.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4479	Vitamin B12-absorption: Shilling test	04.00		11.700	103.30 (90.60)	7.800	68.90 (60.40)		
4480	Serotonin	04.00		18.750	165.60 (145.30)	12.500	110.40 (96.80)		
4482	Free thyroxine (FT4)	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	04.00		37.080	327.50 (287.30)	24.720	218.40 (191.60)		
4485	Insulin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4486	C-Peptide	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4487	Calcitonin	04.00		18.900	166.90 (146.40)	12.600	111.30 (97.60)		
4488	B-Type Natriuretic Peptide	04.00		47.040	415.50 (364.50)	31.360	277.00 (243.00)		
4490	Releasing hormone response	04.00		50.000	441.70 (387.50)	33.350	294.60 (258.40)		
4491	Vitamin B12	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4492	Vitamin D3: Calcitroil (RIA)	04.00		75.000	662.50 (581.10)	50.000	441.70 (387.50)		
4493	Drug concentration: Quantitative	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4494	Free hormone assay	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4495	Growth hormone	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4496	Hormone concentration: Quantitative	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4497	Carbohydrate deficient transferrin	04.00		29.060	256.70 (225.20)	19.370	171.10 (150.10)		
4499	Cortisol	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4500	DHEA sulphate	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4501	Testosterone	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4502	Free testosterone	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4503	Oestradiol	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4505	Oestriol	04.00		10.800	95.40 (83.70)	7.200	63.60 (55.80)		
4506	Multiple antigen specific IgE screening test for Atopy	04.00		37.260	329.10 (288.70)	24.800	219.10 (192.20)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4507	Thyrotropin (TSH)	04.00		19.600	173.10 (151.80)	13.070	115.40 (101.20)		
4508	Combined antigen specific IgE	04.00		24.480	216.20 (189.60)	16.600	146.60 (128.60)		
4509	Free tri-iodothyronine (FT3)	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4511	Renin activity	04.00		18.900	166.90 (146.40)	12.600	111.30 (97.60)		
4512	Parathormone	04.00		17.080	150.90 (132.40)	11.390	100.60 (88.20)		
4513	IgE: Total	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4514	Antigen specific IgE	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4515	Aldosterone	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4516	Follitropin (FSH)	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4517	Lutropin (LH)	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4518	Soluble transferrin receptor	04.00		11.250	99.40 (87.20)	7.500	66.20 (58.10)		
4519	Prostate specific antigen	04.00		14.490	128.00 (112.30)	9.660	85.30 (74.80)		
4520	17 Hydroxy progesterone	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4521	Progesterone	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4522	Alpha-feto protein	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4523	ACTH	04.00		21.740	192.00 (168.40)	14.490	128.00 (112.30)		
4524	Free PSA	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4526	Sex hormone binding globulin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4527	Gastrin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4528	Ferritin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4529	Anti-DNA antibodies	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4530	Antiplatelet antibodies	04.00		15.300	135.10 (118.50)	10.200	90.10 (79.00)		
4531	Hepatitis: Per antigen or antibody	04.00		14.490	128.00 (112.30)	9.660	85.30 (74.80)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4532	Transcobalamine	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4533	Folic acid	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4534	Prostatic acid phosphatase	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4536	Erythrocyte folate	04.00		17.480	154.40 (135.40)	11.650	102.90 (90.30)		
4537	Prolactin	04.00		12.420	109.70 (96.20)	8.280	73.10 (64.10)		
4538	Procalcitonin: Semi-quantitative	04.00		32.000	282.70 (248.00)	21.330	188.40 (165.30)		
4539	Procalcitonin: Quantitative	04.00		46.000	406.30 (356.40)	30.670	270.90 (237.60)		
4540	HCG: Quantitative as used for Down's screen	04.00		15.000	132.50 (116.20)	10.000	88.30 (77.50)		
4546	First trimester Downs screen	04.00		53.500	472.60 (414.60)	35.670	315.10 (276.40)		
4552	Second Trimester Down's screen	04.00		33.620	297.00 (260.50)	22.410	197.90 (173.60)		
4553	Thyroglubulin	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
4554	SCC marker	04.00		20.000	176.70 (155.00)	13.330	117.70 (103.20)		
21.13	**Clinical pathology: Miscellaneous**								
4544	Attendance in theatre	04.00		27.000	238.50 (209.20)				
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
22.1	**Exfoliative cytology**								
4561	Sputum, all body fluids and tumour aspirates: First unit	04.00		13.400	136.50 (119.70)	8.900	90.70 (79.60)		
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	04.00		7.800	79.50 (69.70)	5.200	53.00 (46.50)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4564	Performance of fine-needle aspiration for cytology	04.00		15.000	152.80 (134.00)				
4565	Examination of fine needle aspiration in theatre	04.00		90.000	916.70 (804.10)	60.000	611.20 (536.10)		
4566	Vaginal or cervical smears, each	04.00		11.000	112.00 (98.20)	7.000	71.30 (62.50)		
22.2	**Histology**								
4567	Histology per sample	04.00		20.000	192.90 (169.20)	13.300	128.30 (112.50)		
4571	Histology per additional block, each	04.00		11.600	111.90 (98.20)	7.700	74.30 (65.20)		
4575	Histology and frozen section in laboratory	04.00		22.700	218.90 (192.00)	15.100	145.60 (127.70)		
4577	Histology and frozen section in theatre	04.00		90.000	867.90 (761.30)	60.000	578.60 (507.50)		
4578	Second and subsequent frozen sections, each	04.00		20.000	192.90 (169.20)	13.400	129.20 (113.30)		
4579	Attendance in theatre - no frozen section performed	04.00		45.000	433.90 (380.60)	30.000	289.30 (253.80)		
4582	Serial step sections (including item 4567)	04.00		23.300	224.70 (197.10)	15.600	150.40 (131.90)		
4584	Serial step sections per additional block, each	04.00		13.500	130.20 (114.20)	9.000	86.80 (76.10)		
4587	Histology consultation	04.00		10.100	97.40 (85.40)	6.700	64.60 (56.70)		
4589	Special stains	04.00		6.700	64.60 (56.70)	4.500	43.40 (38.10)		
4591	Immunofluorescence studies	04.00		20.700	199.60 (175.10)	13.800	133.10 (116.80)		
4592	Immunoperoxidase studies	04.00		40.000	385.70 (338.30)	26.670	257.20 (225.60)		
4593	Electron microscopy	04.00		94.000	906.40 (795.10)	63.000	607.50 (532.90)		
4595	Foetal autopsy excluding histology	04.00		73.000	703.90 (617.50)	48.670	469.30 (411.70)		
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	135.70 (119.00)	15.000	135.70 (119.00)		
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	04.00		45.000	407.10 (357.10)	45.000	407.10 (357.10)		
4752	Cell culture: Chorionic villi	04.00		60.000	542.80 (476.10)	60.000	542.80 (476.10)		
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	04.00		135.000	1221.30 (1071.30)	135.000	1221.30 (1071.30)		

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	04.00		270.000	2442.70 (2142.70)	270.000	2442.70 (2142.70)		
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	04.00		70.000	633.30 (555.50)	70.000	633.30 (555.50)		
4760	FISH procedure, including cell culture	04.00		115.000	1040.40 (912.60)	115.000	1040.40 (912.60)		
4761	FISH analysis per probe system	04.00		35.000	316.60 (277.70)	35.000	316.60 (277.70)		
23.2	**DNA-testing**								
4763	Blood: DNA extraction	04.00		45.000	407.10 (357.10)	45.000	407.10 (357.10)		
4764	Blood: Genotype per person: Southern blotting	04.00		89.000	805.20 (706.30)	89.000	805.20 (706.30)		
4765	Blood: Genotype per person: PCR	04.00		60.000	542.80 (476.10)	60.000	542.80 (476.10)		
4766	HIV Drug Resistance Testing	04.00		513.000	4641.10 (4071.10)	342.000	3094.10 (2714.10)		
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	04.00		90.000	814.20 (714.20)	90.000	814.20 (714.20)		
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	04.00		188.000	1700.80 (1491.90)	188.000	1700.80 (1491.90)		
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	04.00		120.000	1085.60 (952.30)	120.000	1085.60 (952.30)		
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	The indicated amount 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 Indicated amount	09.00		1.000	7.64 (6.70)	1.000	7.64 (6.70)		
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof	04.00		18.000	137.50 (120.60)				
5007	Normal hours: General practitioner: 18,00 clinical procedure units per hour or part thereof	04.00				18.000	137.50 (120.60)		
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them	04.00							
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)								04.00

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
	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.								
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								
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								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
0378	Laser acupuncture using more than 6 points								
0379	Electro-acupuncture								
0380	Scalp acupuncture								
0381	Micro-acupuncture (ear, hand)								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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								

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	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								
	1801	Diagnostic paracentesis: Abdomen								
	1803	Therapeutic paracentesis: Abdomen								
	10.	URINARY SYSTEM								
	1841	Renal biopsy (needle)								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	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								
	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								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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)								
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								

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Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
15.	ENDOCRINE SYSTEM								
3001	Implantation of pellets (excluding cost of material)								
16.	EYE								
3002	Gonioscopy								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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)								

Code		Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
					RVU	Fee	RVU	Fee	RVU	Fee
	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								
	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								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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.)								
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								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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								
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 atheroschlerotic 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)								

Code	Description	Ver	Add	Specialists		General Practitioners / non-designated Specialists		Anaesthesiology	
				RVU	Fee	RVU	Fee	RVU	Fee
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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MEDICAL SCIENTISTS

Medical Scientists 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR MEDICAL SCIENTISTS WITH EFFECT FROM 1 JANUARY 2009

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	34.40 (30.20)
201	Genetic counselling. Duration: 11-20min.	05.03		1.500	103.20 (90.50)
202	Genetic counselling. Duration: 21-30min.	05.03		2.500	171.90 (150.80)
203	Genetic counselling. Duration: 31-40min.	05.03		3.500	240.70 (211.10)
204	Genetic counselling. Duration: 41-50min.	05.03		4.500	309.50 (271.50)
205	Genetic counselling. Duration: 51-60min.	05.03		5.500	378.30 (331.80)
206	Genetic counselling. Duration: 61-70min.	05.03		6.500	447.10 (392.20)
207	Genetic counselling. Duration: 71-80min.	05.03		7.500	515.80 (452.50)
208	Genetic counselling. Duration: 81-90min.	05.03		8.500	584.60 (512.80)
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 TECHNOLOGY

Medical Technology 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY MEDICAL LABORATORY TECHNOLOGISTS, WITH EFFECT FROM 1 JANUARY 2009

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.

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	33.00 (28.90)
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	04.00		3.650	26.80 (23.50)
3710	Antibody titration	04.00		7.200	52.80 (46.30)
3712	Antibody identification	04.00		8.450	62.00 (54.40)
3713	Bleeding time (does not include the cost of the simplate device)	04.00		6.940	50.90 (44.60)
3714	Blood volume, dye method	04.00		7.200	52.80 (46.30)
3715	Buffy layer examination	04.00		19.900	145.90 (128.00)
3717	Bone marrow cytological examination only	04.00		19.900	145.90 (128.00)
3722	Capillary fragility: Hess	04.00		2.020	14.80 (13.00)
3723	Circulating anticoagulants	04.00		5.850	42.90 (37.60)
3724	Coagulation factor inhibitor assay	04.00		57.560	422.00 (370.20)
3726	Activated protein C resistance	04.00		26.000	190.60 (167.20)
3727	Coagulation time	04.00		3.160	23.20 (20.40)
3729	Cold agglutinins	04.00		3.600	26.40 (23.20)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3730	Protein S: Functional	04.00		37.500	275.00 (241.20)
3731	Compatibility for blood transfusion	04.00		3.600	26.40 (23.20)
3732	Cryoglobulin	04.00		3.600	26.40 (23.20)
3734	Protein C (chromogenic)	04.00		30.290	222.10 (194.80)
3735	Anti-thrombin III (chromogenic)	04.00		22.000	161.30 (141.50)
3736	Plasminogen (chromogenic)	04.00		61.650	452.00 (396.50)
3737	Lupus Russel Viper method	04.00		17.000	124.60 (109.30)
3738	Lupus Kaolin Exner method	04.00		25.000	183.30 (160.80)
3739	Erythrocyte count	04.00		2.250	16.50 (14.50)
3740	Factors V and VII: Qualitative	04.00		7.200	52.80 (46.30)
3741	Coagulation factor assay: Functional	04.00		9.450	69.30 (60.80)
3743	Erythrocyte sedimentation rate	04.00		3.000	22.00 (19.30)
3744	Fibrin stabilizing factor (urea test)	04.00		4.500	33.00 (28.90)
3746	Fibrin monomers	04.00		2.700	19.80 (17.40)
3753	Osmotic fragility (before and after incubation)	04.00		18.000	132.00 (115.80)
3755	Full blood count (including items 3739, 3762, 3763, 3785, 3791)	04.00		10.500	77.00 (67.50)
3756	Full cross match	04.00		7.200	52.80 (46.30)
3757	Coagulation factors: Quantitative	04.00		32.200	236.10 (207.10)
3758	Factor VIII related antigen	04.00		60.460	443.30 (388.90)
3759	Coagulation factor correction study	04.00		11.720	85.90 (75.40)
3762	Haemoglobin estimation	04.00		1.800	13.20 (11.60)
3763	Contact activated product assay	04.00		16.200	118.80 (104.20)
3764	Grouping: A B and O antigens	04.00		3.600	26.40 (23.20)
3765	Grouping: Rh antigen	04.00		3.600	26.40 (23.20)
3767	Euglobulin Lysis time	04.00		25.580	187.60 (164.60)
3768	Haemoglobin A2 (column chromatography)	04.00		15.000	110.00 (96.50)
3769	Haemoglobin electrophoresis	04.00		26.820	196.60 (172.50)
3770	Haemoglobin-S (solubility test)	04.00		3.600	26.40 (23.20)
3772	Haptoglobin: Quantitative	04.00		9.450	69.30 (60.80)
3773	Ham's acidified serum test	04.00		8.000	58.70 (51.50)
3775	Heinz bodies	04.00		2.250	16.50 (14.50)
3776	Haemosiderin in urinary sediment	04.00		2.250	16.50 (14.50)
3783	Leucocyte differential count	04.00		6.200	45.50 (39.90)
3785	Leucocytes: Total count	04.00		1.800	13.20 (11.60)
3786	QBC malaria concentration and fluorescent staining	04.00		25.000	183.30 (160.80)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3787	LE-cells	04.00		8.300	60.90 (53.40)
3789	Neutrophil alkaline phosphatase	04.00		28.000	205.30 (180.10)
3791	Packed cell volume: Haematocrit	04.00		1.800	13.20 (11.60)
3792	Plasmodium falciparum: Monoclonal immunological identification	04.00		9.000	66.00 (57.90)
3793	Plasma haemoglobin	04.00		6.750	49.50 (43.40)
3795	Platelet aggregation per aggregant	04.00		12.140	89.00 (78.10)
3797	Platelet count	04.00		2.250	16.50 (14.50)
3799	Platelet adhesiveness	04.00		4.500	33.00 (28.90)
3801	Prothrombin consumption	04.00		5.850	42.90 (37.60)
3803	Prothrombin determination (two stages)	04.00		5.850	42.90 (37.60)
3805	Prothrombin index	04.00		6.000	44.00 (38.60)
3806	Therapeutic drug level: Dosage	04.00		4.500	33.00 (28.90)
3809	Reticulocyte count	04.00		3.000	22.00 (19.30)
3810	Schumm's test	04.00		3.600	26.40 (23.20)
3811	Sickling test	04.00		2.250	16.50 (14.50)
3814	Sucrose lysis test for PNH	04.00		3.600	26.40 (23.20)
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	04.00		21.100	154.70 (135.70)
3820	Thrombo - Elastogram	04.00		26.000	190.60 (167.20)
3825	Fibrinogen titre	04.00		3.600	26.40 (23.20)
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	04.00		8.000	58.70 (51.50)
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	04.00		16.000	117.30 (102.90)
3832	Red cell pyruvate kinase: Quantitative	04.00		16.000	117.30 (102.90)
3834	Red cell Rhesus phenotype	04.00		9.900	72.60 (63.70)
3835	Haemoglobin F in blood smear	04.00		5.850	42.90 (37.60)
3837	Partial thromboplastin time	04.00		5.850	42.90 (37.60)
3841	Thrombin time (screen)	04.00		7.160	52.50 (46.10)
3843	Thrombin time (serial)	04.00		7.650	56.10 (49.20)
3847	Haemoglobin H	04.00		2.250	16.50 (14.50)
3851	Fibrin degeneration products (diffusion plate)	04.00		10.350	75.90 (66.60)
3853	Fibrin degeneration products (latex slide)	04.00		4.500	33.00 (28.90)
3854	XDP (Dimer test or equivalent latex slide test)	04.00		8.500	62.30 (54.60)
3855	Haemagglutination inhibition	04.00		9.900	72.60 (63.70)
Microscopic and miscellaneous tests					
3863	Autogenous vaccine	04.00		12.600	92.40 (81.10)
3864	Entomological examination	04.00		20.700	151.80 (133.20)
3865	Parasites in blood smear	04.00		5.600	41.10 (36.10)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	04.00		4.900	35.90 (31.50)
3868	Fungus identification	04.00		6.300	60.90 (53.40)
3869	Faeces (including parasites)	04.00		4.900	35.90 (31.50)
3875	Inclusion bodies	04.00		4.500	33.00 (28.90)
3878	Crystal identification polarized light microscopy	04.00		4.500	33.00 (28.90)
3879	Campylobacter in stool: Fastidious culture	04.00		9.900	72.60 (63.70)
3880	Antigen detection with polyclonal antibodies	04.00		4.500	33.00 (28.90)
3881	Mycobacteria	04.00		3.000	22.00 (19.30)
3882	Antigen detection with monoclonal antibodies	04.00		10.800	79.20 (69.50)
3883	Concentration techniques for parasites	04.00		3.000	22.00 (19.30)
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	04.00		6.300	46.20 (40.50)
3885	Cytochemical stain	04.00		5.450	40.00 (35.10)
Bacteriology					
3887	Antibiotic susceptibility test: Per organism	04.00		8.000	58.70 (51.50)
3888	Adhesive tape preparation	04.00		2.700	19.80 (17.40)
3889	Clostridium difficile toxin: Monoclonal immunological	04.00		12.400	90.90 (79.70)
3890	Antibiotic assay of tissues and fluids	04.00		13.900	101.90 (89.40)
3891	Blood culture: Aerobic	04.00		5.850	42.90 (37.60)
3892	Blood culture: Anaerobic	04.00		5.850	42.90 (37.60)
3893	Bacteriological culture: Miscellaneous	04.00		6.300	46.20 (40.50)
3894	Radiometric blood culture	04.00		10.800	79.20 (69.50)
3895	Bacteriological culture: Fastidious organisms	04.00		9.900	72.60 (63.70)
3896	In vivo culture: Bacteria	04.00		16.000	117.30 (102.90)
3897	In vivo culture: Virus	04.00		16.000	117.30 (102.90)
3899	Bacterial exotoxin production (in vivo assay)	04.00		20.700	151.80 (133.20)
3901	Fungal culture	04.00		4.500	33.00 (28.90)
3902	Clostridium difficile (cytotoxicity neutralisation)	04.00		30.000	220.00 (193.00)
3903	Antibiotic level: Biological fluids	04.00		11.700	85.80 (75.30)
3904	Rotavirus latex slide test	04.00		5.620	41.20 (36.10)
3905	Identification of virus or rickettsia	04.00		20.700	151.80 (133.20)
3906	Identification: Chlamydia	04.00		16.000	117.30 (102.90)
3907	Culture for staphylococcus aureus	04.00		2.250	16.50 (14.50)
3908	Anaerobe culture: Comprehensive	04.00		9.900	72.60 (63.70)
3909	Anaerobe culture: Limited procedure	04.00		4.500	33.00 (28.90)
3911	Beta-lactamase assay	04.00		4.500	33.00 (28.90)
3914	Sterility control test: Biological method	04.00		4.500	33.00 (28.90)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3915	Mycobacterium culture	04.00		4.500	33.00 (28.90)
3916	Radiometric tuberculosis culture	04.00		10.800	79.20 (69.50)
3918	Mycoplasma culture: Comprehensive	04.00		9.900	72.60 (63.70)
3919	Identification of mycobacterium	04.00		9.900	72.60 (63.70)
3920	Mycobacterium: Antibiotic sensitivity	04.00		9.900	72.60 (63.70)
3921	Antibiotic synergistic study	04.00		20.700	151.80 (133.20)
3922	Viable cell count	04.00		1.350	9.90 (8.68)
3923	Biochemical identification of bacterium: Abridged	04.00		3.150	23.10 (20.30)
3924	Biochemical identification of bacterium: Extended	04.00		12.500	91.70 (80.40)
3925	Serological identification of bacterium: Abridged	04.00		3.150	23.10 (20.30)
3926	Serological identification of bacterium: Extended	04.00		10.200	74.80 (65.60)
3927	Grouping for streptococci	04.00		7.300	53.50 (46.90)
3928	Antimicrobic substances	04.00		3.800	27.90 (24.50)
3929	Radiometric mycobacterium identification	04.00		14.000	102.60 (90.00)
3930	Radiometric mycobacterium antibiotic sensitivity	04.00		25.000	183.30 (160.80)
3931	Helicobacter: Monoclonal immunological	04.00		12.400	90.90 (79.70)
4650	Antibiotic MIC per organism per antibiotic	04.00		8.000	58.70 (51.50)
4651	Non-radiometric automated blood cultures	04.00		13.900	101.90 (89.40)
4652	Rapid automated bacterial identification per organism	04.00		15.000	110.00 (96.50)
4653	Rapid automated antibiotic susceptibility per organism	04.00		17.000	124.60 (109.30)
4654	Rapid automated MIC per organism per antibiotic	04.00		17.000	124.60 (109.30)
Serology					
3959	Rose Waaler agglutination test	04.00		4.500	33.00 (28.90)
3960	Gonococcal, listeria or echinococcus agglutination	04.00		9.500	69.70 (61.10)
3961	Slide agglutination test	04.00		2.630	19.30 (16.90)
3963	Serum complement level: Each component	04.00		3.150	23.10 (20.30)
3967	Auto-antibody: Sensitized erythrocytes	04.00		4.500	33.00 (28.90)
3968	Herpes virus typing: Monoclonal immunological	04.00		20.690	151.70 (133.10)
3969	Western blot technique	04.00		74.000	542.60 (476.00)
3970	Epstein-Barr virus antibody titer	04.00		6.750	49.50 (43.40)
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	04.00		14.100	103.40 (90.70)
3933	IgE: Total: EMIT or ELISA	04.00		11.700	85.80 (75.30)
3934	Auto antibodies by labelled antibodies	04.00		16.000	117.30 (102.90)
3935	Sperm antibodies	04.00		16.000	117.30 (102.90)
3936	Virus neutralisation test: First antibody	04.00		75.000	549.90 (482.40)
3937	Virus neutralisation test: Each additional antibody	04.00		15.000	110.00 (96.50)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3938	Precipitation test per antigen	04.00		4.500	33.00 (28.90)
3939	Agglutination test per antigen	04.00		5.500	40.30 (35.40)
3940	Haemagglutination test: Per antigen	04.00		9.900	72.60 (63.70)
3941	Modified Coombs' test for brucellosis	04.00		4.500	33.00 (28.90)
3943	Antibody titer to bacterial exotoxin	04.00		3.600	26.40 (23.20)
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.400	90.90 (79.70)
3945	Complement fixation test	04.00		5.850	42.90 (37.60)
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	04.00		14.050	103.00 (90.40)
3947	C-reactive protein	04.00		10.840	79.50 (69.70)
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	04.00		12.950	94.90 (83.20)
3949	Qualitative Kahn, VDRL or other flocculation	04.00		2.250	16.50 (14.50)
3950	Neutrophil phagocytosis	04.00		25.200	184.80 (162.10)
3951	Quantitative Kahn, VDRL or other flocculation	04.00		3.600	26.40 (23.20)
3952	Neutrophil chemotaxis	04.00		67.950	498.20 (437.00)
3953	Tube agglutination test	04.00		4.150	30.40 (26.70)
3955	Paul Bunnell: Presumptive	04.00		2.250	16.50 (14.50)
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	04.00		8.500	62.30 (54.60)
3971	Immuno-diffusion test: Per antigen	04.00		3.150	23.10 (20.30)
3972	Respiratory syncytial virus (ELISA technique)	04.00		35.000	256.60 (225.10)
3973	Immuno electrophoresis: Per immune serum	04.00		9.450	69.30 (60.80)
3974	Polymerase chain reaction	04.00		75.000	549.90 (482.40)
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	04.00		12.000	88.00 (77.20)
3978	Lymphocyte transformation	04.00		51.700	379.10 (332.50)
4601	Panel typing: Antibody detection: Class I	04.00		36.000	264.00 (231.60)
4602	Panel typing: Antibody detection: Class II	04.00		44.000	322.60 (283.00)
4603	HLA test for specific locus/antigen - serology	04.00		27.000	198.00 (173.70)
4604	HLA typing: Class I - serology	04.00		52.000	381.30 (334.50)
4605	HLA typing: Class II - serology	04.00		52.000	381.30 (334.50)
4606	HLA typing: Class I & II - serology	04.00		90.000	659.90 (578.90)
4607	Cross matching T-cells (per tray)	04.00		18.000	132.00 (115.80)
4608	Cross matching B-cells	04.00		38.000	278.60 (244.40)
4609	Cross matching T- & B-cells	04.00		48.000	351.90 (308.70)
Biochemical tests: Blood					
3991	Abnormal pigments: Qualitative	04.00		4.500	33.00 (28.90)
3993	Abnormal pigments: Quantitative	04.00		9.000	66.00 (57.90)
3995	Acid phosphate	04.00		5.180	38.00 (33.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
3998	Amino acids Quantitative (Post derivatisation HPLC)	04.00		78.120	572.80 (502.50)
3999	Albumin	04.00		4.800	35.20 (30.90)
4000	Alcohol	04.00		12.400	90.90 (79.70)
4001	Alkaline phosphatase	04.00		5.180	38.00 (33.30)
4002	Alkaline phosphatase-iso-enzymes	04.00		11.700	85.80 (75.30)
4003	Ammonia: Enzymatic	04.00		7.710	56.50 (49.60)
4004	Ammonia: Monitor	04.00		4.500	33.00 (28.90)
4005	Alpha-1-antitrypsin: Total	04.00		7.200	52.80 (46.30)
4006	Amylase	04.00		5.180	38.00 (33.30)
4007	Arsenic in blood, hair or nails	04.00		36.250	265.80 (233.20)
4009	Bilirubin: Total	04.00		4.770	35.00 (30.70)
4010	Bilirubin: Conjugated	04.00		3.620	26.50 (23.20)
4014	Cadmium: Atomic absorption	04.00		18.120	132.90 (116.60)
4016	Calcium: Ionized	04.00		6.750	49.50 (43.40)
4017	Calcium: Spectrophotometric	04.00		3.620	26.50 (23.20)
4018	Calcium: Atomic absorption	04.00		7.250	53.20 (46.70)
4019	Carotene	04.00		2.250	16.50 (14.50)
4020	Carnitine (Total or free) in biological fluid: Each	04.00		11.690	85.70 (75.20)
4021	Carnitine (Total or free) in muscle: Each	04.00		23.380	171.40 (150.40)
4022	Acyl Carnitine	04.00		23.380	171.40 (150.40)
4023	Chloride	04.00		2.590	19.00 (16.70)
4026	LDL cholesterol (chemical determination)	04.00		6.900	50.60 (44.40)
4027	Cholesterol total	04.00		5.340	39.20 (34.40)
4028	HDL cholesterol	04.00		6.900	50.60 (44.40)
4029	Cholinesterase: Serum or erythrocyte: Each	04.00		7.480	54.80 (48.10)
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	04.00		9.000	66.00 (57.90)
4031	Total CO2	04.00		5.180	38.00 (33.30)
4032	Creatinine	04.00		3.620	26.50 (23.20)
4040	Homocysteine (random)	04.00		15.300	112.20 (98.40)
4041	Homocysteine (after Methionine load)	04.00		18.100	132.70 (116.40)
4042	D-Xylose absorption test: Two hours	04.00		13.150	96.40 (84.60)
4045	Fibrinogen: Quantitative	04.00		3.600	26.40 (23.20)
4049	Glucose tolerance test (2 specimens)	04.00		8.970	65.80 (57.70)
4050	Glucose strip-test with photometric reading	04.00		1.800	13.20 (11.60)
4051	Galactose	04.00		11.250	82.50 (72.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4052	Glucose tolerance test (3 specimens)	04.00		13.170	96.60 (84.70)
4053	Glucose tolerance test (4 specimens)	04.00		17.370	127.40 (111.80)
4057	Glucose: Quantitative	04.00		3.620	26.50 (23.20)
4061	Glucose tolerance test (5 specimens)	04.00		21.560	158.10 (138.70)
4062	Galactose-1-phosphate uridyl transferase	04.00		16.000	117.30 (102.90)
4063	Fructosamine	04.00		7.200	52.80 (46.30)
4064	HbA1C	06.04		14.250	104.50 (91.70)
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.00		46.880	343.70 (301.50)
4067	Lithium: Flame ionisation	04.00		5.180	38.00 (33.30)
4068	Lithium: Atomic absorption	04.00		7.480	54.80 (48.10)
4071	Iron	04.00		6.750	49.50 (43.40)
4073	Iron-binding capacity	04.00		7.650	56.10 (49.20)
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	04.11		6.750	49.50 (43.40)
4079	Ketones in plasma: Qualitative	04.00		2.250	16.50 (14.50)
4081	Drug level-biological fluid: Quantitative	04.00		10.800	79.20 (69.50)
4083	Lysosomal enzyme assay	04.00		36.560	268.10 (235.20)
4085	Lipase	04.00		5.180	38.00 (33.30)
4091	Lipoprotein electrophoresis	04.00		9.000	66.00 (57.90)
4093	Osmolality: Serum or urine	04.00		6.750	49.50 (43.40)
4094	Magnesium: Spectrophotometric	04.00		3.620	26.50 (23.20)
4095	Magnesium: Atomic absorption	04.00		7.250	53.20 (46.70)
4096	Mercury: Atomic absorption	04.00		18.120	132.90 (116.60)
4098	Copper: Atomic absorption	04.00		18.120	132.90 (116.60)
4105	Protein electrophoresis	04.00		9.000	66.00 (57.90)
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	04.00		20.000	146.60 (128.60)
4109	Phosphate	04.00		3.620	26.50 (23.20)
4113	Potassium	04.00		3.620	26.50 (23.20)
4114	Sodium	04.00		3.620	26.50 (23.20)
4117	Protein: Total	04.00		3.110	22.80 (20.00)
4121	pH, pCO2 or pO2: Each	04.00		6.750	49.50 (43.40)
4123	Pyruvic acid	04.00		4.500	33.00 (28.90)
4125	Salicylates	04.00		4.500	33.00 (28.90)
4127	Caeruloplasmin	04.00		4.500	33.00 (28.90)
4128	Phenylalanine: Quantitative	04.00		11.250	82.50 (72.40)
4130	Aspartate aminotransferase (AST)	04.00		5.400	39.60 (34.70)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4131	Alanine aminotransferase (ALT)	04.00		5.400	39.60 (34.70)
4132	Creatine kinase (CK)	04.00		5.400	39.60 (34.70)
4133	Lactate dehidrogenase (LD)	04.00		5.400	39.60 (34.70)
4134	Gamma glutamyl transferase (GGT)	04.00		5.400	39.60 (34.70)
4135	Aldolase	04.00		5.400	39.60 (34.70)
4136	Angiotensin converting enzyme (ACE)	04.00		9.000	66.00 (57.90)
4137	Lactate dehydrogenase isoenzyme	04.00		10.800	79.20 (69.50)
4138	CK-MB: Immunoinhibition/precipitation	04.11		10.800	79.20 (69.50)
4139	Adenosine deaminase	04.00		5.400	39.60 (34.70)
4143	Serum/plasma enzymes	04.00		5.400	39.60 (34.70)
4144	Transferrin	04.00		11.700	85.80 (75.30)
4146	Lead: Atomic absorption	04.00		15.000	110.00 (96.50)
4147	Triglyceride	04.00		7.930	58.10 (51.00)
4149	Red cell magnesium	04.00		11.700	85.80 (75.30)
4151	Urea	04.00		3.620	26.50 (23.20)
4152	CK-MB: Mass determination: Quantitative (Automated)	04.00		12.400	90.90 (79.70)
4153	CK-MB: Mass determination: Quantitative (Not automated)	04.00		17.470	128.10 (112.40)
4154	Myoglobin quantitative: Monoclonal immunological	04.00		12.400	90.90 (79.70)
4155	Uric acid	04.00		3.780	27.70 (24.30)
4157	Vitamin A-saturation test	04.00		15.300	112.20 (98.40)
4158	Vitamin E (tocopherol)	04.00		3.600	26.40 (23.20)
4159	Vitamin A	04.00		6.300	46.20 (40.50)
4161	Troponin isoforms: Each	04.00		20.000	146.60 (128.60)
4163	Apoprotein AI: Turbidometric method	04.00		8.280	60.70 (53.20)
4165	Apoprotein AII: Turbidometric method	04.00		8.280	60.70 (53.20)
4167	Apoprotein B: Turbidometric method	04.00		8.280	60.70 (53.20)
4170	Lipoprotein (a)(Lp(a)) assay	04.00		12.420	91.10 (79.90)
4171	Sodium + potassium + chloride + CO2 + urea	04.00		15.840	116.10 (101.80)
4172	ELISA/EMIT technique	04.00		12.420	91.10 (79.90)
4181	Quantitative protein estimation: Mancini method	04.00		7.760	56.90 (49.90)
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	04.00		8.280	60.70 (53.20)
4183	Quantitative protein estimation: Labelled antibody	04.00		12.420	91.10 (79.90)
4185	Lactose	04.00		10.800	79.20 (69.50)
4187	Zinc: Atomic absorption	04.00		18.120	132.90 (116.60)
Biochemical tests: Urine					
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	04.00		1.500	11.00 (9.65)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4189	Abnormal pigments	04.00		4.500	33.00 (28.90)
4193	Alkapton test: Homogentisic acid	04.00		4.500	33.00 (28.90)
4194	Amino acids: Quantitative (Post derivatisation HPLC)	04.00		78.120	572.80 (502.50)
4195	Amino laevulinic acid	04.00		18.000	132.00 (115.80)
4197	Amylase	04.00		5.180	38.00 (33.30)
4198	Arsenic	04.00		18.120	132.90 (116.60)
4199	Ascorbic acid	04.00		2.250	16.50 (14.50)
4201	Bence-Jones protein	04.00		2.700	19.80 (17.40)
4204	Calcium: Atomic absorption	04.00		7.250	53.20 (46.70)
4205	Calcium: Spectrophotometric	04.00		3.620	26.50 (23.20)
4209	Lead: Atomic absorption	04.00		15.000	110.00 (96.50)
4211	Bile pigments: Qualitative	04.00		2.250	16.50 (14.50)
4213	Protein: Quantitative	04.00		2.250	16.50 (14.50)
4216	Mucopolysaccharides: Qualitative	04.00		3.600	26.40 (23.20)
4217	Oxalate	04.00		9.380	68.80 (60.40)
4218	Glucose: Quantitative	04.00		2.250	16.50 (14.50)
4219	Steroids: Chromatography (each)	04.00		7.200	52.80 (46.30)
4221	Creatinine	04.00		3.620	26.50 (23.20)
4223	Creatinine clearance	04.00		7.650	56.10 (49.20)
4227	Electrophoresis: Qualitative	04.00		4.500	33.00 (28.90)
4237	5-Hydroxy-indole-acetic acid: Screen test	04.00		2.700	19.80 (17.40)
4247	Ketones: Excluding dip-stick method	04.00		2.250	16.50 (14.50)
4248	Reducing substances	04.00		1.800	13.20 (11.60)
4251	Metanephrines: Column chromatography	04.00		22.050	161.70 (141.80)
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	04.00		27.000	198.00 (173.70)
4254	Nitrosonaphtol test for tyrosine	04.00		2.250	16.50 (14.50)
4263	pH: Excluding dip-stick method	04.00		0.900	6.60 (5.79)
4265	Thin layer chromatography: One way	04.00		6.750	49.50 (43.40)
4266	Thin layer chromatography: Two way	04.00		11.250	82.50 (72.40)
4268	Organic acids: Quantitative: GCMS	04.00		109.380	802.00 (703.50)
4269	Phenylpyruvic acid: Ferric chloride	04.00		2.250	16.50 (14.50)
4271	Phosphate excretion index	04.00		22.050	161.70 (141.80)
4272	Porphobilinogen qualitative screen: Urine	04.00		5.000	36.70 (32.20)
4273	Porphobilinogen/ALA: Quantitative each	04.00		15.000	110.00 (96.50)
4283	Magnesium: Spectrophotometric	04.00		3.620	26.50 (23.20)
4284	Magnesium: Atomic absorption	04.00		7.250	53.20 (46.70)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4285	Identification of carbohydrate	04.00		7.650	56.10 (49.20)
4287	Identification of drug: Qualitative	04.00		4.500	33.00 (28.90)
4288	Identification of drug: Quantitative	04.00		10.800	79.20 (69.50)
4293	Urea clearance	04.00		5.400	39.60 (34.70)
4297	Copper: Spectrophotometric	04.00		3.620	26.50 (23.20)
4298	Copper: Atomic absorption	04.00		18.120	132.90 (116.60)
4301	Chloride	04.00		2.590	19.00 (16.70)
4309	Urobilinogen: Quantitative	04.00		6.750	49.50 (43.40)
4313	Phosphates	04.00		3.620	26.50 (23.20)
4315	Potassium	04.00		3.620	26.50 (23.20)
4316	Sodium	04.00		3.620	26.50 (23.20)
4319	Urea	04.00		3.620	26.50 (23.20)
4321	Uric acid	04.00		3.620	26.50 (23.20)
4323	Total protein and protein electrophoresis	04.00		11.250	82.50 (72.40)
4325	VMA: Quantitative	04.00		11.250	82.50 (72.40)
4326	Catecholamines (HPLC)	04.00		78.120	572.80 (502.50)
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	04.11		46.880	343.70 (301.50)
4335	Cystine: Quantitative	04.00		12.600	92.40 (81.10)
4336	Dinitrophenol hydrazine test: Ketoacids	04.00		2.250	16.50 (14.50)
Biochemical tests: Faeces					
4339	Chloride	04.00		2.590	19.00 (16.70)
4343	Fat: Qualitative	04.00		3.150	23.10 (20.30)
4345	Fat: Quantitative	04.00		22.050	161.70 (141.80)
4347	Ph	04.00		0.900	6.60 (5.79)
4351	Occult blood: Chemical test	04.00		2.250	16.50 (14.50)
4352	Occult blood: Monoclonal antibodies	04.00		10.000	73.30 (64.30)
4357	Potassium	04.00		3.620	26.50 (23.20)
4358	Sodium	04.00		3.620	26.50 (23.20)
4362	Elastase quantitative ELISA	04.00		47.000	344.60 (302.30)
4363	Stercobilinogen: Quantitative	04.00		6.750	49.50 (43.40)
Biochemical tests: Miscellaneous					
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	04.00		5.000	36.70 (32.20)
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	04.00		20.000	146.60 (128.60)
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	04.00		20.000	146.60 (128.60)
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	04.00		30.000	220.00 (193.00)
4370	Drug level in biological fluid: Monoclonal immunological	04.00		12.400	90.90 (79.70)
4371	Amylase in exudate	04.00		5.180	38.00 (33.30)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4372	Fluoride in biological fluids and water	04.00		15.620	114.50 (100.40)
4374	Trace metals in biological fluid: Atomic absorption	04.00		18.130	132.90 (116.60)
4375	Calcium in fluid: Spectrophotometric	04.00		3.620	26.50 (23.20)
4376	Calcium in fluid: Atomic absorption	04.00		7.250	53.20 (46.70)
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	04.11		21.880	160.40 (140.70)
4380	Lecithin in amniotic fluid: L/S ratio	04.00		27.000	198.00 (173.70)
4390	Foam test: Amniotic fluid	04.00		3.150	23.10 (20.30)
4391	Renal calculus: Chemistry	04.00		5.400	39.60 (34.70)
4392	Renal calculus: Crystallography	04.00		16.250	119.10 (104.50)
4395	Sweat: Sodium	04.00		3.620	26.50 (23.20)
4396	Sweat: Potassium	04.00		3.620	26.50 (23.20)
4397	Sweat: Chloride	04.00		2.590	19.00 (16.70)
4399	Sweat collection by iontophoresis (excluding collection material)	04.00		4.500	33.00 (28.90)
4400	Tryptophane loading test	04.00		22.050	161.70 (141.80)
Cerebrospinal fluid					
4401	Cell count	04.00		3.450	25.30 (22.20)
4407	Cell count, protein, glucose and chloride	04.00		7.650	56.10 (49.20)
4409	Chloride	04.00		2.590	19.00 (16.70)
4416	Sodium	04.00		3.620	26.50 (23.20)
4417	Protein: Qualitative	04.00		0.900	6.60 (5.79)
4419	Protein: Quantitative	04.00		3.110	22.80 (20.00)
4421	Glucose	04.00		3.620	26.50 (23.20)
4423	Urea	04.00		3.620	26.50 (23.20)
4425	Protein electrophoresis	04.00		12.600	92.40 (81.10)
RNA/DNA based tests and andrology					
RNA/DNA based tests and andrology: RNA/DNA based tests					
4430	Recombinant DNA technique	04.00		25.000	183.30 (160.80)
4431	Ribosomal RNA targeting for bacteriological identification	04.00		35.000	256.60 (225.10)
4432	Ribosomal RNA amplification for bacteriological identification	04.00		75.000	549.90 (482.40)
4433	Bacteriological DNA identification (LCR)	04.00		25.000	183.30 (160.80)
4434	Bacteriological DNA identification (PCR)	04.00		75.000	549.90 (482.40)
RNA/DNA based tests and andrology: Andrology					
4435	Mixed antiglobulin reaction: Semen	04.00		6.600	48.40 (42.50)
4436	Friberg test: Semen	04.00		14.500	106.30 (93.20)
4437	Kremer test: Semen	04.00		3.600	26.40 (23.20)
4440	Semen analysis: Cell count	04.00		7.650	56.10 (49.20)
4441	Semen analysis: Cytology	04.00		7.200	52.80 (46.30)
4442	Semen analysis: Viability + motility - 6 hours	04.00		6.000	44.00 (38.60)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4443	Semen analysis: Supravital stain	04.00		5.440	39.90 (35.00)
4445	Seminal fluid: Alpha glucosidase	04.00		20.000	146.60 (128.60)
4446	Seminal fluid fructose	04.00		3.150	23.10 (20.30)
4447	Seminal fluid: Acid phosphatase	04.00		5.180	38.00 (33.30)
Immunology					
4448	HCG: Latex agglutination: Qualitative (side room)	04.00		4.000	29.30 (25.70)
4449	HCG: Latex agglutination: Semi-quantitative (side room)	04.00		9.310	68.30 (59.90)
4450	HCG: Monoclonal immunological: Qualitative	04.00		10.000	73.30 (64.30)
4451	HCG: Monoclonal immunological: Quantitative	04.00		12.400	90.90 (79.70)
4455	Anti IgE receptor antibody test (10 samples and dilution)	04.00		161.560	1184.60 (1039.10)
4456	Eosinophil cationic protein	04.00		27.810	203.90 (178.90)
4457	Mast cell tryptase	04.00		96.870	710.30 (623.10)
4458	Micro-alburninuria: Radio-isotope method	04.00		12.420	91.10 (79.90)
4459	Acetyl choline receptor antibody	04.00		158.120	1159.30 (1016.90)
4460	CA-199 tumour marker	04.00		20.000	146.60 (128.60)
4462	CA-125 tumour marker	04.00		20.000	146.60 (128.60)
4463	C6 complement functional essay	04.00		45.000	329.90 (289.40)
4466	Beta-2-microglobulin	04.00		12.420	91.10 (79.90)
4468	CA-549	04.00		20.000	146.60 (128.60)
4469	Tumour markers: Monoclonal immunological (each)	04.00		20.000	146.60 (128.60)
4470	CA-195 tumour marker	04.00		20.000	146.60 (128.60)
4471	Carcino-embryonic antigen	04.00		20.000	146.60 (128.60)
4477	Neuron specific enolase	04.00		20.000	146.60 (128.60)
4479	Vitamin B12-absorption: Shilling test	04.00		11.700	85.80 (75.30)
4480	Serotonin	04.00		18.750	137.50 (120.60)
4482	Free thyroxine (FT4)	04.00		17.480	128.20 (112.50)
4485	Insulin	04.00		12.420	91.10 (79.90)
4490	Releasing hormone response	04.00		50.000	366.60 (321.60)
4491	Vitamin B12	04.00		12.420	91.10 (79.90)
4492	Vitamin D3: Calcitroil (RIA)	04.00		75.000	549.90 (482.40)
4493	Drug concentration: Quantitative	04.00		12.420	91.10 (79.90)
4494	Free hormone assay	04.00		17.480	128.20 (112.50)
4495	Growth hormone	04.00		12.420	91.10 (79.90)
4496	Hormone concentration: Quantitative	04.00		12.420	91.10 (79.90)
4497	Carbohydrate deficient transferrin	04.00		29.060	213.10 (186.90)
4499	Cortisol	04.00		12.420	91.10 (79.90)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4500	DHEA sulphate	04.00		12.420	91.10 (79.90)
4501	Testosterone	04.00		12.420	91.10 (79.90)
4502	Free testosterone	04.00		17.480	128.20 (112.50)
4503	Oestradiol	04.00		12.420	91.10 (79.90)
4505	Oestriol	04.00		10.800	79.20 (69.50)
4506	Multiple antigen specific IgE screening test for Atopy	04.00		37.260	273.20 (239.60)
4507	Thyrotropin (TSH)	04.00		19.600	143.70 (126.10)
4508	Combined antigen specific IgE	04.00		24.480	179.50 (157.50)
4509	Free tri-iodothyronine (FT3)	04.00		17.480	128.20 (112.50)
4512	Parathormone	04.00		17.080	125.20 (109.80)
4513	IgE: Total	04.00		12.420	91.10 (79.90)
4514	Antigen specific IgE	04.00		12.420	91.10 (79.90)
4515	Aldosterone	04.00		12.420	91.10 (79.90)
4516	Follitropin (FSH)	04.00		12.420	91.10 (79.90)
4517	Lutropin (LH)	04.00		12.420	91.10 (79.90)
4519	Prostate specific antigen	04.00		14.490	106.20 (93.20)
4520	17 Hydroxy progesterone	04.00		12.420	91.10 (79.90)
4521	Progesterone	04.00		12.420	91.10 (79.90)
4522	Alpha-feto protein	04.00		12.420	91.10 (79.90)
4523	ACTH	04.00		21.740	159.40 (139.80)
4526	Sex hormone binding globulin	04.00		12.420	91.10 (79.90)
4527	Gastrin	04.00		12.420	91.10 (79.90)
4528	Ferritin	04.00		12.420	91.10 (79.90)
4529	Anti-DNA antibodies	04.00		12.420	91.10 (79.90)
4530	Antiplatelet antibodies	04.00		15.300	112.20 (98.40)
4531	Hepatitis: Per antigen or antibody	04.00		14.490	106.20 (93.20)
4532	Transcobalamine	04.00		12.420	91.10 (79.90)
4533	Folic acid	04.00		12.420	91.10 (79.90)
4534	Prostatic acid phosphatase	04.00		12.420	91.10 (79.90)
4536	Erythrocyte folate	04.00		17.480	128.20 (112.50)
4537	Prolactin	04.00		12.420	91.10 (79.90)
4540	HCG: Quantitative as used for Down's screen	04.00		15.000	110.00 (96.50)
Clinical pathology: Miscellaneous					
4544	Attendance in theatre	04.00		27.000	198.00 (173.70)
Exfoliative cytology					
4561	Sputum, all body fluids and tumour aspirates: First unit	04.00		13.400	113.30 (99.40)

Code	Description	Ver	Add	Medical Technology	
				RVU	Fee
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	04.00		7.800	66.00 (57.90)
4564	Performance of fine-needle aspiration for cytology	04.00		15.000	126.90 (111.30)
4565	Examination of fine needle aspiration in theatre	04.00		90.000	761.10 (667.60)
4566	Vaginal or cervical smears, each	04.00		11.000	93.00 (81.60)
Human Genetics					
Cytogenitc					
4750	Cell culture: Lymphocytes, cord blood	04.00		15.000	112.60 (98.80)
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	04.00		45.000	337.90 (296.40)
4752	Cell culture: Chorionic villi	04.00		60.000	450.50 (395.20)
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	04.00		135.000	1013.70 (889.20)
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	04.00		270.000	2027.40 (1778.40)
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	04.00		70.000	525.60 (461.10)
4760	FISH procedure, including cell culture	04.00		115.000	863.50 (757.50)
4761	FISH analysis per probe system	04.00		35.000	262.80 (230.50)
DNA-testing					
4763	Blood: DNA extraction	04.00		45.000	337.90 (296.40)
4764	Blood: Genotype per person: Southern blotting	04.00		89.000	668.30 (586.20)
4765	Blood: Genotype per person: PCR	04.00		60.000	450.50 (395.20)
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	04.00		90.000	675.80 (592.80)
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	04.00		188.000	1411.70 (1238.30)
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	04.00		120.000	901.10 (790.40)

MENTAL HEALTH INSTITUTIONS

Mental Health Institutions 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF MENTAL HEALTH CARE FACILITIES WITH EFFECT FROM 1 JANUARY 2009

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 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.	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
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.	06.04
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

8 INSTITUTIONS REGISTERED IN TERMS OF THE MENTAL HEALTH ACT 1973 WITH A PRACTICE NUMBER COMMENCING WITH "55"

Code	Description	Ver	Add	Mental Health Institutions	
				RVU	Fee
004	General ward fee: with overnight stay	04.00		10.000	911.70 (799.70)
005	General ward fee: without overnight stay	04.00		7.355	670.50 (588.20)
006	General ward fee: under 5 hours stay	04.00		3.808	347.20 (304.60)

Code	Description	Ver	Add	Mental Health Institutions	
				RVU	Fee
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.	05.03		-	-
055	Electroconvulsive therapy (ECT) (No theatre fee chargeable)	04.00		4.997	455.60 (399.60)
231	Monitors	06.04		1.463	133.40 (117.00)
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.	04.00		-	-

NATUROPATHS

Naturopaths 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY NATUROPATHS WITH EFFECT FROM 1 JANUARY 2009

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 naturopath - qualifications of the naturopath - 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	09.00

ITEMS

1.	**Consultations**				
Code	**Description**	**Ver**	**Add**	**Naturopathy**	
				RVU	**Fee**
10010	Consultation (initial or follow up). Duration 5 - 15 mins	09.00		10.000	-
10020	Consultation (initial or follow up). Duration 16 - 30 mins	09.00		22.500	-
10090	Consultation, each additional full 15 mins, to a maximum of 60 mins	09.00		15.000	-
2.	**Diagnostic Procedures**				
20010	Vega testing	09.00		15.000	-
20020	Life blood testing	09.00		15.000	-
3.	**Treatment Procedures**				
30010	Hydrotherapy	09.00		30.000	-
30011	Hydrotherapy, each additional full 15 mins, after initial 30 mins, to a maximum of 60 mins	09.00		15.000	-
30020	Electrotherapy	09.00		15.000	-
30021	Electrotherapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
30030	Vibration therapy	09.00		15.000	-
30031	Vibration therapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
30040	Light therapy	09.00		15.000	-
30041	Light therapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
30050	Thermal therapy	09.00		15.000	-
30051	Thermal therapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
30060	Massage therapy	09.00		30.000	-
30061	Massage therapy, each additional full 15 min, after initial 30 mins, to a maximum of 60 mins	09.00		15.000	-
30070	Exercise therapy	09.00		15.000	-
30071	Exercise therapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
30080	Reflex therapy	09.00		15.000	-
30081	Reflex therapy, each additional full 15 min, after initial 15 min, to a maximum of 60 mins	09.00		15.000	-
4.	**Medicines and Materials**				
40100	Proprietary Naturopathic medicine, appropriate NAPPI codes to be charged	09.00		-	-
40200	Non-proprietary Naturopathic medicine	09.00		-	-
40300	Naturopathic ointments / creams	09.00		-	-
40400	Naturopathic syrups and tonics	09.00		-	-

OCCUPATIONAL AND ART THERAPY

Occupational and Art Therapy 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OCCUPATIONAL AND ART THERAPISTS, EFFECTIVE FROM 1 JANUARY 2009

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 OCCUPATIONAL THERAPY (R2145 - 31 July 1992)

GENERAL RULES

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 occupational therapy 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. Rule 006 does not apply to art therapy.	05.02
008	The provision of assistive devices shall 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. Modifier 0008 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
009	Materials used in the construction of orthoses or pressure garments 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. Modifier 0009 must be quoted after the appropriate code numbers to show that this rule is applicable. Rule 009 does not apply to art therapy.	04.00
010	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. Modifier 0010 must be quoted after the appropriate code numbers to show that this rule is applicable.	04.00
011	Where the therapist performs treatments away from the treatment rooms, travelling costs to be charged according to AA rates e.g. for domicilliary treatments or treatments in nursing homes. Modifier 0011 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
012	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: i The name and practice number of the consulting occupational or art therapist. ii The name of the member. iii The name of the patient. iv The name of the medical scheme. v The membership number of the patient. vi The nature of the treatment. vii The date on which the service was rendered. viii The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	05.02

Code	Description	Ver	Add	Occupational Therapy		Arts Therapy	
				RVU	Fee	RVU	Fee
013	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. Please note: In the case of occupational therapy, a code will only be required when a standard proprietary (off the shelf) product is used. When a splint or support is made by the occupational therapist using or modifying one or more components, a code cannot accurately identify this non-standard product. Please refer to annexure itemising the most commonly made non-standard products used in occupational therapy and bill accordingly. The Occupational Therapy Association of S A has made available a generic list of non-proprietary splints and pressure garments commonly made by practitioners. The type of materials used to manufacture these products is at the discretion of the practitioner concerned. Price of splints and pressure garments may vary. See Annexures A & B.						04.00
Modifiers							
0006	Add 50% of the total fee for the procedure. Modifier 0006 does not apply to art therapy.						04.00
0008	Assistive devices 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
0009	Materials used for orthoses or pressure garments 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. See Annexures A & B for non-standard products. Modifier 0009 does not apply to art therapy.						05.02
0010	Materials used in treatment 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
0011	Travelling costs according to AA rates. 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
0021	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.						04.00
ITEMS							
1	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**						
Code	**Description**	**Ver**	**Add**	**Occupational Therapy**		**Arts Therapy**	
				RVU	**Fee**	**RVU**	**Fee**
108	Interview, guidance or consultation: 30 minute duration.	06.02		21.250	129.30 (113.40)	21.250	70.80 (62.10)
109	Interview, guidance or consultation. Each additional 15 mins. A maximum of four instances of this code may be charged per session.	06.02	+	10.630	64.70 (56.80)	10.625	35.40 (31.10)
	Time based items in this section exclude time spent on procedures charged in addition to the consultation	05.02					
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		-	-	-	-
110	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.	05.02		16.500	100.40 (88.10)	22.140	73.70 (64.60)
501	Treatment in nursing home or other health care facilities. Relevant fee plus (once per day)	09.00	+	10.000	60.80 (53.30)	10.000	33.30 (29.20)
503	Domicillary treatments: Relevant fee plus	09.00	+	20.000	121.70 (106.80)	20.000	66.60 (58.40)
2	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT.**						
201	Observation and screening.	04.00		7.500	45.60 (40.00)	10.000	33.30 (29.20)
203	Specific evaluation for a single aspect of dysfunction (Specify which aspect).	04.00		7.500	45.60 (40.00)	10.000	33.30 (29.20)
205	Specific evaluation of dysfunction involving one part of the body for a specific functional problem (Specify part and aspects evaluated)	04.00		22.500	136.90 (120.10)	30.000	99.90 (87.60)
207	Specific evaluation for dysfunction involving the whole body (Specify condition and which aspects evaluated).	04.00		45.000	273.80 (240.20)	60.000	199.90 (175.40)
209	Specific in depth evaluation of certain functions affecting the total person (Specify the aspects assessed).	04.00		75.000	456.30 (400.30)	100.000	333.10 (292.20)

Code	Description	Ver	Add	Occupational Therapy		Arts Therapy	
				RVU	Fee	RVU	Fee
211	Comprehensive in depth evaluation of the total person (Specify aspects assessed)	04.00		105.000	638.80 (560.40)	140.000	466.30 (409.00)
Measurement for designing.							
213	Measurement for designing a static or dynamic orthosis	09.00		7.500	45.60 (40.00)		
217	A pressure garment for one limb.	04.00		7.500	45.60 (40.00)		
219	A pressure garment for one hand.	04.00		7.500	45.60 (40.00)		
221	A pressure garment for the trunk.	04.00		7.500	45.60 (40.00)		
223	A pressure garment for the face (chin strap only).	04.00		7.500	45.60 (40.00)		
225	A pressure garment for the face (full face mask).	04.00		7.500	45.60 (40.00)		
	The whole body or part thereof will be the sum total of the parts	04.00					
227	Specific built-in musical aids	05.03				10.000	33.30 (29.20)
3	**PROCEDURES OF THERAPY.**						
301	Group treatment in a task-centered activity, per patient (Treatment time 60 minutes or more).	04.00		10.000	60.80 (53.30)	8.840	47.40 (41.60)
303	Placement of a patient in an appropriate treatment situation requiring structuring the environment, adapting equipment and positioning the patient. This does not require individual attention for the whole treatment session, per patient)	04.00		15.000	91.30 (80.10)	10.000	33.30 (29.20)
305	Groups directed to achieve common aims, per patient) (Treatment time 60 minutes or more).	04.00		20.000	121.70 (106.80)	16.500	88.40 (77.50)
307	Simultaneous treatment with two to four patients, each with specific problems, utilising individual activities, per patient (Treatment time 60 minutes or more)	04.00		20.000	121.70 (106.80)	20.000	66.60 (58.40)
308	Simultaneous treatment with two to four neuro-behavioural and stress related conditions or severe head injury patients, each with specific problems, utilising individual activities, per patient (Treatment time 90 minutes or more)	04.00		30.000	182.50 (160.10)	30.000	99.90 (87.60)
	Individual and undivided attention during treatment sessions utilising specific activity and/or techniques in an integrated treatment session	04.00					
309	On level one (15 minutes).	04.00		10.000	60.80 (53.30)	10.000	53.60 (47.00)
311	On level two (30 minutes).	04.00		20.000	121.70 (106.80)	20.000	107.20 (94.00)
313	On level three (45 minutes).	04.00		30.000	182.50 (160.10)	30.000	160.70 (141.00)
315	On level four (60 minutes).	04.00		40.000	243.40 (213.50)	40.000	214.30 (188.00)
317	On level five (90 minutes).	04.00		50.000	304.20 (266.80)	50.000	267.90 (235.00)
319	On level six (120 minutes).	04.00		60.000	365.00 (320.20)	60.000	321.50 (282.00)
4	**PROCEDURES REQUIRED TO PROMOTE TREATMENT.**						
401	Recommendations as regards to assistive devices, environmental adaptations, alternative/compensatory methods, handling the patient	04.00		15.000	91.30 (80.10)	10.000	53.60 (47.00)
	Designing and constructing a custom-made adaptation, assistive device, splint or simple pressure garment for treatment in a task-centered activity (specify the adaptation, assistive device, splint or simple pressure garment)	04.00					
403	On level one.	04.00		10.000	60.80 (53.30)	10.000	53.60 (47.00)
405	On level two.	04.00		20.000	121.70 (106.80)	20.000	107.20 (94.00)
407	On level three.	04.00		30.000	182.50 (160.10)	30.000	160.70 (141.00)
409	On level four.	04.00		40.000	243.40 (213.50)	40.000	214.30 (188.00)
411	On level five.	04.00		50.000	304.20 (266.80)	50.000	267.90 (235.00)
413	On level six.	04.00		60.000	365.00 (320.20)	60.000	321.50 (282.00)
415	Designing and constructing a static orthosis.	04.00		60.000	365.00 (320.20)		
417	Designing and constructing a dynamic orthosis.	04.00		120.000	730.10 (640.40)		
	Designing and constructing pressure garment for:	04.00					

Code	Description	Ver	Add	Occupational Therapy		Arts Therapy	
				RVU	Fee	RVU	Fee
419	Limb.	04.00		60.000	365.00 (320.20)		
421	Face (chin strap only).	04.00		45.000	273.80 (240.20)		
423	Face (full face mask).	04.00		60.000	365.00 (320.20)		
425	Trunk.	04.00		90.000	547.60 (480.40)		
427	Hand.	04.00		90.000	547.60 (480.40)		
	The whole body or part thereof will be the sum total of the parts for the first garment and 75% of the fee for any additional garments made on the same pattern	04.00					
431	Planning and preparing in depth home programme on a monthly basis.	04.00		90.000	547.60 (480.40)	120.000	399.70 (350.60)
434	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.	05.03					
	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					
List of splints and pressure garments exempted from NAPPI codes							
Annexure A							
	Numbers and names of splints to be used with modifier 0009						04.00
701	Static finger extension/flexion splint	04.11		-	-		
702	Dynamic finger extension/flexion	04.11		-	-		
703	Buddy strap	04.00		-	-		
704	DIP/PIP flexion strap	04.00		-	-		
705	MP, PIP, DIP flexion strap	04.00		-	-		
706	Hand based static finger extension/flexion	04.00		-	-		
707	Hand based static thumb extension/flexion/opposition/ abduction	04.00		-	-		
708	Hand based dynamic finger flexion/extension	04.00		-	-		
709	Hand based dynamic thumb flexion/extension/opposition/abduction	04.00		-	-		
710	Static wrist extension/flexion	04.00		-	-		
711	Dynamic wrist extension/flexion	04.00		-	-		
712	Flexion glove	04.00		-	-		
713	Forearm based dynamic finger flexion/extension	04.00		-	-		
714	Forearm based dorsal protection	04.00		-	-		
715	Forearm based volar resting	04.00		-	-		
716	Static elbow extension/flexion	04.00		-	-		
717	Dynamic elbow flexion/extension splint	04.00		-	-		
718	Shoulder abduction splint	04.00		-	-		
719	Static rigid neck splint	04.00		-	-		
720	Static soft neck splint/brace	04.00		-	-		
721	Static knee extension	04.00		-	-		
722	Static foot dorsiflexion	04.00		-	-		
Annexure B							
	Numbers and names of pressure garments to be used with modifier 0009						04.00
801	Glove to wrist	04.00		-	-		
802	Glove to elbow	04.00		-	-		
803	Gauntlet (Glove with palm and thumb only)	04.00		-	-		
804	Sleeve: Upper/forearm	04.00		-	-		
805	Sleeve: full	04.00		-	-		
806	Vest + sleeves	04.00		-	-		
807	Sleeveless vest	04.00		-	-		
808	Upper leg	04.00		-	-		
809	Lower leg	04.00		-	-		
810	Full leg	04.00		-	-		
811	Pants (trunk and full legs)	04.00		-	-		
812	Briefs	04.00		-	-		
813	Anklet	04.00		-	-		
814	Knee length stocking	04.00		-	-		
815	Chin strap	04.00		-	-		
816	Full face mask	04.00		-	-		
817	Neck only	04.00		-	-		
818	Finger sock	04.00		-	-		

Code	Description	Ver	Add	Occupational Therapy		Arts Therapy	
				RVU	Fee	RVU	Fee
Annexure C							
	List of materials used in treatment under modifier 0010						04.00
901	Therapeutic putty	04.00		-	-		
902	Wood, leather, sisal	04.00		-	-		
903	Sponge	04.00		-	-		
904	Elastonet	04.00		-	-		
905	Silicon gel sheeting	04.00		-	-		
Annexure D							
	Assistive devices made by the therapist her/himself to be used with modifier 0008						04.00
1001	Hip abduction cushion	04.00		-	-		
1002	Sponge on a stick	04.00		-	-		
1003	Hand grips (for utensils)	04.00		-	-		
1004	Bath bench	04.00		-	-		
1005	Bath seat	04.00		-	-		
1006	Transfer board	04.00		-	-		
1007	Plate surround	04.00		-	-		
1008	Wheelchair strap	04.00		-	-		

OPTOMETRISTS

Optometrists 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OPTOMETRISTS EFFECTIVE FROM 1 JANUARY 2009

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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	213.00 (186.80)
11081	Optometric Examination & Visual Fields	06.02		35.000	248.50 (218.00)
11021	Optometric-Re-examination	06.02		20.000	142.00 (124.60)
11041	Consultation :15 min. without performing Optometric Exam.	06.02		15.000	106.50 (93.40)
Diagnostic Procedures:					
11303	Cycloplegic Refraction	06.02		15.000	106.50 (93.40)
11323	Preferential Looking (Infants < Two Years)	06.02		15.000	106.50 (93.40)
11346	Corneal Topography	06.02		20.000	142.00 (124.60)
11356	Gonioscopy	06.02		10.000	71.00 (62.30)
11366	Dilated Fundus Examination / BIO	06.02		10.000	71.00 (62.30)
11423	Visual Field	06.02		15.000	106.50 (93.40)
11443	Threshold Visual Fields	06.02		25.000	177.50 (155.70)
11246	Revaluation of Colour Vision	06.02		15.000	106.50 (93.40)
11265	Evaluation of Contrast Sensitivity	06.02		10.000	71.00 (62.30)
11283	Evaluation of Lacrimal System	06.02		10.000	71.00 (62.30)
11604	Photography of Anterior Segment	06.02		10.000	71.00 (62.30)
11624	Photography of Fundus	06.02		10.000	71.00 (62.30)
11644	Photographic Materials	06.02		-	-
Procedures done in isolation					
11141	Evaluation of Refractive Status	06.02		20.000	142.00 (124.60)
11161	Screening for Pathology	06.02		15.000	106.50 (93.40)
11183	Keratometry	06.02		10.000	71.00 (62.30)
11202	Tonometry (Non-contact)	06.02		10.000	71.00 (62.30)
11212	Tonometry (Aplanation)	06.02		10.000	71.00 (62.30)
11221	Screening of Colour Vision	06.02		5.000	35.50 (31.10)
11402	Screening of Visual Fields	06.02		10.000	71.00 (62.30)
12503	Assessment of CL Related Problems - Monocular	06.02		10.000	71.00 (62.30)
12523	Assessment of CL Related Problems - Binocular	06.02		15.000	106.50 (93.40)

Code	Description	Ver	Add	Optometry	
				RVU	Fee
12533	CL Instruction	06.02		15.000	106.50 (93.40)
Dispensing Fees					
11501	Dispensing Fee - Single Vision	06.02		5.000	35.50 (31.10)
11521	Dispensing Fee - Bifocals	06.02		10.000	71.00 (62.30)
11541	Dispensing Fee - Varifocals	06.02		10.000	71.00 (62.30)
11707	Night/Weekend/Public Holiday Visit	06.02		15.000	106.50 (93.40)
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	426.00 (373.70)
11829	Screening Industrial (per hour)	06.02		60.000	426.00 (373.70)
Contact Lens Procedures					
12012	Basic - per visit	06.02		30.000	213.00 (186.80)
12032	Complex - per visit	06.02		30.000	213.00 (186.80)
12052	Advanced - per visit	06.02		30.000	213.00 (186.80)
12072	CL Dispensing and/or Assessment	06.02		15.000	106.50 (93.40)
Binocular Vision/Orthoptics					
13003	Evaluation of Binocular Instability Simple Case	06.02		30.000	213.00 (186.80)
13023	Evaluation of Binocular Instability Complex Case	06.02		60.000	426.00 (373.70)
Visually Related Disorders					
13105	Evaluation of Visually Related Learning Disorders	06.02		90.000	639.00 (560.50)
13125	Evaluation of Eye Movements (e.g. Visigraph)	06.02		30.000	213.00 (186.80)
Colorimetry Codes					
13509	Screening - Rate of Reading Test	06.02		15.000	106.50 (93.40)
13529	Evaluation - Ortho-Didactical Reading Skills	06.02		45.000	319.50 (280.30)
13549	Evaluation - Intuitive Colorimetry	06.02		60.000	426.00 (373.70)
Visual Therapy/Orthoptics Training					
13403	Training Home Therapy Instruction	06.02		10.000	71.00 (62.30)
13423	Training Individual (per 15 minutes)	06.02		15.000	106.50 (93.40)
13445	Training Individual (per 30minutes)	06.02		30.000	213.00 (186.80)
13463	Training Group per Patient (per 15 minutes)	06.02		3.750	26.60 (23.30)
13489	Training Away from Practice	06.02		30.000	213.00 (186.80)
Low Vision Assessment & Training (per Half hour)					
16013	Simple LV Assessment	06.02		30.000	213.00 (186.80)
16033	Complex LV Assessment	06.02		30.000	213.00 (186.80)
16053	Advanced LV Assessment	06.02		30.000	213.00 (186.80)
16073	Simple LV Training	06.02		30.000	213.00 (186.80)
16093	Complex LV Training	06.02		30.000	213.00 (186.80)
16113	Advanced LV Training	06.02		30.000	213.00 (186.80)
Sports Vision - in Office Procedures					
14008	Screening Sports Vision Individual	06.02		20.000	142.00 (124.60)

Code	Description	Ver	Add	Optometry	
				RVU	Fee
14218	Evaluation Sports Vision Individual	06.02		45.000	319.50 (280.30)
14238	Training Sports Vision Individual (per 15 minutes)	06.02		15.000	106.50 (93.40)
	Group fees are per individual member of the group	06.02			
14268	Screening Sports Vision Group	06.02		3.750	26.60 (23.30)
14278	Evaluation Sports Vision Group	06.02		8.750	62.10 (54.50)
14288	Training Sports Vision Group (per 15 minutes)	06.02		3.750	26.60 (23.30)
Sports Vision - Procedures done in the Field					
14309	Screening Sports Vision Individual	06.02		30.000	213.00 (186.80)
14319	Evaluation Sports Vision Individual	06.02		60.000	426.00 (373.70)
14329	Training Sports Vision Individual (per 15 minutes)	06.02		15.000	106.50 (93.40)
	Group fees are per individual member of the group	06.02			
14369	Screening Sports Vision Group	06.02		6.250	44.40 (38.90)
14379	Evaluation Sports Vision Group	06.02		12.500	88.80 (77.90)
14389	Training Sports Vision Group (per 15 minutes)	06.02		3.750	26.60 (23.30)
Reports etc					
19001	Report at request of Medical Aid	06.02		15.000	106.50 (93.40)
19021	Report at Patient's request	06.02		25.000	177.50 (155.70)
19081	Confirming Med. Aid Benefit by tel. or fax (per 10 minutes)	06.02		5.000	35.50 (31.10)
Generic Lenses					
40501	Frames	06.02		-	-
70011	Single Vision lens (up to 6.00Sph)	06.02		2.374	192.30 (168.70)
70021	Special Vision High Powers	06.02		5.786	468.70 (411.10)
70712	Bifocal-Round/flat/top Seg 68*28 Seg	06.02		7.567	613.00 (537.70)
75012	Varifocal Distance to near	06.02		11.869	961.50 (843.40)
80011	Single Vision lens	06.02		2.374	192.30 (168.70)
80021	Special Vision High Powers	06.02		5.104	413.50 (362.70)
80812	Bifocal-Round/flat/top Seg 74*28 Seg	06.02		5.727	464.00 (407.00)
85012	Varifocal Distance to near	06.02		11.128	901.50 (790.80)
84000	Varifocal Intermediate to Near	06.05		11.128	901.50 (790.80)
99999	All other codes	06.02		-	-

ORTHOPTISTS

Orthoptists 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF ORTHOPTISTS WITH EFFECT FROM 1 JANUARY 2009

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	93.50 (82.00)
003	Orthoptic treatment (Ocular motility imbalance)	04.00		8.700	81.40 (71.40)
005	Orthoptic consultation (Hess chart)	04.00		11.100	103.80 (91.10)
007	Orthoptic visual fields charting or field of binocular single vision	04.00		21.700	202.90 (178.00)
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		-	-

OSTEOPATHY

Osteopathy 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY OSTEOPATHS EFFECTIVE FROM 1 JANUARY 2009

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	Osteopathy RVU	Osteopathy Fee
001	Initial consultation/manipulation (fee covering history, examination and treatment)	06.02		16.000	-
	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		8.000	-
	COIDS - Subsequent consultation & examination not requiring treatment	06.02			
003	Consultation/examination where no treatment is required	09.00			
	COIDS - Spinal or extra-spinal joint manipulation ONLY.	06.02			
600	Lifestyle Advice / Counselling	09.00		5.000	-
2.	**High Velocity, Low Amplitude Thrust (HVLAT) Techniques**				
410	Cervical Spine High Velocity, Low Amplitude Thrust (HVLAT) Techniques	09.00		3.000	-
420	Lumbar Spine High Velocity, Low Amplitude Thrust (HVLAT) Techniques	09.00		4.000	-
430	Peripheral Joint High Velocity, Low Amplitude Thrust (HVLAT) Techniques	09.00		3.000	-
440	Thoracic Spine High Velocity, Low Amplitude Thrust (HVLAT) Techniques	09.00		3.000	-
3.	**Other Osteopathic Techniques**				
510	Cranio-Sacral Osteopathic Technique	09.00		20.000	-
520	General Body Adjustment (GBA)	09.00		22.000	-
530	General Osteopathic Treatment (GOT)	09.00		20.000	-
540	Muscle Energy Techniques (MET)	09.00		5.000	-
550	Passive Joint Articulation	09.00		6.000	-
4.	**Modalities/Adjunctive Therapy**				
Soft Tissue Manipulation					
101	Massage	06.02		10.000	-
103	Myofacial pain therapy	06.02		6.000	-
Superficial Heating Therapy					
121	Hydrocollator/Ice pack - Hot or cold packs	06.02		4.000	-
123	Infra-Red Treatment	09.00		8.000	-
Non-heating Modalities					
145	Ultrasound	06.02		8.000	-
149	Interferential treatment	09.00		10.000	-
155	Vibration therapy	06.02		7.000	-

Code	Description	Ver	Add	Osteopathy	
				RVU	Fee
161	TENS	06.02		9.000	-
165	Traction: Mechanical/Static, etc.	06.02		10.000	-
Cold Applications					
173	Cold packs	06.02		4.000	-
Therapeutic Exercise					
187	Proprioceptive neuromuscular facilitation	06.02		6.000	-
189	Gait Analysis & Training	09.00		15.000	-
Immobilisation					
203	Supportive strapping, bracing, splinting and taping	06.02		8.000	-

PHYSICAL REHABILITATION HOSPITALS

Physical Rehabilitation Hospitals 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF REHABILITATION HOSPITALS WITH A PRACTICE NUMBER COMMENCING WITH "59" WITH EFFECT FROM 1 JANUARY 2009

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	445.60 (390.90)
101	Out patients, 6 hours per day (maximum 18 days)	04.00		21.103	940.30 (824.80)
105	General care (maximum 27 days)	04.00		42.013	1872.10 (1642.20)
107	High care (maximum 36 days)	04.00		49.522	2206.70 (1935.70)
109	Rehabilitation ICU (maximum 7 days)	04.00		89.005	3966.10 (3479.00)

PHYSIOTHERAPY

Physiotherapy 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF PHYSIOTHERAPISTS WITH EFFECT FROM 1 JANUARY 2009		
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 1975)		
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 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.	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	29.00 (25.40)
005	Ultraviolet light	04.00		10.000	58.00 (50.80)
006	Laser beam	04.00		15.000	86.90 (76.30)
007	Cryotherapy	04.00		5.000	29.00 (25.40)
2	**LOW FREQUENCY CURRENTS**				
103	Galvanism, Diodynamic current, Tens.	04.00		10.000	58.00 (50.80)
105	Muscle and nerve stimulating currents.	04.00		12.000	69.50 (61.00)
107	Interferential Therapy.	04.00		10.000	58.00 (50.80)
3	**HIGH FREQUENCY CURRENTS**				
201	Shortwave diathermy.	04.00		5.000	29.00 (25.40)
203	Ultrasound.	04.00		10.000	58.00 (50.80)
205	Microwave.	04.00		5.000	29.00 (25.40)
4	**PHYSICAL MODALITIES**				
300	Vibration	04.00		10.000	58.00 (50.80)
301	Percussion	04.00		16.100	93.30 (81.80)
302	Massage	04.00		10.000	58.00 (50.80)
303	Myofacial release/soft tissue mobilisation, one or more body parts	04.00		20.090	116.40 (102.10)
304	Acupuncture	04.00		15.000	86.90 (76.30)
305	Re-education of movement/Exercises (excluding ante- and post-natal exercises)	04.00		10.000	58.00 (50.80)
307	Pre- and post-operative exercises and/or breathing exercises	04.00		10.000	58.00 (50.80)
308	Group exercises (excluding ante- and post-natal exercises - maximum of 10 in a group)	04.00		10.000	58.00 (50.80)
309	Isokinetic treatment.	04.00		10.000	58.00 (50.80)
310	Neural tissue mobilisation	04.00		20.000	115.90 (101.70)
313	Ante and post natal exercises/counselling	04.00		10.000	58.00 (50.80)
314	Lymph drainage	04.00		5.000	29.00 (25.40)
315	Postural drainage.	04.00		10.000	58.00 (50.80)

Code	Description	Ver	Add	Physiotherapy	
				RVU	Fee
317	Traction.	04.00		10.000	58.00 (50.80)
318	Upper respiratory nebulisation and/or lavage	04.00		10.000	58.00 (50.80)
319	Nebulisation	04.00		10.000	58.00 (50.80)
321	Intermittent positive pressure ventilation.	04.00		10.000	58.00 (50.80)
323	Suction: Level 1 (including sputum specimen taken by suction)	04.00		5.000	29.00 (25.40)
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	116.40 (102.10)
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	04.00		5.000	29.00 (25.40)
328	Dry needling	04.00		15.000	86.90 (76.30)
5	**MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION**				
401	Spinal.	04.00		15.000	86.90 (76.30)
402	Pre meditated manipulation	04.00		10.000	58.00 (50.80)
405	All other joints.	04.00		15.000	86.90 (76.30)
407	Immobilisation (excluding materials). Rule 008 does not apply.	04.00		15.000	86.90 (76.30)
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	144.90 (127.10)
502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	04.00		25.000	144.90 (127.10)
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	318.70 (279.60)
504	EMG Biofeedback treatment	04.00		15.000	86.90 (76.30)
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	69.50 (61.00)
506	Stress management	04.00		20.000	115.90 (101.70)
507	Respiratory Re-education and Training. Duration: 30min.	04.00		15.000	86.90 (76.30)
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	86.90 (76.30)
7	**EVALUATION**				
701	Evaluation/counselling at the first visit only (to be fully documented)	04.00		15.000	86.90 (76.30)
702	Complex evaluation/counselling at the first visit only (to be fully documented).	04.00		30.000	173.90 (152.50)
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	86.90 (76.30)
704	Lung function: Peak flow (once per treatment).	04.00		5.000	29.00 (25.40)
705	Computerised/Electronic test for lung pathology	04.00		15.000	86.90 (76.30)
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	86.90 (76.30)
707	Physical Performance test. Must be fully documented.	04.00		20.000	115.90 (101.70)
708	Interview, guidance or consultation with the patient or his family. To be used only once per episode of care.	05.02		15.000	86.90 (76.30)
801	Electrical test for diagnostic purposes (including IT curve and Isokinetic tests) for a specific medical condition	04.00		35.000	202.80 (177.90)
803	Effort test - multistage treadmill.	04.00		35.000	202.80 (177.90)
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	58.00 (50.80)

Code	Description	Ver	Add	Physiotherapy	
				RVU	Fee
903	Domicilliary treatments : Relevant fee plus.	04.00		20.000	115.90 (101.70)
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	58.00 (50.80)
938	Bird or equivalent freestanding nebuliser excluding oxygen domicilliary per day.	04.00		10.000	58.00 (50.80)
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			

PHYTOTHERAPY

Phytotherapy 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PHYTOTHERAPISTS EFFECTIVE FROM 1 JANUARY 2009

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 5 - 15 mins	09.00		10.000	52.00 (45.60)
131	Consultation (initial or follow up). Duration 16 - 30 mins	06.04		22.500	116.90 (102.50)
132	Consultation (initial or follow up). Duration 31 - 45 mins	06.04		37.500	194.90 (171.00)
133	Consultation (initial or follow up). Duration 46 - 60 mins	06.04		52.500	272.80 (239.30)
134	Consultation, each additional full 15 mins, to a maximum of 60 mins	06.04		15.000	78.00 (68.40)
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	3.25 (2.85)
320	Tea mixes, per 10g	06.02		1.000	1.20 (1.05)
330	Capsules/tablets, per capsule	06.02		3.400	4.09 (3.59)
340	Creams/Ointments, per 10ml	06.02		20.100	24.20 (21.20)
350	Syrups, per 10ml	06.02		2.800	3.37 (2.96)
360	Medicinal oils, per 10ml	06.02		1.300	1.56 (1.37)
390	Proprietary materials	06.02		-	-
395	Proprietary medicines	06.02		-	-

PODIATRY

Podiatry 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PODIATRISTS WITH EFFECT FROM 1 JANUARY 2009

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	66.00 (57.90)
302	Consultation (initial or follow up) 11-20 minutes	06.03		15.000	132.00 (115.80)
303	Consultation (initial or follow up) 21-30 minutes	06.03		25.000	220.10 (193.10)
304	Consultation (initial or follow up) 31-45 minutes	06.03		37.500	330.10 (289.60)
006	More than one patient seen at a residence (See note below).	06.02		8.500	67.60 (59.30)
	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	10.30 (9.04)
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	31.00 (27.20)

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	62.10 (54.50)
012	Extended care for chronic disease management or ulcer management (applicable to diabetes, arthritis and peripheral vascular diseases)	04.00		7.400	58.90 (51.70)
013	General podiatric care more than 30 minutes (a combination of items 010 and 011)	04.00		11.800	93.90 (82.40)
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	47.00 (41.20)
015	Subsequent lesion.	04.00		2.900	23.10 (20.30)
016	Cryotherapy first lesion (consultation and treatment).	04.00		7.800	62.10 (54.50)
017	Subsequent lesion.	04.00		3.900	31.00 (27.20)
018	Diathermy first lesion (consultation and treatment).	04.00		6.900	54.90 (48.20)
019	Subsequent lesion.	04.00		3.500	27.90 (24.50)
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	156.00 (136.80)
022	Two nails - one side.	04.00		25.500	202.90 (178.00)
024	Two nails - both sides.	04.00		36.400	289.70 (254.10)
023	One nail - two sides (including consultation).	04.00		25.500	202.90 (178.00)
025	Avulsion with matrix phenolisation (including consultation).	04.00		19.600	156.00 (136.80)
031	Avulsion without matrix phenolisation (including consultation).	04.00		12.800	101.90 (89.40)
Other.					
040	Infection control, per patient	04.00		1.200	9.55 (8.38)
041	Remedial therapy.	04.00		4.900	39.00 (34.20)
042	Sterile pack.	06.03		5.900	47.00 (41.20)
044	Suturing (includes consultation).	04.00		7.800	62.10 (54.50)
046	Incision Biopsy.	04.00		5.900	47.00 (41.20)
047	Removal of foreign body.	04.00		8.900	70.80 (62.10)
048	Suturing / Wound closure material : Cost of material plus 10%	06.03		-	-
146	Excision biopsy.	04.00		8.900	70.80 (62.10)
201	Sterile Surgical Blades (maximum of 2 per patient)	06.03		1.000	7.96 (6.98)
203	Wound dressing material (maximum of 2 per patient)	06.03		2.000	15.90 (13.90)
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	93.90 (82.40)
209	Simple insole material fee	06.03		5.900	47.00 (41.20)
211	Local anaesthetic medication per ampoule (maximum of 5 per patient)	06.03		2.000	15.90 (13.90)
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	22.30 (19.60)
217	Padding and strapping: Metatarsal, per foot	04.00		3.500	27.90 (24.50)

Code	Description	Ver	Add	Podiatry	
				RVU	Fee
219	Padding and strapping: Heel, per foot	04.00		3.500	27.90 (24.50)
Appliances and Orthotics					
	(By arrangement with the scheme concerned).				04.00
043	Biomechanical examination.	04.00		15.700	124.90 (109.60)
051	Neutral impression Plaster of Paris casting	04.00		8.500	67.60 (59.30)
052	Orthotic repair.	04.00		12.800	101.90 (89.40)
053	Temporary orthotic or corrective component.	04.00		12.800	101.90 (89.40)
054	Prescription covering and soft tissue supplements.	04.00		8.900	70.80 (62.10)
055	Silicone devices: Digital	04.00		5.400	43.00 (37.70)
056	Computerised gait analysis	06.02		19.600	156.00 (136.80)
057	Template measurement.	04.00		2.900	23.10 (20.30)
058	Immobilisation casting	06.04		10.600	84.40 (74.00)
059	Simple insole - one foot.	04.00		11.100	88.30 (77.50)
061	Simple insoles - both feet.	04.00		20.100	160.00 (140.40)
060	Silicone devices: metatarsal	04.00		10.700	85.20 (74.70)
064	Silicone devices: heel	04.00		15.900	126.50 (111.00)
	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	152.00 (133.30)
065	Prescription orthotics : both feet.	04.00		38.300	304.80 (267.40)
067	Preformed moulded insoles: Adult, both feet	04.00		22.100	175.90 (154.30)
069	Preformed moulded insoles: Adult, one foot	04.00		11.000	87.50 (76.80)
071	Preformed moulded insoles: Child, both feet	04.00		17.000	135.30 (118.70)
073	Preformed moulded insoles: Child, one foot	04.00		8.500	67.60 (59.30)

Code	Description	Ver	Add	Podiatry RVU	Podiatry Fee
CONSUMABLE LIST					
	STERILISING ITEMS				04.00
	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				

PRIVATE HOSPITALS

Private Hospitals 2009

DRAFT 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 2009

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 relating to each type of hospital/unattached operating theatre unit/day clinic are indicated in the relevant column opposite the item codes.	09.01
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 of private hospitals or unattached operating theatre units/day clinics requesting a 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.	09.01
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/day clinics having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units/day clinics with 76 practice numbers.	09.01
F.1.1	Inspections of new unattached theatre operating units and units requesting a practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units/day clinics having practice numbers with the digits 77 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF.	09.01
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 1998. All accounts must 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.	09.01
H	All accounts must specify 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.	09.01
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
J	Accommodation tariffs includes the following minimum services: 1. Pre-authorisation (up to the date of admission) and supply of the following information: - length of stay - level of care - theatre procedures 2. Provision of ICD-10 and CPT-4/NHRPL/CCSA or other prevailing codes when requesting pre-authorisation 3. Notification of admission 4. Immediate notification of changes to: - length of stay - level of care - theatre procedures 5. Discharge ICD-10 and CPT-4/NHRPL/CCSA or other coding. 6. Motivations for specific services within the hospital as may be required from time to time.	09.01
K	The items listed as non-recoverable in Annexure B shall be deemed to be included in all ward, specialized units and theatre fees, and no charge in respect thereof may be levied.	09.01

SCHEDULE

1 Ward Fees

1.1 General Wards

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

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
				RVU	Fee	RVU	Fee	RVU	Fee
001	Surgical cases (including laminectomies and spinal fusions): per day.	09.01		36.063	1091.30 (957.30)	36.063	1091.30 (957.30)	-	-
002	Thoracic and neurosurgical cases (excluding laminectomies and spinal fusions): per day	09.01		37.888	1146.50 (1005.70)	37.888	1146.50 (1005.70)	-	-
003	Psychiatric general ward fee, per day	09.01		29.854	903.40 (792.50)	29.854	903.40 (792.50)	-	-
	Note : The Psychiatric ward should comply with the Mental Health Care Act	09.01							
004	Medical and neurological cases: per day.	09.01		36.063	1091.30 (957.30)	36.063	1091.30 (957.30)	-	-
005	Paediatric cases (up to 12 years of age)	09.01		44.513	1347.00 (1181.60)	44.513	1347.00 (1181.60)	-	-
	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	698.40 (612.60)	23.079	698.40 (612.60)	19.725	596.90 (523.60)
014	Overnight fee	09.01		-	-	-	-	8.692	263.00 (230.70)
	Hospital to pre-authorise all overnight admissions. Only applicable to 77 practices. Only chargeable for cases with established complications, to the maxmum of one night. Note: A report from the practitioners indicating the nature of the complication should be forwarded to schemes if requested.	09.01							
019	Ambulatory Patient Facility Fee	09.01		10.679	323.20 (283.50)	10.679	323.20 (283.50)	10.679	323.20 (283.50)
	Chargeable for patients admitted for local anaesthetic procedures - No ward fees applicable. Note: A report from the practitioner indicating the nature of the complication should be forwarded to schemes if requested. Note: 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.	09.01							
022	Out-patient wound care facility	04.00		5.263	159.30 (139.70)	5.263	159.30 (139.70)	5.263	159.30 (139.70)
	Pre-authorisation is required. Only chargeable for the treatment of complicated wounds or burns. (Not to be used for routine post-operative care)	09.01							
1.2	**Private Wards**								
020	Private ward	09.01		46.608	1410.40 (1237.20)	46.608	1410.40 (1237.20)	-	-
	Hospitals shall motivate the necessity for accommodation in a private ward, from the attendant practitioner, and such motivation shall be forwarded to the relevant scheme for pre-authorisation. This includes reversed barrier nursing. General ward fees are applicable for isolation or infection control or hospital convenience.	09.01							
021	Private ward on member's request	09.01		-	-	-	-	-	-
	Will only be funded by arrangement with the medical schemes.	09.01							

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 motivation from the attending practitioner stating the reason for accommodation in any specialised unit indicating the date, time of admission and expected length of stay , which shall be forwarded to the relevant medical scheme for pre-authorisation. No charge may be levied to medical schemes for special or private nursing including motivation for admission.								09.01
	ICU and High Care Units The charges referred to under items 200, 201, 202 and 215 includes the cost of all equipment excluding the equipment charges for: Servo and Bear ventilators or equivalent apparatus.								09.01
200	Specialised ICU (As approved by BHF according to General Rule E.1.1) Per day	04.00		195.088	5903.60 (5178.60)	195.088	5903.60 (5178.60)	-	-
	Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. 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). Item 201 will apply if no pre-authorisation is obtained. All admissions to units and wards referred to under 201 to 202 and 215 to 218 shall be confirmed with the relevant scheme for each 72 hours.	09.01							
201	Intensive Care Unit: Per day.	04.00		148.479	4493.10 (3941.30)	148.479	4493.10 (3941.30)	-	-
202	Neonatal Intensive Care Unit: Per day.	04.00		184.863	5594.10 (4907.10)	184.863	5594.10 (4907.10)	-	-
	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 may be charged, as all equipment is included in the fee eg cardiac monitors.	09.01							
215	High Care Ward, Per day.	04.00		95.108	2878.10 (2524.60)	95.108	2878.10 (2524.60)	-	-
216	Neonatal High Care Ward 'A' (Intensive nursing and monitoring)	04.00		103.308	3126.20 (2742.30)	103.308	3126.20 (2742.30)	-	-
217	Neonatal High Care Ward 'B' (Standard nursing and monitoring)	04.00		67.538	2043.80 (1792.80)	67.538	2043.80 (1792.80)	-	-
	All equipment is included in the fee (e.g. cardiac monitors, phototherapy machine etc) for items 216 & 217.	09.01							
218	Neonatal ward fee (Pre-discharge - This fee may not be charged for routine post-natal nursery care).	04.00		44.513	1347.00 (1181.60)	44.513	1347.00 (1181.60)	-	-
2.	**Maternity**								
	1. The maternity fees are a fixed per diem fee and replace all other charges: This fee includes: - After-hour deliveries (including caesareans); - Labour ward other ward fees and nursery fees; - Incubators; - Phototherapy; - Theatre and equipment fees; and - Surgical items (see Annexure C). But EXCLUDES 1. Sections 6.1 to 6.3 (Standard Medicine and Surgical Products); 2. Sections 6.7 to 6.8 (Gases); 3. Nursery fees for all infants in excess of one as in the case of multiple births 4. The costs of additional special treatment of new born infants, e.g. circumcision certified as medically necessary by the attending practitioner 5. 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 an epidural pack, all consumables used, as								09.01

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
	well as nursing time. 6. 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 infant. 7. 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 Health Reference Price List shall be applied to such neonate and an account should 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 the daily nursing fee item 015, must be deducted from the maternity fixed fee from the subsequent day and therefore 017 and 018 must be charged, whether it be a full day or part of a day, that the neonate is admitted for treatment to a ward or specialized unit. 8. If the mother is admitted into a High Care or Intensive Care Unit, the full account is rendered on a fee for service basis, as this is clearly not an uncomplicated delivery. Code 015: nursery fee may be charged in addition. 9. The first day fee includes the cost of admitting the mother, predelivery preparation, monitoring the progress of the labour, delivery and postnatal treatment up until midnight of the day of confinement. 10. The second day is calculated as starting from midnight following the day of the delivery. 11. If, the mother requires admission for stabilisation or treatment of a medical condition such as diabetes, pre-eclampsia, supression of premature labour or urinary tract infection, such an admission falls outside the scope of the maternity fixed fee and an account should then be rendered on a fee for service basis, until such time as the mother goes into labour. If delivery itself is uncomplicated, then the first day (fixed) fee will be chargeable on the date of delivery, and second and subsequent days are applicable until the mother is discharged. 12. Should the mother be admitted to ICU or high care following the delivery the full account must be rendered on a fee for service basis. 13. Admission for suppression of premature labour(up to 37 weeks) with subsequent delivery is a complicated delivery, and an account must be rendered on a fee for service basis. 14. See Annexure C for the list of surgicals contained in the maternity basket which is included in the per diem fee.								
2.1	**Natural births**								
009	First day (Day of confinement).	04.00		174.458	5279.30 (4631.00)	174.458	5279.30 (4631.00)	-	-
	This fee is applicable from the time of admission,and includes the cost of pre-delivery preparation, monitoring the progress of the labour, delivery and postnatal treatment up until midnight of that day.	09.01							
010	Subsequent day(s).Per day	04.00		60.096	1818.60 (1595.30)	60.096	1818.60 (1595.30)	-	-
	From midnight following confinement until discharge	09.01							
017	Subsequent day(s) excluding nursery fee.	04.00		43.717	1322.90 (1160.40)	43.717	1322.90 (1160.40)	-	-
	From midnight following confinement until discharge This fee must be charged when the neonate is considered to be a patient in his/her own right.	09.01							
2.3	**Caesarean**								
012	First day (Day of confinement).	04.00		270.992	8200.50 (7193.40)	270.992	8200.50 (7193.40)	-	-
	This fee is applicable from the time of admission, and includes the cost of pre-delivery preparation, delivery and postnatal treatment up until midnight of that day.	09.01							
013	Subsequent day(s). Per day	04.00		59.583	1803.00 (1581.60)	59.583	1803.00 (1581.60)	-	-
	From midnight following confinement until discharge	09.01							
018	Subsequent day(s) excluding nursery fee	04.00		42.963	1300.10 (1140.40)	42.963	1300.10 (1140.40)	-	-
	From midnight following confinement until discharge This fee must be charged when the neonate is considered to be a patient in his/her own right.	09.01							
2.4	**Other Maternity Fees**								
	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	512.20 (449.30)	16.925	512.20 (449.30)	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
016	Delivery room.	09.01		72.746	2201.40 (1931.10)	72.746	2201.40 (1931.10)	-	-
	This item is not applicable for deliveries by registered midwifes in private practice – See code 030 below.	09.01							
2.4.1	**Epidural fee**								
011	Use of epidural anaesthesia for maternity cases only.	09.01		26.500	801.90 (703.40)	26.500	801.90 (703.40)	-	-
	Note: This item includes all surgicals and nursing but excludes pharmaceuticals.	09.01							
2.4.2	**Birthing Unit**								
	This fee is applicable when a midwife in private practice performs a delivery in a maternity unit.								09.01
	The birthing unit fee may only be charged by an approved maternity unit in a hospital. It includes pre delivery preparation, monitoring the progress of the labour, delivery room and recovery ward for mother and baby and the maternity basket see Annexure C. Pharmaceuticals may be charged in addition. Note: This fee may not be charged together with the per diem fees for maternity								09.01
030	Global fee for a Birthing Unit This fee is chargeable when the patient is discharged within 12 hours from birth.	09.01		109.004	3298.60 (2893.50)	109.004	3298.60 (2893.50)	-	-
031	Global fee for a Birthing Unit. This fee is chargeable when the patient's stay exceeds 12 hours but is discharged within 24 hours from birth.	09.01		169.100	5117.10 (4488.70)	169.100	5117.10 (4488.70)	-	-
032	Additional Birthing Unit fee is chargeable for every additional 12 hours of patient stay beyond 24 hours.	09.01		30.026	908.60 (797.00)	30.026	908.60 (797.00)	-	-
3.	**Emergency Unit and Theatres**								
3.1	**Emergency and Facility Rooms**								
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	1387.70 (1217.30)	45.858	1387.70 (1217.30)	-	-
302	This fee is chargeable 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 and administration of oxygen therapy. Includes the use of the procedure room. No per minute charge may be levied.	09.01		10.533	318.70 (279.60)	10.533	318.70 (279.60)	10.533	318.70 (279.60)
	Note: The minor theatre fee 071 cannot be charged in addition to 302	09.01							
3.2	**Theatre Fees**								
	The exact time of admission to and discharge from the theatre shall be stated, and upon which the theatre charge shall be calculated as follows which includes a cost per minute for those items in the surgical basket								09.01
	The items listed as non-recoverable in Annexure B shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.								09.01
3.2.1	**Excimer Laser Theatre**								
061	Excimer Laser Theatre fee, per minute	04.00		0.650	19.70 (17.30)	0.650	19.70 (17.30)	0.650	19.70 (17.30)
3.2.2	**Minor theatre**								
	This theatre is procedure driven and not facility driven, where simple procedures which require limited instrumentation and drapery, minimum nursing input and local anaesthesia, conscious sedation and short general anaesthetia(<30minutes), are carried out. Basic monitoring equipment is required and a single integrated resuscitation trolley must be available in this theatre								09.01
071	Charge per minute	09.01		0.500	15.10 (13.20)	0.500	15.10 (13.20)	0.429	13.00 (11.40)
3.2.3	**Major theatre**								
081	Charge per minute.	09.01		1.554	47.00 (41.20)	1.554	47.00 (41.20)	1.329	40.20 (35.30)

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				RVU	Fee	RVU	Fee	RVU	Fee
3.2.4	**Specialised Theatre Modifiers**								
	Note: Specialised theatres are to be individually inspected and approved by BHF and Department of Health								09.01
	In addition to the theatre charge 081 calculated as above, a surcharge modifier 0002 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.								09.01
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 (Procedures applicable only to the cranium or spine where surgical penetration of the dura mater is required)	09.01		48.309	1461.88 (1282.35)	48.309	1461.88 (1282.35)	-	-
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 heart transplants and heart-lung transplants. Includes all equipment except item 513, no additional fees may be charged Note: Modifier 0003 surcharge is also applicable to approved provincial hospitals	09.01		110.688	3349.53 (2938.18)	110.688	3349.53 (2938.18)	-	-
4	**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 be charged together with items 053 and 055.								09.01
4.1	**Procedures**								
052	Procedures carried out in an X-ray department using hospital owned equipment under general anaesthesia	09.01		14.342	434.00 (380.70)	14.342	434.00 (380.70)	14.342	434.00 (380.70)
053	Diagnostic Angiograms	09.01		14.342	434.00 (380.70)	14.342	434.00 (380.70)	-	-
055	Electroconvulsive therapy (ECT)	04.00		14.342	434.00 (380.70)	14.342	434.00 (380.70)	14.342	434.00 (380.70)
4.2	**Catheterisation laboratory procedures**								
	As approved by the committee established in terms of General Rule E.1.1								09.01
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information required by the medical scheme. The Catherisation Lab fees 054, 056, 070 and 073 are only chargeable once within a 72 hour period.								09.01
	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 be charged together with items 054, 055, 056, 070 and 073.								09.01
054	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy/ thrombectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital equipped to perform the relevant surgery.	09.01		51.446	1556.80 (1365.60)	51.446	1556.80 (1365.60)	-	-
	Note: For EPS studies, the Bard Apparatus (item 529) is at an additional charge.	09.01							
056	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy/thrombectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery.	09.01		96.929	2933.20 (2573.00)	96.929	2933.20 (2573.00)	-	-

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070	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy/thrombectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital equipped to perform the relevant surgery.	09.01		251.804	7619.80 (6684.00)	251.804	7619.80 (6684.00)	-	-
	Note: EPS for cardiac ablations - items 529 is at an additional charge.	09.01							
073	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy/thrombectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital equipped to perform the relevant surgery.	09.01		186.233	5635.60 (4943.50)	186.233	5635.60 (4943.50)	-	-
075	Catheterisation laboratory film price (once per procedure) is inclusive of the CD and the recording paper charges	09.01		5.546	167.80 (147.20)	5.546	167.80 (147.20)	-	-
	Note: May only be charged once per procedure	09.01							
4.3	**Radiation Oncology**								
4.3.1	***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	461.90 (405.20)	15.263	461.90 (405.20)	-	-
903	Intermediate - Simulation of three or more converging ports, two separate treatment areas or multiple blocks.	04.00		23.283	704.60 (618.10)	23.283	704.60 (618.10)	-	-
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	923.70 (810.30)	30.525	923.70 (810.30)	-	-
905	Computerised Tomographic.	04.00		30.525	923.70 (810.30)	30.525	923.70 (810.30)	-	-
4.3.2	**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	435.20 (381.80)	14.383	435.20 (381.80)	-	-
908	Computerised (intermediate) - Planning requiring three or more ports, two separate treatment areas, multiple blocks or special time dose constraints	04.00		21.942	664.00 (582.50)	21.942	664.00 (582.50)	-	-
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	869.80 (763.00)	28.742	869.80 (763.00)	-	-
4.3.3	**Technical Aids**								
910	Control films (As per radiology film price list).	04.00		-	-	-	-	-	-
911	Dosimetric procedures.	04.00		0.838	25.40 (22.30)	0.838	25.40 (22.30)	-	-
912	Artefacts: Simple - design and construction (simple block or bolus) – charge is exclusive of woods alloy	09.01		2.096	63.40 (55.60)	2.096	63.40 (55.60)	-	-
913	Artefacts: Intermediate - design and construction (multiple blocks, stents, bite blocks, special bolus) - charge is exclusive of woods alloy	09.01		5.704	172.60 (151.40)	5.704	172.60 (151.40)	-	-
914	Artefacts: Complex (specify) - design and construction (irregular blocks, special shields, compensators, wedges, molds or casts) – charge is exclusive of woods alloy	09.01		11.404	345.10 (302.70)	11.404	345.10 (302.70)	-	-
4.3.4	**Linear accelerator treatment**								
915	Photon treatment, single field.	04.00		22.288	674.50 (591.70)	22.288	674.50 (591.70)	-	-
916	Photon treatment, multiple fields	04.00		32.100	971.40 (852.10)	32.100	971.40 (852.10)	-	-
917	Electron treatment.	04.00		22.288	674.50 (591.70)	22.288	674.50 (591.70)	-	-

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919	Brachytherapy - global fee per patient.	04.00		169.388	5125.90 (4496.40)	169.388	5125.90 (4496.40)	-	-
	Note: The fee is inclusive of equipment, consumables, theatre time fees and ward fees	09.01							
4.4	**Stereotactic radiosurgery**								
399	Linear Accelerator radiosurgery - Global Fee	04.00		3682.963	111450.10 (97763.20)	3682.963	111450.10 (97763.20)	-	-
	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	76275.90 (66908.70)	2520.600	76275.90 (66908.70)	-	-
	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							
5	**Standard Charges for Equipment**								
224	Stone basket (reusable) for the removal of kidney-, bladder- or gallstones: Per case	09.01		50.263	1521.00 (1334.20)	50.263	1521.00 (1334.20)	50.263	1521.00 (1334.20)
225	Stereotactic equipment that is permanently attached (non mobile) when used in conjunction with x-rays, CT or MRI imaging and only applicable to intra - cranial, procedures	09.01		48.033	1453.50 (1275.00)	48.033	1453.50 (1275.00)	-	-
	Note: The equipment is to be pre-authorised	09.01							
226	Continuous Passive Exerciser: Per day.	09.01		3.808	115.20 (101.10)	3.808	115.20 (101.10)	3.808	115.20 (101.10)
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	09.01		10.604	320.90 (281.50)	10.604	320.90 (281.50)	10.604	320.90 (281.50)
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	09.01		5.242	158.60 (139.10)	5.242	158.60 (139.10)	5.242	158.60 (139.10)
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	09.01		4.021	121.70 (106.80)	4.021	121.70 (106.80)	4.021	121.70 (106.80)

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	1. Not applicable in Specialised units i.e. ICU and High Care units. Limited to 1 per patient for maximum of 48 hours in ward 2. Only 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 3. Schemes do not carry the liability if use is charged for in any diagnoses not mentioned above	09.01							
	Note: Items 231-235 are standard equipment charges in non specialized units								09.01
231	Cardiac monitors, per day or part thereof	09.01		4.371	132.30 (116.10)	4.371	132.30 (116.10)	-	-
	Note: In high care wards only, private and general wards to be motivated - not to be charged for routine ECG's	09.01							
232	Bird or equivalent free standing nebuliser (excluding oxygen): Per day	04.00		3.129	94.70 (83.10)	3.129	94.70 (83.10)	3.129	94.70 (83.10)
233	Croupettes (excluding oxygen): Per day or part thereof	04.00		0.896	27.10 (23.80)	0.896	27.10 (23.80)	-	-
234	Incubators (excluding oxygen) (not chargeable together with items 215 to 218: Per day or part thereof	04.00		1.675	50.70 (44.50)	1.675	50.70 (44.50)	-	-
235	Oxygen tents (excluding oxygen): Per day or part thereof	04.00		1.458	44.10 (38.70)	1.458	44.10 (38.70)	-	-
236	Mechanical ventilator or equivalent (only in ICU and high care ward if no ICU is available) (excluding oxygen): Per day or part thereof	09.01		13.963	422.50 (370.60)	13.963	422.50 (370.60)	-	-
237	CUSA Note: The fee is inclusive of the CUSA contamination guard	09.01		67.804	2051.80 (1799.80)	67.804	2051.80 (1799.80)	-	-
238	Lasers - Argon or Holium (ophthalmic).	04.00		21.004	635.60 (557.50)	21.004	635.60 (557.50)	21.004	635.60 (557.50)
239	Lasers - CO2 (surgical).	04.00		27.138	821.20 (720.40)	27.138	821.20 (720.40)	27.138	821.20 (720.40)
241	Lasers - Candella . Rates by arrangement with the scheme concerned	09.01		-	-	-	-	-	-
335	Excimer laser: Hire fee per eye	04.00		74.092	2242.10 (1966.80)	74.092	2242.10 (1966.80)	74.092	2242.10 (1966.80)
337	Microkeratome used with an excimer laser, per operation.	04.00		13.608	411.80 (361.20)	13.608	411.80 (361.20)	13.608	411.80 (361.20)
	Note: This tariff can only be charged for the initial surgery per eye and enhancement surgery occurring 12 months or longer after the initial surgery	09.01							
242	Occutomes.	04.00		8.933	270.30 (237.10)	8.933	270.30 (237.10)	8.933	270.30 (237.10)
243	Lasers - YAG (ophthalmic).	04.00		23.683	716.70 (628.70)	23.683	716.70 (628.70)	23.683	716.70 (628.70)
244	Lasers - YAG (surgical).	04.00		29.492	892.50 (782.90)	29.492	892.50 (782.90)	29.492	892.50 (782.90)
	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 6. The C-arm (item 249) , screening table (item 251), cysto urethroscope (item 263) and uretero reno scope (item 519) are not chargeable with these equipment fees	09.01							

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220	Ballistic Lithotripsy/Lithoclast: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment the fee includes items: 249 - C-arm , 251 -screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		18.700	565.90 (496.40)	18.700	565.90 (496.40)	18.700	565.90 (496.40)
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) the fee includes items: 249 - C-arm , 251 - screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		12.454	376.90 (330.60)	12.454	376.90 (330.60)	12.454	376.90 (330.60)
222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment the fee includes items: 249 - C-arm , 251 -screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		124.638	3771.70 (3308.50)	124.638	3771.70 (3308.50)	124.638	3771.70 (3308.50)
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) the fee includes items: 249 - C-arm , 251 -screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		83.021	2512.30 (2203.80)	83.021	2512.30 (2203.80)	83.021	2512.30 (2203.80)
339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment the fee includes items: 249 - C-arm , 251 -screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		8.279	250.50 (219.70)	8.279	250.50 (219.70)	8.279	250.50 (219.70)
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) the fee includes items: 249 - C-arm , 251 - screening table , 263 -cysto urethroscope , 519 -uretero reno scope	09.01		5.525	167.20 (146.70)	5.525	167.20 (146.70)	5.525	167.20 (146.70)
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	8257.10 (7243.10)	272.863	8257.10 (7243.10)	272.863	8257.10 (7243.10)
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	5499.40 (4824.00)	181.733	5499.40 (4824.00)	181.733	5499.40 (4824.00)
249	C Arm	09.01		8.817	266.80 (234.00)	8.817	266.80 (234.00)	8.817	266.80 (234.00)
	Note: Not chargeable with Modifiers 0002, 0003, items 220, 221, 222, 223, 339, 341 and 251.	09.01							
250	Ultrasonic imaging equipment.	04.00		14.738	446.00 (391.20)	14.738	446.00 (391.20)	14.738	446.00 (391.20)
	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	09.01							
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	601.70 (527.80)	19.883	601.70 (527.80)	19.883	601.70 (527.80)
	Note: For codes 252-256 and 343-347, reusable biopsy and polyp forceps are included in the fee.	04.00							
252	Gastroscope (fibre optic/flexible only).	04.00		11.617	351.50 (308.30)	11.617	351.50 (308.30)	11.617	351.50 (308.30)
253	Colonoscope (fibre optic/flexible only)	04.00		12.992	393.20 (344.90)	12.992	393.20 (344.90)	12.992	393.20 (344.90)
254	Duodenoscope (fibre optic/flexible only).	04.00		12.308	372.50 (326.80)	12.308	372.50 (326.80)	12.308	372.50 (326.80)
255	Sigmoidoscope (fibre optic).	04.00		9.979	302.00 (264.90)	9.979	302.00 (264.90)	9.979	302.00 (264.90)
343	Sigmoidoscope (rigid, adults)	04.00		2.050	62.00 (54.40)	2.050	62.00 (54.40)	2.050	62.00 (54.40)
345	Sigmoidoscope (rigid, paediatrics)	04.00		1.658	50.20 (44.00)	1.658	50.20 (44.00)	1.658	50.20 (44.00)
256	Bronchoscope (flexible/fibre optic, adults).	04.00		8.200	248.10 (217.60)	8.200	248.10 (217.60)	8.200	248.10 (217.60)

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
347	Bronchoscope (flexible/fibre optic, paediatrics)	04.00		8.200	248.10 (217.60)	8.200	248.10 (217.60)	8.200	248.10 (217.60)
348	Bronchoscope (rigid, adults)	04.00		3.283	99.30 (87.10)	3.283	99.30 (87.10)	3.283	99.30 (87.10)
349	Bronchoscope (rigid, paediatrics)	04.00		4.788	144.90 (127.10)	4.788	144.90 (127.10)	4.788	144.90 (127.10)
257	Laryngoscope (fibre optic/flexible excluding intubation). For diagnostic purposes only	09.01		4.788	144.90 (127.10)	4.788	144.90 (127.10)	4.788	144.90 (127.10)
258	Sinoscope (rigid only)	04.00		5.463	165.30 (145.00)	5.463	165.30 (145.00)	5.463	165.30 (145.00)
259	Oesophagoscope (rigid only)	04.00		2.725	82.50 (72.40)	2.725	82.50 (72.40)	2.725	82.50 (72.40)
261	Hysteroscope	04.00		3.429	103.80 (91.10)	3.429	103.80 (91.10)	3.429	103.80 (91.10)
262	Colposcope (Not chargeable when item 239 applies)	04.00		4.788	144.90 (127.10)	4.788	144.90 (127.10)	4.788	144.90 (127.10)
263	Cysto Urethroscope (Not chargeable with 220 -223)	09.01		4.108	124.30 (109.00)	4.108	124.30 (109.00)	4.108	124.30 (109.00)
519	Uretho Reno Fibroscope, per case	04.00		14.663	443.70 (389.20)	14.663	443.70 (389.20)	14.663	443.70 (389.20)
264	Arthroscope (including basic reusable instruments and equipment)	04.00		11.200	338.90 (297.30)	11.200	338.90 (297.30)	11.200	338.90 (297.30)
	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							
360	Category 1 - Laparoscopy and thoracoscopy, per case. Note: Refer to Annexure C for a list of items included within this code	09.01		26.825	811.80 (712.10)	26.825	811.80 (712.10)	26.825	811.80 (712.10)
364	Category 2 - Interventional Laparoscopic and Thorascopic procedures, per case. Note: Refer to Annexure C for a list of items included within this code	09.01		31.867	964.30 (845.90)	31.867	964.30 (845.90)	31.867	964.30 (845.90)
294	Transcranial Doppler	04.00		24.417	738.90 (648.20)	24.417	738.90 (648.20)	-	-
295	Ultrasonic Cutting and Coagulating Devices (See section 6.3.3)	09.01		6.721	203.40 (178.40)	6.721	203.40 (178.40)	6.721	203.40 (178.40)
507	Argon Beamer (See section 6.3.2)	09.01		2.721	82.30 (72.20)	2.721	82.30 (72.20)	2.721	82.30 (72.20)
	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	497.00 (436.00)	16.425	497.00 (436.00)	16.425	497.00 (436.00)

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				RVU	Fee	RVU	Fee	RVU	Fee
511	Colour Doppler (external)	04.00		49.167	1487.80 (1305.10)	49.167	1487.80 (1305.10)	49.167	1487.80 (1305.10)
513	Transoesphageal Colour Doppler. (May be charged together with Modifier 0003)	04.00		59.325	1795.20 (1574.70)	59.325	1795.20 (1574.70)	59.325	1795.20 (1574.70)
515	Cardiorhythm Ablater. (May be charged in addition to the catheterisation Laboratory).	04.00		32.313	977.80 (857.70)	32.313	977.80 (857.70)	32.313	977.80 (857.70)
517	Phaco emulsifier	04.00		17.400	526.50 (461.80)	17.400	526.50 (461.80)	17.400	526.50 (461.80)
521	OAS Frameless Stereotaxy	04.00		172.908	5232.40 (4589.80)	172.908	5232.40 (4589.80)	-	-
523	OPD Tacography (Includes paper)	04.00		2.800	84.70 (74.30)	2.800	84.70 (74.30)	-	-
525	RFG3C Lesion Generator (Rhizotomy) Note : Fee to be charged only once per procedure irrespective of the levels of the procedure carried out.	09.01		55.979	1694.00 (1486.00)	55.979	1694.00 (1486.00)	-	-
527	Swift Lase Kit (Tonsillectomy)	04.00		10.908	330.10 (289.60)	10.908	330.10 (289.60)	-	-
529	Bard Apparatus 1. For EPS studies the analogue monoplane unit (item 054) is an additional charge. 2. EPS studies for cardiac ablations - the digital bi-plane unit (item 070) is an additional charge.	09.01		41.879	1267.30 (1111.70)	41.879	1267.30 (1111.70)	-	-
531	Densitometer	04.00		25.817	781.20 (685.30)	25.817	781.20 (685.30)	-	-
533	Civus (Cardiac Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	04.00		70.117	2121.80 (1861.20)	70.117	2121.80 (1861.20)	-	-
535	Ivus (Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	04.00		154.017	4660.70 (4088.30)	154.017	4660.70 (4088.30)	-	-
537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery.	04.00		0.646	19.50 (17.10)	0.646	19.50 (17.10)	-	-
	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. Subject to scheme rules	09.01		282.729	8555.70 (7505.00)	282.729	8555.70 (7505.00)	-	-
541	Stereotactic guided digital imaged cover needle biopsy. Subject to scheme rules	09.01		166.321	5033.00 (4414.90)	166.321	5033.00 (4414.90)	-	-
542	Stereotactic guided digital imaged vacuum assisted core needle biopsy. Subject to scheme rules	09.01		166.321	5033.00 (4414.90)	166.321	5033.00 (4414.90)	-	-
543	Stereotactic guided digital imaged fine needle aspiration. Subject to scheme rules	09.01		116.471	3524.50 (3091.70)	116.471	3524.50 (3091.70)	-	-
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		-	-	-	-	-	-
550	Dynamic non-frame based stereotactic image guided equipment(Stealth Station) for referencing surgery and treatment planning used in conjunction with CT or MRI imaging. Note: This equipment must be pre-authorized	09.01		180.775	5470.40 (4798.60)	180.775	5470.40 (4798.60)	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
560	Low pressure hyperbaric oxygen treatment protocol. Only for Prescribed Minimum Benefits Code 277S: Anaerobic infections - life threatening (when no state facility is available). By arrangement with schemes	09.01		-	-	-	-	-	-
562	Standard pressure hyperbaric oxygen treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
564	US Navy TT5 treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
566	US Navy TT6 treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
568	US Navy TT6 extended treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
570	Comes 30 treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
572	US Navy Table 6A treatment protocol. By arrangement with schemes	09.01		-	-	-	-	-	-
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	7756.70 (6804.10)	256.325	7756.70 (6804.10)	-	-
580	Sequential compression device, per case	04.00		-	-	-	-	-	-
582	Selector ultrasonic aspirator	04.00		-	-	-	-	-	-
584	Cryosurgery acuprobe	04.00		-	-	-	-	-	-
594	Motility machine. By arrangement with schemes	09.01		-	-	-	-	-	-
596	Ph recorder. By arrangement with schemes	09.01		-	-	-	-	-	-
606	Epilepsy monitoring system. By arrangement with schemes	09.01		-	-	-	-	-	-
608	Lynx ultrasound scanner	04.00		-	-	-	-	-	-
610	Intra-operative multi-frequency probe	04.00		-	-	-	-	-	-
612	Flexible laparoscopic probe	04.00		-	-	-	-	-	-
6	**Standard Medicine and Surgical Products**								
	It is recommended that, when such benefits are granted, medicines, 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.								09.01
6.1	**Standard Medicine Charges**								
	Only substances registered and controlled by the Medicines and Related Substances Control Act, Act 101 of 1965, as amended/Medicine Control Council. The amount charged for any item shall not exceed the single exit price (inclusive of VAT) Note: Dispensing fees are not applicable								09.01
6.1.1	**Inpatients and Day patients:** **Dispensed items including ampoules, over the counter and proprietary items issued to inpatients, day patients and to take out (TTO)**								
	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 (TTO)	09.01							
278	Ward stock	04.00		-	-	-	-	-	-
282	Theatre	04.00		-	-	-	-	-	-
6.1.2	**Facility/Emergency rooms: Dispensed items including ampoules, over the counter and proprietary items and TTO's issued to patients treated in the facility rooms (items 301 and 302) when not admitted to a ward**								
	All items which patients take home as TTO's must be shown on accounts.								09.01
	Not to be charged for consumable, disposable and surgical items								04.00

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				RVU	Fee	RVU	Fee	RVU	Fee
407	Pharmacy	04.00		-	-	-	-	-	-
411	Theatre	04.00		-	-	-	-	-	-
413	To Take Out (TTO)	09.01		-	-	-	-	-	-
6.2	**Surgical Products**								
	When used in ward or theatre Refer to Appendix B for a guide to billing on consumable and disposable items. Net acquisition price inclusive of VAT. Items to be fully specified								09.01
	See consumable and disposable list.								04.00
415	Emergency room	04.00		-	-	-	-	-	-
417	Pharmacy	04.00		-	-	-	-	-	-
419	Ward stock	04.00		-	-	-	-	-	-
421	Theatre	04.00		-	-	-	-	-	-
6.3	**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
6.3.1	**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%
6.3.2	**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%
6.3.3	**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%
459	Blades - Single use (sharp hook, dissecting hook, ball) Refer to 5.2	04.00		-	-	-	-	-	-
6.3.4	**Diathermy pencils, laryngeal masks and fluoroshield gloves**								
431	Diathermy pencils	04.00		-	33.33%	-	33.33%	-	33.33%

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				RVU	Fee	RVU	Fee	RVU	Fee
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%
6.4	**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
6.4.1	**Oxygen and Nitrous Oxide**								
	For both gases together, per minute								04.00
283	Gauteng area	09.01		0.110	3.33 (2.92)	0.110	3.33 (2.92)	0.110	3.33 (2.92)
701	Cape Town	04.00		0.151	4.57 (4.01)	0.151	4.57 (4.01)	0.151	4.57 (4.01)
702	Port Elizabeth	04.00		0.134	4.06 (3.56)	0.134	4.06 (3.56)	0.134	4.06 (3.56)
703	East London	04.00		0.149	4.51 (3.96)	0.149	4.51 (3.96)	0.149	4.51 (3.96)
704	Durban	04.00		0.138	4.18 (3.67)	0.138	4.18 (3.67)	0.138	4.18 (3.67)
705	Other areas	04.00		0.123	3.72 (3.26)	0.123	3.72 (3.26)	0.123	3.72 (3.26)
6.4.2	**Oxygen, ward use**								
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex								04.00
284	Gauteng area	09.01		0.162	4.90 (4.30)	0.162	4.90 (4.30)	0.162	4.90 (4.30)
710	Cape Town	04.00		0.268	8.11 (7.11)	0.268	8.11 (7.11)	0.268	8.11 (7.11)
711	Port Elizabeth	04.00		0.258	7.81 (6.85)	0.258	7.81 (6.85)	0.258	7.81 (6.85)
712	East London	04.00		0.248	7.50 (6.58)	0.248	7.50 (6.58)	0.248	7.50 (6.58)
713	Durban	04.00		0.210	6.35 (5.57)	0.210	6.35 (5.57)	0.210	6.35 (5.57)
714	Other areas	04.00		0.200	6.05 (5.31)	0.200	6.05 (5.31)	0.200	6.05 (5.31)
6.4.3	**Oxygen, recovery room or emergency room**								
	Flat rate for oxygen per case								04.00
720	Gauteng area	09.01		0.322	9.74 (8.54)	0.322	9.74 (8.54)	0.322	9.74 (8.54)
721	Cape Town	04.00		0.533	16.10 (14.10)	0.533	16.10 (14.10)	0.533	16.10 (14.10)
722	Port Elizabeth	04.00		0.513	15.50 (13.60)	0.513	15.50 (13.60)	0.513	15.50 (13.60)
723	East London	04.00		0.492	14.90 (13.10)	0.492	14.90 (13.10)	0.492	14.90 (13.10)
724	Durban	04.00		0.421	12.70 (11.10)	0.421	12.70 (11.10)	0.421	12.70 (11.10)
725	Other areas	04.00		0.398	12.00 (10.50)	0.398	12.00 (10.50)	0.398	12.00 (10.50)
6.4.4	**Oxygen in Theatre**								
	Fee for oxygen per minute in the operating theatre when no other gas administered								04.00
730	Gauteng area	09.01		0.010	0.30 (0.26)	0.010	0.30 (0.26)	0.010	0.30 (0.26)
731	Cape Town	04.00		0.018	0.54 (0.47)	0.018	0.54 (0.47)	0.018	0.54 (0.47)
732	Port Elizabeth	04.00		0.017	0.51 (0.45)	0.017	0.51 (0.45)	0.017	0.51 (0.45)
733	East London	04.00		0.017	0.51 (0.45)	0.017	0.51 (0.45)	0.017	0.51 (0.45)
734	Durban	04.00		0.013	0.39 (0.34)	0.013	0.39 (0.34)	0.013	0.39 (0.34)
735	Other areas	04.00		0.013	0.39 (0.34)	0.013	0.39 (0.34)	0.013	0.39 (0.34)
6.4.5	**Carbon Dioxide**								
291	Per minute	04.00		0.020	0.61 (0.54)	0.020	0.61 (0.54)	0.020	0.61 (0.54)
6.4.6	**Laser Mix**								
292	Per minute	04.00		0.387	11.70 (10.30)	0.387	11.70 (10.30)	0.387	11.70 (10.30)

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				RVU	Fee	RVU	Fee	RVU	Fee
6.4.7	**Entonox**								
293	Per 30 minutes	04.00		3.675	111.20 (97.50)	3.675	111.20 (97.50)	3.675	111.20 (97.50)
6.5	**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		-	-	-	-	-	-
7.	**Prostheses and Implantable Surgical Devices**								
7.1	**Prostheses (Surgically implanted)**								
286	A skeletal 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. 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.	09.01		-	-	-	-	-	-
7.2	**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		-	-	-	-	-	-
7.3	**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	586.70 (514.60)	19.388	586.70 (514.60)	-	-
7.4	**Incise drapes**								
298	Incise drapes (See Annexure B)	04.00		-	-	-	-	-	-
299	Ophthalmic drapes. (See Annexure B)	04.00		-	-	-	-	-	-

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				RVU	Fee	RVU	Fee	RVU	Fee
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
7.5	**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
8.	**Procedures : All New And Non Standard Technology**								
121	Benefits to be pre-authorised with the scheme concerned	04.00		-	-	-	-	-	-
9.	**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		-	-	-	-	-	-
ANNEXURES									
	ENDOSCOPIC (laparoscopic & thoracoscopic) GENERIC LIST Notes: Refer to Appendix D for a list of chargeables and non recoverable items per procedure 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. 7. Anti fog glasses are non recoverable								09.01

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
	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%								
ANNEXURE A									
	LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES								09.01

CATEGORY 1 (CPT4 2000 code numbers included where possible)	
Laparoscopy Procedure	**CPT *Code***
Diagnostic laparoscopy	49320
Laparoscopy, surgical; with fulguration of oviducts (with/without transection)	58670
Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring)	58671
Hysteroscopy diagnostic	58555
Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C	58558

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, 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) Laparoscopy, surgical; with fimbrioplasty 58672								
	Laparoscopy, surgical; with fulguration 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								
	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 cholecystectomy 47562								
	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								

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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
	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									
	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								
ANNEXURE B										
	PRINCIPLES The following principles are applicable: 1. At all times best clinical practice must be adhered to and applied in a cost effective manner 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.									09.01

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

¢ 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 6.5.1-6.5.4)
N/A Not used/not applicable
Disposable Means the manufacturer states one time use only.
S/U(Single use) Item Payable 100%
Practice Code References to the NHRPL includes 57/58, 76 and 77

	PRODUCT	THR	WRD	COMMENT
1.	Accessories for AV impulse, Flowtron DVT and similar (impads, sequential stockings, calf garments, sleeves, cuffs and equivalents);	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, Transpore and similar);	C	C	Fractional use is non-chargeable; Full rolls are chargeable when procedure related; Non-chargeable if used for restraining or strapping;
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	
8.	Amalgam Caplets and all dental composites(all materials included in the practitioners fees)	NR	N/A	
9.	Anaesthetic Machines and accessories e.g circuits, masks, trays and inhalation gas containers	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.

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
	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						
	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						

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
	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 6.3.1;					
	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 6.3.1;					
	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 following criteria Warm air blanket may be charged in the following cases and limited to 1 per stay - Infants and children under 4 years of age - 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					
	37.	Blood pressure cuffs-Disposable (Cuffable cuffs, Disposa-Cuff and similar);	NR	NR						
	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.	Burrs – Disposable	R	N/A						
	45.	Burrs - Limited life reusable	F	N/A	Fractional as per BHF Schedule 6.3.1;					
	46.	Burrs (Dental surgery)-reusable and disposable	NR	NR	Included in the Dental Practitioners Fee					
	47.	Burrs (ENT surgery)-disposable	R	N/A						
	48.	Capnograph Set – disposable	NR	NR						
	49.	Cardiac Monitors	NR	C	Equipment fee chargeable in the ward and must be motivated in Wards when a patient is monitored. Item 231. Non-Chargeable in ICU.					
	50.	Cardiotocography paper	NR	NR						
	51.	Catheters (Jacques, Nelaton and similar)- Reusable	NR	NR						
	52.	Cetavlon	NR	NR						
	53.	Chlorhexidine Solution	NR	NR						
	54.	Chlorine Antiseptics (Biocide and similar)	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
55.	Chloromycetin Applicaps	R	C	Two per day in ICU for unconscious or sedated ventilated patients on prescription.					
56.	Cidex	NR	NR						
57.	Clip Removers	NR	NR	Included in Practitioners fee for post-operative care for four weeks					
58.	Collection Charges - Pathology	NR	NR						
59.	Connectors - disposable	C	C	To be specified if not a part of pack. (e.g. Bentley or Cobe)					
60.	Connectors - re-usable	NR	NR						
61.	Cosmetic products (body lotions, powders, creams, oils, mouthwash and shampoos);	N/A	NR						
62.	Cutters – Disposable explain	R	N/A	*Single Use*					
63.	Cutters (bone)-Limited life re useable expand on re useable	F	N/A	Fractional chargeable as per BHF Schedule 6.3.1;					
64.	Cytology Brushes – Disposable	C	N/A	Fully recoverable if supplied by hospital.					
65.	Daylee Towels	NR	NR						
66.	Depilatory Creams	NR	NR						
67.	Dettol	NR	NR						
68.	Diagnostic Strips – Blood	N/A	C	Diabetic patients -account to state Diabetic. Chargeable in : Pancreatitis Patients receiving hyperalimentation Patients in ICU/HC /NICU/ NHC units					
69.	Diagnostic Strips – Blood & Urine (Routine Testing)	NR	NR						
70.	Diathermy Equipment	NR	NR						
71.	Diathermy electrosurgical instruments (pencil, handles)-disposable	R	N/A						
72.	Diathermy electrosurgical instruments (pencils, handles)-Limited life reusable	F	N/A	Part charge as per section 6.3.5;					
73.	Diathermy Plates – disposable	R	N/A	Chargeable to a maximum of the re useable vaue;					
74.	Diathermy grounding Pads – re useable	F	N/A	Chargeable to the manufacturers recommended price (R35-00)					
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 6.3.1;					
83.	Drops (Eye/Ear/Nose)- fractional use	NR	NR						
84.	EABS	NR	NR						
85.	ECG – Electrodes	R	R						
86.	ECG – Equipment	NR	NR						
87.	ECG – Paper	NR	NR						
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					

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
	92.	Epidural Kit/Set	C	N/A	Non chargeable to Maternity code 011 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	NR						
	98.	Films, Video Prints, Compact Discs – disposables (Endoscopic Procedures)	NR	NR						
	99.	Films, Video Prints, Compact Discs, Thermal Paper	C	NR	Refer section 4.3 - item 075 one fee per procedure					
	100.	Fluoroshield Gloves(radiation gloves)	NR	NR						
	101.	Foley's Temp Catheter	C	N/A	On motivation Maximum of R500 and is chargeable to cardiac cases only					
	102.	Formalin in Saline	NR	NR						
	103.	Fosenema / Len-o-lax	N/A	R	When prescribed.					
	104.	Gloves - Sterile	N/A	C	For minor sterile procedures in the ward Non-chargeable with tray					
	105.	Gloves – Non-Sterile	NR	NR						
	106.	Gloves – Sterile (Surgical)	R	NR						
	107.	Glucometer	N/A	N/A	TTO only if authorised by scheme. Otherwise for patient's private account.					
	108.	Gowns in theatre (barrier SABS approved with breathable and fluid impermeable polymer membrane)-Limited life reusable Recommendation is to encourage use of reuseable	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).					
	109.	Gowns in theatre (barrier SABS approved)-Disposable Delete this item so as to encourage use of re-useable gowns which are more cost effective	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.)					
	110.	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 Delete this item so as to encourage use of re-useable gowns	R	N/A	Chargeable with modifiers 0002 and 0003 up to R520 per set to a maximum of 3 sets;					

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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
	111.	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;					
	112.	Gowns in ward (barrier SABS approved)- Disposable	N/A	NR	.					
	113.	Harmonic Scalpel, or equivalent - disposable components	R	N/A	Refer to endoscopic list;					
	114.	Harmonic Scalpel, or equivalent components – reusable.	F	N/A	Chargeable as per section 6.3.3;					
	115.	Head covers (bonnets, caps and similar)	NR	NR						
	116.	Head Strap for CPAP	N/A	C	Chargeable when diagnosis- related, e.g. Burns/infectious diseases.					
	117.	Heart/Lung Machine	NR	NR						
	118.	Heath reflective pads (Critter covers, Neospot and similar);	N/A	C	One daily in Neonatal Specialised Units;					
	119.	Heel Hugger-infant	NR	NR	As per scheme arrangement;					
	120.	Hibitane Obstetric Cream	N/A	NR	Registered ethical product.					
	121.	Hibitane Solution - sachets	NR	NR						
	122.	Humidifying Chamber (Fisher&Paykel and similar)-Disposable	N/A	C	Adults and neonates – one per LOS in specialised units;					
	123.	Hydrogen Peroxide	NR	NR						
	124.	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					
	125.	Ice Pack/Cold Pack - disposable	N/A	C	Appropriate procedures only. Payable according to scheme rules;					
	126.	Incontinence Products - Draw Sheet	NR	NR						
	127.	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.					
	128.	Incontinence Products - Pads . san	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.					
	129.	Incontinence Products - Diapers/ Nappies	NR	C	Paediatric or Geriatrics : Gastro only Others to be charged to patient's private account.					
	130.	Incontinence Products – Pads : Besure/Molicare	N/A	c	Subject to scheme rules					
	131.	Instrument wipes and solutions eg. Anti fork NR	N/A	NR						
	132.	Jellies and Creams (Terracortril, KY and similar)- fractional use	NR	NR						
	133.	K Y Jelly – Sachets	NR	C	Procedure related					
	134.	Lancets, Autolets, Softclix	NR	C	For Diabetic patient's -account to state Diabetic. For hyperalimentation Chargeable in : Pancreatitis In ICU /NICU /HC /NHC A&B Units					
	135.	Laryngeal Masks	F	N/A	2.5% As pe r section 6.3.5 – item 435					
	136.	Laryngeal Masks - disposable	C	N/A						
	137.	Laser Components - disposable	R	N/A						

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
138.	Laser Components - re-usable	F	N/A	Part chargeable as per section 6.3.2					
139.	Laundry Bags	NR	NR						
140.	Ligasure Electrode – Disposable	NR	N/A						
141.	Limb Holder (splint during IVI) – Disposable	N/A	C	1 per patient per stay on motivation.					
142.	Loan Set Fee	NR	NR						
143.	Marking Pen – sterile (Codman Marker and similar)	C	NR	Procedure related: Craniotomy, Neuro & Spinal. Skin flaps Keratotomy					
144.	Maternity Per Diem Fee	C	N/A	Includes surgical items listed in DOH Schedule Ethical products are chargeable					
145.	Meal Supplements	NR	NR						
146.	Meals, Baby Foods, Milk Substitutes	NR	NR						
147.	Medically prescribed feeds E.G enterol and peg feeding	N/A	C	By arrangement with medical scheme					
148.	Medicine Glasses, Spoons and Syringes	NR	c	Only the Syringes chargeable for tube feeding and medicine dosing in Neonatal Specialised Units only One syringe per day.					
149.	Mentor Cable - disposable	NR	NR						
150.	Mentor Cable - re-usable	NR	NR						
151.	Mercurochrome & Methiolate	NR	NR						
152.	Micro Retractor	NR	NR						
153.	Milk Substitutes	NR	NR						
154.	Milton	NR	NR						
155.	Mixing Systems for Cement and Cement	C	N/A	Chargeable as part of Prosthesis, to be included in prosthesis invoice, which accompanies account. Cement containing Antibiotic can be charged separately					
156.	Mother & Baby Pack	NR	NR						
157.	Nasal Cannula – disposable	N/A	C	One per stay if oxygen is administered.					
158.	Nebulising Mask - disposable	N/A	C	One per stay if patient is nebulised.					
159.	Nebulising Mask - Trachea	N/A	C	One per stay if patient is nebulised.					
160.	Neuro Sucker – disposable	C	N/A	Neuro cases only					
161.	Nursing Services	NR	NR						
162.	Operating Instruments - reusable	NR	NR						
163.	Overshoes	NR	NR						
164.	Oximeter	NR	NR						
165.	Oxisensor – disposable	NR	C	One per stay for neonates(up to 28 days) in specialised units; Not paying if equipment not suitable/ compatible. Not to be charged with Oxitip;					
166.	Oxitip	NR	C	One per stay for neonates(up to 28 days) in specialised units; Not to be charged with Oxisensor;					
167.	Oxygen Analysers, Hoods, Attachments – disposable	C	C						
168.	Oxygen Analysers, Hoods, Attachments – re-usable	NR	NR						
169.	Oxygen Mask + tubing– disposable	C	C	In recovery if oxygen is administered post operatively. One per patient per stay;					
170.	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.					
171.	Packing Fee	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
172.	PCA Pump – reusable	NR	C	Applicable to item 230 Excluded in Specialised units i.e. ICU and High Care units. Limited to 1 per patient for maximum of 48 hours in ward Only 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.	PCA Pumps – disposable	NR	C	Excluded in Specialised units i.e. ICU and High Care units. Limited to 1 per patient for maximum of 48 hours in ward Only 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						
174.	Peak Flow Meter	NR	NR							
175.	Peak Flow Meter – disposable Mouth Piece	N/A	R							
176.	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						
177.	Plastic Bags	NR	NR							
178.	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						
179.	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*						
180.	Preparation Items (Shaving Trays, Razor, Scrub Brush)	NR	NR							
181.	Pressure Monitoring Kit - disposable	R	R							
182.	Pressure relieving mattress (Nimbus and similar)	NR	NR							
183.	Pressure relieving products (Novogel, Reston foam and similar)	N/A	NR	Sub						
184.	Probe Covers	N/A	C	One daily in Neonatal Specialised Units						
185.	Prosthesis	C	N/A	Pre-authorised and benefit to be confirmed by scheme. Supplier's invoice to accompany account. Refer section 6.9						
186.	Razors	NR	NR							
187.	Re-breathing bags (anaesthetic machine,ambubag and equivalents)	NR	NR							
188.	Receptal Liners & Shut Off Valves	NR	NR							
189.	Recovery Room	NR	NR							
190.	Safety Pins	NR	NR							
191.	Sampling Lines (Datex and similar)	NR	NR							
192.	Savlon & Savlodil	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
193.	Servo Ventilator (equipment)	N/A	C	Chargeable only in ICU and High Care where applicable.					
194.	Sheepskin	NR	NR						
195.	Skin Prep Solutions	NR	NR						
196.	Space blanket	R	R	Not to be charged with a warm air blanket					
197.	Spatulas, Tongue Depressors	NR	NR						
198.	Specimen Containers	NR	NR						
199.	Spigots	NR	NR						
200.	Spirometer (Incentive and similar)-Dispoasble	NR	NR	Chargeable as TTO					
201.	Spray Top Bottles	NR	NR						
202.	Sprays (Opsite, Disidine)- fractional use	NR	NR						
203.	Sputum Cups	NR	NR						
204.	Sterilising of Instruments or Materials	NR	NR						
205.	Sterilising Solutions, Gases and Tablets	NR	NR						
206.	Steripeel & Equivalents	NR	NR						
207.	Sternal support products (Heart Hugger and similar)	NR	NR	As per scheme arrangement;					
208.	Stethoscopes	NR	NR						
209.	Stitch Cutter	NR	NR						
210.	Stone Baskets – Disposable	R	N/A	1 basket only to a max of R2496 May not be used together item 224 in tariff schedule					
211.	Stone Baskets – re-useable	NR		Re-usable chargeable as per item 224 in tariff schedule					
212.	Suction Nozzle – disposable	R	R						
213.	Swivel Connector – disposable	NR	NR	Part of Ventilator Circuit					
214.	Swivel Connector – re-usable	NR	NR						
215.	Tantol Cleanser / Lotion	N/A	P						
216.	Taps & Reamers	NR	N/A						
217.	Temperature Probe Covers	C	C	One daily in Neonatal Specialised units Not to be charged together with disposable probe.					
218.	Theatre Drapes - Incise	R	N/A	Limited to 1 per case					
219.	Theatre Drapes - Ophthalmic	R	N/A	Limited to 1 per case					
220.	Theatre Drapes- Equipment (Microscope, camera, drill sleeve, Mayo and similar)	NR	N/A	Included in theTheatre fee					
221.	Theatre Drapes– Patient Isolation (Non-woven, paper, plastic, polyethylene based)-Disposable	NR	N/A	➢ Included in the Theatre fee					
222.	Theatre Drapes-Instrument holders (1018 and similar)	NR	N/A	Included in the Theatre fee					
223.	Thermometer- Reusable	NR	NR						
224.	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 Neonatal Specialised Units one per case per every 3 weeks					
225.	Thoraguide Kit (for underwater drainage)	R	C	Chargeable in I.C.U and Emergency Room					
226.	Toiletries (face cloths, toothbrush, soaps, mouthwash and similar)	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
	227.	Topical Anaesthetics (Remicaine and similar)	C	C	When full tube used per patient. Procedure related (Male catheterisation in ward, Haemorrhoidectomy, TUR)					
	228.	Topical anaesthetics (Remicaine, Xylocaine , Anethaine and similar)-fractional use	NR	NR						
	229.	Transducers – disposable	R	R						
	230.	Trays – sterile	NR	C	Small trays, swabbing, ENT – R9.00 Large trays – dressing, cath, multipack – R15.60					
	231.	Tubing – reusable	NR	NR						
	232.	Tubing –disposable	NR	NR						
	233.	Ung Emulsificans	NR	C	Chargeable only When used in treatment on prescription.					
	234.	Vascular sealing devices (Angioseal, Vasoseal, Perclose, The Closer, and similar);	NR	NR						
	235.	Vaseline	NR	NR						
	236.	Ventilators (Servo, Bennett) - equipment	N/A	C	Chargeable only in ICU and High Care where applicable.					
	237.	Water Bottle – Pour			Refer Pour Bottles					
	238.	Wipes (unisolve, baby and similar)	NR	NR						
	239.	X ray detectable swabs in the ward (abdominal swabs, cleaning swabs(paint balls) 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.					
	240.	Xylocaine Spray	NR	NR						
	241.	Yankauer Suction – Plain Yankauer Suction with Control were reuseable	C	C	Disposable max. 2 per case. (One of each) In ward for resuscitation and trauma only					
	242.	Zinc & Castor Oil Cream	N/A	N/A						
ANNEXURE C										
		THEATRE SURGICALS FOR NORMAL VAGINAL DELIVERIES 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								09.01	

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 Stockinette 2 X Silicone Tubing 1 X Add a Line SUTURES = 2 sutures of choice SYRINGES = 7 syringes of choice DRESSINGS 2 X Cotton Wool Balls 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 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 = 7 to 8 sutures of your choice SYRINGES = 13 syringes of choice DRAIN 1 X Corrugated Drain DRESSINGS 15 X Abominal Swabs								

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 X Cotton Wool Balls 5 X Gauze Sterile Xray 1 X Telfa Dressing 1 X Steripad 1 X Tegaderm 1627 5 X Paint Balls								

PSYCHOLOGY

Psychology 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOLOGISTS WITH EFFECT FROM 1 JANUARY 2009

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	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		5.000	49.60 (43.50)
201	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	05.04		15.000	148.80 (130.50)
202	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	05.04		25.000	248.00 (217.50)
203	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	05.04		35.000	347.20 (304.60)
204	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	05.04		45.000	446.40 (391.60)
205	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	05.04		55.000	545.60 (478.60)
206	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	05.04		65.000	644.80 (565.60)
207	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	05.04		75.000	744.00 (652.60)
208	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	05.04		85.000	843.20 (739.60)

Code	Description	Ver	Add	Psychology	
				RVU	Fee
209	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 91-100min.	05.04		95.000	942.40 (826.70)
210	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 101-110min.	05.04		105.000	1041.60 (913.70)
211	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 111-120min.	05.04		115.000	1140.80 (1000.70)
	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	+	7.500	74.40 (65.30)
GROUP SERVICES					
300	Psychology group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	05.03		1.000	9.92 (8.70)
301	Psychology group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	05.03		3.000	29.80 (26.10)
302	Psychology group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	05.03		5.000	49.60 (43.50)
303	Psychology group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	05.03		7.000	69.40 (60.90)
304	Psychology group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	05.03		9.000	89.30 (78.30)
305	Psychology group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	05.03		11.000	109.10 (95.70)
306	Psychology group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	05.03		13.000	129.00 (113.20)
307	Psychology group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	05.03		15.000	148.80 (130.50)
308	Psychology group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	05.03		17.000	168.60 (147.90)
309	Psychology group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	05.03		19.000	188.50 (165.40)
310	Psychology group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	05.03		21.000	208.30 (182.70)
311	Psychology group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	05.03		23.000	228.20 (200.20)

PSYCHOMETRY AND REGISTERED COUNSELLORS

Psychometry & Registered Counsellors 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY PSYCHOMETRISTS WITH EFFECT FROM 1 JANUARY 2009

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	24.80 (21.80)
201	Psychometric testing. Duration: 11-20min.	05.04				1.500	74.40 (65.30)
202	Psychometric testing. Duration: 21-30min.	05.04				2.500	124.00 (108.80)
203	Psychometric testing. Duration: 31-40min.	05.04				3.500	173.60 (152.30)
204	Psychometric testing. Duration: 41-50min.	05.04				4.500	223.20 (195.80)
205	Psychometric testing. Duration: 51-60min.	05.04				5.500	272.80 (239.30)
206	Psychometric testing. Duration: 61-70min.	05.04				6.500	322.40 (282.80)
207	Psychometric testing. Duration: 71-80min.	05.04				7.500	372.00 (326.30)
208	Psychometric testing. Duration: 81-90min.	05.04				8.500	421.60 (369.80)
209	Psychometric testing. Duration: 91-100min.	05.04				9.500	471.20 (413.30)
210	Psychometric testing. Duration: 101-110min.	05.04				10.500	520.80 (456.80)
211	Psychometric testing. Duration: 111-120min.	05.04				11.500	570.40 (500.40)
290	Psychometric testing - per full 15 minutes in excess of 120 minutes.	06.05	+			0.750	37.20 (32.60)
SERVICES RENDERED BY REGISTERED COUNSELLORS							
300	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	06.06		0.500	24.80 (21.80)		
301	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	06.06		1.500	74.40 (65.30)		
302	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	06.06		2.500	124.00 (108.80)		
303	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	06.06		3.500	173.60 (152.30)		
304	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	06.06		4.500	223.20 (195.80)		

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	272.80 (239.30)		
306	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	06.06		6.500	322.40 (282.80)		
307	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	06.06		7.500	372.00 (326.30)		
308	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	06.06		8.500	421.60 (369.80)		
400	Group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	06.06		0.100	4.96 (4.35)		
401	Group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	06.06		0.300	14.90 (13.10)		
402	Group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	06.06		0.500	24.80 (21.80)		
403	Group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	06.06		0.700	34.70 (30.40)		
404	Group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	06.06		0.900	44.60 (39.10)		
405	Group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	06.06		1.100	54.60 (47.90)		
406	Group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	06.06		1.300	64.50 (56.60)		
407	Group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	06.06		1.500	74.40 (65.30)		
408	Group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	06.06		1.700	84.30 (73.90)		
409	Group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	06.06		1.900	94.20 (82.60)		
410	Group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	06.06		2.100	104.20 (91.40)		
411	Group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	06.06		2.300	114.10 (100.10)		
490	Extended group consultation, counselling and/or therapy - per patient per full 15 minutes in excess of 120 minutes	06.06		0.150	7.44 (6.53)		

RADIOGRAPHY

Radiography 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY RADIOGRAPHERS EFFECTIVE FROM 1 JANUARY 2009

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	38.26 (33.56)
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

Code	Description	Ver	Add	Radiography RVU	Radiography Fee
1	**SKELETON**				
1.1	**LIMBS**				
001	Finger, toe	04.00		12.300	37.70 (33.10)
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	49.60 (43.50)
005	Smith-Petersen or equivalent control, in theatre	04.00		134.600	412.30 (361.70)
007	Stress studies, e.g. joint	04.00		16.200	49.60 (43.50)
009	Length studies per right and left pair of long bones	04.00		16.200	49.60 (43.50)
011	Skeletal survey under 5 years	04.00		48.500	148.60 (130.40)
013	Skeletal survey over 5 years	04.00		52.300	160.20 (140.50)
015	Arthrography per joint	04.00		39.500	121.00 (106.10)
1.2	**SPINAL COLUMN**				
017	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	04.00		24.600	75.30 (66.10)
021	Stress studies	04.00		10.000	30.60 (26.80)
025	Scoliosis studies	04.00		39.300	120.40 (105.60)
027	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	04.00		17.000	52.10 (45.70)
	MYELOGRAPHY				
029	Lumbar	04.00		43.100	132.00 (115.80)
031	Thoracic	04.00		40.100	122.80 (107.70)
033	Cervical	04.00		59.400	181.90 (159.60)
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	96.50 (84.60)
1.3	**SKULL**				
039	Skull studies	04.00		32.300	98.90 (86.80)

Code	Description	Ver	Add	Radiography	
				RVU	Fee
041	Paranasal sinuses	04.00		17.000	52.10 (45.70)
043	Facial bones and/or orbits	04.00		34.900	106.90 (93.80)
045	Mandible	04.00		26.000	79.60 (69.80)
047	Nasal bone	04.00		16.200	49.60 (43.50)
049	Mastoid: Bilateral	04.00		50.000	153.20 (134.40)
TEETH					
051	One quadrant	04.00		7.700	23.60 (20.70)
053	Two quadrants	04.00		8.500	26.00 (22.80)
055	Full mouth	04.00		10.800	33.10 (29.00)
057	Rotation tomography of the teeth and jaws	04.00		14.600	44.70 (39.20)
059	Temporo-mandibular joints: Per side	04.00		19.200	58.80 (51.60)
061	Tomography: Per side	04.00		30.500	93.40 (81.90)
063	Localisation of foreign body in the eye	04.00		30.700	94.00 (82.50)
065	Ventriculography	04.00		37.400	114.60 (100.50)
067	Post-nasal studies: Lateral neck	04.00		10.000	30.60 (26.80)
069	Maxillo-facial cephalometry	04.00		26.900	82.40 (72.30)
071	Dacryocystography	04.00		24.200	74.10 (65.00)
2	**ALIMENTARY TRACT**				
073	Sialography (plus 80% for each additional gland)	04.00		24.600	75.30 (66.10)
075	Pharynx and oesophagus	04.00		22.800	69.80 (61.20)
077	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	04.00		31.500	96.50 (84.60)
079	Small bowel meal (control film of abdomen included, except when part of item 081)	04.00		27.700	84.80 (74.40)
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	144.60 (126.80)
083	Barium enema (control film of abdomen included)	04.00		50.900	155.90 (136.80)
085	Biliary tract: ERCP (choledogram and/or pancreatography screening included)	04.00		47.000	144.00 (126.30)
087	Gastric/oesophageal/duodenal intubation control	04.00		20.800	63.70 (55.90)
089	Hypotonic duodenography (077 included)	04.00		57.300	175.50 (153.90)
3	**BILIARY TRACT**				
091	Oral cholecystography	04.00		47.800	146.40 (128.40)
093	Intravenous	04.00		58.600	179.50 (157.50)
095	Operative: First series	04.00		58.100	178.00 (156.10)
097	Subsequent series	04.00		24.000	73.50 (64.50)
099	Post-operative: T-tube	04.00		20.100	61.60 (54.00)
101	Trans-hepatic, percutaneous	04.00		34.600	106.00 (93.00)
103	Tomography of biliary tract: Add	04.00		21.500	65.90 (57.80)
CHEST					
105	Larynx (tomography included)	04.00		42.400	129.90 (113.90)

Code	Description	Ver	Add	Radiography	
				RVU	Fee
107	Chest (item 167 included)	04.00		19.200	58.80 (51.60)
109	Chest and cardiac studies (item 167 included)	04.00		23.100	70.80 (62.10)
111	Ribs	04.00		19.200	58.80 (51.60)
113	Sternum or sterno-clavicular joints	04.00		24.600	75.30 (66.10)
BRONCHOGRAPHY					
115	Unilateral	04.00		33.500	102.60 (90.00)
117	Bilateral	04.00		56.500	173.10 (151.80)
119	Pleurography	04.00		15.700	48.10 (42.20)
121	Laryngography	04.00		15.700	48.10 (42.20)
123	Thoracic inlet	04.00		15.700	48.10 (42.20)
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	52.10 (45.70)
127	Acute abdomen or equivalent studies	04.00		30.700	94.00 (82.50)
6	**URINARY TRACT**				
129	Control film included and bladder views before and after micturition	04.00		67.000	205.20 (180.00)
133	Waterload test: Add	04.00		20.100	61.60 (54.00)
135	Cystography only or urethrography only (retrograde)	04.00		37.600	115.20 (101.10)
CYSTO-URETHROGRAPHY					
137	Retrograde	04.00		33.100	101.40 (88.90)
139	Retrograde-prograde pyelography	04.00		42.400	129.90 (113.90)
141	Aspiration renal cyst	04.00		17.000	52.10 (45.70)
143	Tomography of renal tract: Add	04.00		19.200	58.80 (51.60)
7	**GYNAECOLOGY AND OBSTETRICS**				
145	Pregnancy	04.00		19.200	58.80 (51.60)
147	Pelvimetry	04.00		35.500	108.70 (95.40)
149	Hysterosalpingography	04.00		32.000	98.00 (86.00)
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	804.70 (705.90)
157	Head, repeat examination at the same visit, after contrast, full series	04.00		90.200	276.30 (242.40)
159	Chest	04.00		303.700	930.20 (816.00)
161	Abdomen (including base of chest and/or pelvis)	04.00		353.000	1081.20 (948.40)
163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	04.00		82.100	251.50 (220.60)
165	Limbs and other limited examinations	04.00		82.100	251.50 (220.60)
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	65.50 (57.50)
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	04.00		29.600	90.70 (79.60)
171	Sinography	04.00		44.300	135.70 (119.00)
173	Bone densitometry	05.03		80.900	247.80 (217.40)
175	Mammography: Unilateral or bilateral	04.00		58.100	178.00 (156.10)
177	Repeat mammography, unilateral or bilateral for localisation of tumour	04.00		58.100	178.00 (156.10)
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	53.90 (47.30)
181	Setting of sterile trays	04.00		3.000	9.19 (8.06)
	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	131.70 (115.50)
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	04.00		43.000	131.70 (115.50)
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	131.70 (115.50)
194	Right heart investigation of valve and venous system of the right heart	04.00		43.000	131.70 (115.50)
195	PTCA per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	131.70 (115.50)
196	Left heart investigation of valve of the left heart and ventrical	04.00		43.100	132.00 (115.80)
197	Stent procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	131.70 (115.50)
199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
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	131.70 (115.50)
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		43.000	131.70 (115.50)
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	59.40 (52.10)
187	Theatre investigations with fixed installation : Add	04.00		8.300	25.40 (22.30)

RADIOLOGY

Radiology 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR RADIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2009

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. Please refer to the PET guidelines in Annexure D.

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
  - 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.

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	456.40 (400.40)
00115	X-ray skeletal survey over five years	04.00				10.400	758.30 (665.20)
00120	X-ray sinogram any region	04.00				10.890	794.00 (696.50)
00130	X-ray with mobile unit in other facility	09.00	+			1.900	138.50 (121.50)
	To be added to applicable procedure codes eg 30100.	04.00					
00135	X-ray control view in theatre any region	04.00				5.260	383.50 (336.40)
00140	X-ray fluoroscopy any region	09.00	+			2.260	164.80 (144.60)
	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.	04.00					
00145	X-ray fluoroscopy guidance for biopsy, any region	09.00	+			5.300	386.40 (338.90)
	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	176.40 (154.70)
	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	167.70 (147.10)
00160	X-ray fixed theatre installation (equipment fee only)	04.00				2.260	164.80 (144.60)
	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	09.00	+			1.840	134.20 (117.70)
	Add to the relevant ultrasound examination codes eg 10200.	04.00					
00220	Ultrasound intra-operative study	04.00				7.320	533.70 (468.20)
	Covers all regions studied. Single code per operative procedure.	04.00					
00230	Ultrasound guidance	09.00	+			12.100	882.20 (773.90)
	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	819.50 (718.90)
	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.	04.00					
00250	Ultrasound limited Doppler study any region	05.03				6.500	473.90 (415.70)
	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	1558.10 (1366.80)
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	1233.70 (1082.20)
	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	09.00	+			8.460	616.80 (541.10)
	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	1542.10 (1352.70)
	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	5133.00 (4502.60)
00420	MR Spectroscopy any region	09.00	+			28.900	2107.20 (1848.40)
	May be added to the regional study, once only.	04.00					
00430	MR guidance for needle replacement	09.00	+			42.560	3103.10 (2722.00)
	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	874.90 (767.50)
00450	MR planning study for radiotherapy or surgical procedure	04.00				38.000	2770.70 (2430.40)
00455	MR planning study for radiotherapy or surgical procedure, with contrast	04.00				47.000	3426.90 (3006.10)
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	09.00	+			41.010	2990.10 (2622.90)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00520	Analogue monoplane table with DSA attachment	09.00	+			47.500	3463.30 (3038.00)
	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.	09.00	+			47.500	3463.30 (3038.00)
	A machine code may be added once per complete procedure / patient visit.	04.00					
00540	Digital monoplane screening table	09.00	+			79.920	5827.10 (5111.50)
	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.	09.00	+			93.030	6783.00 (5950.00)
	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.	09.00	+			125.000	9114.00 (7994.70)
	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	2546.10 (2233.40)		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT	04.00		48.330	3523.80 (3091.10)		
00906	Nuclear Medicine study - Venous thrombosis regional	04.00		21.540	1570.50 (1377.60)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
00909	Nuclear Medicine study - Tumour whole body	04.00		34.150	2489.90 (2184.10)		
00912	Nuclear Medicine study - Tumour whole body multiple studies	04.00		47.560	3467.70 (3041.80)		
00915	Nuclear Medicine study - Tumour whole body and SPECT	04.00		47.560	3467.70 (3041.80)		
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT	04.00		60.980	4446.20 (3900.20)		
00921	Nuclear Medicine study – Infection whole body	04.00		31.450	2293.10 (2011.50)		
00924	Nuclear Medicine study – infection whole body with SPECT	04.00		44.860	3270.80 (2869.10)		
00927	Nuclear Medicine study – infection whole body multiple studies	04.00		44.860	3270.80 (2869.10)		
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies	04.00		58.270	4248.60 (3726.80)		
00933	Nuclear Medicine study - Bone marrow imaging limited area	04.00		24.100	1757.20 (1541.40)		
00936	Nuclear Medicine study - Bone marrow imaging whole body	04.00		37.510	2734.90 (2399.00)		
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies	04.00		37.510	2734.90 (2399.00)		
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies	04.00		50.920	3712.70 (3256.80)		
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic	04.00		24.100	1757.20 (1541.40)		
00960	Nuclear Medicine therapy – Hyperthyroidism	04.00		11.990	874.20 (766.80)		
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases	04.00		6.470	471.70 (413.80)		
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy	04.00		6.470	471.70 (413.80)		
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy	04.00		6.470	471.70 (413.80)		
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate	04.00		6.470	471.70 (413.80)		
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy	04.00		6.470	471.70 (413.80)		
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		-	-		
00956	PET/CT scan whole body without contrast	09.00				165.130	-
00957	PET/CT scan whole body with contrast	09.00				163.190	-
00950	PET scan local	09.00				-	-
00951	PET/CT local	09.00				120.000	-
00952	PET/CT local with contrast	09.00				124.680	-
00955	PET scan whole body	09.00				-	-
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	218.70 (191.80)
01020	Emergency call out fee, subsequent cases same trip	04.00				2.000	145.80 (127.90)
01030	Radiologist assistance in theatre, per half hour	04.00				6.000	437.50 (383.80)
01040	Radiographer attendance in theatre, per half hour	04.00				1.600	116.70 (102.40)
01050	Written report on study done elsewhere, short	04.00				1.500	109.40 (96.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
01055	Written report on study done elsewhere, extensive	04.00				4.200	306.20 (268.60)
01060	Written report for medico legal purposes, per hour	04.00				9.720	708.70 (621.70)
01070	Consultation for pre-assessment of interventional procedure	04.00				4.860	354.40 (310.90)
01100	X-ray procedure after hours, per procedure	04.00				2.000	-
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	160.40 (140.70)		
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	145.80 (127.90)
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	281.40 (246.80)
10110	X-ray tomography of the skull	04.00				4.300	313.50 (275.00)
10120	X-ray shuntogram for VP shunt	04.00				15.360	1119.90 (982.40)
10200	Ultrasound of the brain – Neonatal	04.00				7.380	538.10 (472.00)
10210	Ultrasound of the brain including doppler	04.00				13.220	963.90 (845.50)
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	04.00				15.040	1096.60 (961.90)
10300	CT Brain uncontrasted	04.00				22.650	1651.50 (1448.70)
10310	CT Brain with contrast only	04.00				33.280	2426.50 (2128.50)
10320	CT Brain pre and post contrast	04.00				40.480	2951.50 (2589.00)
10325	CT brain pre and post contrast for perfusion studies	05.03				49.100	3580.00 (3140.40)
	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	5656.50 (4961.80)
10335	CT of the brain pre and post contrast with angiography	04.00				97.910	7138.80 (6262.10)
10340	CT brain for cranio-stenosis including 3D	04.00				34.160	2490.70 (2184.80)
10350	CT Brain stereotactic localisation	04.00				19.360	1411.60 (1238.20)
10360	CT base of skull coronal high resolution study for CSF leak	05.03				34.900	2544.60 (2232.10)
10400	MR of the brain, limited study	04.00				43.560	3176.00 (2786.00)
10410	MR of the brain uncontrasted	04.00				63.800	4651.80 (4080.50)
10420	MR of the brain with contrast	04.00				75.940	5536.90 (4856.90)
10430	MR of the brain pre and post contrast	04.00				104.040	7585.80 (6654.20)
10440	MR of the brain pre and post contrast, for perfusion studies	04.00				107.440	7833.70 (6871.70)
10450	MR of the brain plus angiography	04.00				92.200	6722.50 (5896.90)
10460	MR of the brain pre and post contrast plus angiography	04.00				121.230	8839.10 (7753.60)
10470	MR angiography of the brain uncontrasted	04.00				58.500	4265.40 (3741.60)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
10480	MR angiography of the brain contrasted	04.00				74.020	5396.90 (4734.10)
10485	MR of the brain, with diffusion studies	04.00				79.000	5760.00 (5052.60)
10490	MR of the brain, pre and post contrast, with diffusion studies,	04.00				110.640	8067.00 (7076.30)
10492	MR study of the brain plus angiography plus diffusion, uncontrasted	04.00				95.000	6926.60 (6076.00)
10495	MR of the brain pre and post contrast plus angiography and diffusion	04.00				125.440	9146.10 (8022.90)
10500	Arteriography of intracranial vessels: 1 - 2 vessels	04.00				48.600	3543.50 (3108.30)
10510	Arteriography of intracranial vessels: 3 - 4 vessels	04.00				82.330	6002.80 (5265.60)
10520	Arteriography of extra-cranial (non-cervical) vessels	04.00				48.440	3531.90 (3098.20)
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels	04.00				118.090	8610.20 (7552.80)
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography	04.00				97.570	7114.00 (6240.40)
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography	04.00				37.290	2718.90 (2385.00)
10560	Venography of dural sinuses	04.00				52.230	3808.20 (3340.50)
10900	Nuclear Medicine study – Bone regional, static	04.00		21.500	1567.60 (1375.10)		
10905	Nuclear Medicine study – Bone regional, static, with flow	04.00		27.530	2007.30 (1760.80)		
10910	Nuclear Medicine study – Bone regional, static with SPECT	04.00		34.920	2546.10 (2233.40)		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT	04.00		40.940	2985.00 (2618.40)		
10920	Nuclear Medicine study – Brain, planar, complete, static	04.00		16.920	1233.70 (1082.20)		
10925	Nuclear Medicine study – Brain complete static with vascular flow	04.00		22.950	1673.30 (1467.80)		
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT	04.00		30.330	2211.40 (1939.80)		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT	04.00		36.360	2651.10 (2325.50)		
10940	Nuclear Medicine study - CSF flow imaging cisternography	04.00		21.600	1574.90 (1381.50)		
10945	Nuclear Medicine study – Ventriculography	04.00		13.410	977.70 (857.60)		
10950	Nuclear Medicine study - Shunt evaluation static, planar	04.00		13.410	977.70 (857.60)		
10955	Nuclear Medicine study - CFS leakage detection and localisation	04.00		13.410	977.70 (857.60)		
10960	Nuclear medicine study - CSF SPECT	04.00		13.410	977.70 (857.60)		
10970	PET scan of the brain	09.00				-	-
10971	PET/CT scan of the brain uncontrasted	09.00				110.120	-
10972	PET/CT of the brain contrasted	09.00				116.110	-
10980	PET perfusion scan of the brain	09.00				-	-
10981	PET/CT perfusion scan of the brain	09.00				131.070	-
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	286.50 (251.30)
11110	X-ray tomography of the facial bones	04.00				4.300	313.50 (275.00)
11120	X-ray of the nasal bones	04.00				2.390	174.30 (152.90)
11300	CT of the facial bones	04.00				20.960	1528.20 (1340.50)
11310	CT of the facial bones with 3D reconstructions	04.00				30.400	2216.50 (1944.30)
11320	CT of the facial bones/soft tissue, pre and post contrast	04.00				41.260	3008.30 (2638.90)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
11400	MR of the facial soft tissue	04.00				62.400	4549.70 (3991.00)
11410	MR of the facial soft tissue pre and post contrast	04.00				100.600	7334.90 (6434.10)
11420	MR of the facial soft tissue plus angiography, with contrast	04.00				110.300	8042.20 (7054.60)
11430	MR angiography of the facial soft tissue	04.00				74.020	5396.90 (4734.10)
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	259.60 (227.70)
12110	X-ray of the orbits, three or more views, including foramina	04.00				5.300	386.40 (338.90)
12120	X-ray of the orbits for foreign body	04.00				3.560	259.60 (227.70)
12130	X-ray tomography of the orbits	04.00				4.300	313.50 (275.00)
12140	X-ray dacrocystography	04.00				11.200	816.60 (716.30)
12200	Ultrasound of the orbit/eye	04.00				5.130	374.00 (328.10)
12210	Ultrasound of the orbit/eye including doppler	04.00				10.970	799.80 (701.60)
12300	CT of the orbits single plane	04.00				15.700	1144.70 (1004.10)
12310	CT of the orbits, more than one plane	04.00				20.590	1501.30 (1316.90)
12320	CT of the orbits pre and post contrast single plane	04.00				36.030	2627.00 (2304.40)
12330	CT of the orbits pre and post contrast multiple planes	04.00				39.700	2894.60 (2539.10)
12400	MR of the orbits	04.00				62.460	4554.10 (3994.80)
12410	MR of the orbitae, pre and post contrast	04.00				100.640	7337.90 (6436.80)
12900	Nuclear Medicine study – Dacrocystography	04.00		20.770	1514.40 (1328.40)		
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	199.80 (175.30)
13110	X-ray of the paranasal sinuses, two or more views	04.00				3.660	266.90 (234.10)
13120	X-ray tomography of the paranasal sinuses	04.00				4.300	313.50 (275.00)
13130	X-ray of the naso-pharyngeal soft tissue	04.00				2.740	199.80 (175.30)
13300	CT of the paranasal sinuses single plane, limited study	04.00				7.200	525.00 (460.50)
13310	CT of the paranasal sinuses, two planes, limited study	04.00				12.400	904.10 (793.10)
13320	CT of the paranasal sinuses, any plane, complete study	04.00				15.420	1124.30 (986.20)
13330	CT of the paranasal sinuses, more than one plane, complete study	04.00				20.770	1514.40 (1328.40)
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast	04.00				34.740	2533.00 (2221.90)
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast	04.00				41.010	2990.10 (2622.90)
13400	MR of the paranasal sinuses	04.00				60.270	4394.40 (3854.70)
13410	MR of the paranasal sinuses, pre and post contrast	04.00				96.590	7042.60 (6177.70)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
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	266.90 (234.10)
14110	X-ray orthopantomogram of the jaws and teeth	04.00				4.060	296.00 (259.60)
14120	X-ray maxillofacial cephalometry	04.00				2.770	202.00 (177.20)
14130	X-ray of the teeth single quadrant	04.00				2.000	145.80 (127.90)
14140	X-ray of the teeth more than one quadrant	04.00				2.530	184.50 (161.80)
14150	X-ray of the teeth full mouth	04.00				3.620	263.90 (231.50)
14160	X-ray tomography of the teeth per side	04.00				3.230	235.50 (206.60)
14300	CT of the mandible	04.00				22.280	1624.50 (1425.00)
14310	CT of the mandible, pre and post contrast	04.00				41.260	3008.30 (2638.90)
14320	CT mandible with 3D reconstructions	04.00				30.400	2216.50 (1944.30)
14330	CT for dental implants in the mandible	04.00				27.450	2001.40 (1755.60)
14340	CT for dental implants in the maxilla	04.00				27.450	2001.40 (1755.60)
14400	MR of the mandible/maxilla	04.00				63.800	4651.80 (4080.50)
14410	MR of the mandible/maxilla, pre and post contrast	04.00				98.640	7192.00 (6308.80)
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).						04.00
15100	X-ray tempero-mandibular joint, left	04.00				3.560	259.60 (227.70)
15110	X-ray tempero-mandibular joint, right	04.00				3.560	259.60 (227.70)
15120	X-ray tomography tempero-mandibular joint, left	04.00				4.300	313.50 (275.00)
15130	X-ray tomography tempero-mandibular joint, right	04.00				4.300	313.50 (275.00)
15140	X-ray arthrography of the tempero-mandibular joint, left	04.00				15.410	1123.60 (985.60)
15150	X-ray arthrography of the tempero-mandibular joint, right	04.00				15.410	1123.60 (985.60)
15200	Ultrasound tempero-mandibular joints, one or both sides	04.00				6.560	478.30 (419.60)
15300	CT of the tempero-mandibular joints	04.00				25.380	1850.50 (1623.20)
15310	CT of the tempero-mandibular joints plus 3D reconstructions	04.00				34.500	2515.50 (2206.60)
15320	CT arthrogram of the tempero-mandibular joints	04.00				35.960	2621.90 (2299.90)
15400	MR of the tempero-mandibular joints	04.00				63.800	4651.80 (4080.50)
15410	MR of the tempero-mandibular joints, pre and post contrast	04.00				100.840	7352.40 (6449.50)
15420	MR arthrogram of the tempero-mandibular joints	04.00				74.710	5447.30 (4778.30)
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

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
16100	X-ray of the mastoids, unilateral	04.00				3.590	261.80 (229.60)
16110	X-ray of the mastoids, bilateral	04.00				7.180	523.50 (459.20)
16120	X-ray tomography of the petro-temporal bone, unilateral	04.00				4.300	313.50 (275.00)
16130	X-ray tomography of the petro-temporal bone, bilateral	04.00				8.600	627.00 (550.00)
16140	X-ray internal auditory canal, bilateral	04.00				5.230	381.30 (334.50)
16150	X-ray tomography of the internal auditory canal, bilateral	04.00				4.300	313.50 (275.00)
16300	CT of the mastoids	04.00				12.600	918.70 (805.90)
16310	CT of the internal auditory canal	04.00				21.470	1565.40 (1373.20)
16320	CT of the internal auditory canal, pre and post contrast	04.00				34.200	2493.60 (2187.40)
16330	CT of the ear structures, limited study	04.00				13.400	977.00 (857.00)
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes	04.00				43.350	3160.70 (2772.50)
16400	MR of the internal auditory canals, limited study	04.00				43.560	3176.00 (2786.00)
16410	MR of the internal auditory canals, pre and post contrast, limited study	04.00				68.930	5025.80 (4408.60)
16420	MR of the internal auditory canals, pre and post contrast, complete study	04.00				102.640	7483.70 (6564.60)
16430	MR of the ear structures	04.00				64.400	4695.50 (4118.90)
16440	MR of the ear structures, pre and post contrast	04.00				102.640	7483.70 (6564.60)
Sella turcica							
	Code 17100 (sella) and 17110 (tomography) may be combined.						04.00
17100	X-ray of the sella turcica	04.00				3.080	224.60 (197.00)
17110	X-ray tomography of the sella turcica	04.00				4.300	313.50 (275.00)
17300	CT of the sella turcica/hypophysis	04.00				17.450	1272.30 (1116.10)
17310	CT of the sella turcica/hypophysis, pre and post contrast	04.00				42.260	3081.30 (2702.90)
17400	MR of the hypophysis	04.00				43.560	3176.00 (2786.00)
17410	MR of the hypophysis, pre and post contrast	04.00				74.030	5397.70 (4734.80)
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	207.10 (181.70)
18110	X-ray of the salivary ducts, open mouth for calculus	04.00				1.900	138.50 (121.50)
18120	X-ray sialography, per gland	04.00				14.080	1026.60 (900.50)
18200	Ultrasound of the salivary glands/floor of the mouth	04.00				6.560	478.30 (419.60)
18300	CT of the salivary glands, uncontrasted	04.00				12.600	918.70 (805.90)
18310	CT of the salivary glands/floor of the mouth, pre and post contrast	04.00				42.100	3069.60 (2692.60)
18320	CT sialography	04.00				26.280	1916.10 (1680.80)
18400	MR of the salivary glands/floor of the mouth	04.00				63.200	4608.00 (4042.10)
18410	MR of the salivary glands/floor of the mouth, pre and post contrast	04.00				100.840	7352.40 (6449.50)
18900	Nuclear Medicine study - Salivary gland imaging	04.00		20.770	1514.40 (1328.40)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
Soft Tissue							
19900	Nuclear Medicine study - Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
19905	Nuclear Medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
19910	Nuclear Medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
19915	Nuclear Medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3467.70 (3041.80)		
19920	Nuclear medicine study - Infection localisation planar, static	04.00		18.040	1315.30 (1153.80)		
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2293.10 (2011.50)		
19930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2293.10 (2011.50)		
19935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3270.80 (2869.10)		
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	199.80 (175.30)
20110	X-ray of the larynx including tomography	04.00				9.390	684.60 (600.50)
20120	X-ray laryngography	04.00				8.280	603.70 (529.60)
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording	04.00				8.300	605.20 (530.90)
20200	Ultrasound of the thyroid	04.00				6.560	478.30 (419.60)
20210	Ultrasound of soft tissue of the neck	04.00				6.560	478.30 (419.60)
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler	04.00				15.000	1093.70 (959.40)
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	1592.40 (1396.80)
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler	05.03				10.800	787.40 (690.70)
20300	CT of the soft tissues of the neck	04.00				18.250	1330.60 (1167.20)
20310	CT of the soft tissues of the neck, with contrast	04.00				38.150	2781.60 (2440.00)
20320	CT of the soft tissues of the neck, pre and post contrast	04.00				43.810	3194.30 (2802.00)
20330	CT angiography of the extracranial vessels in the neck	04.00				79.360	5786.30 (5075.70)
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain	04.00				107.500	7838.00 (6875.40)
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	9072.40 (7958.20)
20400	Mr of the soft tissue of the neck	04.00				63.600	4637.20 (4067.70)
20410	MR of the soft tissue of the neck, pre and post contrast	04.00				102.040	7439.90 (6526.20)
20420	MR of the soft tissue of the neck and uncontrasted angiography	04.00				92.600	6751.70 (5922.50)
20430	MR angiography of the extracranial vessels in the neck, without contrast	04.00				59.600	4345.60 (3811.90)
20440	MR angiography of the extracranial vessels in the neck, with contrast	04.00				74.020	5396.90 (4734.10)
20450	MR angiography of the extra and intracranial vessels with contrast	04.00				116.050	8461.40 (7422.30)
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast	05.05				135.170	9855.50 (8645.20)
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast	04.00				156.050	11377.90 (9980.60)
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels	04.00				44.430	3239.50 (2841.70)
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels	04.00				50.730	3698.80 (3244.60)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
20520	Arteriography of cervical vessels: carotid and vertebral	04.00				77.630	5660.20 (4965.10)
20530	Arteriography of aortic arch and cervical vessels	04.00				91.970	6705.70 (5882.20)
20540	Arteriography of aortic arch, cervical and intracranial vessels	04.00				108.870	7937.90 (6963.10)
20550	Venography of jugular and vertebral veins	04.00				48.950	3569.00 (3130.70)
Thyroid (Nuclear Medicine)							
21900	Nuclear Medicine study - Thyroid, single uptake	04.00		9.680	705.80 (619.10)		
21910	Nuclear medicine study - Thyroid, multiple uptake	04.00		14.690	1071.10 (939.60)		
21920	Nuclear medicine study - Thyroid imaging with uptake	04.00		17.720	1292.00 (1133.30)		
21930	Nuclear medicine study - Thyroid imaging	04.00		12.720	927.40 (813.50)		
21940	Nuclear medicine study - Thyroid imaging with vascular flow	04.00		18.740	1366.40 (1198.60)		
21950	Nuclear medicine study - Thyroid suppression/stimulation	04.00		12.720	927.40 (813.50)		
21960	PET scan of the thyroid	09.00				-	-
Parathyroid (Nuclear Medicine)							
22900	Nuclear Medicine study - Parathyroid, planar, static	04.00		16.520	1204.50 (1056.60)		
22910	Nuclear medicine study - Parathyroid, planar, static, multiple	04.00		28.910	2107.90 (1849.00)		
22920	Nuclear medicine study - Parathyroid, planar, static with subtraction technique	04.00		21.880	1595.30 (1399.40)		
22930	Nuclear medicine study - Parathyroid SPECT	04.00		13.410	977.70 (857.60)		
22940	PET scan of the parathyroid	09.00				-	-
Soft Tissue							
29900	Nuclear Medicine study - Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
29905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
29910	Nuclear medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
29915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3467.70 (3041.80)		
29920	Nuclear medicine study - Tumour localisation planar, static	04.00		18.040	1315.30 (1153.80)		
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2293.10 (2011.50)		
29930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2293.10 (2011.50)		
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3270.80 (2869.10)		
29940	Nuclear medicine study - Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		
29945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	04.00		36.490	2660.60 (2333.90)		
29950	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		12.390	903.40 (792.50)		
29960	PET scan of the soft tissue of the neck	09.00				-	-
29961	PET/CT scan of the soft tissue of the neck uncontrasted	09.00				105.870	-
29962	PET/CT scan of the soft tissue of the neck contrasted	09.00				111.690	-
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	221.70 (194.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
30110	X-ray of the chest two views, PA and lateral	04.00				3.840	280.00 (245.60)
30120	X-ray of the chest complete with additional views	04.00				4.240	309.10 (271.10)
30130	X-ray of the chest complete including fluoroscopy	04.00				4.480	326.60 (286.50)
30140	X-ray tomography of the chest	04.00				4.300	313.50 (275.00)
30150	X-ray of the ribs	04.00				4.790	349.20 (306.30)
30155	X-ray of the chest and ribs	04.00				6.420	468.10 (410.60)
30160	X-ray of the thoracic inlet	04.00				2.560	186.70 (163.80)
30170	X-ray of the sterno-clavicular joints	04.00				4.210	307.00 (269.30)
30175	X-ray tomography of the sterno-clavicular joint	04.00				4.300	313.50 (275.00)
30180	X-ray of the sternum	04.00				4.210	307.00 (269.30)
30185	X-ray tomography of the sternum	04.00				4.300	313.50 (275.00)
30200	Ultrasound of the chest wall, any region	04.00				6.560	478.30 (419.60)
30210	Ultrasound of the pleural space	04.00				6.560	478.30 (419.60)
30220	Ultrasound of the mediastinal structures	04.00				6.560	478.30 (419.60)
30300	CT of the chest, limited study	04.00				9.500	692.70 (607.60)
30310	CT of the chest uncontrasted	04.00				26.600	1939.50 (1701.30)
30320	CT of the chest contrasted	04.00				42.430	3093.70 (2713.80)
30330	CT of the chest, pre and post contrast	04.00				45.700	3332.10 (2922.90)
30340	CT of the chest, limited high resolution study	04.00				11.200	816.60 (716.30)
30350	CT of the chest, complete high resolution study	04.00				24.010	1750.60 (1535.60)
30355	CT of the chest, complete high resolution study with additonal prone and expiratory studies	05.03				33.300	2428.00 (2129.80)
30360	CT of the chest for pulmonary embolism	04.00				57.120	4164.70 (3653.20)
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	04.00				80.280	5853.40 (5134.60)
30400	MR of the chest	04.00				63.600	4637.20 (4067.70)
30410	MR of the chest with uncontrasted angiography	04.00				92.600	6751.70 (5922.50)
30420	MR of the chest, pre and post contrast	04.00				102.040	7439.90 (6526.20)
30900	Nuclear Medicine study - Lung perfusion	04.00		21.540	1570.50 (1377.60)		
30910	Nuclear Medicine study - Lung ventilation, aerosol	04.00		21.500	1567.60 (1375.10)		
30920	Nuclear Medicine study - Lung perfusion and ventilation	04.00		42.030	3064.50 (2688.20)		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas	04.00		14.170	1033.20 (906.30)		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas	04.00		34.690	2529.30 (2218.70)		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic	05.03		26.510	1932.90 (1695.50)		
30960	Nuclear medine study - alveolar permeability	05.03		26.510	1932.90 (1695.50)		
	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	438.90 (385.00)		
	Stand alone code. Not to be combined with 30920.	05.03					

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
30980	PET scan of the chest	09.00				-	-
30981	PET/CT scan of the chest uncontrasted	09.00				111.440	-
30982	PET/CT scan of the chest contrasted	09.00				117.420	-
30983	PET/CT scan of the chest pre and post contrast	09.00				148.320	-
Oesophagus							
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).						04.00
31100	X-ray barium swallow	04.00				6.600	481.20 (422.10)
31105	Xray 3 phase dynamic contrasted swallow	05.03				12.600	918.70 (805.90)
31110	X-ray barium swallow, double contrast	04.00				7.920	577.50 (506.60)
31120	X-ray barium swallow with cinematography	04.00				10.070	734.20 (644.00)
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	306.20 (268.60)
32210	Ultrasound intravascular (IVUS) first vessel	04.00				8.440	615.40 (539.80)
32220	Ultrasound intravascular (IVUS) subsequent vessels	04.00				5.300	386.40 (338.90)
32300	CT angiography of the aorta and branches	04.00				79.080	5765.90 (5057.80)
32305	CT angiography of the thoracic and abdominal aorta and branches	05.03				105.500	7692.20 (6747.50)
32310	CT angiography of the pulmonary vasculature	04.00				79.080	5765.90 (5057.80)
32400	MR angiography of the aorta and branches	04.00				78.500	5723.60 (5020.70)
32410	MR angiography of the pulmonary vasculature	04.00				105.270	7675.40 (6732.80)
32500	Arteriography of thoracic aorta	04.00				28.260	2060.50 (1807.50)
32510	Arteriography of bronchial intercostal vessels alone	04.00				50.150	3656.50 (3207.50)
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels	04.00				67.430	4916.50 (4312.70)
32530	Arteriography of pulmonary vessels	04.00				63.270	4613.10 (4046.60)
32540	Arteriography of heart chambers, coronary arteries	04.00				44.270	3227.80 (2831.40)
32550	Venography of thoracic vena cava	04.00				28.380	2069.20 (1815.10)
32560	Venography of vena cava, azygos system	04.00				56.310	4105.70 (3601.50)
32570	Venography patency of A-port or other central line	04.00				19.640	1432.00 (1256.10)
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	896.80 (786.70)
	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	597.90 (524.50)
33210	Ultrasound study of the heart trans-oesophageal	04.00				10.520	767.00 (672.80)
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel	04.00				5.200	379.10 (332.50)
33300	CT anatomical/functional study of the heart	04.00				34.610	2523.50 (2213.60)
33310	CT angiography of heart vessels	04.00				81.280	5926.30 (5198.50)
33400	MR of the heart, anatomical study	04.00				62.200	4535.10 (3978.20)
33410	MR of the heart, anatomical and functional study	04.00				69.000	5030.90 (4413.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
33420	MR of the heart, pre and post contrast	04.00				103.040	7512.90 (6590.30)
33430	MR angiography of the heart vessels	04.00				70.710	5155.60 (4522.50)
33440	MR of the heart, anatomical, functional and coronary angiography	04.00				106.840	7789.90 (6833.20)
33900	Nuclear Medicine study - Cardiac shunt detection	04.00		21.500	1567.60 (1375.10)		
33905	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion single study	04.00		26.510	1932.90 (1695.50)		
33910	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion multiple studies	04.00		34.920	2546.10 (2233.40)		
33915	Nuclear Medicine study - Cardiac blood pool imaging, gated SPECT	04.00		13.410	977.70 (857.60)		
33920	Nuclear medicine study - Cardiac blood pool imaging, first pass technique	04.00		26.510	1932.90 (1695.50)		
33925	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi) planar, non gated	04.00		16.520	1204.50 (1056.60)		
33930	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi) planar, non gated	04.00		16.520	1204.50 (1056.60)		
33935	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (non gated)	04.00		16.520	1204.50 (1056.60)		
33940	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT non gated	04.00		16.520	1204.50 (1056.60)		
33945	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (gated)	04.00		28.910	2107.90 (1849.00)		
33950	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT (gated)	04.00		28.910	2107.90 (1849.00)		
33955	Nuclear medicine study - Plus wall movement and ejection fraction, SPECT	04.00		6.020	438.90 (385.00)		
33960	Nuclear medicine study - Cardiac hot spot imaging (infarction) planar	04.00		21.500	1567.60 (1375.10)		
33965	Nuclear medicine study - Cardiac hot spot imaging (infarction) SPECT	04.00		13.410	977.70 (857.60)		
33970	Nuclear Medicine study - Multi stage treadmill ECG test	04.00		6.660	485.60 (426.00)		
33980	PET scan of the heart	09.00				-	-
33981	PET/CT scan of the heart?	09.00				153.140	-
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	761.20 (667.70)
34101	X-Ray mammography unilateral, including ultrasound	06.04				8.352	609.00 (534.20)
	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	685.40 (601.20)
	Once off fee per visit. May be added to 34100	04.00					
34110	X-ray mammography study for localisation	04.00				7.240	527.90 (463.10)
34120	X-ray stereotactic mammography – localisation	04.00				10.400	758.30 (665.20)
34130	X-ray stereotactic mammography – biopsy	04.00				11.600	845.80 (741.90)
34140	X-ray of biopsy specimen of the mamma	04.00				2.740	199.80 (175.30)
34150	X-ray Mammotome hand held biopsy apparatus	04.00				9.800	714.50 (626.80)
34200	Ultrasound study of the breast	04.00				7.900	576.00 (505.30)
34205	Ultrasound guided aspiration FNA/localisation of the breast	04.00				12.100	882.20 (773.90)
34300	Computer assisted diagnosis for mammography	04.00				1.400	102.10 (89.60)
34400	MR study of the breast	04.00				62.600	4564.30 (4003.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
34410	MR study of the breast pre and post contrast	04.00				100.840	7352.40 (6449.50)
34900	PET scan of the breast/mamma	09.00				-	-
Soft Tissue							
39900	Nuclear medicine study - Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
39905	Nuclear medicine study - Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
39910	Nuclear medicine study - Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
39915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3467.70 (3041.80)		
39920	Nuclear medicine study - Infection localisation planar, static	04.00		18.040	1315.30 (1153.80)		
39925	Nuclear medicine study - Infection localisation planar, static, multiple studies	04.00		31.450	2293.10 (2011.50)		
39930	Nuclear medicine study - Infection localisation planar, static and SPECT	04.00		31.450	2293.10 (2011.50)		
39935	Nuclear medicine study - Infection localisation planar, static, multiple studies, SPECT	04.00		44.860	3270.80 (2869.10)		
39940	Nuclear medicine study - Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		
39945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple	04.00		36.490	2660.60 (2333.90)		
39950	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		12.390	903.40 (792.50)		
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	242.10 (212.40)
40105	X-ray of the abdomen supine and erect, or decubitus	04.00				5.360	390.80 (342.80)
40110	X-ray of the abdomen multiple views including chest	04.00				8.100	590.60 (518.10)
40120	X-ray tomography of the abdomen	04.00				4.300	313.50 (275.00)
40140	X-ray barium meal single contrast	04.00				8.870	646.70 (567.30)
40143	X-ray barium meal double contrast	04.00				11.990	874.20 (766.80)
40147	X-ray barium meal double contrast with follow through	04.00				15.800	1152.00 (1010.50)
40150	X-ray small bowel enteroclysis (meal)	04.00				25.450	1855.60 (1627.70)
	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	1425.40 (1250.40)
40157	X-ray small bowel meal with pneumocolon	04.00				25.630	1868.70 (1639.20)
40160	X-ray large bowel enema single contrast	04.00				12.970	945.70 (829.60)
40165	X-ray large bowel enema double contrast	04.00				19.630	1431.30 (1255.50)
40170	X-ray guided gastro oesophageal intubation	04.00				1.600	116.70 (102.40)
40175	X-ray guided duodenal intubation	04.00				2.800	204.20 (179.10)
40180	X-ray defaecogram	04.00				12.970	945.70 (829.60)
40190	X-ray guided reduction of intussusception	04.00				16.270	1186.30 (1040.60)
40200	Ultrasound study of the abdominal wall	04.00				5.540	403.90 (354.30)
40210	Ultrasound study of the whole abdomen including the pelvis	04.00				8.240	600.80 (527.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
40300	CT study of the abdomen	04.00				26.410	1925.60 (1689.10)
40310	CT study of the abdomen with contrast	04.00				44.820	3267.90 (2866.60)
40313	CT study of the abdomen pre and post contrast	04.00				52.990	3863.60 (3389.10)
40320	CT of the pelvis	04.00				26.130	1905.20 (1671.20)
40323	CT of the pelvis with contrast	04.00				47.480	3461.90 (3036.80)
40327	CT of the pelvis pre and post contrast	04.00				53.870	3927.80 (3445.40)
40330	CT of the abdomen and pelvis	04.00				38.500	2807.10 (2462.40)
40333	CT of the abdomen and pelvis with contrast	04.00				62.170	4532.90 (3976.20)
40337	CT of the abdomen and pelvis pre and post contrast	04.00				67.430	4916.50 (4312.70)
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast	04.00				74.110	5403.50 (4739.90)
40345	CT of the chest, abdomen and pelvis without contrast	04.00				70.120	5112.60 (4484.70)
40350	CT of the chest, abdomen and pelvis with contrast	04.00				88.350	6441.80 (5650.70)
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast	04.00				93.050	6784.50 (5951.30)
40360	CT of the base of skull to symphysis pubis with contrast	04.00				102.730	7490.20 (6570.40)
40365	CT colonoscopy	04.00				34.780	2535.90 (2224.50)
	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	4708.70 (4130.40)
40410	MR of the abdomen pre and post contrast	04.00				100.840	7352.40 (6449.50)
40420	MR of the pelvis, soft tissue	04.00				64.580	4708.70 (4130.40)
40430	MR of the pelvis, soft tissue, pre and post contrast	04.00				102.040	7439.90 (6526.20)
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying	04.00		21.500	1567.60 (1375.10)		
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies	04.00		34.920	2546.10 (2233.40)		
40910	Nuclear Medicine study - Gastro intestinal protein loss	04.00		21.500	1567.60 (1375.10)		
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies	04.00		34.920	2546.10 (2233.40)		
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic	04.00		21.500	1567.60 (1375.10)		
40925	Nuclear medicine study – Acute GIT bleed multiple studies	04.00		34.920	2546.10 (2233.40)		
40930	Nuclear medicine study - Meckel's localisation	04.00		20.770	1514.40 (1328.40)		
40935	Nuclear medicine study - Gastric mucosa imaging	04.00		20.770	1514.40 (1328.40)		
40940	Nuclear medicine study - colonic transit multiple studies	05.03		44.860	3270.80 (2869.10)		
	Stand alone code	05.03					
40950	PET scan of the abdomen and pelvis	09.00				-	-
40951	PET/CT scan of the abdomen and pelvis uncontrasted	09.00				119.530	-
40952	PET/CT scan of the abdomen and pelvis contrasted	09.00				129.310	-
40953	PET/CT scan of the abdomen and pelvis pre and post contrast	09.00				140.500	-
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	1378.00 (1208.80)
41105	X-ray ERCP reporting on images done in theatre	04.00				2.400	175.00 (153.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
41110	X-ray cholangiography intra-operative	04.00				8.450	616.10 (540.40)
41120	X-ray T-tube cholangiography post operative	04.00				14.050	1024.40 (898.60)
41130	X-ray transhepatic percutaneous cholangiography	04.00				32.340	2358.00 (2068.40)
41200	Ultrasound study of the upper abdomen	04.00				7.000	510.40 (447.70)
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	714.50 (626.80)
	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	4002.90 (3511.30)
41400	MR study of the liver/pancreas	04.00				64.780	4723.20 (4143.20)
41410	MR study of the liver/pancreas pre and post contrast	04.00				100.840	7352.40 (6449.50)
41420	MRCP	04.00				49.200	3587.30 (3146.80)
41430	MR study of the abdomen with MRCP	04.00				92.980	6779.40 (5946.80)
41440	MR study of the abdomen pre and post contrast with MRCP	04.00				133.600	9741.00 (8544.70)
41900	Nuclear Medicine study - Liver and spleen, planar views only	04.00		21.500	1567.60 (1375.10)		
41905	Nuclear Medicine study - Liver and spleen, with flow study	04.00		27.530	2007.30 (1760.80)		
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT	04.00		34.920	2546.10 (2233.40)		
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT	04.00		40.940	2985.00 (2618.40)		
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic	04.00		21.500	1567.60 (1375.10)		
41925	Nuclear Medicine study – hepatobiliary tract including flow	04.00		26.510	1932.90 (1695.50)		
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies	04.00		34.920	2546.10 (2233.40)		
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies	04.00		39.920	2910.60 (2553.20)		
41940	Nuclear medicine study - Gall bladder ejection fraction	04.00		6.020	438.90 (385.00)		
41945	Nuclear medicine study – Biliary gastric reflux study	04.00		20.770	1514.40 (1328.40)		
Renal tract							
42100	X-ray tomography of the renal tract	04.00				4.300	313.50 (275.00)
	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	1812.60 (1590.00)
42115	X-ray excretory urogram including tomography with micturating study	04.00				32.860	2395.90 (2101.70)
42120	X-ray cystography	04.00				15.050	1097.30 (962.50)
42130	X-ray urethrography	04.00				15.370	1120.70 (983.10)
42140	X-ray micturating cysto-urethrography	04.00				19.300	1407.20 (1234.40)
42150	X-ray retrograde/prograde pyelography	04.00				12.530	913.60 (801.40)
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre	04.00				2.410	175.70 (154.10)
42160	X-ray prograde pyelogram – percutaneous	04.00				32.670	2382.00 (2089.50)
42200	Ultrasound study of the renal tract including bladder	04.00				7.420	541.00 (474.60)
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney	04.00				3.800	277.10 (243.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	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	772.90 (678.00)
42300	CT of the renal tract for a stone	04.00				25.150	1833.70 (1608.50)
42400	MR of the renal tract for obstruction	04.00				47.000	3426.90 (3006.10)
42410	MR of the kidneys without contrast	04.00				64.580	4708.70 (4130.40)
42420	MR of the kidneys pre and post contrast	04.00				102.240	7454.50 (6539.00)
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)	04.00		21.940	1599.70 (1403.20)		
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow	04.00		27.960	2038.60 (1788.20)		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT	04.00		35.350	2577.40 (2260.90)		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT	04.00		41.370	3016.40 (2646.00)		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow	04.00		26.510	1932.90 (1695.50)		
42930	Nuclear Medicine study – Renovascular study, baseline	04.00		26.510	1932.90 (1695.50)		
42940	Nuclear Medicine study – Renovascular study, with intervention	04.00		26.510	1932.90 (1695.50)		
42950	Nuclear medicine study - indirect voiding cystogram	05.05		6.020	438.90 (385.00)		
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	291.60 (255.80)
43110	X-ray pelvimetry multiple views	04.00				5.800	422.90 (371.00)
43120	X-ray hystero-salpingography	04.00				10.030	731.30 (641.50)
43130	X-ray hystero-salpingography with introduction of contrast	04.00				13.530	986.50 (865.40)
43200	Ultrasound study of the pelvis transabdominal	04.00				5.700	415.60 (364.60)
43205	Ultrasound study of the female pelvis transvaginal	04.00				7.210	525.70 (461.10)
43210	Ultrasound study of the prostate transrectal	04.00				7.380	538.10 (472.00)
43215	Ultrasound transrectal prostate volume for brachytherapy	04.00				10.400	758.30 (665.20)
43220	Ultrasound study of the testes	04.00				7.380	538.10 (472.00)
43225	Ultrasound study for male impotence including doppler and injection of vaso contrictor	04.00				15.000	1093.70 (959.40)
	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	984.30 (863.40)
43240	Ultrasound guided amniocenthesis	04.00				5.840	425.80 (373.50)
43250	Ultrasound study of the pregnant uterus, first trimester	04.00				4.200	306.20 (268.60)
43260	Ultrasound study of the pregnant uterus, second trimester	04.00				6.360	463.70 (406.80)
43270	Ultrasound study of the pregnant uterus, third trimester, first visit	04.00				6.360	463.70 (406.80)
43273	Ultrasound study of the pregnant uterus, third trimester, follow-up visit	04.00				4.200	306.20 (268.60)
43277	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit	04.00				8.170	595.70 (522.50)
43280	Ultrasound doppler of the umbilical cord for resistive index	04.00				3.800	277.10 (243.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	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	479.80 (420.90)
43400	MR study of pelvic reproductive organs - limited study	04.00				47.600	3470.60 (3044.40)
43405	MR study for pelvimetry	04.00				20.000	1458.20 (1279.10)
43410	MR study of pelvic reproductive organs - complete – uncontrasted	04.00				64.580	4708.70 (4130.40)
43420	MR study of pelvic reproductive organs - complete – pre and post contrast	04.00				102.240	7454.50 (6539.00)
43950	Nuclear medicine study - Radio pharmaceutical voiding cystogram	04.00		21.500	1567.60 (1375.10)		
43960	Nuclear medicine study - Testicular imaging	04.00		26.510	1932.90 (1695.50)		
43970	Nuclear medicine study - hystero-salpingography	05.03		26.510	1932.90 (1695.50)		
43961	PET scan of the testis	09.00				-	-
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	1335.70 (1171.70)
44205	Ultrasound study of the IVC and pelvic veins including Doppler	05.03				14.000	1020.80 (895.40)
	This is a stand alone code and may not be added to 44200.	05.03					
44300	CT angiography of abdominal aorta and branches	04.00				76.720	5593.80 (4906.80)
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen	04.00				94.320	6877.10 (6032.50)
44310	CT angiography of the pelvis	04.00				78.640	5733.80 (5029.60)
44320	CT angiography of the abdominal aorta and pelvis	04.00				89.540	6528.50 (5726.80)
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	8687.50 (7620.60)
44330	CT portogram	04.00				74.400	5424.70 (4758.50)
44400	MR angiography of abdominal aorta and branches	04.00				76.640	5588.00 (4901.80)
44500	Arteriography of abdominal aorta alone	04.00				28.120	2050.30 (1798.50)
44503	Arteriography of aorta plus coeliac, mesenteric branches	04.00				75.630	5514.30 (4837.10)
44505	Arteriography of aorta plus renal, adrenal branches	04.00				63.010	4594.20 (4030.00)
44507	Arteriography of aorta plus non-visceral branches	04.00				60.790	4432.30 (3888.00)
44510	Arteriography of coeliac, mesenteric vessels alone	04.00				64.350	4691.90 (4115.70)
44515	Arteriography of renal, adrenal vessels alone	04.00				49.490	3608.40 (3165.30)
44517	Arteriography of non-visceral abdominal vessels alone	04.00				54.910	4003.60 (3511.90)
44520	Arteriography of internal and external iliac vessels alone	04.00				56.720	4135.60 (3627.70)
44525	Venography of internal and external iliac veins alone	04.00				62.110	4528.60 (3972.50)
44530	Corpora cavernosography	04.00				25.060	1827.20 (1602.80)
44535	Vasography, vesciculography	04.00				29.190	2128.30 (1866.90)
44540	Venography of inferior vena cava	04.00				26.120	1904.50 (1670.60)
44543	Venography of hepatic veins alone	04.00				53.770	3920.50 (3439.00)
44545	Venography of inferior vena cava and hepatic veins	04.00				68.910	5024.40 (4407.40)
44550	Venography of lumbar azygos system alone	04.00				43.890	3200.10 (2807.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
44555	Venography of inferior vena cava and lumbar azygos veins	04.00				65.460	4772.80 (4186.70)
44560	Venography of renal, adrenal veins alone	04.00				43.990	3207.40 (2813.50)
44565	Venography of inferior vena cava and renal/adrenal veins	04.00				68.390	4986.50 (4374.10)
44570	Venography of spermatic, ovarian veins alone	04.00				40.390	2944.90 (2583.20)
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins	04.00				73.990	5394.80 (4732.30)
44580	Venography indirect splenoportogram	04.00				48.670	3548.60 (3112.80)
44583	Venography direct splenoportogram	04.00				31.590	2303.30 (2020.40)
44587	Venography transhepatic portogram	04.00				66.750	4866.90 (4269.20)
Soft Tissue							
49900	Nuclear Medicine study – Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
49905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
49910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
49915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3467.70 (3041.80)		
49920	Nuclear medicine study – Infection localisation planar, static	04.00		18.040	1315.30 (1153.80)		
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies	04.00		31.450	2293.10 (2011.50)		
49940	Nuclear medicine study – Infection localisation planar, static and SPECT	04.00		31.450	2293.10 (2011.50)		
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3270.80 (2869.10)		
49960	Nuclear medicine study – Regional lymph node mapping dynamic	04.00		5.010	365.30 (320.40)		
49965	Nuclear medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		
49970	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	04.00		37.510	2734.90 (2399.00)		
49975	Nuclear medicine study – Regional lymph node mapping SPECT	04.00		13.410	977.70 (857.60)		
49980	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		13.410	977.70 (857.60)		
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	510.40 (447.70)
50105	X-ray of the spine scoliosis view AP and lateral	04.00				12.000	874.90 (767.50)
50110	X-ray of the spine scoliosis view AP and lateral including stress views	04.00				18.540	1351.80 (1185.80)
50120	X-ray bone densitometry	04.00				11.520	839.90 (736.80)
50130	X-ray guided lumbar puncture	04.00				4.800	350.00 (307.00)
50140	X-ray guided cisternal puncture cisternogram	04.00				22.980	1675.50 (1469.70)
50300	CT quantitive bone mineral density	04.00				11.830	862.50 (756.60)
50500	Arteriogram of the spinal column and cord, all vessels	04.00				127.230	9276.60 (8137.40)
50510	Venography of the spinal, paraspinal veins	04.00				58.450	4261.70 (3738.30)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
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	301.90 (264.80)
51110	X-ray of the cervical spine, one or two views	04.00				3.010	219.50 (192.50)
51120	X-ray of the cervical spine, more than two views	04.00				4.280	312.10 (273.80)
51130	X-ray of the cervical spine, more than two views including stress views	04.00				7.580	552.70 (484.80)
51140	X-ray Tomography cervical spine	04.00				4.300	313.50 (275.00)
51160	X-ray myelography of the cervical spine	04.00				27.460	2002.20 (1756.30)
51170	X-ray discography cervical spine per level	04.00				25.170	1835.20 (1609.80)
51300	CT of the cervical spine limited study	04.00				9.500	692.70 (607.60)
51310	CT of the cervical spine – regional study	04.00				13.910	1014.20 (889.60)
51320	CT of the cervical spine – complete study	04.00				37.130	2707.20 (2374.70)
51330	CT of the cervical spine pre and post contrast	04.00				58.850	4290.90 (3763.90)
51340	CT myelography of the cervical spine	04.00				47.190	3440.70 (3018.20)
51350	CT myelography of the cervical spine following myelogram	04.00				21.690	1581.50 (1387.30)
51400	MR of the cervical spine, limited study	04.00				44.400	3237.30 (2839.70)
51410	MR of the cervical spine and cranio-cervical junction	04.00				64.820	4726.20 (4145.80)
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	04.00				102.140	7447.20 (6532.60)
51900	Nuclear Medicine study – Bone regional cervical	04.00		21.500	1567.60 (1375.10)		
51910	Nuclear Medicine study – Bone tomography regional cervical	04.00		13.410	977.70 (857.60)		
51920	Nuclear Medicine study – with flow	04.00		6.020	438.90 (385.00)		
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	234.00 (205.30)
52110	X-ray of the thoracic spine, more than two views	04.00				4.000	291.60 (255.80)
52120	X-ray tomography thoracic spine	04.00				4.300	313.50 (275.00)
52140	X-ray of the thoracic spine, more that two views including stress views	04.00				6.640	484.10 (424.60)
52150	X-ray myelography of the thoracic spine	04.00				18.620	1357.60 (1190.90)
52300	CT of the thoracic spine limited study	04.00				9.500	692.70 (607.60)
52305	CT of the thoracic spine – regional study	04.00				13.910	1014.20 (889.60)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
52310	CT of the thoracic spine complete study	04.00				35.780	2608.80 (2288.40)
52320	CT of the thoracic spine pre and post contrast	04.00				58.850	4290.90 (3763.90)
52330	CT myelography of the thoracic spine	04.00				48.090	3506.30 (3075.70)
52340	CT myelography of the thoracic spine following myelogram	04.00				20.370	1485.20 (1302.80)
52400	MR of the thoracic spine, limited study	04.00				46.600	3397.70 (2980.40)
52410	MR of the thoracic spine	04.00				64.340	4691.20 (4115.10)
52420	MR of the thoracic spine pre and post contrast	04.00				101.420	7394.70 (6486.60)
52900	Nuclear Medicine study – Bone regional dorsal	04.00		21.500	1567.60 (1375.10)		
52910	Nuclear Medicine study – Bone tomography regional dorsal	04.00		13.410	977.70 (857.60)		
52920	Nuclear Medicine study – with flow	04.00		6.020	438.90 (385.00)		
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					
53100	X-ray of the lumbar spine – stress study only	04.00				4.140	301.90 (264.80)
53110	X-ray of the lumbar spine, one or two views	04.00				3.560	259.60 (227.70)
53120	X-ray of the lumbar spine, more than two views	04.00				4.460	325.20 (285.30)
53130	X-ray of the lumbar spine, more that two views including stress views	04.00				7.520	548.30 (481.00)
53140	X-ray tomography lumbar spine	04.00				4.300	313.50 (275.00)
53160	X-ray myelography of the lumbar spine	04.00				23.940	1745.50 (1531.10)
53170	X-ray discography lumbar spine per level	04.00				25.170	1835.20 (1609.80)
53300	CT of the lumbar spine limited study	04.00				9.500	692.70 (607.60)
53310	CT of the lumbar spine – regional study	04.00				13.910	1014.20 (889.60)
53320	Ct of the lumbar spine complete study	04.00				37.640	2744.40 (2407.40)
53330	CT of the lumbar spine pre and post contrast	04.00				58.850	4290.90 (3763.90)
53340	CT myelography of the lumbar spine	04.00				49.110	3580.70 (3141.00)
53350	CT myelography of the lumbar spine following myelogram	04.00				23.460	1710.50 (1500.40)
53400	MR of the lumbar spine, limited study	04.00				46.200	3368.50 (2954.80)
53410	MR of the lumbar spine	04.00				64.320	4689.70 (4113.80)
53420	MR of the lumbar spine pre and post contrast	04.00				103.290	7531.10 (6606.20)
53900	Nuclear medicine study – Bone regional lumbar	04.00		21.500	1567.60 (1375.10)		
53910	Nuclear medicine study – Bone tomography regional lumbar	04.00		13.410	977.70 (857.60)		
53920	Nuclear medicine study – with flow	04.00		6.020	438.90 (385.00)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
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	261.00 (228.90)
54110	X-ray of the sacro-iliac joints	04.00				4.100	298.90 (262.20)
54120	X-ray tomography – sacrum and/or coccyx	04.00				4.300	313.50 (275.00)
54300	CT of the sacrum – limited study	04.00				7.600	554.10 (486.10)
54310	CT of the sacrum – complete study – uncontrasted	04.00				25.610	1867.30 (1638.00)
54320	CT of the sacrum with contrast	04.00				46.930	3421.80 (3001.60)
54330	CT of the sacrum pre and post contrast	04.00				52.970	3862.10 (3387.80)
54400	MR of the sacrum	04.00				65.000	4739.30 (4157.30)
54410	MR of the sacrum pre and post contrast	04.00				101.040	7367.00 (6462.30)
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	266.90 (234.10)
55110	X-ray tomography – pelvis	04.00				4.300	313.50 (275.00)
55300	CT of the bony pelvis limited	04.00				9.500	692.70 (607.60)
55310	CT of the bony pelvis complete uncontrasted	04.00				25.610	1867.30 (1638.00)
55320	CT of the bony pelvis complete 3D recon	04.00				37.470	2732.00 (2396.50)
55330	CT of the bony pelvis with contrast	04.00				46.930	3421.80 (3001.60)
55340	CT of the bony pelvis – pre and post contrast	04.00				52.970	3862.10 (3387.80)
55400	MR of the bony pelvis	04.00				65.000	4739.30 (4157.30)
55410	MR of the bony pelvis pre and post contrast	04.00				102.240	7454.50 (6539.00)
55900	Nuclear medicine study – Bone regional pelvis	04.00		21.500	1567.60 (1375.10)		
55910	Nuclear medicine study – Bone tomography regional pelvis	04.00		13.410	977.70 (857.60)		
55920	Nuclear medicine study – with flow	04.00		6.020	438.90 (385.00)		
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	231.90 (203.40)
56110	X-ray of the right hip	04.00				3.180	231.90 (203.40)
56120	X-ray pelvis and hips	04.00				6.020	438.90 (385.00)
56130	X-ray tomography – hip	04.00				4.300	313.50 (275.00)
56140	X-ray of the hip/s – stress study	04.00				4.380	319.40 (280.20)
56150	X-ray arthrography of the hip joint including introduction contrast	04.00				15.750	1148.40 (1007.40)
56160	X-ray guidance and introduction of contrast into hip joint only	04.00				7.410	540.30 (473.90)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
56200	Ultrasound of the hip joints	04.00				6.500	473.90 (415.70)
56300	CT of hip – limited	04.00				9.500	692.70 (607.60)
56310	CT of hip – complete	05.05				27.370	1995.60 (1750.50)
56320	CT of hip – complete with 3D recon	04.00				39.780	2900.40 (2544.20)
56330	CT of hip with contrast	04.00				43.260	3154.20 (2766.80)
56340	CT of hip pre and post contrast	04.00				47.880	3491.00 (3062.30)
56400	MR of the hip joint/s, limited study	04.00				44.900	3273.70 (2871.70)
56410	MR of the hip joint/s	04.00				64.100	4673.70 (4099.70)
56420	MR of the hip joint/s, pre and post contrast	04.00				101.640	7410.80 (6500.70)
56900	Nuclear medicine study – Bone regional pelvis	04.00		21.500	1567.60 (1375.10)		
56910	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
56920	Nuclear medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
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	329.60 (289.10)
60110	X-ray upper limbs - any region – tomography	04.00				4.300	313.50 (275.00)
60200	Ultrasound upper limb – soft tissue - any region	04.00				7.380	538.10 (472.00)
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler	04.00				13.640	994.50 (872.40)
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler	04.00				13.640	994.50 (872.40)
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis	04.00				12.540	914.30 (802.00)
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler	04.00				17.260	1258.50 (1103.90)
60300	CT of the upper limbs limited study	04.00				9.500	692.70 (607.60)
60310	CT angiography of the upper limb	04.00				78.280	5707.60 (5006.70)
60400	MR of the upper limbs limited study, any region	04.00				44.800	3266.50 (2865.40)
60410	MR angiography of the upper limb	04.00				74.660	5443.60 (4775.10)
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral	04.00				45.670	3329.90 (2921.00)
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral	04.00				82.670	6027.60 (5287.40)
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral	04.00				56.750	4137.80 (3629.60)
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral	04.00				88.110	6424.30 (5635.40)
60540	Venography, antegrade of upper limb veins, unilateral	04.00				26.120	1904.50 (1670.60)
60550	Venography, antegrade of upper limb veins, bilateral	04.00				49.430	3604.00 (3161.40)
60560	Venography, retrograde of upper limb veins, unilateral	04.00				31.010	2261.00 (1983.30)
60570	Venography, retrograde of upper limb veins, bilateral	04.00				54.810	3996.30 (3505.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
60580	Venography, shuntogram, dialysis access shunt	04.00				23.790	1734.60 (1521.60)
60900	Nuclear medicine study – Venogram upper limb	04.00		37.120	2706.50 (2374.10)		
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	221.70 (194.50)
61105	X-ray of the right clavicle	04.00				3.040	221.70 (194.50)
61110	X-ray of the left scapula	04.00				3.040	221.70 (194.50)
61115	X-ray of the right scapula	04.00				3.040	221.70 (194.50)
61120	X-ray of the left acromio-clavicular joint	04.00				3.140	228.90 (200.80)
61125	X-ray of the right acromio-clavicular joint	04.00				3.140	228.90 (200.80)
61128	X-ray of acromio-clavicular joints plus stress studies bilateral	04.00				7.680	560.00 (491.20)
61130	X-ray of the left shoulder	04.00				3.480	253.70 (222.50)
61135	X-ray of the right shoulder	04.00				3.480	253.70 (222.50)
61140	X-ray of the left shoulder plus subacromial impingement views	04.00				5.920	431.60 (378.60)
61145	X-ray of the right shoulder plus subacromial impingement views	04.00				5.920	431.60 (378.60)
61150	X-ray of the left subacromial impingement views only	04.00				3.240	236.20 (207.20)
61155	X-ray of the right subacromial impingement views only	04.00				3.240	236.20 (207.20)
61160	X-ray arthrography shoulder joint including introduction of contrast	04.00				15.830	1154.20 (1012.50)
61170	X-ray guidance and introduction of contrast into shoulder joint only	04.00				7.410	540.30 (473.90)
61200	Ultrasound of the left shoulder joint	04.00				6.500	473.90 (415.70)
61210	Ultrasound of the right shoulder joint	04.00				6.500	473.90 (415.70)
61300	CT of the left shoulder joint – uncontrasted	04.00				24.360	1776.10 (1558.00)
61305	CT of the right shoulder joint – uncontrasted	04.00				24.360	1776.10 (1558.00)
61310	CT of the left shoulder – complete with 3D recon	04.00				37.660	2745.90 (2408.70)
61315	CT of the right shoulder – complete with 3D recon	04.00				37.660	2745.90 (2408.70)
61320	CT of the left shoulder joint - pre and post contrast	04.00				48.630	3545.70 (3110.30)
61325	CT of the right shoulder joint - pre and post contrast	04.00				48.630	3545.70 (3110.30)
61400	MR of the left shoulder	04.00				64.640	4713.00 (4134.20)
61405	MR of the right shoulder	04.00				64.640	4713.00 (4134.20)
61410	MR of the left shoulder pre and post contrast	04.00				101.040	7367.00 (6462.30)
61415	MR of the right shoulder pre and post contrast	04.00				101.040	7367.00 (6462.30)
Humerus							
62100	X-ray of the left humerus	04.00				2.940	214.40 (188.10)
62105	X-ray of the right humerus	04.00				2.940	214.40 (188.10)
62300	CT of the left upper arm	04.00				24.360	1776.10 (1558.00)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
62305	CT of the right upper arm	04.00				24.360	1776.10 (1558.00)
62310	CT of the left upper arm contrasted	04.00				39.970	2914.30 (2556.40)
62315	CT of the right upper arm contrasted	04.00				39.970	2914.30 (2556.40)
62320	CT of the left upper arm pre and post contrast	04.00				48.580	3542.10 (3107.10)
62325	CT of the right upper arm pre and post contrast	04.00				48.580	3542.10 (3107.10)
62400	MR of the left upper arm	04.00				64.200	4681.00 (4106.10)
62405	MR of the right upper arm	04.00				64.200	4681.00 (4106.10)
62410	MR of the left upper arm pre and post contrast	04.00				102.040	7439.90 (6526.20)
62415	MR of the right upper arm pre and post contrast	04.00				102.040	7439.90 (6526.20)
62900	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
62905	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
62910	Nuclear medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
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	228.90 (200.80)
63105	X-ray of the right elbow	04.00				3.140	228.90 (200.80)
63110	X-ray of the left elbow with stress	04.00				4.340	316.40 (277.50)
63115	X-ray of the right elbow with stress	04.00				4.340	316.40 (277.50)
63120	X-ray arthrography elbow joint including introduction of contrast	04.00				15.890	1158.60 (1016.30)
63130	X-ray guidance and introduction of contrast into elbow joint only	04.00				7.410	540.30 (473.90)
63200	Ultrasound of the left elbow joint	04.00				6.500	473.90 (415.70)
63205	Ultrasound of the right elbow joint	04.00				6.500	473.90 (415.70)
63300	CT of the left elbow	04.00				24.360	1776.10 (1558.00)
63305	CT of the right elbow	04.00				24.360	1776.10 (1558.00)
63310	CT of the left elbow – complete with 3D recon	04.00				37.660	2745.90 (2408.70)
63315	CT of the right elbow – complete with 3D recon	04.00				37.660	2745.90 (2408.70)
63320	CT of the left elbow contrasted	04.00				39.970	2914.30 (2556.40)
63325	CT of the right elbow contrasted	04.00				39.970	2914.30 (2556.40)
63330	CT of the left elbow pre and post contrast	04.00				48.630	3545.70 (3110.30)
63335	CT of the right elbow pre and post contrast	04.00				48.630	3545.70 (3110.30)
63400	MR of the left elbow	04.00				64.640	4713.00 (4134.20)
63405	MR of the right elbow	04.00				64.640	4713.00 (4134.20)
63410	MR of the left elbow pre and post contrast	04.00				101.040	7367.00 (6462.30)
63415	MR of the right elbow pre and post contrast	04.00				101.040	7367.00 (6462.30)
63905	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
63910	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
63915	Nuclear medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
Forearm							
64100	X-ray of the left forearm	04.00				2.940	214.40 (188.10)
64105	X-ray of the right forearm	04.00				2.940	214.40 (188.10)
64110	X-ray peripheral bone densitometry	04.00				1.960	142.90 (125.40)
64300	CT of the left forearm	04.00				24.360	1776.10 (1558.00)
64305	CT of the right forearm	04.00				24.360	1776.10 (1558.00)
64310	CT of the left forearm contrasted	04.00				39.970	2914.30 (2556.40)
64315	CT of the right forearm contrasted	04.00				39.970	2914.30 (2556.40)
64320	CT of the left forearm pre and post contrast	04.00				48.580	3542.10 (3107.10)
64325	CT of the right forearm pre and post contrast	04.00				48.580	3542.10 (3107.10)
64400	MR of the left forearm	04.00				64.200	4681.00 (4106.10)
64405	MR of the right forearm	04.00				64.200	4681.00 (4106.10)
64410	MR of the left forearm pre and post contrast	04.00				98.040	7148.30 (6270.40)
64415	MR of the right forearm pre and post contrast	04.00				98.040	7148.30 (6270.40)
64900	Nuclear medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
64905	Nuclear medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
64910	Nuclear medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
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	224.60 (197.00)
65105	X-ray of the right hand	04.00				3.080	224.60 (197.00)
65110	X-ray of the left hand – bone age	04.00				3.080	224.60 (197.00)
65120	X-ray of a finger	04.00				2.670	194.70 (170.80)
65130	X-ray of the left wrist	04.00				3.180	231.90 (203.40)
65135	X-ray of the right wrist	04.00				3.180	231.90 (203.40)
65140	X-ray of the left scaphoid	04.00				3.300	240.60 (211.10)
65145	X-ray of the right scaphoid	04.00				3.300	240.60 (211.10)
65150	X-ray of the left wrist, scaphoid and stress views	04.00				7.560	551.20 (483.50)
65155	X-ray of the right wrist, scaphoid and stress views	04.00				7.560	551.20 (483.50)
65160	X-ray arthrography wrist joint including introduction of contrast	04.00				15.930	1161.50 (1018.90)
65170	X-ray guidance and introduction of contrast into wrist joint only	04.00				7.410	540.30 (473.90)
65200	Ultrasound of the left wrist	04.00				6.500	473.90 (415.70)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
65210	Ultrasound of the right wrist	04.00				6.500	473.90 (415.70)
65300	CT of the left wrist and hand	04.00				24.360	1776.10 (1558.00)
65305	CT of the right wrist and hand	04.00				24.360	1776.10 (1558.00)
65310	CT of the left wrist and hand - complete with 3D recon	04.00				37.660	2745.90 (2408.70)
65315	CT of the right wrist and hand - complete with 3D recon	04.00				37.660	2745.90 (2408.70)
65320	CT of the left wrist and hand contrasted	04.00				39.970	2914.30 (2556.40)
65325	CT of the right wrist and hand contrasted	04.00				39.970	2914.30 (2556.40)
65330	CT of the left wrist and hand pre and post contrast	04.00				48.630	3545.70 (3110.30)
65335	CT of the right wrist and hand pre and post contrast	04.00				48.630	3545.70 (3110.30)
65400	MR of the left wrist and hand	04.00				64.640	4713.00 (4134.20)
65405	MR of the right wrist and hand	04.00				64.640	4713.00 (4134.20)
65410	MR of the left wrist and hand pre and post contrast	04.00				101.040	7367.00 (6462.30)
65415	MR of the right wrist and hand pre and post contrast	04.00				101.040	7367.00 (6462.30)
65900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
65905	Nuclear Medicine study – bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
65910	Nuclear Medicine study – bone tomography regional	04.00		13.410	977.70 (857.60)		
Soft Tissue							
69900	Nuclear medicine study – Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	04.00		47.560	3467.70 (3041.80)		
69920	Nuclear medicine study – Infection localisation planar, static	04.00		18.040	1315.30 (1153.80)		
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies	04.00		31.450	2293.10 (2011.50)		
69930	Nuclear medicine study – Infection localisation planar, static and SPECT	04.00		31.450	2293.10 (2011.50)		
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		44.860	3270.80 (2869.10)		
69940	Nuclear medicine study – Regional lymph node mapping dynamic	04.00		6.020	438.90 (385.00)		
69945	Nuclear medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	04.00		37.510	2734.90 (2399.00)		
69955	Nuclear medicine study – Regional lymph node mapping SPECT	04.00		13.410	977.70 (857.60)		
69960	Nuclear medicine study – Lymph node localisation with gamma probe	04.00		13.410	977.70 (857.60)		
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	329.60 (289.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
70110	X-ray lower limbs - any region-tomography	04.00				4.300	313.50 (275.00)
70120	X-ray of the lower limbs full length study	04.00				6.460	471.00 (413.20)
70200	Ultrasound lower limb – soft tissue - any region	04.00				7.380	538.10 (472.00)
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler	04.00				13.640	994.50 (872.40)
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler	04.00				13.640	994.50 (872.40)
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis	04.00				13.640	994.50 (872.40)
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	1433.40 (1257.40)
70300	CT of the lower limbs limited study	04.00				9.500	692.70 (607.60)
70310	CT angiography of the lower limb	04.00				79.430	5791.40 (5080.20)
70320	CT angiography abdominal aorta and outflow lower limbs	04.00				98.340	7170.20 (6289.60)
70400	MR of the lower limbs limited study	04.00				46.400	3383.10 (2967.60)
70410	MR angiography of the lower limb	04.00				76.660	5589.40 (4903.00)
70420	MR angiography of the abdominal aorta and lower limbs	04.00				118.860	8666.30 (7602.00)
70500	Angiography of pelvic and lower limb arteries unilateral	04.00				40.590	2959.50 (2596.10)
70505	Angiography of pelvic and lower limb arteries bilateral	04.00				75.920	5535.50 (4855.70)
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral	04.00				61.230	4464.40 (3916.10)
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral	04.00				85.660	6245.60 (5478.60)
70520	Angiography translumbar aorta with full peripheral study	04.00				45.680	3330.60 (2921.60)
70530	Venography, antegrade of lower limb veins, unilateral	04.00				25.460	1856.30 (1628.30)
70535	Venography, antegrade of lower limb veins, bilateral	04.00				49.430	3604.00 (3161.40)
70540	Venography, retrograde of lower limb veins, unilateral	04.00				31.170	2272.70 (1993.60)
70545	Venography, retrograde of lower limb veins, bilateral	04.00				56.790	4140.70 (3632.20)
70560	Lymphangiography, lower limb, unilateral	04.00				51.040	3721.40 (3264.40)
70565	Lymphangiography, lower limb, bilateral	04.00				83.970	6122.40 (5370.50)
70900	Nuclear medicine study – Venogram lower limb	04.00		37.120	2706.50 (2374.10)		
Femur							
71100	X-ray of the left femur	04.00				2.940	214.40 (188.10)
71105	X-ray of the right femur	04.00				2.940	214.40 (188.10)
71300	CT of the left femur	04.00				24.520	1787.80 (1568.20)
71305	CT of the right femur	04.00				24.520	1787.80 (1568.20)
71310	CT of the left upper leg contrasted	04.00				41.830	3049.90 (2675.40)
71315	CT of the right upper leg contrasted	04.00				41.830	3049.90 (2675.40)
71320	CT of the left upper leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
71325	CT of the right upper leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
71400	MR of the left upper leg	04.00				64.800	4724.70 (4144.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
71405	MR of the right upper leg	04.00				64.800	4724.70 (4144.50)
71410	MR of the left upper leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
71415	MR of the right upper leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
71900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
71905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
71910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
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	202.00 (177.20)
72105	X-ray of the right knee one or two views	04.00				2.770	202.00 (177.20)
72110	X-ray of the left knee, more than two views	04.00				3.320	242.10 (212.40)
72115	X-ray of the right knee, more than two views	04.00				3.320	242.10 (212.40)
72120	X-ray of the left knee including patella	04.00				4.620	336.90 (295.50)
72125	X-ray of the right knee including patella	04.00				4.620	336.90 (295.50)
72130	X-ray of the left knee with stress views	04.00				5.820	424.30 (372.20)
72135	X-ray of the right knee with stress views	04.00				5.820	424.30 (372.20)
72140	X-ray of left patella	04.00				2.770	202.00 (177.20)
72145	X-ray of right patella	04.00				2.770	202.00 (177.20)
72150	X-ray both knees standing – single view	04.00				2.800	204.20 (179.10)
72160	X-ray arthrography knee joint including introduction of contrast	04.00				15.810	1152.70 (1011.10)
72170	X-ray guidance and introduction of contrast into knee joint only	04.00				7.410	540.30 (473.90)
72200	Ultrasound of the left knee joint	04.00				6.500	473.90 (415.70)
72205	Ultrasound of the right knee joint	04.00				6.500	473.90 (415.70)
72300	CT of the left knee	04.00				24.520	1787.80 (1568.20)
72305	CT of the right knee	04.00				24.520	1787.80 (1568.20)
72310	CT of the left knee complete study with 3D reconstructions	04.00				35.930	2619.70 (2298.00)
72315	CT of the right knee complete study with 3D reconstructions	04.00				35.930	2619.70 (2298.00)
72320	CT of the left knee contrasted	04.00				41.830	3049.90 (2675.40)
72325	CT of the right knee contrasted	04.00				41.830	3049.90 (2675.40)
72330	CT of the left knee pre and post contrast	04.00				49.760	3628.10 (3182.50)
72335	CT of the right knee pre and post contrast	04.00				49.760	3628.10 (3182.50)
72400	MR of the left knee	04.00				64.100	4673.70 (4099.70)
72405	MR of the right knee	04.00				64.100	4673.70 (4099.70)
72410	MR of the left knee pre and post contrast	04.00				100.840	7352.40 (6449.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
72415	MR of the right knee pre and post contrast	04.00				100.840	7352.40 (6449.50)
72900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
72905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
72910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
Lower Leg							
73100	X-ray of the left lower leg	04.00				2.940	214.40 (188.10)
73105	X-ray of the right lower leg	04.00				2.940	214.40 (188.10)
73300	CT of the left lower leg	04.00				24.520	1787.80 (1568.20)
73305	CT of the right lower leg	04.00				24.520	1787.80 (1568.20)
73310	CT of the left lower leg contrasted	04.00				41.830	3049.90 (2675.40)
73315	CT of the right lower leg contrasted	04.00				41.830	3049.90 (2675.40)
73320	CT of the left lower leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
73325	CT of the right lower leg pre and post contrast	04.00				49.710	3624.50 (3179.40)
73400	MR of the left lower leg	04.00				64.200	4681.00 (4106.10)
73405	MR of the right lower leg	04.00				64.200	4681.00 (4106.10)
73410	MR of the left lower leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
73415	MR of the right lower leg pre and post contrast	04.00				102.040	7439.90 (6526.20)
73900	Nuclear Medicine study – bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
73905	Nuclear Medicine study – bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
73910	Nuclear Medicine study – bone tomography regional	04.00		13.410	977.70 (857.60)		
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	242.10 (212.40)
74105	X-ray of the right ankle	04.00				3.320	242.10 (212.40)
74110	X-ray of the left ankle with stress views	04.00				4.520	329.60 (289.10)
74115	X-ray of the right ankle with stress views	04.00				4.520	329.60 (289.10)
74120	X-ray of the left foot	04.00				2.800	204.20 (179.10)
74125	X-ray of the right foot	04.00				2.800	204.20 (179.10)
74130	X-ray of the left calcaneus	04.00				2.740	199.80 (175.30)
74135	X-ray of the right calcaneus	04.00				2.740	199.80 (175.30)
74140	X-ray of both feet – standing – single view	04.00				2.800	204.20 (179.10)
74145	X-ray of a toe	04.00				2.670	194.70 (170.80)
74150	X-ray of the sesamoid bones one or both sides	04.00				2.800	204.20 (179.10)
74160	X-ray arthrography ankle joint including introduction of contrast	04.00				15.910	1160.00 (1017.50)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
74170	X-ray guidance and introduction of contrast into ankle joint	04.00				7.410	540.30 (473.90)
74210	Ultrasound of the left ankle	04.00				6.500	473.90 (415.70)
74215	Ultrasound of the right ankle	04.00				6.500	473.90 (415.70)
74220	Ultrasound of the left foot	04.00				6.500	473.90 (415.70)
74225	Ultrasound of the right foot	04.00				6.500	473.90 (415.70)
74290	Ultrasound bone densitometry	04.00				2.040	148.70 (130.40)
74300	CT of the left ankle/foot	04.00				24.520	1787.80 (1568.20)
74305	CT of the right ankle/foot	04.00				24.520	1787.80 (1568.20)
74310	CT of the left ankle/foot – complete with 3D recon	04.00				37.810	2756.80 (2418.20)
74315	CT of the right ankle/foot – complete with 3D recon	04.00				37.810	2756.80 (2418.20)
74320	CT of the left ankle/foot contrasted	04.00				41.830	3049.90 (2675.40)
74325	CT of the right ankle/foot contrasted	04.00				41.830	3049.90 (2675.40)
74330	CT of the left ankle/foot pre and post contrast	04.00				49.710	3624.50 (3179.40)
74335	CT of the right ankle/foot pre and post contrast	04.00				49.710	3624.50 (3179.40)
74400	MR of the left ankle	04.00				64.100	4673.70 (4099.70)
74405	MR of the right ankle	04.00				64.100	4673.70 (4099.70)
74410	MR of the left ankle pre and post contrast	04.00				100.640	7337.90 (6436.80)
74415	MR of the right ankle pre and post contrast	04.00				100.640	7337.90 (6436.80)
74420	MR of the left foot	04.00				64.200	4681.00 (4106.10)
74425	MR of the right foot	04.00				64.200	4681.00 (4106.10)
74430	MR of the left foot pre and post contrast	04.00				102.040	7439.90 (6526.20)
74435	MR of the right foot pre and post contrast	04.00				102.040	7439.90 (6526.20)
74900	Nuclear Medicine study – Bone limited/regional static	04.00		21.500	1567.60 (1375.10)		
74905	Nuclear Medicine study – Bone limited static plus flow	04.00		27.530	2007.30 (1760.80)		
74910	Nuclear Medicine study – Bone tomography regional	04.00		13.410	977.70 (857.60)		
Soft Tissue							
79900	Nuclear Medicine study – Tumour localisation planar, static	04.00		20.740	1512.20 (1326.50)		
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	04.00		35.170	2564.30 (2249.40)		
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	04.00		34.150	2489.90 (2184.10)		
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	04.00		47.560	3467.70 (3041.80)		
79920	Nuclear Medicine study – Infection localisation planar, static	04.00		18.430	1343.80 (1178.80)		
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	04.00		31.840	2321.50 (2036.40)		
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	04.00		31.840	2321.50 (2036.40)		
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	04.00		45.250	3299.30 (2894.10)		
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	04.00		6.020	438.90 (385.00)		
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	04.00		24.100	1757.20 (1541.40)		

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	04.00		37.510	2734.90 (2399.00)		
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	04.00		13.410	977.70 (857.60)		
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	04.00		13.410	977.70 (857.60)		
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	683.20 (599.30)
80605	Fine needle aspiration biopsy, any region	04.00				4.220	307.70 (269.90)
80610	Cutting needle, trochar biopsy, any region	04.00				6.360	463.70 (406.80)
80620	Tumour/cyst ablation chemical	04.00				25.370	1849.80 (1622.60)
80630	Tumour ablation radio frequency, per lesion	05.03				21.210	1546.50 (1356.60)
80640	Insertion of CVP line in radiology suite	04.00				8.990	655.50 (575.00)
80645	Peripheral central venous line insertion	05.03				12.120	883.70 (775.20)
80650	Infiltration of a peripheral joint, any region	05.03				6.400	466.60 (409.30)
	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					
Neuro intervention							
81600	Intracranial aneurysm occlusion, direct	04.00				214.520	15641.10 (13720.30)
81605	Intracranial arteriovenous shunt occlusion	04.00				254.820	18579.40 (16297.70)
81610	Dural sinus arteriovenous shunt occlusion	04.00				264.330	19272.80 (16906.00)
81615	Extracranial arteriovenous shunt occlusion	04.00				157.280	11467.60 (10059.30)
81620	Extracranial arterial embolisation (head and neck)	04.00				163.120	11893.40 (10432.80)
81625	Caroticocavernous fistula occlusion	04.00				192.290	14020.20 (12298.40)
81630	Intracranial angioplasty for stenosis, vasospasm	04.00				126.920	9254.00 (8117.50)
81632	Intracranial stent placement (including PTA)	05.03				133.720	9749.80 (8552.50)
81635	Temporary balloon occlusion test	04.00				83.420	6082.30 (5335.40)
	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	12991.50 (11396.10)
81645	Intracranial aneurysm occlusion with balloon remodelling	04.00				216.350	15774.50 (13837.30)
81650	Intracranial aneurysm occlusion with stent assistance	04.00				230.450	16802.60 (14739.10)
81655	Intracranial thrombolysis, catheter directed	04.00				58.940	4297.40 (3769.60)
	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	558.50 (489.90)
81665	Neurolysis, head and neck, per level	05.03				20.140	1468.40 (1288.10)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
81670	Nerve block, head and neck, radio frequency, per level	05.03				19.040	1388.20 (1217.70)
81680	Nerve block, coeliac plexus or other regions, per level	05.03				9.280	676.60 (593.50)
Thorax							
82600	Chest drain insertion	04.00				8.820	643.10 (564.10)
82605	Trachial, bronchial stent insertion	04.00				30.360	2213.60 (1941.80)
Gastrointestinal							
83600	Oesophageal stent insertion	04.00				31.220	2276.30 (1996.80)
83605	GIT balloon dilation	04.00				24.360	1776.10 (1558.00)
83610	GIT stent insertion (non-oesophageal)	04.00				32.020	2334.60 (2047.90)
83615	Percutaneous gastrostomy, jejunostomy	04.00				25.360	1849.00 (1621.90)
Hepatobiliary							
84600	Percutaneous biliary drainage, external	04.00				33.980	2477.50 (2173.20)
84605	Percutaneous external/internal biliary drainage	04.00				37.210	2713.10 (2379.90)
84610	Permanent biliary stent insertion	04.00				51.220	3734.60 (3276.00)
84615	Drainage tube replacement	04.00				20.220	1474.30 (1293.20)
84620	Percutaneous bile duct stone or foreign object removal	04.00				49.980	3644.10 (3196.60)
84625	Percutaneous gall bladder drainage	04.00				29.580	2156.70 (1891.80)
84630	Percutaneous gallstone removal, including drainage	04.00				69.250	5049.20 (4429.10)
84635	Transjugular liver biopsy	04.00				24.930	1817.70 (1594.50)
84640	Transjugular intrahepatic Portosystemic shunt	04.00				119.470	8710.80 (7641.10)
84645	Transhepatic Portogram including venous sampling, pressure studies	04.00				81.890	5970.80 (5237.50)
84650	Transhepatic Portogram with embolisation of varices	04.00				100.810	7350.30 (6447.60)
84655	Percutaneous hepatic tumour ablation	04.00				15.680	1143.30 (1002.90)
84660	Percutaneous hepatic abscess, cyst drainage	04.00				13.200	962.40 (844.20)
84665	Hepatic chemoembolisation	04.00				59.440	4333.90 (3801.70)
84670	Hepatic arterial infusion catheter placement	04.00				60.300	4396.60 (3856.70)
Urogenital							
85600	Percutaneous nephrostomy, external drainage	04.00				29.970	2185.20 (1916.80)
85605	Percutaneous double J stent insertion including access	04.00				40.820	2976.30 (2610.80)
85610	Percutaneous renal stone, foreign body removal including access	04.00				66.790	4869.80 (4271.80)
85615	Percutaneous nephrostomy tract establishment	04.00				29.270	2134.10 (1872.00)
85620	Change of nephrostomy tube	04.00				15.900	1159.30 (1016.90)
85625	Percutaneous cystostomy	04.00				16.520	1204.50 (1056.60)
85630	Urethral balloon dilatation	04.00				14.240	1038.30 (910.80)
85635	Urethral stent insertion	04.00				31.220	2276.30 (1996.80)
85640	Renal cyst ablation	04.00				11.920	869.10 (762.40)
85645	Renal abscess, cyst drainage	04.00				15.160	1105.30 (969.60)

Code	Description	Var	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
85655	Fallopian tube recanalisation	04.00				45.060	3285.40 (2881.90)
Spinal							
86600	Spinal vascular malformation embolisation	04.00				275.160	20062.50 (17598.70)
86605	Vertebroplasty per level	04.00				22.300	1625.90 (1426.20)
86610	Facet joint block per level, uni- or bilateral	05.03				9.540	695.60 (610.20)
	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	595.00 (521.90)
86620	Epidural block	04.00				9.420	686.80 (602.50)
86625	Chemonucleolysis, including discogram	04.00				18.320	1335.70 (1171.70)
86630	Spinal nerve ablation per level	04.00				11.600	845.80 (741.90)
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	4123.90 (3617.50)
87601	Percutaneous transluminal angioplasty: iliac	04.00				55.760	4065.60 (3566.30)
87602	Percutaneous transluminal angioplasty: femoropopliteal	04.00				60.160	4386.40 (3847.70)
87603	Percutaneous transluminal angioplasty: subpopliteal	04.00				73.340	5347.40 (4690.70)
87604	Percutaneous transluminal angioplasty: brachiocephalic	04.00				67.120	4893.90 (4292.90)
87605	Percutaneous transluminal angioplasty: subclavian, axillary	04.00				60.160	4386.40 (3847.70)
87606	Percutaneous transluminal angioplasty: extracranial carotid	04.00				71.620	5222.00 (4580.70)
87607	Percutaneous transluminal angioplasty: extracranial vertebral	04.00				73.300	5344.40 (4688.10)
87608	Percutaneous transluminal angioplasty: renal	04.00				87.690	6393.70 (5608.50)
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	04.00				87.690	6393.70 (5608.50)
87620	Aorta stent-graft placement	04.00				120.750	8804.10 (7722.90)
87621	Stent insertion (including PTA): aorta, IVC	04.00				73.870	5386.00 (4724.60)
87622	Stent insertion (including PTA): iliac	04.00				76.370	5568.30 (4884.50)
87623	Stent insertion (including PTA): femoropopliteal	04.00				77.970	5684.90 (4986.80)
87624	Stent insertion (including PTA): subpopliteal	04.00				84.550	6164.70 (5407.60)
87625	Stent insertion (including PTA): brachiocephalic	04.00				98.470	7179.60 (6297.90)
87626	Stent insertion (including PTA): subclavian, axillary	04.00				86.690	6320.70 (5544.50)
87627	Stent insertion (including PTA): extracranial carotid	04.00				106.990	7800.90 (6842.90)
87628	Stent insertion (including PTA): extracranial vertebral	04.00				100.550	7331.30 (6431.00)
87629	Stent insertion (including PTA): renal	04.00				98.590	7188.40 (6305.60)
87630	Stent insertion (including PTA): coeliac, mesenteric	04.00				98.590	7188.40 (6305.60)
87631	Stent-graft placement: iliac	04.00				76.370	5568.30 (4884.50)
87632	Stent-graft placement: femoropopliteal	04.00				77.970	5684.90 (4986.80)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
87633	Stent-graft placement: brachiocephalic	04.00				98.470	7179.60 (6297.90)
87634	Stent-graft placement: subclavian, axillary	04.00				82.770	6034.90 (5293.80)
87635	Stent-graft placement: extracranial carotid	04.00				120.430	8780.80 (7702.50)
87636	Stent-graft placement: extracranial vertebral	04.00				114.730	8365.20 (7337.90)
87637	Stent-graft placement: renal	04.00				98.590	7188.40 (6305.60)
87638	Stent-graft placement: coeliac, mesenteric	04.00				98.590	7188.40 (6305.60)
87650	Thrombolysis in angiography suite, per 24 hours	04.00				45.820	3340.80 (2930.50)
	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	5663.10 (4967.60)
87652	Atherectomy, per vessel	04.00				91.890	6699.90 (5877.10)
87653	Percutaneous tunnelled / subcutaneous arterial or venous central or other line insertion	05.03				28.150	2052.50 (1800.40)
87654	Thrombolysis follow-up	04.00				23.570	1718.50 (1507.50)
87655	Percutaneous sclerotherapy, vascular malformation	04.00				21.100	1538.40 (1349.50)
87660	Embolisation, mesenteric	04.00				100.430	7322.60 (6423.30)
87661	Embolisation, renal	04.00				99.360	7244.50 (6354.80)
87662	Embolisation, bronchial, intercostal	04.00				108.340	7899.30 (6929.20)
87663	Embolisation, pulmonary arteriovenous shunt	04.00				103.220	7526.00 (6601.80)
87664	Embolisation, abdominal, other vessels	04.00				101.440	7396.20 (6487.90)
87665	Embolisation, thoracic, other vessels	04.00				97.600	7116.20 (6242.30)
87666	Embolisation, upper limb	04.00				90.920	6629.20 (5815.10)
87667	Embolisation, lower limb	04.00				92.140	6718.10 (5893.10)
87668	Embolisation, pelvis, non-uterine	04.00				117.120	8539.50 (7490.80)
87669	Embolisation, uterus	04.00				113.880	8303.20 (7283.50)
87670	Embolisation, spermatic, ovaria veins	04.00				85.820	6257.30 (5488.90)
87680	Inferior vena cava filter placement	04.00				61.840	4508.90 (3955.20)
87681	Intravascular foreign body removal	04.00				85.030	6199.70 (5438.30)
87682	Revision of access port (tunnelled or implantable)	05.03				14.120	1029.50 (903.10)
87683	Removal of access port (tunnelled or implantable)	05.04				11.120	810.80 (711.20)
87690	Superior petrosal venous sampling	04.00				73.010	5323.30 (4669.60)
87691	Pancreatic stimulation test	04.00				89.790	6546.80 (5742.80)
87692	Transportal venous sampling	04.00				76.950	5610.60 (4921.60)
87693	Adrenal venous sampling	04.00				55.010	4010.90 (3518.30)
87694	Parathyroid venous sampling	04.00				86.660	6318.60 (5542.60)
87695	Renal venous sampling	04.00				55.010	4010.90 (3518.30)

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
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
	Contrast Index Price Range - 2004 contrast prices						04.00
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>>						04.00
ANNEXURE D. PET GUIDELINES							
A.	**INDICATIONS**						
	For the purposes of this guideline, only established indications for PET-CT are included and this relates to the more common types of malignancies as seen in practice. While some of the less common forms of cancer may also yield advantages with PET-CT imaging, there is as yet insufficient published data to support the general use and these have been excluded in the list below. This situation may change as new research and information becomes available.						09.00
	1. Non-small cell lung carcinoma (NSCC) a) Primary diagnosis of lesions i. >10mm diameter lesions where conventional imaging and biopsy have been inconclusive. b) Staging especially where curative surgery is planned i. Evaluation of primary tumour (T-stage). ii. Suspected nodal disease or characterization of nodal disease iii. Suspected distal metastases of determining extent of metastases. iv. Solitary distal metastasis where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery. c) Investigation of suspected recurrence (restaging) i. Local or regional recurrence ii. Nodal or distal recurrence iii. Determine the extent of proven recurrent disease iv. Differentiate fibrotic mass from active disease d) All patients with proven carcinoma of the lung, who are considered for curative resection, should be imaged with PETCT prior to surgery. e) Current available literature confirms that PET-CT is more accurate than CT or PET alone for staging and restaging of NSCC.						09.00
	2. Hodgkin's and Non-Hodgkin's Lymphoma a) Single most accurate imaging modality for Hodgkins and Non-Hodgkins lymphoma. b) Staging i. All patients prior to commencing treatment as baseline, following diagnosis. ii. Indicated at completion of therapy to confirm complete response. c) Monitoring of response to treatment i. Numerous studies have confirmed that mid-treatment PET scans predict clinical outcome. ii. Prognostic value and role in modification of therapeutic regime. d) Investigation of residual or recurrent disease (restaging) i. Where conventional imaging is equivocal for residual disease. ii. Suspected nodal recurrence. iii. Differentiating recurrent and residual disease from post-therapeutic fibrosis and scarring.						09.00
	3. Thyroid carcinoma a) Not indicated for primary diagnosis. b) Staging i. Primary examination of choice is I-123 whole body scintigraphy. ii. Only indicated for differentiated and medullary carcinoma of the thyroid in patients with negative I-123, but with a high index of suspicion for nodal or distal metastases on cross sectional imaging or where whole body I-123 scan is equivocal. c) Investigation of residual or recurrent disease (restaging) i. Elevated thyroglobulin despite negative whole body scintigraphy for differentiated thyroid carcinoma. ii. Elevated calcitonin levels and equivocal imaging findings for medullary thyroid carcinoma. iii. Solitary distal metastasis where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery.						09.00

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	4. Head and neck carcinoma a) Primary diagnosis i. There is little, if any, role for PET-CT in primary diagnosis of mucosal lesions. ii. Limited to identifying primary tumour in histologically proven metastatic squamous cell carcinoma in cervical nodes. b) Staging of the primary tumour prior to therapy i. Local nodes which are equivocal on CI (conventional imaging). ii. Suspected distal adenopathy iii. Suspected distal metastases iv. All patients where uni- or bilateral surgery is planned (may alter management and approach by up to 50% and is significantly more accurate than CT alone). v. Excellent sensitivity (95%) for local and distal nodal disease (specificity in local disease may be affected by physiological uptake). c) Investigation of residual or recurrent disease (restaging) i. Differentiating fibrosis and recurrence where routine imaging is equivocal and may reduce the number of equivocal findings by up to 50%. ii. Following neo-adjuvant therapy for re-staging. iii. Suspected local or distal recurrence. iv. Differentiating post-therapeutic changes from residual or recurrent tumours poses significant problems for CT and MRI. PET-CT is significantly more accurate than routine cross sectional imaging in this regard.						09.00
	5. Breast cancer a) There is no role for PET-CT in the primary diagnosis, sentinel node mapping or imaging of locally contained node negative tumours. b) No role for carcinoma-in-situ. c) PET-CT imaging is limited to patients with infiltrating ductal carcinoma. d) Staging i. Only indicated if there is a significant chance of distal disease as determined by axillary dissection or where conventional imaging is equivocal. ii. Can result in up to 57% change of stage and management compared to other CI (conventional imaging). iii. High accuracy (86% vs. 77% for CT alone) for nodal and distal metastases in patient with infiltrating ductal carcinoma. e) Investigation of recurrent disease (restaging) i. Suspected local or regional recurrence. ii. Suspected nodal or distal metastatic recurrence. iii. Differentiate post therapeutic fibrosis from recurrent or residual tumour. iv. Significantly more accurate for nodal and distal recurrence than conventional imaging.						09.00
	6. Colorectal cancer a) No role in the diagnosis of the primary tumour. b) Accurate for staging (89%) and restaging (88%) c) Staging i. Suspected distal nodal metastases where conventional imaging is equivocal, particularly distal nodes. ii. Suspected distal metastases. iii. Evaluation of suspected single metastases considered for curative surgical resection to exclude concomitant disease. iv. May result in changes in treatment in up to 27% of patients. d) Investigation of residual or recurrent disease (restaging) i. Suspected local pelvic or distal recurrence. ii. Differentiate local and distal post therapeutic changes from residual and recurrent disease. iii. Evaluate and restage following neo-adjuvant therapy. iv. Evaluate patients with rising tumour markers and normal or equivocal conventional imaging.						09.00
	7. Stomach carcinoma - GIST a) In GIST tumours FDG tracer uptake is established. i. Indicated to determine response to treatment as determined by tumour activity on PET-CT measuring tracer uptake (SUV). ii. Paradigm shift in assessing tumour responses to treatment. iii. Response to Imatinib (Gleevec) can be predicted with 18FFDG as early as 24h after commencing treatment and long before any change in tumour size is demonstrated on conventional imaging. iv. Baseline study before commencing treatment is essential to determine degree of tracer uptake for post-treatment comparison. b) Variable uptake of tracer in other stomach tumours, which is difficult to explain and to predict. Routine imaging is not supported in other types of stomach tumours, at this stage.						09.00
	8. Testicular Carcinoma a) Complex histology and variable uptake of different histological sub-groups. b) Limited to seminoma and teratoma in the following cases: i. Evaluate residual mass to differentiate residual/recurrent tumour from fibrosis. ii. Suspected recurrence but normal or equivocal conventional imaging findings.						09.00
	9. Oesophageal carcinoma a) Not indicated for primary diagnosis. b) Staging for nodal and distal metastases (90% accurate) i. Indicated for N-staging, particularly where there is suspected distal nodal disease or where conventional imaging is equivocal. ii. Indicated for M- staging where distal metastases are suspected. iii. Strongly indicated for patient undergoing curative surgery to exclude distal disease. c) Investigation of residual or recurrent disease (restaging) i. Restaging for patients who have undergone neo-adjuvant chemotherapy. ii. Suspected local or distal recurrent disease. iii. Differentiate post therapeutic fibrosis from recurrent or residual disease.						09.00

Code	Description	Ver	Add	Nuclear Medicine		Radiology	
				RVU	Fee	RVU	Fee
	10.Melanoma a) No role in primary diagnosis which is primarily a surgical/histological diagnosis. b) Staging is determined by depth of penetration of the primary tumour and presence of sentinel node at surgery. i. Indicated for Stage 3 and 4 disease where there is a high incidence of distal nodal and metastatic disease. ii. Solitary distal metastasis on conventional imaging where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery. iii. Overall N and M staging is significantly more accurate than conventional imaging (97% vs 80%). c) Investigation of recurrent disease (restaging) i. Modality of choice for recurrent nodal and distal metastatic disease. ii. Differentiate post therapeutic fibrosis from recurrent or residual disease. d) PET-CT may alter management in up to 34% of patients with Stage III and IV disease.						09.00
	11.Ovarian carcinoma a) Most cases present as advanced disease. b) Recurrence is frequent and the overall 5-y survival for advanced disease is only 17%. c) Diagnosis and initial staging require a laparotomy as small peritoneal deposits may be difficult to demonstrate on imaging i. PET-CT is indicated where surgical or conventional imaging findings are equivocal for primary staging. ii. PET-CT is accurate for demonstrating nodal and distal disease. iii. Sensitivity is limited by size of peritoneal deposits. It is more accurate for macroscopic disease. d) Investigation of recurrent disease (restaging) i. Superior to CT and MRI for recurrence (92% sens. and 75% spec.). ii. Alternative to a second look laparotomy (presents significant cost saving potential). iii. Definite role for patients with rising tumour marker where conventional imaging is negative for recurrence.						09.00
	12.Carcinoma of unknown primary a) By definition, unknown primary tumors are those that remain undetected after all diagnostic resources have been used. b) PET-CT may detect up to 57% primary tumours when conventional cross sectional imaging has been negative. c) PET-CT is indicated where conventional imaging has failed to identify a primary malignancy.						09.00
B.	**LIMITED VALUE AND RELATIVE CONTRAINDICATIONS**						
	These conditions are those where there is variable or poor uptake of the tracer FDG or where imaging is routinely performed with tracers other than FDG which are not locally available. This may result in false negative findings using FDG and the routine use of PET-CT should be discouraged.						09.00
	1. Urological Malignancy a) No role in diagnosis and staging of renal cell carcinoma b) Prostate limited to suspected recurrence in histologically proven high grade tumours. Prostate is ideally imaged with Choline as tracer. c) No role for diagnosis and staging of bladder carcinoma 2. Broncho-alveolar cell carcinoma 3. Small cell carcinoma of the lung 4. Hepatocellular carcinoma 5. Sarcomas 6. Neuro-endocrine tumours 7. Anaplastic thyroid carcinoma which is Grade 4 by definition, at diagnosis. 8. Suspected brain tumours where MRI is more sensitive and specific. 9. Tumours with large mucinous components. 10.Lobular carcinoma of the breast						09.00
	In addition to these tumours, imaging should be used with caution in patients who are diabetic or who have recently used high doses of cortico-steroids.						09.00

REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES

Registered Nurses In Private Practice and Nursing Agencies 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY REGISTERED NURSES IN PRIVATE PRACTICE AND NURSING AGENCIES, EFFECTIVE FROM 1 JANUARY 2009

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
005	Individual consultation, counseling, planning and/or assessment. 5 - 15 minutes.	09.01		2.747	22.50 (19.70)	10.000	50.80 (44.60)
006	Individual consultation, counseling, planning and/or assessment. 16 - 30 minutes.	09.01		6.180	50.60 (44.40)	22.500	114.40 (100.40)
001	Individual consultation, counseling, planning and/or assessment. 31 - 45 minutes.	09.01		10.300	84.30 (73.90)	37.500	190.70 (167.30)
002	Individual consultation, counseling, planning and/or assessment. 46+ minutes.	06.03		14.200	116.20 (101.90)	52.500	266.90 (234.10)
014	For emergency consultation/visit, all hours - See General Rule 2.	04.00				7.700	63.00 (55.30)
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	37.70 (33.10)	4.600	37.70 (33.10)
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	37.70 (33.10)	4.600	37.70 (33.10)
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	37.70 (33.10)	4.600	37.70 (33.10)
452	Immunisation	04.00				3.000	24.60 (21.60)
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.	05.02		24.300	198.90 (174.50)	24.300	198.90 (174.50)
036	When a SRN returns to add medication to an existing IV infusion	05.02		12.200	99.90 (87.60)	12.200	99.90 (87.60)
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	349.50 (306.60)		
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	505.00 (443.00)		
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	30.30 (26.60)		
037	Enrolled nurse, per hour	05.03		5.100	41.70 (36.60)		
038	Registered nurse, per hour	05.03		6.460	52.90 (46.40)		

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	72.00 (63.20)	8.800	72.00 (63.20)
041	Treatment of extensive wounds/bums requiring extensive nursing management eg irrigation, etc.	04.00		12.400	101.50 (89.00)	12.400	101.50 (89.00)
042	Treatment of moderate wounds/Burns eg drains or fistulas and inserting of sutures	04.00		11.000	90.00 (78.90)	11.000	90.00 (78.90)
045	Laser treatment for wound healing where prescribed by medical practitioner	04.00		7.670	62.80 (55.10)	7.670	62.80 (55.10)
RESPIRATORY SYSTEM.							
050	Nebulization/Inhalation.	04.00		3.800	31.10 (27.30)	3.800	31.10 (27.30)
051	Tracheostomy care.	04.00		7.900	64.70 (56.80)	7.900	64.70 (56.80)
052	Peak flow measurement.	04.00		3.100	25.40 (22.30)	3.100	25.40 (22.30)
	For ICU trained nurses registered with SANC as such and nurses working in the occupational health setting but not for a company. (Item 053)	04.00					
053	Flow volume test: inspiration/expiration using ELF/similar machine.	04.00				13.100	107.20 (94.00)
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	188.30 (165.20)
061	Performing ECG only.	04.00				4.600	37.70 (33.10)
062	Effort test - bicycle.	04.00				16.900	138.30 (121.30)
063	Effort test - multistage treadmill.	04.00				38.400	314.30 (275.70)
MUSCULOSKELETAL SYSTEM.							
070	Application or removal splints and prosthesis.	04.00		3.900	31.90 (28.00)	3.900	31.90 (28.00)
071	Application or removal of traction	04.00		7.700	63.00 (55.30)	7.700	63.00 (55.30)
072	Application of skin traction	04.00		7.700	63.00 (55.30)	7.700	63.00 (55.30)
GASTRO INTESTINAL SYSTEM.							
080	Nasogastric tube insertion, feeding and removal.	04.00		9.200	75.30 (66.10)	9.200	75.30 (66.10)
082	Enema administration	04.00		4.800	39.30 (34.50)	4.800	39.30 (34.50)
083	Aspiration of stomach/gastric lavage.	04.00				6.900	56.50 (49.60)
084	Faecal impaction/manual removal.	04.00		8.700	71.20 (62.50)	8.700	71.20 (62.50)
URINARY SYSTEM.							
090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying.	04.00		9.500	77.80 (68.20)	9.500	77.80 (68.20)
091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal.	04.00		5.800	47.50 (41.70)	5.800	47.50 (41.70)
093	Incontinence management (30 minutes) This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and teaching.	04.00		9.500	77.80 (68.20)	9.500	77.80 (68.20)
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	131.80 (115.60)	16.100	131.80 (115.60)

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	39.30 (34.50)	4.800	39.30 (34.50)
	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	39.30 (34.50)	4.800	39.30 (34.50)
200	Simple stoma - a well constructed, sited stoma which is easy to pouch. Very little or no peristomal skin excoriation.	04.00		8.800	72.00 (63.20)	8.800	72.00 (63.20)
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	101.50 (89.00)	12.400	101.50 (89.00)
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	90.00 (78.90)	11.000	90.00 (78.90)
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	1022.30 (896.80)	124.900	1022.30 (896.80)
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	1123.00 (985.10)	137.200	1123.00 (985.10)
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	1308.80 (1148.10)	159.900	1308.80 (1148.10)
250	Clinic visits after 6 months per half hour plus one procedure - eg irrigation, enema, etc. - plus material	04.00		10.000	81.90 (71.80)	10.000	81.90 (71.80)
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	1726.20 (1514.20)
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	2255.00 (1978.10)
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	604.10 (529.90)

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	738.30 (647.60)
402	Fourth Stage.	04.00				12.300	100.70 (88.30)
405	Phototherapy, per day	04.00				15.400	126.00 (110.50)
406	Visit to patient during first stage labour (may not be charged in conjunction with item 400)	04.00				10.000	81.90 (71.80)
410	Assisting at delivery (if a medical practitioner/midwife is requested to take over delivery due to complications during a home delivery)	09.01				27.600	225.90 (198.20)
420	Ante natal visits (excluding ante-natal exercises), per visit	04.00				7.700	63.00 (55.30)
421	Post natal visits (excluding post- natal exercises), per visit	04.00				11.500	94.10 (82.50)
425	Ante-natal or post-natal exercise classes, per patient	06.03				6.200	50.70 (44.50)
For advanced midwives registered with SANC only:							
404	Cardiotocography	04.00				10.000	81.90 (71.80)
WELL BABY CLINICS							
	Emergency equipment must be available in the baby clinic						04.00
450	Consultation	04.00				4.800	39.30 (34.50)
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	176.80 (155.10)
501	Individual therapy. (irrespective of time)	04.00				30.700	251.30 (220.40)
502	Family/marital/group per patient - specify number.	04.00				6.200	50.70 (44.50)
503	Play therapy/Home stimulation programme.	04.00				16.900	138.30 (121.30)
504	Co-therapist.	04.00				16.900	138.30 (121.30)
RENAL DIALYSIS							
092	Peritoneal dialysis per day	04.00		16.900	138.30 (121.30)	16.900	138.30 (121.30)
608	Home dialysis training in centre per 30 minutes	04.00		16.000	131.00 (114.90)	16.000	131.00 (114.90)
610	Home dialysis training or follow up at patient's home per 30 minutes (to maximum of 24 hours)	04.00		28.200	230.80 (202.50)	28.200	230.80 (202.50)
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	523.80 (459.50)	64.000	523.80 (459.50)
MEDICINES AND MATERIALS							
301	Consumables used, and charged according to rule 05	05.03		-	-	-	-

SOCIAL WORKERS

Social Workers 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SOCIAL WORKERS, EFFECTIVE FROM 1 JANUARY 2009

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	26.30 (23.10)
201	Social worker consultation, counselling and/or therapy. Duration: 11-20min.	05.03		1.500	78.80 (69.10)
202	Social worker consultation, counselling and/or therapy. Duration: 21-30min.	05.03		2.500	131.40 (115.30)
203	Social worker consultation, counselling and/or therapy. Duration: 31-40min.	05.03		3.500	183.90 (161.30)
204	Social worker consultation, counselling and/or therapy. Duration: 41-50min.	05.03		4.500	236.40 (207.40)
205	Social worker consultation, counselling and/or therapy. Duration: 51-60min.	05.03		5.500	289.00 (253.50)
206	Social worker consultation, counselling and/or therapy. Duration: 61-70min.	05.03		6.500	341.50 (299.60)
207	Social worker consultation, counselling and/or therapy. Duration: 71-80min.	05.03		7.500	394.10 (345.70)
208	Social worker consultation, counselling and/or therapy. Duration: 81-90min.	05.03		8.500	446.60 (391.80)
209	Social worker consultation, counselling and/or therapy. Duration: 91-100min.	05.03		9.500	499.10 (437.80)

Code	Description	Ver	Add	Social Workers	
				RVU	Fee
210	Social worker consultation, counselling and/or therapy. Duration: 101-110min.	05.03		10.500	551.70 (483.90)
211	Social worker consultation, counselling and/or therapy. Duration: 111-120min.	05.03		11.500	604.20 (530.00)
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	5.25 (4.61)
301	Social worker group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	05.03		0.300	15.80 (13.90)
302	Social worker group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	05.03		0.500	26.30 (23.10)
303	Social worker group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	05.03		0.700	36.80 (32.30)
304	Social worker group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	05.03		0.900	47.30 (41.50)
305	Social worker group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	05.03		1.100	57.80 (50.70)
306	Social worker group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	05.03		1.300	68.30 (59.90)
307	Social worker group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	05.03		1.500	78.80 (69.10)
308	Social worker group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	05.03		1.700	89.30 (78.30)
309	Social worker group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	05.03		1.900	99.80 (87.50)
310	Social worker group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	05.03		2.100	110.30 (96.80)
311	Social worker group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	05.03		2.300	120.80 (106.00)

SPEECH THERAPY AND AUDIOLOGY

Speech Therapists and Audiologists 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR SERVICES BY SPEECH THERAPISTS AND AUDIOLOGISTS, EFFECTIVE FROM 1 JANUARY 2009

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 1800 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.	09.00
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	RVU	Fee
1010	Audiology consultation. Duration 5 - 15 mins	09.00				10.000	60.20 (52.80)
1011	Audiology consultation. Duration 16 - 30 mins	06.02				22.500	135.40 (118.80)
1012	Audiology consultation. Duration 31 - 45 mins	06.02				37.500	225.70 (198.00)
1013	Audiology consultation. Duration 46 - 60 mins	06.02				52.500	316.00 (277.20)
1015	Prolonged audiology consultation, each additional full 15 mins, to a maximum of 60 mins	06.02				15.000	90.30 (79.20)
1.1.2	**Speech Therapy Consultations**						
1020	Speech therapy consultation. Duration 5 - 15 mins	09.00		10.000	61.00 (53.50)		
1021	Speech therapy consultation. Duration 16 - 30 mins	06.02		22.500	137.20 (120.40)		
1022	Speech therapy consultation. Duration 31 - 45 mins	06.02		37.500	228.70 (200.60)		
1023	Speech therapy consultation. Duration 46 - 60 mins	06.02		52.500	320.20 (280.90)		
1.2	**Assessment & Treatment**						
1.2.1	**Speech Therapy Assessment & Treatment**						
1050	Speech therapy assessment and treatment. Duration 5 - 15 mins	09.03		10.000	61.00 (53.50)		
1051	Speech therapy assessment and treatment. Duration 16 - 30 mins	06.02		22.500	137.20 (120.40)		

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
1052	Speech therapy assessment and treatment. Duration 31 - 45 mins	06.02		37.500	228.70 (200.60)		
1053	Speech therapy assessment and treatment. Duration 46 - 60 mins	06.02		52.500	320.20 (280.90)		
2.	**Speech, Voice, Language and Hearing Disorders**						
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy)	06.02		15.000	91.50 (80.30)		
	Note: Professional Group Consultations - no fee to be charged.	04.00					
0009	Preparation of a home programme	06.02		15.000	91.50 (80.30)		
	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	183.00 (160.50)	30.000	180.60 (158.40)
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	Air conduction, pure tone audiogram	09.00				15.000	103.30 (90.60)
	Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of the tone that the patient can heard 50 percent of the time, is recorded for a number of frequencies on each ear. The air and bone conduction thresholds are compared to differentiate between conductive, sensorineural, or mixed hearing losses. Cannot be used with codes 1900;1120; 1121.						
1105	Bone conduction pure tone audiogram	09.00				12.000	82.60 (72.50)
	Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. In pure tone audiometry, earphones are placed and the patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of the tone that the patient can hear 50 percent of the time, is recorded for a number of frequencies on each ear. Bone thresholds (1105) are obtained in a similar manner except a bone oscillator is used on the mastoid or forehead to conduct the sound instead of tones through earphones. The air and bone thresholds are compared to differentiate between conductive, sensorineural, or mixed hearing losses. Cannot be used with codes 1905; 1120;1121.						
1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277)	09.00				15.000	103.30 (90.60)
	Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves unique to that specific diagnosis. In speech audiometry, earphones are placed and the patient is asked to repeat bisyllabic (spondee) words. The softest level at which the patient can correctly repeat 50 percent of the spondee words is called the speech reception threshold. The threshold is recorded for each ear in 1115. The process occurs in 1110, in addition to a speech threshold test in 1115. The word discrimination score in 1110 is the percentage of spondee words that a patient can repeat correctly at a given intensity level above his or her speech reception threshold. This is also measured for each ear at two ore more intensities per ear. Cannot be used with codes 1910;1122;1115.						
1115	Speech audiogram screening	09.00				5.000	34.40 (30.20)
	Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves unique to that specific diagnosis. In speech threshold audiometry, earphones are placed and the patient is asked to repeat bisyllabic (spondee) words. The softest level at which the patient can correctly repeat 50 percent of the spondee words is called the speech reception threshold. The threshold is recorded for each ear in 1115. The process can occur alone (as screening procedure) or in addition to a speech discrimination test (as in 1110). Cannot be used with codes 1110;1915.						
1120	Visual reinforcement audiometry (VRA)	09.00				40.000	281.40 (246.80)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	Visual reinforcement audiometry (VRA) is used to test hearing in infants and in both difficult-to-test children and adults. The process includes case history and otologic examination, typically conducted in a sound booth. Lighted toys are used as reinforcement for response to auditory stimuli. Stimuli may include frequency-specific signals, calibrated noises, or live voice. The results are usually recorded on an audiogram. The interpretation o f the testing addresses the type and the severity of hearing loss and any recommendations. Two audiologists perform this procedure. Cannot be used with codes 1100;1105; 1121.						
1121	Conditioning play audiometry	09.00				40.000	281.40 (246.80)
	Often physicians or technicians can diagnose a cause or hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. Conditioning play audiometry tests pure tone air and bone conduction and speech thresholds in children. Test sounds can be presented with earphones or sound field testing (pure tone air conduction only). The child is conditioned to perform a simple task (i.e. drop a block in a bucket) when the test sound is heard. Two audiologists perform this procedure. Cannot be used with codes 1100;1105; 1120.						
1122	Select picture audiometry	09.00				40.000	281.40 (246.80)
	In select picture audiometry, the patient is placed in a booth w or w/out earphones. Patient is asked to identify different pictures with the instructions given at different intensity levels. A threshold level for speech, which is the intensity level at which the patient responds correctly 50% of the time, is obtained. Two audiologists perform this procedure. Cannot be used with codes 1110;1115.						
1125	Tinnitus Evaluation	09.00				15.000	103.30 (90.60)
	Earphones are placed and tones of the same pitch but different intensities are presented to each ear (binaural) or tones of different intensities and pitches are presented to the same ear (monaural). The patient is asked to compare the loudness of the tones with the pitch and intensity levels of tinnitus that he/she experiences. Similarities with tinnitus in intensities and pitch that are perceived by the patient as the same as the tinnitus are measured. The narrow band noise or white noise masking intensity and pitch that cancels out the perceived tinnitus is also measured.						
B.	**Middle Ear Function Evaluation**						
1200	Tympanometry	09.00				8.000	52.10 (45.70)
	Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. Tympanometry varies the pressure in the external ear canal and identifies the pressure at which maximum sound transmission occurs. This corresponds to current middle ear pressure status. The pressures are recorded and compared to normal values. Cannot be used with code 1215.						
1205	Immittance Measurements - Impedance / Stapedial reflex (3276): Limited reflex spectrum (eg : 1-2 frequencies)	09.00				4.000	26.00 (22.80)
	The audiologist places a probe in one ear (ipsilateral ear) to measure the impedance of the middle ear and places an earphone on the patient's opposite ear (contralateral ear). A loud sound is presented in either the contralateral or ipsilateral ear and the change in impedance caused by the contraction of the stapedius is measured. Cannot be used with code 1210.						
1210	Immittance Measurements - Impedance / Stapedial reflex (3276): Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies)	09.00				12.000	78.10 (68.50)
	The audiologist places a probe in one ear (ipsilateral ear) to measure the impedance of the middle ear and places an earphone on the patient's opposite ear (contralateral ear). A loud sound is presented in either the contralateral or ipsilateral ear and the change in impedance caused by the contraction of the stapedius is measured. Cannot be used with code 1205.						
1215	High Frequency Tympanometry (impedance testing) - for peadiatric population	09.00				8.000	52.10 (45.70)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	The audiologist places a probe in one ear (ipsilateral ear) to measure the impedance of the middle ear and places an earphone on the patient's opposite ear (contralateral ear). A loud sound is presented in either the contralateral or ipsilateral ear and the change in impedance caused by the contraction of the stapedius is measured. A different probe tone frequency must be used for the pediatric population which requires a separate or combined piece of equipment Cannot be used with code 1200.						
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral	09.00				12.000	78.10 (68.50)
	Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. Tympanometry varies the pressure in the external ear canal and identifies the pressure at which maximum sound transmission occurs. This corresponds to current middle ear pressure status. The pressures are recorded and compared to normal values. For Eustachian tube function testing three tympanograms are performed for each ear in three different pressure conditions namely 1. Tympanogram with normal pressure applied 2. Tympanogram with Valsalva maneuver 3. Tympanogram with Toynbee maneuver (swallow). The specialized equipment displays the results of the three test graphically in comparison with each other.						
1225	Rinné & Weber tests	09.00				4.000	27.50 (24.10)
	Tuning fork tests that can be performed with different tuning forks or with the bone conductor (oscillator) through the diagnostic audiometer. It is performed to confirm the presence or not of an air-bone gap as measured with pure tone air and bone conduction audiometry. This is an important result for pre - operative considerations. This test uses the Weber and Rinne tuning fork tests to differentiate conductive from sensory-neural hearing loss.						
C.	**Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology**						
1300	Tone Decay (for retro cochlear pathology)	09.00				8.000	55.10 (48.30)
	Earphones are placed. A tone is presented to a patient at a volume above the patient's lower hearing level for that time. Measurements are made of the time that tone is audible or the increase in volume needed to maintain an audible tone over time. This is performed at different frequencies. .These measurements are compared to establish norms and can be reported at different tone frequencies. Abnormal results are indicative of retro-cochlear pathology.						
1305	Reflex decay (for retro cochlear pathology)	09.00				8.000	52.10 (45.70)
	The audiologist places a probe to measure impedance in one ear (ipsilateral ear) and places an earphone on the other ear (contralateral ear). A loud tone is presented to one of the ears and maintained for 10 seconds. The impedance change (acoustic reflex) is measured by the probe. In a normal ear, the reflex persists for 10 seconds. In an abnormal ear, the reflex diminishes at least 50% in the first five seconds.						
1310	Short Increment Sensitivity Index (SISI)	09.00				5.000	34.40 (30.20)
	Earphones are placed and tones are presented to the patient. The loudness of the tones is increased in small increments. The patient is tested on the ability to detect slight changes in loudness. A percentage of the correctly identified loudness changes are recorded. Results above a specific percentage indicates cochlear pathology.						
1315	Most comfortable levels (MCL) & Uncomfortable levels (UCL) : Air conduction	09.00				8.000	55.10 (48.30)
	Most comfortable levels & Uncomfortable levels - for cochlear pathology and/or for purposes of selection of hearing aid technology or hearing aid programming. Earphones are placed and tones are above threshold are presented to the patient. The loudness of the tones is increased in small increments. The patient is asked to judge where the loudness levels at different frequencies are at the most comfortable intensities. Another series of tests are performed level where the patient is asked to judge the level of the perceived sound as uncomfortable loudness level at different frequencies. Results below a specific level could be indicative of cochlear pathology. This result is also a very important prerequisite for hearing aid programming at comfortable levels.						
1320	Most comfortable levels (MCL) & Uncomfortable levels (UCL) : Speech thresholds	09.00				4.000	27.50 (24.10)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	Most comfortable levels & Uncomfortable levels - for cochlear pathology and/or for purposes of selection of hearing aid technology or hearing aid programming. In speech threshold audiometry, earphones are placed and the patient is asked to listen to bisyllabic (spondee) words at different intensity levels. The patient has to judge the levels at which the speech is perceived as the most comfortable as well as uncomfortable. These results are recorded and used to compare with other speech tests to get information about the patient's 'dynamic speech discrimination range'. It give information about retro-cochlear pathology (a possible 'roll-over' speech audiogram as a result) or cochlear pathology (loudness recruitment). It also gives information about prognosis with hearing amplification and indicates whether further examinations are necessary. The process can occur in addition to a speech discrimination test or to a (as in 1110 or 1115).						
1325	Test for functional hearing loss	09.00				10.000	68.90 (60.40)
	The test is for pseudohypacusis (malingering) and includes special tests and techniques such as the Lombard test, 'Count the tones- technique', 'confusion' test, etc in addition to conventional hearing tests procedures. Description of the Lombard test: This is principally a test for pseudophypacusis (malingering). The patient reads a passage into a microphone while the audiologist makes noise (masking) in earphones the patient is wearing. The patient's voice volume while reading is measured as the masking level is increased. If the patient increases his or her voice volume with the increase in masking as is normal, it is assumed that the noise (masking) was heard by the patient. This level may prove to be lower than the patient had previously volunteered.						
1331	Stenger test, pure tone	09.00				5.000	34.40 (30.20)
	The test is for unilateral pseudohypacusis (malingering). It is based on the principle that if two sounds of the same frequency but different intensities are presented simultaneously to both ears, only the louder tone will be heard. Tones are presented to the good ear at a level above that ear's threshold to obtain a response. Tones are presented to the poor ear simultaneously. The intensity of the sound in the poor ear is then increased while the intensity presented to the good ear remains the same. The patient will respond until the intensity of the tones in the poor ear exceeds that of the good ear. At that point, the patient will not respond because the patient is not supposed to hear out o f the poor ear. However, the patient should still respond, as the intensity of presentation the good ear has not changed.						
1332	Stenger test, speech	09.00				5.000	34.40 (30.20)
	This is a test for unilateral pseudohypacusis (malingering). It is based on the principle that if two sounds of the same frequency and different intensities are presented simultaneously to both ears, only the louder will be heard. Bisyllabic (spondee) words are presented to the good ear at a level above that ear's threshold to respond. Then words are presented simultaneously to the poor ear. The intensity of the words in the poor ear is then increased while the intensity presented to the good ear remains the same. The patient will respond until the intensity of the words in the poor ear exceeds that of the good ear.						
1335	Fistula test - (for peri-lymph fluid leakage)	09.00				15.000	103.30 (90.60)
	This test combination is performed exactly: As a pure tone air conduction test (as in 1100) and as the complete speech audiometry test (as in 1110). In cases where a perilymph fistel leakage is suspected this test may be performed or on special request from a ENT-surgeon. Firstly tests 1100 and 1110 must be performed. Thereafter the patient has to lie down for 30 minutes on his or her right or left side in the sound proof booth with the affected ear turned upwards. After 30 minutes the tests 1100 and 1110 are repeated. Results are recorded and compared with results in the sitting position. If there are prescribed significant changes between the sitting and the lying positions, a diagnosis of the presence of a perilymph fistel in the affected ear can be made.						

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	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. Deviations from this billing guideline requires motivation. 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)						09.00
1400	Central Auditory Processing Disorders test, test to be specified.	09.00				13.000	91.50 (80.30)
	The audiologist evaluates central auditory function. Central auditory processes are the auditory mechanisms that are responsible for what the brain does with what the ears hear. Many individuals have no difficulty detecting the presence of sound but have other auditory difficulties related to central auditory processes such as understanding conversation in noisy environments, following complex directions, and learning new vocabulary words. There are two major categories of tests: behavioral tests and electrophysiologic tests. The behavioral tests can be monotonic of dichotic. Monotonic tests use a single stimulus presented to one ear at a time or test in which two stimuli are presented to one ear. Dichotic tests use the same stimulus applied to both ears. Testing may be performed on only one ear (monaural) or both ears simultaneously (binaural). Specific types of tests that can be given include monaural low-redundancy speech tests; dichotic speech tests; temporal patterning tests and binaural interaction tests. The audiologist selects the appropriate battery of central auditory function tests after evaluating the patient using routine hearing tests. Central auditory function tests are used to differentiate central from peripheral hearing loss and occasionally to identify the site of a lesion in the central nervous system.						
E.	**Electro-Physiological Examinations/Auditory Evoked Potentials (AEP)**						
1500	Diagnostic Neurological short latency ABR (Auditory Brainstem Response) Bilateral; single decibel (2692)	09.00				60.000	422.20 (370.40)
	Auditory evoked potentials (AEPs) enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulation. The origin of the ABR is believed to be the auditory nerve and brainstem. The neurological ABR is recorded using supra-threshold click stimuli. It enables evaluation of the integrity of auditory neural pathway and synchronicity of auditory stimuli from the cochlear to the brainstem. The audiologist interprets the results of the tests.						
1505	AABR - Bilateral (Automated Auditory Brainstem Response). Cannot be charged with 1510	09.00				30.000	195.30 (171.30)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulation. The origin of the ABR is believed to be the auditory nerve and brainstem. AABR makes use of objective response detection. A single, low intensity click stimulus is presented and the software interprets the resulting waveform (using a template and/or statistical significance as reference) as a pass (response present) or refer (response absent). AABR is used for hearing screening purposes. Cannot be used together with item 1510.						
1510	Screening ABR - Bilateral (Auditory Brainstem Response) . Cannot be charged with 1505	09.00				20.000	130.20 (114.20)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the ABR is believed to be the auditory nerve and brainstem. A single, low intensity click stimulus is presented and the resulting waveform is interpreted by the audiologist as a pass (response present) or refer (response absent). This ABR is used for hearing screening purposes. The audiologist interprets the results of the tests. Cannot be used together with item 1505.						
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli	09.00				60.000	422.20 (370.40)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the ABR is believed to be the auditory nerve and brainstem. By varying the click stimulus intensity, the threshold response can be determined. Objective threshold determination using click ABR correlates well with psycho-acoustic hearing threshold at high frequencies. The audiologist interprets the results of the tests.						
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli	09.00				80.000	562.90 (493.80)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the ABR is believed to be the auditory nerve and brain stem. Bone conduction ABR testing is used to determine whether middle ear pathology is present or is used in the case of patients with no external ear. An additional bone oscillator in used with the standard ABR equipment. By varying the bone conduction stimulus intensity, the threshold response can be determined. Objective threshold determination using bone conduction ABR correlates well with psycho-acoustic sensorineural hearing threshold. The procedure for bone ABR is an additional procedure and may be determined at different frequencies. The audiologist interprets the results of the tests.						
	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	09.00				30.000	211.10 (185.20)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the electrical response is believed to be the auditory nerve and brainstem. Brief tones of different frequencies can be used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using tone burst ABR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1532;1533;1534.						
1532	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	09.00				60.000	422.20 (370.40)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the electrical response is believed to be the auditory nerve and brainstem. Brief tones of different frequencies can be used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using tone burst ABR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1531;1533;1534.						
1533	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	09.00				90.000	633.20 (555.40)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the electrical response is believed to be the auditory nerve and brainstem. Brief tones of different frequencies can be used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using tone burst ABR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1531;1532;1534.						
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	09.00				120.000	844.30 (740.60)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the electrical response is believed to be the auditory nerve and brainstem. Brief tones of different frequencies can be used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using tone burst ABR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests.						
	Combinations of items 1541 to 1544 cannot be billed together.	06.02					
1541	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 1 frequency	09.00				25.000	175.90 (154.30)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The MLAEP and SCAEP follow the ABR in latency and their origin is therefore the higher up the auditory pathway than ABR (ranging from the auditory brainstem to auditory cortex). Tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using these AEP correlate well with psycho-acoustic hearing threshold. The MLAEP and SCAEP may also be used to determine the site and / or nature of auditory-neural pathology. The audiologist interprets the results of the tests. Cannot be used together with items 1542;1543;1544.						
1542	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies	09.00				50.000	351.80 (308.60)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The MLAEP and SCAEP follow the ABR in latency and their origin is therefore the higher up the auditory pathway than ABR (ranging from the auditory brainstem to auditory cortex). Tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using these AEP correlate well with psychoacoustic hearing threshold. The MLAEP and SCAEP may also be used to determine the site and / or nature of auditory-neural pathology. The audiologist interprets the results of the tests. Cannot be used together with items 1541;1543;1544.						
1543	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies	09.00				75.000	527.70 (462.90)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The MLAEP and SCAEP follow the ABR in latency and their origin is therefore the higher up the auditory pathway than ABR (ranging from the auditory brainstem to auditory cortex). Tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using these AEP correlate well with psychoacoustic hearing threshold. The MLAEP and SCAEP may also be used to determine the site and / or nature of auditory-neural pathology. The audiologist interprets the results of the tests. Cannot be used together with items 1541;1542;1544.						
1544	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses(2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies	09.00				100.000	703.60 (617.20)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The MLAEP and SCAEP follow the ABR in latency and their origin is therefore the higher up the auditory pathway than ABR (ranging from the auditory brainstem to auditory cortex). Tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the toneburst stimulus intensity (at one frequency), the threshold response can be determined. Objective threshold determination using these AEP correlate well with psycho-acoustic hearing threshold. The MLAEP and SCAEP may also be used to determine the site and / or nature of auditory-neural pathology. The audiologist interprets the results of the tests. Cannot be used with items 1541;1542;1543.						
	Combinations of items 1551 to 1554 cannot be billed together.	06.02					
1551	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 1 frequency	09.00				30.000	211.10 (185.20)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The ASSEP is an evoked by continuous stimuli characterized by periodic amplitude and frequency modulation of a carrier frequency. Continuous tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the stimulus intensity (at one frequency), the threshold response can be determined. ASSR makes use of objective response detection, where the software interprets the resulting waveform (using a statistical measure of significance or correlation) to determine whether a response is present or absent. Objective threshold determination using the ASSR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests.. Cannot be used together with items 1552;1553;1554.						
1552	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 2 frequencies	09.00				40.000	281.40 (246.80)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The ASSEP is an evoked by continuous stimuli characterized by periodic amplitude and frequency modulation of a carrier frequency. Continuous tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the stimulus intensity (at one frequency), the threshold response can be determined. ASSR makes use of objective response detection, where the software interprets the resulting waveform (using a statistical measure of significance or correlation) to determine whether a response is present or absent. Objective threshold determination using the ASSR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1551;1553;1554.						
1553	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 3 frequencies	09.00				60.000	422.20 (370.40)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The ASSEP is an evoked by continuous stimuli characterized by periodic amplitude and frequency modulation of a carrier frequency. Continuous tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the stimulus intensity (at one frequency), the threshold response can be determined. ASSR makes use of objective response detection, where the software interprets the resulting waveform (using a statistical measure of significance or correlation) to determine whether a response is present or absent. Objective threshold determination using the ASSR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1551;1552; 1554.						
1554	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 4 frequencies	09.00				80.000	562.90 (493.80)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The ASSEP is an evoked by continuous stimuli characterized by periodic amplitude and frequency modulation of a carrier frequency. Continuous tones of different frequencies are used to objectively evaluate frequency specific hearing sensitivity. By varying the stimulus intensity (at one frequency), the threshold response can be determined. ASSR makes use of objective response detection, where the software interprets the resulting waveform (using a statistical measure of significance or correlation) to determine whether a response is present or absent. Objective threshold determination using the ASSR correlates well with psycho-acoustic hearing threshold. The audiologist interprets the results of the tests. Cannot be used together with items 1551;1552;1553.						
1560	P300 Cognitive AEP (Auditory Evoked Potential) or MMN (Mismatch Negativity)	09.00				35.000	246.30 (216.10)
	AEPs enable objective evaluation of the auditory system. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The P300 and MMN are electrophysiological assessments of auditory processing of changes in auditory stimuli at the cognitive level. As such stimuli, be it tonal or speech stimuli, are presented at supra-threshold levels. These AEPs are not correlates of psycho-acoustic hearing threshold.						
1565	Electrocochleography: unilateral (2699)	09.00				45.000	316.60 (277.70)
	An electrode is placed through the tympanic membrane into the promontory of the inner ear. An alternative method is to use a electrode that can be placed against the tympanic membrane. The ear is stimulated and recordings are made of the electrical response of the cochlear nerve. This can be done under local, topical or general anesthesia or in the case of the electrode against the tympanic membrane, no anesthesia. Cannot be charged with item 1570.						
1570	Electrocochleography: bilateral (2700)	09.00				90.000	633.20 (555.40)
	An electrode is placed through the tympanic membrane into the promontory of the inner ear. An alternative method is to use a electrode that can be placed against the tympanic membrane. The ear is stimulated and recordings are made of the electrical response of the cochlear nerve. This can be done under local, topical or general anesthesia or in the case of the electrode against the tympanic membrane, no anesthesia. Cannot be charged with item 1565.						
1575	Cochlear nerve function test - intra-operative monitoring - per 30min	09.00				30.000	211.10 (185.20)
	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) - Bilateral Air conduction threshold determination using click stimuli. Electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations. The origin of the electrical response is believed to be the auditory nerve and brain stem. Test is only performed during neuro-otology ear or balance surgery (with ENT-surgeon and neuro-surgeon)- where the nerve could be damaged eg 'acoustic neuroma tumor removal, facial nerve tumor removal,, vestibular neurectomy . By this procedure or monitoring of the hearing/nerve the audiologist warns the surgeons if there are any changes in hearing nerve activity during surgery in order to preserve and not damage the nerve during surgery. The Audiologist interprets the results of the tests. Duration charged for cannot exceed the duration of the operation.						
1580	Evoked otoacoustic emissions (OAE); limited	09.00				15.000	93.90 (82.40)
	Single stimulus level, either transient or distortion products. A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound. The clicking sound passes through the tympanic membrane, middle ear, and then to the inner ear. In the inner ear, the sound is picked up by the hair cells in the cochlea. Computerized equipment is then able to record an echo off the hair cell in the cochlea. 1580 of the test is limited to a single stimulus level. Report 1580 of the test is limited to a single stimulus level. Cannot be used together with item 1581.						
1581	Evoked otoacoustic emissions (OAE): comprehensive	09.00				30.000	195.30 (171.30)
	A comprehensive diagnostic evaluation. A probe tip is placed in the ear canal. The probe tip emits a repeated clicking sound. The clicking sound passes through the tympanic membrane, middle ear, and then to the inner ear. In the inner ear, the sound is picked up by the hair cells in the cochlea. Computerized equipment is then able to record an echo off the hair cell in the cochlea. Report 1581 if the test is comprehensive or a diagnostic evaluation. Cannot be used together with item 1580.						

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
F.	**Balance/Vestibular Examinations and Treatment**						
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253).	09.00				55.000	387.00 (339.50)
	Nystagmus is uncontrolled rapid movement of the eyeball in a horizontal, vertical, or rotary motion. It can be a symptom of a disturbance in the patient's vestibular system and can be induced to measure the difference between the patient's right and left vestibular functions. ENG (electronystagmography) electrodes are placed and the patient is asked to look straight ahead, 30 degrees to 45 degrees to the right, and 30 degrees to 45 degrees to the left.Computerized recordings are made to detect spontaneous nystagmus. The patient is placed in a variety of positions, including supine with head extended dorsally, left, and right and sitting, in an attempt to induce nystagmus. Cannot be used with item 1605						
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG	09.00				55.000	407.30 (357.30)
	Positional Nystagmus Nystagmus is uncontrolled rapid movement of the eyeball in a horizontal, vertical, or rotary motion. It can be a symptom o f a disturbance in the patient's vestibular system and can be induced to measure the difference between the patient's right and left vestibular functions. The patient is placed in a variety of positions, including supine with head extended dorsally, left, and right and sitting, in an attempt to induce nystagmus. Computerized recordings are made to detect spontaneous nystagmus. When using VNG (Videonystagmography) a infrared camera with video goggles and Eye TV monitor are used to detect recordings. VNG is highly diagnostic for disorders that produce a torsional eye movement (BPPV with positive Dix Hallpike). Cannot use with item 1600.						
1610	Eye Visualization – spontaneous and positional nystagmus – monocular	09.00				35.000	219.20 (192.30)
	Provides both still and full motion video recording of eye position and eye movement for the diagnosis and treatment of vestibular and ocular motility disorders. It is video based and hence generates a video record of the eye as long as a tape recording is made. It is highly diagnostic for disorders that produce a torsional eye movement (BPPV with positive Dix Hallpike).						
1615	Videonystagmoscopy: spontaneous and positional nystagmus. (Only camera/goggles, without computerised VNG software)	09.00				35.000	227.90 (199.90)
	Provides both still and full motion video recording of eye position and eye movement for the diagnosis and treatment of vestibular and ocular motility disorders. It is video based and hence generates a video record of the eye as long as a tape recording is made. It is highly diagnostic for disorders that produce a torsional eye movement (BPPV with positive Dix Hallpike). Cannot be used together with items 1600;1605.						
1620	Oculo-motor/central tests using electro-nystagmography (ENG)	09.00				25.000	185.10 (162.40)
	Consists of: - Saccade Test - Smooth Pursuit Test - Optokinetic Test - Gaze Nystagmus Test Cannot be used with item 1625.						
1625	Oculo-motor/central tests using video-nystagmography (VNG)	09.00				25.000	185.10 (162.40)
	Consists of: - Saccade Test - Smooth Pursuit Test - Optokinetic Test - Gaze Nystagmus Test Cannot be used with item 1620.						
1630	DVA (Dynamic Visual Acuity) test using Video-nystagmography (VNG)	09.00				10.000	74.10 (65.00)
	The dynamic visual acuity (DVA) test provides a functional measure of oscillopsia in patients with vestibular loss. It is sensitive to changes in both peripheral and central vestibular function, and can detect unilateral vestibular loss in the plane of the head rotation. Subjects are asked to read a Snellen chart with the head stationary, and then during rapid head rotations. Visual stimuli in the later conditions are presented only with the head moving at a predetermined velocity that, at the relatively high rotational frequencies used, elicits a robust VOR to compensate for head motion. If visual acuity drops 2 log MAR during head rotation in any direction, the test indicates that the patient is experiencing oscillopsia due to poor compensation for head motion.						
1635	Caloric test using ENG electro-nystagmography (3255)	09.00				50.000	370.30 (324.80)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	Nystagmus is uncontrolled rapid movement of the eyeball in a horizontal, vertical, or rotary motion. It can be a symptom o f a disturbance in the patient's vestibular system and can be induced to measure the difference between the patient's right and left vestibular functions. In this test, each ear is separately irrigated with cold water and then warm water to create nystagmus in the patient. ENG recordings are evaluated to detect any difference between the nystagmus of the right side and the life side. Four irrigations occur: a warm and cold irrigation for both the right and the left ear. Cannot be used with item 1640.						
1640	Caloric test using VNG electro-nystagmography (3255)	09.00				50.000	370.30 (324.80)
	Nystagmus is uncontrolled rapid movement of the eyeball in a horizontal, vertical, or rotary motion. It can be a symptom o f a disturbance in the patient's vestibular system and can be induced to measure the difference between the patient's right and left vestibular functions. In this test, each ear is separately irrigated with cold water and then warm water to create nystagmus in the patient. ENG recordings are evaluated to detect any difference between the nystagmus of the right side and the life side. Four irrigations occur: a warm and cold irrigation for both the right and the left ear. Cannot be used with item 1635.						
1645	Posturography	09.00				25.000	185.10 (162.40)
	Computerized posturography tests a patient's sensory organization, motor control, evoked postural responses (EMG), and sway patterns to assess balance and postural instability by systematic manipulation of somatosensory and visual information. The patient is placed in the posturography system. The system is made up of a force plate that controls foot support and a visual surround reference that can be controlled. Force transducers measure the vertical and horizontal force output of the patient's feet. The patient's center-of-force is used as an estimate of body sway during testing. A sway bar and potentiometer is placed at the pelvis and shoulder, which measures anterior-posterior position. Displacement of the visual surround is changes as the ankle angel is changed. In the posture portion of posturography, the support surface rotates faster than the body can move, producing a sway and ankle rotation that is opposite of what normally occurs in a standing position on a fixed surface. This exaggerated sway produced a stretching of the ankle joint, which is recorded as three surface EMG signals form the gastrocnemius and tibialis anterior muscles of the legs to a computer that records the data. Patient with normal function will maintain balance while patients with a disturbance of balance will elicit abnormal results. The EMG portion of posturography along with the sensory organization and motor control tests help differentiate between the possible diagnoses causing the patient's imbalance and postural instability.						
1650	Rotational Chair test	09.00				15.000	97.70 (85.70)
	Nystagmus is uncontrolled rapid movement of the eyeball in a horizontal, vertical, or rotary motion. It can be a symptom o f a disturbance in the patient's vestibular system and can be induced to measure the difference between the patient's right and left vestibular functions. The patients is seated in a rotary chair with the head bent forward 30 degrees. ENG electrodes or a VNG Video goggles with infrared camera are placed to measure nystagmus while the chair is rotated with the patient's eyes closed. A recording is made and studied to determine and abnormal labyrinthi response on one side or the other						
1655	Otolith repositioning/canalith maneuvre	06.02				25.000	150.50 (132.00)
1660	Vestibular rehabilitation (neuromuscular) re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception	06.02				25.000	150.50 (132.00)
G.	**Cochlear Implant Tests**						
1700	Cochlear Implants: Pre-implant round window promontory testing	09.00				45.000	293.00 (257.00)
	In cases where speech tests were not possible because of very limited speech and language acquisition (e.g. prelingually deaf adults) This test is designed to determine if electrical stimulation of the auditory nerve will result in sound. It involves stimulating the promontory with small pulses. A physician inserts an electrode through the eardrum under local anaesthetic. The audiologist delivers small amounts of electrical current at different frequencies and the patient indicate when they hear a sound.						
1710	Cochlear Implants : Electrode mapping : per 15min (max 120min)	09.00				15.000	111.10 (97.50)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	The audiologist programs the speech processor based on the patient's responses to computer generated sounds delivered to the implant. As the useful dynamic range for electrical stimulation is relatively narrow and varies across patients and electrodes there is a need to individually tailor the amplitudes of electrical stimulation for each patient. Psychophysical measurements establish the useful range for each electrode and this information is stored digitally in the patient's speech processor. This process of mapping is crucial in providing maximum speech information through the multi channel cochlear implant.						
1720	Cochlear Implants : Implant test : Four test modes : intra- or post-operatively	09.00				5.000	34.40 (30.20)
	Electrode impedance is performed to confirm integrity of the implant electrodes.						
1725	Cochlear Implants : Neural Response Telemetry : intra-operatively (during cochlear implant surgery)	09.00				20.000	148.10 (129.90)
	The NRT tool provides a simple way to directly record neural responses. Information from NRT gives the audiologist or surgeon confirmation that the cochlear implant is effectively stimulating the hearing nerve fibres in the inner ear. During NRT testing, an electrical signal is sent to the implant electrode and the activity of the hearing nerve fibres is recorded. This non-invasive, objective test is quicker and easier than other standard methods and does not require sedation or the use of external recording electrodes.						
1730	Cochlear Implants : Neural Response Telemetry : post-operatively (after cochlear implant surgery)	09.00				55.000	378.80 (332.30)
	NRT measurements assist clinicians in selecting and optimising initial programming parameters - speeding and simplifying the programming of young children. NRT uses radiofrequency telemetry technology to measure the action potentials of the auditory nerve. The test can be performed at any time by connecting a speech processor to a programming system running the NRT software on a computer. A pulse is delivered from one electrode to the hearing nerve fibres in the inner ear. The hearing nerve fibres respond to the pulse. The implant system sends the response back to the computer which collects the information. The steps are repeated to build a profile of the responsiveness of the hearing nerve fibres at different sites on the electrode array.						
1735	Cochlear Implants : Electrical Stapedius Reflex Thresholds : intra-operatively only	09.00				13.000	96.30 (84.50)
	The stapedius reflex is measured in response to electrical stimulation within the cochlea by direct observation during surgery. The use of electrically evoked stapedius reflex thresholds (eSRT) has been suggested as a useful means for creating a cochlear implant speech processor programme.						
1740	Cochlear Implants : Comprehensive speech perception testing, pre- and post-cochlear implant, per 15min (max 45min)	09.00				15.000	105.50 (92.50)
	The desired outcomes for patients using cochlear implants relate to improved speech perception. A vast array of test are used to determine progress and assist in programming. (92601-92602). A diagnostic analysis of a cochlear implant including programming is done post-operatively to fit the previously placed external devices, connect to the implant and programmed. Cochlear implants are equipped with software that allows for different programming specific to the patient's daily activities. Threshold levels, volume, pulse widths, live-voice speech adjustments, input of dynamic range and frequency shaping templates are evaluated and set according to the individual's needs. This is done for patients older than 7 years of age in 92603 Patients older than 7 years of age are able to provide significant feedback for fine-tuning adjustment. Report 92604 for subsequent modifications or reprogramming.						
H.	**Hearing Amplification / Hearing Aids**						
1800	Hearing aid evaluation - per ear	09.00				15.000	93.90 (82.40)
	Evaluation of pure tone thresholds and/ or speech thresholds with one or more hearing aid per ear is done to ascertain the effectiveness of a hearing aid for a specific hearing loss or in comparison to another hearing aid other See Rule B.						
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading)	09.00				13.000	91.50 (80.30)

Code	Description	Ver	Add	Speech Therapy		Audiology	
				RVU	Fee	RVU	Fee
	Evaluation of pure tone thresholds in a sound field environment:The patient is asked to respond to tones of different pitches (frequencies) and intensities. The threshold, which is the lowest intensity of the tone that the patient can hear 50 percent of the time, is recorded for a number of frequencies on each ear. This will be done with a hearing aid inserted in the ear to ascertain the effectiveness of a hearing aid. Evaluation of speech audiometry in a sound field environment : The patient is asked to repeat bisyllabic (spondee) words. The softest level at which the patient can correctly repeat 50 percent of the spondee words is called the speech reception threshold. The threshold is recorded for each ear . The word discrimination score is the percentage of spondee words that a patient can repeat correctly at a given intensity level above his or her speech reception threshold. This is also measured for each ear with the hearing aid inserted to ascertain its effectiveness.						
1810	Insertion gain measurement, per ear	09.00				10.000	65.10 (57.10)
	Electro acoustic evaluation for hearing aid. A physical hearing aid examination with hearing aid in patient's ear and connected to an Insertion Gain meter comparing the unaided in situ measurement with the aided in situ measurement. Instrument used to compare the electro acoustical characteristics of a monaural hearing aid with the specifications for that aid.						
1815	Re-programming of hearing aid, per ear	09.00				10.000	62.60 (54.90)
	A hearing aid would be connected to the Hi-Pro box, and/or the patients ears/ears as well as connected to a computer to reprogramme the parameters of said instrument.						
1820	Technical adjustment of hearing aid/device, per ear.	09.00				6.000	37.60 (33.00)
	The audiologist inspects the hearing aid and checks the battery. The aid is cleaned and the power and clarity are checked using a special stethoscope, which attaches to the hearing aid. These may also include re-tubing of an ear mould, drilling into an ear mould or hearing aid, reshaping of an ear mould or hearing aid.						
1825	Repairs to hearing aids	06.02				-	-
1830	Global charge for supply and fitting of hearing aid and follow-up (By arrangement with scheme).	09.00				-	-
	This would include the charge of supplying which includes the initial measurement for the instrument as well as the fitting to ensure good fitting and programming of said instrument to suit the hearing requirements of a patient as per evaluation.						
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		-	-	-	-

SUBACUTE FACILITIES

Sub Acute Facilities 2009

DRAFT NATIONAL REFERENCE PRICE LIST IN RESPECT OF PRIVATE SUB ACCUTE FACILITIES WITH A "049" PRACTICE NUMBER, WITH EFFECT FROM 1 JANUARY 2009

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	Fee
001	Ward fee, per day	04.00		10.000	817.70 (717.30)

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	182.10 (159.70)
105	General care (ward/supporting facilities and equipment)	04.00		10.286	841.10 (737.80)
	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	852.90 (748.20)
005	General ward fee: under 5 hours stay	04.00		2.266	185.30 (162.50)
007	General ward fee: without ovemight stay	04.00		5.392	440.90 (386.80)

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. To charged using the appropriate NAPPI code.				09.00
284	PWV area	04.00		-	-
710	Cape Town	04.00		-	-
711	Port Elizabeth	04.00		-	-
712	East London	04.00		-	-
713	Durban	04.00		-	-
714	Other areas	04.00		-	-

TISSUE TRANSPORTATION

Tissue Transportation 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR TISSUE TRANSPORTATION, EFFECTIVE FROM 1 JANUARY 2009						
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**	**Accredited Blood and Blood Product Couriers**		
				RVU	**Fee**	
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		-		-

UNATTACHED OPERATING THEATRE UNITS

Unattached Operating Theatre Units 2009

DRAFT 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 2009

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	8.76 (7.68)
010	General anaesthetic theatre, Per minute	04.00		0.923	27.50 (24.10)
015	Dental anaesthetic theatre (Applicable to units registered for dental procedures only), Per minute	04.00		0.623	18.60 (16.30)
061	Excimer laser theatre fee, per minute	04.00		0.662	19.70 (17.30)

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	323.20 (283.50)
025	Day rate.	04.00		12.442	370.70 (325.20)
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	318.80 (279.60)
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	320.90 (281.50)
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	158.70 (139.20)
335	Excimer laser: Hire fee per eye	04.00		75.258	2242.00 (1966.70)
337	Microkeratome used with an excimer laser, per operation	04.00		13.823	411.80 (361.20)
GASES					
Oxygen and Nitrous Oxide					
	For both gases together, per minute				04.00
283	PWV area	04.00		0.112	3.34 (2.93)
701	Cape Town	04.00		0.154	4.59 (4.03)
702	Port Elizabeth	04.00		0.137	4.08 (3.58)
703	East London	04.00		0.151	4.50 (3.95)
704	Durban	04.00		0.140	4.17 (3.66)
705	Other areas	04.00		0.125	3.72 (3.26)
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	4.89 (4.29)
710	Cape Town	04.00		0.273	8.13 (7.13)
711	Port Elizabeth	04.00		0.262	7.81 (6.85)
712	East London	04.00		0.252	7.51 (6.59)
713	Durban	04.00		0.213	6.35 (5.57)
714	Other areas	04.00		0.203	6.05 (5.31)
Oxygen, recovery room and emergency units					
	Flat rate for oxygen per case				04.00
720	PWV area	04.00		0.327	9.74 (8.54)
721	Cape Town	04.00		0.542	16.10 (14.10)
722	Port Elizabeth	04.00		0.519	15.50 (13.60)
723	East London	04.00		0.500	14.90 (13.10)
724	Durban	04.00		0.427	12.70 (11.10)
725	Other areas	04.00		0.404	12.00 (10.50)

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	0.30 (0.26)
731	Cape Town	04.00		0.018	0.54 (0.47)
732	Port Elizabeth	04.00		0.017	0.51 (0.45)
733	East London	04.00		0.017	0.51 (0.45)
734	Durban	04.00		0.014	0.42 (0.37)
735	Other areas	04.00		0.013	0.39 (0.34)
Carbon Dioxide					
291	Per minute	04.00		0.020	0.60 (0.53)
Laser					
292	Per minute	04.00		0.392	11.70 (10.30)
Entonox					
293	Per 30 minutes	04.00		3.731	111.20 (97.50)
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)				05.03

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	Hysteroscopy with removal impacted foreign body (58562)				
	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				

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	APPENDIX B				05.03

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).

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

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	Practice Code References to the NRPL-HS includes 57/58, 76 and 77				
	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)				05.03

Code	Description	Ver	Add	Unattached operating theatres / Day clinics	
				RVU	Fee
	Semi-Elemental High Protein And 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), 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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