Code	Description	Ver	Add	Clinical Technology RVU	Fee
				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	Clinical Technology 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

Dental Practitioners 2009

	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

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	

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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	M P	Lab	T C
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	

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

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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	Frequency of benefits. The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as "twice a calendar year" rather than once in every six months.	05.02									
	Radiographs and records. Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.	05.02									
	New vs. established patient. A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.	05.02									
II.	**DENTAL PROCEDURES AND SERVICES**										
A.	**DIAGNOSTIC SERVICES**										
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.	06.03									
CLINICAL ORAL EXAMINATIONS											
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented. Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.	06.03									
General Dental Practitioner											
Code	**Description**	**Ver**	**General Dental Practice**	**Maxillo-facial and Oral Surgery**	**Orthodontics**	**Oral Medicine and Periodontics**	**Prosthodontics**	**Oral Pathology**	**MP**	**Lab**	**TC**
8101	Oral examination	06.03	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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008)										
8104	Limited oral examination	06.03	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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
	A consultation is a diagnostic service rendered by a dentist, other than the practitioner providing treatment, whose opinion or advice for the purpose of determining the patient's dental needs and proposing treatment regarding a specific problem is requested. A consultation requires and includes a written report to the practitioner or patient who requested the consultation. It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded). Comment: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation. When the consulting dentist assumes responsibility for the continuing care of the patient, any service rendered by him/her will cease to be a consultation, and an appropriate oral examination code should be reported. Code 8106 (special report) may not be reported in addition to this code										
Maxillo Facial Surgeon											
8901	Consultation - MFOS	04.00		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

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8707	Periodontal screening - Periodontist	06.03				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