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										
	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.										05.02
	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.										06.03
	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										
009	Surgery guidelines:										
	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 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:										
	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									05.02 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	
	[illegible] 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.										
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.									05.02	

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
D.	**Modifiers**										
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. A service or procedure was performed by more than one practitioner b A service or procedure has been increased or reduced. c. Only part of a service was performed. d. An adjunctive service was performed. e. A service or procedure was provided more than once. f. The fee/benefit was altered due to a financial agreement.										06.03
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)										
	Surgical assistant services should be identified by adding Modifier 8001 to the usual procedure code(s) – See Rule 009.										06.03
8003	Minimum assistant surgeon										
	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.	06.03	141.73 (124.32)	141.73 (124.32)		141.73 (124.32)					06.03
8005	Maximum multiple procedures (same incision) - MFO surgeon										
	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.	06.03	220.05 (193.03)	220.05 (193.03)		220.05 (193.03)					06.03
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)										
	See Modifier 8009.										06.03
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)										
	Surgical assistant services should be identified by adding Modifier 8007 to the usual procedure code(s) – See Rule 009.										06.03
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)										
	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.										06.03
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)										
	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.										06.03
8010	Open reduction (PLUS 75% of the appropriate benefit)										
	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.										06.03
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)										
	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.										06.03
8012	Reduced services (benefit MINUS X % as determined by the practitioner)										
	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.										06.03
8013	Multiple modifiers										
											06.03

Code	Description	Ver	General	Maxillo-	Orthodontic	Oral	Prosthodont			

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

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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
	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

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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 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.										
8701	Consultation - periodontist	06.03				158.50 (139.00)					06.03 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)			

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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
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

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.										