GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. 1369 **24 December 2008**

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

REGULATIONS RELATING TO THE OBTAINMENT OF INFORMATION AND THE PROCESS OF DETERMINATION AND PUBLICATION OF THE REFERENCE PRICE LIST 2009

REFERENCE PRICE LISTS 2009

The Director-General of the National Department of Health has, in terms of regulation 8 of the Regulations Relating to the Obtainment of Information and the Process of Determination and Publication of the Reference Price Lists, determined the Reference Price Lists for 2009 in the Schedule.

MR T.D MSELEKU
DIRECTOR-GENERAL: HEALTH

SCHEDULE

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ACUPUNCTURE AND CHINESE MEDICINE

Acupuncture & Chinese Medicine 2009

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

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

RULES

01	All accounts must be presented with the following information clearly stated: - name of the practitioner - qualifications of the practitioner - BHF practice number - Postal address and telephone number - Date on which the service(s) were provided - Applicable item codes - The nature of the treatment - The surname and initials of the member - The first name of the patient - The name of the medical scheme - The membership number of the patient - The name and practice number of the referring practitioner	09.00
02	When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately.	09.00
03	Not more than two separate techniques may be charged for at each session.	09.00
04	The maximum number of acupuncture treatments per course to be charged for is limited to ten. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient.	09.00

ITEMS

Code	Description	Ver	Add	Chinese Medicine & Acupuncture	
				RVU	Fee
1.	**Consultations**				
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or diagnosis				09.00
1100	Consultation (up to 15 mins)	09.00		10.000	93.80 (82.30)
1101	Consultation (16-30 mins)	09.00		22.500	211.10 (185.10)
1102	Consultation (31-45 min)	09.00		37.500	351.80 (308.60)
1103	Consultation (46-60 min)	09.00		52.500	492.50 (432.00)
1110	Consultation, each additional full 15 mins beyond 60 mins	09.00		15.000	140.70 (123.40)
2.	**Treatments**				
3100	First treatment (needles, plus maximum of two speciality therapy techniques)	09.00		39.524	370.70 (325.20)
3200	Follow-up treatment (needles, plus maximum of two speciality therapy techniques)	09.00		36.145	339.00 (297.40)
3.	**Speciality Therapy Techniques**				
4010	Moxibustion	09.00		22.770	213.60 (187.40)
4020	Cupping	09.00		19.493	182.80 (160.40)
4030	Dermal needle therapy (plum-blossom or seven-star)	09.00		18.184	170.60 (149.60)
4040	Auricular therapy (micro acupuncture)	09.00		32.146	301.50 (264.50)
4050	Scalp acupuncture	09.00		27.308	256.10 (224.70)
4060	Shilao (diet therapy)	09.00		23.712	222.40 (195.10)
4070	Tui-Na (massage/pressure)	09.00		34.226	321.00 (281.60)

Ambulance Services

Ambulance Services 2009

NATIONAL REFERENCE PRICE LIST FOR AMBULANCE SERVICES, EFFECTIVE FROM 1 JANUARY 2009		
The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well. In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL PRICES ARE VAT EXCLUSIVE.		
Preamble		
It is recommended that, when such benefits are granted, the following should be clearly specified in the scheme's rules: · The limitation, if any, for such benefits.		
REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE		
GENERAL RULES		
001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.	04.00
002	No after hours fees may be charged	04.00
003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.	04.00
004	Guidelines for information required on each account : · Name of service · BHF practice number · Address · Telephone number · Pre-authorisation number · The name of the member · The name of the patient · The name of the medical scheme · The membership number of the member · Diagnosis of patient's condition · Summary of medical procedures undertaken on patient and vital signs of patient · Summary of all equipment used · The date on which the service was rendered. · Name and HPCSA registration number of care providers · Name, practice number and HPCSA registration number of medical doctor · Response vehicle: Details of vehicle driver and intervention undertaken on patient · The code number of the procedure used in the National Reference Price List.	04.00
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.	05.04
Definitions of Ambulance Patient Transfer		
	Basic Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient in transit. Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA). (e.g. Initiating and/or maintaining IV therapy, nebulisation etc.) whilst patient in transit. Advanced Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Paramedic	04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	(CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers. NOTES: Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ALS to be charged. · If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ILS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ILS to be charged. · In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital. · In order to bill as an intermediate life support call, a registered intermediate life support provider must have examined, treated and monitored the patient while in transit to hospital. · Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient or ALS monitoring and presence is not required. the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call not an ALS call). Where an ILS provider is in attendance at a callout but does not do any interventions at an ILS level on the patient or ILS monitoring and presence is not required, the billing will be BLS. · Where the management undertaken by a paramedic or AEA fall within the scope of practice of a BAA the call must be at a BLS level. Please Note : · The amounts reflected in the NRPL for each level of care is inclusive of any disposables (except for pacing pads, heimlich valves, high capacity giving sets, dial a flow, intra-osseous needles) and drugs used in the management of the patient, as per attached nationally approved medication protocols. · Haemaccel and colloid solution may be charged separately. · Claims for patient discharges home will only be entertained if accompanied by a written motivation from the attending physician who requested such transport - clearly stating why an ambulance is required for such a transport and what medical assistance the patient requires on route.								
DEFINITION: RESPONSE VEHICLES									
	Response vehicles only - Advance Life Support (ALS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under items 131 and 133. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered. 2. In the event of a service rendering ALS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ALS bill under items 131 and 133. Since the ALS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ALS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ALS services rendered.								04.00

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
	3. Should a response vehicle go to a scene and not render any ALS treatment then the said response vehicle may not levy a bill. 4. Notwithstanding that, item 151 applies to all ALS resuscitation per the notes in this schedule. Response vehicle only - Intermediate Life Support (ILS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ILS rate under items 125 and 127. Furthermore the ILS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ILS services rendered. 2. In the event of a service rendering ILS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ILS bill under items 125 and 127. Since the ILS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ILS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ILS services rendered. 3. Should a response vehicle go to a scene and not render any ILS treatment then the said response vehicle may not levy a bill.								
1	**BASIC LIFE SUPPORT**								
Metropolitan area									
Code	**Description**	**Ver**	**Add**	**Ambulance Services : Advanced Life Support**		**Ambulance Services : Intermediate Life Support**		**Ambulance Services : Basic Life Support**	
				RVU	**Fee**	**RVU**	**Fee**	**RVU**	**Fee**
100	Up to 45 minutes	05.04		171.276	848.10	171.276	848.10	171.276	848.10
102	Up to 60 minutes	05.04		228.156	1129.80	228.156	1129.80	228.156	1129.80
103	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		57.084	282.70	57.084	282.70	57.084	282.70
Long distance									
111	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		2.843	14.10	2.843	14.10	2.843	14.10
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.95	1.000	4.95	1.000	4.95
2	**INTERMEDIATE LIFE SUPPORT**								
Metropolitan area									
125	Up to 45 minutes	05.04		231.226	1145.00	231.226	1145.00	-	-
127	Every 15 minutes thereafter or part thereof, where specially motivated	05.04		77.075	381.70	77.075	381.70	-	-
Long distance									
129	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		3.850	19.10	3.850	19.10	-	-
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.95	1.000	4.95	-	-
3	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT**								
Metropolitan area									
131	Up to 60 minutes	05.04		406.641	2013.60	-	-	-	-
133	Every 15 minutes thereafter or part thereof, where specially motivated.	05.04		101.660	503.40	-	-	-	-
Long distance									
141	Per km (> 100 km) DISTANCE TRAVELLED BY PATIENT	05.04		5.072	25.10	-	-	-	-

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
142	Per km (> 100 km) (ALS return - non patient carrying kilometres) to a maximum of R1986.40	06.02		1.000	4.95	-	-	-	-
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**								
151	Resuscitation fee, per incident	04.00		454.000	2248.10	454.000	2248.10	-	-
153	Doctor per hour	04.00		130.000	643.70	130.000	643.70	-	-
	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion-synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (Oral or nasal) with assisted ventilation	04.00							
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.								04.00
5.	**AEROMEDICAL TRANSFERS**								
	BY ARRANGEMENT WITH MEDICAL SCHEME								04.00
Rotorwing Rates									
	Definitions: 1. Helicopter rates are determined according to aircraft type 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C) 4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated. 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 7. Rates are calculated according to time; from throttle open, to throttle closed. 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 9. Hot loads restricted to 8 minutes ground time and must be denoted.								04.00
	AIRCRAFT TYPE A (RA): HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119 AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC) BO105, 206CT, AS355, A109 AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC) HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100								04.00
500	Basic Call Cost (Start up)	04.00							
Flying Time									
531	30 minutes	04.00							
533	45 minutes	04.00							
535	60 minutes	04.00							
537	75 minutes	04.00							

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
539	90 minutes	04.00							
541	105 minutes	04.00							
543	120 minutes	04.00							
Staff and Consumables									
581	30 minutes	04.00							
583	45 - 75 minutes	04.00							
585	90 - 105 minutes	04.00							
587	120 minutes	04.00							
Aircraft Type D									
591	Hourly rate plus 20%	04.00							
Winching									
595	Winching, per lift	04.00							
Fixed Wing Rates									
	DEFINITIONS: 1. Group A must fall within the Cat 138 Ops as determined by Civil Aviation. 2. Please note that no fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee would be advised. The definition of use of these aircraft needs to be narrowed down further to eliminate abuse. 3. Staff and consumables cost can only be used if patient has been treated. 5. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients)								04.00
Group A (FA)									
	Composed of flying cost per kilometer, staff cost per hour and equipment cost								04.00
Staff cost per hour									
621	Doctor	04.00							
623	ICU Sister	04.00							
625	Paramedic	04.00							
Equipment Cost									
631	Per patient, per hour	04.00							
Aircraft cost (per kilometer)									
651	Beechcraft Duke	04.00							
653	Lear 24F	04.00							
655	Lear 35	04.00							
657	Falcon 10	04.00							
659	King Air 200	04.00							
661	Mitsubishi MU2	04.00							
663	Cessna 402	04.00							
665	Beechcraft Baron	04.00							
667	Citation II	04.00							
669	Pilatus PC12	04.00							

Code	Description	Ver	Add	Ambulance Services : Advanced Life Support		Ambulance Services : Intermediate Life Support		Ambulance Services : Basic Life Support	
				RVU	Fee	RVU	Fee	RVU	Fee
Group B - Emergency Charters									
	1. No staff and equipment fee allowed. 2. Cost to be reviewed per case. 3. Only allowed if a Group A aircraft is not available within an optimal period for transportation and stabilisation of the patient.				04.00				
6	**NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**								
	Registered Basic Ambulance Assistant Qualification · Oxygen · Entonox · Oral Glucose Registered Ambulance Emergency Assistant Qualification As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Soluble Aspirin Registered Paramedic Qualification As above, plus · Oral glyceryl trinitrate, activated charcoal · Ipratropium bromide inhalant solution · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer. · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.				04.00				

BIOKINETICS

Biokinetics 2009

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

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

GENERAL RULES

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

MODIFIERS

ITEMS

1. Consultations / Patient Education / Counseling

Code	Description	Ver	Add	Biokinetics RVU	Biokinetics Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00		-	-
901	Initial consultation including: a problem focused history; a short problem focused examination; and straightforward biokinetic decision making but excluding evaluation. To be charged only once per course of treatment. (inclusive of lung function tests)	06.01		16.700	71.00 (62.30)
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination; and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment.	06.01		11.700	49.80 (43.70)
905	Consultation at hospital (global fee including a problem focused history; a problem focused examination; and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment.	06.01		16.700	71.00 (62.30)
922	Patient education (based upon the evaluation outcomes)	06.01		16.300	69.30 (60.80)
936	Health promotion and lifestyle modifications	06.01		-	-
2.	**Evaluation / Diagnostic Procedures**				
908	Simple evaluation at the first visit only (to be fully documented)	06.01		10.000	42.50 (37.30)
909	Complex evaluation at the first visit only (to be fully documented).	06.01		16.700	71.00 (62.30)
912	Anthropometric/body composition assessment	06.01		10.000	42.50 (37.30)
913	Ergological testing evaluation of body segment, limb or joint	06.01		28.500	121.20 (106.40)

Code	Description	Ver	Add	Biokinetics	
				RVU	Fee
914	Neurological patients: Ergological evaluation	06.01		16.700	71.00 (62.30)
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	06.01		16.700	71.00 (62.30)
916	Perceptual motor evaluation (perception and gross motor function)	06.01		16.700	71.00 (62.30)
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	06.01		28.500	121.20 (106.40)
918	Physical work capacity with full ECG	06.01		28.500	121.20 (106.40)
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	06.01		28.500	121.20 (106.40)
921	Isokinetic testing by means of specialised electronic equipment	06.01		28.500	121.20 (106.40)
3.	**Therapeutic Procedures (Physical Rehabilitation)**				
	Maximum of 3 modalities, per diagnosis, may be charged per visit				04.00
923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	06.01		16.300	69.30 (60.80)
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	06.01		16.300	69.30 (60.80)
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	06.01		16.300	69.30 (60.80)
927	Posture, gait and activities of daily living (ADL), with/without equipment use	06.01		16.300	69.30 (60.80)
928	A rehabilitative exercise prescription	06.01		16.300	69.30 (60.80)
929	Callisthenics exercises	06.01		16.300	69.30 (60.80)
930	Group session with high risk patients, per patient (maximum 10 patients)	06.01		8.800	37.40 (32.80)
931	Passive and active range of motion exercise therapy	06.01		16.300	69.30 (60.80)
933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, Low-Back pain/ Lumbago etc.	06.01			
934	Group exercise sessions, per patient	06.01		8.800	37.40 (32.80)

CHIROPRACTORS

Chiropractors 2009

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

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

GENERAL RULES

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

MODIFIERS

CHIROPRACTORS RECOMMENDED REIMBURSEMENT RATES

1	**Consultations**				
Code	**Description**	**Ver**	**Add**	**Chiropractice**	
				RVU	**Fee**
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	05.02			
301	Consultation	05.03		25.000	108.10 (94.80)
2	**Diagnostic procedures**				
	Only a single item from this section may be charged per patient encounter				05.03
	Radiation Control Council Certificate number to be on account if X-Rays charged				04.00
311	Single diagnostic procedure	05.03		25.000	108.10 (94.80)
312	Two diagnostic procedures	05.03		37.500	162.10 (142.20)
313	Three diagnostic procedures	05.05		50.000	216.20 (189.60)
3	**Immobilisation or therapeutic exercises in relation to preparation or fitting of appliances**				
	Only a single item from this section may be charged per patient encounter				05.03
321	Single instance of immobilization or therapeutic exercises	05.03		10.000	43.20 (37.90)
322	Two instances of immobilization or therapeutic exercises	05.03		15.000	64.80 (56.90)

Code	Description	Ver	Add	Chiropractice	
				RVU	Fee
4	**Treatment (therapeutic procedures)**				
	Only a single item from this section may be charged per patient encounter				05.03
331	Single treatment procedure	05.03		10.000	43.20 (37.90)
332	Two treatment procedures	05.03		15.000	64.80 (56.90)
333	Three treatment procedures	05.03		20.000	86.50 (75.80)
334	Four treatment procedures	05.03		25.000	108.10 (94.80)
335	Five treatment procedures	05.03		30.000	129.70 (113.80)
336	Six treatment procedures	05.03		35.000	151.30 (132.70)
5	**Consumables**				
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				05.03
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.	05.06		-	-
110	X-Ray films	06.00		-	-

CLINICAL TECHNLOGY

Clinical Technologists 2009

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

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

GENERAL RULES

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

MODIFIERS

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

ITEMS

Surgical Support

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
010	Ablations	04.00		219.700	1845.70 (1619.00)
011	Preparation of extra-corporeal equipment for surgical procedures.	04.00		196.700	1652.50 (1449.50)
012	Operation of heart laser during myocardial revascularisation	04.00		219.700	1845.70 (1619.00)
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	04.00		20.300	170.50 (149.60)
014	Radiofrequency Catheter Ablations	04.00		219.700	1845.70 (1619.00)
	Not to be charged with item 012	05.03			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	04.00		19.400	163.00 (143.00)
	May only submit once in theatre and once in catheterisation laboratory	05.03			
017	Standby with extra-corporeal equipment for surgery within hospital	04.00		58.800	494.00 (433.30)
	Cannot be used with 011	05.03			
019	Standby within the hospital for coronary angioplasty.	04.00		19.400	163.00 (143.00)
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	04.00		58.800	494.00 (433.30)
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	04.00		10.000	84.00 (73.70)
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	04.00		196.700	1652.50 (1449.50)
027	Preparation and operation of a pre- and post-operative blood salvage device.	04.00		19.400	163.00 (143.00)
029	Preparation and operation of an autotransfusion cell washing system.	04.00		77.100	647.70 (568.20)
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	04.00		61.700	518.30 (454.70)
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	04.00		14.600	122.70 (107.60)
034	Lymph compression treatment.	04.00		22.500	189.00 (165.80)
116	Preparation and operation of an artificial heart (Berlin-Heart)	04.00		219.700	1845.70 (1619.00)
118	Daily monitoring of artificial heart, per hour	04.00		33.400	280.60 (246.10)
157	Standby with extra corporeal equipment (maximum 4 hours) (per event)	04.00		26.300	220.90 (193.80)

Pulmonology

	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.				04.00
035	Nebulization (per one procedure).	04.00		12.300	103.30 (90.60)
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	04.00		24.200	203.30 (178.30)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
039	Flow-volume determinations.	04.00		30.600	257.10 (225.50)
041	Flow-volume (Pre-post B-D).	04.00		50.800	426.80 (374.40)
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	04.00		24.200	203.30 (178.30)
045	Gas distribution measurements.	04.00		24.200	203.30 (178.30)
047	Diffusion determinations.	04.00		24.200	203.30 (178.30)
049	Exercise testing (EIA).	04.00		17.100	143.70 (126.00)
050	ECMO change-out and re-establishment.	04.00		46.300	389.00 (341.20)
051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	04.00		24.200	203.30 (178.30)
053	Allergy tests.	04.00		11.400	95.80 (84.00)
055	If RAST included add (per allergen).	04.00	+	11.400	95.80 (84.00)
057	Bronchial provocation testing.	04.00		40.800	342.80 (300.70)
059	Compliance measurements.	04.00		24.200	203.30 (178.30)
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	04.00		6.000	50.40 (44.20)
Cardiology					
062	Assist in preparations and operations of Rotablator Procedures	04.00		29.900	251.20 (220.30)
063	Cardiac catheterisation for the first hour.	04.00		40.300	338.60 (297.00)
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	04.00		10.000	84.00 (73.70)
064	Intravascular Ultrasound (IVUS)	04.00		25.700	215.90 (189.40)
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine	05.03			
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	84.00 (73.70)
066	Cardiac Cath Right Heart Studies	04.00		56.000	470.50 (412.70)
067	Cardiac Electro physiology and related procedures for first FOUR hours.	04.00		67.900	570.40 (500.40)
069	Temporary and single Pacemaker procedures.	04.00		40.300	338.60 (297.00)
070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	04.00		46.300	389.00 (341.20)
	Not to be charged in conjunction with items 063 or 065	05.03			
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	04.00		10.000	84.00 (73.70)
072	Multisite Pacing (Bi-ventricular pacing)	04.00		46.300	389.00 (341.20)
073	Dilatation procedures and stents.	04.00		55.400	465.40 (408.30)
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	04.00		10.000	84.00 (73.70)
075	Pacemaker checking and/or reprogramming.	04.00		14.000	117.60 (103.20)
077	24 Hour Holter ambulatory monitoring.	04.00		55.400	465.40 (408.30)
079	Cardiac exercise stress testing.	04.00		29.100	244.50 (214.40)
081	Recording of twelve lead ECG.	04.00		7.700	64.70 (56.70)
087	M Mode echocardiogram.	04.00		16.600	139.50 (122.30)
089	2D echocardiogram.	04.00		29.400	247.00 (216.70)
091	Doppler flow.	04.00		32.300	271.40 (238.00)

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
093	Colour imaging.	04.00		32.300	271.40 (238.00)
095	ECG signal averaging (Hi-Res).	04.00		53.700	451.10 (395.70)
097	Ambulatory bloodpressure monitoring.	04.00		18.600	156.30 (137.10)
099	Vector cardiogram.	04.00		55.400	465.40 (408.30)
111	Transoesophageal echocardiogram.	04.00		43.100	362.10 (317.60)
Neurology					
	Preparation, recording and analyses/technical report of:				04.00
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	05.03		74.100	622.50 (546.10)
179	Auditory evoked potentials, full audiological examination, bilateral	05.03		74.100	622.50 (546.10)
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	05.03		37.110	311.80 (273.50)
181	Somatosensory evoked potentials, unilateral, upper limb	05.03		37.110	311.80 (273.50)
182	Somatosensory evoked potentials, unilateral, lower limb	05.03		37.110	311.80 (273.50)
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	125.20 (109.80)
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	04.00		43.100	362.10 (317.60)
183	Electronystagmography for spontaneous and positional nystagmus (3253)	05.03		24.150	202.90 (178.00)
184	Caloric test done with electronystagmography (3255)	05.03		67.570	567.70 (497.90)
119	Sleep EEG.	04.00		31.400	263.80 (231.40)
185	Overnight polysomnography	05.03		264.830	2224.80 (1951.60)
186	Obstructive sleep apnea screening	05.03		137.170	1152.40 (1010.80)
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	1158.40 (1016.20)
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	2224.80 (1951.60)
125	Multiple sleep latency test (MSLT)	04.00		111.100	933.40 (818.70)
127	Overnight CPAP titration.	04.00		104.200	875.40 (767.90)
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	05.02	+	17.420	146.30 (128.40)
133	EEG with special activation.	04.00		49.400	415.00 (364.00)
135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	04.00		14.900	125.20 (109.80)
137	Intra-operative evoked potentials for the 1st hour	04.00		55.400	465.40 (408.30)
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	04.00		37.100	311.70 (273.40)
141	Intra-operative EEG (carotid endarterectomy).	04.00		26.300	220.90 (193.80)
143	Transcranial or Carotid Doppler (bilateral).	04.00		39.400	331.00 (290.40)
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	389.00 (341.20)
146	Chronic haemodialysis (acetate dialysate)	04.00		149.400	1255.10 (1101.00)
148	Chronic haemodialysis (bicarbonate dialysate)	04.00		159.600	1340.80 (1176.10)
	In the case of items 146 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning materials, equipment set-up, up to 5 hours treatment time, equipment rental	05.03			

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee
147	Peritoneal dialysis, per day	04.00		16.800	141.10 (123.80)
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visits; and home visits. However, they exclude Tenckhoff catheter and insertion thereof; and disposables required for a transfer set change (usually 6 monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies; b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.	05.03			
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period.	05.03		1700.000	14281.70 (12527.80)
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	05.03		2360.000	19826.40 (17391.50)
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	04.00		33.400	280.60 (246.10)
150	Acute haemodialysis	04.00		317.200	2664.80 (2337.50)
	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	208.30 (182.80)
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	417.50 (366.30)
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	625.90 (549.00)
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	04.00		99.300	834.20 (731.80)
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	139.50 (122.30)
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	244.50 (214.40)
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	84.00 (73.70)
161	Complete semen analysis.	04.00		31.700	266.30 (233.60)
163	Semen wash for A I.	04.00		30.300	254.60 (223.30)
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	04.00		368.700	3097.40 (2717.10)
	Cannot be used with items 161, 163, 167 and 169	05.03			
167	Ovum and embryo freezing.	04.00		131.300	1103.10 (967.60)
169	Semen freezing.	04.00		30.300	254.60 (223.30)
Miscellaneous					
171	Travelling per km in excess of 16km (in own car).	04.00		0.675	5.67 (4.97)
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			

Code	Description	Ver	Add	Clinical Technology	
				RVU	Fee

DENTAL PRACTITIONERS

Dental Practitioners 2009

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	MP	Lab	TC
D.	**Modifiers**										
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. A service or procedure was performed by more than one practitioner. b. A service or procedure has been increased or reduced. c. Only part of a service was performed. d. An adjunctive service was performed. e. A service or procedure was provided more than once. f. The fee/benefit was altered due to a financial agreement.									06.03	
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)									06.03	
	Surgical assistant services should be identified by adding Modifier 8001 to the usual procedure code(s) – See Rule 009.										
8003	Minimum assistant surgeon	06.03	144.33 (126.61)	144.33 (126.61)		144.33 (126.61)					
	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	224.08 (196.56)	224.08 (196.56)		224.08 (196.56)					
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.										
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)									06.03	
	See Modifier 8009.										
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)									06.03	
	Surgical assistant services should be identified by adding Modifier 8007 to the usual procedure code(s) – See Rule 009.										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)									06.03	
	When emergency surgery is performed after hours, such surgical procedures can be identified by adding Modifier 8008 to the procedure codes by each participating member of the surgical team.										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)									06.03	
	When multiple procedures (under the same anaesthetic but through another incision) are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The additional procedures should be identified by adding the appropriate modifier (M8009 or M8006) to the additional procedure codes.										
8010	Open reduction (PLUS 75% of the appropriate benefit)									06.03	
	When an open reduction is required for surgical procedures indicated in the schedule, the open reduction should be identified by adding Modifier 8010 in addition to the usual procedure code. TEMPORARY NOTE: Modifier 8010 applies only to codes 9035 and 9037. Two codes for "Open Reduction" was introduced so that the use of this modifier can be eliminated.										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)									06.03	
	When the service provided by a practitioner is greater than that is usually required for the listed procedure, it may be identified by adding Modifier 8030 to the usual procedure code – See Rule 007.										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)									06.03	
	Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.										
8013	Multiple modifiers									06.03	

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	126.70 (111.10)								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).										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8102	Comprehensive oral examination	06.03	204.60 (179.50)								B
	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	61.40 (53.90)								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	61.40 (53.90)								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	106.70 (93.60)								B
	Periodontal screenings include but are not limited to a periodontal charting of the complete dentition; plaque index and bleeding index. The findings should be recorded, is a part of the patient's clinical record and should be retained by the dentist.										
8190	Consultation - second opinion or advice	06.03	126.70 (111.10)								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		161.40 (141.60)							S
8902	Consultation - MFOS (detailed)	06.03		422.50 (370.60)							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	364.50 (319.80)	546.90 (479.70)	546.90 (479.70)					+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			161.40 (141.60)						A
8803	Consultation - Orthodontis (subsequent, retention and post treatment)	04.00			94.00 (82.50)						A
8837	Diagnosis and treatment planning - Orthodontist	04.00			75.00 (65.80)						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				161.40 (141.60)					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				422.50 (370.60)					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				126.30 (110.80)					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				126.30 (110.80)					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				126.30 (110.80)					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				222.20 (194.90)					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				94.00 (82.50)					S
	Subsequent consultation for same disease/condition.										
Prosthodontist											
8501	Consultation - Prosthodontis	04.00					161.40 (141.60)				A
8507	Comprehensive consultation - Prosthodontist	06.03					259.20 (227.40)				A
	Examination, diagnosis and treatment planning.										
8506	Detailed consultation - Prosthodontist	06.03					422.50 (370.60)				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						161.40 (141.60)			
9205	Consultation - oral pathologist (subsequent)	04.00						94.00 (82.50)			

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
RADIOGRAPHS/DIAGNOSTIC IMAGING											
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders. A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes. Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical practice.										06.03
8107	Intraoral radiograph - periapical	06.03	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)				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	397.00 (348.20)	397.00 (348.20)	397.00 (348.20)	397.00 (348.20)	397.00 (348.20)				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	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)	51.30 (45.00)				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	88.30 (77.50)	88.30 (77.50)	88.30 (77.50)	88.30 (77.50)	88.30 (77.50)				B
8114	Extraoral radiograph - hand-wrist	06.03	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)				B
	Use to report extraoral radiographs such as hand-wrist radiographs.										
8115	Extraoral radiograph - panoramic	04.00	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)				B
8116	Extraoral radiograph - cephalometric	05.02	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)				B
8118	Extraoral radiograph - skull/facial bone	05.02	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)	205.00 (179.80)				B
8121	Oral and/or facial image (digital/conventional)	06.03	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)				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	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)	55.10 (48.30)			+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	138.60 (121.60)	138.60 (121.60)	138.60 (121.60)	138.60 (121.60)	138.60 (121.60)			+L	B
	See code 8117. Report this code when models are mounted on a movable condyle articulator.										

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8122	Microbiological studies	06.03									B
	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	57.30 (50.20)								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	15.10 (13.30)								
	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	172.70 (151.50)				259.20 (227.40)				A
8505	Pantographic recording	04.00	250.70 (219.90)				376.00 (329.80)				A
8508	Electrognathographic recording	04.00	268.40 (235.40)				402.60 (353.20)				A
8509	Electrognathographic recording with computer analysis	04.00	445.60 (390.90)				668.40 (586.30)				A
8811	Tracing and analysis of extra-oral film	04.00	23.80 (20.90)	23.80 (20.90)	23.80 (20.90)	23.80 (20.90)	23.80 (20.90)				B
8839	Diagnostic setup (orthodontics)	04.00	105.80 (92.80)		158.60 (139.10)						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	77.80 (68.20)			107.20 (94.10)	77.80 (68.20)				B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.										
8159	Prophylaxis - complete dentition	06.03	152.90 (134.10)			215.60 (189.10)	152.90 (134.10)				B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.										
8160	Removal of gross calculus	06.03									B
	This procedure is used when profuse bleeding prevents immediate polishing. May not be used concurrent with any other prophylactic procedure on the same day.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8179	Polishing - complete dentition (periodontally compromised patient)	06.03	89.30 (78.30)								B
	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	166.10 (145.70)								B
	Comment: See code 8177 descriptor; Include codes 8155 (Polishing – complete dentition), 8159 (Prophylaxis – complete dentition) and 8179 (Plaque removal – periodontal compromised pst). Code 8180 should not be used concurrent with codes 8179.										
TOPICAL FLUORIDE TEATMENT											
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or "swish." For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.										06.03
8161	Topical application of fluoride - child	06.03	77.80 (68.20)			77.80 (68.20)	77.80 (68.20)				B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.										
8162	Topical application of fluoride - adult	06.03	77.80 (68.20)			77.80 (68.20)	77.80 (68.20)				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	144.40 (126.70)						T	+L	B
8175	Space maintainer - removable	04.00	186.10 (163.30)							+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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8150	Tobacco counselling	06.03									B
	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	77.80 (68.20)			155.70 (136.60)	155.70 (136.60)				B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plague, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.										
8153	Oral hygiene instruction - each additional visit	06.03	57.00 (50.00)			75.00 (65.80)	75.00 (65.80)				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	51.30 (45.00)				51.30 (45.00)		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	299.00 (262.30)							+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	90.50 (79.40)							+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.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8177	Oral hygiene instruction (periodontally compromised patient)	06.03	117.80 (103.30)								B
	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	63.60 (55.80)								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	154.80 (135.80)						T		B
8342	Amalgam - two surfaces	04.00	190.80 (167.40)						T		B
8343	Amalgam - three surfaces	04.00	232.60 (204.00)						T		B
8344	Amalgam - four or more surfaces	04.00	259.20 (227.40)						T		B
RESIN-BASED COMPOSITE RESTORATIONS											
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays" If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention.										06.03
8350	Resin crown - anterior primary tooth (direct)	06.03	337.70 (296.20)						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	169.90 (149.00)						T		B

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8352	Resin - two surfaces, anterior	04.00	213.70 (187.40)						T		B
8353	Resin - three surfaces, anterior	04.00	255.40 (224.00)						T		B
8354	Resin - four or more surfaces, anterior	06.03	284.90 (249.90)						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	184.20 (161.60)						T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.										
8368	Resin - two surfaces, posterior	04.00	227.90 (199.90)						T		B
8369	Resin - three surfaces, posterior	04.00	275.40 (241.60)						T		B
8370	Resin - four or more surfaces, posterior	04.00	296.20 (259.80)						T		B
GOLD FOIL RESTORATIONS											
8561	Gold foil class I or IV	04.00	450.70 (395.40)				676.00 (593.00)		T		A
8563	Gold foil class V	04.00	527.30 (462.50)				790.90 (693.80)		T		A
8565	Gold foil class III	04.00	663.30 (581.80)				995.00 (872.80)		T		A
INLAY/ONLAY RESTORATIONS											
	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.										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	236.40 (207.30)				466.20 (409.00)		T	+L	A
8362	Inlay/onlay - metal - two surfaces	04.00	345.60 (303.20)				676.00 (593.00)		T	+L	A
8363	Inlay/onlay - metal - three surfaces	04.00	576.30 (505.50)				1048.20 (919.50)		T	+L	A
8364	Inlay/onlay - metal - four or more surfaces	04.00	696.90 (611.30)				1048.20 (919.50)		T	+L	A

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
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
8371	Inlay - porcelain - one surface	05.02	284.90 (249.90)				563.10 (493.90)		T	(+L)	A
8372	Inlay/onlay - porcelain - two surfaces	05.02	420.60 (368.90)				810.90 (711.30)		T	(+L)	A
8373	Inlay/onlay - porcelain - three surfaces	05.02	693.10 (608.00)				1260.00 (1105.30)		T	(+L)	A
8374	Inlay/onlay - porcelain - four or more surfaces	05.02	839.40 (736.30)				1260.00 (1105.30)		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	284.90 (249.90)				563.10 (493.90)		T	(+L)	A
8382	Inlay/onlay - resin - two surfaces	05.02	420.60 (368.90)				810.90 (711.30)		T	(+L)	A
8383	Inlay/onlay - resin - three surfaces	05.02	693.10 (608.00)				1260.00 (1105.30)		T	(+L)	A
8384	Inlay/onlay - resin - four or more surfaces	05.02	839.40 (736.30)				1260.00 (1105.30)		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	888.70 (779.60)				1308.40 (1147.70)		T	+L	A
8403	Crown - 3/4 cast metal	04.00	888.70 (779.60)				1308.40 (1147.70)		T	+L	A
8404	Crown - 3/4 porcelain/ceramic	05.02	839.30 (736.20)				1260.00 (1105.30)		T	+L	A