BOARD NOTICE

BOARD NOTICE 152 OF 2012

MEDICAL AND DENTAL PROFESSIONS BOARD

HEALTH PROFESSIONS ACT, 1974 (ACT NO.56 OF 1974)

PROPOSED GUIDELINE TARIFFS FOR MEDICAL PRACTITIONERS AND DENTISTS

The Medical and Dental Professions Board intends, under section 53 (3) (d) of the Health Professions Act, 1974 (Act No. 56 of 1974), to determine and publish a fee ("Guideline Tariffs") to be used as a norm in the adjudication of complaints of overcharging.

Interested persons are invited to submit any substantiated comments or representations in writing on the proposed Guideline Tariffs to the Registrar, Health Professions Council of South Africa (for the attention of the General Manager: Professional Boards) on or before 16h00 of the 19th of October 2012 by:-

(a) posting them to P O Box 205, Pretoria, 0001;
(b) delivering them by hand at 553 Madiba Street (previously Vermeulen Street), Arcadia, Pretoria, 0002; or
(c) e-mailing them to bhekiM@hpcsa.co.za.

Benefits of the guideline tariffs

- To guide the professions and protect the public.

- Minimising complaints of 'overcharging' and fair determination of these complaints.

The impact of the Guideline tariffs for registered practitioners

- Permit practitioners to set individual fee schedules.
- Keep record of written informed consent given by patients.

The impact of the Guideline tariffs for members of the public

- Patients will be billed only in accordance with the written informed consent they have given to a practitioner for services received in the event that the fee charged is more than the Guideline tariff.
- Patients must familiarise themselves with the benefits their medical aid scheme cover for services received from practitioners.

SCHEDULE

Definitions

1. In this notice, "**the Act**" means the Health Professions Act, 1974 (Act No. 56 of 1974) and any word or phrase to which a meaning has been assigned in the Notice shall have that meaning, unless the context otherwise indicates; **"Board"** means Medical and Dental Professions Board as established in terms of section 15 of the Act.

DR. B MJAMBA-MATSHOBA

REGISTRAR

DATE: 7/9/2012

GUIDELINE TARIFFS FOR SERVICES BY MEDICAL PRACTITIONERS				10000			11400			11000	
Published in terms of Section 53 (3) (d) of the HEALTH PROFESSIONS ACT (56 OF 1974)											
Note that this schedule is based on the 2006 NHRPL which was inflated by 46.66%. The 2006 NHRPL is available in database format at http://www.hpcsa.co.za	**Version**	**Add**	**CF**	**Units**	**BF**	**Value**	**Flag**	**CF**	**Units**	**BF**	**Value**	**Flag**	**CF**	**Units**	**BF**	**Value**	**Flag**
In terms of section 53(1) of the Health Professions Act, 1974 (Act No. 56 of 1974) every person registered under the Act (in this section referred to as the practitioner) shall, unless the circumstances render it impossible for him or her to do so, before rendering any professional services inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he or she intends to charge for such services -																	-
(a) when so requested by the person concerned; or																	
(b) when such fee exceeds the Guideline Tariffs for such services,																	
and shall in a case to which paragraph (b) relates, also inform the person concerned of the usual fee.																	
Every person registered under the Act shall, unless the circumstances render it impossible for him or her to do so, before rendering any professional services also inform the person to whom the services are to be rendered or any person responsible for the maintenance of such person, of the fee which he or she intends to charge for such services if such fee exceeds the medical aid rates.																	
RULES GOVERNING THE STRUCTURE						-					-					-	
A. Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counseling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.	2004.00					-					-					-	
B. Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 0173-0175, 0161-0164, 0166-0169)	2006.04					-					-					-	
C. Comparable services: A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is	2005.02					-					-					-	

D.	Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be	2004.00	-	-	-
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital	2004.00	-	-	-
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself	2004.00	-	-	-
G.	Post-operative care: (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions	2004.00	-	-	-
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days	2004.00	-	-	-
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.	2004.00	-	-	-
K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists	2004.00	-	-	-
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged	2004.00	-	-	-
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion	2004.00	-	-	-
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention	2004.00	-	-	-
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme	2004.00	-	-	-
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this	2004.00	-	-	-

Q.	Intensive care/High Care: Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)	2006.05	-	-	-
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)	2004.00	-	-	-
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.	2004.00	-	-	-
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Category 1: Cases requiring intensive monitoring	2004.00	-	-	-
U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall	2004.00	-	-	-
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods	2004.00	-	-	-
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used	2004.00	-	-	-
Z.	No fee is subject to more than one reduction	2004.00	-	-	-
AA.	Procedures to exclude cost of isotope	2004.00	-	-	-
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes	2004.00	-	-	-
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp	2004.00	-	-	-

EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account	2004.00	-	-	-
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.	2004.00	-	-	-
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years	2004.00	-	-	-
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").	2004.00	-	-	-
XX.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic	2004.00	-	-	-
YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)	2004.00	-	-	-
	MODIFIERS GOVERNING THE STRUCTURE		-	-	-
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere	2004.00	-	-	-
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms	2006.05	-	-	-

0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d) Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee.	2004.00					-					-			-
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use	2004.00					-					-			-
0007	a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation - 15,00 clinical procedure units irrespective of the number of items of equipment provided. b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - 15,00 clinical procedure units irrespective of the number of items of equipment provided.	2004.00	20	15.000	1.0	R	139.85	20	15.000	1.0	R	139.85			-
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon	2004.00					-					-			-
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units	2004.00					-					-			-
0010	Local anaesthetic: (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. (b) The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.	2004.00					-					-			-
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)	2006.04					-					-			-

0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged	2004.00					-						-	-
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff	2004.00					-						-	-
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions	2004.00					-						-	-
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	2005.06	10	7.500	1.0	R	112.91	10	7.500	1.0	R	112.91	-
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists	2004.00					-						-	-
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists	2004.00					-						-	-
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable	2004.00					-						-	-
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis	2004.00					-						-	-
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	2004.00	20	27.000	1.0	R	251.72	20	27.000	1.0	R	251.72	-
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	2004.11	20	77.000	1.0	R	717.87	20	77.000	1.0	R	717.87	-
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	2004.00	20	115.500	1.0	R	1 076.79	20	115.500	1.0	R	1 076.79	-
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	2004.11	20	77.000	1.0	R	717.87	20	77.000	1.0	R	717.87	-
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	2004.00	20	32.000	1.0	R	298.33	20	32.000	1.0	R	298.33	-
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	2004.11	20	77.000	1.0	R	717.87	20	77.000	1.0	R	717.87	-

0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot	2004.00					-						-		-
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%	2004.00					-						-		-
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed	2004.00					-						-		-
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure	2004.00					-						-		-
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts	2004.00					-						-		-
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere	2004.00					-						-		-
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee	2004.00					-						-		-
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (for other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhere in the Tariff)	2004.00					-						-		-
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083	2004.00					-						-		-
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope	2004.00	20	45.000	1.0	R	419.54	20	45.000	1.0	R	419.54			-
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins	2004.00					-						-		-
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%	2004.00					-						-		-
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.	2004.00					-						-		-
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	2004.00	20	21.000	1.0	R	195.79	20	21.000	1.0	R	195.79			-
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)	2004.00					-						-		-
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure	2004.00					-						-		-
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)	2004.00					-						-		-
0080	Multiple examinations: Full Fee	2004.00					-						-		-
0081	Repeat examinations: No reduction	2004.00					-						-		-
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction	2004.00					-						-		-
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used	2004.00					-						-		-
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit (This information is obtainable from the Radiological Society of SA)	2004.00					-						-		-

0085	Left Side' modifier to be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined	2004.00					-					-				-
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations	2004.00					-					-				-
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)	2004.00					-					-				-
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)	2004.00					-					-				-
0092	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)	2004.00					-					-				-
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials	2004.00					-					-				-
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope	2004.00					-					-				-
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee	2004.00					-					-				-
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units	2004.00					-					-				-
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	2004.00	60	6.000	1.0	R	53.31	60	6.000	1.0	R	53.31				-
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%	2004.00					-					-				-
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes	2004.00					-					-				-
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g. a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region	2004.00					-					-				-
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee	2004.00					-					-				-
6103	Post-contrast study: Bone tumour: 100% of the fee	2004.00					-					-				-
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable	2004.00					-					-				-
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items	2004.00					-					-				-
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00					-					-				-
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability	2004.00					-					-				-
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"	2004.00					-					-				-
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain	2004.00					-					-				-

6110	MRI spectroscopy: 50% of fee	2004.00	-					-					-			
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)	2004.00	-					-					-			
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00	-					-					-			
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)	2004.00	-					-					-			
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure	2004.00	-					-					-			
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value	2004.00	-					-					-			
I.	Consultative Services		-					-					-			
I.a	General Practitioner visits		-					-					-			
I.b	Specialists tiered consultation structure		-					-					-			
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only		-					-					-			
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02	-					-					-			
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02	-					-					-			
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02	-					-					-			
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)	2006.02	-					-					-			
0166	Psychiatry (22): First hospital consultation/visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes	2006.06	-					-					-			
0167	Psychiatry (22): First hospital consultation/visit with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 21 and 35 minutes	2006.06	-					-					-			
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes	2006.06	-					-					-			
0169	Psychiatry (22): First hospital consultation/visit with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 46 and 60 minutes	2006.06	-					-					-			
I.c	General practitioner and specialist services		-					-					-			
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02	-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91			

0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02						-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure	2006.02						-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02						-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02						-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)	2006.02						-	130	15.000	1.0	R	253.13	10	17.000	1.0	R	255.91
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)	2006.04		10	15.000	1.0	R	225.85	10	15.000	1.0	R	225.85					-
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists (may only be charged once per day) (not to be used with items 0109 or ICU items 1204-1214). For a healthy neonate please use item 0109 for a hospital follow-up visit	2006.04						-					-					-
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes	2006.06	+	10	15.000	1.0	R	225.85	10	15.000	1.0	R	225.85					-
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.04	+	10	6.000	1.0	R	90.34	10	6.000	1.0	R	90.34					-
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.05	+	10	8.000	1.0	R	120.40	10	8.000	1.0	R	120.40					-
0147	For an unscheduled emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof	2006.05	+	10	14.000	1.0	R	210.74	10	14.000	1.0	R	210.74					-
0148	For elective after-hours services on request of the patient or family (non emergency) (refer to general rule B): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0148. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the normal hours period as reflected in general rule B.	2006.05	+	10	-	1.0		-	10	-	1.0		-					-
0149	After-hours bona fide emergency consultation/visit (21:00-6:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0149. Note: The after-hour period applicable to this item is from Monday to Sunday 21:00-6:00	2006.05		10	-	1.0		-	10	-	1.0		-					-
I.e	Pre-anaesthetic assessment							-					-					-

0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes	2006.04					-	10	16.000	1.0	R	240.81	10	16.000	1.0	R	240.81
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes	2006.04					-	10	16.000	1.0	R	240.81	10	16.000	1.0	R	240.81
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes	2006.04					-	10	16.000	1.0	R	240.81	10	16.000	1.0	R	240.81
I.f	Prenatal visits and new born attendance						-					-					-
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107)	2006.02	12	33.000	1.0	R	496.72	12	33.000	1.0	R	496.72					-
	Item 0107 can be used once only for given confinement	2004.00					-					-					-
0113	New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113)	2006.02	12	45.000	1.0	R	677.40	12	45.000	1.0	R	677.40					-
I.g	Consultative services: Miscellaneous						-					-					-
0130	Telephone consultation (all hours)	2004.00					-	10	12.000	1.0	R	180.68	10	12.000	1.0	R	180.68
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) ("Consultation" via SMS or electronic media included)	2004.00	10	5.000	1.0	R	75.23	10	5.000	1.0	R	75.23					-
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent	2004.00	10	9.000	1.0	R	135.51	10	9.000	1.0	R	135.51					-
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent	2004.00	10	21.430	1.0	R	322.64	10	21.430	1.0	R	322.64					-
II.	Medicine, material, supplies and use of own equipment						-					-					-
II.a	Medicine codes						-					-					-
II.a.1	Dispensing of medicine by licensed dispensing medical practitioners						-					-					-
0197	Licensed dispensing medical practitioners: Dispensing cost - R16.00 for medicine with a cost of R100,00 or more (VAT inclusive), or 16% for medicine costing less than R100,00 (VAT inclusive). Add to each Nappi code to provide for the dispensing cost.	2006.02					-					-					-
II.a.2	Once-off administration of medicine used during a consultation						-					-					-
0198	Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS R16,00 for medicine with a cost of R100,00 or more, or 16% for medicine costing less than R100,00 PLUS VAT on the 16%/R16,00. (Where applicable, VAT should be added to the 16%/R 16,00 only and not to the SEP, since the SEP is VAT inclusive). [According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.	2006.02					-					-					-
II.a.3	Cost of chemotherapy drugs						-					-					-
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.	2006.02					-					-					-
II.b	Material codes						-					-					-
II.b.1	Prosthesis and/or internal fixation						-					-					-

0200	Prosthesis and/or internal fixation: This item provides for a charge for prosthesis and/or internal fixation. Charge for prosthesis and/or internal fixation at cost price PLUS 26% (up to a maximum of R 26,00). (Where applicable, VAT should be added to the above). The appropriate Nappi code(s), where applicable, for the prosthesis and/or internal fixation used, must be provided.	2006.02					-					-	-
II.b.2	Material used during a consultation						-					-	-
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.	2006.02					-					-	-
II.c	Setting of sterile tray						-					-	-
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate	2005.06	20	10.000	1.0	R	93.27	20	10.000	1.0	R	93.27	-
II.d	Own equipment used in treatment						-					-	-
5930	Surgical laser apparatus: Hire fee for own equipment	2004.00	20	109.000	1.0	R	1 016.18	20	109.000	1.0	R	1 016.18	-
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)	2004.00					-					-	-
III.	PROCEDURES						-					-	-
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999	2005.03					-					-	-
	GENERAL MODIFIERS GOVERNING THIS SECTION						-					-	-
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)	2006.04					-					-	-
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged	2004.00					-					-	-
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general Rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff	2004.00					-					-	-
	MODIFIERS GOVERNING SECTION 1						-					-	-
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions	2004.00					-					-	-
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)	2005.06	10	7.500	1.0	R	112.91	10	7.500	1.0	R	112.91	-
1	General						-					-	-
1.1	Injections, Infusions and Inhalation Sedation Treatment						-					-	-
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	2004.00	20	6.000	1.0	R	55.88	20	6.000	1.0	R	55.88	-
0204	Inhalation sedation: Per additional quarter-hour or part thereof	2004.00	20	3.000	1.0	R	28.01	20	3.000	1.0	R	28.01	-
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours	2004.00	20	12.000	1.0	R	111.90	20	12.000	1.0	R	111.90	-

0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	2004.00	20	6.000	1.0	R	55.88		20	6.000	1.0	R	55.88			-
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	2004.00	20	8.000	1.0	R	74.65		20	8.000	1.0	R	74.65			-
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	2004.00	20	6.000	1.0	R	55.88		20	6.000	1.0	R	55.88			-
0209	Umbilical artery cannulation at birth	2004.00	20	18.000	1.0	R	167.77		20	18.000	1.0	R	167.77			-
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	2004.00	20	3.250	1.0	R	30.36		20	3.250	1.0	R	30.36			-
0211	Exchange transfusion: First and subsequent (including after-care)	2004.00	20	80.000	1.0	R	745.89		20	80.000	1.0	R	745.89			-
	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)	2004.00					-						-			-
1.2	Chemotherapy treatment (not in chemotherapy facilities)						-						-			-
0213	Treatment with cytostatic agents: Administering of Chemotherapy: Intramuscular or subcutaneous: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00	20	5.000	1.0	R	46.64		20	5.000	1.0	R	46.64			-
0214	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous bolus technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00	20	9.000	1.0	R	83.89		20	9.000	1.0	R	83.89			-
0215	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous infusion technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	2004.00	20	14.000	1.0	R	130.52		20	14.000	1.0	R	130.52			-
1.3	Oncology related services in non-oncology facilities						-						-			-
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included	2006.06	20	394.860	1.0	R	3 681.21	Z	20	315.890	1.0	R	2 945.00	Z		-
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included	2006.02	20	262.410	1.0	R	2 446.37	Z	20	209.930	1.0	R	1 957.12	Z		-
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included	2006.02	20	77.810	1.0	R	725.36	Z	20	77.810	1.0	R	725.36	Z		-
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)	2006.02	20	42.650	1.0	R	397.58	Z	20	42.650	1.0	R	397.58	Z		-
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS						-						-			-
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.	2006.06					-						-			-
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifiers (see Modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448	2006.04					-						-			-
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.	2006.05					-						-			-

0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.	2006.05	-	-					-
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.	2006.05	-	-					-
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units	2006.04	-	-					-
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute	2006.06	-	-					-
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic	2006.04	-	-					-
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute	2006.06	-	-					-
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time	2006.04	-	-					-
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added	2006.04	-	-					-
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.	2006.05	-	-					-
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added	2006.04	-	-					-
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).	2006.05	-	-					-
0036	Anaesthetic administered by general practitioners: The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time [refer to modifier 0023] plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.	2006.05	-	-					-
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	2006.04	-	-	30	3.000	1.0	R	175.53
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage	2006.04	-	-					-

0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof	2006.04					-					-					-	
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units	2006.04					-					-					-	
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	2006.04					-					-	30	3.000	1.0	R	175.53	
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	2006.04					-					-	30	3.000	1.0	R	175.53	
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added	2006.04					-					-	30	3.000	1.0	R	175.53	
0044	Neonates (i.e. up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to Modifier 0043: Cases under one year of age	2006.04					-					-	30	3.000	1.0	R	175.53	
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.	2006.06					-					-					-	
	Modifiers 5441 to 5448	2006.04					-					-					-	
	Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items)																	
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	2006.04					-					-	30	1.000	1.0	R	58.52	
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units	2006.04					-					-	30	2.000	1.0	R	117.02	
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	2006.04					-					-	30	3.000	1.0	R	175.53	
5444	Shaft of femur: Add four (4,00) anaesthetic units	2006.04					-					-	30	4.000	1.0	R	234.03	
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	2006.04					-					-	30	5.000	1.0	R	292.55	
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	2006.04					-					-	30	8.000	1.0	R	468.07	
	POST-OPERATIVE ALLEVIATION OF PAIN						-					-					-	
0045	Post-operative alleviation of pain:	2006.04					-					-					-	
	(a) When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique																	
	(b) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility.																	
	(c) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)																	
2	Integumentary System						-					-					-	
2.1	Allergy						-					-					-	
0217	Allergy: Patch tests: First patch	2004.00	20	4.000	1.0	R	37.25	20	4.000	1.0	R	37.25					-	
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	2004.00	20	2.800	1.0	R	26.10	20	2.800	1.0	R	26.10					-	
0219	Allergy: Patch tests: Each additional patch	2004.00	20	2.000	1.0	R	18.63	20	2.000	1.0	R	18.63					-	
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	2004.00	20	1.900	1.0	R	17.75	20	1.900	1.0	R	17.75					-	
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	2004.00	20	2.800	1.0	R	26.10	20	2.800	1.0	R	26.10					-	
2.2	Skin (general)						-					-					-	
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	2004.00	20	4.000	1.0	R	37.25	20	4.000	1.0	R	37.25					-	
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	2004.00	20	8.000	1.0	R	74.65	20	8.000	1.0	R	74.65					-	
0225	Epilation: Per session	2004.00	20	8.000	1.0	R	74.65	20	8.000	1.0	R	74.65					-	
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session	2004.00	20	8.000	1.0	R	74.65	20	8.000	1.0	R	74.65	30	4.000	1.0	R	234.06	T
0228	PUVA Treatment: Maximum of 21 treatments	2004.00	20	20.000	1.0	R	186.40	20	20.000	1.0	R	186.40					-	

0229	PUVA: Follow-up or maintenance therapy once a week	2004.00	20	20.000	1.0	R	186.40		20	20.000	1.0	R	186.40					-		
0230	UVR-Treatment	2004.00	20	20.000	1.0	R	186.40		20	20.000	1.0	R	186.40					-		
0231	UVR-Follow-up - for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp	2004.00	20	5.500	1.0	R	51.33		20	5.500	1.0	R	51.33					-		
0233	Biopsy without suturing: First lesion	2004.00	20	6.000	1.0	R	55.88		20	6.000	1.0	R	55.88		30	3.000	1.0	R	175.55	T
0234	Biopsy without suturing: Subsequent lesions (each)	2004.00	20	3.000	1.0	R	28.01		20	3.000	1.0	R	28.01		30	3.000	1.0	R	175.55	T
0235	Biopsy without suturing: Maximum for multiple additional lesions	2004.00	20	18.000	1.0	R	167.77		20	18.000	1.0	R	167.77		30	3.000	1.0	R	175.55	T
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	2004.00	20	12.000	1.0	R	111.90		20	12.000	1.0	R	111.90		30	3.000	1.0	R	175.55	T
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	2004.00	20	6.000	1.0	R	55.88		20	6.000	1.0	R	55.88		30	3.000	1.0	R	175.55	T
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	2004.00	20	3.000	1.0	R	28.01		20	3.000	1.0	R	28.01		30	3.000	1.0	R	175.55	T
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	2004.00	20	42.000	1.0	R	391.57		20	42.000	1.0	R	391.57		30	3.000	1.0	R	175.55	T
0244	Repair of nail bed	2004.00	20	30.000	1.0	R	279.67		20	30.000	1.0	R	279.67		30	3.000	1.0	R	175.55	T
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	2004.00	20	14.000	1.0	R	130.52		20	14.000	1.0	R	130.52		30	3.000	1.0	R	175.55	T
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	2004.00	20	7.000	1.0	R	65.26		20	7.000	1.0	R	65.26		30	3.000	1.0	R	175.55	T
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	2004.00	20	30.000	1.0	R	279.67		20	30.000	1.0	R	279.67		30	3.000	1.0	R	175.55	T
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	2004.00	20	15.000	1.0	R	139.91		20	15.000	1.0	R	139.91		30	3.000	1.0	R	175.55	T
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	2004.00	20	20.000	1.0	R	186.40		20	20.000	1.0	R	186.40		30	3.000	1.0	R	175.55	T
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	2004.00	20	87.000	1.0	R	811.15		20	87.000	1.0	R	811.15		30	3.000	1.0	R	175.55	T
0259	Removal of foreign body superficial to deep fascia (except hands)	2004.00	20	20.000	1.0	R	186.40		20	20.000	1.0	R	186.40		30	3.000	1.0	R	175.55	T
0261	Removal of foreign body deep to deep fascia (except hands)	2004.00	20	31.000	1.0	R	289.06		20	31.000	1.0	R	289.06		30	3.000	1.0	R	175.55	T
0271	Kurtin planing for acne scarring: Whole face	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0273	Kurtin planing for acne scarring: Extensive	2004.00	20	70.000	1.0	R	652.62		20	70.000	1.0	R	652.62		30	4.000	1.0	R	234.06	T
0275	Kurtin planing for acne scarring: Limited	2004.00	20	30.000	1.0	R	279.67		20	30.000	1.0	R	279.67		30	4.000	1.0	R	234.06	T
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	2004.00	20	103.000	1.0	R	960.30		20	103.000	1.0	R	960.30		30	4.000	1.0	R	234.06	T
0279	Surgical treatment for axillary hyperhidrosis	2004.00	20	64.000	1.0	R	596.60		20	64.000	1.0	R	596.60		30	4.000	1.0	R	234.06	T
0280	Laser treatment for small skin lesions: First lesion	2004.00	20	14.000	1.0	R	130.52		20	14.000	1.0	R	130.52		30	3.000	1.0	R	175.55	T
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	2004.00	20	7.000	1.0	R	65.26		20	7.000	1.0	R	65.26		30	3.000	1.0	R	175.55	T
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	2004.00	20	56.000	1.0	R	522.09		20	56.000	1.0	R	522.09		30	3.000	1.0	R	175.55	T
0283	Laser treatment for large skin lesions: Limited area	2004.00	20	30.000	1.0	R	279.67		20	30.000	1.0	R	279.67		30	4.000	1.0	R	234.06	T
0284	Laser treatment for large skin lesions: Extensive area	2004.00	20	70.000	1.0	R	652.62		20	70.000	1.0	R	652.62		30	4.000	1.0	R	234.06	T
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	2004.00	20	56.630	1.0	R	527.96	Z	20	56.630	1.0	R	527.96	Z					-	
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	2004.00	20	43.440	1.0	R	404.92	Z	20	43.440	1.0	R	404.92	Z					-	
2.3	Major plastic repair						-						-						-	
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	2004.00	20	234.000	1.0	R	2 181.51		20	187.200	1.0	R	1 745.20		30	4.000	1.0	R	234.06	T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	2004.00	20	410.000	1.0	R	3 822.44		20	328.000	1.0	R	3 057.92		30	4.000	1.0	R	234.06	T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	2004.00	20	800.000	1.0	R	7 458.33		20	640.000	1.0	R	5 966.69		30	4.000	1.0	R	234.06	T
0292	Distant flaps: First stage	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0293	Contour grafts (excluding cost of material)	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	2004.11	20	#######	1.0	R	11 187.49		20	960.000	1.0	R	8 949.97		30	6.000	1.0	R	351.09	T
0295	Local skin flaps (large, complicated)	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0296	Other procedures of major technical nature	2004.00	20	206.000	1.0	R	1 920.46		20	164.800	1.0	R	1 536.37		30	4.000	1.0	R	234.06	T
0297	Subsequent major procedures for repair of same lesion	2004.00	20	104.000	1.0	R	969.54		20	104.000	1.0	R	969.54		30	4.000	1.0	R	234.06	T
0298	Lower abdominal dermo-lipectomy	2004.00	20	170.000	1.0	R	1 584.91		20	136.000	1.0	R	1 267.99		30	5.000	1.0	R	292.58	T
0299	Major abdominal lipectomy with repositioning of umbilicus	2004.00	20	275.000	1.0	R	2 563.84		20	220.000	1.0	R	2 050.98		30	5.000	1.0	R	292.58	T
2.4	Lacerations, scars, tumours, cysts and other skin lesions						-						-						-	
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)	2004.00	20	14.000	1.0	R	130.52		20	14.000	1.0	R	130.52		30	3.000	1.0	R	175.55	T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	2004.00	20	7.000	1.0	R	65.26		20	7.000	1.0	R	65.26		30	3.000	1.0	R	175.55	T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	2004.00	20	64.000	1.0	R	596.60		20	64.000	1.0	R	596.60		30	4.000	1.0	R	234.06	T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	2004.00	20	128.000	1.0	R	1 193.34		20	120.000	1.0	R	1 118.69		30	4.000	1.0	R	234.06	T
0304	Major debridement of wound, sloughectomy or secondary suture	2004.00	20	50.000	1.0	R	466.22		20	50.000	1.0	R	466.22		30	3.000	1.0	R	175.55	T

0305	Needle biopsy - soft tissue	2004.00	20	25.000	1.0	R	233.04	20	25.000	1.0	R	233.04	30	3.000	1.0	R	175.55	T
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	2004.00	20	27.000	1.0	R	251.66	20	27.000	1.0	R	251.66	30	3.000	1.0	R	175.55	T
0308	Each additional small procedure done at the same time	2004.00	20	14.000	1.0	R	130.52	20	14.000	1.0	R	130.52	30	3.000	1.0	R	175.55	T
0310	Radical excision of nailbed	2004.00	20	38.000	1.0	R	354.32	20	38.000	1.0	R	354.32	30	3.000	1.0	R	175.55	T
0311	Excision of large benign tumour (more than 5 cm)	2004.00	20	55.000	1.0	R	512.71	20	55.000	1.0	R	512.71	30	3.000	1.0	R	175.55	T
0313	Extensive resection for malignant soft tissue tumour including muscle	2004.00	20	283.900	1.0	R	2 646.84	20	227.120	1.0	R	2 117.42	30	4.000	1.0	R	234.06	T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	2004.00	20	104.000	1.0	R	969.54	20	104.000	1.0	R	969.54	30	4.000	1.0	R	234.06	T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	2004.00	20	55.000	1.0	R	512.71	20	55.000	1.0	R	512.71	30	3.000	1.0	R	175.55	T
2.5	Breasts						-					-					-	
0316	Fine needle aspiration for soft tissue (all areas)	2004.00	20	15.000	1.0	R	139.91	20	15.000	1.0	R	139.91					-	
0317	Aspiration of cyst or tumour	2004.00	20	9.000	1.0	R	83.89	20	9.000	1.0	R	83.89	30	3.000	1.0	R	175.55	T
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	2004.00	20	42.000	1.0	R	391.57	20	42.000	1.0	R	391.57	30	3.000	1.0	R	175.55	T
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	2004.00	20	94.200	1.0	R	878.18	20	94.200	1.0	R	878.18	30	3.000	1.0	R	175.55	T
0323	Subareolar cone excision of ducts of wedge excision of breast	2004.00	20	90.000	1.0	R	839.02	20	90.000	1.0	R	839.02	30	3.000	1.0	R	175.55	T
0324	Wedge excision of breast and axillary dissection	2004.00	20	225.000	1.0	R	2 097.62	20	180.000	1.0	R	1 678.18	30	5.000	1.0	R	292.58	T
0325	Total mastectomy	2004.00	20	155.000	1.0	R	1 445.00	20	124.000	1.0	R	1 156.09	30	5.000	1.0	R	292.58	T
0327	Total mastectomy with axillary gland biopsy	2004.00	20	185.000	1.0	R	1 724.67	20	148.000	1.0	R	1 379.74	30	5.000	1.0	R	292.58	T
0329	Total mastectomy with axillary gland dissection	2004.00	20	275.000	1.0	R	2 563.84	20	220.000	1.0	R	2 050.98	30	5.000	1.0	R	292.58	T
0330	Nipple and areola reconstruction	2004.00	20	95.000	1.0	R	885.65	20	95.000	1.0	R	885.65	30	4.000	1.0	R	234.06	T
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	2004.00	20	234.000	1.0	R	2 181.51	20	187.200	1.0	R	1 745.20	30	4.000	1.0	R	234.06	T
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	2004.00	20	410.000	1.0	R	3 822.44	20	328.000	1.0	R	3 057.92	30	4.000	1.0	R	234.06	T
0334	Removal of breast implant by means of capsulectomy: Per breast	2004.00	20	234.000	1.0	R	2 181.51	20	187.200	1.0	R	1 745.20	30	4.000	1.0	R	234.06	T
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	2004.00	20	150.000	1.0	R	1 398.51	20	120.000	1.0	R	1 118.69	30	4.000	1.0	R	234.06	T
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	2004.00	20	234.000	1.0	R	2 181.51	20	187.200	1.0	R	1 745.20	30	5.000	1.0	R	292.58	T
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	2004.00	20	410.000	1.0	R	3 822.44	20	328.000	1.0	R	3 057.92	30	5.000	1.0	R	292.58	T
0341	Gynaecomastia: Unilateral	2004.00	20	92.000	1.0	R	857.64	20	92.000	1.0	R	857.64	30	3.000	1.0	R	175.55	T
0343	Gynaecomastia: Bilateral	2004.00	20	161.000	1.0	R	1 501.02	20	128.800	1.0	R	1 200.82	30	3.000	1.0	R	175.55	T
2.6	Burns						-					-					-	
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	2004.00	20	276.000	1.0	R	2 573.08	20	220.800	1.0	R	2 058.46	30	5.000	1.0	R	292.58	T
0353	Tangential excision and grafting: Small	2004.00	20	100.000	1.0	R	932.29	20	100.000	1.0	R	932.29	30	5.000	1.0	R	292.58	T
0354	Tangential excision and grafting: Large	2004.00	20	200.000	1.0	R	1 864.58	20	160.000	1.0	R	1 491.64	30	5.000	1.0	R	292.58	T
2.7	Hands (skin)						-					-					-	
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	2004.00	20	147.400	1.0	R	1 374.17	20	120.000	1.0	R	1 118.69	30	4.000	1.0	R	234.06	T
0357	Small skin graft in acute hand injury	2004.00	20	45.000	1.0	R	419.58	20	45.000	1.0	R	419.58	30	3.000	1.0	R	175.55	T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	2004.00	20	192.000	1.0	R	1 789.93	20	153.600	1.0	R	1 431.95	30	3.000	1.0	R	175.55	T
0361	Z-plasty	2004.00	20	220.100	1.0	R	2 052.01	20	176.080	1.0	R	1 641.52	30	3.000	1.0	R	175.55	T
0363	Local flap and skin graft	2004.00	20	150.000	1.0	R	1 398.51	20	120.000	1.0	R	1 118.69	30	3.000	1.0	R	175.55	T
0365	Cross finger flap (all stages)	2004.00	20	192.000	1.0	R	1 789.93	20	153.600	1.0	R	1 431.95	30	3.000	1.0	R	175.55	T
0367	Palmar flap (all stages)	2004.00	20	192.000	1.0	R	1 789.93	20	153.600	1.0	R	1 431.95	30	3.000	1.0	R	175.55	T
0369	Distant flap: First stage	2004.00	20	158.000	1.0	R	1 473.01	20	126.400	1.0	R	1 178.38	30	3.000	1.0	R	175.55	T
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	2004.00	20	77.000	1.0	R	717.88	20	77.000	1.0	R	717.88	30	3.000	1.0	R	175.55	T
0373	Transfer neurovascular island flap	2004.00	20	230.500	1.0	R	2 148.95	20	184.400	1.0	R	1 719.10	30	3.000	1.0	R	175.55	T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	2004.00	20	242.400	1.0	R	2 259.82	20	193.920	1.0	R	1 807.83	30	3.000	1.0	R	175.55	T
0375	Dupuytren's contracture: Fasciotomy	2004.00	20	51.000	1.0	R	475.46	20	51.000	1.0	R	475.46	30	3.000	1.0	R	175.55	T
0376	Dupuytren's contracture: Fasciectomy	2004.00	20	218.000	1.0	R	2 032.36	20	174.400	1.0	R	1 625.97	30	3.000	1.0	R	175.55	T
2.8	Acupuncture						-					-					-	
	Please note: General Rule M not applicable to section 2.8 of this price list	2004.00					-					-					-	
0377	Standard acupuncture	2004.00	20	10.000	1.0	R	93.27	20	10.000	1.0	R	93.27					-	
0378	Laser acupuncture using more than 6 points	2004.00	20	14.000	1.0	R	130.52	20	14.000	1.0	R	130.52					-	
0379	Electro-acupuncture	2004.00	20	14.000	1.0	R	130.52	20	14.000	1.0	R	130.52					-	
0380	Scalp acupuncture	2004.00	20	10.000	1.0	R	93.27	20	10.000	1.0	R	93.27					-	
0381	Micro-acupuncture (ear, hand)	2004.00	20	10.000	1.0	R	93.27	20	10.000	1.0	R	93.27					-	
	RULES GOVERNING THE SECTION ACUPUNCTURE						-					-					-	

CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp	2004.00					-						-											-	
3	Musculo-skeletal System						-						-											-	
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS						-						-											-	
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis	2004.00					-						-											-	
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)	2004.00	20	27.000	1.0	R	251.72		20	27.000	1.0	R	251.72											-	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement	2004.11	20	77.000	1.0	R	717.87		20	77.000	1.0	R	717.87											-	
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	2004.00	20	115.500	1.0	R	1 076.79		20	115.500	1.0	R	1 076.79											-	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units	2004.11	20	77.000	1.0	R	717.87		20	77.000	1.0	R	717.87											-	
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units	2004.00	20	32.000	1.0	R	298.33		20	32.000	1.0	R	298.33											-	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units	2004.11	20	77.000	1.0	R	717.87		20	77.000	1.0	R	717.87											-	
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot	2004.00					-						-											-	
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100%	2004.00					-						-											-	
3.1	Bones						-						-											-	
3.1.1	Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)						-						-											-	
0383	Fracture (reduction under general anaesthetic): Scapula	2004.00	20	-	1.0		-	v	20	-	1.0		-	v	30	3.000	1.0	R	175.55	TM					
0387	Fracture (reduction under general anaesthetic): Clavicle	2004.00	20	77.000	1.0	R	717.88		20	77.000	1.0	R	717.88		30	3.000	1.0	R	175.55	TM					
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	2004.00	20	175.700	1.0	R	1 638.00		20	140.560	1.0	R	1 310.37		30	3.000	1.0	R	175.55	TM					
0389	Fracture (reduction under general anaesthetic): Humerus	2004.00	20	111.600	1.0	R	1 040.38		20	111.600	1.0	R	1 040.38		30	3.000	1.0	R	175.55	TM					
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	2004.00	20	77.000	1.0	R	717.88		20	77.000	1.0	R	717.88		30	3.000	1.0	R	175.55	TM					
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	2004.00	20	210.000	1.0	R	1 957.86		20	168.000	1.0	R	1 566.28		30	3.000	1.0	R	175.55	TM					
0402	Fracture (reduction under general anaesthetic): Carpal bone	2004.00	20	64.000	1.0	R	596.60		20	64.000	1.0	R	596.60		30	3.000	1.0	R	175.55	TM					
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	2004.00	20	51.000	1.0	R	475.46		20	51.000	1.0	R	475.46		30	3.000	1.0	R	175.55	TM					
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	2004.00	20	118.300	1.0	R	1 102.85		20	118.300	1.0	R	1 102.85		30	3.000	1.0	R	175.55	TM					
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	2004.00	20	-	1.0		-	ß	20	-	1.0		-	ß	30	3.000	1.0	R	175.55	TM					
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	2004.00	20	52.000	1.0	R	484.84		20	52.000	1.0	R	484.84		30	3.000	1.0	R	175.55	TM					
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	2004.00	20	48.000	1.0	R	447.45		20	48.000	1.0	R	447.45		30	3.000	1.0	R	175.55	T					
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	2004.00	20	102.000	1.0	R	950.92		20	102.000	1.0	R	950.92		30	3.000	1.0	R	175.55	TM					
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	2004.00	20	-	0.0		-	ß	20	-	0.0		-	ß	30	3.000	1.0	R	175.55	T					
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	2004.00	20	320.000	1.0	R	2 983.27		20	256.000	1.0	R	2 386.68		30	3.000	1.0	R	175.55	TM					
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	2004.00	20	237.000	1.0	R	2 209.52		20	189.600	1.0	R	1 767.64		30	3.000	1.0	R	175.55	TM					
0425	Fracture (reduction under general anaesthetic): Patella	2004.00	20	51.000	1.0	R	475.46		20	51.000	1.0	R	475.46		30	3.000	1.0	R	175.55	TM					