GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7280 **20 March 2026**

DENTAL GAZETTE 2026

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Compensation Fund

GOVERNMENT NOTICE

DEPARTMENT OF EMPLOYMENT AND LABOUR

No. ..... **DATE: .....**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT No. 130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Nomakhosazana Meth, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2026.

2. Medical Tariffs will increase by 6% for the financial year 2026/27.

3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2026 and exclude 15% VAT

Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

- The Compensation Fund requires that any Medical Service Provider, treating patients in terms of the COID Act, must be registered with The Compensation Fund through the submission of copies of the following documents to the nearest labour centre:
  a. A duly completed original Banking Details form (WAC 33) (download in PDF from www.labour.gov.za)
  b. The latest copy of valid BHF certificate
  c. Recent bank statement with bank stamp or bank letter
  d. Proof of practice address not older than 3 months.
  e. SARS VAT registration number/ certificate if VAT registered. (If this is not provided the medical practitioner will be registered as a non-VAT vendor)
  f. A power of attorney is required if the MSP has appointed a third party to do their administration of their COID claims.

2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

- To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

  a. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)
  b. Register on the CompEasy application having the following documents to upload
     - A certified copy of identity document (not older than a month from the date of application)
     - Latest copy of valid BHF certificate
     - Proof of address not older than 3 months

- In the case where a medical service provider has appointed a third party to administer their COID claims with the Fund, the following ADDITIONAL documents must be uploaded:

  - An appointment letter for proxy (the template is available online)
  - The proxy's certified identity document (not older than a month from the date of application)
  - There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

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3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

- Third Parties that provide administration services on behalf of medical service providers must take note of the following:
  - **a.** They must be able to obtain and make available copies of the original claim documents and medical invoices from medical service providers.
  - **b.** They must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.
- The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information relates to a period prior to them being contracting to a third party.

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

Medical Service Providers are encouraged to take note of the following guidance when treating patients in terms of the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

- **a.** Employees as defined in the COID Act of 1993, are generally free to choose their preferred Medical Service Provider, provided that such choice is exercised reasonably and without prejudice to the employee or the Compensation Fund.
  - An exception applies where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to its employees, e.g. Hospital, nursing and other medical services, as contemplated in Section 78 of the COID Act, in such cases, treatment arrangements may differ.
- **b.** In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report. Medical Service providers should cooperate with such referrals where they occur.
- **c.** Medical Service Providers are reminded that in accordance with section 76(3)(b) of the COID Act, medical expenses may not be recovered from the employee. Providers should therefore avoid billing employees directly for services that fall within accepted COID claims.
- **d.** Where a change of Medical Service Providers occurs, the first treating doctor is generally regarded as the principal treating doctor, unless the case is transferred to a specialist.
- **e.** To promote continuity of care and avoid disputes, Medical Service Providers are encouraged not to treat an employee who is already under the care of another practitioner without first consulting or informing the principal treating doctor.
- **f.** Any changes of medical service providers should be supported by sufficient reasons, and such reasons should be communicated to the Compensation Fund to ensure clarity and proper case management.
- **g.** In line to section 5 of the National Health Act no 61 of 2003, a health care provider may not refuse a person emergency medical treatment. In emergency situations, Medical Service Providers are not required to obtain prior authorisation from the Compensation Fund before rendering such treatment even if the claim has not yet been registered or accepted.

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h. Employees who seek medical treatment do so at their own risk where they have not informed their employer and/or the Compensation Fund of possible grounds for a COID claim. Medical Service Providers should be aware that, under such circumstances, The Compensation Fund may not accept responsibility for the settlements of the medical expenses incurred.
i. Where a claim is repudiated by the Compensation Fund, the employee is regarded in the same position as any other member of the public in respect of payment for medical services rendered.

5. OVERVIEW OF THE COID CLAIMS PROCESS

- All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

a. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details and progress of the claim can be viewed on the online processing system for registered users of the system.
b. Proof of identity is required through the submission of a copy of an Identity document/card, will be required for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.
c. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.
d. Once an incident is reported to the Fund a claims number will be allocated to acknowledge receipt, but this does not imply acceptance of liability for the claim.
e. On acceptance of liability for claims in terms of the COID Act, all reasonable medical expenses, arising from the related medical condition shall be paid to medical service providers, and in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.
f. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable. The employer and the employee will be informed of this decision, and the injured employee will be liable for payment of medical costs incurred.
g. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.
h. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.
    - All medical invoices for accepted claims must be submitted, in the prescribed manner within 36 months of the date of acceptance of liability.
    - And or within 36 months from the date of service, which ever may apply.
    - Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.
i. All service providers should be registered on the Compensation Fund claims processing system to capture medical invoices and medical reports for medical services rendered.
j. Submission of medical reports and invoices is permitted solely for claims where liability has been accepted by the Compensation Fund and where payment of reasonable medical expenses is authorised.

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6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED OR DISEASED EMPLOYEES

Submission of Medical Reports

- In terms of section 74(1)– (5) of the Compensation for Occupational Injuries and Diseases Act, 1993 (COID Act), every Medical Service Provider shall submit the prescribed medical reports when claiming from the Compensation Fund.
- The First Medical Report (W.CL 4), completed after the initial consultation, shall:
  - Confirm the clinical description of the injury or disease.
  - Detail all procedures performed; and
  - Record all referrals to other medical service providers, where applicable.
- All follow up consultations shall be recorded on a Progress Medical Report (W.CL 5). Any procedure or operation performed during the reporting period shall be clearly detailed, including all referrals, where applicable.
- A Progress Medical Report shall cover a maximum period of thirty (30) days, except where a procedure has been performed during that period, in which case an additional operation report shall be submitted.
- Where multiple procedures are performed on the same date of service, only one medical report shall be submitted in respect of that service date.
- Upon stabilisation of the injury or disease, a Final Medical Report (W.CL 5F) shall be completed and submitted
- Medical Service Providers shall attach a medical report or other appropriate medical documentation to every claim submitted to the Compensation Fund.
- Medical Service Providers shall retain copies of all submitted medical reports and shall make such records available to the Compensation Commissioner upon request.
- With effect from 1 April 2025, **ALL** medical practitioners shall submit relevant patient records together with medical invoices for services rendered. **(This includes hospitals, anaesthetists and any other practitioners that have not previously been required to do so)**

Submission of Medical Invoices

- Medical invoices shall be submitted only in respect of claims for which liability has been formally accepted by the Compensation Fund and where payment of reasonable medical expenses has been authorised.
- The submission of medical invoices without the required accompanying medical documentation shall be strictly prohibited and shall result in rejection of the invoice.
- Duplicate invoices shall not be submitted under any circumstances.
- Running accounts or statements shall not be accepted and shall be rejected at system level.

Minimum Information Requirements for Medical Invoices

Every medical invoice submitted to the Compensation Fund shall, at a minimum, include the following information:

- The allocated Compensation Fund claim number.
- The full name, surname and identity number of the employee.
- The name and Compensation Fund registration number of the employer, as reflected on the Employer's Report of Accident (W.CL 2);

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- The date of accident.
- The date(s) of service rendered.
- The Medical Service Provider's BHF practice number.
- The VAT registration number of the Medical Service Provider, where applicable.
- The applicable tariff code(s) as published in the approved tariff gazettes.
- The amount claimed per tariff code, quantity, total amount claimed including the correct sequencing of modifiers where applicable.
- A unique invoice number.

(Medical invoices that do not comply with the prescribed minimum information requirements shall be rejected and shall not be processed for payment).

VAT and Tariff Application

- Published tariff amounts shall be assessed exclusive of VAT.
- VAT shall be applied only where the Medical Service Provider is a registered VAT vendor and has supplied a valid VAT registration number on the invoice.
- Where no VAT registration number is provided, the Medical Service Provider shall be regarded as a non-VAT vendor and VAT shall not be applied.
- Notwithstanding the above, the following tariffs shall be processed as VAT inclusive:
  - Per diem tariffs applicable to private hospitals; and
  - VAT exempt tariff codes applicable to private ambulance services.

Pharmaceuticals and Referrals

- All pharmaceutical claims shall be submitted in accordance with the NAPPI file and shall be accompanied by the original prescription(s).
- Where a referral is required, the referring practitioner's referral letter shall accompany the medical invoice.

Enforcement and Non-Compliance

- The Compensation Fund shall withhold payment of any medical invoice that fails to comply with the billing and submission requirements prescribed in this document and as published in the Government Gazette.
- Noncompliance with these billing requirements shall result in rejection of claims and may result in further remedial or enforcement action by the Compensation Fund.

7. INVOICING REQUIREMENT ON MEDICAL CLAIMS FOR ICD-10 CODES

As part of improved delivery service and efficiency, The Compensation Fund has implemented ICD-10 rules that must be adhered to when submitting medical invoices. This will be rolled out in a phased approach. The first phase currently active on the system is outlined below:

ICD-10 Validations

ICD-10 validations will apply in accordance with the national ICD-10 Phase 3 and Phase 4.1 requirements and include the following:

- Valid ICD-10 codes as per the SA ICD-10 Master Industry Table
- Maximum level of specificity: ICD-10 codes must be valid at the correct 3-, 4-, or 5-character level
- Valid ICD-10 primary codes (codes not valid as primary will be rejected)
- Compliance with the dagger and asterisk rule

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- Compliance with sequelae coding rules
- Age edits for ICD-10 codes with age requirements
- Gender edits
- All injury and poisoning codes must be accompanied by external cause codes

Please ensure that you are familiar with the above requirements to avoid unnecessary claim rejections. The date and requirements for the next phase will be communicated in due course.

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the **following** requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund. This requires that they ensure the following:
    a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
    b. Use Strong Encryption and Hashing.
    c. Place Behind a Gateway.
    d. Implement IP Blacklists and Whitelists.
    e. Harden Your FTPS Server.
    f. Utilize Good Account Management.
    g. Use Strong Passwords.
    h. Implement File and Folder Security.
    i. Secure your administrator and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE: Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
BATCH HEADER				
1	Header identifier = 1	1	Numeric	*
2	Switch internal Medical aid reference number	5	Alpha	
3	Transaction type = M	1	Alpha	
4	Switch administrator number	3	Numeric	
5	Batch number	9	Numeric	*
6	Batch date (CCYYMMDD)	8	Date	*
7	Scheme name	40	Alpha	*
8	Switch internal	1	Numeric	
DETAIL LINES				
1	Transaction identifier = M	1	Alpha	*
2	Batch sequence number	10	Numeric	*
3	Switch transaction number	10	Numeric	*
4	Switch internal	3	Numeric	
5	CF Claim number	20	Alpha	*
6	Employee surname	20	Alpha	*
7	Employee initials	4	Alpha	*
8	Employee Names	20	Alpha	*
9	BHF Practice number	15	Alpha	*
10	Switch ID	3	Numeric	
11	Patient reference number (account number)	11	Alpha	*
12	Type of service	1	Alpha	
13	Service date (CCYYMMDD)	8	Date	*
14	Quantity / Time in minutes	7	Decimal	*
15	Service amount	15	Decimal	*
16	Discount amount	15	Decimal	*
17	Description	30	Alpha	*
18	Tariff	10	Alpha	*
19	Service fee	1	Numeric	
20	Modifier 1	5	Alpha	
21	Modifier 2	5	Alpha	
22	Modifier 3	5	Alpha	
23	Modifier 4	5	Alpha	
24	Invoice Number	10	Alpha	*
25	Practice name	40	Alpha	*
26	Referring doctor's BHF practice number	15	Alpha	
27	Medicine code (NAPPI CODE)	15	Alpha	*
28	Doctor practice number - sReferredTo	30	Numeric	
29	Date of birth / ID number	13	Numeric	*
30	Service Switch transaction number – batch number	20	Alpha	
31	Hospital indicator	1	Alpha	*
32	Authorisation number	21	Alpha	*
33	Resubmission flag	5	Alpha	*
34	Diagnostic codes	64	Alpha	*

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*

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MSPs PAID BY THE COMPENSATION FUND

Discipline Code:	Discipline Description:
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists)
076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics

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078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services: (Wheelchairs and Gases only)
094	Prosthodontic

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

DENTAL GAZETTE 2026

DENTAL SERVICES TARIFF OF FEES AS FROM 01 APRIL 2026
Practice Type 054 (General Dental)
Practice Type 062 (Maxillo-Facial and Oral Surgery)
Practice Type 094 (Prosthodontist)

GENERAL RULES

1	**Rules**
	The following Rules apply to all Practitioners
001	Tariff code 8101 refers to a Full Mouth Examination, charting and treatment planning and no further examination fees shall be chargeable for an oral examination (Tariff code 8101) or comprehensive examination (Tariff code 8102) until the treatment plan resulting from these type of examinations is completed. This includes the issuing of a prescription where only medication is prescribed. Tariff code 8104 refers to a consultation for a specific problem and not to a full mouth examination, charting and treatment planning. This includes the issuing of a prescription where only medication is prescribed.
002	Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in this schedule shall be based on the fee in respect of a comparable service that is listed therein and Rule 002 must be indicated together with the tariff code.
003	In the case of a prolonged or costly dental service or procedure, the Dental Practitioner shall ascertain beforehand from the Commissioner whether financial responsibility in respect of such treatment will be accepted.
005	Except in exceptional cases the service of a specialist shall be available only on the recommendation of the attending Dental or Medical practitioner. Referring practitioners shall indicate to the specialist that the patient is being treated in terms of the Compensation for Occupational Injuries and Diseases Act.
007	"Normal consulting hours" are between 08:00 and 17:00 on weekdays, and between 08:00 and 13:00 on Saturdays.
008	A Dental Practitioner shall submit his or her invoice for treatment to the employer of the employee concerned and to the Compensation Fund.
009	Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment that is not listed in the schedule for dentists in general practice. Benefits in respect of specialists charging treatment procedures not listed in the schedule for that specialty, shall be allocated as follows : General Dental Practitioners Schedule 100% Other Dental Specialists Schedules 2/3
010	Fees charged by Dental Technicians for their services (PLUS L) shall be indicated on the Dentist's invoice against the tariff code 8099. Such Dentist's invoice shall be accompanied by the actual invoice of the Dental Technician (or a copy thereof) and the invoice of the Dental Technician shall bear the signature of the Dentist (or the person authorised by him) as proof that it has been compiled correctly. "L" comprises the fee charged by the Dental Technician for his services as well as the cost of teeth. For example, tariff code 8231 is specified as follows: Rc 8231 ..... X 8099(8231) ..... Y Total ..... R(X+Y)
011	Modifiers may only be used where (M/W) appears against the tariff code in the schedule
	8001 Assistant Surgeon - Specialist (1/3 of the appropriate benefit)
	8002 Specialist fee/benefit (Plus 50% of the appropriate benefit)
	8005 Maximum multiple procedures (same incision) - Maxilo-Facial and Oral (MFO) Surgeon
	8006 Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)
	8007 Assistant Surgeon - General Dental Practitioner (15% of the appropriate benefit)
	8008 Emergency surgery - after hours (PLUS 25% of the appropriate benefit)
	8009 Multiple surgical procedures - second procedure (75% of the appropriate benefit)
	8010 Open reduction (PLUS 75% of the appropriate benefit)

012	In cases where treatment is not listed in the schedule for Dentists in general practice or Specialists, the appropriate fee listed in the medical schedules shall be charged and the relevant tariff code in the medical schedules indicated.
013	Cost of material (VAT inclusive): This rule provides for the charging of material costs where indicated against the relative tariff codes by the words "(See Rule 013)". Material should be charged for at cost plus a handling fee not exceeding 35%, up to R6334.87 A maximum handling fee of 10% shall apply above a cost of R6334.87 A maximum handling fee of R9502.16 will apply. **Note:** Tariff code 8220 (suture) is applicable to all registered practitioners.
014	**Surgery guidelines:** Follow-up care for therapeutic surgical procedures: The fee for an operation shall, unless otherwise stated, include normal post-operative care for a period not less than one month. If a Practitioner does not complete the post-operative care, the Practitioner shall arrange for post-operative care without additional charges. A fee for post-operative treatment of a prolonged or specialized nature may be charged as agreed upon between the Practitioner and the patient.
2	**Explanations**
Additions, deletions and revisions	
	A summary listing all additions, deletions and revisions applicable to this schedule is found in Appendix A. New Tariff codes added to the schedule are identified with the symbol * placed before the Tariff code. In instances where a tariff code has been revised, the symbol * is placed before the Tariff code.
Tooth identification and designation of areas of the oral cavity:	
	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.
Treatment categories:	
	Treatment Categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows: Basic Dentistry - designated as (B) in the treatment category column Advanced Dentistry - designated as (A) in the treatment category column Surgery - designated as (S) in the treatment category column
Abbreviations used in Dental Coding	
	DM - Direct Material Column +D - Add fee for denture + L - Add laboratory fee + M - Add material fee
MP - Mouth Part Column	
	M - Maxilla/ Mandible Q - Quadrant S - Sextant T - Tooth
TC - Treatment Category Column	
	A - Advanced Dentistry B - Basic Dentistry S - Surgery
Practice type codes :	
	5400 General Dental Practitioner 6200 Specialist Maxillo Facial and Oral Surgeon 9400 Specialist Prosthodontist
VAT	
	Fees are VAT exclusive

	GENERAL DENTAL PRACTITIONERS						
(1). (M/W)	**PREAMBLE** The dental procedure codes for General Dental Dractitioners are divided into twelve (12) categories of services. The procedures have been grouped according to the category with which the procedures are most frequently identified. The categories are created solely for convenience in using the schedule and should not be interpreted as excluding certain types of Oral Care Providers from performing or reporting such procedures. These categories are similar to that in the "Current Dental Terminology" Third Edition (CDT-3).						
(2). (M/W)	Procedures not described in the general practitioner's schedule should be reported by referring to the relevant specialist's schedule. Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment codes that are not listed in the schedule for Dentists in general practice. (See Rules 009 and 011).						
(3). (M/W)	Oral and maxillofacial surgery (Section J of the Schedule): The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the Practitioner performing the operation, with the indicated minimum (see Modifier 8007). The Compensation Fund must be informed beforehand that another Dentist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to The Compensation Fund.						
I	**GENERAL DENTAL PRACTITIONERS**						
Code	**Procedure description**	**DM /+L**	**MP**	**TC**	**General Dental Practice (054)**	**Maxillo-facial and Oral Surgery (062)**	**Prosthodontics (094)**
A. DIAGNOSTIC **Clinical oral evaluation**							
8101	Oral examination Charting and treatment planning (See Rule 001)			B	**395.01**	-	-
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 001).						
8102	Comprehensive oral examination			B	**515.62**	-	-
An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 001)						

8104	Examination or consultation for a specific problem not requiring a full mouth examination, charting and treatment planning			B	**155.96**	-	-
	An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment. **Comment:** This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g.,recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.						
Radiographs/Diagnostic imaging							
8107	Intraoral radiograph - periapical			B	**150.70**	**150.7**	**150.7**
	Eight and more radiographs of any combination of tariff codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.						
8108	Intraoral radiographs - complete series			B	**1133.45**	**1201.99**	**1201.99**
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.						
8112	Intraoral radiograph - bitewing			B	**150.70**	**150.7**	**150.7**
	Eight and more radiographs of any combination of tariff codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.						
8113	Intraoral radiograph - occlusal			B	**234.78**	**234.78**	**234.78**
8115	Extraoral radiograph - panoramic			B	**620.45**	**620.45**	**620.45**
8116	Extraoral radiograph - cephalometric			B	**620.45**	**620.45**	**620.45**
8118	Extraoral radiograph - skull/facial bone			B	**620.45**	**620.45**	**620.45**
OTHER DIAGNOSTIC PROCEDURES							
8117	Diagnostic models	+L		B	**169.34**	**169.56**	**169.56**
	Also known as study models or diagnostic casts. Models used to aid diagnosis and treatment planning. Diagnostic models should be retained as part of the patient's clinical record and may only be used for diagnostic purposes. Includes diagnostic models mounted on a hinge articulator.						
8119	Diagnostic models mounted	+L		B	**435.39**	**435.39**	**435.39**
	See tariff code 8117. Report this tariff code when models are mounted on a movable condyle articulator.						
8121	Oral and/or facial image (digital/conventional)			B	**169.34**	**169.56**	**169.56**
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.						
8194	CBCT capture *and interpretation* with limited field of view –less than one whole jaw		M	A	**507.11**	**507.22**	**507.22**
8195	CBCT capture *and interpretation* with limited field of view of one full dental arch - mandible		M	A	**507.11**	**507.22**	**507.22**
8196	CBCT capture *and interpretation* with limited field of view of one full dental arch – maxilla without orbits and/or cranium		M	A	**507.11**	**507.22**	**507.22**
8197	CBCT capture *and interpretation* with limited field of view of both dental arches – without orbits and or cranium		M	A	**507.11**	**507.22**	**507.22**
8198	CBCT capture *and interpretation* for TMJ series including two or more exposures.		M	A	**507.11**	**507.22**	**507.22**
8199	CBCT capture *and interpretation* with limited field of view of one full dental arch – maxilla with orbits and/or cranium		M	A	**507.11**	**507.22**	**507.22**
8200	CBCT capture *and interpretation* with field of view of both dental arches – with orbits and/or cranium		M	A	**507.11**	**507.22**	**507.22**

B. PREVENTIVE **This schedule, applicable to occupational injuries and diseases, excludes preventive services**							
C. RESTORATIVE							
AMALGAM RESTORATIONS(including polishing)							
Please Note : All adhesives, liners and bases are included as part of the restoration. If pins are used, they should be reported separately. See tariff codes 8345, 8347 and 8348 for post and/or pin retention.							
8341	Amalgam - one surface		T	B	**403.13**	-	-
8342	Amalgam - two surfaces		T	B	**504.64**	-	-
8343	Amalgam - three surfaces		T	B	**606.38**	-	-
8344	Amalgam - four or more surfaces		T	B	**604.70**	-	-
RESIN-BASED COMPOSITE RESTORATIONS							
Resin refers to a broad category of materials including but not limited to composites and may include bonded composite, light -cured composite, etc. Light - curing, acid etching and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers/compomers, when used as restorations should be reported with these tariff codes . If pins are used, they should be reported separately.See tariff codes 8345, 8347 and 8348 for post and/or pin retention. The fees are inclusive of direct pulp capping (tariff code 8301) and rubber dam application (tariff code 8304)							
8351	Resin - one surface, anterior		T	B	**394.30**	-	-
8352	Resin - two surfaces, anterior		T	B	**503.68**	-	-
8353	Resin - three surfaces, anterior		T	B	**666.07**	-	-
8354	Resin - four or more surfaces, anterior		T	B	**739.62**	-	-
	Use to report the involvement of four or more surfaces or the incisal line angle. The incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.						
8367	Resin one surface, posterior		T	B	**476.70**	-	-
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth.						
8368	Resin two surfaces, posterior		T	B	**653.18**	-	-
8369	Resin three surfaces, posterior		T	B	**712.41**	-	-
8370	Resin - four or more surfaces, posterior		T	B	**755.63**	-	-
Inlay / Onlay restorations							
METAL INLAYS/ONLAYS Use these tariff codes for single metal inlay/onlay restorations. The fee for metal inlays on anterior teeth (incisors and canines) are determined 'by arrangement' with the Compensation Commissioner.							
8361	Inlay, metallic - one surface, posterior	+L	T	A	**808.40**	-	**1212.6**
8362	Inlay/onlay - metal - two surfaces	+L	T	A	**1045.79**	-	**1568.69**
8363	Inlay/onlay - metal - three surfaces	+L	T	A	**2156.76**	-	**3235.14**
8364	Inlay/onlay - metal - four or more surfaces	+L	T	A	**2157.01**	-	**3235.51**
CERAMIC AND / OR RESIN INLAYS							
Porcelain / ceramic inlays include either all ceramic or porcelain inlays. Composite / resin inlays must be laboratory processed **NOTE:** The fees exclude the application of a rubber dam (tariff code 8304).							
8371	Inlay - porcelain - one surface	+L	T	A	**731.98**	-	**1097.97**
8372	Inlay/onlay - porcelain - two surfaces	+L	T	A	**1069.43**	-	**1604.14**
8373	Inlay/onlay - porcelain - three surfaces	+L	T	A	**1784.70**	-	**2677.06**
8374	Inlay/onlay - porcelain - four or more surfaces	+L	T	A	**2157.01**	-	**3235.51**

CROWNS-SINGLE RESTORATIONS							
Use these tariff codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants. Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming. Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations.							
8401	Crown - full cast metal	+L	T	A	**2561.79**	-	**3553.84**
8403	Crown - 3/4 cast metal	+L	T	A	**2561.79**	-	**3553.84**
8404	Crown - 3/4 porcelain/ceramic	+L	T	A	**2561.79**	-	**3553.84**
8405	Crown - resin laboratory	+L	T	A	**2561.79**	-	**3553.84**
	Refers to all resin-based crowns that are indirectly fabricated. All fiber, porcelain or ceramic reinforced polymer materials/systems are considered resin-based crowns.						
8407	Crown - resin with metal	+L	T	A	**2734.70**	-	**3955.76**
8409	Crown - porcelain/ceramic	+L	T	A	**2734.70**	-	**3553.84**
8411	Crown - porcelain with metal	+L	T	A	**2734.70**	-	**4437.46**
Other restorative							
8133	Recement inlay, onlay, crown or veneer.		T	B	**234.78**	-	**352.16**
	Use to report the recementation of a permanent single inlay, onlay, crown or veneer. See tariff code 8514 in the Fixed Prosthodontic Section for the recementation of a bridge retainer. **Comment:** This tariff code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration.						
8142	Recement inlay/onlay/veneer		T	A	**199.91**	-	**253.91**
	Use to report the recementation of a permanent inlay/onlay/veneer						
8134	Recement cast core or post		T	A	**199.91**	-	**253.91**
8135	Removal of inlays and crowns (per unit) and bridges (per abutment) or sectioning of a bridge, part of which is to be retained as a crown following the failure of a bridge		T	A	**461.16**	-	**461.16**
	This procedure involves the removal of a permanent inlay, onlay or crown. Comment: This tariff code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration						
8156	Removal of inlay/onlay/Veneer				**398.63**	-	**398.63**
	This procedure involves the removal of a permanent inlay, onlay or veneer.						
8137	Emergency crown (chair-side)	+L	T	A	**788.83**	-	**788.83**
	A temporary crown, usually made of resin and in the surgery, which is fitted over a damaged tooth for the immediate protection in tooth injury. Includes emergency crowns manufactured for the replacement of previously fitted, lost or damaged permanent crowns. **Comment:** This tariff code should not be used as an interim restoration during restorative treatment and should not be reported on the same day on which an impression is taken to replace a previously fitted lost or damaged permanent crown.						
8138	Remove retention post.				**247.53**		**247.53**
	This procedure involves the removal of an intact prefabricated and/or cast posts intended for retention purposes. Report per post. See code 8330 in the "Endodontic Section" for the removal of endodontic posts or instruments. This code may not be used for the removal of temporary or provisional posts.						
8330	Removal of root canal obstruction		T	B	**308.81**	-	**308.81**
	This procedure involves the treatment of a non-negotiable root canal blocked by foreign bodies (e.g.,removal and/or bypassing of a fractured instrument) or calcification of 50% or more of a root to achieve an apical seal and forego surgical treatment – Report per canal. This tariff code may be submitted by the servicing provider and on the same day as a root canal therapy if the obstruction is not iatrogenic by that provider.						

8331	Repair of perforation defects.		T	B	**247.53**		**247.53**
	The code is intended to be used for the non-surgical seal of perforation caused by resorption and/or decay but not if the perforation is iatrogenic by that provider. See Rule 002 and Appendix A for the cost						
8345	Prefabricated post retention, per post (in addition to restoration)		T	B	**341.04**	-	**341.04**
	Should not be used with tariff codes 8398 or 8376 (Core build-ups) Remuneration excludes cost of posts – See tariff code 8379						
8347	Pin retention - first pin (in addition to restoration)		T	B	**234.78**	-	**234.78**
	Should not be used with tariff codes 8398 or 8376 (Core build-ups).						
8348	Pin retention - each additional pin (in addition to restoration)		T	B	**202.77**	-	**202.77**
	Should not be used with tariff codes 8398 or 8376 (Core build-ups). Limitation: A maximum of two additional pins may be levied.						
8355	Veneer - resin (chair-side)		T	B	**747.74**	-	**747.74**
	Involves direct layering of material over tooth. No laboratory processing.						
8357	Prefabricated metal crown		T	B	**496.51**	-	**496.51**
	Includes all preformed metal crowns e.g. stainless steel, nickel-chrome and gold anodised crowns, with or without resin window.						
8366	Pin retention as part of cast restoration, irrespective of number of pins		T	A	**362.53**	-	**543.8**
8376	Core build-up with prefabricated posts		T	B	**1210.09**	-	**1210.09**
	The direct build-up of a mutilated crown around a prefabricated post to provide a rigid base for retention of a crown restoration. This procedure includes posts and core material. Remuneration excludes cost of posts – See tariff code 8379.						
8379	Cost of prefabricated posts - add on to tariff code 8376		T	A	**Rule 013**	-	**Rule 013**
	Applicable to pre-fabricated noble metal, ceramic, iridium and titanium posts – see tariff code 8345 and 8376.						
8391	Cast core with single post	+L	T	A	**549.52**	-	-
	Report in addition to crown.						
8392	Cast post (each additional)	+L	T	A	**439.70**	-	-
	To be used with tariff code 8391 for each additional cast posts on the same tooth.						
8397	Cast core with pins (any number of pins)	+L	T	A	**879.58**	-	**1319.37**
	The cast core with pins is intended to be used on grossly broken down vital teeth. Report in addition to crown.						
8398	Core build -up, including any pins Refers to the building up of an anatomical crown when a restorative crown will be placed, irrespective of the number of pins used.		T	B	**879.58**	-	**879.58**
	The direct build-up of a mutilated crown to provide a rigid base for retention of a crown restoration irrespective of the number of pins used. This tariff code should not be reported when the procedure only involves a filler to eliminate any undercut, concave irregularity in the preparation, etc.						
8413	Repair crown (permanent or provisional)	+L	T	A	**537.02**	-	**537.02**
	This procedure involves the repair of a permanent crown (e.g. facing replacement). Excludes the removal (tariff code 8153) and recementation (tariff code 8133) of the crown. This tariff code may also be reported for the repair/replacement of a provisional crown (tariff code 8410) after a period of two months. This tariff code may not be used for the repair/replacement of a temporary restorations, which is included as part of the restoration.						
8414	Additional fee for provision of a crown within an existing clasp or rest	+L	T	A	**168.40**	-	**168.4**

D. ENDODONTICS							
* Preamble: **1.**The Health Professions Council of SA has ruled that, with the exception of diagnostic intra -oral radiographs, fees for only three further intra -oral radiographs may be charged for each completed root canal therapy on a single -canal tooth; or a further five intra -oral radiographs for each completed root canal therapy on a multi -canal tooth. **2.** The fee for the application of a rubber dam (See tariff code 8304 in the category "Adjunctive General Services ") may only be charged concurrent with the following procedures: - Gross pulpal debridement, primary and permanent teeth, for the relief of pain (tariff code 8132) - Apexification of a root canal (tariff code 8305) - Ceramic and or resin inlays (tariff codes 8371 to 8374) - Pulpotomy (tariff code 8307) - Complete root canal therapy (tariff codes 8328, 8329 and 8332 to 8340) - Removal or bypass of a fractured post or instrument (tariff code 8330). - Bleaching of non vital teeth (tariff codes 8325 and 8327) and - Ceramic and or resin inlays (tariff codes 8371 to 8374) **3.** After endodontic preparatory visits (tariff codes 8332, 8333 and 8334) have been charged, fees for endodontic treatment completed at a single visit (tariff codes 8329, 8338, 8339 and 8340) may not be levied. **4.** Where tariff code 8132 is charged, no other endodontic procedures may be charged at the same visit on the same tooth.Tariff codes 8338, 8329, 8339 and 8340 (single visit) may be charged at the subsequent visit, even if tariff code 8132 was used for the initial relief of pain. **5.**No other endodontic procedure may, in respect of the same tooth, be charged concurrent to tariff code 8307 and a completed root canal therapy should not be envisaged (tariff code 8304 excluded)							
PULP CAPPING							
8301	Direct pulp capping		T	B	**285.02**	-	-
	This procedure involves the covering of the exposed dental pulp with a protective material to stimulate repair of the injured pulpal tissue. Excludes the final restoration.						
8303	Indirect pulp capping The permanent filling is not completed at the same visit		T	B	**285.02**	-	-
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.						
PULPOTOMY							
8307	Amputation of pulp (pulpotomy)		T	B	**183.42**	-	**183.42**
	This procedure involves the removal of a portion of the tooth's pulp and the placement of a medicament to fix or modify the superficial pulp tissue. Excludes the final restoration. This tariff code should not be used as the first stage of root canal therapy and may not be reported with other root canal therapy tariff codes on the same tooth. Report tariff code 8304 (application of a rubber dam) in addition to this tariff code.						
8132	Pulp removal (pulpectomy)		T	B	**379.25**	-	**379.25**
	This procedure involves the removal of the complete pulp from the pulp chamber and root canal(s) for the relief of acute pain prior to root canal therapy. The tariff code is intended to be used for the emergency treatment of acute pain and should not be reported as the first stage of scheduled endodontic treatment. The practitioner reappoints the patient for complete root canal theray at a later date. Report tariff code 8304 (application of a rubber dam) in addition to this tariff code.						
ENDODONTIC THERAPY (including the treatment plan, clinical procedures and follow-up care)							
	Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report tariff code 8304 (application of a rubber dam) in addition to these tariff codes.						
Preparatory Visits (Obturation not done at same visit)							
8332	Root canal preparatory visit - single canal tooth		T	B	**234.78**	-	**234.78**
	Limitation: A maximum of four visits per tooth may be charged.						
8333	Root canal preparatory visit - multi canal tooth		T	B	**572.44**	-	**572.44**
	Limitation: A maximum of four visits per tooth may be charged.						

Obturation of canals at a subsequent visit							
	Tariff codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with tariff codes 8332, 8333 and 8334 (endodontic preparatory visits and repreparation of previously obturated canal).						
8335	Root canal obturation - anteriors and premolars - first canal		T	B	**1069.67**	-	**1069.67**
8328	Root canal obturation - anteriors and premolars - each additional canal		T	B	**411.73**	-	**411.73**
8336	Root canal obturation - posteriors - first canal		T	B	**1469.69**	-	**1469.69**
8337	Root canal obturation - posteriors - each additional canal		T	B	**435.39**	-	**435.39**
Complete Therapy (Preparation and obturation of root canals completed at a single visit)							
	Tariff codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with tariff codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).						
8338	Root canal therapy - anteriors and premolars - first canal		T	B	**1632.08**	-	**1632.08**
8329	Root canal therapy - anteriors and premolars - each additional canal		T	B	**518.72**	-	**518.72**
8339	Root canal therapy - posteriors - first canal		T	B	**2241.75**	-	**2241.75**
8340	Root canal therapy - posteriors - each additional canal		T	B	**546.67**	-	**546.67**
ENDODONTIC RETREATMENT							
8334	Re - preparation of previously obturated canal, per canal		T	B	**347.25**	-	**520.88**
	This procedure includes the removal of old root canal filling material and the procedures necessary to prepare the canals to place the canal filling. Report 8334 per canal. See tariff codes 8328, 8335, 8336 and 8337 for the obturation of root canals. This procedure excludes the removal of endodontic posts (tariff code 8330). Report tariff code 8304 (application of a rubber dam) in addition to this tariff code. **Note** (Applicable to prosthodontist only):Procedure tariff codes 8631,8633 and 8334 include all X-rays and repeat visits.						
8323	Re-treatment of previously completed root canal therapy, each additional canal - anterior or premolar.		T	B	**280.56**		**338.43**
8324	Re-treatment of previously completed root canal therapy, each additional canal - molar.		T	B	**280.56**		**338.43**
PERIRADICULAR PROCEDURES							
9015	Apicectomy including retrograde root filling where necessary anterior tooth		T	S	**1147.49**	**1721.15**	**1721.15**
9016	Apicectomy including retrograde root filling where necessary posterior tooth		T	S	**1714.17**	**3446.13**	**2571.12**
Other endodontic procedures							
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment		T	B	**182.95**	-	**182.95**
8325	Bleaching of non - vital teeth, per tooth as a separate procedure		T	A	**529.24**	-	**529.24**
8327	Each additional visit for bleaching of non - vital tooth as a separate procedure		T	A	**251.49**	-	**251.49**

E. PROSTHODONTICS (REMOVABLE) **Complete dentures (including routine post - delivery care)**							
8231	Full upper **and** lower dentures inclusive of soft base or metal base, where applicable	+L	M	B	**3735.59**	-	**5603.39**
8232	Full upper **or** lower dentures inclusive of soft base or metal base, where applicable.	+L	M	B	**2302.44**	-	**3453.66**
8244	Immediate denture – Maxillary	+L	M	B	**1991.59**	-	**2987.69**
	A removable complete denture constructed for placement immediately after removal of the remaining natural teeth. This procedure includes limited follow - up care only and excludes subsequent rebasing/relining procedure(s) and/or the replacement with new complete denture. See interim prosthesis for immediate and/or provisional partial dentures.						
8245	Immediate denture – Mandibular	+L	M	B	**1991.59**	-	**2987.69**
	See tariff code 8244 for descriptor.						
8246	Immediate denture – Partial	+L	T	B	**1394.13**	-	**2091.31**
	Report in addition to tariff codes for partial dentures tariff codes 8233 - 8241						
8643	Complete dentures - Maxillary and Mandibular (with complications)	+L		B	-	-	**11529.14**
8645	Complete upper and lower dentures with major complications	+L		B	-	-	**14180.23**
8649	Complete denture - Maxillary or Mandibular (with complications)	+L	M	B	-	-	**7099.56**
PARTIAL DENTURES (including routine post - delivery care)							
8233	Partial denture, one tooth	+L	M	B	**1069.43**	-	**1069.43**
8234	Partial denture, two teeth	+L	M	B	**1069.43**	-	**1069.43**
8235	Partial denture, three teeth	+L	M	B	**1598.64**	-	**1598.64**
8236	Partial denture, four teeth	+L	M	B	**1598.64**	-	**1598.64**
8237	Partial denture, five teeth	+L	M	B	**1598.64**	-	**1598.64**
8238	Partial denture, six teeth	+L	M	B	**2130.98**	-	**2130.98**
8239	Partial denture, seven teeth	+L	M	B	**2130.98**	-	**2130.98**
8240	Partial denture, eight teeth	+L	M	B	**2130.98**	-	**2130.98**
8241	Partial denture, nine or more teeth	+L	M	B	**2130.98**	-	**2130.98**
8281	Metal (e.g. chrome cobalt, etc.) base to partial denture, per denture.	+L	M	B	**2845.04**	-	**2845.04**
	The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., tariff codes 8251, 8253, 8255 and 8257). See tariff codes 8233 to 8241 for the resin denture base required concurrent to tariff code 8281						
8671	Metal (e.g. Chrome cobalt or gold) partial denture	+L	M	A	-	-	**7099.56**
Adjustments to dentures							
8275	Adjust complete or partial denture				**161.46**	-	**164.78**
	After six months or for patient of another Practitioner						
8662	Remounting and occlusal adjustment of dentures	+L		B	-	-	**1021.91**
Repairs to complete or partial dentures							
	Professional fees should not be levied for the repair of dentures/intra - oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.						
8269	Repair of denture or other intra - oral appliance	+L	M	B	**306.31**	-	**359.9**
	See tariff code 8273 (Impression to repair/modify a denture)						
8270	Add clasp to existing partial denture (One or more clasps) Tariff code 8270 is in addition to tariff code 8269.	+L	M	B	**202.77**	-	**202.77**
	One or more clasps.Tariff code 8270 may be reported in addition to tariff code 8269. See tariff code 8273 (Impression to repair/modify a denture).						

8271	Add tooth to existing partial denture (One or more teeth) Tariff code 8271 is in addition to tariff code 8269.	+L	M	B	**202.77**	-	**202.77**
	One or more teeth.Tariff code 8271 may be reported in addition to tariff code 8269.						See tariff
	code 8273 (Impression to repair/modify a denture).						
8273	Impression to repair or modify a denture or other intra -oral appliance	+L		B	**161.42**	-	**164.78**
	May be reported in addition to the appropriate tariff code in this subsection when an impression is required. Includes any number of impressions.						
DENTURE REBASE PROCEDURES							
	Rebase – The partial or complete removal and replacement of the denture base.						
8259	Re - base of denture (laboratory)	+L	M	B	**879.58**	-	**1319.37**
8261	Re - model of denture	+L	M	B	**1444.38**	-	**1444.38**
DENTURE RELINE PROCEDURES							
	Reline - The addition of material to the fitting surface of a denture base						
8263	Reline of denture in selfcuring acrylic (intra - oral)		M	B	**549.52**	-	**824.28**
8267	Reline complete or partial denture (laboratory)	+L	M	B	**1267.89**	-	**1267.89**
	Soft base re - line per denture (heat cured). Tariff code 8267 cannot be charged concurrent with tariff codes 8231 to 8241						
OTHER REMOVABLE PROSTHETIC PROCEDURES							
8255	Stainless steel clasp or rest, per clasp or rest	+L		B	**220.67**	-	**220.67**
	Tariff codes 8255, 8257 cannot be charged concurrent with tariff codes 8269 (repair of denture) or 8281 (metal framework).						
8257	Lingual bar or palatal bar	+L	M	B	**267.01**	-	**267.01**
8265	Tissue conditioner and soft self - cure interim re - line, per denture				**364.92**	-	**547.39**
F. MAXILLOFACIAL PROSTHETICS This schedule, applicable to occupational injuries and diseases, excludes maxillofacial prosthetic services.							
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect. Where maxillofacial implantology and other applicable prosthodontic services are used for the reconstruction of craniofacial defects, use the appropriate codes from *Implants /Restorative/Removable Prosthodontics/Fixed Prosthodontics.* The correct ICD 10 Code indicates the use of these codes in Maxillofacial Prosthetics						
9196	Planning for Craniofacial Reconstruction – Simple	+L/+ M		S	**938.30**	**1407.63**	**1407.63**
	The Surgical – Prosthodontic – Laboratory planning of straight forward (e.g. Okay 1Classification) maxillary resections. This should include CT and /or Computer analysis of resection margins and short, medium and long term restorative protocols. To this tariff code must be added the costs of Laboratory or CAD / CAM production (e.g.Rapid Prototyping) (See Appendix A)						
9197	Planning for Craniofacial Reconstruction – Complex	+L/+ M		S	**14504.76**	-	**21756.66**
	The Surgical – Prosthodontic – Laboratory planning of more complex (e.g. Okay Classification 2 and 3) maxillary resections. This should include CT and /or Computer analysis of resection margins, short, medium and long term restorative protocols.						
	To this code must: **1.** be added the costs of Laboratory or CAD / CAM production (e.g. Rapid Prototyping) See Appendix A **2.** Where maxillofacial implantology and other applicable prosthodontic services are used for the reconstruction of craniofacial defects, use the codes supplied in "Implant Services" and restorative sections of this schedule. **3.** The ICD 10 Code indicates the use of these codes in Maxillofacial Prosthetics. **4.** Implantology and prosthodontic services used for Craniofacial reconstruction (excluding standard implantology) are more complex and carry greater time commitment.						

G. IMPLANT SERVICES Report surgical implant procedures using tariff codes in this section; prosthetic devices should be reported using existing fixed or removable prosthetic tariff codes. **Endosteal implants** Endosteal dental implants are placed into the alveolar and / or basal bone of the mandible or maxilla and transecting only one cortical plate.							
H. ORAL AND MAXILLOFACIAL SURGERY Refer to the specialist maxillo- facial and oral surgeon schedule for surgical services not listed in this schedule.							
EXTRACTIONS							
8201	Extraction - tooth or exposed tooth roots (first per quadrant)		T	B	**234.78**	**352.16**	-
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, tariff code 8937 should be reported.						
SURGICAL EXTRACTIONS (includes routine postoperative care)							
8213	Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.		T	S	**1041.25**		-
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth roots and closure. Report per tooth. The removal of more than one root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown.						
8937	Surgical removal of tooth		T	S	**708.86**	**1063.23**	-
	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap, removal of bone and / or other section of tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure. Tariff code 8220 is applicable when suture material is provided by the Practitioner (Rule 013).						
8953	Surgical removal of residual roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.		T	S	-	**1528.92**	-

DISTRACTION OSTEOGENESIS							
9067	Distraction of the alveolar ridge across one to two tooth sites		T		**3875.66**	**5813.37**	-
9068	Distraction of the alveolar ridge -across three to five tooth sites		T		**3875.66**	**5813.37**	-
9070	Distraction of the alveolar ridge -full arch		M		**3875.66**	**5813.37**	-
9073	Distraction for the reconstruction of the mandibular body (per side)				**3875.66**	**5813.37**	-
9078	Distraction for the reconstruction of the mandibular condyle and tempero - mandibular joint				**3875.66**	**5813.37**	-
9080	Distraction for the reconstruction of the midface (internal distractor)				**3875.66**	**5813.37**	-
9082	Distraction for the reconstruction of the midface (external distractor)				**3875.66**	**5813.37**	-
9084	Removal of an internal or external distractor device				**744.55**	**998.58**	-
I. ADJUNCTIVE GENERAL SERVICES **Unclassified treatment**							
MISCELLANEOUS SERVICES							
8131	Palliative [emergency] treatment for dental pain. This is typically reported on a "per visit" basis for emergency treatment of dental pain where no other treatment item is applicable or applied for treatment of the same tooth.		T	B	**234.78**	**234.78**	**352.16**
	This tariff code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This tariff code should not be used when more adequately described procedures exists and cannot be reported with other procedure tariff codes (diagnostic procedures and professional visits excluded).						
ANAESTHESIA							
8141	Inhalation sedation - first 15 minutes or part thereof			B	**208.01**	**208.01**	**208.01**
8143	Inhalation sedation - each additional 15 minutes			B	**112.49**	**112.49**	**112.49**
	No additional fee/benefit to be charged for gases used in the case of tariff codes 8141 and 8143.						
8144	Intravenous sedation			B	**109.38**	**109.38**	**109.38**
8145	Local anaesthetic, per visit Tariff code 8145 includes the use of the wand			B	**51.36**	**51.36**	**51.36**
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. **Comment:** The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Tariff code 8145 includes the use of the Wand.						
8471	Procedural sedation or General anaesthesia - Assessment			B	**415.44**	-	-
8472	Procedural sedation - first 30 minutes			B	**292.99**	-	-
8473	Procedural sedation - each additional 15 minutes or part thereof			B	**75.56**	-	-
8474	Procedure room for Sedation				**1727.03**	**1727.03**	-
8499	General anaesthetic			B			
	The relevant tariff codes published in the Government Gazette for Medical Practitioners shall apply to general anaesthetics for dental procedures.						
8895	Examination under general anaesthesia		M	B	**364.05**	-	-

PROFESSIONAL VISITS							
8129	Office/hospital visit – after regularly scheduled hours			B	**567.91**	-	-
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate tariff code numbers for actual services rendered. After regularly scheduled hours is defined as weekends and night visits between 18h00 and 07h00 the following day. **Limitation:** Tariff code 8129 can only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.						
8140	House/extended care facility/hospital call			B	**362.29**	-	-
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate tariff code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.						
Drugs, medication and materials							
8183	Intra - muscular or sub - cutaneous injection therapy, per injection (Not applicable to local anaesthetic)			B	**97.92**	-	-
8220	Use of suture material provided by Practitioner			B	**Rule013**	**Rule013**	-
8109	Infection control, per dentist, per hygienist, per dental assistant, per visit. Tariff code 8109 includes the provision by the Dentist of new rubber gloves, masks, etc. for each patient.				**34.63**	**34.63**	**34.63**
8110	Provision of sterilized and wrapped instrumentation in consulting rooms.The use of this tariff code is limited to heat, autoclave or vapour sterilised and wrapped instruments.				**97.69**	**97.69**	**97.69**
8304	Rubber dam, per arch (Refer to the guidelines for the application of a rubber dam in the preamble to the category D "Endodontics")				**172.44**	-	**172.44**
8306	Cost of Mineral Trioxide Aggregate			B	**Rule013**	-	**Rule 013**
II	**SPECIALIST PROSTHODONTIST** **(M) See Rule 009**						
	A. DIAGNOSTIC PROCEDURES						
8501	Consultation - Prosthodontist			B	-	-	**435.39**
8503	Occlusal analysis on adjustable articulator			A	**593.74**	-	**890.57**
8505	Pantographic recording			A	**866.15**	-	**1299.16**
8506	Detailed consultation - Prosthodontist			A	-	-	**1444.62**
	Detailed clinical examination, recording, radiographic interpretation, diagnosis, treatment planning and case presentation. Note: Tariff code 8506 is a separate procedure from tariff code 8507 and is applicable to craniomandibular disorders, implant placement or orthognatic surgery where extensive restorative procedures will be required.						
8507	Comprehensive consultation - Prosthodontist Examination, diagnosis and treatment planning			A	-	-	**890.57**
8508	Electrognathographic recording			A	**963.61**	-	**1445.34**
8509	Electrognathographic recording with computer analysis.			A	**1544.76**	-	**2317.02**
B. Preventive procedures This schedule, applicable to occupational injuries and diseases, excludes preventive services.							

C. Treatment procedures Emergency treatment							
8514	Recement bridge		T	B	**227.37**	**-**	**341.04**
	Use to report the recementation of a permanent inlay -, onlay -, or crown retainer - reported per retainer. May be used to report the recementation of a Maryland bridge. Report tariff code 8133 for the recementation of a single permananet inlay, onlay or crown. **Comment**: This tariff code cannot be used for the recementation of temporary or provisional restorations, which is included as part of the restoration. Previously tariff code 8133 included the recementation of bridge retainers.						
8517	Re-implantation of an avulsed tooth, including fixations as required	+L	T	S	**606.94**	**-**	**910.37**
Provisional treatment							
8723	Provisional splinting - extracoronal (wire) - per sextant	+L	M	A	**487.50**	**487.5**	**731.98**
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	+L	M	A	**713.83**	**713.83**	**1071.81**
8727	Provisional splinting - intracoronal - per tooth	+L	T	A	**227.13**	**227.13**	**341.04**
8410	Provisional crown	+L	T	A	**586.42**	**-**	**879.58**
	The intended use of a provisional crown is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis.						
Occlusal adjustment							
8551	Major occlusal adjustment This procedure cannot be carried out without study models mounted on an adjustable articulator.			A	**678.60**	**-**	**1017.86**
	Comment: **(1)** A complete occlusal adjustment involves the grinding of teeth to the equivalent of two or more quadrants. **(2)** Several appointments of varying length and sedation to attain relaxation of the muscularity muscles may be necessary. Submit tariff code 8551 for payment at the last visit if several appointments to complete the procedure are required.						
8553	Minor occlusal adjustment			A	**525.91**	**788.83**	**788.83**
	An occlusal adjustment involves the grinding of the occluding surfaces of teeth to develop harmonious relationships between each other, their supporting structures, muscles of mastication and temporomandibular joints. Comment: **(1)** Partial occlusal adjustment for the relief of symptomatic teeth involves the selective grinding of teeth to the equivalent of one quadrant or less. **(2)** Payment for this procedure is limited to one visit per treatment plan. **(3)** Cannot be submitted for the adjustment of dentures or restorations provided as part of a treatment plan (including opposing teeth).						
VENEERS							
8554	Veneer - resin (laboratory)	+L	T	A	**1710.34**	**-**	**2565.38**
	Involves an impression being taken and laboratory processing.						
Posts and copings							
8581	Cast core with single post	+L	T	A	-	-	**881.44**
	See also GDP tariff code 8391						
8582	Cast core with double post	+L	T	A	-	-	**1267.89**
	See also GDP tariff code 8392						
8583	Cast core with triple post	+L	T	A	-	-	**1589.34**
	See also GDP tariff code 8392						
8587	Coping metal	+L	T	A	**506.00**	**-**	**758.96**
	A thimble coping may utilise pins for additional retention. Generally used to parallel an abutment tooth for bridge and splints. May be similarly used to parallel an implant abutment where implant bodies are not parallel. A dome -shaped coping is generally used on an endodontically treated abutment tooth for an overdenture.						

OTHER IMPLANT SERVICES							
8592	Crown - implant/abutment supported	+L	T	A	-	-	**5431.9**
	An artificial crown that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented.						
8600	Cost of implant components				**Rule 013**	-	**Rule 013**
Connectors							
8597	Locks and milled rests	+L	T	A	**239.94**	-	**359.9**
8599	Precision attachments	+L	M	A	**586.42**	-	**879.58**
	Each set of male and female components should be reported as one precision attachment. Includes semi - precision attachments						
Resin bonded retainers							
8617	Retainer cast metal (Maryland type retainer)	+L	T	A	**729.86**	-	**1094.74**
Endodontic procedures **Root canal therapy** **Procedure codes 8631, 8633 and 8635 include all X - rays and repeat visits**							
8631	Root canal therapy - first canal		T	B	-	-	**3110.13**
8633	Root canal therapy - each additional canal		T	B	-	-	**777.11**
8635	Apexification of root canal, per visit		T	B	**346.31**	-	**519.44**
8640	Removal of fractured post or instrument from root canal		T	B	**605.99**	-	**909.89**
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)		T	A	**967.02**	-	**1450.46**
	Includes separation of a multirooted tooth into separate sections containing the root and overlying portion of the crown. It may also include the removal of one or more of those sections.						
OTHER REMOVABLE PROSTHETIC PROCEDURES							
8661	Diagnostic dentures (inclusive of tissue conditioning treatment)	+L		A	-	-	**7099.56**
8663	Chrome cobalt base for full denture (extra charge)	+L	M	B	**1426.13**	-	**2139.08**
8664	Remount of crown or bridge for extensive prosthetics			A	**694.20**	-	**1041.25**
8667	Soft base, per denture (heat cured)	+L	M	B	**1425.01**	-	**2137.41**
8672	Additional fee for altered cast technique for partial denture	+L	M	B	**209.96**	-	**314.93**
8674	Additive partial denture	+L	M	B	**2144.85**	-	**3217.11**
III	**SPECIALIST MAXILLO - FACIAL AND ORAL SURGEONS**						
	PREAMBLE (See Rule 011)						
1.(M/W)	If extractions (tariff codes 8201 and 8202) are carried out by specialists in maxillo - facial and oral surgery, the fees shall be equal to the appropriate tariff fee plus 50 per cent (See Modifier 8002).						
2.(M/W)	The fee for more than one operation or procedure performed through the same incision shall be calculated as the fee for the major operation plus the tariff fee for the subsidiary operation to the indicated maximum of R756.11 for each such subsidiary operation or procedure (See Modifier 8005)						

3.(M/W)	The fee for more than one operation or procedure performed under the same anaesthetic but through another incision shall be calculated on the tariff fee for the major operation plus: *75% for the second procedure / operation (See Modifier 8009)* *50% for the third and subsequent procedures / operations (See Modifier 8006).* This rule shall not apply where two or more unrelated operations are performed by Practitioners in different specialities, in which case each Practitioner shall be entitled to the full fee for his operation. If, within four months, a second operation for the same condition or injury is performed, the fee for the second operation shall be half of that for the first operation.The fee for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a Practitioner does not himself complete the post-operative care, he shall arrange for it to be completed without extra charge: provided that in the case of post-operative treatment of a prolonged or specialised nature, such fee as may be agreed upon between the Practitioner and the Compensation Fund may be charged.							
4.(M/W)	The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum of R384.50 (See Modifier 8007). The assistant's fee payable to a maxillo- facial and oral surgeon shall be calculated at 33,33% of the appropriate scheduled fee (See Modifier 8001). The assistant's name must appear on the invoice rendered to the Compensation Fund.							
5.(M/W)	The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (See Modifier 8008).							
6.(M/W)	In cases where treatment is not listed in this schedule for General Practitioners or Specialists, the appropriate fee listed in the medical schedule(s) shall be charged, and the relevant medical tariff code must be indicated (See Rule 012).							
III	**SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS** **(M) See Rule 009**							
Tariff code	**Procedure description**							
CONSULTATIONS AND VISITS								
8901	Consultation - MFOS			S	-	**430.83**		
8902	Consultation - MFOS (detailed)			S	-	**1207.95**		
	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation. Tariff code 8902 is a separate procedure from tariff code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction.							
8903	House/Hospital/Nursing home consultation - MFOS			S	-	**480.98**		
8904	House/Hospital/Nursing home consultation (subsequent) - MFOS			S	-	**234.78**		
8905	After regularly hours consultation - MFOS			S	-	**692.57**		
8907	House/Hospital/Nursing home consultation (maximum per week) - MFOS			S	-	**795.26**		
	Subsequent consultations, per week, to a maximum of "Subsequent consultation" shall mean, in connection with tariff code 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation.							
Surgical preparation of mouth for dentures								
Alveoloplasty								
	Surgical alteration of the shape and condition of the alveolar process to restore a normal contour, usually in preparation for denture construction.							
8955	Alveoplasty alveolectomy - not in conjuction with extractions (per quadrant)		Q	S	**1062.41**	**1593.32**	-	
8956	Alveoplasty alveolectomy - in conjuction with extractions (per quadrant)		Q	S	**1062.41**	**1593.32**	-	
8957	Alveolotomy or alveolectomy - concurrent with or independent of extractions (per jaw)		M	S	**1398.92**	**2098.27**	-	

Post Surgical Complications							
8931	Local treatment of post - extraction haemorrhage (excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia).			S	**767.76**	**1151.59**	-
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.						
8933	Treatment of haemorrhage in the case of blood dyscrasias, e.g. hemophilia, per week			S	**2723.93**	**4085.69**	-
9235	Severe nasal bleeding - anterior pack			S	-	**1045.12**	-
9236	Severe nasal bleeding - anterior + posterior pack or cauterization			S	-	**1567.74**	-
9223	Ligation of maxillary artery			S	-	**5121.16**	-
8935	Treatment of post- extraction septic socket where patient is referred by another registered practitioner			S	**203.32**	**304.97**	-
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.						
Repair/reconstructive procedures							
8990	Repair by primary suture				**987.80**	**1309.45**	-
9006	Lip reconstruction following an injury or tumour removal: primary closure				-	**7135.73**	-
9018	Lip reconstruction following an injury or tumour removal: simple advancement, rotation flap (Abbe or Estlander) (first stage)				-	**5382.41**	-
9020	Lip reconstruction following an injury or tumour removal: simple advancement, rotation flap (Abbe or Estlander) (subsequent stages)				-	**5382.41**	-
9022	Lip reconstruction following an injury or tumour removal: Total complicated reconstruction with a complicated advancement flap (Bernard flap)				-	**2717.44**	-
OTHER SURGICAL PROCEDURES							
8909	Closure of oral - antral fistula - acute or chronic			S	**2673.62**	**4010.23**	-
8911	Caldwell - Luc procedure			S	**1048.94**	**1573.33**	-
8917	Biopsies - intra - oral		M	S	**554.08**	**831.08**	-
	Incisional/excisional (e.g. epulis). This procedure does not include the cost of the essential pathological evaluations.						
8919	Biopsy of bone - needle		M	S	**1018.85**	**1528.2**	-
8921	Biopsy – extra-oral bone/soft tissue		M	S	**1084.44**	**1626.58**	-
8961	Auto - transplantation of tooth	+L		S	**2293.09**	**3439.46**	-
8965	Peripheral neurectomy			S	**2293.09**	**3439.46**	-
8966	Functional repair of oronasal fistula (local flaps)			S	**3246.97**	**4870.21**	-
8962	Harvest illiac crest graft			S	**2311.86**	**3467.62**	-
8963	Harvest rib graft			S	**2659.76**	**3989.45**	-
8964	Harvest cranium graft			S	**2079.25**	**3118.72**	-
8977	Surgical repair of maxilla or mandible - major			S	**5451.52**	**8176.87**	-
	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage) Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure.						

8979	Harvesting of autogenous grafts (intra -oral)			S	375.13	562.66	-
8998	Craniofacial transcutaneous endosseus implant		S		1319.64	1979.4	-
	The placement of an implant through the skin into any part of the craniofacial skeleton; for anchorage of a facial prosthesis or hearing aids; or for purposes of post - cancer or post - traumatic reconstruction						
8999	Craniofacial transmucosal endosseus implant		S		1319.64	1979.4	-
	The transmucosal placement of an implant into any part of the craniofacial skeleton, excluding the alveolar processes, for anchorage of facial prosthesis; or for purposes of post - cancer or post - traumatic reconstruction.						
8606	Placement of implant fixtures outside the oral cavity	+M	M	S	1319.64	1979.4	-
	(e.g. for the retention of extraoral prosthesis such as ears, noses, faces limbs and digits).						
9048	Removal of internal fixation devices, per site			S	1204.67	1806.91	-
9206	Surgical removal of reconstruction plate			S	744.55	1117.01	-
SURGICAL PREPARATION OF JAWS FOR PROSTHETICS							
8995	Gingivectomy, per jaw	+L	M	S	2081.96	3122.79	-
8997	Sulcoplasty / Vestibuloplasty	+L	M	S	5256.15	7883.84	-
9003	Repositioning mental foramen and nerve, per side	+L	M	S	3185.97	4778.72	-
9004	Lateralization of inferior dental nerve (including bone grafting)			S	6316.87	9474.83	-
9005	Total alveolar ridge augmentation by bone graft	+L	M	S	5348.81	8022.81	-
9007	Total alveolar ridge augmentation by alloplastic material	+L	M	S	3449.02	5173.27	-
9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites.	+L	M	S	2204.56	3306.67	-
9009	Alveolar ridge augmentation across 3 or more tooth sites	+L	M	S	2458.67	3687.82	-
9010	Sinus lift procedure	+L	M	S	3481.03	5221.28	-
EXCISION OF BONE TISSUE							
8987	Reduction of mylohyoid ridges, per side	+L		S	2347.38	3520.89	-
8989	Removal torus mandibularis	+L		S	2347.38	3520.89	-
8991	Removal of torus palatinus	+L		S	2347.38	3520.89	-
8993	Reduction of hypertrophic tuberosity, per side	+L	M	S	1043.53	1565.21	-
SURGICAL INCISION							
8908	Removal of roots from maxillary antrum involving Caldwell -Luc procedure and closure of oral - antral communication			S	3481.03	5221.28	-
9011	Incision and drainage of pyogenic abscesses (intra - oral approach)		M	S	654.39	981.54	-
9013	Incision & drainage of abscess - extra - oral (pyogenic).		M	S	890.36	1335.48	-
	E.g., Ludwig's angina.						
9017	Decortication, saucerisation and sequestrectomy for osteomyelitis of the mandible.		M	S	4724.52	7086.43	-
9019	Sequestrectomy - intra - oral, per sextant and / or per ramus.		M	S	1018.05	1527	-
REPAIR OF TRAUMATIC WOUNDS							
8192	Appositioning (i.e., suturing) of soft tissue injuries.			S	1176.43	-	-
	Use to report the suturing of recent small wounds. Excludes the closure of surgical incisions.						
COMPLICATED SUTURING							
Please Note : Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.							
9021	Suture - reconstruction, minor (excludes closure of surgical incisions).			S	1147.49	1721.15	-
9023	Suture - reconstruction, major (excludes closure of surgical incisions).			S	2422.69	3633.86	-

TREATMENT OF FRACTURES							
Alveolus Fractures							
9024	Dento - alveolar fracture, per sextant	+L	S	S	**1147.49**	**1721.15**	-
Mandibular Fractures							
9025	Treatment by closed reduction, with intermaxillary fixation.		M	S	**2545.91**	**3818.68**	-
9027	Treatment of compound fracture, involving eyelet wiring.		M	S	**3573.85**	**5360.5**	-
9029	Treatment by metal cap splintage or Gunning's splints.	+L	M	S	**3962.02**	**5942.73**	-
9031	Treatment by open reduction with restoration of occlusion by splintage.	+L	M	S	**5867.23**	**8800.4**	-
8940	Endoscopic management of a condylar fracture – report per side.			S	**1934.28**	**2900.64**	-
Mandibulectomy/mandibulotomy							
9098	Partial mandibulectomy			S	-	**6432.03**	-
Maxillary fractures with special attention to occlusion **Please Note** :When open reduction is required for tariff codes 9035 and 9037, Modifier 8010 may be applied.							
9035	Le Fort I or Guerin fracture	+L		S	**3582.43**	**5373.37**	-
9036	Open treatment of maxillary fracture – Le Fort I	+L		S	**2720.87**	**4081.25**	-
9037	Le Fort II or middle third of face fracture	+L		S	**5867.23**	**8800.4**	-
9038	Open treatment of maxilla fracture - Le Fort II or middle third face	+L		S	**4457.49**	**6686.06**	-
9039	Le Fort III or craniofacial dislocation or comminuted mid -facial fractures requiring open reduction and splintage	+L	M	S	**8411.07**	**12615.98**	-
Zygoma / Orbit / Antral - complex fractures							
9041	Zygomatic arch fracture - closed reduction.			S	**2545.91**	**3818.68**	-
	Gillies or temporal elevation.						
9043	Zygomatic arch fracture - open reduction			S	**5099.64**	**7649.08**	-
	Unstable and / or comminuted zygoma fractures, treatment by open reduction or Caldwell - Luc operation.						
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting).			S	**7645.23**	**11467.27**	-
9291	Zygomatic fracture-open reduction with fixation at two sites.			S	**3875.66**	**5813.37**	-
8944	Zygomatic fracture-open reduction with fixation at three or more sites.			S	**3875.66**	**5813.37**	-
9293	Zygomatic fracture-closed reduction.			S	**1934.28**	**2900.64**	-
8946	Zygomatic reconstruction (osteotomy or onlay).			S	**8126.25**	**12189.74**	-
8947	Anthrostomy for the placement of a sinuspack in order to reduce a zygomatic fracture			S	-	**1688.06**	-
9046	Placement of zygomaticus fixture, per fixture.			S	**6394.24**	**9590.88**	-
9273	Open treatment of an orbital wall fracture.			S	-	**3710.45**	-
9275	Major orbital reconstruction (comminuted orbital fractures).			S	-	**3710.45**	-
9277	Secondary reconstruction of orbital defect.			S	-	**3710.45**	-
9279	Eyelid surgery for facial paralysis including tarsoraphy (excludes material).			S	-	**4886.79**	-
9283	Repair by superior rectus, levator or frontalis muscle operation.			S	-	**4964.83**	-

FUNCTIONAL CORRECTION OF MALOCCLUSIONS							
For tariff codes 9063 to 9072 the full fee may be charged i.e. notes 2 and 3 of Rule 011 will not apply							
9047	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation).	+L	M	S	**10704.15**	**16055.42**	-
9049	Anterior segmental osteotomy of mandible (Köle).	+L	M	S	**8918.19**	**13376.62**	-
9050	Total subapical osteotomy		M	S	**18009.28**	**27012.57**	-
9051	Genioplasty		M	S	**5099.64**	**7649.08**	-
9052	Midfacial exposure (for maxillary and nasal augmentation or pyramidal Le Fort II osteotomy).			S	**8250.42**	**12375.02**	-
9055	Maxillary posterior segment osteotomy (Schukardt) 1 or 2 stage procedure.	+L		S	**8918.19**	**13376.62**	-
9057	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure.	+L		S	**8918.19**	**13376.62**	-
9059	Le Fort I osteotomy - one piece	+L		S	**16816.90**	**25224.08**	-
9062	Le Fort I osteotomy - multiple segments	+L		S	**21851.41**	**32775.48**	-
9060	Le Fort I osteotomy with inferior repositioning and inter - positional grafting.	+L		S	**19556.75**	**29333.65**	-
9061	Palatal osteotomy			S	**5867.23**	**8800.4**	-
9063	Le Fort II osteotomy for the correction of facial deformities or faciostenosis and post- traumatic deformities.	+L		S	**21273.13**	**31908.1**	-
9069	Functional tongue reduction (partial glossectomy).			S	**3827.79**	**5741.4**	-
9071	Geniohyoidotomy				**2293.09**	**3439.46**	-
9072	Functional closure of a secondary oro -nasal fistula and associated structures with bone grafting corn fete procedure.	+L		S	**16816.90**	**25224.08**	-
TEMPORO- MANDIBULAR JOINT PROCEDURES **Please Note:** For tariff codes 9081, 9083 and 9092 the full fee may be charged per side							
9074	Diagnostic arthroscopy			S	**2579.99**	**3869.79**	-
9075	Condylectomy or coronoidectomy or both (extra - oral approach).			S	**5266.82**	**7899.84**	-
9076	Arthrocentesis TMJ			S	**1543.16**	**2314.63**	-
9053	Coronoidectomy (intra - oral approach).			S	**3185.97**	**4778.72**	-
9077	Intra - articular injection, per injection.			S	**383.41**	**575.08**	-
9079	Trigger point injection, per injection.			S	**301.89**	**452.81**	-
9081	Condylectomy (Ward/Kostecka).			S	**2546.24**	**3819.17**	-
9083	Temporo- mandibular joint arthroplasty.			S	**6373.07**	**9559.12**	-
9085	Reduction of temporo - mandibular joint dislocation without anaesthetic.			S	**506.48**	**759.68**	-
9087	Reduction of temporo - mandibular joint dislocation, with anaesthetic.			S	**1018.85**	**1528.2**	-
9089	Reduction of temporo - mandibular joint dislocation, with anaesthetic and immobilisation.			S	**2546.24**	**3819.17**	-
9091	Reduction of temporo - mandibular joint dislocation requiring open reduction.			S	**5353.11**	**8029.27**	-
9092	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy).	+L		S	**17307.45**	**25959.88**	-

SALIVARY GLANDS							
9095	Removal of sublingual salivary gland.				**3061.79**	**4592.45**	-
9096	Removal of salivary gland (extra - oral).				**4471.52**	**6706.94**	-
IMPLANTS							
For tariff codes 9180 to 9192 the full fee may be charged, i.e. note 2 of Rule 011 will not apply.							
9180	Placement of sub - periosteal implant - Preparatory procedure / operation.		M	S	**3519.38**	**5278.81**	-
9181	Placement of sub - periosteal implant prosthesis /operation.	+L	M	S	**3519.38**	**5278.81**	-
9182	Surgical placement of endosteal implant plate.	+L		S	**1766.44**	**2649.53**	-
9183	Surgical placement of endosseus implant – first per quadrant.	+M	T	S	**2328.76**	**3492.96**	-
	Also known as a root form implant; endosseus or an osseo - integrated implant. This procedure involves: **(1)** the surgical placement of a one stage and/or the first stage of a two stage surgery endosteal implant (fixture) and **(2)** the placement of a healing abutment/cap (when appropriate). Tariff code 9183 includes the surgical placement of a one -piece endosteal implant (incorporating both the implant and integral fixed abutment) and should also be used to report the placement of an endosteal plate form implant. In such instances laboratory fees applies. See tariff code 9190 hereunder for second stage surgery and tariff code 9189 to report the cost of the endosteal implant body.						
9189	Cost of implants				**Rule 013**	**Rule 013**	-
9190	Surgical exposure of endosseus implant – first per quadrant	+M	T	S	**860.27**	**1290.35**	**1290.57**
	This procedure involves the **(1)** surgical re - exposure (uncovery or second stage surgery) of that portion of the submerged endosteal implant that receives the attachment device, and **(2)** the connection of a healing abutment or temporary prosthesis. This is usually done after the implant has matured in the bone for several months. The purpose of a healing abutment or collar is to create an emergence profile in the gum tissues for the future implant crown. Some implants are designed to remain exposed in the mouth right after they are placed, abolishing an uncovery procedure. See tariff code 9189 to submit the cost of other implant components.						
9191	Surgical placement of abutment - second per jaw	+M	T	S	**645.17**	**967.7**	**967.7**
9192	Surgical placement of abutment - third and subsequent per jaw	+M	T	S	**429.58**	**644.34**	**644.34**
9198	Implant removal		T	S	**1430.36**	**2145.43**	-
	This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant and closure.						
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure).	+L	M	A	**1555.90**	**2333.73**	-
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure).	+L	M	A	**2333.85**	**3500.6**	-
8772	Submucosal connective tissue autograft (isolated procedure).			A	**1771.15**	**2656.6**	-
8767	Bone regenerative / repair procedure at a single site Excluding cost of regenerative material - see tariff code 8770.			A	**1896.79**	**2845.04**	-
8769	Membrane removal (used for guided tissue regeneration).			A	**755.67**	**1133.45**	-
Please Note :Tariff codes 8761, 8762, 8767 and 8769 should be claimed only as part of implant surgery.							

ADMINISTRATIVE AND LABORATORY SERVICES	
8099	Dental laboratory service
	The dental laboratory services invoice should be attached. Use for submission of dental laboratory services. See Rule 10

SECTION 1 - PREPARATORY WORK		
Please Note: The below Dental Technology services codes,may only be billed with code 8099		
Code	**Code Description**	**Rand**
9301	Casting and trimming of model in plaster (yellow/white), per model	53.15
9303	Casting and trimming of model in super-hard stone (die-stone) per model	75.96
9305	Casting and trimming of study model, per model	140.34
9307	Casting and trimming of gnathostatic model, per model.	182.70
9312	Gingival tissue mask per implant	303.82
9314	Refractory model, per unit	160.45
9315	Models and duplicate models (virgin model) for crown and bridge, work inclusive of one removable die	221.91
9319	Each additional removable die for items 9315 and 9317 per die	50.34
9320	Indexed or model tray per die (not more than 9319)	50.34
9321	Occlusion block, per block	193.93
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	36.52
9329	Fit and supply of disposable articulator	95.62
9330	Delivery / Collection fee per completed procedure (maximum 4)	101.35
SECTION 2 - PROSTHETIC SERVICES USING ACRYLIC		
9331	Full upper and lower dentures	2608.21
9333	Full upper or lower denture	1526.07
	PARTIAL DENTURES	
9351	Set-up and finish of one-tooth denture	699.89
9352	Set-up and finish of two-tooth denture	744.72
9353	Set-up and finish of three-tooth denture	798.09
9354	Set-up and finish of four-tooth denture	842.92
9355	Set-up and finish of five-tooth denture	910.79
9356	Set-up and finish of six-tooth denture	1087.53
9357	Set-up and finish of seven-tooth denture	1292.93
9358	Set-up and finish of eight-tooth denture	1371.80
9359	Set-up and finish nine or more tooth denture	1405.51
	REPAIR SERVICE	
9391	Basic charge which includes repair of one fracture, or addition of one tooth, or addition of one clasp	444.05
9393	Additional charge for each additional fracture, or tooth, or clasp	137.87
	ADDITIONAL SERVICES	
9413	Reline/rebase of single denture	888.09
9415	Remodel of single denture	1365.85
9417	Soft base reline per denture	2242.93
9423	Lingual or palatal bar	334.61
9431	Special Tray, acrylic, each	219.21
9435	Provision of single arm clasp, to partial denture	115.28
9439	Provision of single arm clasp with rest, to partial denture	258.43
9441	Provision of double arm clasp with rest, to partial denture	348.65
9443	Provision of preformed Roach clasp, to partial denture	149.10
9445	Provision of rest only to partial denture	149.10
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	199.55

SECTION 3 -COBALT CHROME /GOLD PROSTHETIC SERVICES		
	A FULL METAL DENTURES	
9451	Metal base for full upper or full lower denture each	**1790.23**
9453	Basic charge - which excludes models and any special trays which may be required by the dentist, but includes refractory model	**1565.62**
9481	Additional charge for each soldering joint	**264.16**
9497	Basic fee if a new section is to be fabricated and where item 9495 does not apply (9301)	**463.60**
SECTION 4 -CROWN AND BRIDGE PROSTHETIC SERVICES		
	PORCELAIN (CERAMIC) SERVICES	
9501	Ceramic jacket crown/Ceromer crown or pontic	**1779.11**
9515	Porcelain shoulder per unit (not applicable to pontics)	**157.75**
	GOLD AND ACRYLIC VEIN	
9524	Indirect Composite Resin inlay	**393.60**
9525	Class IV, MO, DO, cervical/occlusal inlay	**1197.42**
9533	Full metal pontic	**1074.05**
9553	Composite/acrylic veneer crown/pontic, indirect	**1981.47**
9563	Temporary acrylic/composite crown per unit	**683.26**
9566	Porcelain/ Ceromer facing replaced	**1441.69**
SECTION 5 -ORTHODONTIC APPLIANCES - NOT A FUNDED TREATMENT		
	ORTHODONTIC SERVICES - NOT A FUNDED TREATMENT	
SECTION 6 -MATERIALS		
	PROSTHETIC/RESTORATIVE SERVICES	
9700	Diatorics 1 X 6/8	-
9702	Diatorics, odds, anterior	-
9720	Soft base material per denture	-
9722	Acrylic per denture	-
9724	Cost of precision attachment, per attachment	-
9728	Cost of lingual / palatal bar	-
9734	Cost of dolder bar and clips, per gram or per clip	-
	METAL	
9741	Cost of Cobalt Chrome casting alloy	-
9742	Cost of specialised Cobalt Chrome casting metal e g Vitallium, Titanium	-
9748	Cost of non-precious casting alloy	-
9760	Composite restoration material	-
9780	Positioning and finishing of complete (male and female) pre-fabricated burn-out attachment	**885.17**
9782	Positioning and soldering of complete (male and female) precision attachment	**739.10**
9786	Trimming, waxing and finishing of implant abutment - crown and bridge work only, per abutment	**401.57**