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DEPARTMENT OF TRANSPORT

NO. 191 **10 March 2021**

ROAD ACCIDENT FUND ACT, 1996 (ACT NO. 56 of 1996)

ROAD ACCIDENT FUND MEDICAL TARIFF

The Minister of Transport, in terms of section 26 of the Road Accident Fund Act, 1996 (Act No. 56 of 1996) herewith gives notice of his intention to prescribe the tariffs in the Schedule.

All interested parties who have any objections, inputs or comments to the proposed tariffs are called upon to lodge their objections, inputs or comments, within a period of twenty one (21) days from the date of publication of this Notice to:

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ROAD ACCIDENT FUND
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Short title and commencement

2. These fees are published for comments.

Road Accident Fund Tariff 2020/2021

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AMBULANCE SERVICES

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent.
Modifier values are rounded to the nearest cent. When new item prices are calculated,

REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF EMERGENCY CARE

GENERAL RULES

001	Long distance claims (items 111, 129 and 141) to be rejected unless distance travelled by patient is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected. Long distance charges may not include item codes 100, 103, 125, 127, 131 or 133.
002	No after hours fees may be charged
003	Item code 151 may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation.
004	Guidelines for information required on each account : · Name of service · BHF practice number · Address · Telephone number · Pre-authorisation number · The name of the patient · Diagnosis of patient's condition · Summary of medical procedures undertaken on patient and vital signs of patient · Summary of all equipment used · The date on which the service was rendered. · Name and HPCSA registration number of care providers · Name, practice number and HPCSA registration number of medical doctor · Response vehicle: Details of vehicle driver and intervention undertaken on patient · The code number of the procedure used in the National Reference Price List.
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.
006	A BLS service (Practice type "51200") may not charge for ILS or ALS, an ILS service (Practice type "51100") may not charge for ALS. An ALS service (Practice type "51000") may charge all codes.

	Definitions of Ambulance Patient Transfer
	Basic Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient in transit.
	Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA). (e.g. Initiating and/or maintaining IV therapy, nebulisation etc.) whilst patient in transit.
	Advanced Life Support - A callout where patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Paramedic (CCA and NDIP) whilst patient in transport. This includes all incubated neonatal transfers.
	NOTES: - Incubator transfers require ALS trained personnel in accordance with the HPCSA ruling. - If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ALS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ALS to be charged. - If a hospital or the attending physician requires a Paramedic to accompany the patient on a transfer in the event of the patient needing ILS intervention the doctor requesting the Paramedic must write a detailed motivational letter in order for ILS to be charged. - In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital. - Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient or ALS monitoring and presence is not required, the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call not an ALS call). - Where an ILS provider is in attendance at a callout but does not do any interventions at an ILS level on the patient or ILS monitoring and presence is not required, the billing will be BLS. - Where the management undertaken by a paramedic or AEA fall within the scope of practice of a BAA the call must be at a BLS level. **Please Note :** **-** The amounts reflected in the tariff schedule for each level of care is inclusive of any disposables (except for pacing pads, heimlich valves, high capacity giving sets, dial a flow, intra-osseous needles) and drugs used in the management of the patient. - Haemaccel and colloid solution may be charged separately. · Claims for patient discharges home will only be entertained if accompanied by a written motivation from the attending physician who requested such transport - clearly stating why an ambulance is required for such a transport and what medical assistance the patient requires on route.

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	Definition: Response Vehicles:
	Response Vehicle Only - Advance Life Support (ALS): A clear defintion must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under items 131 and 133. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered. 2. In the event of a service rendering ALS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ALS bill under items 131 and 133. Since the ALS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider, which will be levied at a BLS rate. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ALS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ALS services rendered. 3. Should a response vehicle go to a scene and not render any ALS treatment then the said response vehicle may not levy a bill. 4. Notwithstanding that, item 151 applies to all ALS resuscitation per the notes in this schedule.
	Response vehicle only - Intermediate Life Support (ILS) A clear definition must be drawn between the acute primary response and a booked call. 1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to a member of the public who is ill or injured at work, home or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service which is transporting the patient shall not be able to levy a bill, as the cost of transportation is included in the ILS rate under items 125 and 127. Furthermore the ILS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ILS services rendered. 2. In the event of a service rendering ILS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ILS bill under items 125 and 127. Since the ILS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider. This ensures that there is only one bill levied per patient. Furthermore the response vehicle ILS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ILS services rendered. 3. Should a response vehicle go to a scene and not render any ILS treatment then the said response vehicle may not levy a bill.

1	BASIC LIFE SUPPORT					
	Metropolitan Area:					
CODE:	**DESCRIPTION:**	**EMS Primary Response**		**Interhospital transfer**		**2020 Tariff**
		Units:	**Value:**	**Units:**	**Value:**	
100	Up to 45 minutes		R 1 803,21			R 1 902,99
102	Up to 60 minutes		R2 402,17			R 2 535,09
103	Every 15 minutes thereafter or part thereof, where specially motivated		R601,07			R 634,33
	Long distance					
111	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		R 29,99			R 31,65
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of **R 1800**		R 10,52			R 11,11
104	Call out fee (under 100km travel to scene)					
113	Non patient carrying rate per km up to a maximum of R1800					
2	**INTERMEDIATE LIFE SUPPORT**					
	Metropolitan Area:					
CODE:	**DESCRIPTION:**	**EMS Primary Response**		**Interhospital transfer**		**2020 Tariff**
		Units:	**Value:**	**Units:**	**Value:**	
125	Up to 45 minutes		R 2434.53			
127	Every 15 minutes thereafter or part thereof, where specially motivated		R 811.56			
	Long distance					
129	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		R 40.65			
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R		R 10.52			
126	Call out fee (under 100km travel to scene)					
128	Non patient carrying rate per km up to a maximum of R1800					

3	ADVANCED LIFE SUPPORT/INTENSIVE CARE UNIT					
	Metropolitan Area:					
CODE:	**DESCRIPTION:**	**EMS Primary Response**		**Interhospital transfer**		**2020 Tariff**
		Units:	**Value:**	**Units:**	**Value:**	
131	Up to 60 minutes		4281.29			
133	Every 15 minutes thereafter or part thereof, where specially motivated		1070.32			
	Long distance					
141	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		53.41			
142	Per km (> 100 km) (ALS return - non patient carrying kilometres)		10.52			
143	Non patient carrying rate per km up to a maximum of R1800					
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**					
CODE:	**DESCRIPTION:**	**EMS Primary Response**		**Interhospital transfer**		**2020 Tariff**
		Units:	**Value:**	**Units:**	**Value:**	
151	Resuscitation fee, per incident		R 4 779,87			R 5 044,36
153	Doctor per hour		R 1 368,55			R 1 444,28
	Note : A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: · Administration of advanced cardiac life support drugs. · Cardioversion-synchronised or unsynchronised (defibrillation) · External cardiac pacing · Endotracheal intubation (Oral or nasal) with assisted ventilation					
	Note : Where a doctor callout fee is charged the name and HPCSA registration number and BHF practise number of the doctor must appear on the bill.					

5	**AEROMEDICAL TRANSFERS**					
	ROTOR WING RATES					
	Definitions: 1. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 2. If flying time is mostly in night time (as per definition above), then bill night time operation rates 3. Call out charge includes Basic Call Cost plus other flying time incurred. 4. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 5. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 6. Rates are calculated according to time; from throttle open, to throttle closed. 7. Helicopters must fall within the Cat 138 Ops as determined by Civil Aviation.					
		EMS Primary Response				**2020 Tariff**
	Daylight operations	**Units:**	**Value:**			
500	Basic Call Cost (Start-up)		R 3 354,62			R 3 540,24
	Flying Time					
	30 minutes		R 15 095,79			R 15 931,09
	Additional 15 minutes (after first 30 minutes)		R 7 547,24			R 7 964,85
	Night time operations					
	Basic Call Cost (Start-up)					
	Flying Time					
	30 minutes		R 15 095,79			R 15 931,09
	Additional 15 minutes (after first 30 minutes)		R 7 547,24			R 7 964,85
	Hot Loads (up to 8 minutes)					
	Per transfer					
	FIXED WING RATES (ACTUAL COST REIMBURSED UP TO STATED MAXIMUM)					
	DEFINITIONS:					
	1. Group A and Group B must fall within the Cat 138 Ops as determined by Civil Aviation.					
	4. 2nd patient transferred at 40% reduction of cost per km. (only if aircraft capability allows for multiple patients)					
	Group A					
	Including flying cost, staff cost and equipment cost, per kilometre		R117,08			R 123,56
	Guardian Citation II		R119,71			R 126,33

	Guardian Falcon		R80,25			R 84,69
	Hawker HS 125 - 800		R77,62			R 81,91
	King Air 200		R121,03			R 127,73
	Learjet 55		R102,61			R 108,29
	Learjet 56		R44,73			R 47,21
	Pilatus PC 12					
	Group B - Unlisted aircraft					
6	**NATIONALLY APPROVED MEDICATIONS WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS**					
	Registered Basic Ambulance Assistant Qualification: · Oxygen · Entonox · Oral Glucose Registered Ambulance Emergency Assistant Qualification: As above, plus · Intravenous fluid therapy · Intravenous dextrose 50% · B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol) · Soluble Aspirin Registered Paramedic Qualification: As above, plus · Oral glyceryl trinitrate, activated charcoal · Ipratropium bromide inhalant solution · Endotracheal Adrenaline and Atropine · Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide · Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine and Tramadol may only be administered after permission has been obtained from the relevant supervising medical officer. · Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.					

BIOKINETICS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include the full range of diagnostic and evaluation procedures within the scope of practice of the biokineticist, including for example: anthropometric / body composition assessments, ergological testing evaluations and perceptual motor evaluation
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. This limitation shall be inclusive of a maximum of one group treatment procedure (code 12), where applicable. Treatment procedures include the full range of rehabilitative or preventive treatment or care procedures within the scope of practice of the biokineticist, including for example: hydrotherapy, callisthenics exercises and programme prescription for individuals with CHD.
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report as soon as possible if further treatment is necessary. Further continuance of treatment should only be considered if recommended by the medical practitioner(s) and others involved in the rehabilitation of the patient.
011	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.

1	Consultations / Patient Education / Counseling			
CODE:	**DESCRIPTION**	**Units:**	**Value:**	**2020 Tariff**
107	Appointment not kept			
901	Initial consultation including: a problem focused history; a short problem focused examination; and straightforward biokinetic decision-making but excluding evaluation. To be charged only once per course of treatment. (inclusive of lung function tests)	16.70	R 140,89	R 148,69
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination; and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment	11.70	R 98,80	R 104,26
905	Consultation at hospital (global fee including a problem focused history; a problem focused examination; and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment.	16.70	R 140,89	R 148,69
922	Patient education (based upon the evaluation outcomes)	16.30	R 118,00	R 124,53
936	Health promotion and lifestyle modifications		R 118,79	R 125,37

CODE:	DESCRIPTION	Units:	Value:	2020 Tariff
2	**Evaluation / Diagnostic Procedures**			
908	Simple evaluation at the first visit only (to be fully documented)	10.00	R 72,49	R 76,50
909	Complex evaluation at the first visit only (to be fully documented).	16.70	R 120,77	R 127,45
912	Anthropometric/body composition assessment	10.00	R 72,49	R 76,50
913	Ergological testing evaluation of body segment, limb or joint	28.50	R 206,28	R 217,69
914	Neurological patients: Ergological evaluation	16.70	R 120,77	R 127,45
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	16.70	R 120,77	R 127,45
916	Perceptual motor evaluation (perception and gross motor function)	16.70	R 120,77	R 127,45
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	28.50	R 206,28	R 217,69
918	Physical work capacity with full ECG	28.50	R 206,28	R 217,69
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	28.50	R 206,28	R 217,69
921	Isokinetic testing by means of specialised electronic equipment	28.50	R 206,28	R 217,69
3	**Therapeutic Procedures (Physical Rehabilitation)**			
	Maximum of 3 modalities, per diagnosis, may be charged per visit			
923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	16.30	R 232,46	R 245,32
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	16.30	R 118,00	R 124,53
926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	16.30	R 118,00	R 124,53
927	Posture, gait and activities of daily living (ADL), with/without equipment use	16.30	R 118,00	R 124,53
928	A rehabilitative exercise prescription	16.30	R 118,00	R 124,53
929	Callisthenics exercises	16.30	R 118,00	R 124,53
930	Group session with high risk patients, per patient (maximum 10 patients)	8.80	R 63,67	R 67,20
931	Passive and active range of motion exercise therapy	16.30	R 232,46	R 245,32
933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, Low-Back pain/ Lumbago etc.		R 118,79	R 125,37
934	Group exercise sessions, per patient	8.80	R 63,67	R 67,20

CHINESE MEDICINE

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

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

1	**CONSULTATIONS**			
CODE:	**DESCRIPTION:**	**UNITS:**	**VALUE:**	**2020 Tariff**
1100	Consultation (up to 15 mins)	10.00	R 159,57	R 168,40
1101	Consultation (16-30 mins)	22.50	R 358,88	R 378,74
1102	Consultation (31-45 min)	37.50	R 598,31	R 631,41
1103	Consultation (46-60 min)	52.50	R 837,60	R 883,95
1110	Consultation, each additional full 15 mins beyond 60 mins	10.00	R 239,43	R 252,68
2	**TREATMENTS**			
3100	First treatment (needles, plus maximum of two speciality therapy techniques)	39.52	R 630,54	R 665,43
3200	Follow-up treatment (needles, plus maximum of two speciality therapy techniques)	36.14	R 576,73	R 608,64
3	**SPECIALITY THERAPY TECHNIQUES**			
4010	Moxibustion	22.77	R 363,22	R 383,32
4020	Cupping	19.49	R 310,99	R 328,20
4030	Dermal needle therapy (plum-blossom or seven-star)	18.18	R 290,08	R 306,13
4040	Auricular therapy (micro acupuncture)	32.14	R 512,80	R 541,17
4050	Scalp acupuncture	27.30	R 435,84	R 459,95
4060	Shilao (diet therapy)	23.71	R 378,35	R 399,28
4070	Tui-Na (massage/pressure)	34.22	R 545,95	R 576,16

CHIROPRACTORS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

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

1	Consultations			
CODE:	**DESCRIPTION:**	**UNITS:**	**VALUE:**	**2020 Tariff**
107	Appointment not kept			
301	Consultation	25.00	R 215,09	R 226,99
2	**Diagnostic procedures**			
	Only a single item from this section may be charged per patient encounter			
	Radiation Control Council Certificate number to be on account if X-Rays charged			
311	Single diagnostic procedure	25.00	R 183,91	R 194,09
312	Two diagnostic procedures	37.50	R 275,74	R 290,99
313	Three diagnostic procedures	50.00	R 367,69	R 388,04

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
3	**Immobilisation or therapeutic exercises in relation to preparation or fitting of appliances**			
	Only a single item from this section may be charged per patient encounter			
321	Single instance of immobilization or therapeutic exercises	10.00	R 73,54	R 77,61
322	Two instances of immobilization or therapeutic exercises	15.00	R 110,37	R 116,48
4	**Treatment (therapeutic procedures)**			
	Only a single item from this section may be charged per patient encounter			
331	Single treatment procedure	10.00	R 73,54	R 77,61
332	Two treatment procedures	15.00	R 110,37	R 116,48
333	Three treatment procedures	20.00	R 147,08	R 155,22
334	Four treatment procedures	25.00	R 183,91	R 194,09
335	Five treatment procedures	30.00	R 220,48	R 232,68
336	Six treatment procedures	35.00	R 257,45	R 271,70
5	**Consumables**			
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus: • 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and • a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands			
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.			
110	X-Ray films		R133.40	

CLINICAL PATHOLOGY

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

1	The account or statement contemplated in section 59(1) of the Act must contain the following - i. the surname, first name and other initials, if any, of the patient; ii. the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; iii. the relevant diagnostic and such other item code numbers that relates to such relevant health service; iv. the date on which each relevant health service was rendered; v. the nature and cost of each relevant health service rendered, including the supply of medicine to the patient; and the name, quantity and dosage of and net amount payable by the patient in respect of, the medicine;
2	No "shopping list" must be distributed to doctors and no group tests will be carried out.
3	No charge to be raised in respect of services such as sample handling and after hours services.
4	Interaction with patient for collecting of specimens shall be limited to those specimens that are physiologically expelled, such as sputum and urine and taking of venous and peripheral blood.
5	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.
	Modifier 0097: Pathology tests performed by non-pathologists: Where items under Clinical Pathology (Section 21) and Anatomical Pathology (Section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.

1. Haematology

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3705	Alkali resistant haemoglobin		4,50	R 82,48	3,00		R 87,04
3709	Antiglobulin test (Coombs' or trypsinzied red cells)		3,65	R 66,57	2,45		R 70,25
3710	Antibody titration		7,20	R 131,55	4,80		R 138,83
3711	Arneth count		2,25		1,50		
3712	Antibody identification		8,45	R 154,58	5,65		R 163,13
3713	Bleeding time (does not include the cost of the simplate device)		6,94	R 127,21	4,63		R 134,25
3714	Blood volume, dye method		7,20	R 131,55	4,80		R 138,83
3715	Buffy layer examination		19,90	R 364,01	13,27		R 384,15
3716	Mean Cell Volume		2,25	R 21,71	1,50		R 22,91

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3718	Quantitative reverse transcriptase polymerase chain reaction (QR-PCR) for monitoring minimal residual disease (MRD) in leukaemia patients		183,68		122,45		
3717	Bone marrow cytological examination only		19,90	R 364,01	13,27		R 384,15
3719	Bone marrow: Aspiration		8,40		5,60		
3720	Bone marrow trephine biopsy		32,60		21,70		
3721	Bone marrow aspiration and trephine biopsy (excluding histology)		36,80		24,50		
3722	Capillary fragility: Hess		2,02	R 36,97	1,35		R 39,02
3723	Circulating anticoagulants		5,85	R 106,82	3,90		R 112,73
3724	Coagulation factor inhibitor assay		57,56	1 052.17	38,37		
3726	Activated protein C resistance		26,00	R 475,57	17,30		R 501,88
3727	Coagulation time		3,16	R 57,49	2,11		R 60,67
3728	Anti-factor Xa Activity		53,60		35,73		
3729	Cold agglutinins		3,60	R 66,04	2,40		R 69,69
3730	Protein S: Functional		37,50	R 685,40	25,00		R 723,33
3731	Compatibility for blood transfusion		3,60	R 66,04	2,40		R 69,69
3732	Cryoglobulin		3,60	R 66,04	2,40		R 69,69
3734	Protein C (chromogenic)		30,29	R 553,58	20,19		R 584,21
3735	Anti-thrombin III (chromogenic)		22,00	R 402,42	14,70		R 424,69
3736	Plasminogen (chromogenic)		61,65	1 127.28	41,10		
3737	Lupus Russel Viper method		17,00	R 310,99	11,30		R 328,20
3738	Lupus Kaolin Exner method		25,00	R 457,28	16,70		R 482,58
3739	Erythrocyte count		2,25	R 40,91	1,50		R 43,17
3740	Factors V and VII: Qualitative		7,20	R 131,55	4,80		R 138,83
3741	Coagulation factor assay: Functional		9,45	R 172,86	6,30		R 182,42
3742	Coagulation factor assay: Immunological		4,50		3,00		
3743	Erythrocyte sedimentation rate		3,00	R 54,46	2,00		R 57,47
3744	Fibrin stabilizing factor (urea test)		4,50	R 82,48	3,00		R 87,04
3746	Fibrin monomers		2,70	R 49,46	1,80		R 52,20
3748	Plasminogen activator inhibitor (PAI-I)		65,95		43,97		
3750	Tissue plasminogen Activator (tPA)		67,79		45,19		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3751	Osmotic fragility (screen)		2,25		1,50		
3752	Osmotic fragility test: Quantitative		10,00		6,65		
3753	Osmotic fragility (before and after incubation)		18,00	R 329,41	12,00		R 347,64
3754	ABO Reverse Group		5,50	R 54,73	3,67		R 57,76
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)		10,50	R 192,20	7,00		R 202,84
3756	Full cross match		7,20	R 131,55	4,80		R 138,83
3757	Coagulation factors: Quantitative		32,20	R 588,83	21,47		R 621,41
3758	Factor VIII related antigen		60,46	1 105.31	40,31		
3759	Coagulation factor correction study		11,72	R 214,43	7,81		R 226,30
3761	Factor XIII related antigen		61,11		40,74		
3762	Haemoglobin estimation		1,80	R 33,02	1,20		R 34,85
3763	Contact activated product assay		16,20	R 296,13	10,80		R 312,52
3764	Grouping: A B and O antigens		3,60	R 66,04	2,40		R 69,69
3765	Grouping: Rh antigen		3,60	R 66,04	2,40		R 69,69
3766	PIVKA		43,49	R 467,67	28,99		R 493,55
3767	Euglobulin Lysis time		25,58	R 274,29	17,05		R 289,47
3768	Haemoglobin A2 (column chromatography)		15,00	R 490,17	10,00		R 517,29
3769	Haemoglobin electrophoresis		26,82	R 66,04	17,88		R 69,69
3770	Haemoglobin-S (solubility test)		3,60	R 66,04	2,40		R 69,69
3771	Factor III-availability test		5,85		3,90		
3772	Haptoglobin: Quantitative		9,45	R 172,86	6,30		R 182,42
3773	Ham's acidified serum test		8,00	R 146,16	5,33		R 154,25
3775	Heinz bodies		2,25	R 40,91	1,50		R 43,17
3776	Haemosiderin in urinary sediment		2,25	R 40,91	1,50		R 43,17
3781	Heparin tolerance		7,20		4,80		
3783	Leucocyte differential count		6,20	R 113,40	4,15		R 119,67
3785	Leucocytes: Total count		1,80	R 33,02	1,20		R 34,85
3786	QBC malaria concentration and fluorescent staining		25,00	R 457,28	16,70		R 482,58
3787	LE-cells		8,30	R 151,81	5,55		R 160,21
3789	Neutrophil alkaline phosphatase		28,00	R 512,14	18,70		R 540,48

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3791	Packed cell volume: Haematocrit		1,80	R 33,02	1,20		R 34,85
3792	Plasmodium falciparum: Monoclonal immunological identification		9,00	R 164,44	6,00		R 173,54
3793	Plasma haemoglobin		6,75	R 123,27	4,50		R 130,09
3794	Platelet sensitivities		18,64		12,43		
3795	Platelet aggregation per aggregant		12,14	R 222,06	8,09		R 234,35
3796	Platelet antibodies: Agglutination		5,40		3,60		
3797	Platelet count		2,25	R 40,91	1,50		R 43,17
3799	Platelet adhesiveness		4,50	R 82,48	3,00		R 87,04
3801	Prothrombin consumption		5,85	R 106,82	3,90		R 112,73
3803	Prothrombin determination (two stages)		5,85	R 106,82	3,90		R 112,73
3805	Prothrombin index		6,00	R 109,98	4,00		R 116,07
3806	Therapeutic drug level: Dosage		4,50	R 82,48	3,00		R 87,04
3807	Recalcification time		2,25		1,50		
3809	Reticulocyte count		3,00	R 54,46	2,00		R 57,47
3810	Schumm's test		3,60	R 66,04	2,40		R 69,69
3811	Sickling test		2,25	R 40,91	1,50		R 43,17
3814	Sucrose lysis test for PNH		3,60	R 66,04	2,40		R 69,69
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)		21,10	R 385,72	14,07		R 407,06
3820	Thrombo - Elastogram		26,00	R 475,57	17,33		R 501,88
3825	Fibrinogen titre		3,60	R 66,04	2,40		R 69,69
3828	Soluble urokrinase Plasminogen Activator Receptor (suPAR) ELISA		36,13		24,09		
3829	Glucose 6-phosphate-dehydrogenase: Qualitative		8,00	R 146,16	5,33		R 154,25
3830	Glucose 6-phosphate-dehydrogenase: Quantitative		16,00	R 292,84	10,70		R 309,04
3832	Red cell pyruvate kinase: Quantitative		16,00	R 292,84	10,70		R 309,04
3834	Red cell Rhesus phenotype		9,90	R 181,28	6,60		R 191,31
3835	Haemoglobin F in blood smear		5,85	R 106,82	3,90		R 112,73
3837	Partial thromboplastin time		5,85	R 106,82	3,90		R 112,73
3841	Thrombin time (screen)		7,16	R 130,90	4,77		R 138,14

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3843	Thrombin time (serial)		7,65	R 139,97	5,10		R 147,72
3847	Haemoglobin H		2,25	R 40,91	1,50		R 43,17
3851	Fibrin degeneration products (diffusion plate)		10,35	R 189,31	6,90		R 199,79
3853	Fibrin degeneration products (latex slide)		4,50	R 82,48	3,00		R 87,04
3854	XDP (Dimer test or equivalent latex slide test)		8,50	R 155,23	5,67		R 163,82
3855	Haemagglutination inhibition		9,90	R 181,28	6,60		R 191,31
3856	D-Dimer (quantitative)		27,52	R 437,15	18,35		R 461,34
3857	Ristocetin Cofactor		35,53		23,69		
3858	Heparin removal		28,88		19,25		
2	**Microscopic and miscellaneous tests**						
3863	Autogenous vaccine		12,60	230,22	8,40		R 242,96
3864	Entomological examination		20,70	378,48	13,80		R 399,42
3865	Parasites in blood smear		5,60	102,22	3,73		R 107,88
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)		4,90	89,46	3,30		R 94,41
3868	Fungus identification		8,30	R 151,81	5,50		R 160,21
3869	Faeces (including parasites)		4,90	R 89,46	3,27		R 94,41
3872	Automated urine microscopy		8,72		5,81		
3873	Transmission electron microscopy		85,00		57,00		
3874	Scanning electron microscopy		100,00		67,00		
3875	Inclusion bodies		4,50	82,48	3,00		R 87,04
3878	Crystal identification polarized light microscopy		4,50	82,48	3,00		R 87,04
3879	Campylobacter in stool: Fastidious culture		9,90	181,28	6,60		R 191,31
3880	Antigen detection with polyclonal antibodies		4,50	82,48	3,00		R 87,04
3881	Mycobacteria		3,00	54,46	2,00		R 57,47
3882	Antigen detection with monoclonal antibodies		10,80	197,73	7,20		R 208,67
3883	Concentration techniques for parasites		3,00	54,46	2,00		R 57,47
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana		6,30	115,37	4,20		R 121,75
3885	Cytochemical stain		5,45	99,72	3,65		R 105,24

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3	**Bacteriology**						
4650	Antibiotic MIC per organism per antibiotic		8,00	146,16	5,33		R 154,25
4651	Non-radiometric automated blood cultures		13,90	254,03	9,27		R 268,09
4652	Rapid automated bacterial identification per organism		15,00	274,29	10,00		R 289,47
4653	Rapid automated antibiotic susceptibility per organism		17,00	310,99	11,33		R 328,20
4654	Rapid automated MIC per organism per antibiotic		17,00	310,99	11,33		R 328,20
3887	Antibiotic susceptibility test: Per organism		8,00	R 146,16	5,33		R 154,25
3888	Adhesive tape preparation		2,70	R 49,46	1,80		R 52,20
3889	Clostridium difficile toxin: Monoclonal immunological		12,40	R 226,54	8,27		R 239,08
3890	Antibiotic assay of tissues and fluids		13,90	R 254,03	9,27		R 268,09
3891	Blood culture: Aerobic		5,85	R 106,82	3,90		R 112,73
3892	Blood culture: Anaerobic		5,85	R 106,82	3,90		R 112,73
3893	Bacteriological culture: Miscellaneous		6,30	R 115,37	4,20		R 121,75
3894	Radiometric blood culture		10,80	R 197,73	7,20		R 208,67
3895	Bacteriological culture: Fastidious organisms		9,90	R 181,28	6,60		R 191,31
3896	In vivo culture: Bacteria		16,00	R 292,84	10,65		R 309,04
3897	In vivo culture: Virus		16,00	R 292,84	10,65		R 309,04
3898	Bacterial exotoxin production (in vitro assay)		4,50		3,00		
3899	Bacterial exotoxin production (in vivo assay)		20,70	378,48	13,80		R 399,42
3900	Cytomegalovirus (CMV) pp65 antigen detection assay		59,20		39,47		
3901	Fungal culture		4,50	82,48	3,00		R 87,04
3902	Clostridium difficile (cytotoxicity neutralisation)		30,00	548,58	20,00		R 578,93
3903	Antibiotic level: Biological fluids		11,70	214,17	7,80		R 226,02
3904	Rotavirus latex slide test		5,62	102,88	3,75		R 108,57
3905	Identification of virus or rickettsia		20,70	378,48	13,80		R 399,42
3906	Identification: Chlamydia		16,00	292,84	10,65		R 309,04
3907	Culture for staphylococcus aureus			40,91			R 43,17
3908	Anaerobe culture: Comprehensive		9,90	181,28	6,60		R 191,31
3909	Anaerobe culture: Limited procedure		4,50	82,48	3,00		R 87,04

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3911	Beta-lactamase assay		4,50	82,48	3,00		R 87,04
3914	Sterility control test: Biological method		4,50	82,48	3,00		R 87,04
3915	Mycobacterium culture		4,50	82,48	3,00		R 87,04
3916	Radiometric tuberculosis culture		10,80	197,73	7,20		R 208,67
3917	Mycoplasma culture: Limited		2,25		1,50		
3918	Mycoplasma culture: Comprehensive		9,90	181,28	6,60		R 191,31
3919	Identification of mycobacterium		9,90	181,28	6,60		R 191,31
3920	Mycobacterium: Antibiotic sensitivity		9,90	181,28	6,60		R 191,31
3921	Antibiotic synergistic study		20,70	378,48	13,80		R 399,42
3922	Viable cell count		1,35	24,6	0,90		R 25,96
3923	Biochemical identification of bacterium: Abridged		3,15	57,36	2,10		R 60,53
3924	Biochemical identification of bacterium: Extended		12,50	228,64	8,33		R 241,29
3925	Serological identification of bacterium: Abridged		3,15	57,36	2,10		R 60,53
3926	Serological identification of bacterium: Extended		10,20	186,28	6,80		R 196,59
3927	Grouping for streptococci		7,30	133,66	4,85		R 141,06
3928	Antimicrobic substances		3,80	69,46	2,50		R 73,30
3929	Radiometric mycobacterium identification		14,00	255,87	9,30		R 270,03
3930	Radiometric mycobacterium antibiotic sensitivity		25,00	457,28	16,70		R 482,58
3931	Helicobacter: Monoclonal immunological		12,40	226,54	8,27		R 239,08
4655	Mycobacteria: MIC determination - E Test		16,50		11,00		
4656	Mycobacteria: Identification HPLC		35,00		23,33		
4657	Mycobacteria: Liquefied, concentrated, fluorochrome stain		9,90		6,60		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4	**Serology**						
3932	Antibodies to human immunodeficiency virus (HIV): ELISA		14,10	257,71	9,40		R 271,97
3933	IgE: Total: EMIT or ELISA		11,70	214,17	7,80		R 226,02
3934	Auto antibodies by labelled antibodies		16,00	292,84	10,65		R 309,04
3935	Sperm antibodies		16,00	292,84	10,65		R 309,04
3936	Virus neutralisation test: First antibody		75,00	1 371.71	50,00		
3937	Virus neutralisation test: Each additional antibody		15,00	274,29	10,00		R 289,47
3938	Precipitation test per antigen		4,50	82,48	3,00		R 87,04
3939	Agglutination test per antigen		5,50	100,51	3,67		R 106,07
3940	Haemagglutination test: Per antigen		9,90	181,28	6,60		R 191,31
3941	Modified Coombs' test for brucellosis		4,50	82,48	3,00		R 87,04
3942	Hepatitis Rapid Viral Ab		12,24	196,41	8,16		R 207,28
3943	Antibody titer to bacterial exotoxin		3,60	66,04	2,40		R 69,69
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag		12,40	226,54	8,27		R 239,08
3945	Complement fixation test		5,85	106,82	3,90		R 112,73
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag		14,05	256,79	9,37		R 271,00
3947	C-reactive protein		10,84	198,51	7,23		R 209,49
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag		12,95	236,67	8,63		R 249,77
3949	Qualitative Kahn, VDRL or other flocculation		2,25	40,91	1,50		R 43,17
3950	Neutrophil phagocytosis		25,20	461,1	16,80		R 486,61
3951	Quantitative Kahn, VDRL or other flocculation		3,60	66,04	2,40		R 69,69
3952	Neutrophil chemotaxis		67,95	1 242.79	45,30		
3953	Tube agglutination test		4,15	76,17	2,76		R 80,38
3955	Paul Bunnell: Presumptive		2,25	R 40,91	1,50		R 43,17
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)		8,50	R 155,23	5,67		R 163,82
3957	Paul Bunnell: Absorption		4,50		3,00		
3958	Anti Gad/Ia2 Ab		67,95		45,30		
3959	Rose Waaler agglutination test		4,50	1 080.19	3,00		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
3960	Gonococcal, listeria or echinococcus agglutination		9,50	82,48	6,30		R 87,04
3961	Slide agglutination test		2,63	173,65	1,75		R 183,26
3962	Rebuck skin window		5,40	48,15	3,60		R 50,81
3963	Serum complement level: Each component		3,15	57,36	2,10		R 60,53
3965	Anti Ia2 Antibodies		36,00	572,13	24,00		R 603,79
3966	Anti Gad Antibodies		36,00		24,00		
3967	Auto-antibody: Sensitized erythrocytes		4,50	82,48	3,00		R 87,04
3968	Herpes virus typing: Monoclonal immunological		20,69	378,35	13,79		R 399,29
3969	Western blot technique		74,00	1 352.90	49,00		
3970	Epstein-Barr virus antibody titer			123,27			R 130,09
3971	Immuno-diffusion test: Per antigen		3,15	57,36	2,10		R 60,53
3972	Respiratory syncytial virus (ELISA technique)		35,00	639,75	23,00		R 675,15
3973	Immuno electrophoresis: Per immune serum		9,45	172,86	6,30		R 182,42
3974	Polymerase chain reaction		75,00	1 371.71	50,00		
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)		12,00	219,3	8,00		R 231,43
3977	Counter immuno-electrophoresis		6,75		4,50		
3978	Lymphocyte transformation		51,70	944,95	34,50		R 997,24
3980	Bilharzia Ag Serum/Urine		14,50	142,87	9,67		R 150,78
3982	Histone Ab		16,00		10,67		
3984	Quantiferon TB assay		44,80		29,87		
3986	Anti R7-V		59,59		39,73		
4600	Anti-CCP		17,46	277,45	11,64		R 292,80
4601	Panel typing: Antibody detection: Class I		36,00	658,16	24,00		R 694,58
4602	Panel typing: Antibody detection: Class II		44,00	804,58	29,30		R 849,10
4603	HLA test for specific locus/antigen - serology		27,00	493,72	18,00		R 521,04
4604	HLA typing: Class I - serology		52,00	950,74	34,70		R 1 003,35
4605	HLA typing: Class II - serology		52,00	950,74	34,70		R 1 003,35
4606	HLA typing: Class I & II - serology		90,00	1 645.87	60,00		
4607	Cross matching T-cells (per tray)		18,00	329,41	12,00		R 347,64

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4608	Cross matching B-cells		38,00	694,87	25,30		R 733,32
4609	Cross matching T- & B-cells		48,00	877,86	32,00		R 926,43
4610	Helicobacter: Pylori antigen test		34,60	549,89	23,07		R 580,32
4611	Erythropoietin		20,00		13,33		
4612	HTLV I/II		20,00		13,33		
4613	Anti-Gm1 Antibody Assay		75,00		50,00		
4614	HIV Ab - Rapid Test		12,00	190,75	8,00		R 201,30
5.	**Skin tests**						
	Note: For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section						
6	**Biochemical tests: Blood**						
3991	Abnormal pigments: Qualitative		4,50	82,48	3,00		R 87,04
3993	Abnormal pigments: Quantitative		9,00	164,44	6,00		R 173,54
3995	Acid phosphate		5,18	94,85	3,45		R 100,10
3996	Serum Amyloid A		8,28		5,52		
3997	Acid phosphatase fractionation		1,80		1,20		
3998	Amino acids Quantitative (Post derivatisation HPLC)		78,12	1 428.81	52,08		
3999	Albumin		4,80	R 87,75	3,20		R 92,61
4000	Alcohol		12,40	R 226,54	8,27		R 239,08
4001	Alkaline phosphatase		5,18	R 94,85	3,45		R 100,10
4002	Alkaline phosphatase-iso-enzymes		11,70	R 214,17	7,80		R 226,02
4003	Ammonia: Enzymatic		7,71	R 141,03	5,14		R 148,83
4004	Ammonia: Monitor		4,50	R 82,48	3,00		R 87,04
4005	Alpha-1-antitrypsin: Total		7,20	R 131,55	4,80		R 138,83
4006	Amylase		5,18	R 94,85	3,45		R 100,10
4007	Arsenic in blood, hair or nails		36,25	R 662,90	24,17		R 699,58
4008	Bilirubin - Reflectance		4,77		3,18		
4009	Bilirubin: Total		4,77	R 87,35	3,18		R 92,18

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4010	Bilirubin: Conjugated		3,62	R 66,30	2,41		R 69,97
4011	Breath Hydrogen Test		21,56		14,37		
4012	CSF Nicotinic Acid		12,42		8,28		
4013	CSF Glutamine		11,25		7,50		
4014	Cadmium: Atomic absorption		18,12	331,12	12,08		R 349,44
4016	Calcium: Ionized		6,75	123,27	4,50		R 130,09
4017	Calcium: Spectrophotometric		3,62	66,3	2,41		R 69,97
4018	Calcium: Atomic absorption		7,25	132,21	4,83		R 139,53
4019	Carotene		2,25	40,91	1,50		R 43,17
4020	Carnitine (Total or free) in biological fluid: Each		11,69	213,91	7,79		R 225,75
4021	Carnitine (Total or free) in muscle: Each		23,38	427,55	15,59		R 451,21
4022	Acyl Carnitine		23,38	427,55	15,59		R 451,21
4023	Chloride		2,59	47,49	1,73		R 50,12
4025	Chol/HDL/LDL/Trig		27,07	430,31	18,05		R 454,12
4026	LDL cholesterol (chemical determination)		6,90	126,03	4,60		R 133,00
4027	Cholesterol total		5,34	97,61	3,56		R 103,01
4028	HDL cholesterol		6,90	126,03	4,60		R 133,00
4029	Cholinesterase: Serum or erythrocyte: Each		7,48	136,95	4,99		R 144,53
4030	Cholinesterase phenotype (Dibucaine or fluoride each)		9,00	164,44	6,00		R 173,54
4031	Total CO2		5,18	94,85	3,45		R 100,10
4032	Creatinine		3,62	66,3	2,41		R 69,97
4033	CSF-Immunoglobulin G		9,45		6,30		
4034	C1-Esterase Inhibitor		9,45	150,1	6,30		R 158,41
4035	CSF-Albumin		9,45	150,1	6,30		R 158,41
4036	CSF-IgG Index		22,05		14,70		
4038	Glutamic acid		29,06		19,37		
4040	Homocysteine (random)		15,30	279,81	10,20		R 295,29
4041	Homocysteine (after Methionine load)		18,10	330,86	12,06		R 349,17
4042	D-Xylose absorption test: Two hours		13,15	240,35	8,75		R 253,65
4045	Fibrinogen: Quantitative		3,60	66,04	2,40		R 69,69

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4047	Hollander test		24,75		16,50		
4049	Glucose tolerance test (2 specimens)		8,97	164,18	5,98		R 173,26
4050	Glucose strip-test with photometric reading		1,80	33,02	1,20		R 34,85
4051	Galactose		11,25	205,62	7,50		R 217,00
4052	Glucose tolerance test (3 specimens)		13,17	240,61	8,78		R 253,92
4053	Glucose tolerance test (4 specimens)		17,37	317,57	11,58		R 335,14
4057	Glucose: Quantitative		3,62	66,3	2,41		R 69,97
4061	Glucose tolerance test (5 specimens)		21,56	394,27	14,37		R 416,09
4062	Galactose-1-phosphate uridyl transferase		16,00	292,84	10,70		R 309,04
4063	Fructosamine		7,20	131,55	4,80		R 138,83
4064	Glycated haemoglobin:Chromatography/HbA1C		14,25	260,61	9,50		R 275,03
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda		46,88	857,47	31,25		R 904,92
4067	Lithium: Flame ionisation		5,18	94,85	3,45		R 100,10
4068	Lithium: Atomic absorption		7,48	136,95	4,99		R 144,53
4071	Iron		6,75	123,27	4,50		R 130,09
4073	Iron-binding capacity		7,65	139,97	5,10		R 147,72
4076	Blood gases: Astrup/pO2 and ancillary tests - can only be used to a maximum of 6 times per patient per calendar day		19,10	303,89	12,73		R 320,71
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb		6,75	123,27	4,50		R 130,09
4079	Ketones in plasma: Qualitative		2,25	R 40,91	1,50		R 43,17
4080	Everolimus assay		63,95		42,63		
4081	Drug level-biological fluid: Quantitative		10,80	R 197,73	7,20		R 208,67
4082	Tacrolimus assay		20,10		13,40		
4083	Lysosomal enzyme assay		36,56	668,56	24,37		R 705,55
4084	Thymidine kinase		20,00		13,33		
4085	Lipase		5,18	94,85	3,45		R 100,10
4086	Lactate		16,00		10,67		
4091	Lipoprotein electrophoresis		9,00	164,44	6,00		R 173,54
4092	Orosmucoid		9,45		6,30		
4093	Osmolality: Serum or urine		6,75	123,27	4,50		R 130,09

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4094	Magnesium: Spectrophotometric		3,62	66,3	2,41		R 69,97
4095	Magnesium: Atomic absorption		7,25	132,21	4,83		R 139,53
4096	Mercury: Atomic absorption		18,12	331,12	12,08		R 349,44
4098	Copper: Atomic absorption		18,12	331,12	12,08		R 349,44
4105	Protein electrophoresis		9,00	164,44	6,00		R 173,54
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class		20,00	365,85	13,20		R 386,09
4109	Phosphate		3,62	R 66,30	2,41		R 69,97
4111	Phospholipids		3,15		2,10		
4113	Potassium		3,62	66,3	2,41		R 69,97
4114	Sodium		3,62	66,3	2,41		R 69,97
4117	Protein: Total		3,11	56,96	2,07		R 60,11
4121	pH, pCO2 or pO2: Each		6,75	123,27	4,50		R 130,09
4123	Pyruvic acid		4,50	82,48	3,00		R 87,04
4125	Salicylates		4,50	82,48	3,00		R 87,04
4126	Secretin-pancreozymin response		26,10		17,40		
4127	Caeruloplasmin		4,50	82,48	3,00		R 87,04
4128	Phenylalanine: Quantitative		11,25	205,62	7,50		R 217,00
4129	Glutamate dehydrogenase (GDH)		5,40		3,60		
4130	Aspartate aminotransferase (AST)		5,40	98,67	3,60		R 104,13
4131	Alanine aminotransferase (ALT)		5,40	98,67	3,60		R 104,13
4132	Creatine kinase (CK)		5,40	98,67	3,60		R 104,13
4133	Lactate dehidrogenase (LD)		5,40	98,67	3,60		R 104,13
4134	Gamma glutamyl transferase (GGT)		5,40	98,67	3,60		R 104,13
4135	Aldolase		5,40	98,67	3,60		R 104,13
4136	Angiotensin converting enzyme (ACE)		9,00	164,44	6,00		R 173,54
4137	Lactate dehydrogenase isoenzyme		10,80	197,73	7,20		R 208,67
4138	CK-MB: Immunoinhibition/precipitation		10,80	197,73	7,20		R 208,67
4139	Adenosine deaminase		5,40	98,67	3,60		R 104,13
4142	Red cell enzymes: Each		7,80		5,20		
4143	Serum/plasma enzymes		5,40	98,67	3,60		R 104,13
4144	Transferrin		11,70	214,17	7,80		R 226,02

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4146	Lead: Atomic absorption		15,00	274,29	10,00		R 289,47
4147	Triglyceride		7,93	145,24	5,29		R 153,28
4148	Tay - Sachs Study		36,56		24,37		
4149	Red cell magnesium		11,70	214,17	7,80		R 226,02
4151	Urea		3,62	66,3	2,41		R 69,97
4152	CK-MB: Mass determination: Quantitative (Automated)		12,40	226,54	8,27		R 239,08
4153	CK-MB: Mass determination: Quantitative (Not automated)		17,47	319,54	11,65		R 337,22
4154	Myoglobin quantitative: Monoclonal immunological		12,40	226,54	8,27		R 239,08
4155	Uric acid		3,78	69,2	2,52		R 73,03
4156	Vitamin D3		12,42	199,44	8,28		R 210,48
4157	Vitamin A-saturation test		15,30	279,81	10,20		R 295,29
4158	Vitamin E (tocopherol)		3,60	66,04	2,40		R 69,69
4159	Vitamin A		6,30	115,37	4,20		R 121,75
4160	Vitamin C (ascorbic acid)		2,25		1,50		
4161	Troponin isoforms: Each		20,00	365,85	13,33		R 386,09
4163	Apoprotein AI: Turbidometric method		8,28	151,55	5,52		R 159,94
4165	Apoprotein AII: Turbidometric method		8,28	151,55	5,52		R 159,94
4167	Apoprotein B: Turbidometric method		8,28	151,55	5,52		R 159,94
4170	Lipoprotein (a)(Lp(a)) assay		12,42	227,19	8,28		R 239,76
4171	Sodium + potassium + chloride + CO2 + urea		15,84	289,68	10,56		R 305,71
4172	ELISA/EMIT technique		12,42	227,19	8,28		R 239,76
4173	Sirolimus Assay		78,00		52,00		
4181	Quantitative protein estimation: Mancini method		7,76	141,95	5,17		R 149,80
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method		8,28	151,55	5,52		R 159,94
4183	Quantitative protein estimation: Labelled antibody		12,42	227,19	8,28		R 239,76
4184	C-reactive protein (Ultra sensitive)		11,68	185,62	7,79		R 195,89
4185	Lactose		10,80	197,73	7,20		R 208,67
4186	Vitamin B6		15,30	243,37	10,20		R 256,84
4187	Zinc: Atomic absorption		18,12	331,12	12,08		R 349,44

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Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
7	**Biochemical tests: Urine**						
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)		1,50	27,63	1,00		R 29,16
4189	Abnormal pigments		4,50	82,48	3,00		R 87,04
4193	Alkapton test: Homogentisic acid		4,50	82,48	3,00		R 87,04
4194	Amino acids: Quantitative (Post derivatisation HPLC)		78,12	1 428.81	52,08		
4195	Amino laevulinic acid		18,00	329,41	12,00		R 347,64
4197	Amylase		5,18	94,85	3,45		R 100,10
4198	Arsenic		18,12	331,12	12,08		R 349,44
4199	Ascorbic acid		2,25	40,91	1,50		R 43,17
4201	Bence-Jones protein		2,70	49,46	1,80		R 52,20
4203	Phenol		3,60		2,40		
4204	Calcium: Atomic absorption		7,25	132,21	4,83		R 139,53
4205	Calcium: Spectrophotometric		3,62	66,3	2,41		R 69,97
4206	Calcium: Absorption and excretion studies		25,00		16,70		
4209	Lead: Atomic absorption		15,00	274,29	10,00		R 289,47
4210	Urine collagen telopeptides		36,50		24,33		
4211	Bile pigments: Qualitative		2,25	40,91	1,50		R 43,17
4213	Protein: Quantitative		2,25	40,91	1,50		R 43,17
4216	Mucopolysaccharides: Qualitative		3,60	66,04	2,40		R 69,69
4217	Oxalate		9,38	171,55	6,25		R 181,04
4218	Glucose: Quantitative		2,25	40,91	1,50		R 43,17
4219	Steroids: Chromatography (each)		7,20	131,55	4,80		R 138,83
4220	Klinolab Newborn Screen		36,56		24,37		
4221	Creatinine		3,62	R 66,30	2,41		R 69,97
4223	Creatinine clearance		7,65	R 139,97	5,10		R 147,72
4227	Electrophoresis: Qualitative		4,50	R 82,48	3,00		R 87,04
4228	Foetal Lung Maturity		36,56		24,37		
4229	Uric acid clearance		7,65		5,10		
4230	Urine/Fluid - Specific Gravity		0,90	14,34	0,60		R 15,13

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4231	Metabolites HPLC (High Pressure Liquid Chromatography		37,50		25,00		
4232	Metabolites (Gaschromatography/Mass spectrophotometry)		46,80		31,20		
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)		37,50		25,00		
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)		46,80		31,20		
4235	Inborn errors of metabolism (IEM) screening test by Tandem Mass Spectrometry for the detection of aminoacidopathies and cacylcamtine metabolic defects		70,86		47,24		
4237	5-Hydroxy-indole-acetic acid: Screen test		2,70	49,46	1,80		R 52,20
4238	5HIAA (Hplc)		78,12		52,08		
4239	5-Hydroxy-indole-acetic acid: Quantitative		6,75		4,50		
4247	Ketones: Excluding dip-stick method		2,25	40,91	1,50		R 43,17
4248	Reducing substances		1,80	33,02	1,20		R 34,85
4251	Metanephrines: Column chromatography		22,05	R 403,21	14,70		R 425,52
4252	Metanephrine (Hplc)		78,12		52,08		
4253	Aromatic amines (gas chromatography/mass spectrophotometry)		27,00	R 493,72	18,00		R 521,04
4254	Nitrosonaphtol test for tyrosine		2,25	R 40,91	1,50		R 43,17
4255	Orotic Acid - Urine		9,45		6,30		
4256	Very long Chain Fatty Acids		129,38		86,25		
4261	Micro Albumin: Quantitative		12,42	197,46	8,28		R 208,39
4262	Micro Albumin: Qualitative		4,50	71,57	3,00		R 75,53
4263	pH: Excluding dip-stick method		0,90	16,44	0,60		R 17,35
4265	Thin layer chromatography: One way		6,75	123,27	4,50		R 130,09
4266	Thin layer chromatography: Two way		11,25	205,62	7,50		R 217,00
4267	Total organic matter screen: Infrared		31,25		20,83		
4268	Organic acids: Quantitative: GCMS		109,38	2 000.14	72,92		
4269	Phenylpyruvic acid: Ferric chloride		2,25	40,91	1,50		R 43,17
4270	Chromium Total Urine		18,12		12,08		

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Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4271	Phosphate excretion index		22,05	403,21	14,70		R 425,52
4272	Porphobilinogen qualitative screen: Urine		5,00	91,43	3,33		R 96,49
4273	Porphobilinogen/ALA: Quantitative each		15,00	274,29	10,00		R 289,47
4283	Magnesium: Spectrophotometric		3,62	66,3	2,41		R 69,97
4284	Magnesium: Atomic absorption		7,25	132,21	4,83		R 139,53
4285	Identification of carbohydrate		7,65	139,97	5,10		R 147,72
4287	Identification of drug: Qualitative		4,50	R 82,48	3,00		R 87,04
4288	Identification of drug: Quantitative		10,80	R 197,73	7,20		R 208,67
4293	Urea clearance		5,40	R 98,67	3,60		R 104,13
4297	Copper: Spectrophotometric		3,62	66,3	2,41		R 69,97
4298	Copper: Atomic absorption		18,12	331,12	12,08		R 349,44
4300	Indican or indole: Qualitative		3,15		2,10		
4301	Chloride		2,59	47,49	1,73		R 50,12
4307	Ammonium chloride loading test		22,05		14,70		
4309	Urobilinogen: Quantitative		6,75	123,27	4,50		R 130,09
4313	Phosphates		3,62	66,3	2,41		R 69,97
4315	Potassium		3,62	66,3	2,41		R 69,97
4316	Sodium		3,62	66,3	2,41		R 69,97
4319	Urea		3,62	66,3	2,41		R 69,97
4321	Uric acid		3,62	66,3	2,41		R 69,97
4322	Fluoride		5,18		3,45		
4323	Total protein and protein electrophoresis		11,25	205,62	7,50		R 217,00
4325	VMA: Quantitative		11,25	205,62	7,50		R 217,00
4326	Catecholamines (HPLC)		78,12	1 428.81	52,08		
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda		46,88	857,47	31,25		R 904,92
4328	Immunoglobulin D		9,45		6,30		
4335	Cystine: Quantitative		12,60	230,22	8,40		R 242,96
4336	Dinitrophenol hydrazine test: Ketoacids		2,25	40,91	1,50		R 43,17
4337	Hydroxyproline: Quantitative		18,90		12,60		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
8	**Biochemical tests: Faeces**						
4339	Chloride		2,59	47,49	1,73		R 50,12
4343	Fat: Qualitative		3,15	57,36	2,10		R 60,53
4345	Fat: Quantitative		22,05	403,21	14,70		R 425,52
4347	Ph		0,90	16,44	0,60		R 17,35
4350	M2 Pyruvate Kinase quantitative ELISA		63,35		42,23		
4351	Occult blood: Chemical test		2,25	40,91	1,50		R 43,17
4352	Occult blood: Monoclonal antibodies		10,00	182,73	6,67		R 192,84
4357	Potassium		3,62	66,3	2,41		R 69,97
4358	Sodium		3,62	66,3	2,41		R 69,97
4359	Secretory IgA		9,45		6,30		
4361	Stercobilin		2,25		1,50		
4362	Elastase quantitative ELISA		47,00	859,44	31,33		R 907,00
4363	Stercobilinogen: Quantitative		6,75	123,27	4,50		R 130,09
4364	Chymotrypsin determination: Enzymatic		7,47		4,98		
9	**Biochemical tests: Miscellaneous**						
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each		5,00	91,43	3,33		R 96,49
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each		20,00	365,85	13,33		R 386,09
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each		20,00	365,85	13,33		R 386,09
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each		30,00	548,58	20,00		R 578,93
4370	Drug level in biological fluid: Monoclonal immunological		12,40	226,54	8,27		R 239,08
4371	Amylase in exudate		5,18	94,85	3,45		R 100,10
4372	Fluoride in biological fluids and water		15,62	285,47	10,41		R 301,27
4373	Breast milk analysis		6,75		4,50		
4374	Trace metals in biological fluid: Atomic absorption		18,13	331,25	12,09		R 349,58

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Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4375	Calcium in fluid: Spectrophotometric		3,62	66,3	2,41		R 69,97
4376	Calcium in fluid: Atomic absorption		7,25	132,21	4,83		R 139,53
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)		21,88	400,19	14,59		R 422,33
4378	Urea breath test		58,00		38,67		
4380	Lecithin in amniotic fluid: L/S ratio		27,00	493,72	18,00		R 521,04
4381	Lamellar body count in amniotic fluid		10,00		6,70		
4382	Bilirubin in amniotic fluid: Spectrophotometric essay		9,45		6,30		
4386	Oestrogen/Progesterone receptors: Fluorescent method		20,70		13,80		
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique		230,00		153,00		
4388	Gastric contents: Maximal stimulation test		27,00		18,00		
4389	Gastric fluid: Total acid per specimen		2,25		1,50		
4390	Foam test: Amniotic fluid		3,15	57,36	2,10		R 60,53
4391	Renal calculus: Chemistry		5,40	98,67	3,60		R 104,13
4392	Renal calculus: Crystallography		16,25	297,18	10,80		R 313,62
4393	Saliva: Potassium		3,62		2,41		
4394	Saliva: Sodium		3,62		2,41		
4395	Sweat: Sodium		3,62	66,3	2,41		R 69,97
4396	Sweat: Potassium		3,62	66,3	2,41		R 69,97
4397	Sweat: Chloride		2,59	47,49	1,73		R 50,12
4399	Sweat collection by iontophoresis (excluding collection material)		4,50	82,48	3,00		R 87,04
4400	Tryptophane loading test		22,05	403,21	14,70		R 425,52
10	**Cerebrospinal fluid**						
4401	Cell count		3,45	63,28	2,30		R 66,78
4407	Cell count, protein, glucose and chloride		7,65	139,97	5,10		R 147,72
4409	Chloride		2,59	47,49	1,73		R 50,12
4415	Potassium		3,62		2,41		
4416	Sodium		3,62	R 66,30	2,41		R 69,97

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4417	Protein: Qualitative		0,90	R 16,44	0,60		R 17,35
4419	Protein: Quantitative		3,11	56,96	2,07		R 60,11
4421	Glucose		3,62	66,3	2,41		R 69,97
4423	Urea		3,62	66,3	2,41		R 69,97
4425	Protein electrophoresis		12,60	230,22	8,40		R 242,96
11	**RNA/DNA based tests and andrology**						
11.1	**RNA/DNA based tests and andrology: RNA/DNA based tests**						
4424	HLA test for specific allele DNA-PCR		36,00		24,00		
4426	HLA typing low resolution Class I DNA-PCR per locus		100,00		67,00		
4427	HLA typing low resolution Class II DNA-PCR per locus		74,00		49,30		
4428	HLA typing high resolution Class I or II DNA-PCR per locus		66,00		44,00		
4429	Quantitative PCR (DNA/RNA)		84,30	1 384.87	56,20		
4430	Recombinant DNA technique		25,00	457,28	16,67		R 482,58
4431	Ribosomal RNA targeting for bacteriological identification		35,00	639,75	23,33		R 675,15
4432	Ribosomal RNA amplification for bacteriological identification		75,00	1 371.71	50,00		
4433	Bacteriological DNA identification (LCR)		25,00	457,28	16,67		R 482,58
4434	Bacteriological DNA identification (PCR)		75,00	1 371.71	50,00		
11.2	**RNA/DNA based tests and andrology: Andrology**						
4435	Mixed antiglobulin reaction: Semen		6,60	120,77	4,40		R 127,45
4436	Friberg test: Semen		14,50	265,21	9,67		R 279,88
4437	Kremer test: Semen		3,60	66,04	2,40		R 69,69
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.		150,00	2 383.49	100,00		
4440	Semen analysis: Cell count		7,65	139,97	5,10		R 147,72
4441	Semen analysis: Cytology		7,20	131,55	4,80		R 138,83

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4442	Semen analysis: Viability + motility - 6 hours		6,00	109,98	4,00		R 116,07
4443	Semen analysis: Supravital stain		5,44	99,59	3,63		R 105,10
4445	Seminal fluid: Alpha glucosidase		20,00	365,85	13,33		R 386,09
4446	Seminal fluid fructose		3,15	57,36	2,10		R 60,53
4447	Seminal fluid: Acid phosphatase		5,18	94,85	3,45		R 100,10
12	**Immunology**						
4448	HCG: Latex agglutination: Qualitative (side room)		4,00	73,14	2,67		R 77,19
4449	HCG: Latex agglutination: Semi-quantitative (side room)		9,31	170,49	6,21		R 179,92
4450	HCG: Monoclonal immunological: Qualitative		10,00	182,73	6,67		R 192,84
4451	HCG: Monoclonal immunological: Quantitative		12,40	226,54	8,27		R 239,08
4452	Bone Specific Alk Phosphatase		20,00		13,33		
4455	Anti IgE receptor antibody test (10 samples and dilution)		161,56	2 954.30	107,71		
4456	Eosinophil cationic protein		27,81	508,72	18,54		R 536,87
4457	Mast cell tryptase		96,87	1 771.24	64,58		
4458	Micro-albuminuria: Radio-isotope method		12,42	227,19	8,28		R 239,76
4459	Acetyl choline receptor antibody		158,12	2 891.29	105,41		
4460	CA-199 tumour marker		20,00	365,85	13,33		R 386,09
4461	Nuclear Matrix Protein 22		35,00		23,33		
4462	CA-125 tumour marker		20,00	365,85	13,33		R 386,09
4463	C6 complement functional essay		45,00	822,87	30,00		R 868,40
4464	House dust mite antigen ELIZA		20,31		13,54		
4466	Beta-2-microglobulin		12,42	227,19	8,28		R 239,76
4467	Chromograqnin A		47,00	746,83	31,33		R 788,15
4468	CA-549		20,00	365,85	13,30		R 386,09
4469	Tumour markers: Monoclonal immunological (each)		20,00	365,85	13,33		R 386,09
4470	CA-195 tumour marker		20,00	365,85	13,33		R 386,09
4471	Carcino-embryonic antigen		20,00	365,85	13,33		R 386,09
4472	MCA antigen tumour marker		20,00		13,33		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4473	TSH Receptor Ab		17,48		11,65		
4474	Cast Per Allergen		27,81	440,31	18,54		R 464,67
4475	CA-724		20,00	317,83	13,33		R 335,42
4476	Neopterin		20,00		13,33		
4477	Neuron specific enolase		20,00	365,85	13,33		R 386,09
4478	Osteocalcin		31,40	499,11	20,93		R 526,73
4479	Vitamin B12-absorption: Shilling test		11,70	214,17	7,80		R 226,02
4480	Serotonin		18,75	342,96	12,50		R 361,94
4482	Free thyroxine (FT4)		17,48	319,68	11,65		R 337,37
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)		37,08	589,49	24,72		R 622,11
4485	Insulin		12,42	227,19	8,28		R 239,76
4486	C-Peptide		12,42	197,46	8,28		R 208,39
4487	Calcitonin		18,90	300,47	12,60		R 317,10
4488	B-Type Natriuretic Peptide		47,04	747,75	31,36		R 789,13
4490	Releasing hormone response		50,00	914,3	33,35		R 964,89
4491	Vitamin B12		12,42	227,19	8,28		R 239,76
4492	Vitamin D3: Calcitroil (RIA)		75,00	1 371.71	50,00		
4493	Drug concentration: Quantitative		12,42	227,19	8,28		R 239,76
4494	Free hormone assay		17,48	319,68	11,65		R 337,37
4495	Growth hormone		12,42	227,19	8,28		R 239,76
4496	Hormone concentration: Quantitative		12,42	227,19	8,28		R 239,76
4497	Carbohydrate deficient transferrin		29,06	531,35	19,37		R 560,75
4499	Cortisol		12,42	227,19	8,28		R 239,76
4500	DHEA sulphate		12,42	227,19	8,28		R 239,76
4501	Testosterone		12,42	227,19	8,28		R 239,76
4502	Free testosterone		17,48	319,68	11,65		R 337,37
4503	Oestradiol		12,42	227,19	8,28		R 239,76
4504	Anti-mullerian hormone		49,65		33,10		
4505	Oestriol		10,80	R 197,73	7,20		R 208,67
4506	Multiple antigen specific IgE screening test for Atopy		37,26	R 681,45	24,80		R 719,16

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4507	Thyrotropin (TSH)		19,60	R 358,62	13,07		R 378,46
4508	Combined antigen specific IgE		24,48	R 447,81	16,60		R 472,59
4509	Free tri-iodothyronine (FT3)		17,48	R 319,68	11,65		R 337,37
4511	Renin activity		18,90		12,60		
4512	Parathormone		17,08	312,44	11,39		R 329,73
4513	IgE: Total		12,42	227,19	8,28		R 239,76
4514	Antigen specific IgE		12,42	227,19	8,28		R 239,76
4515	Aldosterone		12,42	227,19	8,28		R 239,76
4516	Follitropin (FSH)		12,42	227,19	8,28		R 239,76
4517	Lutropin (LH)		12,42	227,19	8,28		R 239,76
4518	Soluble transferrin receptor		11,25		7,50		
4519	Prostate specific antigen		14,49	265,08	9,66		R 279,75
4520	17 Hydroxy progesterone		12,42	227,19	8,28		R 239,76
4521	Progesterone		12,42	227,19	8,28		R 239,76
4522	Alpha-feto protein		12,42	227,19	8,28		R 239,76
4523	ACTH		21,74	397,56	14,49		R 419,56
4524	Free PSA		20,00	317,83	13,33		R 335,42
4526	Sex hormone binding globulin		12,42	227,19	8,28		R 239,76
4527	Gastrin		12,42	227,19	8,28		R 239,76
4528	Ferritin		12,42	227,19	8,28		R 239,76
4529	Anti-DNA antibodies		12,42	227,19	8,28		R 239,76
4530	Antiplatelet antibodies		15,30	279,81	10,20		R 295,29
4531	Hepatitis: Per antigen or antibody		14,49	265,08	9,66		R 279,75
4532	Transcobalamine		12,42	227,19	8,28		R 239,76
4533	Folic acid		12,42	227,19	8,28		R 239,76
4534	Prostatic acid phosphatase		12,42	227,19	8,28		R 239,76
4536	Erythrocyte folate		17,48	319,68	11,65		R 337,37
4537	Prolactin		12,42	227,19	8,28		R 239,76
4538	Procalcitonin: Semi-quantitative		32,00	508,85	21,33		R 537,01
4539	Procalcitonin: Quantitative		46,00	731,44	30,67		R 771,91

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4540	HCG: Quantitative as used for Down's screen		15,00	274,29	10,00		R 289,47
4546	First trimester Downs screen		53,50	850,23	35,67		R 897,28
4552	Second Trimester Down's screen		38,22	534,63	25,48		R 564,21
4553	Thyroglubulin		20,00	317,83	13,33		R 335,42
4554	SCC marker		20,00		13,33		
13	**Clinical pathology: Miscellaneous**						
4544	Attendance in theatre		27,00	493,72			R 521,04
4547	After- hours service: (Monday to Friday) 17h00 to 08h00, Saturday 13h00 to Monday 08h00 and public holidays: Units for service plus 50%						
4549	Minimum cost: After-hours			290,47			R 306,54
4551	Unlisted pathology service: Cost for items not listed in the current Pathology schedule (Sections 21, 22 and 23) will be based on the code for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the units for a comparable service in the coding structure. New items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note general rule C and item 6999 are not applicable to pathology services (Sections 21, 22 and 23).						
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be coded separately						

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
ANATOMICAL PATHOLOGY							
Code	**Description**	**Add-on Codes**	**Pathologists**		**Other Specialists?General Practitioners**		
			UNITS	**VALUE**	**UNITS**	**VALUE**	
1	**Exfoliative cytology**						
4559	Cytology preparation using approved liquid bases cytology method: First unit		27,32		18,21		
4560	Cytology preparation using approved liquid bases cytology method: Each additional unit		9,00		6,00		
4561	Sputum, all body fluids and tumour aspirates: First unit		13,40	282,71	8,90		R 298,35
4563	Sputum, all body fluids and tumour aspirates: Each additional unit		7,80	164,44	5,20		R 173,54
4564	Performance of fine-needle aspiration for cytology		15,00	316,39			R 333,90
4565	Examination of fine needle aspiration in theatre		90,00	1 897.53	60,00		
4566	Vaginal or cervical smears, each		11,00	232,19	7,00		R 245,04
2	**Hystology**						
4567	Histology per sample/specimen each		20,00		13,30		
4571	Histology per additional block, each		11,60		7,70		
4575	Histology and frozen section in laboratory		22,70		15,10		
4577	Histology and frozen section in theatre		403,50		269,00		
4578	Second and subsequent frozen sections, each		97,50		65,00		
4579	Attendance in theatre - no frozen section performed		45,00		30,00		
4582	Serial step sections (including item 4567)		23,30		15,60		
4584	Serial step sections per additional block, each		13,50		9,00		
4587	Histology consultation		10,10		6,70		
4589	Special stains		6,70		4,50		

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4590	Special procedures (special procedures are confined to polarization, decalcification and submission of blocks for radiological examination to identify microcalcifications)		6,70		4,50		
4591	Immunofluorescence studies		20,70		13,80		
4592	Immunoperoxidase studies		40,00		26,67		
4593	Electron microscopy		94,00		63,00		
4595	Foetal autopsy excluding histology		73,00		48,67		

Human Genetics

Code	Description	Add-on Codes	Pathologists		Other Specialists?General Practitioners		
			UNITS	VALUE	UNITS	VALUE	
1	**Cytogenic**						
4750	Cell culture: Lymphocytes, cord blood		15,00	280,74	15,00		R 296,27
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures		45,00	842,6	45,00		R 889,22
4752	Cell culture: Chorionic villi		60,00	1123,47	60,00		R 1 185,64
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique		135,00	2527,67	135,00		R 2 667,53
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique		270,00	5055,48	270,00		R 5 335,22
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques		70,00	1310,54	70,00		R 1 383,06
4760	FISH procedure, including cell culture		115,00	2153,14	115,00		R 2 272,28
4761	FISH analysis per probe system		35,00	655,01	35,00		R 691,25
2	**DNA-testing**						
4763	Blood: DNA extraction		45,00	842,6	45,00		R 889,22
4764	Blood: Genotype per person: Southern blotting		89,00	1666,39	89,00		R 1 758,60
4765	Blood: Genotype per person: PCR		60,00	1123,47	60,00		R 1 185,64

Code	Description	Add-on Codes	Pathologists		Other Specialists/General Practitioners		2020 Tariff
			UNITS	VALUE	UNITS	VALUE	
4766	HIV Drug Resistance Testing		513,00		342,00		
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction		90,00	1685,2	90,00		R 1 778,45
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting		188,00	3519,85	188,00		R 3 714,62
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR		120,00	2246,41	120,00		R 2 370,71

CLINICAL TECHNOLOGISTS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

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

MODIFIERS

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

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
	Surgical Support			
010	Ablations	219.70	R 3 139,40	R 3 313,11
011	Preparation of extra-corporeal equipment for surgical procedures.	196.70	R 2 810,78	R 2 966,31
012	Operation of heart laser during myocardial revascularisation	219.70	R 3 139,40	R 3 313,11
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	20.30	R 290,08	R 306,13
014	Radiofrequency Catheter Ablations	219.70	R 3 139,40	R 3 313,11
	Not to be charged with item 012			
015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	19.40	R 277,32	R 292,66
	May only submit once in theatre and once in catheterisation laboratory			
017	Standby with extra-corporeal equipment for surgery within hospital	58.80	R 840,37	R 886,87
	Cannot be used with 011			
019	Standby within the hospital for coronary angioplasty.	19.40	R 277,32	R 292,66
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	58.80	R 840,37	R 886,87
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	10.00	R 142,87	R 150,77
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	196.700	R 2 810,78	R 2 966,31
027	Preparation and operation of a pre- and post-operative blood salvage device.	19.40	R 277,32	R 292,66
029	Preparation and operation of an autotransfusion cell washing system.	77.10	R 1 101,76	R 1 162,73
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	61.70	R 881,67	R 930,46

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	14.60	R 208,78	R 220,33
034	Lymph compression treatment.	22.50	R 321,39	R 339,17
116	Preparation and operation of an artificial heart (Berlin-Heart)	219.70	R 3 139,40	R 3 313,11
118	Daily monitoring of artificial heart, per hour	33.40	R 477,15	R 503,55
157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	26.30	R 375,85	R 396,65
	Pulmonology			
	Items 035 to 061 apply only to outpatient department and normal wards - Not high care or intensive care, except item 050 which applies to intensive care only.			
035	Nebulization (per one procedure).	12.30	R 175,76	R 185,48
037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	24.20	R 345,72	R 364,85
039	Flow-volume determinations.	30.60	R 437,15	R 461,34
041	Flow-volume (Pre-post B-D).	50.80	R 725,91	R 766,08
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	24.20	R 345,72	R 364,85
045	Gas distribution measurements.	24.20	R 345,72	R 364,85
047	Diffusion determinations.	24.20	R 345,72	R 364,85
049	Exercise testing (EIA).	17.10	R 244,43	R 257,95
050	ECMO change-out and re-establishment.	46.30	R 661,58	R 698,19
051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	24.20	R 345,72	R 364,85
053	Allergy tests.	11.40	R 163,00	R 172,01
055	If RAST included add (per allergen).	11.40	R 163,00	R 172,01
057	Bronchial provocation testing.	40.80	R 583,05	R 615,31
059	Compliance measurements.	24.20	R 345,72	R 364,85
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	6.00	R 85,77	R 90,52
	Cardiology			
062	Assist in preparations and operations of Rotablator Procedures	29.90	R 427,29	R 450,93
063	Cardiac catheterisation for the first hour.	40.30	R 575,94	R 607,81
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	10.00	R 142,87	R 150,77
064	Intravascular Ultrasound (IVUS)	25.70	R 367,30	R 387,62
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine			

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	10.00	R 142,87	R 150,77
066	Cardiac Cath Right Heart Studies	56.00	R 800,11	R 844,38
067	Cardiac Electro physiology and related procedures for first FOUR hours.	67.90	R 970,34	R 1 024,03
069	Temporary and single Pacemaker procedures.	40.30	R 575,94	R 607,81
070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	46.30	R 661,58	R 698,19
	Not to be charged in conjunction with items 063 or 065			
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	10.00	R 142,87	R 150,77
072	Multisite Pacing (Bi-ventricular pacing)	46.30	R 661,58	R 698,19
073	Dilatation procedures and stents.	55.40	R 791,69	R 835,50
074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	10.00	R 142,87	R 150,77
075	Pacemaker checking and/or reprogramming.	14.00	R 200,09	R 211,17
077	24 Hour Holter ambulatory monitoring.	55.400	R 791,69	R 835,50
079	Cardiac exercise stress testing.	29.10	R 415,84	R 438,85
081	Recording of twelve lead ECG.	7.70	R 109,98	R 116,06
087	M Mode echocardiogram.	16.60	R 237,32	R 250,45
089	2D echocardiogram.	29.40	R 420,05	R 443,29
091	Doppler flow.	32.20	R 461,49	R 487,03
093	Colour imaging.	32.20	R 461,49	R 487,03
095	ECG signal averaging (Hi-Res).	53.70	R 767,35	R 809,81
097	Ambulatory bloodpressure monitoring.	18.60	R 265,74	R 280,44
099	Vector cardiogram.	55.40	R 791,69	R 835,50
111	Transoesophageal echocardiogram.	43.10	R 615,93	R 650,02
	Neurology			
	Preparation, recording and analyses/technical report of:			
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	74.10	R 1 059,01	R 1 117,61
179	Auditory evoked potentials, full audiological examination, bilateral	74.10	R 1 059,01	R 1 117,61
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	37.11	R 530,29	R 559,64
181	Somatosensory evoked potentials, unilateral, upper limb	37.11	R 530,29	R 559,64
182	Somatosensory evoked potentials, unilateral, lower limb	37.11	R 530,29	R 559,64
115	Additional 2 nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	14.90	R 212,85	R 224,63

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	43.10	R 615,93	R 650,02
183	Electronystagmography for spontaneous and positional nystagmus (3253)	24.15	R 345,07	R 364,16
184	Caloric test done with electronystagmography (3255)	67.57	R 965,60	R 1 019,03
119	Sleep EEG.	31.400	R 448,73	R 473,56
185	Overnight polysomnography	264.83	R 3 784,41	R 3 993,81
186	Obstructive sleep apnea screening	137.17	R 1 960,15	R 2 068,61
187	Long term EEG monitoring with a minimum of 8 hours (but less than 16 hours) recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	137.89	R 1 970,41	R 2 079,44
188	Long term EEG monitoring with 16 to 24 hours recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	264.83	R 3 784,41	R 3 993,81
125	Multiple sleep latency test (MSLT)	111.10	R 1 587,59	R 1 675,44
127	Overnight CPAP titration.	104.20	R 1 489,06	R 1 571,45
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	17.420	R 249,03	R 262,81
133	EEG with special activation.	49.40	R 705,92	R 744,98
135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	14.90	R 212,85	R 224,63
137	Intra-operative evoked potentials for the 1st hour	55.40	R 791,69	R 835,50
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	37.10	R 530,16	R 559,50
141	Intra-operative EEG (carotid endarterectomy).	26.30	R 375,85	R 396,65
143	Transcranial or Carotid Doppler (bilateral).	39.40	R 563,05	R 594,21
	Dialysis			
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), Continuous renal replacement therapy (CRRT), Aphaeresis, Auto transfusion and cell recovery (AT).	46.30	R 661,58	R 698,19
146	Chronic haemodialysis (acetate dialysate)	149.400	R 2 134,85	R 2 252,98
148	Chronic haemodialysis (bicarbonate dialysate)	159.600	R 2 280,75	R 2 406,95
	In the case of items 146 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning ma			
147	Peritoneal dialysis, per day	16.800	R 240,09	R 253,37
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables; cost of machine and machine disposables; professional fee; initial training; in-centre follow-up visit. These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than a 30 days in any one cycle (for example due to complications or death of the patient): a. if the period of treatment is 26 days or more in that cycle, the full fee applies;			

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
	b. if the period of treatment is up to 25 days in that cycle, the fee should be prorated according to number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified.			
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period.	1700.00	R 24 292,59	R 25 636,77
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	2360.00	R 33 723,67	R 35 589,72
149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	33.40	R 477,15	R 503,55
150	Acute haemodialysis	317.20	R 4 532,68	R 4 783,49
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental			
151	Treatment procedures for CRRT up to 6 hours or part thereof provided that such part comprises 50% or more of the time	24.80	R 354,27	R 373,88
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than 6 hours of the time	49.70	R 710,13	R 749,42
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	74.50	R 1 064,53	R 1 123,44
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	99.30	R 1 418,81	R 1 497,31
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	16.60	R 237,32	R 250,45
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours).	29.10	R 415,84	R 438,85
	Reproductive Health			
159	Post Vasectomy semen analysis.	10.00	R 142,87	R 150,77
161	Complete semen analysis.	31.70	R 452,81	R 477,86
163	Semen wash for A I.	30.30	R 433,07	R 457,04
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	368.70	R 5 268,60	R 5 560,13
	Cannot be used with items 161, 163, 167 and 169			
167	Ovum and embryo freezing.	131.30	R 1 876,35	R 1 980,18
169	Semen freezing.	30.30	R 433,07	R 457,04
	Miscellaneous			
171	Travelling per km in excess of 16km (in own car).	0.67	R 9,60	R 10,13
173	Equipment hire (By arrangement).		R 811,56	R 856,46
175	Medication / Material			
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).			

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	In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.			

DENTAL TECHNICIANS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
1	**Preparatory work**			
	The following section includes comsumables, however it excludes materials.			
9301	Casting and trimming of model in plaster(yellow/white), per model	2,714	R 37,76	R 39,85
9303	Casting and trimming of model in superhard stone(diestone) per model	3,857	R 53,54	R 56,51
9305	Casting and trimming of study model, per model	7,143	R 99,19	R 104,68
9307	Casting and trimming of gnathostatic model, per model..	9,286	R 129,05	R 136,20
9309	New trimmed base to supplied model, per model	3,286	R 45,52	R 48,04
9311	Trimming of supplied model, per model	2.000	R 27,89	R 29,43
9312	Gingival tissue mask per implant	15,429	R 214,30	R 226,16
9313	Duplicating model, per model	8,286	R 115,24	R 121,62
9314	Refractory model, per unit	8,143	R 113,14	R 119,40
9315	Models and duplicate models (virgin model) for crown and bridge (work inclusive of one removable die)	11,286	R 156,68	R 165,35
9317	Sectional models for crown and bridge (work inclusive of one removable die)	10.000	R 138,92	R 146,61
9319	Each additional removable die for items 9315 and 9317 per die	2,571	R 35,65	R 37,62
9320	Pindex or indexed model tray per die (not more than 9319)	2,571	R 35,65	R 37,62
9321	Occlusion block, per block	9,857	R 136,95	R 144,53
9323	Occlusion block on baseplate, per block	12,429	R 172,73	R 182,29
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	1,857	R 25,78	R 27,21
9329	Fit and supply of disposable articulator	4,857	R 67,49	R 71,22
9330	Delivery charge per completed procedure (invoiced)	5,143	R 71,43	R 75,39
2	**Prosthetic services using Acrylic**			
	The tariff under this section excludes the fees for models and occlusion blocks. The following section includes consumables, however it excludes materials.			
A	**Full Dentures**			
9331	Full upper and lower dentures	132,571	R 1 841,62	R 1 943,52
9333	Full upper or lower denture	77,571	R 1 077,56	R 1 137,18
9335	Set-up and waxing of full upper and lower dentures	45,714	R 635,01	R 670,15
9337	Set-up and waxing of full upper or lower denture	30,571	R 424,66	R 448,15
9339	Waxing and finishing of full upper and lower dentures	81,286	R 1 129,13	R 1 191,60
9341	Waxing and finishing of full upper or lower denture	45,429	R 631,19	R 666,12
9343	Additional fee for dentures on fully adjustable articulator at request of dentist	129,429	R 1 798,08	R 1 897,57
9345	Additional fee for immediate dentures, or tooth socketed	1,857	R 25,78	R 27,21
9346	Additional fee for immediate dentures, per tooth not socketed..	1.000	R 13,94	R 14,72
9347	Additional fee for each retry from the third and upwards at an agreed quantum of time to be calculated at hourly rate of	29,429	R 408,87	R 431,49
9351	Set-up and finish of one-tooth denture	35,571	R 494,12	R 521,46

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9352	Set-up and finish of two-tooth denture	37,857	R 525,82	R 554,92
9353	Set-up and finish of three-tooth denture	40,571	R 563,58	R 594,76
9354	Set-up and finish of four-tooth denture	42,857	R 595,28	R 628,22
9355	Set-up and finish of five-tooth denture	46,286	R 643,03	R 678,62
9356	Set-up and finish of six-tooth denture	55,286	R 768,01	R 810,51
9357	Set-up and finish of seven-tooth denture	65,714	R 912,85	R 963,36
9358	Set-up and finish of eight-tooth denture	69,714	R 968,50	R 1 022,09
9359	Set-up and finish nine or more tooth denture	71,429	R 992,31	R 1 047,22
9361	Set-up and waxing of one-tooth denture	10,143	R 140,89	R 148,69
9362	Set-up and waxing of two-tooth denture	12,286	R 170,76	R 180,21
9363	Set-up and waxing of three-tooth denture	14.000	R 194,44	R 205,20
9364	Set-up and waxing of four-tooth denture	16,286	R 226,27	R 238,79
9365	Set-up and waxing of five-tooth denture	18.000	R 249,95	R 263,78
9366	Set-up and waxing of six-tooth denture	21,286	R 295,73	R 312,10
9367	Set-up and waxing of seven-tooth denture	23,429	R 325,46	R 343,47
9368	Set-up and waxing of eight-tooth denture	25,143	R 349,28	R 368,60
9369	Set-up and waxing of nine or more tooth denture	26,857	R 373,22	R 393,87
9371	Waxing and finishing of one-tooth denture	27,857	R 386,90	R 408,31
9372	Waxing and finishing of two-tooth denture	28,429	R 394,79	R 416,64
9373	Waxing and finishing of three-tooth denture	28,857	R 400,84	R 423,02
9374	Waxing and finishing of four-tooth denture	29,429	R 408,87	R 431,49
9375	Waxing and finishing of five-tooth denture	30,571	R 424,66	R 448,15
9376	Waxing and finishing of six-tooth denture	31,714	R 440,57	R 464,95
9377	Waxing and finishing of seven-tooth denture	39,571	R 549,76	R 580,18
9378	Waxing and finishing of eighth-tooth denture	41,143	R 571,47	R 603,09
9379	Waxing and finishing of nine or more tooth denture	43,429	R 603,31	R 636,69
9383	Additional fee for finishing denture in tooth colour material, per tooth	6,857	R 95,38	R 100,65
9385	Additional fee for supplying finished denture on duplicate model	13.00	R 180,62	R 190,62
C	**Repair Service**			
9391	Basic charge which includes repair of one fracture, or addition of one tooth, or addition of one clasp	10.000	R 313,49	R 330,84
9393	Additional charge for each additional fracture, or tooth, or clasp	7.000	R 97,35	R 102,74
9395	Additional fee for using wire strengthener	8.000	R 111,16	R 117,31
9397	Additional fee for using pre-formed strengthener	8,571	R 118,92	R 125,51
9398	Additional fee for using mesh strengthener in repair procedure	13,571	R 188,65	R 199,09
D	**Additional Services**			
9401	Clear base	10.000	R 138,92	R 146,61
9403	Dox grinding of upper and lower dentures	12,714	R 176,55	R 186,31
9405	Inlay to artificial tooth, one surface only, per inlay	21,857	R 303,49	R 320,29
9406	Inlay to artificial tooth, multisurfaces e.g. horseshoe or L-type inlay, per inlay	28.000	R 389,00	R 410,53
9407	Heka base technique per upper or lower denture	30.000	R 416,76	R 439,82
9409	Frego frame	13.000	R 180,62	R 190,62
9410	Bleaching tray	14,429	R 200,36	R 211,44
9411	Template per upper or lower denture	35,857	R 498,06	R 525,62
9413	Reline/rebase of single denture	45,143	R 627,25	R 661,96
9415	Remodel of single denture	69,429	R 964,42	R 1 017,79

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9417	Soft base reline per denture	114.000	R 1 583,64	R 1 671,27
9419	Soft base to new denture, per denture	114.000	R 1 583,64	R 1 671,27
9421	Gum tinting per denture	21,143	R 293,63	R 309,88
9423	Lingual or palatal bar	17.000	R 236,27	R 249,34
9425	Cleaning and polishing of existing denture, per denture	13,857	R 192,59	R 203,25
9427	Mesh strengthener	11,857	R 164,71	R 173,82
9429	Theatre/ Consultation out of Laboratory per hour or part thereof	29,429	R 408,87	R 431,49
9431	Special Tray, acrylic, each	11,143	R 154,84	R 163,41
9432	Special Tray Light Cure each	12,143	R 168,78	R 178,12
9433	Special Tray in base plate material, each	11,429	R 158,79	R 167,57
9435	Provision of single arm clasp, to partial denture	5,857	R 81,43	R 85,94
9437	Provision of double arm clasp, to partial denture	10,143	R 140,89	R 148,69
9439	Provision of single arm clasp with rest, to partial denture	13,143	R 182,60	R 192,70
9441	Provision of double arm clasp with rest, to partial denture	17,714	R 246,27	R 259,90
9443	Provision of preformed Roach clasp, to partial denture	7,571	R 105,24	R 111,07
9445	Provision of rest only to partial denture	7,571	R 105,24	R 111,07
9447	Cast Clasp	26,571	R 369,14	R 389,57
9448	Casting and trimming of Model from impression inside occlusion block or wax try in	4,857	R 67,49	R 71,22
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	10,143	R 140,89	R 148,69
3	**Cobalt Chrome/Gold Prosthetic Services**			
	The tariff under this section excludes the fees for models. The following section includes consumables, however it excludes materials.			
A	**Full Metal Dentures**			
9451	Metal base for full upper or full lower denture each	91.000	R 1 264,10	R 1 334,05
B	**Partial Metal Dentures**			
9453	Basic charge - which excludes models and any special trays (see item 9431 to 9433) which may be required by the dentist	79,571	R 1 105,45	R 1 166,61
9455	Additional charge for each one arm clasp	3,286	R 45,52	R 48,04
9457	Additional charge for each Roach clasp	5,571	R 77,49	R 81,77
9459	Additional charge for each rest	3.000	R 41,83	R 44,15
9461	Additional charge for continuous clasp, per tooth	3,286	R 45,52	R 48,04
9463	Additional charge for lingual bar, per tooth passed	7,714	R 107,08	R 113,01
9465	Additional charge for palatal bar	12,286	R 170,76	R 180,21
9467	Additional charge for onlay	32,714	R 454,39	R 479,53
9469	Additional charge for saddle with finishing line, per tooth	5,429	R 75,51	R 79,69
9471	Additional charge for saddle without finishing line, per tooth	3,143	R 43,68	R 46,09
9473	Additional charge for horseshoe saddle, per tooth	5,429	R 75,51	R 79,69
9475	Additional charge for fitting of tooth to metal backing, per tooth	3,714	R 51,57	R 54,42
9479	Additional charge for fitting one distal-extension hinge	11.000	R 152,87	R 161,32
9480	Additional charge per milled edge per tooth	9,571	R 133,00	R 140,36
9481	Additional charge for each soldering joint	13,429	R 186,54	R 196,87
9483	Additional charge for soldering retention	16,286	R 226,27	R 238,79
9485	Additional charge for each additional retention soldering joint	5.000	R 69,46	R 73,30
9487	Additional charge for each welding joint	16,429	R 228,25	R 240,88

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9489	Additional charge for fitting swing lock	13,429	R 186,54	R 196,87
9491	Additional charge for each backing cast	13,143	R 182,60	R 192,70
9493	Additional charge for each Steels backing or pontic cast (Plastic work to be charged in addition)	14,286	R 198,51	R 209,50
C	**Chrome Cobalt and Repairs**			
9495	Basic fee for the repairing of or addition to any appliance necessitating the casting of a model (9301)	20,714	R 287,71	R 303,63
9497	Basic fee if a new section is to be fabricated and where item 9495 does not apply (9301)	23,571	R 327,44	R 345,56
4	**Crown and Bridge Prosthetic Services**			
	The tariffs under this section excludes the tariff for models. The following section includes consumables, however it excludes materials.			
A	**Porcelain (Ceramic) Services**			
9501	Ceramic jacket crown/Ceromer crown or pontic	90,429	1256,21	R 1 325,72
9502	Ceramic metal substitute coping	73.000	1014,15	R 1 070,27
9505	Porcelain veneer crown or pontic	119,429	1658,89	R 1 750,68
9507	Post-solder invested joint, per joint	24,429	339,28	R 358,05
9511	Inlay in porcelain veneer crown	39,429	547,66	R 577,96
9512	Ceramic, inlay/onlay, bridge retainer	92,714	1287,91	R 1 359,17
9515	Porcelain shoulder per unit (not applicable to pontics)	8.000	111,16	R 117,31
9520	Addition fee for crown- & bridge work performed on a movable condyle articulator per unit	3,857	53,54	R 56,50
9521	Full metal crown, MOD, three-quarter crown	73,857	1026,12	R 1 082,90
9524	Indirect Composite Resin inlay	20.000	277,84	R 293,21
9525	Class IV, MO, DO, cervical/occlusal inlay	60,857	845,36	R 892,14
9526	Additional fee for one piece casting of crown or inlay on post.	18,571	257,98	R 272,25
9531	Pin-ledge inlay	69.000	958,63	R 1 011,67
9533	Full metal pontic	54,571	758,14	R 800,09
9535	Coping or abutment thimble cast	51,143	710,52	R 749,84
9537	Precision lock and rest cast	72,571	1008,23	R 1 064,02
9538	Lock and rest cast	34,714	482,28	R 508,97
9539	Casting of rest only	20,714	287,71	R 303,63
9541	Metal inlay or post, cast direct	22.000	305,6	R 322,51
9543	Gold/pre-solder invested joint	21,857	303,49	R 320,28
9545	Cast post with thimble, indirect	36,429	506,09	R 534,09
9546	Multiple Post	60,286	837,47	R 883,81
9547	Manufacture cast post and core to existing crown	47,571	660,93	R 697,50
9549	C.S.P. attachment (Steiger)	160,571	2230,63	R 2 354,06
9550	Milling milled edge per unit	51,143	710,52	R 749,84
9551	Telescope crown	126.000	1750,32	R 1 847,17
9553	Composite/acrylic veneer crown/pontic, indirect	100,714	1399,07	R 1 476,49
9557	Composite/acrylic jacket crown, indirect	71,143	988,36	R 1 043,05
9559	Composite/acrylic veneer post crown	99,571	1383,16	R 1 459,69
9560	Indirect Composite Resin Veneer	42,143	585,41	R 617,80
9561	Composite/acrylic jacket crown, direct	48,571	674,61	R 711,94
9563	Temporary acrylic/composite crown per unit	34,714	482,28	R 508,97

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9564	Heat formed template supplied to dentist for the manufacture of temporary restorations	17,429	242,19	R 255,59
9565	Composite/acrylic-facing replaced	40,429	561,6	R 592,68
9566	Porcelain/ Ceromor facing replaced	73,286	1017,96	R 1 074,29
9569	Waxing of crown to existing denture	28,571	396,77	R 418,72
9570	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate of	29,429	408,87	R 431,49
5	**Orthodontic Appliances**			
	The tariffs under this section excludes the tariff for models. The following section includes consumables, however it excludes materials.			
A	**Orthodontic Services**			
9571	Basic charge which includes acrylic base	36,143	502,14	R 529,93
9572	Basic charge non acrylic base	17,429	242,19	R 255,59
9573	Additional charge for fitting first expansion screw	6,857	95,38	R 100,66
9575	Additional fee for fitting subsequent expansion screws	5,857	81,43	R 85,94
9576	Additional fee for full aclusal bite plate	20,286	281,92	R 297,52
9577	Additional fee for bite plate anterior	6,857	95,38	R 100,66
9578	Additional fee for bite plate posterior	6,857	95,38	R 100,66
9579	Additional fee for fitting tongue guard	8,571	118,92	R 125,50
9581	Additional fee for flat or inclined plane	5,286	73,41	R 77,47
9583	Additional fee for Adams Crib	6,286	87,35	R 92,18
9585	Additional fee for Jackson Crib	6,571	91,3	R 96,35
9587	Additional fee for ball clasp	7,429	103,14	R 108,85
9589	Additional fee for single arm clasp	5,714	79,33	R 83,72
9591	Additional fee for double arm clasp	10.000	138,92	R 146,61
9593	Additional fee for fitting single loop finger spring	4,714	65,38	R 69,00
9595	Additional fee for fitting double loop finger spring	5,571	77,49	R 81,78
9597	Additional fee for fitting Buccal retraction spring	4,143	57,62	R 60,81
9599	Additional fee for fitting apron spring	10,714	148,92	R 157,16
9603	Additional fee for fitting coffin spring	10,286	142,87	R 150,78
9605	Additional fee for fitting Quad Helix	11,429	158,79	R 167,58
9607	Additional fee for fitting flapper or “T”-spring	8,571	118,92	R 125,50
9609	Additional fee for fitting all springs with tubing, each	9,571	133	R 140,36
A.2	**Arches**			
9611	Additional fee for fitting labial arch	5,429	75,51	R 79,69
9613	Additional fee for fitting buccal arch	6,429	89,19	R 94,13
9615	Additional fee for fitting Roberts retractor	12.000	166,68	R 175,90
9617	Invisible Retainer	15,857	220,22	R 232,41
9619	Additional fee for fitting twinwire arch extra-oral arch	15.000	208,51	R 220,05
9620	Additional fee Lip bumper	6,286	87,35	R 92,18
9621	Additional fee for fitting extra-oral arch	14,286	198,51	R 209,49
9622	Additional fee for fitting space maintainer arch	6,286	87,35	R 92,18
A.3	**Welding and Soldering**			
9623	Additional fee for each spot-welding joint	2,857	39,73	R 41,93

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9625	Additional fee for each soldering joint	4,571	63,54	R 67,06
9627	Additional fee for each invested soldering joint	12,714	176,55	R 186,32
9629	Additional fee for each hook for elastic traction	4,143	57,62	R 60,81
B	**Mouth Protectors and MYO Functional Appliances**			
9631	Gum guard	26,857	373,22	R 393,87
9633	Oral Screen	33.000	458,46	R 483,83
9635	Andresen or Norwegian appliance	59.000	819,58	R 864,93
9637	Tooth positioner	68.000	944,56	R 996,83
9639	Gunning splint	90,571	1258,18	R 1 327,80
9641	Frankel appliance	87,429	1214,5	R 1 281,70
9643	Chin cap	29.000	402,95	R 425,25
9645	Bionator	59,143	821,68	R 867,15
9646	Diagnostic set-up	56,857	789,85	R 833,56
9647	Snoring Appliance	53,714	746,17	R 787,46
C	**Fixed Appliances**			
9651	Pinched or swaged band with welded attachment (excluding	17,429	242,19	R 255,59
9653	Pinched or swaged band with soldered attachment	22,857	317,57	R 335,14
D	**Additional Services**			
9662	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate of		408,87	R 431,49
6	**Materials**			
A	**Prosthetic/Restorative Services**			
9700	Diatorics 1 X 6/8		R -	
9702	Diatorics, odds, anterior		R -	
9704	Diatorics, odds, posterior		R -	
9720	Soft base material per denture		R -	
9722	High impact acrylic per denture		R -	
9724	Cost of precision attachment, per attachment		R -	
9726	Preformed Ball or Roach Clasp		R -	
9728	Cost of lingual I palatal bar		R -	
9729	Cost of mesh strengthener		R -	
9730	Cost of pre-fabricated burn-out component, per component		R -	
9732	Cost of other attachment components e.g. Nylon caps, sleeves etc		R -	
9734	Cost of dolder bar and clips, per gram or per clip		R -	
9736	Cost of implant components		R -	
9738	Cost of preformed strengthener		R -	
9739	Additional Charge Goldplating		R -	
B	**Metal**			
9740	Cost of gold wire, per gram		R -	
9741	Cost of Cobalt Chrome casting alloy		R -	
9742	Cost of specialised Cobalt Chrome casting metal e g Vitallium, Titanium		R -	
9744	Cost of precious casting alloy		R -	

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
9746	Cost of semi-precious casting alloy		R -	
9748	Cost of non-precious casting alloy		R -	
9752	Cost of platinum foil		R -	
9754	Cost of gold solder, per gram		R -	
9755	Etching for bonding (metal or ceramic)		R -	
9756	Cost of silver solder, per gram		R -	
9757	Ceromer material - per unit		R -	
9758	Fiber re-enforced material per unit		R -	
9760	Composite restoration material		R -	
9761	Ceramic material		R -	
C	**Orthodontic Services**			
9762	Cost of anterior orthodontic attachment, per attachment		R -	
9763	Orthodontic material		R -	
9764	Cost of posterior orthodontic attachment, per attachment		R -	
9765	Preformed components		R -	
9766	Cost of expansion screw, per screw		R -	
9767	Soldering material		R -	
9768	Cost of buccal tube/transfer tube, per tube		R -	
9770	Cost of J-hook, per hook		R -	
9772	Cost of lingual buttons, per button		R -	
9774	Cost of invisible retainer material		R -	
9776	Cost of mouth protector material		R -	
9778	Cost of arch wire		R -	
9779	Dual laminate material		R -	
7	**Precision Attachments and Implant Services**			
	The following section includes consumbables, however it excludes materials.			
9780	Positioning and finishing of complete (male and female) pre-fabricated burn-out attachment	45.000	625,14	R 659,73
9782	Positioning and soldering of complete (male and female) precision attachment	37,571	521,87	R 550,75
9783	Implant stent per unit	34,714	482,28	R 508,97
9784	Alignment of dolder bar and clips	47,429	658,82	R 695,27
9786	Triming, waxing and finishing of implant abutment - crown and bridge work only, per abutment	20,429	283,63	R 299,32
9787	Waxing, milling and finishing of a custom abutment	39,857	553,71	R 584,35
9788	Implant superstructure (edentulous cases) including placing of preformed parts, per section cast	217,857	3026,39	R 3 193,85
9789	Finishing of prosthesis on implant structure per arch	79,571	1105,45	R 1 166,62

DENTAL THERAPISTS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

001	Item 001 refers to a Full Mouth Examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.
002	a. Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been. b. Every account shall contain the following particulars: i. the first name of the patient; ii. the practice number; iii. date on which every service was rendered; iv. where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist; v. a statement of whether the account is in accordance with the National Reference Price List; vi. the name of the dental therapist rendering the service must be shown on the account; and vii. the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
8109	Infection control/barrier techniques	1,73	19,47	R 20,55
8110	Sterilized instrumentation	4,46	49,99	R 52,76
8120	Treatment plan completed			
	Diagnostic services			
8101	Oral examination	10,000	112,08	R 118,28
8102	Comprehensive oral examination	16,147	181,02	R 191,04
8104	Limited oral examination	7,791	87,35	R 92,18
8189	Re-examination - existing condition	7,791	87,35	R 92,18
8129	Office/hospital visit – after regularly scheduled hours	24,000	269,16	R 284,05
8140	House/extended care facility/hospital call	15,875	178,12	R 187,98
8190	Consultation - second opinion or advice			
	Radiographs/diagnostic imaging			
8107	Intraoral radiograph - periapical	7,500	84,06	R 88,71
8108	Intraoral radiographs - complete series	60,187	674,74	R 712,08
8112	Intraoral radiograph - bitewing	7,500	84,06	R 88,71
8113	Intraoral radiograph - occlusal	12,894	144,58	R 152,58
8114	Extraoral radiograph - hand-wrist			
8115	Extraoral radiograph - panoramic	30,000	336,38	R 354,99
8116	Extraoral radiograph - cephalometric	30,000	336,38	R 354,99
8118	Extraoral radiograph - skull/facial bone			
8121	Oral and/or facial image (digital/conventional)	8,044	90,11	R 95,10

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
	Preventive services			
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.			
8151	Oral hygiene instruction	7,850	88,14	R 93,02
8153	Oral hygiene instruction - each additional visit	5,746	64,46	R 68,03
8155	Polishing - complete dentition	9,603	107,61	R 113,56
8159	Prophylaxis - complete dentition	17,491	196,15	R 207,00
8161	Topical application of fluoride - child	9,603	107,61	R 113,56
8162	Topical application of fluoride - adult	9,603	107,61	R 113,56
8163	Dental sealant	7,109	79,85	R 84,27
	Note : 8163 chargeable once only in respect of a tooth per annum. Item 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement			
	Extractions during a single visit.			
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	11,200	R 125,50	R 132,45
8202	Extraction - each additional tooth or exposed tooth roots	4,324	R 48,54	R 51,23
8145	Local anaesthetic - per visit	1,700	R 19,21	R 20,27
8220	Cost of suture material			
8931	Treatment of post-extraction haemorrhage	7,304	R 81,83	R 86,35
8935	Treatment of septic socket	7,304	R 81,83	R 86,35
9011	Incision & drainage of abscess - intra-oral (pyogenic)	13,790	R 154,58	R 163,13
8303	Pulp cap - indirect	14,200	R 159,31	R 168,13
	Amalgam restorations (including polishing).			
8341	Amalgam - one surface	20,491	229,69	R 242,40
8342	Amalgam - two surfaces	25,263	283,24	R 298,91
8343	Amalgam - three surfaces	30,795	345,33	R 364,44
8344	Amalgam - four or more surfaces	34,301	384,53	R 405,81
	Only one of the above items may be charged per tooth within a year.			

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
	Resin restorations (using resin bonding technique)			
8351	Resin - one surface, anterior	24,795	277,97	R 293,35
8352	Resin - two surfaces, anterior	31,165	349,41	R 368,74
8367	Resin - one surface, posterior	26,880	301,26	R 317,93
8369	Resin - three surfaces, posterior	40,164	450,18	R 475,09
8370	Resin - four or more surfaces, posterior	43,202	484,51	R 511,32
8368	Resin - two surfaces, posterior	33,249	372,95	R 393,59
8353	Resin - three surfaces, anterior	37,242	417,55	R 440,65
8354	Resin - four or more surfaces, anterior	41,566	466,09	R 491,88
8350	Resin crown - anterior primary tooth (direct)	44,683	501,09	R 528,82
	Note: Only one of the above codes may be charged per tooth within a year.			
	Palliative Treatment			
8131	Emergency dental treatment	10,000	112,08	R 118,28
8165	Sedative filling	10,000	112,08	R 118,28
8166	Application of desensitising resin, per tooth	6,603	73,93	R 78,02
8167	Application of desensitising medicament, per visit	7,694	86,3	R 91,08

DIETICIANS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

003	Dietary services are per individual patient.
004	Every account shall contain the following particulars: • the name and practice code number of the referring practitioner • the name of the patient • the nature of the treatment • the date on which the service was rendered • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.
010	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required. Maximum billable time for such a report is 15 minutes.

MODIFIERS

0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
1	**INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT**			
107	Appointment not kept			
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	0,500	53,19	R 56,13
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	1,500	159,58	R 168,41
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	2,500	265,96	R 280,68
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	3,500	372,3	R 392,90
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	4,500	425,71	R 449,27
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	5,500	500,43	R 528,12
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	6,500	591,47	R 624,20

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	7,500	682,5	R 720,27
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	8,500	773,67	R 816,48
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	9,500	864,57	R 912,41
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	10,500	955,47	R 1 008,34
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	11,500	1046,51	R 1 104,42
2	**GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT**			
	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.			
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	0,100	10,66	R 11,25
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	0,300	31,84	R 33,60
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	0,500	53,15	R 56,09
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	0,700	74,72	R 78,85
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	0,900	85,12	R 89,83
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	1,100	100,11	R 105,65
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	1,300	118,27	R 124,81
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	1,500	136,42	R 143,97
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	1,700	154,58	R 163,13
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	1,900	172,99	R 182,56
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	2,100	191,15	R 201,73
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	2,300	209,3	R 220,88

GENETIC COUNSELLORS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

001 Every account shall contain the following particulars:

- the name and practice code number of the referring practitioner
- the name of the patient
- the nature of the treatment
- the date on which the service was rendered
- the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
107	Appointment not kept			
200	Genetic counselling. Duration: 1-10min.	0,500	69,59	R 73,44
201	Genetic counselling. Duration: 11-20min.	1,500	208,64	R 220,18
202	Genetic counselling. Duration: 21-30min.	2,500	348,22	R 367,49
203	Genetic counselling. Duration: 31-40min.	3,500	487,28	R 514,24
204	Genetic counselling. Duration: 41-50min.	4,500	626,72	R 661,40
205	Genetic counselling. Duration: 51-60min.	5,500	696,58	R 735,12
206	Genetic counselling. Duration: 61-70min.	6,500	774,33	R 817,18
207	Genetic counselling. Duration: 71-80min.	7,500	893,38	R 942,81
208	Genetic counselling. Duration: 81-90min.	8,500	1012,57	R 1 068,60
	Sample extraction			
300	DNA extraction - Blood			
310	DNA extraction - Tissue (other than blood and including CVS and amniotic fluid)			
320	DNA extraction - Tissue (paraffin blocks)			
330	RNA extraction - Blood			
340	RNA extraction - Tissue (other than blood and including CVS and amniotic fluid)			
350	RNA extraction - Tissue (paraffin blocks)			
	PCR			
400	PCR-basic (up to four PCR primer sets)			
410	PCR-multiplex (five or more primer sets)			
420	PCR-realtime			
430	PCR-reverse transcriptase			
	Detection Methods			
500	Diagnostic electrophoresis (agarose and polyacrylamide gel electrophoresis and capillary electrophoresis)			
510	Restriction enzyme digestion (use multiples based on cost of enzyme)			
520	Probe hybridisation assays			
530	dHPLC			
540	MLPA			

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
	Southern Blotting			
610	DNA probe labelling (including hybridisation and autoradiography)			
600	Southern blot (digest, gel and blotting)			
	Other			
700	Protein truncation test			
730	Interpretation and reporting			
720	DNA sequencing			
710	Maternal contamination test (prenatal testing)			

HEARING AID ACOUSTICIANS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

GENERAL RULES

003	The fee in respect of more than one evaluation shall be the full fee for the first evaluation plus half the fee in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.
004	Each practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars : • the practice code number of the supplier of service • the name of the collaborating medical practitioner or audiologist • the name of the patient • the nature of the treatment • the date on which the service was rendered • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered
005	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.

CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
001	First consultation (comprehensive)	15,7	15,7	R 16,57
003	Consultation (screening interview)	10	10	R 10,55
021	Test - air conduction	10	10	R 10,55
023	Test - bone conduction	10	10	R 10,55
025	Test - speech hearing tests	14	14	R 14,77
027	Test - free field	12,8	128	R 135,08
029	Test - insertion gain (per ear)	10,9	109	R 115,03
031	Test - binaural loudness balance test, per ear	12,8	128	R 135,08
051	Global charge for supply and fitting of hearing aid and follow-up (By arrangement)			
053	Hearing Aid Evaluation, per ear (refer to General Rule 003)	12,8	128	R 135,08
055	Technical adjustment or replacement of earmolds	21,1	211	R 222,68
057	Repairs/service per instrument (3 X services/4 year cycle)			
059	Tympanogram	10	10	R 10,55
61	Reflex test (stapedial reflex)	10	10	R 10,55
107	Appointment not kept			

HOMEOPATHY

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

	GENERAL RULES
1	All accounts must be presented with the following information clearly stated: • name of homeopath • qualifications of the homeopath • BHF practice number • postal address and telephone number • date on which service(s) were provided • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered • the nature of treatment • the first name of the patient • where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the homeopath • a statement of whether the account is in accordance with the National Reference Price List.
2	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.
	Definition: Consultations
	Consultation: A situation where a homeopathic practitioner takes down a patient's full history and (where applicable) performs an appropriate examination, and repertorisation of the case and study of Materia Medica and/or prescribes or administers treatment and/or medicine or assists the patient with advice. (The method of repertorisation and selection of medicine is determined by the practitioner). Or a voluntary scheduled consultation for the same condition within four (4) months (although the symptoms may differ from those presented during the first consultation). It may imply taking down a history and/or repertorisation of the case and study of Materia Medica and/or examination and/or prescribing or administering of treatment and/or medicine and/or counselling. Multiple complaints attended to during same visit: Only one consultation fee is chargeable although the patient may present with a number of complaints. If the patient has an unrelated complaint at the time of administering e.g. a homeopathic injection as part of a course only a fee for a visit is appropriate. Hospital visits at hospital or nursing home (all hours): By arrangement with Fund/patient
	Definition: Medicines
	Prescribed medicine: Homeopathic medicines are prescribed in accordance with the homeopathic principles and philosophy. The philosophy may consist of a classical, a clinical or a combined classical/clinical approach. The prescription may include proprietary homeopathic medicine, or patient-specific compounded medicine or a combination of both. The prescription may also include specially-imported medicine. The medicine may be prescribed in the form of a tablet, capsules, ampoules, liquid drops, liquid syrup, eardrops, nose drops, eye drops, pillules, granules, powders, ointments, creams, suppositories, stickers, etc. The medicine may be prescribed in a simplex potency, mother tincture (Æ), low potency, multi-potency, etc., and/or complex form. **Proprietary medicine:** These are registered medicines (consonant with the homoeopathic scope of practice) that are available in the open market or trade, or which are bought in bulk from manufacturers or wholesalers and dispensed to patients in smaller volumes without any compounding or manipulation. The dispensing of such medicine requires the appropriate NAPPI Code provided by the manufacturer/distributor.

	Non-proprietary homeopathic medicine: These are homeopathic medicines (consonant with the homeopathic scope of practice) which are formulated and/or prepared and/or manipulated, and/or compounded in-house by the registered homeopathic practitioner, and/or by a registered homeopathic medicine manufacturer in accordance with the prescription and/or formula of the registered homeopathic practitioner and which is not available in the market/trade. **Dispense/dispensing:** In terms of Act 101 of 1965 this means in the case of a medical practitioner, dentist, practitioner, nurse or any prescriber authorised to dispense medicines. i. the interpretation and evaluation of a prescription; ii. the selection, reconstitution, dilution, labelling, recording and supply of the medicine in an appropriate container; iii. the provision of information and instructions to ensure safe and effective use of a medicine by a patient. **Compound/compounding:** Means to prepare, mix, combine, package and label a medicine for dispensing as a result of a prescription for an individual patient by a pharmacist or a person authorised in terms of Act 101 of 1965. **Proprietary materials:** To be used for all material and/or unregistered/unscheduled products used in treatment. The appropriate NAPPI code(s), where applicable, must be provided.
	General Rules on Medicines, supplies, material and use of own equipment in treatment and procedures
	MEDICINE CODE USAGE: Licensed practitioners: • 201: As medicine dispensed to patients may only be used by a practitioner licensed to dispense medicine • 202-204: As compounded medicines which are dispensed to patients may only be used by a practitioner licensed to compound and dispense medicine • 221-224: May be used by a licensed practitioner in the administration or usage of a medicine or material during the consultation. Items 222-224 specifically require a compounding license • 209: The use or administration of proprietary materials during a consultation
	Unlicensed practitioners: • 221: Administered proprietary medicine (consonant with the homeopathic scope of practice) to patients during the consultation as administration does not warrant a dispensing license as per Regulation 18, Act 101 of 1965, which states: Regulation 18, Act 101 (8) for the purposes of this regulation, “compounding and dispensing” does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation • 209: The use or administration of proprietary materials during a consultation • 400: A dispensing code allowing the dispensing of proprietary Homeopathic medicine to a patient for an emergency medical condition on a once-off basis by an unlicensed practitioner. This should only be used bearing in mind the understanding of the term “emergency medical condition” where failure to such an act would prove a danger to the patient or community or as defined by the Regulations to the Medical Schemes Act, 1998 (Act 131 of 1998): “Emergency Medical Condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s life in serious jeopardy.
	Reflection of NAPPI/NHRPL codes on electronic and paper claims: 1. NAPPI Codes are only relevant for Items 201, 221 and, if applicable, 209. 2. Due to the nature of non-proprietary medicine, no NAPPI codes exist for Items 202-204 and 222-224 and the inclusion of the NHRPL codes should be regarded as sufficient. 3. For electronic claims each NHRPL and/or NAPPI code should be reflected on its own line followed by consecutive columns: the Single Exit Price (SEP) or NHRPL value (VAT inclusive) of the specific medicine and the total amount reflecting a VAT inclusive amount.
	Items 201 and 209 provide for the charge of material and medicine used in treatment. • All materials used should be specified on all accounts • Medicine, bandages and other essential materials for home-use by the patient must be obtained from a chemist on prescription or, if a chemist is not readily available, the practitioner may supply it from own stock provided a relevant prescription is attached to the account • Not appropriate for items such as spatulas that are normally used in examinations in the rooms • Not appropriate for items such as syringes, needles and gloves, etc. • Practitioners are not allowed to sell sphygmomanometers (blood pressure meters) or electro-medical devices to patients • For side room testing by practitioners no extra charge in terms of Item 201 is applicable for material or kits used
	The amount charged in respect of proprietary medicines shall be at net acquisition price. In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus: • 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands • a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands

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CODE:	DESCRIPTION:	UNITS:	VALUE:	2020 Tariff
1	**Consultations**			
301	Consultation (initial or follow up). Duration 1 - 15 mins	10,000	92,88	R 98,02
302	Consultation (initial or follow up). Duration 16 - 30 mins	22,500	208,78	R 220,33
303	Consultation (initial or follow up). Duration 31 - 45 mins	37,500	347,83	R 367,08
304	Consultation (initial or follow up). Duration 46 - 60 mins	52,500	487,01	R 513,96
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	15,000	139,18	R 146,88
003	Hospital visit (BY ARRANGEMENT)			
107	Appointment not kept			
2	**Medicines and Materials**			
2.1	**Licensed practitioner in licensed area**			
	Dispensed medicine:			
	• Codes 201-204 are to allow for the dispensing of medicine – either proprietary or non-proprietary • Code 201 requires only a dispensing licence • Codes 202-204 require a combined compounding and dispensing licence			
201	Proprietary homeopathic medicine, all forms. The amount charged in respect of proprietary homeopathic medicines shall be at cost.			
202	Non-proprietary Homoeopathic Medicine - Tablets & Capsules (each)	0,100	1,97	R 2,08
203	Non-proprietary Homoeopathic Medicine - Liquid drops (per ml)	0,230	4,47	R 4,72
204	Non-proprietary Homoeopathic Medicine - Pillules & granules (per ml)	0,230	4,47	R 4,72
	Administered medicine/materials:			
221	Proprietary (administered) medicine, all forms related to homoeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.			
222	Non-proprietary (compounded and administered) homeopathic medicine – Tablets & Capsules (each)	0,100		
223	Non-proprietary (compounded and administered) homeopathic medicine – Liquid drops (per ml)	0,230		
224	Non-proprietary (compounded and administered) homeopathic medicine – Pillules & granules (per ml)	0,230		
209	Proprietary materials			
2.2	**Unlicensed practitioner or licensed practitioner in unlicensed area**			
	Dispensed medicine			
400	**Once-off dispensing:** Once-off dispensing of proprietary homeopathic medicine, all forms, by unlicensed homeopathic practitioners or licensed homeopathic practitioner in an unlicensed area. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code. To be used as emergency only.	1.00		
	Administered medicine:			
221	Proprietary (administered) medicine, all forms related to homeopathic scope of practice. The amount charged in respect of proprietary homeopathic medicines shall be at cost using appropriate NAPPI code.			
209	Proprietary materials (administered)			

HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"

GENERAL RULES				
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
Code	**Description**	**Units**	**Value**	**2020 Tariff**
10	HOSPICE OR SIMILAR APPROVED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"			
950	Ward fee, per day (Inclusive of professional fees and disposables, except for pharmacy dispensed medication).		R 1 263,71	R 1 333,63
955	Home health care, per visit		R 413,61	R 436,49
960	Global fee for a terminally ill patient - By arrangement			

MEDICAL PRACTITIONERS

RULES GOVERNING THE CODING STRUCTURE:

In calculating the Road Accident Fund prices, the following rounding method is used:
Values R10 and below rounded to the nearest cent,
R10+ rounded to the nearest 10 cent.
Modifier values are rounded to the nearest cent.
When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

	Fees calculated: Relative Value Unit (RVU) x Rand Conversion Factor (RCF): Consultation fees RCF - 30.32 **(2020: 31.987)** Procedural fees RCF - 14.45 **(2020: 15.245)** Psychiatrists RCF - 36.27 **(2020: 38.265)**
A.	**Consultations:** Definitions: (a) New and established patients: A consultation/ visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. (c) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.
B.	**Normal hours and after hours:** After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and items 0146 or 0147 (which should be added to the appropriate consultative services code selected from items 0190-0192, 01730175, 0161-0164, 0166-0169).
C.	**Comparable services:** A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used.When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/ services listed in the coding structure? Information regarding the nature and extent of the procedure/ service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/ service listed in the coding structure will not be appropriate in this case; (4) A description of the complexity of the symptoms and concurrent problems must be supplied; (5) Final diagnosis supported by the appropriate ICD-10 code(s); (6) Pertinent physical findings (size, location and number of lesions if applicable); (7) Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; (8) Any further diagnostic or therapeutic procedure(s)/ service(s) to be provided in the follow-up period; and (9) Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure.
D.	**Cancellation of appointments:** Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be.
E.	**Pre-operative visits:** The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital
F.	**Administering of injections and/or infusions:** Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself

G.	**Post-operative care:** (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal aftercare for a period not exceeding ONE month (aftercare is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated postoperative period not requiring any further incisions.
H.	**Removal of lesions:** Items involving removal of lesions include follow-up treatment for 10 days
J.	**Disproportionately low fees:** In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.
K.	**Practice of specialists:** In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists.
L.	**Procedures performed at time of visits:** If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged.
M.	**Procedure planned to be performed later:** In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion.
N.	**"Per consultation":** No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention.
O.	**Costly or prolonged medical services or procedures:** In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the Fund for what amount the Fund will accept responsiility in respect of such treatment, should the practitioner wish any direct paymet from the Fund.
P.	**Travelling fees:** (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. The Fund benefits will not be applicable in such instances.
Q.	**Intensive care/High Care:** Units in respect of items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. (b) Cost of any drugs and/or materials. (c) Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. (d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. (e) Procedural items 1202 and 1212 to 1221. but INCLUDE the following: (f) Performing and interpretation of a resting ECG. (g) Interpretation of chemistry tests and x-rays. (h) Intravenous treatment (items 0206 and 0207), except intravenous infusion in patients under the age of three years (item 0205) that does not form a part of the daily ICU/High Care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management)
R.	**Multiple organ failure:** Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation).

S.	**Ventilation:** Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.
T.	**Ventilation** (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring.
U.	**Obstetric procedures:** (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods
Y.	**Contrast material:** Except where otherwise indicated, radiologists are entitled to charge for contrast material used
Z.	No fee is subject to more than one reduction
AA.	Procedures to exclude cost of isotope
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes
CC.	**Acupuncture:** (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp
EE.	**Ultrasound examinations:** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of the Fund unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the Fund by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist.
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/ operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.

GG.	**Capturing and recording of examinations:** Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years
RR.	The Radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate Radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").
XX.	**Diagnostic services rendered to hospital inpatients:** Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic
YY.	**Diagnostic services rendered to outpatients:** Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital).

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MODIFIERS GOVERNING THE STRUCTURE

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0002	**Written report on X-rays:** The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere.							
0004	**Procedures performed in own procedure rooms:** (a) Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure(s) performed). (b) Modifier 0004 may only be used when the operation/procedure units allocated to a single procedure is higher than 30.00 units. (c) Please note: Only the medical doctor owning/renting the facility and the equipment may use Modifier 0004. Only one person may use this modifier for procedures perfomred in doctor's own procedure rooms. (d) Please note that Modifier 0004 may not be used in conjunction with Modifier 0074 and 0075							
0005	**Multiple therapeutic procedures/operations under the same anaesthetic:** a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/ operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
	c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for aftercare. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d) Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee. e) "+" Means that this item is used in addition to another definitive procedure and is therefore not subject to reduction according to Modifier 0005 (see also Modifier 0082)							
0006	**Visiting specialists performing procedures:** Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use							
0007	a) **Use of own monitoring equipment in the rooms:** Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation - 15,00 clinical procedure units irrespective of the number of items of equipment provided. b) **Use of own equipment in hospital theatre or unattached theatre unit:** Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - 15,00 clinical procedure units irrespective of the number of items of equipment provided.		15.00		15.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0008	**Specialist surgeon assistant:** Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon.							
0009	**Assistant:** The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units.							
0010	**Local anaesthesic:** (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. (b) The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.							
0011	**Emergency procedures:** Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0013	**Endoscopic examinations done at operations:** Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged							
0014	**Operations previously performed by other surgeons:** (a) Use Modifier 0014(a) for information only as an indicator that the operation was previously performed by another surgeon. (b) Where an operation is performed which has previously been performed by another surgeon, e.g. a revision or repeat operation, the units shall be calculated according to the units for the full operation plus additional units to be negotiated under general Rule J: In exceptional cases where the units are disproportionately low in relation to actual service rendered, except where already specified in the structure.							
0015	**Intravenous infusions:** Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions							
0016	**Procedures performed on neonates with a weight of less than 1000g:** Add 50% of the units for the procedure(s) performed (only to be used by paediatric surgeons.) Modifier 0016 may be used in conjunction with Modifier 0019(a) when appropriate.							
0017	**Injections administered by practitioners:** When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item)		7.50		7.50			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.							
0019	(a) **Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision):** Units for procedure + 50% of the units for the procedure performed by the surgeons and a 50% increase in anaesthetic time units for anaesthesiologist. Modifier 0016 may be added to Modifier 0019(b) when appropriate. (b) **Neonates OR low birth weght infants (less than 2500 g) requiring intensive care:** Units for the intensive care items + 50% units for the intensive care items for neonatologists and/or paediatricians.							
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the Fund that there will be no hospital/theatre account.							
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable.							
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.							
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including aftercare)		27.00		27.00			
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement.		77.00		77.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0051	**Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting**: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.		77.00		77.00			
0053	**Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]:** Specialists and general practitioners add 32,00 clinical procedure units.		32.00		32.00			
0055	**Dislocation requiring open reduction:** Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units		77.00		77.00			
0057	**Multiple procedures on feet:** In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.							
0058	**Revision operation for total joint replacement and immediate re-substitution (infected or non-infected):** Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0060	**Musculoskeletal Poly-trauma:** Significant injury to more than one muscular skeletal system. Examples: two long bone fractures, or a long bone fracture and a pelvic fracture, or a long bone fracture and a spinal fracture, or any fracture plus a significant injury to a separate joint, or multiple fractures to a single long bone as in the femur where a proximal and a distal femur fracture are present which necessitates two different surgical approaches and fixation methods, or multiple small bone fractures of the hand or feet as in a crush injury plus any other major muscular skeletal injury. (Modifier 0005 is not applicable in poly-trauma where 100% of the units for all procedures are applicable - see modifier 0060). *Poly-trauma would be, by definition, a significant injury to one or more musculo-skeletal systems:* ** Two long bone fractures,* ** Long bone fracture and hip,* ** Long bone fracture and spinal fracture,* ** Any fracture plus a significant injury to a separate joint,* ** Multiple fractures to a single bone, e.g. femur where a proximal and distal femur fracture is present which necessitates two different surgical approaches and fixation methods,* ** Multiple small bone fractures of the hand or feet, e.g. crush injuries plus any other musculo-skeletal* injuries.							
0061	**Combined procedures on the spine:** In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed by him/her. Each surgeon may be remunerated as an assistant for the procedures performed by the other surgeon, at general practitioner units (refer to modifier 0009).							
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure							
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere							
0066	**Microsurgery of the fallopian-tubes and ovaries:** Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee.							
0067	**Microsurgery of the larynx:** Add 25% to the fee of the operation performed (For other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff).							
0069	**When endoscopic instruments are used during intranasal surgery:** Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.							
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope.		45.00		45.00			
0072	**Non invasive peripheral vascular tests:** The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.							
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%							
0074	**Endoscopic procedures performed with own equipment:** The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.							
0075	**Endoscopic procedures performed in own procedure room:** The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.		21.00		21.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0077	**Physical treatment:** When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)							
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure							
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (items 2957, 2974 or 2975)							
0080	Multiple examinations: No reduction in units.							
0081	Repeat examinations: No reduction							
0082	"+" Means that this item is complementary to a preceding item and is therefore not subject to reduction							
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used							
0084	**Cost for films and thermal paper by non-radiologists:** In the case of radiological services rendered by non-radiolgists where films, thermal paper or magneti media are used, use the film price of 2007 for these media, as compiled by the Radiological Society of South Africa. (This list is available on request at radsoc@iafrica,com.							
0085	Left Side' modifier to be added when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined							
0086	**Vascular groups:** "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: the units are therefore not subject to incerase in terms of modifier 0080: Multiple examinations.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0090	**Doctor's remuneration for participation in a team:** 30.00 Radiology units per 1/2 hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound scanning or X-ray procedures. (Only to be claimed if the medical doctor is hands-on, and not for the interpretation of images only).							
0091	**Diagnostic services rendered to hospital inpatients:** Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)							
0092	**Diagnostic services rendered to outpatients:** Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital)(Refer to rule YY).							
0095	**Radiation materials:** Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular asis, is available from the Soceity of Clinical and Radiation Oncology. This modifier is only to be used by the practice responsiblefo rte cost of this material and where the hospital did not code therefore. Please ntoe that item 0198 and item 0201 should not be used for these materials.							
0096	**Radio-isotope therapy patients who fail to keep their appointments:** The cost of the isotope will be added to the consultation item.							
0097	**Pathology tests performed by non-pathologists:** Where items under Clinical Pathology (Section 21) and Anatomical Pathology (Section 22) fall within the province of other specialists or general practitioners, the units to be used at two-thirds of the pathologist's units.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0099	**Stat basis tests:** For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos: o Stat test requesting may only be done by the referring practitioner and not by the pathologist. o Specimens must be collected on a stat basis where applicable. o Test must be performed on a stat basis. o Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained. o This modifier will only apply during normal working hours and will never be used in combination with item 4547: After-hours service.							
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime):Units for part examined plus 30% of the units. * *Modifier 0160 is appropriate for an aspiration or biopsy procedure performed under direct ultrasound guidance using an ultrasonic aspiration/biopsy transducer.* * *Use units for the part examined plus an additional 30% of the units for the procedure performed*							
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units. * *Modifier 0165 is appropriate in addition to any ultrasound item when an additional contrast study is done.*		6.00		6.00			
5104	**Ultrasound in pregnancy, multiple gestation, after twenty weeks:** Units for part examined plus 50% of the units.							
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes							
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee.							
6103	**Post-contrast study:** Bone tumour: 100% of the fee							
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable							
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items.							
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.							
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.							
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”							
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain							
6110	**MRI spectroscopy:** 50% of fee							
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)							
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)							

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)							
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure							
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is coded at 100% of the unit value. * *Apply modifier 6305 when multiple catheterisations are performed. Refer to items 3557, 3559, 3560, 3562)*							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
I. CONSULTATIVE SERVICES								
I.	**Consultative services: General information:**							
I.a	**New and established patients: Consultations/visits by psychiatrists (22) only**							
	Note: The use of the items 0161-0163 and items 0166-0169 are limited to Psychiatrists (22) only. Other specialists and General Practitioners: Refer to items 0190-0193 and 0173-0175 for basic consultative services.							
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/ visit by psychiatrist - refer to items 0166-0169).						15.00	
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169).						27.50	
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/ visit by psychiatrist - refer to items 0166-0169).						40.00	
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169).						52.50	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0166	Psychiatry (22): First hospital and follow-up consultation/visit with problem focused history, clinical examination and straightforward decision making for a minor problem. . Typically occupies the doctor personally with the patient for between 10 and 20 minutes.						15.00	
0167	Psychiatry (22): First hospital and follow-up consultation/visit with problem focused history, clinical examination and straightforward decision making for a minor problem. . Typically occupies the doctor personally with the patient for between 21 and 35 minutes.						27.50	
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes.						40.00	
0169	Psychiatry (22): First hospital consultation/visit with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 46 and 60 minutes.						52.50	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
I.b.	**General Practitioner and Specialist services**							
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/ or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109). Typically the doctor spends up to 15 minutes with the patient and/or family.		15.00		15.00			
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/ visit - refer to item 0173-0175 or item 0109). Typically the doctor spends between 16-30 minutes with the patient and/or family.		30.00		30.00			
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for preanaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure. Typically the doctor spends between 31-45 minutes with the patient and/or family.		45.00		45.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0193	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for preanaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure. Typically the doctor spends between 46-60 minutes with the patient and/or family.		63.60		63.60			
I.c	**Hospital consultation/visit:**							
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient.		15.00		15.00			
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient.		30.00		30.00			
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient.		45.00		45.00			
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214). Psychiatrists ("22") refer to items 0166-0169 for hospital follow-up visits.		15.00		15.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists (may only be charged once per day) (not to be used with items 0109 or ICU items 1204-1214). For a healthy neonate please use item 0109 for a hospital follow-up visit.		22.50					
I.d	**Add-on consultative services:**							
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes (minimum of 70 minute consultation time).	+	15.00		15.00			
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.	+	6.00		6.00			
0146	For an EMERGENCY consultation/visit AT the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.	+	8.00		8.00			
0147	For an emergency OR unscheduled consultation/visit AWAY from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.	+	14.00		14.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
I.e	**Pre-anaesthetic assessment**							
	Note: Item 0153 will be used for the evaluation of patients at a chronic pain clinic. Only one of the add-on items 0146 or 0147 may be coded and not combinations tereof. Please note item 0145 is not applicable to pre-anaesthetic assessments.							
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes.		16.00		16.00			
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 21 and 35 minutes.		32.00		32.00			
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for 30-45 minutes.		45.00		45.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
I.f	**Prenatal visits and new born attendance**							
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107). *Item 0107 can be used once only for given confinement*		33.00		33.00			
0113	New born attendance: Emergency attendance to newborn at all hours (once per patient) (items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to item 0113)		45.00		45.00			
I.g.	**Consultative services: Miscellaneous**							
0130	Telephone consultation (all hours)		12.00		12.00			
0131	Subsequent injections as part of a planned series of injections for the same condition administered by medical doctors (refer to Modifier 0017)(Not to be coded together with any consultaiton item.		7.50		7.50			
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact) (“Consultation” via SMS or electronic media included)		5.00		5.00		5.00	
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent		9.00		9.00		9.00	
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent		21.43		21.43		21.43	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
II. Medicine, material, supplies and use of own equipment								
II.a	**Medicine codes**							
II.a.1	**Dispensing of medicine by licensed dispensing medical practitioners**							
	2019 legislated Fees: Fees for persons licensed in terms of section 22C (1) (a) of the Act is calculated, exclusive of VAT as follows: a. Where SEP is less than R124 the fee must not exceed 30% of the SEP. b. Where SEP is equal to or greater than R124 the fee must not exceed R37,20 in respect of that medicine or scheduled substance							
0197	2019 legislated Fees: Fees for persons licensed in terms of section 22C (1) (a) of the Act is calculated, exclusive of VAT as follows: a. Where SEP is less than R124 the fee must not exceed 30% of the SEP. b. Where SEP is equal to or greater than R124 the fee must not exceed R37,20 in respect of that medicine or scheduled substance							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
II.a.2	**Once-off administration of medicine used during a consultation**							
0198	Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS legislated tariff for dispensing fees. (Where applicable, VAT should be added to the dispensing fee only and not to the SEP, since the SEP is VAT inclusive).[According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.							
II.a.3	**Cost of chemotherapy drugs**							
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
II.b	**Material codes**							
II.b	**Prosthesis and/or internal fixation**							
0200	Prosthesis and/or internal fixation: This item provides for a charge for prosthesis and/or internal fixation. Charge for prosthesis and/or internal fixation at cost price PLUS 26% (up to a maximum of R 26,00). (Where applicable, VAT should be added to the above.) The appropriate Nappi code(s), where applicable, must be provided.							
II.c	**Material used during a consultation**							
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.							
II.d	**Setting of sterile tray**							
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate		10.00		10.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
II.e	**Own equipment used in treatment**							
II.e.1	**Laser equipment**							
5930	Surgical laser apparatus: Hire fee for own equipment		109.00		109.00			
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement)							
II.e.2	**Calculation of own equipment cost:**							
	Own equipment cost: Use the following formula to calculate equipment fees: Purchase price of the equipment PLUS maintenance cost DIVIDED by the number of examinations that can be done during the manufacturer's lifespan of the equipment PLUS Return on Investment (ROI). *Specify equipment used and reflect modifier in a separate line from the procedure performed but directly underneathh the code for the procedure. Equipment already in use must be calculated on the original figures.*							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
III. PROCEDURES								
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999							
1. General								
1.1	**Injections, Infusions and Inhalation Sedation Treatment**							
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof		6.00		6.00			
0204	Inhalation sedation: Per additional quarter-hour or part thereof		3.00		3.00			
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours		12.00		12.00			
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours		6.00		6.00			
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours		8.00		8.00			
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)		6.00		6.00			
0209	Umbilical artery cannulation at birth		18.00		18.00			
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)		3.25		3.25			
0211	Exchange transfusion: First and subsequent (including after-care)		80.00		80.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)							
1.2	**Chemotherapy treatment (not in chemotherapy facilities)**							
0213	Treatment with cytostatic agents: Administering of Chemotherapy: Intramuscular or subcutaneous: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.		5.00		5.00			
0214	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous bolus technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.		9.00		9.00			
0215	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous infusion technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.		14.00		14.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1.3	**Oncology related services in non-oncology facilties**							
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included		394.86		315.89			
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included		262.41		209.93			
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included.		77.81		62.25			
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)		42.65		42.65			
1.4	**MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS**							
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate that there will be no hospital/theatre account.							
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the “Anaesthetic Performed” column) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see Modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/ anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.							
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.							
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/ anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/ her account the exact anaesthetic time, including the supervision time spent with the patient.							
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/ minute.							
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic							
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute.							
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.							
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.							
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/ anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.							
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0035	Anaesthetic administered by an anaesthesiologist/ anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).							
0036	**Anaesthetic administered by general practitioners:** a. Anaesthesia administered lasting one hour or less: the units (basic units plus time plus the appropriate moifiers) used to calculate the units for an aneaestesia administered by a general practitioner lasting one hour or less, shall be the same as that for a specialist aneasthesiologist. No anaesthesia performed should be less than 7.00 anaesthetic units (modifier 0035). b. Anaesthesia lasting more than one hour, the units used to calculate the units for an anaesthesia administered by a general practitioner will be 4/5(80%) of the total number of units (basic units plus time plus the appropriate modifiers) applicable to the specialist anaesthesiologist. The calculated anaesthetic units shall not be less than 11.00 anaesthetic units.							
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units							
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage							
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof.							
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units							
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units							
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added							
0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to Modifier 0043: Cases under one year of age.							
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.							
	Modifiers 5441 to 5448 Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter “M” is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items)							
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448							
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units							
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units							
5444	Shaft of femur: Add four (4,00) anaesthetic units							
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units							
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units							
	POST-OPERATIVE ALLEVIATION OF PAIN							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0045	Post-operative alleviation of pain: (a) When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique (b) When a second medical practitioner has administered the regional or nerve block for postoperative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (c) None of the above is applicable for routine postoperative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2. Integumentary System								
2.1	**Allergy**							
0217	Allergy: Patch tests: First patch		4.00		4.00			
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs		2.80		2.80			
0219	Allergy: Patch tests: Each additional patch		2.00		2.00			
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens		1.90		1.90			
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen		2.80		2.80			
2.2	**Skin (general)**							
0222	Intralesional injection into areas of pathology e.g. Keloid: Single		4.00		4.00			
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple		8.00		8.00			
0225	Epilation: Per session		8.00		8.00			
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session		8.00		8.00		4.00T	
0228	PUVA Treatment: Maximum of 21 treatments		20.00		20.00			
0229	PUVA: Follow-up or maintenance therapy once a week		20.00		20.00			
0230	UVR-Treatment		20.00		20.00			
0231	UVR-Follow-up - for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp		5.50		5.50			
0232	Biopsy of superficial soft tissue: Back or flank		47.40		47.40		5.00T	
0233	Biopsy without suturing: First lesion		6.00		6.00		3.00T	
0234	Biopsy without suturing: Subsequent lesions (each)	+	3.00		3.00		3.00T	
0235	Biopsy without suturing: Maximum for multiple additional lesions		18.00		18.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0236	Biopsy of superficial soft tissue: Shoulder area		49.10		49.10		3.00T	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing		12.00		12.00		3.00T	
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		49.10		49.10		3.00T	
0239	Biopsy of superficial soft tissue: Forearm and/or wrist		48.50		48.50		3.00T	
0240	Biopsy of superficial soft tissue: Leg or ankle area		48.30		48.30		3.00T	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion		6.00		6.00		3.00T	
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	+	3.00		3.00		3.00T	
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	+	42.00		42.00		3.00T	
0244	Repair of nail bed		30.00		30.00		3.00T	
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion		14.00		14.00		3.00T	
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	+	7.00		7.00		3.00T	
0247	Biopsy of superficial soft tissue: Pelvis and hip area		58.30		58.30		3.00T	
0248	Biopsy of superficial soft tissue: Thigh or knee area		52.30		52.30		3.00T	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion		30.00		30.00		3.00T	
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	+	15.00		15.00		3.00T	
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail		20.00		20.00		3.00T	
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus		87.00		87.00		3.00T	
0258	Incision/removal of foreign body: subcutateous tissue, simple.		31.00		31.00		3.00T	
0259	Removal of foreign body : Muscle or tendon sheath, simple.		43.70		43.70		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0260	Incision/removal of foreign body: subcutateous tissue, complicated.		55.50		55.50		3.00T	
0261	Removal of foreign body: Muscle of tendon sheath, deep/complicated.		74.20		74.20		3.00T	
0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax; less than 3 cm		90.10		90.10		5.00T	
0263	Excision tumour of subcutaneous soft tissue: Shoulder area; less than 3 cm		84.20		84.20		3.00T	
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area; less than 3 cm		94.50		94.50		3.00T	
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area; less than 3 cm		94.70		94.70		3.00T	
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger; less than 1,5 cm		99.30		99.30		3.00T	
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area; less than 3 cm		111.60		111.60		3.00T	
0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area; less than 3 cm		92.10		92.10		3.00T	
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area; less than 3 cm		92.60		92.60		3.00T	
0270	Excision tumour of subcutaneous soft tissue: Foot or toe; less than 1,5 cm		78.30		78.30		3.00T	
0271	Kurtin planing for acne scarring: Whole face		206.00		164.80		4.00T	
0273	Kurtin planing for acne scarring: Extensive		70.00		70.00		4.00T	
0275	Kurtin planing for acne scarring: Limited		30.00		30.00		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months		103.00		103.00		4.00T	
0279	Surgical treatment for axillary hyperhidrosis		64.00		64.00		4.00T	
0274	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, tolidine blue): First stage, up to 5 tissue blocks.		113.90		113.90		5.00T	
0276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional stage after the first stage, up to 5 tissue blocks	+	60.50		60.50		5.00T	
0278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional block after the first 5 tissue blocks, any stage.	+	15.90		15.90		5.00T	
0280	Laser treatment for small skin lesions: First lesion		14.00		14.00		3.00T	
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	+	7.00		7.00		3.00T	
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions		56.00		56.00		3.00T	
0283	Laser treatment for large skin lesions: Limited area		30.00		30.00		4.00T	
0284	Laser treatment for large skin lesions: Extensive area		70.00		70.00		4.00T	
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger		206.00		164.80		4.00T	
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp		56.63		56.63			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device		43.44		43.44			
2.3	**Major plastic repair**							
0288	Harvesting of graft: Fascia lata graft, complex or sheet.		127.40		120.00		4.00T	
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts		234.00		187.20		4.00T	
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap		410.00		328.00		4.00T	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis		800.00		640.00		4.00T	
0292	Distant flaps: First stage		206.00		164.80		4.00T	
0293	Contour grafts (excluding cost of material)		206.00		164.80		4.00T	
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses		1200.00		960.00		6.00T	
0295	Local skin flaps (large, complicated)		206.00		164.80		4.00T	
0296	Other procedures of major technical nature		206.00		164.80		4.00T	
0297	Subsequent major procedures for repair of same lesion		104.00		104.00		4.00T	
0298	Lower abdominal dermo-lipectomy		170.00		136.00		5.00T	
0299	Major abdominal lipectomy with repositioning of umbilicus		275.00		220.00		5.00T	
2.4	**Lacerations, scars, tumours, cysts and other skin lesions**							
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)		14.00		14.00		3.00T	
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	+	7.00		7.00		3.00T	
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage		64.00		64.00		4.00T	
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage		128.00		120.00		4.00T	
0304	Major debridement of wound, sloughectomy or secondary suture		50.00		50.00		3.00T	
0305	Needle biopsy - soft tissue		25.00		25.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude		27.00		27.00		3.00T	
0308	Each additional small procedure done at the same time	+	14.00		14.00		3.00T	
0310	Radical excision of nailbed		38.00		38.00		3.00T	
0311	Excision of large benign tumour (more than 5 cm)							
0313	Extensive resection for malignant soft tissue tumour including muscle		283.90		227.12		4.00T	
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude		104.00		104.00		4.00T	
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude		55.00		55.00		3.00T	
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		13,90		13,90		3.00T	
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof	+	5.30		5.30		3.00T	
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		36.00		36.00		5.00T	
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof	+	11.20		11.20		5.00T	
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		62.50		62.50		6.00T	
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof		19.50		19.50		6.00T	
4880	Biopsy soft tissue: Neck or thorax		46.60		46.60		5.00T	
4881	Biopsy of soft tissue: Deep: Back or flank		100.40		100.40		5.00T	
4882	Biopsy of soft tissue: Deep: Shoulder area		117.60		117.60		5.00T	
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular): Upper arm or elbow area		117.60		117.60		3.00T	
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular): Forearm and/or wrist		106.60		106.60		3.00T	
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular): Thigh or knee area		112.90		112.90		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular): Leg or ankle area		119.50		119.50		3.00T	
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular): Pelvis and hip area		197.70		197.70		4.00T	
2.5	**Breasts**							
0316	Fine needle aspiration for soft tissue (all areas)		15.00		15.00			
0317	Aspiration of cyst or tumour		9.00		9.00		3.00T	
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant		42.00		42.00		3.00T	
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma		94.20		94.20		3.00T	
0323	Subareolar cone excision of ducts of wedge excision of breast		90.00		90.00		3.00T	
0324	Wedge excision of breast and axillary dissection		225.00		180.00		5.00T	
0325	Total mastectomy		155.00		124.00		5.00T	
0327	Total mastectomy with axillary gland biopsy		185.00		148.00		5.00T	
0329	Total mastectomy with axillary gland dissection		275.00		220.00		5.00T	
0330	Nipple and areola reconstruction		95.00		95.00		4.00T	
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral		234.00		187.20		4.00T	
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral		410.00		328.00		4.00T	
0334	Removal of breast implant by means of capsulectomy: Per breast		234.00		187.20		4.00T	
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients		150.00		120.00		4.00T	
0336	Breast reconstruction: Lattisimus dorsi flap, without prosthetic implant.		378.80		303.04		5.00T	
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral		234.00		187.20		5.00T	
0338	Breast reconstruction; Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, suture of donor site included.		467.30		373.84		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral		410.00		328.00		5.00T	
0340	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, with microvascular anastomosis (supercharging)(suture of donor site included)		555.50		444.40		5.00T	
0341	Gynaecomastia: Unilateral		92.00		92.00		3.00T	
0343	Gynaecomastia: Bilateral		161.00		128.80		3.00T	
2.6	**Burns**							
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)		276.00		220.80		5.00T	
0353	Tangential excision and grafting: Small		100.00		100.00		5.00T	
0354	Tangential excision and grafting: Large		200.00		160.00		5.00T	
2.7	**Hands (skin)**							
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler		147.40		120.00		4.00T	
0357	Small skin graft in acute hand injury		45.00		45.00		3.00T	
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing		192.00		153.60		3.00T	
0361	Z-plasty		220.10		176.08		3.00T	
0363	Local flap and skin graft		150.00		120.00		3.00T	
0365	Cross finger flap (all stages)		192.00		153.60		3.00T	
0367	Palmar flap (all stages)		192.00		153.60		3.00T	
0369	Distant flap: First stage		158.00		126.40		3.00T	
0371	Distant flap: Subsequent stage (not subject to general modifier 0005)		77.00		77.00		3.00T	
0373	Transfer neurovascular island flap		230.50		184.40		3.00T	
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)		242.40		193.92		3.00T	
0375	Dupuytren's contracture: Fasciotomy		51.00		51.00		3.00T	
0376	Dupuytren's contracture: Fasciectomy		218.00		174.40		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2.8	**Acupuncture**							
	Please note: General Rule M not applicable to section 2.8 of this price list							
	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp							
0377	Standard acupuncture		10.00		10.00			
0378	Laser acupuncture using more than 6 points		14.00		14.00			
0379	Electro-acupuncture		14.00		14.00			
0380	Scalp acupuncture		10.00		10.00			
0381	Micro-acupuncture (ear, hand)		10.00		10.00			
3. Musculo-Skeletal System								
3.1	**Bones**							
3.1.1	**Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)**							
0383	Fracture (reduction under general anaesthetic): Scapula		112.30		112.30		3.00TM	
0384	Fracture: Scapula: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable).		284.20		227.36			
0386	Fracture: Clavicle: Open reduction and internal fixation (Modifier 0051, 0052 not applicable).		209.40		167.52			
0387	Fracture: Clavicle (reduction under general anaesthetic)		93.80		93.80		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure (Modifiers not applicable).		175.70		140.56		3.00TM	
0389	Fracture: Humerus: (reduction under general anaesthetic)		129.60		129.60		3.00TM	
0390	Fractur: Humerus: Open reduction and internal fixation (Modifier 0051 not applicable).		255.30		204.24		3.00TM	
0391	Fracture: Radius and/or Ulna: (reduction under general anaesthetic)		135.70		120.00		3.00TM	
0392	Fracture: Radius or Ulna: Open reduction and internal fixation (Modifier 0051 not applicable).		193.50		154.80		3.00TM	
0401	Fracture: Carpal bone: Open reduction and internal fixation (Modifier 0052 not applicable)		208.70		166.96		3.00TM	
0402	Fracture: Carpal bone: (reduction under general anaesthetic)		119.30		119.30		3.00TM	
0403	Fracture: Bennett fracture: (reduction under general anaesthetic)		84.50		84.50		3.00TM	
0404	Fracture: Bennet fracture/dislocation: Open reduction and internal fixation (Modifiers 0051, 0052, 0055 not applicable)		179.80		143.84		3.00TM	
0405	Fracture: Metacarpal bone (reduction under general anaesthesia)		75.40		75.40		3.00TM	
0406	Fracture: Metacarpal bone: Open reduction and intenal fixation (Modifier 0052 not applicable)		163.60		130.88		3.00TM	
0409	Fracture: Finger phalanx: Distal, Simple: (reduction under general anaesthetic)		77.00		77.00		3.00TM	
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (Modifier 0052 not applicable.)		141.10		120.00		3.00TM	
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound							
0413	Fracture: Finger phalanx, proximal or middle (reduction under general anaesthetic.)		50.00		50.00		3.00TM	
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifier 0052 not applicable)		169.90		135.92		3.00TM	
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound							
0417	Fracture: Pelvis fracture closed (reduction under general anaesthetic)		132.70		120.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0419	Fracture: Pelvis: Open reductin and internal fixation (Modifier 0051 not applicable.)		354.49		283.59		3.00TM	
0420	Fracture: Acetabulum: Open reduction and internal fixation (Modifiers 0051 not applicable)		560.00		448.00		3.00TM	
0421	Fracture: Femur: Neck or Shaft: (reduction under general anaesthetic)		279.10		223.28		3.00TM	
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (Modifiers 0051 not applicable		392.30		313.84		3.00TM	
0425	Fracture: Patella (reduction under general anaesthetic)		82.50		82.50		3.00TM	
0429	Fracture: Tibia with or without fibula (reduction under general anaesthetic)		143.40		120.00		3.00TM	
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (Modifiers 0051 not applicable)		293.20		234.56		3.00TM	
0433	Fracture: Fibula shaft (reduction under general anaesthetic)		112.40		112.40		3.00TM	
0435	Fracture: Malleolus of ankle (reduction under general anaesthetic)		126.80		120.00		3.00TM	
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)		207.10		165.68		3.00TM	
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle		128.00		120.00		3.00TM	
0438	Fracture: Talus: Open reduction and internal fixation (Modifiers 0051,0052 not applicable.)		311.60		249.28		3.00TM	
0439	Fracture: Tarsal bones (excluding talus and calcaneus) (reduction under general anaesthetic)		76.60		76.60		3.00TM	
0440	Fracture: Calcaneus fracture: Open reduction with internal fixation (Modifiers 0051, 0052 not applicable)		403.50		322.50		3.00TM	
0441	Fracture: Metatarsal bones (reduction under general anaesthetic)		66.80		66.80		3.00TM	
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (Modifiers 0052 not applicable)		154.70		123.76		3.00TM	
0443	Fracture: Toe phalanx: Distal Simple (reduction under general anaesthetic)		66.80		66.80		3.00TM	
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (Modifiers 0052 not applicable)		144.50		120.00		3.00TM	
0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0447	Fracture (reduction under general anaesthetic): Other: Simple		26.00		26.00		3.00TM	
0449	Fracture (reduction under general anaesthetic): Other: Compound							
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed		*		*		3.00T	
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest		230.00		184.00		3.00TM	
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical		*		*		3.00TM	
0456	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Rest							
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical		*		*		3.00TM	
0462	Fracture (reduction under general anaesthetic): Compression fracture: Rest							
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical		*		*		3.00TM	
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest		*		*		3.00TM	
3.1.1.1	**Bones: Operations for fractures**							
0465	Fractures involving large joints: includes the metaphysis of the relative bone. Modifiers 0051, 0052 applicable when open reduction and internal fixation are performed.		288.00		230.40		3.00TM	
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (Modifier 0052 not applicable)		210.90		168.72		3.00TM	
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)		43.00		43.00		3.00TM	
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna		328.20		262.56		3.00TM	
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones		181.00		144.80		3.00TM	
3.1.1.2	**Bones: Radical resection of bone tumours**							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		415.00		332.00		10TM	
0481	Radical resection of bone tumour: Fibula		240.10		192.08		4.00TM	
0482	Radical resection of bone tumour: Femur or knee		371.80		297.44		5.00TM	
0483	Radical resection of malignant bone tumour: Scapula		237.70		190.16		6.00TM	
0484	Radical resection of bone tumour: Clavicle		413.80		331.04		6.00TM	
0485	Radical resection of bone tumour: Metatarsal		185.00		148.00		4.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.1.2	**Bony operations**							
3.1.2.1	**Bony operations: Bone grafting**							
0497	Resection of bone or tumour with or without grafting (benign)		282.00		225.60		3.00TM	
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits		340.00		272.00		3.00TM	
0499	Grafts to cysts: Large bones		192.00		153.60		3.00TM	
0501	Grafts to cysts: Small bones		128.00		120.00		3.00TM	
0503	Grafts to cysts: Cartilage graft		206.00		164.80		3.00TM	
0505	Grafts to cysts: Inter-metacarpal bone graft		147.00		120.00		3.00TM	
0506	Harvesting of graft: Cartilage graft, costochondral		91.10		91.10		6T	
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)		50.00		50.00		3.00TM	
3.1.2.2	**Bony operations: Acute or chronic osteomyelitis**							
0509	Acute or chronic osteomyelitis: Conservative treatment		*		*			
0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care							
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including FOUR weeks after-care		128.00		120.00		3.00TM	
3.1.2.3	**Bony operations: Osteotomy**							
0514	Osteotomy: Sternum: Repair of pectus excavatum		330.00		264.99		3.00TM	
0515	Osteotomy: Sternum: Repair of pectus carinatum		330.00		264.99		3.00TM	
0516	Osteotomy: Pelvic		320.00		256.00		3.00TM	
0521	Osteotomy: Femoral: Proximal (Modifier 0051 is applicable)		320.00		256.00		3.00TM	
0527	Osteotomy: Knee region (Modifier 0051 is applicable)		320.00		256.00		3.00TM	
0528	Osteotomy: Os Calcis (Dwyer operation) (Modifier 0051 is applicable)		115.00		115.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation (Modifier 0051 is applicable)		120.00		120.00		3.00TM	
0531	Rotational osteotomy of tibia and fibula - stand alone procedure		278.90		223.12		3.00TM	
0532	Rotation osteotomy of the Radius, Ulna or Humerus (Modifier 0051 is applicable)		160.00		128.00		3.00TM	
0533	Osteotomy: Single metatarsal (Modifier 0051 is applicable)		60.00		60.00		3.00TM	
0534	Osteotomy: Multiple metatarsal osteotomies (Modifier 0051 is applicable)		150.00		120.00		3.00TM	
3.1.2.4	**Bony operations: Exostosis**							
0535	Exostosis: Excision: Readily accessible sites		60.00		60.00		3.00TM	
0537	Exostosis: Excision: Less accessible sites		96.00		96.00		3.00TM	
3.1.2.5	**Bony operations: Biopsy**							
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)		50.00		50.00		4.00TM	
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)		32.00		32.00		4.00TM	
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site Anaesthetic: as per bone.		64.00		64.00		As per bone	
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site Anaesthetic: as per bone.		96.00		96.00		As per bone	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.2	**Joints**							
3.2.1	**Joints: Dislocations**							
0547	Joint: Dislocation: Clavicle either end		96.50		96.50		3.00TM	
0549	Joint: Dislocation: Shoulder		112.10		112.10		3.00TM	
0551	Joint: Dislocation: Elbow		133.60		120.00		3.00TM	
0552	Joint: Dislocation: Wrist		115.50		115.50		3.00TM	
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation		130.00		120.00		3.00TM	
0555	Joint: Dislocation: Lunate		136.30		120.00		3.00TM	
0556	Joint: Dislocation: Carpo-metacarpo dislocation		117.20		117.20		3.00TM	
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)		107.30		107.30		3.00TM	
0559	Joint: Dislocation: Hip		220.50		176.40		3.00TM	
0561	Joint: Dislocation: Knee, with manipulation		181.20		144.96		3.00TM	
0563	Joint: Dislocation: Patella		136.90		120.00		3.00TM	
0565	Joint: Dislocation: Ankle		98.60		98.60		3.00TM	
0567	Joint: Dislocation: Sub-Talar dislocation		92.00		92.00		3.00TM	
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal		77.00		77.00		3.00TM	
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)		39.41		39.41		3.00TM	
0573	Joint: Dislocation: Spine with or without paralysis							
3.2.2	**Joints: Operations for dislocations**							
0578	Operations for dislocations: Recurrent dislocation of shoulder		200.00		160.00		3.00TM	
0579	Operations for dislocations: Recurrent dislocation of all other joints		161.00		128.80		3.00TM	
3.2.3	**Joints: Capsular operations**							
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)		51.00		51.00		3.00TM	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)		96.00		96.00		3.00TM	
0585	Capsulectomy digital joint		64.00		64.00		3.00TM	
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints		90.00		90.00		3.00TM	
0587	Release of digital joint contracture		128.00		120.00		3.00TM	
3.2.4	**Joints: Synovectomy**							
0589	Synovectomy: Digital joint		77.00		77.00		3.00TM	
0592	Synovectomy: Large joint		160.00		128.00		3.00TM	
0593	Tendon synovectomy		203.70		162.96		3.00TM	
3.2.5	**Joints: Arthrodesis**							
0597	Arthrodesis: Shoulder		224.00		179.20		3.00TM	
0598	Arthrodesis: Elbow		180.00		144.00		3.00TM	
0599	Arthrodesis: Wrist		180.00		144.00		3.00TM	
0600	Arthrodesis: Digital joint		128.00		120.00		3.00TM	
0601	Arthrodesis: Hip		320.00		256.00		3.00TM	
0602	Arthrodesis: Knee		180.00		144.00		3.00TM	
0603	Arthrodesis: Ankle		180.00		144.00		3.00TM	
0604	Arthrodesis: Sub-talar		130.00		120.00		3.00TM	
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)		180.00		144.00		3.00TM	
0607	Arthrodesis: Mid-tarsal wedge resection		180.00		144.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.2.6	**Joints: Arthroplasty**							
0614	Arthroplasty: Debridement large joints		160.00		128.00		3.00TM	
0615	Arthroplasty: Excision medial or lateral end of clavicle		116.00		116.00		3.00TM	
0617	Shoulder: Acromioplasty		192.00		153.60		3.00TM	
0619	Shoulder: Partial replacement		277.00		221.60		5.00TM	
0620	Shoulder: Total replacement		416.00		332.80		5.00TM	
0621	Elbow: Excision head of radius		96.00		96.00		3.00TM	
0622	Elbow: Excision		192.00		153.60		3.00TM	
0623	Elbow: Partial replacement		188.00		150.40		3.00TM	
0624	Elbow: Total replacement		282.00		225.60		3.00TM	
0625	Wrist: Excision distal end of ulna		96.00		96.00		3.00TM	
0626	Wrist: Excision single bone		110.00		110.00		3.00TM	
0627	Wrist: Excision proximal row		166.00		132.80		3.00TM	
0631	Wrist: Total replacement		249.00		199.20		3.00TM	
0635	Digital Joint: Total replacement		192.00		153.60		3.00TM	
0637	Hip: Total replacement		416.00		332.80		3.00TM	
0641	Hip: Prosthetic replacement of femoral head		288.00		230.40		3.00TM	
0643	Hip: Girdlestone		320.00		256.00		3.00TM	
0645	Knee: Partial replacement		277.00		221.60		3.00TM	
0646	Knee: Total replacement		416.00		332.80		3.00TM	
0649	Ankle: Total replacement		290.40		232.32		3.00TM	
0650	Ankle: Astragalectomy		154.00		123.20		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.2.7	**Joints: Miscellaneous (joints)**							
0658	Aspiration and/or injection: Small joint, bursa (e.g. fingers,toes) (excluding aftercare, Modifier 0005 not applicable)		11.40		11.40		3.00T	
0659	Aspiration and/or injection: Intermediate joint, bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)(excluding aftercare, Modifier 0005 not applicable)		12.00		12.00		3.00T	
0660	Aspiration and/or injection: Major joint, bursa (e.g. shoulder, hip, knee joint, subcromial bursa)(excluding aftercare, Modifier 0005 not applicable.)		14.60		14.60		4.00T	
0661	Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)		9.00		9.00		3.00T	
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint		7.50		7.50		3.00T	
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	+	4.00		4.00		3.00T	
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)		60.00		60.00		3.00T	
0669	Manipulation large joint under general anaesthetic (not including after-care) (Modifier 0005 not applicable) - Anaesthetic: Knee/Shoulder.		43.10		43.10		3.00T	
0669a	Manipulation large joint under general anaesthetic (not including after-care) (modifier 0005 not applicable) - Anaesthetic: Hip						4.00T	
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Knee/Shoulder		*		*		3.00T	
0670a	The consultation fee only should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthaetic: Hip						4.00T	
0673	Meniscectomy or operation for other internal derangement of knee		185.70		148.56		4.00TM	
3.2.8	**Joints: Joint ligament reconstruction or suture**							
0675	Joint ligament reconstruction or suture: Ankle: Collateral		160.00		128.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0676	Joint ligament reconstruction or suture: Ankle: (e.g. Watson-Jones type)		191.50		153.20		3.00TM	
0677	Joint ligament reconstruction or suture: Knee: Collateral		196.80		157.44		4.00TM	
0678	Joint ligament reconstruction or suture: Knee: Cruciate		277.60		182.08		4.00TM	
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee		324.40		259.52		4.00TM	
0680	Joint ligament reconstruction or suture: Digital joint ligament		229.80		183.84		3.00TM	
3.3	**Amputations**							
3.3.1	**Amputations: Specific Amputations**							
0682	Amputation: Fore-quarter amputation		397.80		318.24		15.00TM	
0683	Amputation: Through shoulder		323.00		258.40		9.00TM	
0685	Amputation: Upper arm or fore-arm							
0681	Amputation Humerus: Includes primary closure		211.60		169.28		4.00TM	
0684	Amputation: Forearm		213.50		170.48		3.00TM	
0687	Amputation: Metacarpal: One Ray		206.10		164.88		3.00TM	
0691	Amputation: Finger or Thumb		189.30		146.60		3.00TM	
0693	Hindquarter amputation		470.70		376.56		15.00TM	
0695	Amputation: Through hip		373.10		298.48		10.00TM	
0697	Amputation: Through thigh		245.00		196.00		5.00TM	
0699	Amputation: Below knee, through knee or Syme		277.20		221.76		4.00TM	
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		204.10		163.28		4.00TM	
0688	Amputation: Foot, Midtarsal (Chopart type)		165.70		132.00		3.00TM	
0701	Amputation: Foot, Trans-metatarsal		223.80		179.04		3.00TM	
0703	Amputation: Foot: One ray							
0705	Amputation: Toe		167.10		133.68		3.00TM	
3.3.2	**Amputations: Post-amputation reconstruction**							
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		150.70		120.56		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		173.90		139.12		3.00TM	
0696	Re-amputation: Thigh, through femur, any level		217.30		173.84		3.00TM	
0698	Re-amputation: Leg, through tibia and fibula		198.20		158.56		3.00TM	
0706	Finger or thumb: Local advancement flaps (V-Y Plasty), with neurectomy, any joint.		186.30		149.04		3.00TM	
0707	Krukenberg reconstruction		331.70		265.36		3.00TM	
0709	Post-amputation reconstruction: Metacarpal transfer							
0711	Pollicisation of the finger (to include all stages)		455.90		364.72		3.00TM	
0712	Post-amputation reconstruction: Toe to thumb transfer		800.00		640.00		3.00TM	
0700	Scar revision/secondary closure: Amputated shoulder		128.10		120.00		3.00TM	
0702	Scar revision/secondary closure: Amputated humerus		163.10		130.48		3.00TM	
0704	Scar revision/secondary closure: Amputated forearm		184.10		147.28		3.00TM	
0708	Re-amputation: Humerus		223.10		178.48		6.00TM	
0710	Re-amputation: Through forearm		206.00		164.80		3.00TM	
3.4	**Muscles, tendons and fasciae**							
3.4.1	**Muscles, tendons and fasciae: Investigations**							
0713	Electromyography		75.00		75.00		3.00T	
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)		57.00		57.00		3.00T	
0715	Strength duration curve per session		10.50		10.50		3.00T	
0717	Electrical examination of single nerve or muscle		9.00		9.00		3.00T	
0718	Oxidative study for mitochondrial function		64.00		64.00			
0721	Voltage integration during isometric contraction		12.00		12.00		3.00T	
0723	Tonometry with edrophonium		8.00		8.00		3.00T	
0725	Isometric tension studies with edrophonium		10.00		10.00		3.00T	
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral		8.00		8.00			
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral		14.00		14.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0729	Tendon reflex time		7.00		7.00		3.00T	
0730	Limb brain somatosensory studies (per limb)		49.00		49.00			
0731	Vision and audio-sensory studies		49.00		49.00			
0733	Motor nerve conduction studies (single nerve)		26.00		26.00			
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)		31.00		31.00		3.00T	
0737	Biopsy for motor nerve terminals and end plates		20.00		20.00		3.00T	
0739	Combined muscle biopsy with end plates and nerve terminal biopsy		34.00		34.00		3.00T	
0740	Muscle fatigue studies		20.00		20.00		3.00T	
0741	Muscle biopsy		20.00		20.00		8.00T	
0742	Global fee for all muscle studies, including histochemical studies		262.00					
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase		20.25					
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase		33.30					
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase		5.70					
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase		1.60					

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Staatskoerant

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REPUBLIEK VAN SUID AFRIKA

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase		9.90					
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase		13.70					
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase		25.90					
4715	Biochemical estimations on muscle biopsy specimens: Enolase		32.70					
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase		37.70					
4719	Biochemical estimations on muscle biopsy specimens: Aldolase		15.75					
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase		11.06					
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase		34.70					
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase		40.30					
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase		28.80					
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study		43.00					
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)		14.00					
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)		20.00					
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies		71.00					
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)		69.00					
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation		82.00					
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia		143.00					

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy		75.00					
3.4.2	**Muscles, tendons and fasciae: Decompression Operations**							
0743	Major compartmental decompression							
0744	Decompression operation: Fasciotomy only							
5550	Decompression Faciotomy: Buttock compartments:(unilateral)		243.00		194.40		5.00TM	
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		151.90		121.50		3.00TM	
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		253.10		202.50		3.00TM	
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/ or nerve		123.70		120.00		3.00TM	
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/ or nerve		162.10		129.70		3.00TM	
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		130.80		120.00		3.00TM	
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		171.50		137.20		3.00TM	
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		137.30		120.00		4.00TM	
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe		86.60		86.60		3.00TM	
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		226.30		181.00		3.00TM	
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		354.50		283.60		3.00TM	
5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		166.80		133.40		3.00TM	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		321.10		256.90		3.00TM	
5563	Decompression Faciotomy: Fingers and/or hand		165.60		132.50		3.00TM	
3.4.3	**Muscles, tendons and fasciae: Muscle and tendon repair**							
0745	Muscle and tendon repair: Biceps humeri		109.00		109.00		3.00T	
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff		96.00		96.00		3.00TM	
0747	Muscle and tendon repair: Rotator cuff		134.00		120.00		4.00T	
0748	Muscle and tendon repair: Debridement rotator cuff		139.70		120.00		4.00T	
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure		271.90		217.52		4.00T	
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon		128.00		120.00		3.00T	
0757	Muscle and tendon repair: Achilles tendon repair		197.60		158.08		4.00T	
0759	Muscle and tendon repair: Other single tendon		77.00		77.00		3.00T	
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (modifier 0005 applicable)		220.30		176.24		3.00T	
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (modifier 0005 applicable)		249.60		199.68		3.00T	
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (modifier 0005 applicable)		191.30		153.04		3.00T	
0763	Muscle and tendon repair: Tendon or ligament injection		9.00		9.00		3.00T	
0764	Hand: Flexor tendon repair: Secondary, Zone 1		243.90		195.12		3.00T	
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)		249.60		199.68		3.00T	
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)		190.60		152.48		3.00T	
0767	Hand: Flexor tendon suture: Primary (per tendon)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0768	Repair: Intrinsic muscles of hand (each) (modifier 0005 applicable)		125.30		100.24		3.00T	
0769	Hand: Flexor tendon suture: Secondary (per tendon)							
0771	Extensor tendon suture: Primary (per tendon)		164.80		131.84		3.00T	
0773	Extensor tendon suture: Secondary (per tendon)		170.00		136.00		3.00T	
0774	Repair of Boutonniere deformity or Mallet finger with graft		216.60		173.28		3.00T	
3.4.4	**Muscles, tendons and fasciae: Tendon graft**							
0775	Free tendon graft		160.00		128.00		3.00T	
0776	Reconstruction of pulley for flexor tendon		180.20		144.16		3.00T	
0777	Tendon graft: Finger: Flexor		192.00		153.60		3.00T	
0779	Tendon graft: Finger: Extensor		122.00		120.00		3.00T	
0780	Two stage flexor tendon graft using silastic rod		240.00		192.00		3.00T	
3.4.5	**Muscles, tendons and fasciae: Tendolysis**							
0781	Tendon freeing operation, except where specified elsewhere		64.00		64.00		3.00T	
0782	Carpal tunnel syndrome		123.00		120.00		3.00T	
0783	Tenolysis: De Quervain		38.00		38.00		3.00T	
0784	Trigger finger		38.00		38.00		3.00T	
0785	Flexor tendon freeing operation following free tendon graft or suture		276.10		220.88		3.00T	
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon		212.20		170.00		3.00T	
0788	Intrinsic tendon release per finger		64.00		64.00		3.00T	
0789	Central tendon tenotomy for Boutonniere deformity		64.00		64.00		3.00T	
3.4.6	**Muscles, tendons and fasciae: Tenodesis**							
0790	Tenodesis: Digital joint (each)(Modifier 0005 applicable)		176.20		140.96		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.4.7	**Muscles, tendons and fasciae: Muscle tendon and facia transfer**							
0791	Single tendon transfer		96.00		96.00		3.00T	
0792	Multiple tendon transfer		128.00		120.00		3.00T	
0793	Hamstring to quadriceps transfer		141.00		120.00		3.00T	
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon		320.00		256.00		5.00T	
0795	Tendon transfer at elbow		116.00		116.00		3.00T	
0802	Radial club hand repair - stand alone procedure		360.30		288.24		3.00T	
0803	Hand tendons: Single tendon transfer (first)		216.20		172.96		3.00T	
0809	Hand tendons: Substitution for intrinsic paralysis of hand		330.60		264.48		3.00T	
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)		220.60		176.48		3.00T	
3.4.8	**Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening**							
0812	Percutaneous Tenotomy: All sites		140.50		120.00		3.00T	
0813	Torticollis		96.00		96.00		5.00T	
0815	Scalenotomy		132.00		120.00		5.00T	
0817	Scalenotomy with excision of first rib		190.00		152.00		3.00TM	
0821	Tennis elbow		96.00		96.00		3.00T	
0822	Open release elbow (Mitals) - stand alone procedure		278.20		222.56		3.00TM	
0823	Excision or slide for Volkmann's Contracture		192.00		153.60		3.00T	
0825	Hip: Open muscle release		116.00		116.00		7.00T	
0829	Knee: Quadriceps plasty		160.00		128.00		3.00T	
0831	Knee: Open tenotomy		141.00		120.00		3.00T	
0835	Calf		96.00		96.00		4.00T	
0837	Open elongation tendon Achilles		96.00		96.00		4.00T	
0838	Percutaneous "Hoke" elongation tendo Achilles		79.30		79.30		4.00T	
0845	Foot: Plantar fasciotomy		70.00		70.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0846	Foot: Postero-medial release for club-foot		192.00		153.60		3.00T	
3.5	**Bursae and ganglia**							
0847	Excision: Semimembranosus		90.00		90.00		4.00T	
0849	Excision: Prepatellar		45.00		45.00		3.00T	
0851	Excision: Olecranon		81.80		81.80		3.00T	
0853	Excision: Small bursa or ganglion		80.90		80.90		3.00T	
0855	Excision: Compound palmar ganglion or synovectomy		128.00		120.00		3.00T	
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)		9.00		9.00		3.00T	
3.6	**Musculo-skeletal system: Miscellaneous**							
3.6.1	**Musculo-skeletal system: Miscellaneous: Leg equalisation and congenital hips and feet**							
0859	Leg equalisation and congenital hips and feet: Leg shortening		282.00		225.60		3.00TM	
0861	Leg equalisation and congenital hips and feet: Leg lengthening		416.00		332.80		3.00TM	
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level		116.00		116.00		3.00TM	
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip		109.00		109.00		3.00TM	
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips		160.00		128.00		3.00TM	
0868	Open reduction of congenital dislocation of the hip		186.00		148.80		3.00TM	
0869	Subsequent plasters		32.00		32.00			
0873	Congenital club foot: Manipulation and plaster: One foot							
0874	Ponseti technique assistant (medical practitioner)		13.00		13.00			
3.6.2	**Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis**							
0883	Removal of internal fixatives or prosthesis: Readily accessible		44.40		44.40		3.00T	
0884	Removal of internal fixatives: Less accessible		127.00		75.50		5.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0885	Removal of prosthesis for infection soon after operation - Anaesthetic: As per bone (specify) + M.		128.00		120.00		As per bone (Specify) + M	
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the item for total joint replacement of the specific joint	+	64.00		64.00		6.00TM	
3.6.2.1	**Musculo-skeletal system: Miscellaneous: Removal of foreign bodies.**							
0644	Removal of foreign body: Shoulder, subcutaneous		49.70		49.70		3.00T	
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous		41.70		41.70		3.00T	
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular		109.00		109.00		3.00T	
0651	Exploration with removal of deep foreign body: Forearm or wrist		122.80		122.80		3.00T	
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue		45.30		45.30		6.00T	
0653	Removal of foreign body: Pelvis or ip, subfascial or intramuscular		186.90		149.52		6.00T	
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular		120.60		120.00		4.00T	
0655	Removal of foreign body: Foot, subcutaneous		40.00		40.00		3.00T	
0656	Removal of foreign body: Foot, deep		94.20		94.20		3.00T	
0657	Removal of foreign body: Foot, complicated		110.50		110.50		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.7	**Plasters (exclusive of after-care)**							
0887	Application of long leg cast (femur to toes, humerus)(excludig aftercare)(first cast included in procedure)		29.50		29.50		3.00T	
0888	Application of short limb cast (forearm, lower leg)(excluding aftercare)(first cast included in procedure)		18.40		18.40		3.00T	
0889	Application of spica, plaster jacket or hinged cast brace (excluding aftercare)(first cast included in procedure)		32.00		32.00		4.00T	
0891	Application of turnbuckle cast for scoliosis (excluding after-care)(first cast included in procedure)		49.30		49.30		5.00T	
0892	Application of cast: Revision (walker, window, bivalve)(excluding aftercare)		18.90		18.90		5.00T	
0894	Application of cast: Clubfoot (excluding after-care)(first cast included in procedure)		34.00		34.00		5.00T	
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)							
3.8	**Musculo-skeletal system: Special areas**							
3.8.1	**Special areas: Foot and Ankle**							
0895	Club foot: Revision club foot release - stand alone procedure		302.70		242.16		3.00TM	
0896	Club foot: Posterior release only - stand alone procedure		159.30		127.44		3.00TM	
0900	Excision tarsal coalition - stand alone procedure		141.50		120.00		3.00TM	
0901	Tenotomy: Single tendon		63.30		63.30		3.00TM	
0903	Hammer toe: One toe		99.50		99.50		3.00TM	
0905	Filleting of toe or Ruiz-Mora procedure		99.50		99.50		3.00TM	
0906	Arthrodesis Hallux		148.00		120.00		3.00TM	
0907	Silver bunionectomy or similar for Hallux Valgus		126.20		120.00		3.00TM	
0909	Excision arthroplasty		145.20		120.00		3.00TM	
0910	Cheilectomy or metatarsophangeal implant Hallux		183.00		146.40		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure		189.20		151.36		3.00TM	
5730	Hallux Valgus double osteotomy etc.		182.60		146.08		3.00TM	
5731	Distal soft tissue procedure for Hallux Valgus		173.60		138.88		3.00TM	
5732	Aitkin procedure or similar		166.80		133.44		3.00T	
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)		91.99		91.00		3.00TM	
5735	Repair angular deformity toe (lesser toes)		97.20		97.20		3.00TM	
5736	Sesamoidectomy		97.80		97.80		3.00TM	
5737	Repair major foot tendons e.g. Tib Post		147.30		120.00		3.00TM	
5738	Repair of dislocating peroneal tendons		173.20		138.56		3.00T	
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot		202.30		161.84		3.00TM	
5740	Steindler strip - plantar fascia		97.20		97.20		3.00T	
5741	Kelikian syndactilly (one web space)		97.20		97.20		3.00T	
5742	Tendon transfer foot		172.00		137.60		3.00T	
5743	Capsulotomy metatarsophalangeal joints: Foot		86.80		86.80		3.00T	
3.8.2	**Big toe (refer to section 3.8.1 for procedures on big toe)**							
3.8.3	**Special areas: Reimplantations**							
0912	Replantation of amputated upper limb proximal to wrist joint		730.00		584.00		3.00TM	
0913	Replantation of thumb		670.00		536.00		3.00TM	
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)		580.00		464.00		3.00TM	
0915	Replantation operation through the palm		1270.00		1016.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.8.4	**Special areas: Hands: (Note: Skin: See Integumentary System)**							
0919	Tumours: Epidermoid cysts		35.00		35.00		3.00TM	
0920	Tumours: Ganglion or fibroma		77.50		77.50		3.00TM	
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)		86.00		86.00		3.00TM	
0922	Removal of foreign bodies requiring incision: Under local anaesthetic							
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic						3.00TM	
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum		37.00		37.00		3.00TM	
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		110.00		110.00		3.00TM	
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic		16.00		16.00		3.00TM	
3.8.5	**Special areas: Spine**							
	Notes regardint eh use of Modifier 0005 in cases where bone graft procedures and instrumentation are performed in combination with arthrodesis(fusion): i.) Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together: - Bone graft procedures and instrumentation are to be coded in addition to arthrodesis. - When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition. ii.) Modifier 0005 (multiple procedures/operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. Osteotomy, Laminectomy.							
0927	Excision of one vertebral body, for a lesion within the body (no decompression)		207.00		165.60		3.00TM	
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	+	42.00		42.00		3.00TM	
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)		339.00		271.20		3.00TM	
0930	Posterior osteotomy of spine: One vertebral segment	+	103.00		103.00		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0931	Posterior spinal fusion: One level		385.00		308.00		3.00TM	
0932	Posterior osteotomy of spine: Each additional vertebral segment	+	103.00		103.00		3.00TM	
0933	Anterior spinal osteotomy with disc removal: One vertebral segment		315.00		252.00		3.00TM	
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	+	103.00		103.00		3.00TM	
0938	Anterior fusion base of skull to C2		449.00		359.20		4.00TM	
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon		160.00		128.00		3.00TM	
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon		160.00		128.00		3.00TM	
0941	Anterior interbody fusion: One level		360.00		288.00		3.00TM	
0942	Anterior interbody fusion: Each additional level	+	102.00		102.00		3.00TM	
0944	Posterior fusion: Occiput to C2		390.00		312.00		4.00TM	
0946	Posterior spinal fusion: Each additional level	+	111.00		111.00		3.00TM	
0948	Posterior interbody lumbar fusion: One level		364.00		291.20		3.00TM	
0950	Posterior interbody lumbar fusion: Each additional interspace	+	95.00		95.00		3.00TM	
0959	Excision of coccyx		96.00		96.00		3.00TM	
0961	Costo-transversectomy		198.00		158.40		3.00TM	
0963	Antero-lateral decompression of spinal cord or anterior debridement		326.00		260.80		3.00TM	
3.8.6	**Special areas: Spinal deformities**							
	Please note : Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).							
0952	Posterior fusion for spinal deformity: Up to 6 levels		359.00		287.20		3.00TM	
0954	Posterior fusion for spinal deformity: 7 to 12 levels		547.00		437.60		3.00TM	
0955	Posterior fusion for spinal deformity: 13 or more levels		593.00		474.40		3.00TM	
0956	Anterior fusion for spinal deformity: 2 or 3 levels		410.00		328.00		3.00TM	
0957	Anterior fusion for spinal deformity: 4 to 7 levels		444.00		355.20		3.00TM	
0958	Anterior fusion for spinal deformity: 8 or more levels		539.00		431.20		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3.8.7	**Special areas: All spinal problems**							
0943	Laminectomy with decompression of nerve roots and disc removal: One level		240.00		192.00		3.00TM	
0960	Posterior non-segmental instrumentation		167.00		133.60		5.00TM	
0962	Posterior segmental instrumentation: 2 to 6 vertebrae		176.00		140.80		5.00TM	
0964	Posterior segmental instrumentation: 7 to 12 vertebrae		201.00		160.80		5.00TM	
0966	Posterior segmental instrumentation:13 or more vertebrae		245.00		196.00		5.00TM	
0968	Anterior instrumentation: 2 to 3 vertebrae		159.00		127.20		5.00TM	
0969	Skull or skull-femoral traction including two weeks after-care		64.00		64.00			
0970	Anterior instrumentation: 4 to 7 vertebrae		185.00		148.00		5.00TM	
0971	Halo-splint and POP jacket including two weeks after-care		116.00		116.00			
0972	Anterior instrumentation: 8 or more vertebrae		206.00		164.80		5.00TM	
0974	Additional pelvic fixation of instrumentation other than sacrum		108.00		108.00		5.00TM	
5750	Reinsertion of instrumentation		276.00		220.80		6.00TM	
5751	Removal of posterior non-segmental instrumentation		173.00		138.40		6.00TM	
5752	Removal of posterior segmental instrumentation		175.00		140.00		6.00TM	
5753	Removal of anterior instrumentation		204.00		163.20		6.00TM	
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels		295.00		236.00		3.00TM	
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)		304.00		243.20		3.00TM	
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels		321.00		256.80		3.00TM	
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	+	63.00		63.00		3.00TM	
5759	Laminectomy for decompression diskectomy, etc. revision operation		352.00		281.60		3.00TM	
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level		301.00		240.80		3.00TM	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	+	68.00		68.00		3.00TM	
5763	Anterior disc removal and spinal decompression cervical: One level		344.00		275.20		3.00TM	
5764	Anterior disc removal and spinal decompression cervical: Each additional level	+	81.00		81.00		3.00TM	
5765	Vertebral corpectomy for spinal decompression: One level		466.00		372.80		3.00TM	
5766	Vertebral corpectomy for spinal decompression: Each additional level	+	88.00		88.00		3.00TM	
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)		71.00		71.00			
3.9	**Facial bone procedures**							
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9							
0987	Repair of orbital floor (blowout fracture)		184.60		147.68		4.00TM	
0988	Genioplasty		263.00		210.40		4.00TM	
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I		202.20		161.76		4.00TM	
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II		302.00		241.60		4.00TM	
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III		433.00		346.40		4.00TM	
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy		970.00		776.00		4.00TM	
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy		302.00		241.61		4.00TM	
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)		1103.00		882.40		4.00TM	
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)		1654.00		1323.20		4.00TM	
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement		*		*			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation		302.00		241.60		3.00TM	
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation		184.00		147.20		3.00TM	
0998	Excision mandible bone, e.g. osteomyelitis, abscess		219.30		175.44		3.00TM	
1000	Excision facial bone, e.g. osteomyelitis, abscess		144.30		120.00		5.00TM	
1001	Temporo-mandibular joint: Reconstruction for dysfunction		206.00		164.80		4.00TM	
1002	Harvesting: Bone for contouring of benign bony growths (e.g. fibrous dysplasia)		189.20		151.36		5.00TM	
1003	Manipulation: Immobilisation and follow-up of fractured nose		35.00		35.00		3.00TM	
1005	Nasal fracture without manipulation		*		*			
1006	Fracture: Nose and septum, open reduction		177.40		141.92		5.00TM	
1007	Mandibulectomy		320.00		256.00		5.00TM	
1008	Excision: Torus Mandibularis		84.10		84.10		5.00TM	
1009	Maxillectomy or excision zygoma for malignant tumours		396.80		317.44		5.00TM	
1010	Excision: Torus Palatinus		83.30		83.30		5.00TM	
1011	Bone graft to mandible		206.00		164.80		4.00TM	
1012	Adjustment of occlusion by ramisection		227.00		181.60		4.00TM	
1013	Fracture of arch of zygoma without displacement		*		*			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)		131.00		120.00		3.00TM	
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)		262.00		209.60		3.00TM	
4. Respiratory System								
1018	Flexible nasopharyngolaryngoscope examination		51.94		51.94			
1019	ENT endoscopy in rooms with rigid endoscope		12.00					
1020	Repair of perforated septum: Any method		141.90		120.00		4.00T	
1022	Functional reconstruction of nasal septum		121.20		120.00		4.00T	
1023	Harvesting of graft: Cartlage graft of nasal septum		124.80		120.01		5.00T	
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)		30.00		30.00		4.00T	
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)		64.60		64.60		4.00T	
1026	Biopsy: Intranasal		14.70		14.70		4.00T	
1027	Dacrocystorhinostomy		210.00		168.00		5.00T	
1028	Lysis: Intranasal synechia		21.60		21.60		5.00T	
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)		62.60		62.60		4.00T	
1030	Endoscopic turbinectomy: Laser or microdebrider		90.00		90.00		4.00T	
1031	Removal of single nasal polyp at rooms (at initial consultation only)		25.40		25.40			
1033	Removal of multiple polyps in hospital under general anaesthetic		81.80		81.80		4.00T	
1034	Autogenous nasal bone transplant: Bone removal included		100.00		100.00		4.00T	
1035	Functional endoscopic sinus surgery: Unilateral		140.00		120.00		4.00T	
1036	Functional endoscopic sinus surgery: Bilateral		245.00		196.00		4.00T	
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic		8.00		8.00			
1038	Hypophysectomy or excision of pituitary tumour: Transnasal/transseptal approach (total procedure)		461.40		369.12		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic		35.00		35.00		4.00T	
1040	Repair of CSF leak: Ethmoid region, transnasal endoscopic approach (Modifier 0069 not applicable)		343.50		274.80		5.00T	
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging		40.00		40.00		6.00T	
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach		365.50		292.40		5.00T	
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging		60.00		60.00		6.00T	
1044	Transnasal endoscopic decompression: Transnasal endoscopic optic nerve (Modifier 0069 does not apply)		368.30		294.64		5.00T	
1045	Ligation anterior ethmoidal artery		135.40		120.00		6.00T	
1047	Caldwell-Luc operation: Unilateral		137.30		120.00		4.00T	
1048	Endonasal frontal sinus drainage, with or without removal of tissue (Modifier 0069 not applicable)		152.20					
1049	Ligation internal maxillary artery		196.00		156.80		6.00T	
1050	Vidian neurectomy (transantral or transnasal)		113.00		113.00		4.00T	
1051	Removal nasopharyngeal fibroma		285.00		228.00		6.00T	
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic		50.00		50.00		4.00T	
1053	Frontal sinus drainage, trephine operation		93.10		93.10		4.00T	
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)		37.30					
1055	External frontal ethmoidectomy		190.70		152.56		4.00T	
1056	Craniofacial approach procedure: with exposure of the anterior cranial fossa to treat an extradural lesion/defect at the skull base which requires lateral rhinotomy, ethmoidectomy, sphenoidectomy; without maxillectomy or orbital exenteration (total procedure)		741.60		593.28		11.00T	
1057	External ethmoidectomy and/or sphenoidectomy		199.40		159.52		4.00T	
1058	Sublabial transseptal sphenoidotomy		137.00		120.00		4.00T	
1059	Frontal osteomyelitis		341.60		273.28		11.00T	
1060	Obliteration of frontal sinus		291.10		232.88		4.00T	
1061	Lateral rhinotomy		164.00		131.20		4.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1062	Excision nasolabial cyst		186.10		148.88		4.00T	
1063	Removal of foreign bodies from nose: At rooms		10.00		10.00		4.00T	
1065	Removal of foreign body from nose: Under general anaesthetic		38.60		38.60		4.00T	
1067	Proof puncture at rooms: Unilateral		10.00		10.00		4.00T	
1069	Proof puncture, uni- or bilateral under general anaesthetic		35.00		35.00		4.00T	
1071	Proetz treatment (consultation fee only to be charged for first treatment)		4.00		4.00			
1077	Septum abscess: At rooms, including after-care		8.00		8.00			
1079	Septum abscess: Under general anaesthetic		35.00		35.00			
1081	Oro-antral fistula (without Caldwell-Luc)		111.80		111.80		4.00T	
1083	Choanal atresia: Intranasal approach		113.00		113.00		5.00T	
1084	Choanal atresia: Transpalatal approach		194.00		155.20		7.00T	
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip		350.00		280.00		5.00T	
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction		210.00		168.00		5.00T	
1089	Forehead rhinoplasty (all stages): Total		552.00		441.60		5.00T	
1091	Forehead rhinoplasty (all stages): Partial		414.00		331.20		5.00T	
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft		138.00		120.00		5.00T	
1095	Full nasal reconstruction for secondary cleft lip deformity		357.90		286.32		5.00T	
1097	Partial nasal reconstruction for cleft lip deformity		199.70		159.76		5.00T	
1099	Columella reconstruction or lengthening		138.00		120.00		5.00T	
4890	Endoscopy: Sinus/nasal, with maxillary antrostomy		64.60		64.60		5.00T	
4891	Endoscopy: Sinus/nasal, with maxillary antrostomy and removal of tissue		103.00		103.00		5.00T	
4892	Endoscopy: Sinus/nasal, with partial anterior ethmoidectomy		91.20		91.20		5.00T	
4893	Endoscopy: Sinus/nasal, with medial or inferior orital wall decompression		280.60		224.48		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision		214.10		179.28		7.00T	
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision		291.10		232.88		7.00T	
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision		275.10		220.08		7.00T	
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision		291.10		232.88		7.00T	
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision		245.70		196.56		7.00T	
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision		244.30		195.44		7.00T	
4.2	**Throat**							
1101	Tonsillectomy (dissection of the tonsils)		75.00		75.00		4.00T	
1102	Laser tonsillectomy		75.00		75.00		6.00T	
1105	Removal of adenoids		40.00		40.00		4.00T	
1100	Control of oropharyngeal haemorrhage with secondary surgical intervention, primary or secondary (e.g. post tonsillectomy)		136.80		136.80		10.00T	
1103	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, without closure.		165.70		132.56		7.00T	
1104	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, with local flap closure.		266.70		213.36		7.00T	
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)		168.30		134.64		5.00T	
1107	Opening of quinsy: At rooms		12.00		12.00		6.00T	
1108	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser): Follow-up operation performed by the same surgeon		85.00		85.00		5.00T	
1109	Opening of quinsy: Under general anaesthetic		35.00		35.00		6.00T	
1110	Ludwig's Angina: Drainage		42.00		42.00		9.00T	
1111	Post tonsillectomy or adenoidectomy haemorrhage		46.00		46.00		6.00T	
1096	Removal of foreign body: Pharynx		40.50		40.50		5.00T	
1112	Pharyngeal pouch operation		231.80		185.44		5.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1098	Resection: Lateral pharyngeal wall or pyriform sinus, closure by advancement of lateral and posterio pharangeal walls		286.90		229.52		6.00T	
1113	Retropharyngeal abscess: Internal approach		35.00		35.00		6.00T	
1115	Retropharyngeal abscess: External approach		85.00		85.00		6.00T	
1114	Pharyngectomy: Partial		237.90		190.32		7.00T	
1116	Functional reconstruction of palate and uvula		168.30		134.64		5.00T	
4.3	**Larynx**							
1117	Laryngeal intubation		10.00		10.00			
1120	Intubation, endotracheal, emergency procedure		34.00		34.00			
1118	Laryngeal stroboscopy with video capture		39.00		39.00		6.00T	
1121	Stroboscopy - equipment cost		100.00		100.00			
1122	Laryngeal function studies		11.60		11.60			
1119	Laryngectomy without block dissection of the neck		430.00		344.00		7.00T	
4904	Laryngectomy: Total, with radical neck dissection		508.70		406.96		7.00T	
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection		434.80		347.84		7.00T	
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection		563.20		450.56		7.00T	
4907	Laryngectomy: Hemilaryngectomy, horisontal		429.70		343.76		7.00T	
4908	Laryngectomy: Hemilaryngectomy, laterovertical		391.00		312.80		7.00T	
4909	Laryngectomy: Hemilaryngectomy, anterovertical		405.10		324.08		7.00T	
4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical		414.20		331.36		7.00T	
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)		35.00					
1124	Arytenoidectomy/arytenoidopexy: External approach		115.70		115.70		8.00T	
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)		81.10		81.10		6.00T	
1126	Post laryngectomy for voice restoration		139.50		120.00		9.00T	
1127	Tracheotomy		90.00		90.00		9.00T	
1128	Endolaryngeal operations		75.00		75.00		8.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure		294.40		235.52		8.00T	
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)		41.40		41.40		6.00T	
1131	Direct laryngoscopy plus foreign body removal		64.60		64.60		6.00T	
4913	Pharyngolaryngectomy: with radical neck dissection, without reconstruction		571.10		456.88		7.00T	
4914	Pharyngolaryngectomy: with radical neck dissection, with reconstruction		667.50		534.00		7.00T	
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal		275.60		220.48		8.00T	
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy		427.60		342.08		9.00T	
4918	Laryngoplasty: Open reduction of fracture		367.20		293.76		8.00T	
4919	Laryngoplasty: Cricoid split		230.30		184.24		8.00T	
4922	Tracheostoma: Revision, without flap rotation, simple		102.40		102.40		9.00T	
4923	Tracheostoma: Revision, with flap rotation, complex		167.30		133.84		9.00T	
4926	Tracheostomy: Fenestration with skin flaps		180.40		144.32		9.00T	
4927	Tracheostomy: Revision of scar		104.50		104.50		9.00T	
4928	Tracheostomy/fistula: Closure, without plastic repair		104.50		104.50		9.00T	
4929	Tracheostomy/fistula: Closure, with plastic repair		149.80		120.00		9.00T	
4932	Tracheobronchoscopy: Through established tracheostomy incision		37.70		37.70		6.00T	
4933	Tracheoplasty: Cervical		260.10		208.08		8.00T	
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage		329.00		263.20		8.00T	
4.4	**Bronchial procedures**							
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy							
1132	Bronchoscopy: Diagnostic bronchoscopy		65.00		65.00		6.00T	
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body		80.00		80.00		8.00T	
1134	Bronchoscopy: Bronchoscopy with laser		75.00				8.00T	
1136	Nebulisation in rooms (inhalants not included)		12.00		12.00		12.00c	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1137	Bronchial lavage						8.00T	
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)		350.00		280.00		12.00T	
4.5	**Pleura**							
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)		50.00		50.00		3.00T	
1141	Insertion of intercostal catheter (under water drainage)		50.00		50.00		6.00T	
1142	Intra-pleural block		36.00		36.00		36.00c	
1143	Paracentesis chest: Diagnostic		8.00		8.00		3.00T	
1145	Paracentesis chest: Therapeutic		13.00		13.00		3.00T	
1147	Pneumothorax: Induction (diagnostic)		25.00		25.00			
1149	Pleurectomy		250.00		200.00		11.00T	
1151	Decortication of lung		350.00		280.00		11.00T	
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)		55.00		55.00		3.00T	
4.6	**Pulmonary procedures**							
4.6.1	**Pulmonary procedures: Surgical**							
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)		32.00		32.00		5.00T	
1157	Pneumonectomy		350.00		280.00		11.00T	
1159	Pulmonary lobectomy		389.50		311.60		11.00T	
1161	Segmental lobectomy		365.00		292.00		11.00T	
1163	Excision tracheal stenosis: Cervical		375.00		300.00		8.00T	
1164	Excision tracheal stenosis: Intra thoracic		350.00		280.00		12.00T	
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks		215.00		172.00		12.00T	
1168	Thoracoplasty: Complete		250.00		200.00		11.00T	
1169	Thoracoplasty: Limited (osteoplastic)		200.00		160.00		11.00T	
1171	Drainage empyema (including six weeks after treatment)		170.00		136.00		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1173	Drainage of lung abscess (including six weeks after treatment)		170.00		136.00		11.00T	
1175	Thoracotomy (limited): For lung or pleural biopsy		115.00		115.00		11.00T	
1177	Major: Diagnostic, as for inoperable carcinoma		215.00		172.00		11.00T	
1179	Thoracoscopy		89.00		89.00		11.00T	
1181	Lung transplant: Unilateral		600.00		480.00		15.00T	
1182	Harvesting donor lung: Unilateral		120.00		120.00		5.00T	
1183	Excision or plication of emphysematous cyst: Unilateral		250.00		200.00		11.00T	
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)		438.00		350.40		11.00T	
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence		100.00		100.00		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4.6.2	**Pulmonary function tests**							
1186	Flow volume test: Inspiration/expiration		30.00		30.00		30.00c	
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation - thereafter item 1186 applies)		50.00		50.00		50.00c	
1187	Exhaled nitric oxide detemination (not to children under 4 years of age)		6.10		6.10			
1189	Forced expirogram only		10.00		10.00		10.00c	
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry		45.31					
1191	N2 single breath distribution		10.00		10.00		10.00c	
1192	Peak expiratory flow only		5.00		5.00		5.00c	
1197	Compliance and resistance, using oesophageal balloon		24.00		24.00		24.00c	
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry		55.89		55.89			
1199	Pulmonary stress testing: For determination of VO2 max		96.50		96.50			
1201	Maximum inspiratory/expiratory pressure		5.00		5.00		5.00c	
4.6.2.2	**Pulmonary function tests: Specialised services**							
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method		37.76					
1195	Thoracic gas volume		37.93					
1196	Determination of resistance to airflow, oscillary or plethysmographic methods		45.31					
1200	Carbon monoxide diffusing capacity, any method		38.06					

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4.7	**Intensive care (In Intensive Care or High Care Unit): Respiratory, Cardiac, General.**							
4.7.1	**Intensive Care: Neonatal procedures**							
1202	Insertion of central venous catheter via peripheral vein in neonates		40.00		40.00		40.00c	
4.7.2	**Intensive care: Items for Intensive Care:**							
	NOTE: when these procedures are performed by an anaesthesiologist, he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.							
4.7.2.1	**Intensive care: Category 1: Intensive Monitoring**							
1204	Intensive care: Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per calendar day		30.00		30.00		30.00c	
4.7.2.2	**Intensive care: Category 2: Active system support**							
	Please note: Doctors must please discuss amongst themselves who will be recognised as the principle doctor in each case. The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109							
1205	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): First day		100.00		100.00		100.00c	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1206	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): Subsequent days, per calendar day		50.00		50.00		50.00c	
1207	Intensive care: Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): After two weeks, per calendar day		30.00		30.00		30.00c	
4.7.2.3	**Intensive care: Category 3: Multiple Organ Failure**							
1208	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary medical doctor)		137.00		120.00		137.00c	
1209	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved medical doctor)		58.00		58.00		58.00	
1210	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)		50.00		50.00		50.00c	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4.7.3	**Intensive care: Procedures**							
	NOTE: when these procedures are performed by an anaesthesiologist, he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.							
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) - 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150.00 clinical procedure units per doctor. Resuscitation units includes all necessary addsional procedures, e.g. infusion, intubation, etc.							
1212	Ventilation: First day		75.00		75.00		75.00c	
1213	Ventilation: Subsequent days, per calendar day		50.00		50.00		50.00c	
1214	Ventilation: After two weeks, per calendar day		25.00		25.00		25.00c	
1215	Insertion of arterial pressure cannula		25.00		25.00		25.00c	
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring		50.00		50.00		50.00c	
1217	Insertion of central venous line via peripheral vein		10.00		10.00		10.00c	
1218	Insertion of central venous line via subclavian or jugular veins		25.00		25.00		25.00c	
1219	Hyperalimentation (daily tariff)		15.00		15.00		15.00c	
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)		30.00		30.00		30.00c	
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)		30.00		30.00		30.00c	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4.8	**Hyperbaric Oxygen Therapy**							
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic). b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias. f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis. i. Bone and soft tissue radiation necrosis. j. Compromised skin grafts and flaps. k. Acute thermal burns. l. Acute bloodloss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia).							
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT		30.00		30.00			
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT		101.13		101.13			
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Routine HBO table (2-2,5 ATA x 90-120 min): PROFESSIONAL COMPONENT		60.00		60.00			
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT		131.26		131.26			
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Emergency HBO table (2,5-3 ATA x 90-120 min): PROFESSIONAL COMPONENT		80.00		80.00			
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT		131.26		131.26			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT5 (2,8 ATA x 135 min): PROFESSIONAL COMPONENT		90.00		90.00			
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT		214.18		214.18			
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6 (2,8 ATA x 285 min): PROFESSIONAL COMPONENT		190.00		190.00			
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT		386.42		386.42			
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min): PROFESSIONAL COMPONENT		327.00		327.00			
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		680.85		680.85			
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		678.28		678.28			
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		671.85		671.85			
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour: Minimum 40,00 clinical procedure units; maximum 320,00 clinical pro							
5. Mediastinal Procedures								
1222	Mediastinal tumours		285.00		228.00		11.00T	
1223	Mediastinoscopy		95.00		95.00		5.00T	
1224	Mediastinotomy		115.00		115.00		11.00T	
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs		350.00		280.00		11.00T	
1226	Removal of single rib with a lesion		282.00		225.60		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6. Cardiovascular System								
6.1	**Cardiovascular system: General**							
1227	Prolonged neonatal resuscitation		20.00		20.00		20.00	
	NOTE: Items 1228 and 1229 professional component for performing of the ECG. The consultation/visit item should be added.							
1228	General Practitioner's professional component for performing an ECG only: Without effort: ½ (item 1232)				4.50			
1229	General Practitioner's professional component for performing an ECG only: Without and with effort: ½ (item 1233)				6.50			
	NOTE: Professional component for a physician interpreting an ECG (items 1230 and 1231) : A specialist physician is entitled to the following items for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him/her for interpretation.							
1230	Professional component for a physician interpreting an ECG: without effort.		6.00					
1231	Professional component for a physician interpreting an ECG: With and without effort.		10.00					
1232	Electrocardiogram: Without effort (Interpretation included)		9.00		9.00			
1233	Electrocardiogram: With and without effort (Interpretation included)		13.00		13.00			
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus (nterpretation included)		40.00		40.00			
1235	Multi-stage treadmill test (Interpretation included)		60.00		60.00			
1236	Electrocardiogram without effort: Under 4 years old (Interpretation included)		18.00		18.00			
1237	24 Hour ambulatory blood pressure: Hire fee		30.00		30.00			
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee		55.00		55.00			
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation		27.00		27.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1240	Signal averaged electrocardiogram		80.00		80.00			
1241	X-ray Screening: Chest		4.00		4.00			
1242	X-ray screening: Prosthetic valves		10.00		10.00			
1243	Two week event triggered ambulatory ECG monitoring: Equipment hire		55.00		55.00			
1244	Two week event triggered ambulatory ECG monitoring: Interpretation		25.00		25.00			
1245	Angiography cerebral: First two series		34.30		34.30		4.00T	
1246	Angiography peripheral: Per limb		25.00		25.00		4.00T	
1247	Cardioversion for arrhythmias (any method) with doctor in attendance		65.00		65.00		6.00T	
1248	Paracentesis of pericardium		50.00		50.00		9.00T	
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing		51.00		51.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.2	**Invasive Cardiology**							
6.2.1	**Invasive cardiology: Cardiac catheterisation**							
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)		140.00				9.00T	
1250	Endomyocardial biopsy		70.00		70.00		9.00T	
1251	Transeptal puncture		70.00		70.00		9.00T	
1252	Left heart catheterisation with coronary angiography (with or without biopsy)		140.00				9.00T	
1253	Right heart catheterisation (with or without biopsy)		70.00				9.00T	
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts		40.00		40.00		9.00T	
1255	Tilt test							
6.2.2	**Invasive cardiology: Electrophysiological study**							
1256	Ventricular stimulation study		160.00				9.00T	
1257	Full electrophysiological study		300.00				9.00T	
1262	Electrophysiological mapping		500.00		400.00			
6.2.3	**Invasive cardiology: Pacemakers**							
1258	Pacemaker: Permanent - single chamber		155.00		124.00		9.00T	
1259	Pacemaker: Permanent - dual chamber		230.00		184.00		9.00T	
1272	Coronary sinus lead imlantation (add to either item 1258: Pacemaker: Permanent - single chamber or item 1259: Pacemaker: Permanent - dual chamber)	+	120.60		120.00		4.00T	
1260	AV nodal ablation		300.00		240.00		9.00T	
1261	Accessory pathway ablation		600.00		480.00		9.00T	
1263	Insertion transvenous implantable defibrillator		212.00		169.60		15.00T	
1264	Test for implantable transvenous defibrillator		120.00		120.00		15.00T	
1265	Renewal of pacemaker/pulse generator/neurostimulator unit only, team fee		125.00		120.00		9.00T	
1266	Resiting pacemaker generator		80.00		80.00			
1267	Repositioning of catheter electrode		50.00		50.00		9.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1268	Threshold testing: Own equipment		15.00					
1269	Threshold testing: Hospital equipment		11.00					
1270	Programming of atrio-ventricular sequential pacemaker		50.00		50.00			
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)		120.00		120.00		9.00T	
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer		200.00		160.00		9.00T	
1296	Fractional flow reserve (FFR): First vessel (add on code)	+	28.00		28.00			
1298	Fractional flow reserve (FFR): Each addisional vessel (add on code)	+	22.40		22.40			
1300	Renal denervation (RDN), per artery, (Modifier 0005 applicable)		223.00		178.40			
6.2.4	**Invasive cardiology: Percutaneous translumical angioplasty**							
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion		260.00		208.00		13.00T	
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion		140.00		120.00		13.00T	
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion		60.00		60.00		13.00T	
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion		40.00		40.00		13.00T	
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)		60.00		60.00		13.00T	
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)		40.00		40.00		13.00T	
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty		260.00		208.00		15.00T	
1283	Use of balloon procedure as in item 1282: Second cardiologist		140.00		120.00		15.00T	
1284	Atherectomy: Single lesion: First cardiologist		300.00		240.00			
1285	Atherectomy: Single lesion: Second cardiologist		180.00		144.00			
1286	Insertion of intravascular stent: First cardiologist		100.00		100.00			
1287	Insertion of intravascular stent: Second cardiologist		50.00		50.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1290	Use of balloon procedures including: First paediatric cardiologist (33): Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty; Closure atrial septal defect; Closure of patient ductus							
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)							
6.2.5	**Invasive cardiology: Paediatric cardiac catheterisation**							
1288	Cardiac catheterisation for congenital heart disease: All ages above 1 year old		210.00		168.00		12.00T	
1289	Paediatric cardiac catheterisation: Infants below the age of one year		263.00		210.40		12.00T	
5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation - PROFESSIONAL COMPONENT (Refer to item 5934 for calculation of own equipment cost)		61.90					
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal - PROFESSIONAL COMPONENT (Refer to item 5934 for calculation of own equipment cost)		84.00					
5961	Balloon angioplasty: pulmonary, mitral valve or tricuspid valve		437.70				10.00T	
5962	Balloon angioplasty: aortic valve (congenital aortic stenosis)		424.10				10.00T	
5963	Balloon angioplasty: pulmonary, artery branches: First Vessel		202.00				10.00T	
5964	Balloon angioplasty: pulmonary artery brances: subsequent vessels (per vessel)	+	101.60				10.00T	
5965	Balloon angioplasty: aorta for congenital lesion/coarctation		629.70				10.00T	
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, Systemic vein): First vessel		451.40				5.00T	
5967	Balloon angioplasty, collateral vessel (incl MAPCA): Subsequent vessels (per vessel)	+	122.85				5.00T	
5968	Balloon angioplasty: venous system (IVC, SVC, Systemic vein)		451.40				5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		451.40				5.00T	
5970	Cutting balloon angioplasty, cardiovascular structure: subsequent vessels (per vessel)	+	112.85				5.00T	
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		132.52				6.00T	
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)	+	81.49				6.00T	
5974	Stent placement,branch pulmonary artery: First vessel		132.52				6.00T	
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)	+	76.98				6.00T	
5976	Stent placement coarctation of the aorta		132.52				6.00T	
5980	Stent patent ductus arteriosus and interatrial communication		132.52				6.00T	
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		132.52				6.00T	
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		310.80				10.00T	
5986	VSD closure, percutaneous, device placement		412.40				10.00T	
5987	PFO closure with device		310.80				10.00T	
5989	PDA closure-coil or ductal device		276.50				6.00T	
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		276.50				6.00T	
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		276.50				6.00T	
5992	Closure interatrial communication (Fontan fenestration etc)		310.80				10.00T	
5995	Rapid right ventricular pacing for percutaneous procedure		51.00				10.00T	
5996	Removal of embolised device/materials		80.60				6.00T	
5998	Biopsy: Endomyocardial		236.10				7.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.3	**Cardiac surgery**							
1294	Patent ductus arteriosus		320.00		256.00		13.00T	
1295	Pericardiectomy for constrictive pericarditis		400.00		320.00		15.00T	
1297	Coarctation of aorta		425.00		340.00		15.00T	
1299	Systemo-pulmonary anastomosis		425.00		340.00		15.00T	
1301	Mitral valvotomy: Closed heart technique		350.00		280.00		15.00T	
1302	Heart transplant		875.00		700.00		15.00T	
1303	Harvesting donor heart		75.00		75.00		5.00T	
1305	Operative implantation of cardiac pacemaker by thoracotomy		220.00		176.00		15.00T	
1307	Re-exploration after cardiac surgery		215.00		172.00		15.00T	
1308	Heart and lung transplant		1000.00		800.00		15.00T	
1309	Harvesting donor heart and lungs		120.00		120.00		5.00T	
1311	Pericardial drainage		140.00		120.00		13.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.3.1	**Cardiac surgery: Open heart surgery**							
1312	Evaluation of coronary angiogram by cardiothoracic surgeon		25.00					
1320	Repeat open heart surgery (additional fee above procedure fee)		250.00		200.00		15.00T	
1321	Stand-by fee for coronary angioplasty		30.00		30.00		30.00c	
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour		20.00					
6.3.1.1	**Cardiac surgery: Open heart surgery: Congenital conditions**							
1323	Atrial septal defect: Osteum secundum		500.00		400.00		15.00T	
1325	Atrial septal defect: Sinus venosus or osteum primum		563.00		450.40		15.00T	
1327	Atrial septal defect: Ventricular septal defect		603.80		483.04		15.00T	
1329	Atrial septal defect: Fallot's tetralogy		563.00		450.40		15.00T	
1330	Atrial septal defect: Pulmonary stenosis		500.00		400.00		15.00T	
1331	Transposition of large vessels (venous repair)		563.00		450.40		15.00T	
1332	Transposition of great arteries (arterial repair)		750.00		600.00		15.00T	
1333	Ebstein's Anomaly		563.00		450.40		15.00T	
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)		548.80		439.04		20,00T	
1335	Total anomalous venous drainage		563.00		450.40		15.00T	
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)		658.90		527.12		20.00T	
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass		500.00		400.00		15.00T	
1338	Fontan type repair		750.00		600.00		15.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.3.1.2	**Cardiac surgery: Open heart surgery: Acquired conditions**							
1360	Closure: Left atrial appendage (LAA)		828.00		662.40			
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		397.50		318.000			
1339	Mitral valve replacement		657.00		525.60		15.00T	
1340	Mitral valvuloplasty		688.00		550.40		15.00T	
1341	Aortic valve replacement		623.80		499.04		15.00T	
1342	Tricuspid annulo plasty		188.00		150.40		15.00T	
1343	Double valve replacement		968.90		775.12		15.00T	
1344	Acute dissecting aneurysm repair		750.00		600.00		15.00T	
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest		1000.00		800.00		15.00T	
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)		100.00		100			
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)		175.00		140.00			
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins		750.00		600.00		15.00T	
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery		781.00		624.80		15.00T	
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery		813.00		650.40		15.00T	
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm		875.00		700.00		15.00T	
1352	Cardiac aneurysm		563.00		450.40		15.00T	
1353	Ascending/descending thoracic aortic aneurysm repair		625.00		500.00		15.00T	
1354	Arrhythmia surgery		688.00		550.40		15.00T	
1355	Cardiac tumour		625.00		500.00		15.00T	
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)		188.00		150.40		15.00T	
1358	Harvesting of radial artery		175.00		140.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.4	**Peripheral vascular system**							
6.4.1	**Peripheral vascular system: Investigations**							
1357	Skin temperature test: Response to reflex heating		15.00		15.00			
1359	Skin temperature test: Response to reflex cooling		15.00		15.00			
1361	Cold sensitivity test		17.00		17.00			
1363	Oscillometry test		5.00		5.00			
1365	Sweating test		17.00		17.00			
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site		26.30		26.30			
1367	Doppler blood tests		6.00		6.00			
5369	Doppler arterial pressures		6.00		6.00			
5371	Doppler arterial pressures with exercise		10.00		10.00			
5373	Doppler segmental pressures and wave forms		12.00		12.00			
5375	Venous doppler examination (both limbs)		9.00		9.00			
5377	Venous plethysmography		16.00		16.00			
5379	Supra-orbital doppler test		5.00		5.00			
5381	Carotid non-invasive complex tests		39.00		39.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6.4.2	**Peripheral vascular system: Arterio-venous abnormalities**							
1369	Fistula or aneurysm (as for grafting of various arteries)							
6.4.3	**Arteries**							
6.4.3.1	**Peripheral vascular system: Arteries: Aorta-iliac and major branches**							
1372	Abdominal aorta and iliac artery: Unruptured		540.00		432.00		15.00T	
1373	Abdominal aorta and iliac artery: Ruptured		600.00		480.00		15.00T	
1375	Grafting and/or thrombo-endarterectomy for thrombosis		444.00		355.20		15.00T	
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis		594.00		475.20		15.00T	
6.4.3.2	**Peripheral vascular system: Arteries: Iliac artery**							
1379	Prosthetic grafting and/or thrombo-endarterectomy		300.00		240.00		13.00T	
6.4.3.3	**Peripheral vascular system: Arteries: Peripheral**							
1385	Prosthetic grafting		255.00		204.00		5.00T	
1387	Vein grafting proximal to knee joint		300.00		240.00		5.00T	
1388	Vein grafting distal to knee joint		444.00		355.20		5.00T	
1389	Endarterectomy when not part of another specified procedure		264.00		211.20		5.00T	
1390	Carotid endarterectomy		321.00		256.80		15.00T	
1393	Embolectomy: Peripheral embolectomy transfemoral		168.00		134.40		5.00T	
1395	Miscellaneous arterial procedures: Arterial suture: Trauma		125.00		100.00		5.00T	
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included bec		264.00		211.20		15.00T	
1397	Profundoplasty		210.00		168.00		5.00T	
1399	Distal tibial (ankle region)		456.00		364.80		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1401	Femoro-femoral		254.00		203.20		5.00T	
1402	Carotid-subclavian		288.00		230.40		8.00T	
1403	Axillo-femoral: (Bifemoral + 50%of the units)		288.00		230.40		8.00T	
6.4.4	**Peripheral vascular system: Veins**							
1407	Ligation of saphenous vein		50.00		50.00		3.00T	
1408	Placement of Hickman catheter or similar		91.00		91.00		4.00T	
1410	Litigation of inferior vena cava: Abdominal		180.00		144.00		8.00T	
1412	Umbrella operation on inferior vena cava: Abdominal		100.00		100.00		8.00T	
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral		141.00		120.00		3.00T	
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral		247.00		197.60		3.00T	
1417	Extensive sub-fascial ligation of perforating veins		125.00		120.00		3.00T	
1419	Lesser varicose vein procedures		31.00		31.00		3.00T	
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9) injections per leg (excluding cost of material)		9.00		9.00			
1422	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: First vein		96.20		96.20		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1424	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: subsequent veins (Modifier 0005 is not applicable)		47.00		47.00		5.00T	
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)		240.00		192.00		11.00T	
1427	Thrombectomy: Illio-femoral		175.00		140.00		6.00T	
6.4.5	**Peripheral vascular system: Portal hypertension**							
1429	Porto-caval shunt		500.00		400.00		11.00T	
6.5	**Cardiac rehabilitation**							
1431	Cardiac rehabilitation: Phase II: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 5 patients per group		12.00		12.00			
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group		6.00		6.00			
	Please note: a. A practitioner is only allowed to instruct one group at a time. b. Benefits are limited to 3 times per week for a period of 60 minutes with a maximum of 3 months.							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
7. Lympho Reticular System								
7.1	**Spleen**							
1435	Splenectomy (in all cases)		221.30		177.04		9.00T	
1436	Splenorrhaphy		231.80		185.44		9.00T	
7.2	**Lymph nodes and lymphatic channels**							
1439	Excision of lymph node for biopsy: Neck or axilla		65.00		65.00		4.00T	
1441	Excision of lymph node for biopsy: Groin		65.00		65.00		3.00T	
1442	Lymphadenectomy: Modified radical neck dissection, cervical		310.50		248.40		5.00T	
1443	Simple excision of lymph nodes for tuberculosis		91.00		91.00		3.00T	
1445	Radical excision of lymph nodes of neck: Total: Unilateral		315.00		252.00		5.00T	
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral		235.00		188.00		5.00T	
1449	Radical excision of lymph nodes of axilla		160.00		128.00		4.00T	
1451	Radical excision of lymph nodes of groin: Ilio-inguinal		175.00		140.00		4.00T	
1453	Radical excision of lymph nodes of groin: Inguinal		150.00		120.00		4.00T	
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes (Histology to be provided) - stand alone procedure		275.00		220.00		6.00T	
1459	Staging laparotomy for lymphoma (including splenectomy		245.00		196.00		7.00T	
1460	Sentinel lymph node(s): Intra-operative identification; INCLUDES injection of non-radioactive dye, when performed	+	40.40		40.40			
7.3	**Bone marrow and stem cell transplantation and harvesting.**							
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells		58.00		58.00		5.00T	
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)		39.00		39.00		5.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis		42.00		42.00		5.00T	
1457	Bone marrow biopsy: By trephine		13.00		13.00		3.00T	
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula		8.00		8.00			
1437	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic donor lymphocyte infusions - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		28.10		28.10			
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		36.90		36.90			
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		36.80		36.80			
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		23.50		23.50			
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		23.80		23.80			
1448	Bone marrow harvesting for transplant - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		101.00		101.00		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
8. Digestive System								
8.1	**Oral cavity**							
1461	All dental procedures						4.00T	
1463	Surgical biopsy of tongue or palate: Under general anaesthetic		35.00		35.00		4.00T	
1465	Surgical biopsy of tongue or palate: Under local anaesthetic		15.00		15.00		4.00T	
1467	Drainage of intra-oral abscess		31.00		31.00		4.00T	
1469	Local excision of mucosal lesion of oral cavity		23.00		23.00		4.00T	
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure		549.00		439.20		7.00T	
1473	Complicated reconstruction following major ablative procedure for head and neck cancer						7.00T	
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty		215.00		172.00		6.00T	
1477	Cleft palate: Secondary repair		174.20		139.36		6.00T	
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)		240.00		192.00		6.00T	
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)		227.00		181.60		6.00T	
1480	Repair of oronasal fistula (large) e.g. distant flap		227.00		181.60		6.00T	
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage		138.00		120.00		5.00T	
1482	Repair of oronasal fistula (large): Second stage		138.00		120.00		5.00T	
1483	Alveolar periosteal or other flaps for arch closure		138.00		120.00		4.00T	
1486	Closure of anterior nasal floor		138.00		120.00		5.00T	
1462	Removal of embedded foreign body: Vestibule of mouth, simple		41.10		41.10		5.00T	
1464	Removal of embedded foreign body: Vestibule of mouth, complicated		73.10		73.10		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1466	Removal of embedded foreign body: Dentoalveolar structures, soft tissues		52.80		52.80		5.00T	
8.2	**Lips**							
1484	Cleft lip repair: Lip adhesion (cleft lip)		95.00		95.00		5.00T	
1485	Local excision of benign lesion of lip							
1487	Resection for lip malignancy		91.00		91.00		4.00T	
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)		227.00		181.60		5.00T	
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages		251.60		201.28		5.00T	
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage		329.90		263.92		5.00T	
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage		227.00		181.60		5.00T	
1493	Cleft lip repair: Total revision of secondary cleft lip deformities		251.60		201.28		5.00T	
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity		91.00		91.00		5.00T	
1495	Abbé or Estlander type flap (all stages included)		273.10		218.48		5.00T	
1497	Vermilionectomy		94.90		94.90		4.00T	
1499	Lip reconstruction following an injury: Direct repair		105.60		105.60		4.00T	
1501	Lip reconstruction following an injury or tumour removal: Flap repair		206.00		164.80		4.00T	
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)		206.00		164.80		4.00T	
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)		104.00		104.00		4.00T	
8.3	**Tongue**							
1505	Partial glossectomy		225.00		180.00		6.00T	
1507	Local excision of lesion of tongue		27.00		27.00		4.00T	
8.4	**Palate, uvula and salivary glands**							
1509	Wide excision of lesion of palate		100.00		100.00		5.00T	
1511	Radical resection of palate (including skin graft)		250.00		200.00		7.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1513	Excision of ranula		85.60		85.60		5.00T	
1515	Excision of sublingual salivary gland		120.00		120.00		4.00T	
1517	Excision of submandibular salivary gland		146.00		120.00		4.00T	
1519	Excision of submandibular salivary gland with suprahyoid dissection		150.00		120.00		5.00T	
1521	Excision of submandibular salivary gland: With radical neck dissection		352.00		281.60		6.00T	
1523	Local resection of parotid tumour		169.60		135.68		5.00T	
1525	Partial parotidectomy		310.00		248.00		5.00T	
1526	Total parotidectomy with preservation of facial nerve		358.50		286.80		5.00T	
1527	Total parotidectomy		358.50		286.80		5.00T	
1529	Parotidectomy: Extracapsular		300.00		240.00		5.00T	
1531	Drainage of parotid abscess		25.00		25.00		4.00T	
1533	Closure of salivary fistula		91.00		91.00		4.00T	
1535	Dilatation of salivary duct		10.00		10.00		4.00T	
1537	Operative removal of salivary calculus		55.00		55.00		4.00T	
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated		58.50		58.50		5.00T	
1539	Salivary duct: Meatotomy		20.00		20.00		5.00T	
1541	Branchial cyst and/or fistula: Excision		140.00		120.00		5.00T	
1543	Excision of cystic hygroma		140.00		120.00		5.00T	
1544	Ludwig's Angina: Drainage		42.00		42.00		9.00T	
8.5	**Oesophagus**							
1545	Oesophagoscopy with rigid instrument: First and subsequent		47.00		47.00		4.00T	
1549	Oesophagoscopy with dilatation of stricture		70.00		70.00		4.00T	
1550	Oesophagoscopy with removal of foreign body		70.00		70.00		4.00T	
1551	Oesophagoscopy with insertion of indwelling oesophageal tube		80.00		80.00		4.00T	
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)		80.00		80.00		4.00T	
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)		65.00		65.00		4.00T	
1554	Per-oral small bowel biopsy							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1555	Repair of tracheal oesophageal fistula and oesophageal atresia		400.00		320.00		15.00T	
1557	Oesophageal dilatation		40.00		40.00		4.00T	
1559	Oesophagectomy: Two stage		500.00		400.00		11.00T	
1560	Oesophagectomy: Three stage		550.00		440.00		11.00T	
1561	Thoraco-abdominal oesophagogastrectomy		500.00		400.00		11.00T	
1562	Plus endoscopic therapy for gastro-oesophageal reflux or Barrett's oesophagus (by radiofrequency,implantation or endoscopic plication): ADD to upper gastrointestinal endoscopy (item 1587)(accessories and hire of generator additional)	+	80.60		80.60		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure		243.10		194.48		11.00T	
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure		350.00		280.00		11.00T	
1566	Private fee: Gastroplasty		325.00		260.00		8.00T	
1567	Bochdalek hernia repair in newborn		250.00		200.00		14.00T	
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair		375.00		300.00		11.00T	
1569	Oesophagomyotomy: Laparotomy, with fundoplication if performed (Heller type procedure)		280.80		224.64		7.00T	
1575	Insertion of indwelling oesophageal tube by laparotomy		142.00		120.00		6.00T	
1578	Anorectal manometry and physiological assessment		100.00		100.00		4.00T	
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach		400.00		320.00		11.00T	
1580	Oesophageal manometry 4-6 channel		110.00		110.00		4.00T	
1581	Removal of benign oesophageal tumours		285.00		228.00		11.00T	
1582	Advanced oesophageal function assessment (impedance or provocative test or high definition 3D rendering)		150.00		120.00		4.00T	
1583	Excision of intrathoracic oesophageal diverticulum		250.00		200.00		11.00T	
1584	Ambulatory oesophageal or gastric pH or bile or impedance studies: Hire cost (item 0201 applicable for disposable or semi-disposable devices)		55.00		55.00			
1585	Ambulatory oesophageal or gastric pH or bile or impedance studies: Interpretation		27.00		27.00			
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		357.10		258.68		7.00T	
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic (Item 1807 may not be added to this item.)		314.70		251.76		7.00T	
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): ADD to major procedure (modifier 0005 does not apply)		48.30		48.30		7.00T	
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		348.20		278.56		7.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		378.10		302.48		7.00T	
5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		382.20		305.76		15.00T	
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		411.80		329.44		15.00T	
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracoabdominal approach (not applicable to neonatal surgery)		451.20		360.96		15.00T	
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		492.50		394.00		15.00T	
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery) (item 1807 may not be added to this item)		463.60		370.88		7.00T	
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery) (item 1807 may not be added to this item)		520.90		416.72		7.00T	
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure) (item 1807 may not be added to this item)		377.70		302.16		7.00T	
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		313.10		250.48		15.00T	
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		389.80		311.84		7.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
8.6	**Stomach**							
1587	Upper gastro-intestinal endoscopy with hospital equipment (including biopsy) (refer to Modifier 0074 for use of own equipment)		48.75		48.75		4.00T	
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587) or small bowel endoscopy (item 1626) as appropriate, per lesion)	+	25.00		25.00		4.00T	
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy devices (endoscopic haemostasis): ADD to gastroscopy (item 1587),small bowel endoscopy (item 1626) or colonoscopy (item 1653 or item 1656)	+	34.00		34.00		6.00T	
1591	Plus removal of foreign bodies (stomach or small bowel): ADD to gastro-intestinal endoscopy (Item 1587) or small bowel endoscopy (item 1626)	+	25.00		25.00		4.00T	
1593	Augmented histamine test: Gastric intubation with x-ray screening		5.00		5.00			
1597	Gastrostomy or Gastrotomy		147.50		120.00		6.00T	
1598	Gastrotomy with suture repair of bleeding ulcer		251.20		200.00		6.00T	
1599	Pyloromyotomy (Rammstedt)		116.00		116.00		6.00T	
1601	Local excision of ulcer or benign neoplasm		195.60		156.48		6.00T	
1603	Vagotomy: Abdominal		150.00		120.00		6.00T	
1604	Vagotomy: Thoracic		150.00		120.00		11.00T	
1605	Truncal or selective with drainage procedures		250.00		200.00		6.00T	
1607	Vagotomy and antrectomy		320.00		256.00		6.00T	
1609	Highly selective vagotomy		250.00		200.00		6.00T	
1611	Pyloroplasty		180.20		144.16		6.00T	
1613	Gastroenterostomy		203.60		162.88		6.00T	
1615	Suture of perforated gastric or duodenal ulcer or wound or injury		200.00		160.00		7.00T	
1617	Partial gastrectomy		328.30		262.64		7.00T	
1619	Total gastrectomy		384.43		307.54		7.00T	
1621	Revision of gastrectomy or gastro-enterostomy		375.00		300.00		7.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1625	Gastro-esophageal operation for portal hypertension (Tanner)		375.00		300.00		11.00T	
8.7	**Duodenum**							
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure, with or without biopsy: Hospital equipment used (Refer to Modifier 0074 for the use of own equipment)		120.00		120.00		6.00T	
1627	Duodenal intubation (under X-ray screening)		8.00					
1629	Duodenal intubation with biliary drainage after gall bladder stimulation		21.00					
1631	Duodenal intubation: Under 3 years of age		15.00					
8.8	**Intestines**							
1632	H2 breath test (intestines)		9.00		9.00			
1633	Complete test using lactose or lactulose		27.00		27.00			
1634	Enterotomy or Enterostomy		202.60		162.08		6.00T	
1635	Intestinal obstruction of the newborn		240.00		192.00		7.00T	
1637	Operation for relief of intestinal obstruction		240.00		192.00		7.00T	
1639	Resection of small bowel with enterostomy or anastomosis		244.90		195.92		6.00T	
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering		538.90		431.12		11.00T	
1640	Resection of small bowel for congenital atresia, proximal segment, with tapering		623.50		498.80		11.00T	
1641	Entero-enterostomy or entero-colostomy for bypass		213.10		170.48		6.00T	
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire cost (item 0201 applicable for video capsule - disposable single patient use) (Please note: All patients should have had a normal gastroscopy and colonoscopy)		150.00		120.00			
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report		90.00		90.00			
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury		185.20		148.16		6.00T	
1647	Closure of intestinal fistula		258.00		206.40		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1649	Excision of Meckel's diverticulum		179.80		143.84		6.00T	
1651	Excision of lesion of mesentery		171.60		137.28		4.00T	
1652	Laparotomy for mesenteric thrombosis		300.00		240.00		8.00T	
1653	Total colonoscopy with hospital equipment (including biopsy) (refer to Modifier 0074 for use of own equipment		90.00		90.00		4.00T	
1654	PLUS Poluppectomy: ADD to colonoscopy (Item 1653 or item 1656): per lesion	+	30.00		30.00		4.00T	
1656	Left-sided colonoscopy		60.00		60.00		4.00T	
1657	Right or left hemicolectomy or segmental colectomy		325.00		260.00		6.00T	
1658	Reconstruction of colon after Hartman's procedure		359.40		287.52		6.00T	
1661	Colotomy: Including removal of tumour or foreign body		205.70		164.56		6.00T	
1663	Total colectomy		390.00		312.00		6.00T	
1665	Colostomy or ileostomy isolated procedure		233.80		187.04		6.00T	
1666	Continent ileostomy pouch (all types)		300.00		240.00		6.00T	
1667	Colostomy: Closure		179.10		143.28		5.00T	
1668	Revision of ileostomy pouch		375.00		300.00		6.00T	
1669	Total proctocolectomy and ileostomy		480.00		384.00		7.00T	
1670	Restorative proctocolectomy with ileal pouch - anal anastomosis		565.20		452.16		7.00T	
1671	Colomyotomy (Reilly operation)		185.00		148.00		6.00T	
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (Paediatric surgeons add Modifier 0016)		20.50		20.50		4.00T	
1659	Surgeon present assisting with air enema for reduction of inussuception (Paediatric surgeons add Modifier 0016)		60.60		60.60			
1636	Oral food challenge test		14.10		14.10			
8.9	**Appendix**							
1673	Drainage of appendix abscess		150.00		120.00		5.00T	
1675	Appendicectomy		160.00		128.00		4.00T	
8.10	**Rectum and anus**							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.		48.75		48.75		3.00T	
1677	Sigmoidoscopy: First and subsequent, with or without biopsy		13.00		13.00		3.00T	
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	+	25.00		25.00		3.00T	
1679	Sigmoidoscopy with removal of polyps, first and subsequent		30.00		30.00		3.00T	
1681	Proctoscopy with removal of polyps: First time		21.00		21.00		3.00T	
1683	Proctoscopy with removal of polyps: Subsequent times		15.00		15.00		3.00T	
1685	Endoscopic fulguration of tumour		50.00		50.00		4.00T	
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary		381.30		305.04		6.00T	
1688	Total mesorectal excision with colo-anal anastomosis with or without proximal diverting stoma		432.70		346.16		7.00T	
1689	Perineal resection of rectum							
	Please note: Items 1691 and 1692: Abdominal and/or perineal assistant's fee to be charged additionally.							
1691	Abdomino-perineal resection of rectum: Abdominal surgeon		409.30		327.44		7.00T	
1692	Abdomino-perineal resection of rectum: Perineal surgeon		158.50		126.80			
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)		200.00		160.00		4.00T	
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour		400.00		320.00		7.00T	
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz		300.00		240.00		6.00T	
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge		200.00		160.00		6.00T	
1701	Repair of prolapsed rectum: Abdominal: Perineal		236.60		189.28		5.00T	
1703	Repair of prolapsed rectum: Thierisch suture		35.00		35.00		4.00T	
1705	Incision and drainage of peri-anal abscess		40.00		40.00		3.00T	
1707	Drainage of submucous abscess		40.00		40.00		3.00T	
1709	Drainage of ischio-rectal abscess		87.00		87.00		3.00T	
1711	Excision of pelvi-rectal fistula		200.00		160.00		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1713	Excision of fistula-in-ano		105.00		105.00		3.00T	
1715	Operation for fissure-in-ano		66.80		66.80		3.00T	
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid		10.00		10.00		3.00T	
1721	Sclerosing injection for haemorrhoids: Per injection		5.00		5.00			
1723	Haemorrhoidectomy		120.00		120.00		3.00T	
1725	Drainage of external thrombosed pile		12.50		12.50		3.00T	
1727	Multiple procedures (haemorrhoids, fissure, etc.)		90.00		90.00		3.00T	
1728	Biopsy of ano-rectal wall, for congenital megacolon		60.60		60.60		5.00T	
1729	Excision of anal skin tags		25.00		25.00		3.00T	
1731	Operation for low imperforate anus		105.00		105.00		6.00T	
1733	Anoplasty: Y-V-plasty		41.00		41.00		3.00T	
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)		90.00		90.00			
1735	Anal sphincteroplasty for incontinence		120.00		120.00		3.00T	
1737	Dilation of ano-rectal stricture		12.50		12.50		3.00T	
1739	Closure of recto-vesical fistula		241.00		192.80		5.00T	
1741	Closure of recto-urethral fistula		241.00		192.80		5.00T	
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor		27.00		27.00			
8.11	**Liver**							
1743	Needle biopsy of liver		30.30		30.30		3.00T	
1745	Biopsy of liver by laparotomy		125.00		120.00		4.00T	
1744	Extensive debridement, haemostatis and packing of liver wound or injury		483.80		387.04		13.00T	
1746	Re-exploration of liver wound for removal of packing		192.90		154.32		13.00T	
1747	Drainage of liver abscess or cyst		179.10		143.28		7.00T	
1748	Body composition measured by bio-electrical impedance		3.00		3.00			
1749	Hemi-hepatectomy: Right		564.00		451.20		9.00T	
1751	Hemi-hepatectomy: Left		521.10		416.88		9.00T	
1752	Extended right or left hepatectomy		570.90		456.72		9.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1753	Partial or segmental hepatectomy		378.00		302.40		9.00T	
1754	Hepatico-jejunostomy		369.20		295.36		9.00T	
1755	Liver transplant		1400.80		1120.64		15.00T	
1756	Harvesting donor hepatectomy		616.20		492.96		5.00T	
1757	Simple suture of liver wound or injury		214.20		171.36		13.00T	
1758	Complex suture of liver wound or injury, including hepatic artery ligation		296.60		237.28		13.00T	
8.12	**Biliary tract**							
1759	Cholecystostomy		171.60		137.28		6.00T	
1761	Cholecystectomy		225.00		180.00		6.00T	
1762	Cholecystectomy and operative cholangiogram		255.00		204.00		6.00T	
1763	With exploration of common bile duct		264.50		211.60		6.00T	
1765	Exploration of common bile duct: Secondary operation		327.70		262.16		6.00T	
1767	Reconstruction of common bile duct		371.70		297.36		6.00T	
1766	Resection bile duct tmour: Intrahepatic		407.40		324.92		7.00T	
1768	Resection bile duct tumour: Extrahepatic		327.70		262.16		7.00T	
1769	Cholecysto-enterostomy or gastrostomy		236.30		189.04		6.00T	
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	+	25.60		25.60		6.00T	
1773	Transduodenal sphincteroplasty		225.00		180.00		6.00T	
1774	Balloon dilatation of common bile duct strictures		125.00		120.00		6.00T	
1775	Excision choledochal cyst with reconstruction		327.70		262.16		6.00T	
1777	Porto-enterostomy for biliary atresia		400.00		320.00		11.00T	
8.13	**Pancreas**							
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus		105.90		105.90		4.00T	
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	+	30.00		30.00		6.00T	
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	+	15.82		15.82		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	+	30.00		30.00		4.00T	
1780	Gastric and duodenal intubation		8.00		8.00			
1781	Procedure (excluding laboratory tests)		21.00		21.00			
1783	Drainage of pancreatic abscess		239.30		191.44		6.00T	
1784	Debridement pancreatic necrosis		348.40		278.72		6.00T	
1785	Internal drainage of pancreatic cyst		250.60		200.48		6.00T	
1786	Internal drainage of pancreatic cyst with Roux-Y		306.80		245.44		6.00T	
1787	Operative pancreatogram: ADD	+	10.00		10.00			
1788	Biopsy of pancreas		177.70		142.16		6.00T	
1789	Pancreatico-duodenectomy		704.80		563.84		8.00T	
1791	Local, partial or subtotal pancreatectomy		351.30		281.04		8.00T	
1792	Near-total pancreatectomy (with preservation of duodenum)		415.90		332.72		8.00T	
1793	Distal pancreatectomy with internal drainage		377.40		301.92		8.00T	
1794	Total pancreatectomy		421.50		337.20		8.00T	
8.14	**Peritoneal cavity**							
1797	Pneumo-peritoneum: First		13.00		13.00		4.00T	
1799	Pneumo-peritoneum: Repeat		6.00		6.00		4.00T	
1800	Peritoneal lavage		20.00		20.00			
1801	Diagnostic paracentesis: Abdomen		8.00		8.00			
1803	Therapeutic paracentesis: Abdomen		13.00		13.00			
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	+	45.00		45.00		5.00T	
1808	Omentectomy - stand alone procedure		189.20		151.36		6.00T	
1809	Laparotomy		196.00		156.80		4.00T	
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)		344.00		275.20		10.00T	
1811	Suture of burst abdomen		188.30		150.64		7.00T	
1812	Laparotomy for control of surgical haemorrhage		105.00		105.00		9.00T	
1813	Drainage of sub-phrenic abscess		180.00		144.00		7.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal		248.40		198.72		5.00T	
1817	Drainage of other intraperitoneal abscess: (Transrectal approach)		74.80		74.80		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
9. Herniae								
1819	Inguinal or femoral hernia: Adult		125.00		120.00		4.00T	
1821	Inguinal or femoral hernia: Child under 14 years		90.00		90.00		4.00T	
1823	Inguinal hernia: Infant under one year		100.00		100.00		4.00T	
1825	Recurrent inguinal or femoral hernia		155.00		124.00		4.00T	
1827	Strangulated hernia or femoral hernia		238.00		190.00		7.00T	
1829	Epigastric hernia		93.30		93.30		4.00T	
1831	Umbilical hernia: Adult		140.00		120.00		4.00T	
1833	Umbilical hernia: Child under 14 years		60.00		60.00		4.00T	
1835	Incisional hernia		166.80		133.44		4.00T	
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to item for the incisional or ventral hernia repair)	+	77.00		77.00		4.00T	
1837	Repair of omphalocele in new-born (one or more procedures)		275.00		220.00		7.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
10. Urinary System								
10.1	**Kidney**							
1839	Renal biopsy: Per kidney: Open		71.00		71.00		5.00T	
1841	Renal biopsy: Needle		30.00		30.00		3.00T	
1843	Peritoneal dialysis: First day		33.00		33.00			
1845	Peritoneal dialysis: Every subsequent day (per calendar day)		33.00		33.00			
1847	Haemodialysis: Subsequent calender day, per hour with a maximum of 4 hours per calender day (e.g. item 1847 x 4). Appropriate for haemodialysis in intensive or high care unit (the medical dooctor does not have to be present for the duration of the treatment)		21.00		21.00			
1849	Haemodialysis: First calender day: Appropriate for haemodialysis in intensive or high care unit (the medical doctor does not have to be present for the duration of the treatment)		168.00		134.40			
1851	Chronic haemodialysis: Per week (in general ward or out-patient dialysis unit)		55.00		55.00			
1852	Continuous haemodialysis per calender day in intensive or high care unit		33.00		33.00			
1853	Nephrectomy: Primary nephrectomy		225.00		180.00		5.00T	
1855	Nephrectomy: Secondary nephrectomy		267.00		213.00		5.00T	
1857	Radical with regional lymph adenectomy for tumour		280.00		224.00		6.00T	
1859	Nephrectomy: Partial		267.00		213.60		5.00T	
1860	Laparoscopic nephrectomy, partial (Item 1807 may not be added to this item)		374.90		299.92		7.00T	
1862	Laparoscopic nephrectomy, includes partial ureterectomy (Item 1807 may not be added to this item)		301.20		240.96		7.00T	
1861	Symphysiotomy for horse-shoe kidney		287.00		229.60		6.00T	
1863	Nephro-ureterectomy		305.00		244.00		5.00T	
1865	Nephrotomy with drainage nephrostomy		189.00		151.20		6.00T	
1868	Nephrolithotomy, for congenital kidney abnormality, complicated		335.50		268.40		7.00T	
1869	Nephrolithotomy		227.00		181.60		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25% of the units		284.00		227.20		5.00T	
1871	Staghorn stone: Surgical		341.00		272.80		6.00T	
1873	Suture renal laceration (renorraphy)		193.00		154.40		6.00T	
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy		34.00		34.00		3.00T	
1878	Ablation of renal tumour: Cryotherapy, percutaneous, unilateral		132.50		106.00		7.00T	
1877	Operation for renal cyst: Marsupialisation or excision		189.00		151.20		5.00T	
1879	Closure renal fistula		189.00		151.20		5.00T	
1880	Laparoscopic ablation of renal mass or lesion(s) (item 1807) may not be added to this item)		294.90		235.92		7.00T	
1881	Pyeloplasty		252.00		201.60		5.00T	
1882	Pyeloplasty, complicated.(Secondary procedure for congenital kidney abnormality or solitary kidney)		409.60		327.68		7.00T	
1883	Pyelostomy		189.00		151.20		5.00T	
1885	Pyelolithotomy		189.00		151.20		5.00T	
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)		223.00		178.40		5.00T	
1889	Nephrectomy for Allograft: Living or dead		255.00		204.00		5.00T	
1891	Perinephric abscess or renal abscess: Drainage		200.00		160.00		7.00T	
1892	Laparoscopic drainage of lymphocele to peritoneal cavity (item 1897 may not be added to this item)		161.80		129.44		6.00T	
1893	Aberrant renal vessels: Repositioning with pyeloplasty		210.00		168.00		5.00T	
1894	Auto transplantation of kidney		420.00		336.00		10.00T	
1895	Allo transplantation of kidney		420.00		336.00		10.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
10.2	**Ureter**							
1897	Ureterorraphy: Suture of ureter		147.00		120.00		5.00T	
1898	Ureterorraphy: Lumbar approach		189.00		151.20		5.00T	
1899	Ureteroplasty		181.00		144.80		5.00T	
1901	Ureterolysis		118.00		118.00		5.00T	
1902	Ureterolysis: Lumbar approach		189.00		151.20		5.00T	
1903	Ureterectomy only		137.00		120.00		5.00T	
1904	Ureterectomy with bladder cuff - stand-alone procedure		294.80		235.84		7.00T	
1905	Ureterolithotomy		265.80		212.64		5.00T	
1907	Cutaneous ureterostomy: Unilateral		108.00		108.00		5.00T	
1909	Cutaneous ureterostomy: Bilateral		189.00		151.20		5.00T	
1911	Uretero-enterostomy: Unilateral		137.00		120.00		5.00T	
1913	Uretero-enterostomy: Bilateral		240.00		192.00		5.00T	
1915	Uretero-ureterostomy		137.00		120.00		5.00T	
1917	Transuretero-ureterostomy		155.00		124.00		5.00T	
1919	Closure of ureteric fistula		147.00		120.00		5.00T	
1921	Immediate deligation of ureter		147.00		120.00		5.00T	
1923	Ureterolysis for retrocaval ureter with anastomosis		168.00		134.40		5.00T	
1924	Ureterocalicostomy		331.10		264.88		7.00T	
1925	Uretero-pyelostomy		252.00		201.60		5.00T	
1927	Uretero-neo-cystostomy: Unilateral		316.10		252.88		5.00T	
1929	Uretero-neo-cystostomy: Bilateral		444.15		379.32		5.00T	
1931	Uretero-neo-cystostomy: With Boariplasty		351.80		281.44		5.00T	
1932	Laparoscopic uretero-neocystostomy, excludes cystoscopy and urethral stent insertion (item 1807 may not be added to this item)		382.30		305.84		6.00T	
1933	Uretero-sigmoidostomy with rectal bladder and colostomy		252.00		201.60		5.00T	
1935	Uretero-ileal conduit		388.00		310.40		5.00T	
1937	Replacement of ureter by bowel segment: Unilateral		277.00		221.60		5.00T	
1939	Replacement of ureter by bowel segment: Bilateral		485.00		388.00		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1941	Ureterostomy-in-situ: Unilateral		100.00		100.00		5.00T	
1943	Ureterostomy-in-situ: Bilateral		175.00		140.00		5.00T	
10.3	**Bladder**							
1945	Instillation of radio-opaque material for cystography or urethrocystography		5.00		5.00		3.00T	
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder		10.00		10.00		3.00T	
1949	Cystoscopy: Hospital equipment		44.00		44.00		3.00T	
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	+	10.00		10.00		3.00T	
1952	J J Stent catheter	+	44.00		44.00		3.00T	
1953	With hydrodilatation of the bladder for interstitial cystitis	+	5.00		5.00		3.00T	
1954	Uretroscopy	+	35.00				3.00T	
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	+	35.00		35.00		3.00T	
1957	With dilatation of the ureter or ureters	+	25.00		25.00		3.00T	
1959	With manipulation of ureteral calculus	+	20.00		20.00		3.00T	
1961	With removal of foreign body or calculus from urethra or bladder	+	20.00		20.00		3.00T	
1963	With fulguration or treatment of minor lesions, with or without biopsy	+	15.00		15.00		3.00T	
1964	And control of haemorrhage and blood clot evacuation	+	15.00		15.00		3.00T	
1965	And catheterisation of the ejaculatory duct	+	10.00		10.00		3.00T	
1967	With ureteric meatotomy: Unilateral or bilateral	+	15.00		15.00		3.00T	
1969	And cold biopsy	+	15.00		15.00		3.00T	
1971	With cryosurgery for bladder or prostatic disease	+	55.00		55.00		3.00T	
1973	With incision, fulguration or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	+	35.00		35.00		3.00T	
1975	Ultraviolet cystoscopy for bladder tumour		60.00		60.00		3.00T	
1976	Optic urethrotomy		80.00		80.00		3.00T	
1977	Transurethral resection of ejaculatory duct		60.70		60.70		3.00T	
1979	Internal urethrotomy: Female		50.00		50.00		3.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
1981	Internal urethrotomy: Male		76.20		76.20		3.00T	
1983	Transurethral resection of bladder tumour		100.00		100.00		5.00T	
1984	Transurethral resection of bladder tumours: Large multiple tumours		115.00		115.00		5.00T	
1985	Transurethral resection of bladder neck: Female or child		105.00		105.00		5.00T	
1986	Transurethral resection of bladder neck: Male		125.00		120.00		5.00T	
1987	Litholapaxy		80.00		80.00		5.00T	
1989	Cystometrogram		25.00		25.00		3.00T	
1991	Flometric bladder, studies with videocystograph		40.00		40.00		3.00T	
1992	Without videocystograph		25.00		25.00		3.00T	
1993	Voiding cysto-urethrogram		21.00		21.00		3.00T	
1994	Rigiscan examination		66.00		66.00			
1995	Percutaneous aspiration of bladder		10.00		10.00		3.00T	
1996	Bladder catheterisation: Male (not at operation)		6.00		6.00		3.00T	
1997	Bladder catheterisation: Female (not at operation)		3.00		3.00			
1999	Percutaneous cystostomy		24.00		24.00		3.00T	
2001	Total cystectomy: After previous urinary diversion		294.00		235.20		8.00T	
2003	Total cystectomy: With conduit construction and ureteric anastomosis		554.70		443.76		8.00T	
2004	Complete pelvic exenteration for malignancy; includes combinations of removal of bladder, urethral transplantation, with or without hysterectomy, abdominoperineal resection of rectum or colon, colostomy		662.30		529.84		8.00T	
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone		650.00		520.00		8.00T	
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)		700.00		560.00		8.00T	
2007	Partial cystectomy		147.00		120.00		6.00T	
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)		600.00		480.00		8.00T	
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters		462.00		369.90		8.00T	
2010	Reversion of temporary conduit		360.00		288.00		8.00T	
2011	Partial cystectomy with uretero-neo-cystostomy		202.00		161.60		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2012	Reversion of conduit with major urinary tract reconstruction		600.00		480.00		8.00T	
2013	Diverticulectomy (independent procedure): Multiple or single		137.00		120.00		5.00T	
2014	Closure of cystostomy - stand-alone procedure		134.10		120.00		6.00T	
2015	Suprapubic cystostomy		67.00		67.00		5.00T	
2016	Abdomino-neo-urethrostomy		252.00		201.60		5.00T	
2017	Open loop fulguration or excision of bladder tumour		101.00		101.00		5.00T	
2019	Operation for vesico-vaginal or urethra-vaginal fistula		155.00		124.00		5.00T	
2020	Repair of vesico vaginal fistula: Abdominal approach		255.00		204.00		5.00T	
2021	Vesico-plication (Hamilton Stewart)		118.00		118.00		5.00T	
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach		195.00		156.00		5.00T	
2025	Vesico-urethropexy with rectus sling		229.40		183.52		5.00T	
2027	Open operation for ureterocele: Unilateral		118.00		118.00		5.00T	
2029	Open operation for ureterocele: Bilateral		207.00		165.60		5.00T	
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial		264.00		211.20		8.00T	
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent		53.00		53.00		8.00T	
2034	Appendico-vesicostomy, cutaneous		264.30		211.44		6.00T	
2035	Cutaneous vesicostomy		118.00		118.00		5.00T	
2036	Revision of urinary-cutaneous anastomosis, includes repair of fascial defect and hernia		210.10		168.08		7.00T	
2037	Cystoplasty, cysto-urethraplasty, vesicolysis		126.00		120.00		5.00T	
2039	Operation for ruptured bladder		137.00		120.00		6.00T	
2042	Enterocystoplasty plus bowel anastomosis		419.90		335.92		5.00T	
2043	Cysto-lithotomy		132.00		120.00		5.00T	
2045	Excision of patent-urachus or urachal cyst		112.00		112.00		5.00T	
2047	Drainage of perivesical or prevesical abscess		105.00		105.00		5.00T	
2049	Evacuation of clots from bladder: Other than post-operative		132.10		120.00		3.00T	
2050	Evacuation of clots from bladder: Post-operative						4.00T	
2051	Simple bladder lavage: Including catheterisation		12.00		12.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2053	Bladder neck plasty: Male		137.00		120.00		5.00T	
2057	Bladder neck plasty: Female		137.00		120.00		5.00T	
10.4	**Urethra**							
2059	Open biopsy of urethra: Male		45.00		45.00		3.00T	
2061	Open biopsy of urethra: Female		45.00		45.00		3.00T	
2063	Dilatation of urethra stricture: By passage sound: Initial (male)		20.00		20.00		3.00T	
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)		10.00		10.00		3.00T	
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)		20.00		20.00		3.00T	
2069	Dilatation of female urethra		5.00		5.00		3.00T	
2070	Transvaginal urethrolysis, includes cystoscopy		193.00		154.40		4.00T	
2071	Urethrorraphy: Suture of urethral wound or injury		139.00		120.00		4.00T	
2073	External urethrotomy: Pendulous urethra (anterior)		67.00		67.00		3.00T	
2075	Urethraplasty: Pendulous urethra: First stage		71.00		71.00		4.00T	
2077	Urethraplasty: Pendulous urethra: Second stage		145.00		120.00		4.00T	
2079	Reconstruction of female urethra		147.00		120.00		4.00T	
2081	Reconstruction or repair of male anterior urethra (one stage)		261.60		209.28		4.00T	
2083	Reconstruction or repair of prostatic or membranous urethra: First stage		168.00		134.40		6.00T	
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage		168.00		134.40		6.00T	
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage		294.00		235.20		6.00T	
2087	Urethral diverticulectomy: Male or female		147.00		120.00		4.00T	
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units		86.00		86.00			
2089	Marsupialisation of urethral diverticula: Male or female		115.10		115.10		4.00T	
2091	Total urethrectomy: Female		147.00		120.00		5.00T	
2093	Total urethrectomy: Male		189.00		151.20		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2095	Drainage of simple localised perineal urinary extravasation		128.80		120.00		5.00T	
2097	Drainage of extensive perineal and/or abdominal urinary extravasation		137.00		120.00		5.00T	
2099	Fulguration for urethral caruncle or polyp		53.60		53.60		3.00T	
2101	Excision of urethral caruncle		53.60		53.60		3.00T	
2103	Simple urethral meatotomy		26.30		26.30		3.00T	
2105	Incision of deep peri-urethral abscess: Female		123.10		120.00		3.00T	
2107	Incision of deep peri-urethral abscess: Male		123.10		120.00		3.00T	
2104	Debridement of external genitalia and perineum (Fournier's gangrene)		148.80		120.00		4.00T	
2106	Debridement of external genitalia, perineum and abdominal wall (Fournier's gangrene)		187.40		149.92		7.00T	
2109	Badenoch pull-through for intractable stricture or incontinence		181.00		144.80		5.00T	
2108	Sling operation for male urinary incontinence (fascia or synthetic)		211.20		168.96		6.00T	
2110	Removal/Revision: Sling for male urinary incontinence		145.20		120.00		6.00T	
2111	External sphincterotomy		108.00		108.00		5.00T	
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff		272.00		217.60		6.00T	
2113	Drainage of Skene gland abscess or cyst		42.30		42.30		3.00T	
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff		178.10		142.48		6.00T	
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)		168.00		134.40		5.00T	
2116	Urethral meatoplasty		101.50		101.50		3.00T	
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)		150.30		120.24		3.00T	
2121	Closure of urethrovaginal fistula: Including diversionary procedures		189.00		151.20		5.00T	
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff		193.00		154.40		6.00T	
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff		225.30		123.52		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridement of infected tissue		347.70		278.16		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
	11. Male Genital System							
11.1	**Penis**							
2123	Biopsy of penis (independent procedure)		52.10		52.10		3.00T	
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)		16.60		16.60		3.00T	
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive		41.60		41.60		3.00T	
2129	Electrodesiccation: Limited number		20.80		20.80		3.00T	
2131	Electrodesiccation: Multiple extensive		41.60		41.60		3.00T	
2132	Ligation of abnormal venous drainage		106.10		106.10		3.00T	
2133	Circumcision: Clamp procedure		42.30		42.30		3.00T	
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age		60.00		60.00		3.00T	
2139	Circumcision: Dorsal slit of prepuce (independent procedure)		36.80		36.80		3,00T	
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses		101.00		101.00		3.00T	
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra		188.60		150.88		3.00T	
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce		224.60		179.68		3.00T	
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required		168.00		134.40		3.00T	
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter		168.00		134.40		3.00T	
2153	Reconstructive operation for epispadias with incontinence		168.00		134.40		3.00T	
2154	Induction of artificial erection		16.00		16.00		3.00T	
2155	Hypospadias: Urethral reconstruction		187.00		149.60		3.00T	
2157	Hypospadias: Subsequent procedures for repair of urethra: Total		84.00		84.00		3.00T	
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias		300.00		240.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2161	Total amputation of penis: Without gland dissection		210.00		168.00		4.00T	
2163	Total amputation of penis: With gland-dissection		336.00		268.80		6.00T	
2165	Partial amputation of penis: With gland-dissection		210.00		168.00		6.00T	
2167	Partial amputation of penis: Without gland-dissection		84.00		84.00		4.00T	
2168	Excision: Penile plaque (Peyronie disease), <= 5cm in length		235.20		188.16		3.00T	
2170	Excision: Penile plaque (Peyronie disease), >5cm in length		274.90		219.92		3.00T	
2172	Removal of foreign body: Deep penile tissue (e.g. plastic implant)		123.10		120.00		3.00T	
2169	Injection procedure for Peyronie's disease		14.00		14.00		3.00T	
2171	Priapism operation: Irrigation of corpora cavernosa for priapism		42.00		42.00		3.00T	
2173	Priapism operation: Shunt procedure: Any type		252.00		201.60		4.00T	
2174	Priapism operation: Stab shunt		114.40		114.40		4.00T	
11.2	**Testis and epididymis**							
2175	Testis biopsy: Needle (independent procedure)		18.50		18.50		3.00T	
2177	Testis biopsy: Incisional: Independent procedure: Unilateral		58.90		58.90		3.00T	
2179	Testis biopsy: Incisional: Independent procedure: Bilateral		58.90		58.90		3.00T	
2181	Epididymis biopsy: Needle		86.10		86.10		3.00T	
2183	Puncture aspiration hydrocele with or without injection of medication		10.00		10.00		3.00T	
2185	Operation for maldescended testicle: Including herniotomy		135.00		120.00		4.00T	
2187	Operation for torsion appendix testis		119.20		119.20		4.00T	
2189	Operation for torsion testis with fixation of contralateral testis		119.20		119.20		4.00T	
2191	Orchidectomy (total or subcapsular): Unilateral		98.00		98.00		3.00T	
2193	Orchidectomy (total or subcapsular): Bilateral		147.00		120.00		3.00T	
2194	Laparoscopic orchiectomy (item 1807 may not be added to this item)		187.60		150.08		6.00T	
2196	Laparoscopic orchiopexy: Intra-abdominal testis (item 1897 may not be added to this item)		193.10		154.48		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2198	Diagnostic laparoscopy (excluding after-care) (item 1897 may not be added to this item)		94.40		94.40		6.00T	
2195	Radical operation for malignant testis: Excluding gland dissection		155.30		124.24		6.00T	
2197	Operation for hydrocele or spermatocele		99.80		99.80		4.00T	
2199	Varicocelectomy		106.10		106.10		4.00T	
2201	Abdominal ligation of spermatic vein for varicocele		112.80		112.80		4.00T	
2203	Epididymectomy: Unilateral		114.40		114.40		3.00T	
2205	Epididymectomy: Bilateral		158.20		126.56		3.00T	
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)		55.90		55.90		3.00T	
2209	Vasotomy: Unilateral or bilateral		70.40		70.40		3.00T	
2210	Vasogram, seminal vesiculogram: Unilateral		58.10		58.10		3.00T	
2211	Vasogram, seminal vesiculogram: Bilateral		58.10		58.10		3.00T	
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)		91.20		91.20		4.00T	
2213	Suture or repair of testicular injury		110.30		110.30		4.00T	
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma		90.00		90.00		4.00T	
2217	Excision of local lesion of testis or epididymis		90.80		90.80		4.00T	
2219	Vaso-vasostomy: Unilateral		67.00		67.00		3.00T	
2221	Vaso-vasostomy: Bilateral		117.00		117.00		3.00T	
2223	Epididymo-vasostomy: Unilateral		67.00		67.00		3.00T	
2225	Epididymo-vasostomy: Bilateral		117.00		117.00		3.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2227	Incision and drainage of scrotal wall abscess		42.70		42.70		3.00T	
2228	Removal of foreign body: Scrotum		104.90		104.90		3.00T	
2229	Excision of Mullerian duct cyst		189.00		151.20		4.00T	
2231	Excision of lesion of spermatic cord		84.00		84.00		3.00T	
2232	Excision: Retroperitoneal primary or secondary tumours		387.00		309.60		8.00T	
2233	Seminal Vesiculectomy		220.00		176.00		5.00T	
11.3	**Prostate**							
2235	Biopsy prostate: Needle or punch, single or multiple, any approach		23.30		23.30		3.00T	
2237	Biopsy prostate: Incisional, any approach		105.00		105.00		4.00T	
2236	Interstitial device(s): Single or multiple placement (via needl, any approach), or for radiation therapy guidance (e.g. fiducial markers, dosimeter), prostate		29.10		29.10		3.00T	
2239	Transurethral drainage of prostatic abscess		117.40		117.40		4.00T	
2241	Perineal drainage of prostatic abscess		77.00		77.00		4.00T	
2243	Trans-urethral cryo-surgical removal of prostate		126.00		120.00		6.00T	
2245	Trans-urethral resection of prostate		252.00		201.60		6.00T	
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer		126.00		120.00		6.00T	
2249	Trans-urethral resection of post-operative bladder neck contracture		126.00		120.00		5.00T	
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing (item 1807 may not be added to this item		501.80		401.44		8.00T	
2251	Prostatectomy: Perineal: Sub-total		252.00		201.60		6.00T	
2253	Prostatectomy: Perineal: Radical		336.00		268.80		8.00T	
2254	Pelvic lymph adenectomy		175.00		140.00		8.00T	
2255	Supra-pelvic, transversical		252.00		201.60		6.00T	
2257	Retropubic: Sub-total		252.00		201.60		6.00T	
2259	Retropubic: Radical		336.00		268.80		8.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2260	Prostate brachytherapy		230.00		184.00		8.00T	
2265	Cryosurgical ablation of the prostate, includes utrasound guidance		311.40		249.12		6.00T	
2266	Transrectal high-intensity focused ultrasound (HIFU)		336.60		268.80		5.00T	

12. Female Genital System

Code	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia Administered	
			UNITS	VALUE	UNITS	VALUE	UNITS	VALUE
12.1	**Vulva and introitus**							
2271	Removal of tag or polyp							
2278	Perineoplasty, non-obstetrical - stand-alone procedure		67.00		67.00		6.00T	
2279	Colpoperineorraphy: Repair secondary perineal tear, suture of injury of vagina and/or perineum		42.80		42.80		6.00T	
2280	Colpoperineorraphy: Repair third degree tear, including anal sphincter repair, suture of injury of vagina and/or perineum		104.30		104.30		6.00T	
2281	Excision of inclusion cyst							
2283	Hymenectomy/hymenotomy/drainage haematocolpos		53.40		53.40		4.00T	
2285	Drainage haematocolpos							
2287	Clitoris repair for injury: Including skin graft, if required		72.30		72.30		4.00T	
2289	Denervation or alcohol infiltration vulva (Woodruff)							
2291	Vulva: Undercutting skin (ball)							
2293	Vulva and introitus: Drainage of abscess		30.90		30.90		3.00T	
2301	Operation for enlarging introitus: Fenton plasty							

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
12.2	**Vaginal procedures and operations**							
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure		30.80		30.80		3.00T	
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited							
2321	Drainage of vaginal abscess		27.80		27.80		3.00T	
2322	Pudendal nerve block		23.30		23.30			
2323	Reconstruction of vagina after atresia		150.10		120.00		5.00T	
2324	Revision of prosthetic vaginal graft or mesh: Vaginal approach (removal included)		135.70		120.00		5.00T	
2326	Revision of prosthetic vaginal graft or mesh: Abdominal approach (removal included)		266.70		213.36		6.00T	
2320	Revision of prosthetic vaginal graft or mesh: laparoscopic revision (including removal)		239.70		191.76		6.00T	
2325	Construction of artificial vagina: Labial fusion without graft, after stenosis		150.10		120.08		4.00T	
2327	Construction of artificial vagina with graft (skin or bowel)		232.60		186.08		5.00T	
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each							
2328	Paravaginal/site specific defect repair (including repair of cystocele, if performed, laparoscopic approach)		244.60		195.68		6.00T	
2330	Fitting/insertion of pessary or other intravaginal support device		13.40		13.40		4.00T	
2333	Sacrocolpopexy: Abdominal approach with use of mesh		271.70		217.36		4.00T	
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape							
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations							
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape							
2337	Colpopexy: Vaginal, extra-peritoneal approach (sacrospinous, iliococcygeus)		142.40		113.92		5.00T	
2338	Colpopexy:Vaginal, intra-peritoneal approach (uretrosacral, levator myorrhaphy)		195.90		156.72		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2340	Sacrocolpopexy: Laparoscopic with use of mesh		276.30		221.04		6.00T	
2339	Colpotomy: Diagnostic (excluding after-care)		20.00		20.00		4.00T	
2341	Colpotomy: Therapeutic, includes draining of pelvic abscess		123.60		120.00		4.00T	
2343	Vaginal hysterectomy: Without repair		234.60		187.68		6.00T	
2344	Vaginal hysterectomy with unilateral/bilateral salpingectomy and/or oophorectomy, without repair		261.80		209.44		6.00T	
2345	Vaginal hysterectomy with enterocele/apical repair, without salpingectomy and/or oophorectomy		250.50		200.40		6.00T	
2346	Vaginal hysterectomy, laparoscopy assisted (LAVH) with/without bilateral salpingo-oophorectomy		281.10		224.88		6.00T	
2357	Vaginal hysterectomy and enterocele/apical repair with unilateral or bilateral salpingo-oophorectomy		280.90		224.72		6.00T	
2361	Vaginal hysterectomy with bilateral salpingectomy, with or without oophorectomy and enterocele repair; including anterior and/or posterior repair		297.90		238.32		6.00T	
2354	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele		191.10		152.88		5.00T	
2355	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy		192.20		153.76		5.00T	
2358	Anteroposterior colporrhaphy without enterocele/apical repair, with or without perineorrhaphy		236.70		189.36		6.00T	
2359	Anteroposterior colporrhaphy with enterocele/apical repair, with or without perineorrhaphy		259.40		207.52		6.00T	
2360	Insertion of mesh/other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (to be added to appropriate primary procedure code)	+	73.10		73.10		6.00T	
2362	Enterocele repair, vaginal approach - stand-alone procedure		137.70		120.00		5.00T	
2364	Enterocele repair, abdominal approach - stand-alone procedure		238.30		120.00		5.00T	
2363	Amputation of cervic and shortening of support ligaments of uterus for uterine prolapse (Fothergill-Mancehster) - stand-alone procedure		125.20		120.00		5.00T	
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)							
2366	Posterior repair alone							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2367	Other operations for prolapse: Anterior repair - with or without posterior repair							
2368	Uterovesical fistula		226.00		180.80		5.00T	
2369	Vesico- or urethro-vaginal fistula		179.00		143.20		5.00T	
2370	Vesico or urethro-vaginal fistula - Obestetric or radiation		232.00		185.60		5.00T	
2371	Closure of uretero-vaginal fistula with reimplantation of ureter to bladder		318.50		254.80		5.00T	
2372	Closure of uretero-vaginal fistula: Obstetric or radiation							
2373	Closure of recto-vaginal fistula, vaginal or transanal approach		268.60		214.88		5.00T	
2374	Closure of recto-vaginal fistula, abdominal approach		160.90		128.72		5.00T	
2375	Colpocleisis (any method)		144.60		120.00		4.00T	
2377	Le Fort operation							
2379	Vaginal hysterectomy, radical (Schauta type operation)		410.40		328.32		8.00T	
2380	Vaginectomy; simple, partial: Removal of vaginal wall		141.30		120.00		8.00T	
2381	Vaginectomy; simple, complete: Removal of vaginal wall		254.00		203.20		8.00T	
2382	Radical vaginectomy, complete removal of vaginal wall, with removal of para-vaginal tissue		462.30		369.84		8.00T	
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee							
2385	Vaginal laceration or trauma: Repair		86.20		86.20		4.00T	
2386	Paravaginal/site specific defect repair (including repair of cystocele, if performed, abdominal approach		216.00		172.80		6.00T	
2387	Paravaginal /site specific defect repair (including repair of cystocele, if performed), vaginal approach		191.50		153.20		5.00T	
12.3	**Cervix**							
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)		23.80		23.80			
2391	Trachelorraphy, repair of uterine cervix/cervical canal, vaginal approach		147.00		120.00		3.00T	
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2400	Biopsy during pregnancy (excluding after-care)							
2403	Wedge biopsy: Cervix (excluding after-care)							
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)							
2407	Simple trachelectomy/removal of cervix, vaginal or abdominal approach (Uterus intact) - stand alone procedure		99.00		99.00		3.00T	
2408	Radical trachelectomy; with bilateral total pelvic lymphadenectomy with or without para-aortic lymphadenectomy, vaginal or abdominal approach							
2410	Cervical cerclage, any rout, non-obstetrical (Add 1807 if done by laparoscopy)		89.10		89.10		3.00T	
2411	Cervix encirclage: Shirodkar suture							
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic							
2417	Trachelorraphy, repair of cervix, vaginal approach (any method)		87.40		87.40		3.00T	
2418	Repair of tears: Sturmdorff repair of tears							
2421	Removal of cervical stump, vaginal approach		115.20		115.20		5.00T	
2423	Removal of cervical stump, abdominal approach		240.50		192.40		5.00T	
2424	Removall of cervical stump, abdominal approach, with enterocele/apical repair		237.80		190.24		5.00T	
2425	Removal of cervical polyps (excluding after-care)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2427	Removal of penunculated prolapsing cervical myoma		156.00		124.80		3.00T	
2429	Colposcopy of vulva and/or vagina and/or cervix (excluding aftercare)		26.40		26.40		3.00T	
12.4	**Uterus**							
2436	Diagnostic hysteroscopy (excluding aftercare) - stand alone procedure		44.00		44.00		3.00T	
2439	Hysteroscopy with lysis of intrauterine adhesions (any method) (excluding aftercare)		82.80		82.80		3.00T	
2447	Treatment of incomplete abortion, any trimester, completed surgically		85.40		85.40		4.00T	
2465	Uteroplasty: Tompkins							
2469	Subtotal abdominal hysterectomy with or without unilateral or bilateral salpingectomy, and/or oophorectomy		190.00		152.00		6.00T	
2470	Laparoscopy: Subtotal abdominal hysterectomy, with or without removal of tube(s), with or without removal of ovary(s)		232.70		186.16		6.00T	
2471	Total abdominal hysterectomy; with or without unilateral or bilateral salpingectomy, and/or oophorectomy		290.10		232.08		6.00T	
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy							
2475	Radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymphnode sampling, with or without salpingectomy, with or without oophorectomy		532.00		425.60		8.00T	
2476	Laparoscopy, radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymphnode sampling, with or without salpingectomy, with or without oophorectomy		548.00		438.40		8.00T	
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
12.5	**Fallopian tubes**							
2483	Salpingolysis; fallopian tube anatomy restored with preservation of fallopian tube(s) - stand alone procedure		252.00		201.60		4.00T	
2487	Tuboplasty, tubal anastomosis or re-implantation - stand alone procedure		274.50		219.60		4.00T	
2488	Laparoscopy, tuboplasty, tubal anastomosis or re-implantation - stand alone procedure		208.20		166.56		6.00T	
2492	Salpingectomy: Uni- or bilateral for accepted medical reasons (including sterilisation)		103.00		103.00		5.00T	
2493	Diagnostic laparoscopy (excluding aftercare)		94.10		94.10		5.00T	
2499	Laparoscopy (diagnostic) with biopsy (single or multiple) (excluding aftercare) - stand alone procedure		99.70		99.70		5.00T	
2500	Laparoscopy (therapeutic) with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method for endomertiosis AFS stage 1 and 2 - stand alone procedure		202.30		161.84		5.00T	
2501	Laparoscopy (therapeutic) with lysis of adhesions (salpingolysis, ovariolysis) - stand alone procedure		191.80		153.44		5.00T	
2503	Laparoscopy: Plus ovarian drilling							
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
12.6	**Ovaries**							
2525	Wedge resection of ovaries, unilateral or bilateral							
2529	Salpingo-oophorectomy, unilateral or bilateral - stand alone procedure		210.80		168.64		4.00T	
12.7	**Miscellaneous procedures**							
2535	Exenteration: Anterior Exenteration							
2537	Exenteration: Posterior Exenteration							
2541	Presacral neurectomy							
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)		194.40		155.52		6.00T	
2543	Moschowitz operation							
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be added to this item)		216.90		173.52		5.00T	
2545	Surgery for stress incontinence: Vesicourethropexy/urethropexy; abdominal approach		189.30		151.44		5.00T	
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach							
2547	Operations for stress incontinence: Burch colposuspension							
2548	Surgery for stress incontinence: Use of tape/fascia		204.30		163.44		5.00T	
2550	Surgery for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach		168.40		134.72		5.00T	
2551	Laparotomy							
2554	Drainage of pelvic abscess per abdomen							
2556	Drainage of pelvic abscess per vagina (refer to item 2341)							
2558	Drainage intra-abdominal abscess: Delayed closure							
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2570	Ligation of internal iliac vessels (when not part of another procedure)		255.00		180.00		8.00T	
13. Obstetric Procedures								
13.1	**Pre-natal care and procedures**							
13.2	**Confinements**							
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding Caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit)							
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit). See modifier 0011 for emergency caesarean section (all hours)							
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)							
	Global obstetric care includes							
	o All modes of delivery (including Caesarean)							
	o All inductions of labour (medical or surgical)							
	o Intrapartum paracervical and pudential blocks							
	o Intrapartum amnioscopy							
	o Foetal blood sampling							
	o Application of scalp leads							
	o Symphysiotomy							
	o Manual removal of placenta							
	o Repair cervical tears							
	o Correction of uterine inversion							
	o Drainage of vulval haematoma							
	o Repair third degree tear							
	o Repair second degree tear							
	o Repair episiotomy							
	o Resuscitation of newborn by obstetrician							

Modifier	Description	Add-on Codes	Specialists			General Practitioners			Anaesthesia administered		
			Units	Value		Units	Value		Units	Value	
	o Tracheal intubation										
	o Missed confinement										
	Global obstetric care excludes										
	o Prenatal consultations										
	o Prenatal procedures (Items 2603 - 2611)										
	o Emergency hysterectomy for obstetrical reasons										
	o Abdominal operation for repair of ruptured gravid uterus										
	o Intensive care for obstetrical emergencies										
	o Tubal ligation performed as a post-partum procedure										
	o Post-partum complications occurring after discharge from the hospital										
13,3	**Operative procedures (excluding antenatal care)**										
2653	Caesarean-hysterectomy										
2657	Post-partum hysterectomy										
2669	Abdominal operation for ruptured gravid uterus: Repair										

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14. Nervous System								
14.1	**Diagnostic procedures**							
2880	Haemodynamic and authonomic nervous system testing with 'Task Force'system - PROFESSIONAL COMPONENT		29.00					
2681	Visual evoked potentials (VEP): Unilateral		50.00					
2682	Visual evoked potentials (VEP): Bilateral		88.00					
2683	Electro-retinography (Ganzfeld method): Unilateral		60.00					
2684	Electro-retinography (Ganzfeld method): Bilateral		105.00					
2685	Electro-oculography: Unilateral		30.00					
2686	Electro-oculography: Bilateral		53.00					
2687	VEP stable condition (photic drive): Unilateral		50.00					
2689	VEP stable condition (photic drive): Bilateral		88.00					
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP		150.00					
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex		48.00					
2704	Neurostimulation, percutaneous: Sacral nerve		120.80					
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming		8.80					
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment		6.00		6.00			
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation							
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus		80.00					
2709	Full spinogram including bilateral median and posterior-tibial studies		140.00					
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2711	Electro-encephalography (EEG): 20-40 minutes record: Equipment cost for taking of record (Technical component) (refer to item 2712 for interpretation and report)		105.60		105.60			
2712	Clinical interpretation and report of item 2711: Electro-encephalogram (EEG): 20-40 minutes record (Professional component)		16.60		16.60			
6010	24 Hour Electro-encephalogram computerised sixteen or more channel EEG (16-24 hours), (excluding video recording): Equipment cost for taking of record (Technical component)		143.60		120.00			
6011	Clinical interpretation and report of item 6010: 24 hour Electro-encephalogram for computerised sixten or more channel EEG (16-24 hours), (excluding video recording): To be coded once only for each full 24 hour period of monitoring (Professional component)		82.70		82.70			
6030	Electro-encephalogram (EEG): Monitoring (41-60 minutes): Equipment cost for taking of record (Technical component)(refer to item 6020 for interpretation and report)		116.80		116.80			
6020	Clinical interpretation and report of item 6030: Electro-encephalogram (EEG): Monitoring (41-60 minutes)(Professional component)		16.40		16.40			
6031	Electro-encephalogram (EEG): Monitoring (> 60 minutes): Equipment cost for taking of record (Technical component)(refer to item 6020 for interpretation and report)		126.80		120.00			
6021	Clinical interpretation and report of item 6031: Electro-encephalogram (EEG): Monitoring (> 60 minutes)(Professional component)		26.30		26.30			
6033	Electro-encephalogram (EEG): Overnight recording (8-16 hours): Taking of record. Equipment cost for taking of record (Technical component)(refer to item 6023 for interpretation and report)		222.30		177.84			
6023	Clinical interpretation and report of item 6033: Electro-encephalogram (EEG): Overnight recording (8-16 hours)(Professional component)		16.50		16.50			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6018	Combined Video and EEG monitoring (16-24 hours): scalp, subdural or depth. To include: 1. Equipment cost; 2. Technologist's set up cost and electrodes; 3. Technologist's technical report; Neurologist's review of EEG and clinical interpretation: Each full 24 hour period		423.20					
5999	Actigraphy: Patient monitored for a minimum of 72 hours: Taking of record - owner of equipment and taking of record (Technical component) (refer to item 6000 for interpretation and report)		34.00		34.00			
6000	Clinical interpretation and report of item 5999: Actigraphy: Patient monitored for a minimum of 72 hours (Professional component)		13.80		13.80			
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications		18.40		18.40		3.00T	
2714	Cisternal or lateral cervical (C1-C2) puncture: without injection - stand-alone procedure		32.00		32.00		5.00T	
2715	8 Hour ambulatory EEG monitoring (Holter): Hire							
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation							
2717	Electromyography: First							
2718	Electromyography: Subsequent							
2719	Overnight polysomnogram and sleep staging: Equipment Hire		125.00					
2720	Overnight polysomnogram and sleep staging: Interpretation		23.00					
2721	Daytime polysomnogram: Equipment Hire		125.00					
2722	Daytime polysomnogram: Interpretation		17.00					
6014	Sleep testing: Multiple sleep latency test (Technical component)		71.50					
2723	Multiple sleep latency test: Interpretation		125.00					
6016	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation (no EEG) (Technical component)		35.60					

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6015	Clinical interpretation and report of item 6016: Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation (Professional component)		22.40					
2724	Overnight continuous positive airways pressure (CPAP) titration		155.00		124.00			
2728	Unattended overnight home-based polysomnogram: Interpretation		24.50					
2732	Overnight home-based polysomnogram: Interpretation		24.50					
2725	Angiography carotis: Unilateral							
2726	Angiography carotis: Bilateral							
2727	Vertebral artery: Direct needling							
2729	Vertebral catheterisation							
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with item 0714)		60.00					
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)							
2733	Cortical Stimulation							
2734	Wada activation test for hemispheric function: Includes electroencephalographic (EEG) monitoring		172.50		138.00		13.00T	
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician		31.50					
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen		7.00		7.00			
2739	Ventricular puncture: Fontanelle, suture or implanted ventricular catheter/reservoir, without injection, through excising burr hole		41.80		41.80		5.00T	
2741	Ventricular puncture: Fontanelle, suture, or implanted ventricular catheter/reservoir, with injection of medication or other substance for diagnosis or treatment, through excising burr hole		38.80		38.80		5.00T	
2743	Subdural tap, initial, infant unilateral or bilateral: Through fontanelle or suture		34.60		34.60		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2745	Subdural tap(s), subsequent, infant, unilateral or bilateral: Through fontanelle or suture		33.40		33.40		5.00T	
2746	Biopsy: Temporal artery		91.00		91.00			
2679	Cisternal or lateral cervical (C1-C2) puncture: Injection of medication/other substance, diagnosis/treatment		40.50					
2688	Shunt tubing or reservoir puncture: For aspiration or injection procedure		25.90		25.90		5.00T	
2701	Drainage of cererospinal fluid (CSF): by needle or catheter, therapeutic interstitial devices, spinal puncture		25.10		25.10		5.00T	
6001	Sleep electro-encephalography: Infants that fit into a perambulator: Taking of record							
6002	Sleep electro-encephalography: Infants that fit into a perambulator: Interpretation							
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record							
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation							
6024	Functional cortical and subcortical mapping: Stimulation and/or recording of electrodes on brain surface or depth electrodes, to provoke seizures or identify vital brain structures: First 60 minutes of attendance		84.50		84.50			
6025	Functional cortical and subcortical mapping: Stimulation and/or recording of electrodes on brain surface or depth electrodes, to provoke seizures or identify vital brain structures: Each additional 60 minutes of attendance (ADD to item 6024 when appropriate)	+	73.20		73.20			
6026	Electronic anaylysis: Implanted neurostimulator pulse generator system (e.g. rate, pulse amplitude, pulse duration, configuration of wave form, battery status,electrode selectability, output modulation, cycling, impedance and patient compliance measurements),simple or complex brain/spinal cord/peripheral (i.e. cranial nerve, peripheral nerve, sacral nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming		21.10		21.10			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6027	Electronic analysis: Implanted neurostimulator pulse generator system (e.g. rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex, deep brain neurostimulator/pulse generator/transmitter, with initial or subsequent programming: First 60 minutes		73.50		73.50			
6028	Electronic analysis: Implanted neurostimulator pulse generator system (e.g. rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex, deep brain neurostimulator/pulse generator/transmitter, with initial or subsequent programming: Each additional 30 minutes after first 60 minutes. ADD to primary procedure	+	31.50		31.50			
14.2	**Introduction of burr holes for**							
2747	Burr hole(s): Ventricular puncture, includes injection of gas, contrast media, dye or radioactive material		223.80		179.04		9.00T	
2749	Burr hole(s): Implantation of ventricular catheter/reservoir/EEG electrode(s)/pressure recording device or other cerebral monitoring device - stand-alone procedure		108.60		108.60		9.00T	
2751	Burr hole(s) or trephine: Includes biopsy of brain or intracranial lesion (total procedure)		376.60		301.28		9.00T	
2753	Burr hole(s):Includes evacuation and/or drainage of haematoma: extradural or subdural		379.40		303.52		9.00T	
2755	Burr hole(s): Includes aspiration of haematoma or cyst, intracerebral (total procedure)		369.90		295.92		9.00T	
2756	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for leng term seizure monitoring		305.40		244.32		9.00T	
2757	Burr hole(s) or trephine: Includes drainage of brain abscess or cyst (total procedure)		402.80		322.24		9.00T	
2748	Twist drill hole: Subdural or ventricular puncture		139.40		120.00		9.00T	
2750	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for implanting ventricular catheter pressure recording device or other intracerebral monitoring device		92.90		92.90		9.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2752	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for evacuation and/or drainage of subdural haematoma		272.20		217.76		9.00T	
2754	Burr hole(s): or trephine: Includes subsequent tapping (aspiration) of intracranial abscess or cyst		296.40		237.12		9.00T	
2758	Insertion: Subcutaneous reservoir, pump/continuous infusion system, includes connection to ventricular catheter		152.10		121.68		5.00T	
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery		255.90		204.72		9.00T	
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral		218.90		175.12		9.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14,3	**Nerve procedures**							
2759	Nerve biopsy: Peripheral		37.00		37.00		4.00T	
2763	Nerve biopsy: Cranial nerves: Extra-cranial		20.00		20.00		4.00T	
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)		26.00		26.00		4.00T	
2766	Insertion of deep brain stimulotor for movement disorders and pain - first side		352.50		282.00		9.00T	
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)		25.00					
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)		30.00					
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)		35.00					
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)		35.00					
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)		50.00					
14.3.1	**Nerve procedures: Nerve repair or suture**							
2767	Suture brachial plexus (see also items 2837 and 2839)		379.00		303.20		5.00T	
2769	Suture: Large nerve: Primary		297.70		238.16		3.00T	
2771	Suture: Large nerve: Secondary		202.00		161.60		5.00T	
2773	Digital nerve: Primary		199.00		159.20		3.00T	
2775	Digital nerve: Secondary		96.00		96.00		3.00T	
2777	Nerve graft: Simple		309.00		247.20		4.00T	
2779	Fascicular: First fasciculus		202.00		161.60		4.00T	
2781	Fascicular: Each additional fasciculus		50.00		50.00		4.00T	
2783	Fascicular: Nerve flap: To include all stages		224.00		179.20		4.00T	
2782	Nerve pedicle transfer: First stage (not to be used together with item 2783)		309.10		247.28		4.00T	
2784	Nerve pedicle transfer: Second stage (not to be used together with item 2783)		338.30		270.64		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis		124.00		120.00		6.00T	
2787	Fascicular: Grafting of facial nerve		215.00		172.00		5.00T	
14.3.2	**Nerve procedures: Neurectomy**							
2789	Destruction by neurolytic agent: Trigeminal nerve, second and third division branches at foramen ovale (includes radiological monitoring)(total procedure)		143.80		120.00		8.00T	
2791	Trigeminal ganglion: Injection of cortisone							
2793	Trigeminal ganglion: Coagulation through high frequency							
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)		45.50		45.50		5.00T	
2796	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, each additional level (unilateral or bilateral)	+	16.30		16.30		5.00T	
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)		44.00		44.00		5.00T	
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)	+	15.60		15.60		5.00T	
2799	Procedures for pain relief: Intrathecal injections for pain		36.00		36.00		4.00T	
2800	Procedures for pain relief: Plexus nerve block		36.00		36.00		36.00c	
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief). For epidural anaesthetic refer to Modifier 0021. When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical prcdure units should be coded and not the anaesthetic units		36.00		36.00			
2802	Procedures for pain relief: Peripheral nerve block		25.00		25.00		25.00c	
2803	Alcohol injection in peripheral nerves for pain: Unilateral		20.00		20.00		3.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2804	Inserting an indwelling nerve catheter (includes removal of catheter) To be used only with items 2799, 2800, 2801 or 2802		10.00		10.00		10.00c	
2805	Alcohol injection in peripheral nerves for pain: Bilateral		35.00		35.00		3.00T	
2809	Peripheral nerve section for pain		45.00		45.00		3.00T	
2811	Pudendal neurectomy: Bilateral		116.00		116.00		3.00T	
2813	Obturator or Stoffels		96.00		96.00		3.00T	
2815	Interdigital		82.30		82.30		3.00T	
2825	Excision: Neuroma: Peripheral		213.00		170.40		4.00T	
14.3.3	**Nerve procedures: Other nerve procedures**							
2827	Transposition of ulnar nerve		170.00		136.00		3.00T	
2829	Neurolysis: Minor		51.00		51.00		3.00T	
2831	Neurolysis: Major		141.00		120.00		3.00T	
2833	Neurolysis: Digital		141.00		120.00		3.00T	
2835	Scalenotomy		132.00		120.00		6.00T	
2834	Neuroplasty: Sciatic nerve		168.80		135.04		3.00T	
2837	Brachial plexus, suture or neurolysis (item 2767)		223.00		178.40		5.00T	
2839	Total brachial plexus exposure with graft, neurolysis and transplantation		895.20		716.16		6.00T	
2841	Carpal Tunnel							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2843	Lumbar sympathectomy: Unilateral		153.00		122.40		4.00T	
2845	Lumbar sympathectomy: Bilateral		268.00		214.40		6.00T	
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)						11.00T	
2847	Cervical sympathectomy: Unilateral		153.00		122.40		4.00T	
2848	Cervical sympathectomy: Bilateral		268.00		214.40		6.00T	
2849	Sympathetic block: Other levels: Unilateral		20.00		20.00		3.00T	
2851	Sympathetic block: Other levels: Bilateral		35.00		35.00		3.00T	
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion		20.00		20.00		4.00T	
2854	Insertion of vagus nerve stimulator		127.30		120.00		9.00T	
14.4	**Skull procedures**							
2855	Craniectomy: Includes excision of tumour or other bone lesion of skull (total procedure)		396.50		317.30		11.00T	
2857	Excision, intra and extracranial: Benign tumour of cranial bone (e.g. fibrous dysplasia), without optic nerve decompression (total procedure)		587.20		469.76		11.00T	
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)		377.90		302.32		9.00T	
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)		307.10		245.68		9.00T	
2861	Repair of depressed fracture of skull: With brain lacerations: Small							
2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debrdeent of brain (total procedure)		455.10		364.08		11.00T	
2863	Cranioplasty: Skull defect =< 5cm diameter: with/without prosthesis		309.10		247.28		9.00T	
2864	Cranioplasty: Repair of encephalocele, skull vault (total procedure)		501.00		400.80		11.00T	
2865	Craniectomy: Craniosynostosis, sinle cranial suture (total procedure)		279.00		223.20		11.00T	
2867	Craniectomy: Craniosynostosis, muliple cranial sutures (total procedure)		313.70		250.96		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6035	Craniotomy: Craniosynostosis, frontal or parietal bone flap (total procedure)		506.00		404.80		11.00T	
6036	Craniotomy: Craniosynostosis, bifrontal bone flap (total procedure)		499.90		399.92		11.00T	
6037	Craniectomy: Extensive for multiple cranial suture craniosynostosis (e.g. cloverleaf skull); not requiring bone grafts (total procedure)		475.50		380.40		11.00T	
6038	Craniectomy: Extensive for multiple cranial suture craniosynostosis (e.g. cloverleaf skull); recontouring with multiple osteotomies and bone autografts (e.g. barrel-stave procedure)(including obtaining grafts) (total procedure)		537.40		429.92		11.00T	
6039	Excision of beign tumour of cranial bone (e.g. fibrous dysplasia), intra and extracranial, with decompression of optic nerve		643.30		514.64		11.00T	
6040	Craniomegalic skull: Reduction (e.g. treated hydrocephalus) not requiring bone grafts or cranioplasty (total procedure)		371.30		297.04		11.00T	
6042	Craniomegalic skull: Reduction (e.g. treated hydrocephalus), requiring craniotomy and reconstruction with or without bone graft (includes obtaining frafts)(total procedure)		465.40		372.32		11.00T	
6043	Cranioplasty: Skull defect > 5 cm diameter		340.80		272.64		9.00T	
6044	Removal of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/infection or inflammatory reaction due to device, implant and/or graft		264.90		211.92		9.00T	
6045	Replacement of bone flap or prosthetic plate of skull: For malignancy/acquireddeformity of head/open fracture/late effect of fracture/infection or imflammatory reaction due to device, implant or graft (total procedure)		311.40		249.12		9.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6046	Cranioplasty: Skull defect, with reparative brain surgery: with/without prosthesis		421.70		337.36		11.00T	
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =< 5cm diameter (total procedure)		271.40		297.12		9.00T	
6048	Cranioplasty: Includes autograft and obtaining bone grafts; > 5cm diameter (total procedure)		432.70		346.16		9.00T	
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure	+	37.30		37.30			
14.5	**Shunt procedures and Neuroendoscopy**							
2869	Ventriculo-cisternostomy: From the third ventricle to the cisterna magna (total procedure)		409.00		327.20		10.00T	
2871	Creation of shunt: Ventriculo-atrial, -jugular, -auricular		307.20		245.76		10.00T	
2873	Creation of shunt: Ventriculo-peritoneal, -pleural, other terminus		315.40		252.32		10.00T	
2875	Creation of shunt: Subarachnoid-peritoneal, -pleural, or other; percutaneous, lumbar, not requiring laminectomy		192.80		154.24		8.00T	
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure	+	56.00		56.00		8.00T	
6056	Neuroendoscopy: Intracranial, with dissection of adhesions, fenestration of septum pellucidim or intraventricular cysts (includes placement, replacement or removal of ventricular catheter)		451.30		361.04		11.00T	
6057	Neuroendoscopy: Intracranial with fenestration or excision of colloid cyst (includes placement of external ventricular catheter for drainage)		561.00		448.80		11.00T	
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body		364.80		291.84		11.00T	
6059	Neuroendoscopy: Intracranial, with excision of brain tumour (includes placement of external ventricular catheter for drainage)		620.70		496.56		11.00T	
6060	Neuroendoscopy: Intracranial, includes excision of pituitary tumour, transnasal or trans-sphenoidal approach		459.10		367.28		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6061	Creation of subarachnoid/subdural-peritoneal shunt: Pleural or perioneal space or other terminus, through burr hole and directing and tunneling thedistal end of the shunt subcutaneously towards the draining site (non-neuroendoscopic procedure)(total procedure)		290.80		232.64		10.00T	
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (total procedure)		111.40		111.40		10.00T	
6063	Ventriculocisternostomy of the third ventricle: Stereotactic neuroendoscopic method (under CT guidance for stereotactic positioning) (item 6055 and 6148 may not be added.)		358.80		287.04		10.00T	
6064	Replacement/irrigation: Previously placed intraoperatve ventricular catheter		158.30		126.64		10.00T	
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		252.30		201.84		10.00T	
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit		26.00		26.00		10.00T	
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)		180.00		144.00		10.00T	
6068	Cerebospinal fluid (CSF) shunt system: Complete removal with replacement by similar or other shunt at same operation		335.50		268.40		10.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14.6	**Aneurysm repair**							
2876	Carotid aneurysm: Surgery, intracranial, intracranial approach, simple (<15 millimetres) with no calcifications or critical perforating vessels at the aneurysm neck		1011.20		808.96		15.00T	
2877	Anastomosis: Arterial and extracranial-intracranial arteries (e.g. middle cerebral/cortical), including craniotomy (total procedure)		773.20		618.56		15.00T	
2878	Intracranial arteriovenous malformation (IAM): Surgery, infratentorial, simple		842.20		673.76		15.00T	
6075	Intracranial arteriovenous malformation (IAM): Surgery, supratentorial, complex		1236.50		989.20		15.00T	
6076	Intracranial arteriovenous malformation (IAM): Surgery, infratentorial, complex		1330.30		1064.24		15.00T	
6077	Intracranial arteriovenous malformation (IAM): Surgery, dural, simple		648.50		518.80		15.00T	
6078	Intracranial arteriovenous malformation (IAM) : Surgery, dural, complex		1082.60		866.08		15.00T	
6079	Intracranial aneurysm: Complex, intracranial approach, carotid circulation		1249.10		999.28		15.00T	
6080	Intrracranial aneurysm: Surgical, complex, intracranial approach, vertebrobasilar circulation		1369.90		1095.92		15.00T	
6081	Intracranialy aneurysm: Surgical, simple, open posterior cranial fossa approach, vertebrobasilar circulation		1190.80		952.64		15.00T	
6082	Intracranial aneurysm: Surgical, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)		404.20		323.36		15.00T	
6083	Aneurysm: Surgical, for vascular malformation or carotid-carvenous fistula with intracranial and cervical occlusion of carotid artery		770.80		616.64		15.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14.7	**Craniectomy or Craniotomy**							
2879	Craniectomy: Suboccipital: Includes exploration or decompression of cranial nerves (Middle cranial fossa approach)(total procedure)		596.00		476.80		13.00T	
2881	Internal auditory canal: Decompression, middle cranial fossa approach (total procedure)		577.60		462.08		11.00T	
2883	Eighth nerve: Extracranial							
2884	Sub-temporal section of the trigeminal nerve							
2885	Trigeminal tractotomy							
2886	Craniectomy: Suboccipital: Includes cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (e.g. Arnold-Chiari malformation)(total procedure)		652.10		521.68		13.00T	
2887	Vestibular nerve							
2888	Micro vascular deompression of trigeminal, facial and glossopharyngeal nerve (release of pressure on the sensory root of the gasserion ganglion)(subtemporal) If indicated, the nerve or a nerve brance is sectioned, bone flap Is replaced and fastened (total procedure)		570.20		456.16		11.00T	
2892	Micro vascular deompression of cranial nerve (suboccipital)		553.00		442.00		6.00T	
2889	Craniectomy for excision of brain tumour: Infratentorial or posterior fossa through a lateral posterior incision and removal of occipital bone flap for excision of cerebellopontine angle brain tumour		1106.80		885.44		13.00T	
2891	Craniectomy for excision of brain tumour: Infratentorial or posterior fossa for excision of brain tumour. Excludes meningioma, cerebellopontine angle tumour or midline tumour at base of skull		819.70		655.76		13.00T	
2893	Craniectom for excision of brain abscess: Infratentorial or posterior fossa for excision of brain abscess		648.30		518.64		13.00T	
2895	Excision of tumour of glomus jugulare: Intracranial							
2897	Excision of tumour of glomus jugulare: Extracranial							
2898	Excision of tumour of glomus jugulare: Hemispherectomy							
6085	Craniectomy/craniotomy: with exploration of the infratentorial area (below the tentorium of the cerebellum), posterior fossa (total procedure)		596.40		477.12		13.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6086	Craniectomy/craniotomy: with evacuation of infratentorial, intracerebellar haematome (total procedure)		614.30		491.44		13.00T	
6087	Craniectomy/craniotomy: with drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)		631.80		505.44		13.00T	
6088	Cranial decompression caused by excess fluid (e.g. blood and pathological tissue) using posterior fossa approach by drilling/sawing through the occipital bone (total procedure)		605.10		484.08		13.00T	
6090	Craniectomy at base of skull (suboccipital): with freeing and section of one or more cranial nerves (total procedure)		624.00		499.20		11.00T	
6091	Craniectomy at base of skull (suboccipital): with mesencephalic tractotomy or pedunculotomy (resecting a nerve tract as it passes through the mesencephalon or the cerebellar or cerebral peduncle)(total procedure)		494.10		395.28		11.00T	
6092	Craniectomy: with excision of meningioma(neoplasm of meninges) from infratentorial structures or posterior fossa (total procedure)		873.40		698.72		11.00T	
6093	Craniectomy: with excision of midline brain tumour at base of skull; using posterior auricular or transmastoid approach (total procedure)		942.10		753.68		13.00T	
6094	Craniectomy: with excision or fenestration (creating opening for draining) of cyst in the infratentorium or posterior fossa (total procedure)		617.60		494.08		13.00T	
6095	Craniectomy (bone flap craniotomy): with excision of cerebellopontine angle tumour (acoustic neuroma/tumour/vestibular neurofibromatosis (NF 1 or NF2)/angle tumour); using transtemporal (mastoid) approach (total procedure)		1079.60		863.68		11.00T	
6096	Craniectomy (bone flap craniotomy): with excision of cerebellopontine angle tumour (acoustic neuroma/tumour/vestibular neurofibromatosis (NF 1 or NF2)/angle tumour); using combined transtemporal (mastoid) and middle or posterior fossa approach (total procedure)		910.30		728.24		13.00T	
2899	Craniectomy/craniotomy: with evacuation of infratentorial haematoma, subdural or extradural		543.10		434.48		13.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2900	Transcranial exploration of orbit: Removal of lesion (ensuring freedom of movement of extraocular eye muscles). Includes reconstruction of roof of orbit, closure of dura and replacement of skull (total procedure)		625.50		500.40		11.00T	
2916	Craniotomy: with intra-cranial hypophysectomy or excision of pituitary tumour (total procedure)		683.60		546.88		11.00T	
14.8	**Craniotomy for**							
2901	Craniectomy/trephination (bone flap craniotomy): with excision of supratentorial meningioma		756.70		605.36		11.00T	
2902	Craniotomy for subdural implantation of strip- and grid electrodes for seizure monitoring and brain mapping		398.10		311.28		9.00T	
2903	Craniectomy/trephination or bone flap craniotomy: with excision of supratentorial brain tumour, excluding meningioma (total procedure)		650.00		520.00		11.00T	
2904	Craniectomy/craniotomy: with evacuation of supratentorial, intracerebral haematoma		590.20		472.16		11.00T	
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery		489.00		391.20		11.00T	
2906	Craniotomy: skull based repair of encephalocele (total procedure)		493.50		394.80		11.00T	
2907	Craniotomy with elevation of bone flap: with lobectomy of temporal lobe, without electrocorticography during the surgery (total procedure)		730.00		584.24		11.00T	
2908	Craniotomy for Torkildsen anastomosis							
2909	Craniotomy: Repair of dural /cerebrospinal fluid (CSF) leak. Includes surgery for rhinorrhea/otorrhea		474.60		379.68		11.00T	
2910	Arteriovenous malformation (AVM): Surgery, intracranial supratentorial, simple		671.40		537.12		15.00T	
6115	Craniectomy/craniotomy: Supratentorial exploration		487.10		389.68		11.00T	
6116	Incision and subcutaneous placement of cranial bone graft (e.g. split- or full thickness); shaving graft or bone dust; with donor site already exposed for the main procedure.		25.90		25.90			
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)		564.70		451.76		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6118	Decompressive craniectomy/craniotomy: With or without duraplasty, for treating intracranial hypertension (most commonly caused by severe closed-head trauma) without evacuation of associated intraparenchymal haematoma or lobectomy		705.10		564.05		11.00T	
6119	Decompressive craniectomy/craniotomy: With or without duraplasty, for treating intracranial hypertensionwithout evacuation of associated intraparenchymal haematoma, with lobectomy		706.50		565.20		11.00T	
6120	Decompression of (roof of) orbit only: Transcranial approach (total procedure)		548.60		438.88		11.00T	
6121	Exploration of orbit: Transcranial approach with biopsy (total procedure)		561.00		448.80		11.00T	
6123	Cranial decompression: Subtemporal (pseudotumour cerebri, slit ventricle syndrome)		430.00		344.00		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess		566.20		452.96		11.00T	
6126	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision/fenestration of cyst		550.90		440.72		11.00T	
6127	Implantation, chemotherapy agent: Intracavity, brain intracavitary. ADD to main procedure	+	25.70		25.70			
6128	Implantation, subdural: Strip electrodes through 1 or more burr/trephine hole(s). Long-term seizure monitoring		364.50		291.60		11.00T	
6129	Craniotomy with elevation of bone flap: Subdural implantation of an electrode array. Long-term seizure monitoring		453.50		362.80		11.00T	
6130	Craniotomy with elevation of bone flap: Excision of cerebral epileptogenic focus, Including electrocorticography during surgery (includes removal of electrode array)		298.60		238.88		11.00T	
6131	Craniotomy with elevation of bone flap: Lobectomy, temporal lobe, without electrocorticography during surgery(includes removal of electrode array)		763.70		610.96		11.00T	
6132	Craniotomy with elevation of bone flap: Lobectomy, temporal lobe with electrocorticography during surgery		789.70		631.76		11.00T	
6133	Craniotomy with elevation of bone flap: Lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery		699.40		559.52		11.00T	
6134	Craniotomy with elevation of bone flap: Lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery		647.20		517.76		11.00T	
6135	Craniotomy with elevation of bone flap: Transection of corpus callosum		637.10		509.68		11.00T	
6136	Craniotomy with elevation of bone flap: Partial or subtotal (functional) hemispherectomy		643.90		515.12		11.00T	
6137	Craniotomy with elevation of bone flap: Excision or coagulation of choroid plexus		507.90		406.32		11.00T	
6138	Craniotomy with elevation of bone flap: Excision of craniopharyngioma		943.20		754.56		11.00T	
6139	Craniotomy with elevation of bone flap: Selective amygdalohippocampectomy		666.20		532.96		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6140	Craniotomy with elevation of bone flap: Multiple subpial transections, with electrocorticography during surgery		759.80		607.84		11.00T	
6141	Craniectomy/craniotomy: Excision of foreign body from brain		554.30		443.44		11.00T	
6142	Craniectomy/craniotomy: Treatment of penetrating wound of brain		589.90		471.92		11.00T	
14.8.1	**Stereotaxis; Stereotactic Radiosurgery (Cranial): Neurostimulators (Intracranial)**							
2911	Stereotactic biopsy, aspiration, or excision (includes burr hole(s): Intracranial lesion. Includes computed tomography (CT) and/or magnetic resonance (MRI) guidance		409.30		327.44		11.00T	
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat							
2915	Transnasal hypophysectomy		300.00		240.00		11.00T	
2917	Transnasal hypophyseal implants							
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)							
6143	Creation of lesion: Globus pallidus or thalamus, stereotactic, includes burr hole(s) and localising and recording techniques, single or multiple stages		377.80		302.24		11.00T	
6144	Creation of lesion: Subcortical structure(s), other than globus pallidus or thalamus, stereotactic, includes burr hole(s) and localising and recording techniques, single or multiple stages		472.20		377.76		11.00T	
6145	Biopsy, stereotactic: Aspiration/excision for intracranial lesion. Includes burr hole(s)		417.80		334.24		11.00T	
6146	Implantation, stereotactic: Depth electrodes into the cerebrum for long-term seizure monitoring		469.10		375.28		11.00T	
6147	Localisation, stereotactic: Insertion of catheter(s) or probe(s) for placement of radiation source. Includes burr hole(s)		480.40		384.32		9.00T	
6148	Stereotactic computer-assisted (navigational) procedure: Cranial, intradural. ADD to main procedure	+	69.00		69.00			
6149	Stereotactic computer-assisted (navigational) procedure: Cranial, extradural. ADD to main procedure	+	56.40		56.40			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6150	Stereotactic computer-assisted (navigational) procedure: Spinal. ADD to main procedure	+	69.10		69.10			
6151	Creation of lesion: Gasserian ganglion, stereotactic, percutaneous, by neurolytic agent (e.g. alcohol, thermal, electrical, radiofrequency)		260.20		208.16		6.00T	
6152	Creation of lesion: Trigeminal medullary tract, stereotactic method, percutaneous, by neurolytic agent (e.g. alcohol, thermal, electrical, radiofrequency)		331.40		265.12		6.00T	
6153	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): 1 cranial lesion, simple		298.80		239.04			
6154	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): Each additional cranial lesion, simple. ADD to main procedure	+	64.10		64.10			
6155	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): 1 cranial lesion, complex		407.30		325.84			
6156	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): Each additional cranial lesion, complex. ADD to main procedure	+	88.50		88.50			
6157	Stereotactic radiosurgery: Application of stereotactic headframe. ADD to main procedure	+	45.10		45.10			
6158	Implantation of neurostimulator electrodes: Cortical, twist drill or burr hole(s)		292.60		234.08		9.00T	
6159	Craniectomy/craniotomy: Implantation of neurostimulator electrodes, cerebral, cortical		464.40		371.52		11.00T	
6160	Craniotomy/craniectomy/twist drill/burr hole: Thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray). Stereotactic implantation of neurostimulator electrode array in subcortical site, without use of intra-operative microelectrode recording, first array		447.40		357.92		11.00T	
6161	Craniotomy/craniectomy/twist drill/burr hole: Thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray). Stereotactic implantation of neurostimulator electrode array in subcortical site, without use of intraoperative microelectrode recording: Each additional array. ADD to main procedure	+	83.80		83.80			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6162	Craniotomy/craniectomy/twist drill/burr hole: Thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray). Stereotactic implantation of neurostimulator electrode array in subcortical site, with use of intraoperative microelectrode recording: First array		676.60		541.28		11.00T	
6163	Craniotomy/craniectomy/twist drill/burr hole: Thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray). Stereotactic implantation of neurostimulator electrode array in subcortical site, with use of intraoperative microelectrode recording: Each additional array. ADD to main procedure	+	147.50		120.00			
6164	Craniectomy: Implantation of neurostimulator electrodes, cerebellar, cortical		352.10		281.68		11.00T	
6166	Revision/removal: Neurostimulator electrodes, intracranial		171.60		137.28		11.00T	
6167	Insertion/replacement (usually in the infraclavicular area) of cranial neurostimulator pulse generator or receiver with connection to a single electrode array; direct or inductive coupling		156.30		125.04		5.00T	
6168	Insertion/replacement (usually in the infraclavicular area) of cranial neurostimulator pulse generator or receiver with connection to two or more electrode arrays; direct or inductive coupling		255.20		204.16		5.00T	
6169	Revision/removal: Neurostimulator pulse generator/receiverof, cranial		117.00		117.00		3.00T	

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14.8.2	**Surgery of Skull Base**							
14.8.2.1	**Approach Procedures**							
14.8.2.1.1	**Anterior Cranial Fossa**							
6170	Transoral approach: Skull base, brain stem or upper spinal cord for biopsy, decompression/excision of lesion and tracheostomy		742.00		593.60		11.00T	
6171	Transoral approach: Skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion. Includes requiring splitting of tongue and/or mandible and tracheostomy		1020.80		816.64		11.00T	
6172	Craniofacial approach procedure: With exposure of the anterior cranial fossa to treat an extradural lesion/defect at the skull base which requires orbital exenteration, lateral rhinotomy, ethmoidectomy, sphenoidectomy and/or maxillectomy		804.60		643.68		11.00T	
6173	Revision/removal: Cranial neurostimulator pulse generator/receiver		919.30		735.44		11.00T	
6174	Anterior cranial fossa: Craniofacial approach, to treat an extradural lesion/defect at the skull base which requires unilateral or bifrontal craniotomy (included in the approach procedure) with elevation or resection of frontal lobe		866.30		693.04		11.00T	
6175	Anterior cranial fossa: Orbitocranial approach, with exposure of the to treat an extradural lesion/defect at the skull base requiring supraorbital ridge osteotomy (included in the approach procedure) and elevation of the frontal and/or temporal lobes, without orbital exenteration		852.80		682.24		11.00T	
6176	Anterior cranial fossa: Orbitocranial approach, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s), with orbital exenteration		967.20		773.76		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6177	Treatment of lesion/defect at the skull base: Bicoronal (scalp incision), transzygomatic (removal of the zygoma) and/or LeFort1 osteotomy (intraoral approach to fracture the maxilla), with/without internal fixation /without bone graft,		739.50		591.60		11.00T	
14.8.2.1.2	**Middle Cranial Fossa**							
6178	Middle cranial fossa: Pre-auricular approach, Infratemporal , (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with/without disarticulation of the mandible, includes parotidectomy, craniotomy, decompression and/or mobilisation of the facial nerve and/or petrous carotid artery		911.40		729.12		11.00T	
6179	Middle cranial fossa: Post-auricular approach, Infratemporal, middle cranial fossa (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa), includes mastoidectomy, resection of sigmoid sinus, with/without decompression and/or mobilisation of contents of auditory canal or petrous carotid artery		923.80		739.04		11.00T	
6180	Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe		948.00		758.40		11.00T	
14.8.2.1.3	**Posterior Cranial Fossa**							
2897	Resection/excision of neoplastic, vascular or infectious lesion: Base of posterior cranial fossa/jugular foramen/foramen magnum or C1-C3 vertebral bodies, extradural		674.70		539.76		13.00T	
6181	Posterior cranial fossa: Transtemporal approach to jugular foramen/midline skull base, includes mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with/without mobilisation		708.50		566.80		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6182	Posterior cranial fossa: Transcochlear approach to posterior cranial fossa/jugular foramen/midline skull base,includes labyrinthectomy, decompression, with/without mobilisation of facial nerve and/or petrous carotid artery		732.50		586.00		11.00T	
6183	Posterior cranial fossa: Transcondylar (far lateral) approach to jugular foramen /midline skull base, includes occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with/without mobilisation		861.50		689.20		11.00T	
6184	Posterior cranial fossa: Transpetrosal approach to clivus/foramen magnum, includes ligation of superior petrosal sinus and/or sigmoid sinus		848.50		678.80		11.00T	
14.8.2.2	**Definitive Procedures**							
	Note: Definitive Procedures: The definitive procedure(s) describes the repair, biopsy, resection, or excision of various lesions of the skull base and, when appropriate, primary closure of the dura, mucous membranes, and skin.							
14.8.2.2.1	**Base of Anterior Cranial Fossa**							
6185	Resection/excision neoplastic/vascular/infectious lesion: Base of anterior cranial fossa, extradural		640.30		512.24		11.00T	
6186	Resection/excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa (includes dural repair, with/without graft), intradural		716.70		573.36		11.00T	
14.8.2.2.2	**Base of Middle Cranial Fossa**							
6187	Resection/excision of neoplastic/vascular/ infectious lesion: Infratemporal fossa, parapharyngeal space, petrous apex, extradural		651.30		521.04		11.00T	
6188	Resection/excision of neoplastic/vascular/infectious lesion: Infratemporal fossa, parapharyngeal space, petrous apex, includes dural repair, with/without graft, intradural		891.60		713.28		11.00T	
6189	Resection/excision of neoplastic, vascular or infectious lesion: Parasellar area, cavernous sinus, clivus or midline skull base, extradural		857.60		686.08		11.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
6190	Resection/excision of neoplastic, vascular or infectious lesion: Parasellar area/cavernous sinus/clivus or midline skull base, intradural, including dural repair, with/without graft		967.40		773.92		11.00T	
6192	Transection/ligation: Carotid artery in cavernous sinus, with repair by anastomosis/graft. ADD to main procedure	+	553.40		442.72			
6193	Transection or ligation, carotid artery in petrous canal; without repair. ADD to main procedure		109.30		109.30			
6194	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft. ADD to main procedure	+	410.80		328.64			
6195	Destruction of carotid aneurysm/arteriovenous malformation (AVM) or carotid-cavernous fistula by dissection within cavernous sinus		977.50		782.00		15.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
14.8.2.2.3	**Base of Posterior Cranial Fossa**							
5235	Resection/excision of neoplastic, vascular or infectious lesion: Base of posterior cranial fossa/jugular foramen/foramen magnum or C1-C3 vertebral bodies, includes dural repair, with/without graft		989.60		791.68		13.00T	
14.8.2.2.4	**Repair and/or Reconstruction of Surgical Defects of Skull Base**							
6196	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary repair, anterior, middle or posterior cranial fossa following surgery of the skull base, by free tissue graft (e.g. pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)		388.70		310.96		11.00T	
6197	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary ranterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalised vascularised pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)		437.80		350.24		11.00T	
14.9	**Spinal operations**							
	Note: See section 3.8.7 for laminectomy procedures							
2923	Chordotomy: Unilateral		178.00		142.40		3.00TM	
2925	Chordotomy: Open		350.00		280.00		3.00TM	
2927	Rhizotomy: Extradural, but intraspinal		320.00		256.00		3.00TM	
2928	Rhizotomy: Intradural		350.00		280.00		3.00TM	
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach		700.00		560.00		8.00T	
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach		700.00		560.00		8.00T	
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach		350.00		280.00		3.00TM	
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach		350.00		280.00		8.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach		320.00		256.00		7.00T	
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy		225.00		180.00		3.00T	
2937	Repair of meningocele, involving nerve tissue		250.00		200.00		9.00T	
2938	Simple		150.00		120.00		9.00T	
2939	Excision of arterial vascular malformations and cysts of the spinal cord		700.00		560.00		9.00T	
2940	Lumbar osteophyte removal		187.00		149.40		3.00TM	
2941	Cervical or thoracic osteophyte removal		285.00		228.00		3.00TM	
14.10	**Arterial ligations**							
2951	Carotis: Trauma		120.00		120.00		8.00T	
2953	Carotis: For aneurysm (AV anomaly)		150..00		120.00		8.00T	
2955	Removal of carotid body tumour (without vascular reconstruction)		335.60		268.48		8.00T	
14.11	**Medical psychotherapy**							
2957	Psychotherapy (specific psychotherapy with approved evidence based method): Per short session (10-20 minutes)		16.00		16.00		20.00	
2958	Psychoanalytic therapy: Per 60-minute session							
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session							
2963	Pairs, marriage or sex therapy: Per 20-minute session							
2974	Psychotherapy (specific psychotherapy with approved evidence based method): Per intermediate session (21-40 minutes)		32.00		32.00		40.00	
2975	Psychotherapy (specific psychotherapy with approved evidence based method): Per extended session (41 minutes and longer)		48.00		48.00		60.00	
2968	Group therapy: Adults (specify number): Code per person per 80-minute session; Children (specify number): Code per person per 80-minute session		8.00		8.00		26.00	
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session							

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Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session							
14.12	**Physical treatment methods**							
2970	Electro-convulsive treatment (ECT): Each time (See rule Va)		17.00		17.00		17.00	
14.13	**Psychiatric examination methods**							
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per 60 min session		16.00		16.00		60.00	
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)		16.00		16.00		20.00	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
15. Endocrine System								
15.1	**Thyroid**							
2983	Lobectomy: Partial		198.10		158.48		5.00T	
2985	Lobectomy: Total		200.00		160.00		5.00T	
2987	Thyroidectomy: Subtotal		266.00		2212.80		5.00T	
2989	Thyroidectomy: Total		279.00		223.20		5.00T	
2991	Thyroglossal cyst or fistula excision		126.20		120.00		5.00T	
15.2	**Parathyroid**							
2993	Exploration of parathyroid glands for hyperparathyroidism including removal		280.10		224.08		6.00T	
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		335.30		268.24		6.00T	
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		370.70		296.56		12.00T	
2994	Parathyroid: Autotransplantation of parathyriod: ADD to major procedure (modifier 0005 does not apply)	+	70.50		70.50		6.00T	
15.3	**Adrenals**							
2995	Adrenalectomy: Unilateral		225.00		180.00		9.00T	
2997	Bilateral exploration of adrenal glands: Including removal		394.00		315.20		11.00T	
15.4	**Hypophysis**							
2999	Transethmoidal hypophysectomy		300.00		240.00		11.00T	
3000	Transnasal hypophysectomy (see also item 2915)		300.00		240.00		11.00T	
15.5	**Endocrine system: General**							
3001	Implantation of pellets (excluding cost of material) (excluding after-care)		3.00		3.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
15.6	**Ambulatory continuous glucose monitoring of interstitial tissue fluid**							
2996	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours: Includes sensor placement, hook-up, calibration of monitor, patient training, removal of sensor and printout of recording		48.90		48.90			
2998	Ambulatory continuous glucose monitoring: Interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours (includes interpretation and report)		12.30		12.30			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
16. Eye								
	a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra item may be coded where each eye is examined separately on two different occasions **b. Material used is excluded** **c. The cost for photography is not related to the number of photographs taken**							
16.1	**Eye: Procedures performed in rooms**							
16.1.1	**Eye investigations**							
	Note: Not more than three (3) items in this section may be coded during one visit							
3002	Gonioscopy		7.00		7.00			
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)		7.00		7.00			
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)		7.00		7.00			
3006	Keratometry		7.00		7.00			
3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	+	11.68					
3012	Pre-surgical retinal examination before retinal surgery		32.00		32.00			
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for patients over 7 years of age		19.60		19.60			
3038	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for children 7 years and younger		45.00		45.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)		7.00		7.00			
3021	Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations		9.00		9.00			
16.1.2	**Special eye investigations**							
3005	Endothelial cell count		7.00		7.00			
3007	Potential acuity measurement		7.00		7.00			
3008	Contrast sensitivity test		7.00		7.00			
3010	Orthoptics consultation		10.00		10.00			
3011	Orthoptic subsequent sessions		5.00		5.00			
3015	Charting of visual field with manual perimeter		28.00		28.00			
3016	Retinal threshold test without storage facilities		30.00		30.00			
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs		74.00		74.00			
3018	Retinal threshold trend evaluation (additional to item 3017)		16.00		16.00			
3019	Ocular muscle function with Hess screen or perimeter		16.00		16.00			
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery		46.00		46.00			
3022	Digital fluorescein video angiography		68.00		68.00		9.00T	
3023	Digital indocyanine video angiography		110.00		110.00		9.00T	
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039		12.00		12.00			
3025	Electronic tonography		19.00		19.00			
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum		19.30		19.30			
3027	Fundus photography		21.00		21.00			
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye		40.00		40.00			
3029	Anterior segment microphotography		21.00		21.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)		45.00		45.00			
3032	Eyelid and orbit photography		9.00		9.00			
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians		16.00		16.00			
3034	Determination of lens implant power per eye		15.00		15.00			
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional item may be coded - Anaesthetic: As per procedure		22.00		22.00			
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)		36.00		36.00			
3040	Femtosecond Laser: Equipment hire. For one or both eyes done in one session							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
16.2	**Retina**							
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy		306.90		245.52		6.00T	
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye (aftercare excluded)		105.00		105.00		6.00T	
3041	Pan retinal photocoagulation (per eye): Done in one sitting (aftercare excluded)		150.00		120.00		6.00T	
3044	Removal of encircling band and/or buckling material		105.00		105.00		6.00T	
16.3	**Cataract**							
3045	Cataract: Intra-capsular		210.00		168.00		7.00T	
3047	Cataract: Extra-capsular (including capsulotomy)		210.00		168.00		7.00T	
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)		57.00		57.00		7.00T	
3050	Repositioning of intra ocular lens		171.10		136.88		7.00T	
3051	Needling or capsulotomy		130.00		120.00		4.00T	
3052	Laser capsulotomy (aftercare excluded)		105.00		105.00		4.00T	
3057	Removal of lenticulus		210.00		168.00		7.00T	
3058	Exchange of intra ocular lens		236.00		188.80		7.00T	
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)		210.00		168.00		7.00T	
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)		4.00					
16.4	**Glaucoma**							
3061	Drainage operation		247.60		198.08		6.00T	
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)		60.00		60.00		6.00T	
3063	Cyclocryotherapy or cyclodiathermy		105.00		105.00		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3064	Laser trabeculoplasty		105.00		105.00		6.00T	
3065	Removal of blood from anterior chamber		105.00		105.00		4.00T	
3067	Goniotomy		210.00		168.00		7.00T	
16.5	**Intra-ocular foreign body**							
3071	Intra-ocular foreign body: Anterior to Iris		127.00		120.00		4.00T	
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)		210.00		168.00		6.00T	
16.6	**Strabismus**							
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to item 0202)		20.00		20.00			
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles		175.60		140.48		5.00T	
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles		200.00		160.00		5.00T	
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles		120.00		120.00		5.00T	
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles		150.00		120.00		5.00T	
16.7	**Globe**							
3079	Transcleral biopsy		132.00		120.00		4.00T	
3080	Examination of eyes under general anaesthetic where no surgery is done		80.00		80.00		4.00T	
3081	Treatment of minor perforating injury		161.60		129.28		6.00T	
3083	Treatment of major perforating injury		267.50		214.00		6.00T	
3085	Enucleation or Evisceration		105.00		105.00		5.00T	
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis		160.00		128.00		5.00T	
3088	Hydroxyapetite insertion (additional to item 3087)	+	40.00		40.00		5.00T	
3089	Subconjunctival injection if not done at time of operation		10.00		10.00		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3090	Intra vitreal injection drug		47.60		47.60		4..00T	
3091	Retrobulbar injection (if not done at time of operation)		16.00		16.00		4..00T	
3092	External laser treatment for superficial lesions		53.00		53.00			
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation		209.00		167.20		6.00T	
3094	Implantation of intra vitreal drug delivery system		247.60		198.08		4.00T	
3095	Biopsy of vitreous body or anterior chamber contents		105.00		105.00		6.00T	
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy		130.00		120.00		7.00T	
3097	Anterior vitrectomy		280.00		224.00		6.00T	
3098	Removal of silicon from globe		280.00		224.00		6.00T	
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement		419.00		335.20		6.00T	
3100	Lensectomy done at time of posterior vitrectomy		30.00		30.00		7.00T	
16.8	**Orbit**							
3101	Drainage of orbital abscess		105.00		105.00		5.00T	
3103	Orbit: Removal of tumour		240.00		192.00		5.00T	
3104	Removal orbital prosthesis		212.70		170.16		5.00T	
3105	Orbit: Exenteration		275.00		220.00		5.00T	
3107	Orbitotomy requiring bone flap		393.00		314.40		5.00T	
3108	Eye socket reconstruction		206.00		164.80		5.00T	
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously		300.00		240.00		5.00T	
3110	Second stage hydroxyapetite implantation		110.00		110.00		5.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
16.9	**Cornea**							
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)		*		*			
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens in pathological corneal conditions such as: corneal erosion, ulcer, abrasion or corneal wound		12.20		12.20			
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one (1) year		200.00		160.00			
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only		78.85					
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included		166.00		132.80			
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty		135.20		120.00		6.00T	
3117	Removal of foreign body: On the basis of fee per consultation		*		*		4.00T	
3118	Curettage of cornea after removal of foreign body (after-care excluded)		10.00		10.00			
3119	Tattooing		26.00		26.00		4.00T	
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)		150.00		120.00		6.00T	
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	+	52.18		52.18			
3121	Corneal graft (Lamellar or full thickness)		289.00		231.20		6.00T	
3122	Epikeratophakia		289.00		231.20			
3123	Insertion of intra-corneal or intrascleral prosthesis: Pathological cornea		470.80		376.64		6.00T	
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). For use of sterile tray, add item 0202		9.00		9.00			
3125	Keratectomy		127.00		120.00		6.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)		10.00		10.00		4.00T	
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)		150.00		120.00		6.00T	
3129	Additional to item 3128 for the use of own diamond knives	+	40.00		40.00			
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used		96.90		96.90		4.00T	
3131	Cornea: Paracentesis - stand-alone procedure		53.00		53.00		4.00T	
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)		150.00		120.00		6.00T	
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure		116.30		116.30		4.00T	
3136	Conjunctival flap or graft (not for use with pterigium surgery)		95.70		95.70		6.00T	
3138	Removal corneal epithelium and chelating agent for band keratopathy		69.50		69.50		4.00T	
4980	Corneal transplant: Endothelial		274.80		219.84		6.00T	
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)							
4983	Lamellar corneal surgery keratome and equipment							
4985	Corneal cross linking		150.00		150.00		6.00T	
4986	Cross linking: Equipment hire		54.00		54.00			
4988	Endothelial specular microscope for donor corneas							
4989	Endothelial specular microscope for clinical use							
16.10	**Ducts**							
3133	Probing and/or syringing, per duct		10.00		10.00		4.00T	
3135	Insert polythene tubes		51.80		51.80		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3137	Excision of lacrimal sac: Unilateral		132.00		120.00		4.00T	
3139	Dacrocystorhinostomy (Single) with or without polythene tube		210.00		168.00		5.00T	
3141	Sealing Punctum surgical or by cautery: Per eye		24.90		24.90		4.00T	
3142	Sealing Punctum with plugs: Per eye		20.00		20.00		4.00T	
3143	Three-snip operation		10.00		10.00		4.00T	
3145	Repair of caniculus: Primary procedure		132.00		120.00		4.00T	
3147	Repair of caniculus: Secondary procedure		175.00		140.00		4.00T	
16.11	**Iris**							
3149	Iridectomy or iridotomy by open operation as isolated procedure		132.00		120.00		4.00T	
3151	Excision of iris tumour		185.00		148.00		6.00T	
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)		105.00		105.00		4.00T	
3155	Iridocyclectomy for tumour		266.00		212.80		6.00T	
3157	Division of anterior synechiae as isolated procedure		132.00		120.00		4.00T	
3158	Repair iris as in dialysis: Anterior chamber reconstruction		142.00		120.00		4.00T	
16.12	**Lids**							
3161	Tarsorrhaphy		47.00		47.00		4.00T	
3163	Excision of superficial lid tumour		47.00				4.00T	
3165	Repair of skin laceration lid: Simple		27.30		27.30		4.00T	
3167	Diathermy to wart on lid margin		12.00		12.00		4.00T	
3169	Electrolysis of any number of eyelashes: Per eye		15.00		15.00			
3171	Excision of Meibomian cyst. For use of sterile tray, add item 0202		20.40		20.40		4.00T	
3173	Epicanthal folds		128.70		120.00		4.00T	
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)							
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material		187.00		149.60		4.00T	
16.12.1	**Lids: Entropion or ectropion**							
3177	Entropion or ectropion by Cautery		10.00		10.00		4.00T	
3179	Entropion or ectropion by Suture		49.40		49.40		4.00T	
3181	Entropion or ectropion by Open operation		111.50		111.50		4.00T	
3183	Entropion or ectropion by Free skin, mucosal grafting or flap		122.60		120.00		4.00T	
16.12.2	**Lids: Reconstruction of eyelid**							
3185	Staged procedure for partial or total loss of eyelid: First stage		259.00		207.20		4.00T	
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage		206.00		164.80		4.00T	
3189	Full thickness eyelid laceration for tumour or injury: Direct repair		136.50		120.00		4.00T	
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)		150.20		120.16		4.00T	
3172	Blepharoplasty lower eyelid plus fat pad		125.80		120.00		4.00T	
16.12.3	**Lids: Ptosis**							
3193	Repair by superior rectus, levator or frontalis muscle operation		190.00		152.00		4.00T	
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral		137.60		120.00		4.00T	
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral		166.00		132.80		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
16.13	**Conjunctiva**							
3199	Repair of conjunctiva by grafting		132.00		120.00		4.00T	
3200	Repair of lacerated conjunctiva		47.00		47.00		4.00T	
16.14	**Eye: General**							
3196	Diamond knife: Use of own diamond knife during intraocular surgery		12.00					
3198	Excimer laser: Hire fee (per eye)		284.13					
3201	Laser apparatus (ophthalmic): Equipment hire for one or both eyes done in one sitting (Not to be used with IOL Master)		109.00					
3190	Holmium laser apparatus (ophthalmic): Equipment hire for one or both eyes done in one session		109.00					
3202	Phako emulsification apparatus: Equipment hire		109.00					
3203	Vitrectomy apparatus: Equipment hire		120.00					

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
17. Ear								
17.1	**External ear (Pinna)**							
3267	Major congenital deformity reconstruction of external ear: Unilateral		138.00		120.00		5.00T	
3269	Major congenital deformity reconstruction of external ear: Bilateral		242.00		193.60		5.00T	
3270	Excision of superficial pre-auricular fistula		55.00		55.00		4.00T	
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear		*		*			
3272	Excision of complicated pre-auricular fistula		140.00		120.00		4.00T	
5170	Drainage: Haematoma or abscess of external ear		34.80		34.80		5.00T	
5171	Drainage: Abscess of external auditory canal		21.00		21.00		5.00T	
5173	Biopsy: External ear		12.40		12.40		5.00T	
5175	Excision: External ear, partial, simple repair		63.50		63.50		5.00T	
5176	Excision: External ear, complete		66.80		66.80		5.00T	
17.2	**External ear canal**							
3204	External ear canal: Removal of foreign body at rooms with the use of a microscope (excludes loupe) - not to be used combined with item 3206		21.58		21.58			
3205	External ear canal: Removal of foreign body: Under general anaesthetic		21.00		21.00		4.00T	
3208	Biopsy: External auditory canal		15.50		15.50		5.00T	
3215	Meatus atresia: Repair of stenosis of cartilaginous portion		164.00		131.20		4.00T	
3217	Meatus atresia: Congenital		277.00		221.60		4.00T	
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) - not to be used combined with item 3206		17.42		17.42			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3219	Meatus atresia: Removal of osteoma from meatus: Solitary		77.00		77.00		4.00T	
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) - not to be used combined with item 3206		23.14		23.14			
3221	Meatus atresia: Removal of osteoma from meatus: Multiple		215.00		172.00		4.00T	
3216	Excision: Radical, external auditory canal lesion, without neck dissection		252.50		202.00		5.00T	
3222	Excision: Radical, external auditory canal lesion, with neck dissection		381.80		305.44		7.00T	
17.3	**Middle ear**							
3206	Microscopic examination of tympanic membrane including microsuction		8.00		8.00			
3207	Myringotomy: Unilateral		28.00		28.00		4.00T	
3209	Myringotomy: Bilateral		46.00		46.00		4.00T	
3211	Unilateral myringotomy with insertion of ventilation tube		38.00		38.00		4.00T	
3212	Bilateral myringotomy with insertion of unilateral ventilation tube		57.00		57.00		4.00T	
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)		65.00		65.00		4.00T	
3214	Reconstruction of middle ear ossicles (ossiculoplasty)		255.00		204.00		5.000T	
3237	Exploratory tympanotomy		158.90		127.12		5.000T	
3243	Myringoplasty		138.00		120.00		5.000T	
3245	Functional reconstruction of tympanic membrane		277.00		221.60		5.000T	
3249	Stapedotomy and stapedectomy		277.00		221.60		5.000T	
3257	Cortical mastoidectomy		188.50		150.80		5.00T	
3259	Radical mastoidectomy (excluding minor procedures)		277.40		221.92		5.00T	
3261	Muscle grafting to mastoid cavity without tympanoplasty		180.00		144.00		5.00T	
3263	Autogenous bone graft to mastoid cavity		180.00		144.00		5.00T	
3264	Tympanomastoidectomy		375.00		300.00		5.00T	
3265	Reconstruction of posterior canal wall, following radical mastoid		320.00		256.00		5.00T	

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PART 3 OF 4

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)		30.00		30.00		5.00T	
5190	Debridement: Mastoidectomy cavity, complex (anaesthesia/more than routine cleaning)		24.10		24.10		5.00T	
5191	Tympanolysis: Transcanal		119.40		119.40		5.00T	
5193	Implantation/replacement: Electromagnetic temporal bone conduction hearing device		199.60		159.68		5.00T	
5194	Removal/repair: Electromagnetic temporal bone conduction hearing device		199.60		159.68		5.00T	
5196	Implantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy		265.40		212.32		5.00T	
5197	Implantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy		336.20		268.96		5.00T	
5199	Revision: Stapedectomy or stapedotomy		314.90		251.92		5.00T	
5201	Revision: Mastoidectomy resulting in total mastoidectomy		271.50		217.20		5.00T	
5202	Revision: Mastoidectomy resulting in modified radical mastoidectomy		279.50		222.80		5.00T	
5203	Revision: Mastoidectomy followed by tympanoplasty		287.00		229.60		5.00T	
5204	Revision: Mastoidectomy, with apicectomy		346.80		277.44		5.00T	
17.4	**Facial nerve**							
17.4.1	**Facial nerve: Facial nerve tests**							
3223	Percutaneous stimulation of the facial nerve		9.00		9.00		4.00T	
3224	Electroneurography (ENOG)		75.00		75.00		4.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
17.4.2	**Facial nerve: Facial nerve surgery**							
3227	Exploration of facial nerve: Exploration of tympanomastiod segment		297.00		237.60		5.00T	
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)		436.00		348.80		5.00T	
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve		436.00		348.80		5.00T	
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis		124.00		120.00		6.00T	
17.5	**Inner ear**							
17.5.1	**Inner ear: Audiometry**							
3273	Pure tone audiometry (air conduction)		6.50		6.50			
3274	Pure tone audiometry (bone conduction with masking)		6.50		6.50			
3275	Impedance audiometry (tympanometry)		6.50		6.50			
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.		6.50		6.50			
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score		10.00		10.00			
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)		6.50		6.50			
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral		50.00					
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral		88.00					
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels		60.00					
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels		105.00					
2695	Audiology 40Hz response: Unilateral		30.00					
2696	Audiology 40Hz response: Bilateral		53.00					

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
2697	Mid- and long latency auditory evoked potentials: Unilateral		30.00					
2698	Mid- and long latency auditory evoked potentials: Bilateral		53.00					
2699	Electro-cochleography: Unilateral		50.00					
2700	Electro-cochleography: Bilateral		88.00					
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography		140.00				4.00T	
3248	Otoacoustic emission performed as a screening test		33.24		33.24			
3250	Otoacoustic emission (high risk patients only)		66.48		66.48			
17.5.2	**Inner ear: Balance tests**							
3251	Minimal caloric test (excluding consultation fee)		10.00		10.00			
3252	Bithermal Halpike caloric test (excluding consultation fee)							
3253	Electro-nystagmography for spontaneous and positional nystagmus							
3254	Video nystagmoscopy (monocular)		25.00		25.00			
3255	Caloric test done with electronystamography							
3256	Video nystagmoscopy (binocular)		50.00		50.00			
3258	Otolith repositioning manoeuvre		14.00		14.00		4.00T	
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems		71.48		71.48			
5210	Nystagmus test: Spontaneous, including gaze and fixation nystagmus (report included)		10.20		10.20			
5211	Nystagmus test: Positional, minimum of 4 positions (report included)		9.10		9.10			
5212	Caloric vestibular test: Each irrigation (report included)		3.20		3.20			
5213	Nystagmus test: Optokinetic bidirectional, foveal or peripheral stimulation (report included)		7.20		7.20			
5214	Oscillating tracking test (report included)		6.50		6.50			
5215	Rotational testing: Sinusoidal vertical axis		8.00		8.00			

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
5216	Posturography: Dynamic, computerised		25.10		25.10			
17.5.3	**Middle and Inner ear surgery**							
3233	Labyrinthectomy via the middle ear or mastoid		277.00		221.60		5.00T	
3240	Endolymphatic sac surgery		277.00		221.60		5.00T	
3241	Fenestration: Semicircular canal		199.00		159.20		5.00T	
3242	Fenestration: Revision		197.60		158.08		5.00T	
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)		310.00		248.00		5.00T	
3246	Cochlear implant surgery		340.50		272.40		5.00T	
17.6	**Microsurgery of the skull base**							
17.6.1	**Microsurgery of the skull base: Middel fossa approach (i.e transtemporal or supralabyrinthine)**							
3229	Facial nerve decompression: Drilling out the mastoid cavity or combined transmastoid and middle fossa approach requiring excision of a piece of temporal bone, and decompression of the medial to the geniculate ganglion, intratemporal (total procedure)		565.80		452.64		5.00T	
5221	Vestibular nerve section: Translabyrinthine approach (total procedure)		463.20		370.56		5.00T	
5222	Facial nerve: Suture, with/without graft or decompression, includes medial to geniculate ganglion, intratemporal		375.50		300.40		5.00T	
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours or similar middle fossa (resection 2)		535.20		424.00		11.00T	
5224	Removal of acoustic neuroma via the middle fossa approach							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
17.6.2	**Microsurgery of the skull base: Translabyrinthe approach**							
5227	Cochleo-vestibular neurectomy		530.00		424.00		11.00T	
5228	Nerve section: Vestibular, transcranial approach (approach 1): Graft harvesting not included		458.50		366.80		11.00T	
3239	Acoustic neuroma removal translabyrinthine							
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)							
17.6.3	**Microsurgery of the skull base: Transotic approach to the cerebellopontime angle**							
5232	Removal of acoustic neuroma or cyst of the internal auditory canal							
17.6.4	**Microsurgery of the skull base: Intratemporal fossa approach type A**							
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours							
17.6.5	**Microsurgery of the skull base: Intratemporal fossa approach type B**							
5238	Removal of tumour: Temporal bone		643.40		514.72		11.00T	
5239	Removal of tumour of the clivus							
17.6.6	**Microsurgery of the skull base: Intrafemoral approach type C**							
5242	Removal of nasopharyngeal angiofibroma or carcinoma							
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx							

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
17.6.7	**Microsurgery of the skull base: Subtotal petrosectomy**							
5246	Resection of temporal bone: External approach by elevating the auricle with superior flap		804.40		643.52		5.00T	
5247	Petrous apicectomy: Includes radical mastoidectomy through postaural or endaural incision		505.50		404.40		5.00T	
17.6.8	**Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa**							
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland		520.00		416.00		11.00T	
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland		600.00		480.00		8.00T	
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland		660.00		528.00		8.00T	

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
18. Physical Treatment								
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	+	0.75					
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)		13.50					
3281	Ultrasonic therapy		10.00					
3282	Shortwave diathermy		10.00					
3284	Sensory nerve conduction studies (Other specialists/General practitioners use item 0735)		31.00					
3285	Motor nerve conduction studies (Other specialists/General practitioners use item 0733)		26.00					
3287	Spinal joint and ligament injection		20.00		20.00			
3288	Epidural injection (Other specialists/General practitioners use item 2801)		36.00					
3289	Multiple injections: First joint (Other specialists/General practitioners use to item 0663)		7.50					
3290	Multiple injections: Each additional joint (Other specialists/General practitioners use item 0665)	+	4.50					
3291	Tendon or ligament injection (Other specialists/General practitioners use item 0763)		9.00					
3292	Aspiration of joint or inter-articular injection (Other specialists/General practitioners use item 0661)		9.00					
3293	Aspiration or injection of bursa or ganglion (Other specialists/General practitioners use item 0851)		9.00					
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389) (Other specialists/General practitioners use item 2800)		20.00					
3295	Paravertebral root block: Unilateral (Other specialists/General practitioners use item 2800)		20.00					
3296	Paravertebral root block: Bilateral (Other specialists/General practitioners use item 2800)		30.00					
3297	Manipulation of spine performed by a specialist in Physical Medicine (Pr "034")		14.00					
3298	Spinal traction		6.00					

Modifier	Description	Add-on Codes	Specialists		General Practitioners		Anaesthesia administered	
			Units	Value	Units	Value	Units	Value
3299	Manipulation of large joints: Under general anaesthesia (Other specialists/General practitioners use to item 0669) - Anaesthetic: Knee/Shoulder		14.00				3.00T	
3299a	Manipulation of large joints: Under general anaesthesia (Other specialists/General practitioners use to item 0669) - Anaesthetic: Hip						4.00T	
3300	Manipulation of large joints: Without anaesthetic (Other specialists/General practitioners use item 0670)		*					
3301	Muscle fatigue studies (Other specialists/General practitioners use item 0740)		20.00					
3302	Strength duration curve per session (Other specialists/General practitioners use item 0715)		10.50					
3303	Electromyography (Other specialists/General practitioners use item 0713)		75.00					
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (For subsequent treatments by a general practitioner, for the same condition within 4 months after the initial treatment: A code for the treatment only, is applicable: See general rules L and M)		10.00		10.00			

MENTAL HEALTH CARE FACILITIES

	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated,		
	GENERAL RULES		
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.		
C	Where possible, accounts shall reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.		
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on reques		
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.		
E.3.3	Mental Institutions refers to all institutions registered with the Department of Health in terms of the Mental Health Care Act 17 of 2002 having practice code numbers commencing with the digits 55.		
F	Accommodation fees includes the services listed below:		
	A. The minimum services that are required are items 3, 5 and 6.		
	B. If any of the other services included in this list are requested, no additional charge may be levied by the hospital.		
	1 Pre-authorisation (up to the date of admission) of:		
	· length of stay		
	· level of care		
	· theatre procedures		
	2 Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation		
	3 Notification of admission		
	4 Immediate notification of changes to:		
	· length of stay		
	· level of care		
	· theatre procedures		
	5 Reporting of length of stay and level of care		
	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.		
	6 Discharge ICD-10 and CPT-4 coding		

	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.		
	· Including coding of complications and co-morbidity. To be done as accurately as practically possible by the hospital.		
	7 Case management by means of standard documentation and liaiso with hospital appointed case managers		
	· Liaison means communication and sharing of information between case managers, but does not include active case management by the hospital.		
	SCHEDULE	**Tariff**	**2020 Tariff**
8	INSTITUTIONS REGISTERED IN TERMS OF THE MENTAL HEALTH ACT 1973 WITH A PRACTICE NUMBER COMMENCING WITH "55"		
4	General ward fee: with overnight stay	R1 579,04	R 1 666,41
5	General ward fee: without overnight stay	R1 161,49	R 1 225,76
6	General ward fee: under 5 hours stay	R601,33	R 634,61
45	Ward and dispensary drugs. The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 A		
	In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.		
55	Electroconvulsive therapy (ECT) (No theatre fee chargeable)	R789,19	R 832,86
231	Monitors	R231,14	R 243,93
273	To take out. Dispensed items including ampoules, over the counter and proprietary items issued to patients. All items must be shown on accounts. Dispensed items including ampoules, over the counter and proprietary items issued to patients. The same princ	0	

OCCUPATIONAL AND ART THERAPY

Code	Description
	REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF OCCUPATIONAL THERAPY (R2145 - 31 July 1992) Practice Type: Occupational Therapy Code: 066 Practice Type: Art Therapist Code: 067
	GENERAL RULES
6	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency occupational therapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Rule 006 does not apply to art therapy.
8	The provision of assistive devices shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands. Modifier 0008 must be quoted after the appropriate code numbers to show that this rule is applicable.
9	Materials used in the construction of orthoses or pressure garments shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0009 must be quoted after the appropriate code numbers to show that this rule is applicable. Rule 009 does not apply to art therapy.
10	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Modifier 0010 must be quoted after the appropriate code numbers to show that this rule is applicable.
11	Where the therapist performs treatments away from the treatment rooms, travelling costs to be charged according to AA rates e.g. for domicilliary treatments or treatments in nursing homes. Modifier 0011 must be quoted after the appropriate code numbers to show that this rule is applicable.
12	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars:

	i The name and practice number of the consulting occupational or art therapist. ii The name of the patient. iii The nature of the treatment. iv The date on which the service was rendered. v The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.
13	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account. Please note: In the case of occupational therapy, a code will only be required when a standard proprietary (off the shelf) product is used. When a splint or support is made by the occupational therapist using or modifying one or more components, a code cannot accurately identify this non-standard product. Please refer to annexure itemising the most commonly made non-standard products used in occupational therapy and bill accordingly. The Occupational Therapy Association of S A has made available a generic list of non-proprietary splints and pressure garments commonly made by practitioners. The type of materials used to manufacture these products is at the discretion of the practitioner concerned. Price of splints and pressure garments may vary. See Annexures A & B.
	Modifiers
6	Add 50% of the total fee for the procedure. Modifier 0006 does not apply to art therapy.
8	Assistive devices to be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.
9	Materials used for orthoses or pressure garments to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. See Annexures A & B for non-standard products. Modifier 0009 does not apply to art therapy.
10	Materials used in treatment to be charged (exclusive of VAT) at net acquisition price plus - - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.
11	Travelling costs according to AA rates.
21	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.

		2019 Tariff				2020 Tariff			
	ITEMS	Code 066		Code 067		Code 066		Code 067	
1	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**	**UNITS**	**VALUE**	**UNITS**	**VALUE**	**UNITS**	**VALUE**	**UNITS**	**VALUE**
108	Interview, guidance or consultation: 30 minute duration.	21,5	R308,79	21,5	R169,10		R 325,88		R 178,46
109	Interview, guidance or consultation. Each additional 15 mins. A maximum of four instances of this code may be charged per session.	10,63	R154,33	10,625	R84,49		R 162,87		R 89,17
	Time based items in this section exclude time spent on procedures charged in addition to the consultation								
107	Appointment not kept	0		0					
110	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required	16,5	R244,71	22,14	R176,24		R 258,25		R 185,99
2	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT.**								
201	Observation and screening.	7,5	R109,02	10	R79,61		R 115,05		R 84,02
203	Specific evaluation for a single aspect of dysfunction (Specify which aspect).	7,5	R109,02	10	R79,61		R 115,05		R 84,02
205	Specific evaluation of dysfunction involving one part of the body for a specific functional problem (Specify part and aspects evaluated)	22,5	R326,94	30	R238,70		R 345,03		R 251,91
207	Specific evaluation for dysfunction involving the whole body (Specify condition and which aspects evaluated).	45	R653,89	60	R477,52		R 690,07		R 503,94
209	Specific in depth evaluation of certain functions affecting the total person (Specify the aspects assessed).	75	R1 089,86	100	R795,58		R1 150,17		R 839,60
211	Comprehensive in depth evaluation of the total person (Specify aspects assessed)	105	R1 526,20	140	R1 113,76		R1 610,65		R1 175,39
	Measurement for designing.								
213	A static orthosis.	7,5	R109,02	0			R 115,05		
215	A dynamic orthosis.	7,5	R109,02	0			R 115,05		
217	A pressure garment for one limb.	7,5	R109,02	0			R 115,05		
219	A pressure garment for one hand.	7,5	R109,02	0			R 115,05		
221	A pressure garment for the trunk.	7,5	R109,02	0			R 115,05		
223	A pressure garment for the face (chin strap only).	7,5	R109,02	0			R 115,05		
225	A pressure garment for the face (full face mask).	7,5	R109,02	0			R 115,05		
	The whole body or part thereof will be the sum total of the parts								
227	Specific built-in musical aids	0		10	R79,61				R 84,02

	ITEMS	Code 066		Code 067		Code 066		Code 067	
3	**PROCEDURES OF THERAPY.**								
301	Group treatment in a task-centered activity, per patient (Treatment time 60 minutes or more).	10	R145,32	8,84	R113,15		R 153,36		R 119,41
303	Placement of a patient in an appropriate treatment situation requiring structuring the environment, adapting equipment and positioning the patient. This does not require individual attention for the whole treatment session, per patient)	15	R218,17	10	R79,61		R 230,24		R 84,02
305	Groups directed to achieve common aims, per patient) (Treatment time 60 minutes or more).	20	R290,64	16,5	R211,16		R 306,72		R 222,84
307	Simultaneous treatment with two to four patients, each with specific problems, utilising individual activities, per patient (Treatment time 60 minutes or more)	20	R290,64	20	R159,34		R 306,72		R 168,16
308	Simultaneous treatment with two to four neuro-behavioural and stress related conditions or severe head injury patients, each with specific problems, utilising individual activities, per patient (Treatment time 90 minutes or more)	30	R435,97	30	R238,70		R 460,09		R 251,91
	Individual and undivided attention during treatment sessions utilising specific activity and/or techniques in an integrated treatment session								
309	On level one (15 minutes).	10	R145,32	10	R128,17		R 153,36		R 135,26
311	On level two (30 minutes).	20	R290,64	20	R256,10		R 306,72		R 270,27
313	On level three (45 minutes).	30	R435,97	30	R384,02		R 460,09		R 405,27
315	On level four (60 minutes).	40	R581,29	40	R511,82		R 613,45		R 540,14
317	On level five (90 minutes).	50	R726,74	50	R639,87		R 766,95		R 675,28
319	On level six (120 minutes).	60	R871,93	60	R767,92		R 920,18		R 810,41
4	**PROCEDURES REQUIRED TO PROMOTE TREATMENT.**								
401	Recommendations as regards to assistive devices, environmental adaptations, alternative/compensatory methods, handling the patient	15	R218,17	10	R128,17		R 230,24		R 135,26
	Designing and constructing a custom-made adaptation, assistive device, splint or simple pressure garment for treatment in a task-centered activity (specify the adaptation, assistive device, splint or simple pressure garment)								
403	On level one.	10	R145,32	10	R128,17		R 153,36		R 135,26
405	On level two.	20	R290,64	20	R256,10		R 306,72		R 270,27
407	On level three.	30	R435,97	30	R384,02		R 460,09		R 405,27
409	On level four.	40	R581,29	40	R511,82		R 613,45		R 540,14
411	On level five.	50	R726,74	50	R639,87		R 766,95		R 675,28

	ITEMS	Code 066		Code 067		Code 066		Code 067	
413	On level six.	60	R871,93	60	R767,92		R 920,18		R 810,41
415	Designing and constructing a static orthosis.	60	R871,93	60	R767,92		R 920,18		R 810,41
417	Designing and constructing a dynamic orthosis.	120	R1 743,74				R1 840,23		
	Designing and constructing pressure garment for:								
419	Limb.	60	R871,93				R 920,18		
421	Face (chin strap only).	45	R653,89				R 690,07		
423	Face (full face mask).	60	R871,93				R 920,18		
425	Trunk.	90	R1 308,15				R1 380,53		
427	Hand.	90	R1 308,15				R1 380,53		
	The whole body or part thereof will be the sum total of the parts for the first garment and 75% of the fee for any additional garments made on the same pattern								
431	Planning and preparing in depth home programme on a monthly basis.	90	R1 308,15	120	R954,92		R1 380,53		R1 007,76
434	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.								
	By prior arrangement, where it is considered cost savings can be achieved								
	List of splints and pressure garments exempted from NAPPI codes								
	Annexure A								
	Numbers and names of splints to be used with modifier 0009								
701	Static finger extension/flexion splint	0							
702	Dynamic finger extension/flexion	0							
703	Buddy strap	0							
704	DIP/PIP flexion strap	0							
705	MP, PIP, DIP flexion strap	0							
706	Hand based static finger extension/flexion	0							
707	Hand based static thumb extension/flexion/opposition/ abduction	0							
708	Hand based dynamic finger flexion/extension	0							
709	Hand based dynamic thumb flexion/extension/opposition/abduction	0							
710	Static wrist extension/flexion	0							
711	Dynamic wrist extension/flexion	0							

	ITEMS	Code 066		Code 067		Code 066		Code 067	
712	Flexion glove	0							
713	Forearm based dynamic finger flexion/extension	0							
714	Forearm based dorsal protection	0							
715	Forearm based volar resting	0							
716	Static elbow extension/flexion	0							
717	Dynamic elbow flexion/extension splint	0							
718	Shoulder abduction splint	0							
719	Static rigid neck splint	0							
720	Static soft neck splint/brace	0							
721	Static knee extension	0							
722	Static foot dorsiflexion	0							
	Annexure B								
	Numbers and names of pressure garments to be used with modifier 0009	0							
801	Glove to wrist	0							
802	Glove to elbow	0							
803	Gauntlet (Glove with palm and thumb only)	0							
804	Sleeve: Upper/forearm	0							
805	Sleeve: full	0							
806	Vest + sleeves	0							
807	Sleeveless vest	0							
808	Upper leg	0							
809	Lower leg	0							
810	Full leg	0							
811	Pants (trunk and full legs)	0							
812	Briefs	0							
813	Anklet	0							
814	Knee length stocking	0							
815	Chin strap	0							
816	Full face mask	0							

	ITEMS	Code 066		Code 067		Code 066		Code 067	
817	Neck only	0							
818	Finger sock	0							
	Annexure C								
	List of materials used in treatment under modifier 0010	0							
901	Therapeutic putty	0							
902	Wood, leather, sisal	0							
903	Sponge	0							
904	Elastonet	0							
905	Silicon gel sheeting	0							
	Annexure D								
	Assistive devices made by the therapist her/himself to be used with modifier 0008	0							
1001	Hip abduction cushion	0							
1002	Sponge on a stick	0							
1003	Hand grips (for utensils)	0							
1004	Bath bench	0							
1005	Bath seat	0							
1006	Transfer board	0							
1007	Plate surround	0							
1008	Wheelchair strap	0							

OPTOMETRY

Tariff code	Optometry	Tariff Value	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.		
	Description		
11001	Optometric Examination	R518,80	R 547,51
11021	Optometric Re-Examination within six months of 11001/11081	R345,40	R 364,51
11041	Consultation :15 min. without performing Optometric Examination	R258,80	R 273,12
11081	Optometric Examination & Visual Fields	R604,10	R 637,53
11141	Evaluation of Refractive Status	R345,40	R 364,51
11161	Screening for Pathology	R258,80	R 273,12
11171	Ocular Pathology Examination Follow up	R246,20	R 259,82
11183	Keratometry	R173,30	R 182,89
11202	Tonometry (Non-contact)	R173,30	R 182,89
11212	Tonometry (Aplanation)	R173,30	R 182,89
11221	Colour Vision Screening	R173,30	R 182,89
11246	Colour Vision Evaluation	R86,70	R 91,50
11265	Evaluation of Contrast Sensitivity	R258,80	R 273,12
11283	Evaluation of Lacrimal System	R173,30	R 182,89
11303	Cycloplegic Refraction	R258,80	R 273,12
11323	Preferential Looking (Infants < Two Years)	R258,80	R 273,12
11346	Corneal Topography	R173,30	R 182,89
11356	Gonioscopy	R173,30	R 182,89
11366	Dilated Fundus Examination / BIO	R173,30	R 182,89
11402	Visual Field - Screening	R173,30	R 182,89
11423	Visual Field- evaluation	R258,80	R 273,12
11443	Threshold Visual Fields	R432,10	R 456,01
11501	Dispensing Fee - Single Vision	R86,70	R 91,50
11521	Dispensing Fee - Bifocals	R173,30	R 182,89
11541	Dispensing Fee - Varifocals	R258,80	R 273,12
11604	Photography of Anterior Segment	R173,30	R 182,89

Tariff code	Optometry	Tariff Value	2020 Tariff
11624	Photography of Fundus	R173,30	R 182,89
11644	Diagnostic and Photographic Materials		
11702	Pachymetry	R173,30	R 182,89
11707	After Hours or Away from Practice Visit		
11729	Appointment not kept		
11802	Optical Coherence Tomography (OCT)	R432,10	R 456,01
11809	Screening School (per hour)	R 1 036,20	
11829	Screening Industrial (per hour)	R 1 036,20	
11902	Visual Evoked Potentials (VEP) - Unilatera	R345,40	R 364,51
11904	Visual Evoked Potentials (VEP) - Bilateral	R604,10	R 637,53
12012	C Lens Consultation Basic - per 30 minutes	R518,80	R 547,51
12032	C Lens Consultation Complex - per 30 minutes	R690,60	R 728,81
12052	C Lens Consultation Advanced - per 30 minutes	R864,10	R 911,91
12062	C Lens Consultation - Therapeutic - per 30 minutes	R864,10	R 911,91
12072	C Lens Dispensing and/or Assessment	R258,80	R 273,12
12112	C Lens follow-up Examination/Basic Case - per 30 minutes	R258,80	R 273,12
12132	C Lens follow-up Examination/Complex Case - per 30 minutes	R432,10	R 456,01
12152	C Lens follow-up Examination/Advanced Case - per 30 minutes	R518,80	R 547,51
12162	C Lens Follow-up Therapeutic - per 30 minutes	R518,80	R 547,51
12503	C Lens Related Problems Assessment - Monocular	R173,30	R 182,89
12523	C Lens Related Problems Assessment- Binocular	R258,80	R 273,12
12533	C Lens Instruction	R258,80	R 273,12
13003	Binocular Instability Evaluation - Simple Case	R518,80	R 547,51
13023	Binocular Instability Evaluation - Complex Case	R 1 036,20	
13105	Visually Related Learning Disorders Evaluation	R 1 554,80	
13125	Eye Movements Evaluation (E.G. Visigraph)	R518,80	R 547,51
13403	Vision Training - Home Therapy Instruction	R173,30	R 182,89
13423	Vision Training - Individual (per 15 minutes)	R258,80	R 273,12
13445	Vision Training - Individual (per 30 minutes)	R518,80	R 547,51
13463	Vision Training - Group per Patient (per 15 minutes)	R65,60	R 69,23
13489	Vision Training - Away From Practice (add to 13423 or 13463)		
13509	Reading Rate- screening	R258,80	R 273,12

Tariff code	Optometry	Tariff Value	2020 Tariff
13529	Reading Ortho-Didactical skills evaluation	R777,40	R 820,42
13549	Colorimetry Intuitive - evaluation	R1 036,20	R 1 093,54
14008	Sports Vision Individual Screening	R345,40	R 364,51
14218	Sports Vision Individual Evaluation	R777,40	R 820,42
14238	Sports Vision Individual Training (per 15 minutes)	R258,80	R 273,12
14268	Sports Vision Group Screening	R65,60	R 69,23
14278	Sports Vision Group Evaluation	R152,30	R 160,73
14288	Sports Vision Group Training (per 15 minutes)	R65,60	R 69,23
14309	Sports Vision Individual Screening	R518,80	R 547,51
14319	Sports Vision Individual Evaluation	R1 036,20	R 1 093,54
14329	Sports Vision Individual Training (per 15 minutes)	R258,80	R 273,12
14369	Sports Vision Group Screening	R107,60	R 113,55
14379	Sports Vision Group Evaluation	R215,40	R 227,32
14389	Sports Vision Group Training (per 15 minutes)	R65,60	R 69,23
15000	Removal of Foreign Body External Eye Conjunctiva	R246,20	R 259,82
15002	Removal of Foreign Body Embedded Conjunctival/Scleral Nonperforating	R328,10	R 346,25
15004	Removal of Foreign Body Corneal with Slit Lamp	R410,20	R 432,90
15006	Conjunctiva – Incision and Drainage	R410,20	R 432,90
15008	Incision of Conjunctiva; Drainage of Cyst	R410,20	R 432,90
15010	Expression Conjunctival Follicles/Trachoma	R410,20	R 432,90
15012	Lacrimal System - Repair	R410,20	R 432,90
15014	Closure of Lacrimal Punctum by Plug	R410,20	R 432,90
16013	Low Vision Assessment per 30 mins	R518,80	R 547,51
16023	Low Vision Rehabilitation per 30 mins	R518,80	R 547,51
16073	Low Vision Training per 30 mins	R518,80	R 547,51
19001	Report at request of Medical Aid.	R258,80	R 273,12
19021	Report at Patient's request (arising from Series 11001)	R432,10	R 456,01
23801	OTC Eyedrops		
23907	Contact Lens Solutions		
23919	Contact Lens Accessories		
24022	Hard Contact Lens		
24024	Rigid Scleral Contact lens		

Tariff code	Optometry	Tariff Value	2020 Tariff
24202	Bifocal Hard Lens		
25412	Fenestration Hard Lens (per hole)		
25512	Truncation Hard Lens		
26012	Laboratory Service / Modification / Polish		
26115	Analysis of Hard Lens		

ORTHOPTISTS

Tariff code	DESCRIPTION	UNITS	Tariff Value	2020Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	ITEMS			
1	Orthoptic consultation (Ocular motility assessment, comprehensive examination)	10	234,69	R 247,68
3	Orthoptic treatment (Ocular motility imbalance)	8,7	204,17	R 215,47
5	Orthoptic consultation (Hess chart)	11,1	260,87	R 275,30
7	Orthoptic visual fields charting or field of binocular single vision	21,7	508,98	R 537,14
107	Appointment not kept		0,00	

OSTEOPATHS

	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.	
	RULES	**Tariff**
1	All accounts must be presented with the following information clearly stated:	
	- name of osteopath	
	- qualifications of the osteopath	
	- BHF practice number	
	- Postal address and telephone number	
	- Date on which the service(s) were provided	
	- Applicable item codes	
	- The nature of the treatment	
	- The first name of the patient	
	- The name and practice number of the referring practitioner	
2	The fee of more than one procedure performed at the same consultation or visit, shall be the fee for the major procedure plus the fee in respect of each additional procedure, but under no circumstances will additional fees be charged for more than three a	
3	After a series of 10 treatments in respect of one patient for the same condition, the practitioner concerned shall report as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted after	
4	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the correct NAPPI code is supplied on the account.	
	ITEMS	
1	Consultation, Spinal or Joint Manipulation	
1	Initial consultation/manipulation (fee covering history, examination and treatment)	0
	COIDS - Full case history, physical exam & use of diagnostic equipment, but excluding remedies, immobilisation, and manipulative procedure	
2	Subsequent manipulation/examination (fee covering subsequent examination and treatment / manipulation for the same condition)	0
	COIDS - Subsequent consultation & examination not requiring treatment	
3	Consultation/examination where not treatment is required	0
	COIDS - Spinal or extra-spinal joint manipulation ONLY.	
2	Modalities/Adjunctive Therapy	
	Soft Tissue Manipulation	
101	Massage	0
103	Myofacial pain therapy	0
	Deep Heating Radiation	
111	Short wave diathermy	0
113	Microwave diathermy	0
	Superficial Heating Therapy	
121	Hydrocollator/Ice pack - Hot or cold packs	0
123	Infra-red	0
125	Ultra-violet	0
127	Parrafin bath/wax unit	0
129	Whirlpool/Hubbard tank immersion	0
131	Fluidotherapy	0
133	Sitz bath	0
	Non-heating Modalities	

141	Galvanism/Faradic & Sine wave	0
143	Low voltage galvanic iontophoresis	0
145	Ultrasound	0
147	Combined ultrasound & electric stimulation	0
149	Inteferential	0
151	Vacutron/Vasopneumatic devices	0
153	Vacutron plus inteferential	0
155	Vibration therapy	0
157	High voltage pulse direct current	0
159	Electro-Stim 180	0
161	TENS	0
163	Micro current modalities	0
165	Traction: Mechanical/Static, etc.	0
167	Laser therapy	0
	Cold Applications	
171	Cryomatic/Cryotherapy	0
173	Cold packs	0
	Therapeutic Exercise	
187	Proprioceptive neuromuscular facilitation	0
189	Gait training	0
191	Prosthetic fitting and training	0
	Immobilisation	
201	Hard and soft immobilisation	0
203	Supportive strapping, bracing, splinting and taping	0
205	Supportive devices	0

PHARMACY

Practice Type	Procedure Code	Procedure Description	Max	Performed by	Time in Minutes	Fee (VAT exclusive) (Rands)	Fee (VAT inclusive) (Rands)	2019 Tariff	2020 Tariff
60	1(a)	Evaluation of Script	0	Pharmacist	1	Dispensing fee for pharmacists published in terms of the Medicines and Related Substances Act (Act 101 of 1965)		2019 Dispensing fee for pharmacists: Y:\Eco Glades\Office of the Coo\Medical Advisory Unit\Medical Project Plan\Legislation\Government Gazettes\2020 Final Pharmacists dispensing fee.pdf	2020 Dispensing fee for pharmacists Y:\Eco Glades\Office of the Coo\Medical Advisory Unit\Medical Project Plan\Legislation\Government Gazettes\2020 Final Pharmacists dispensing fee.pdf
	1(b)	Preparation of the medicine(s) as per a prescription		Pharmacist	3				
	1(c)	Handing of medicines to the patient/caregiver, including the provision of advice/instructions		Pharmacist	1				
60	2	Compounding special item	0	Pharmacist	10	R178,96	R205,80	R 217,19	R216,09
60	3	Preparation of a sterile product	0	Pharmacist	14	R344,21	R395,85	R 417,75	R415,64
60	4	Preparation of an intravenous admixture or parenteral solution	0	Pharmacist	6	R161,85	R186,13	R 196,43	R195,44
60	5	Preparation of TPN script	0	Pharmacist	13	R341,59	R392,82	R 414,56	R412,46
60	6	preparation of Oncology Script	0	Pharmacist	17	R441,32	R507,52	R 535,60	R532,90
60	7	Establish pharmaco-kinetic impact	0	Pharmacist registered as a specialist in pharmaco-kinetics	18	R495,58	R569,92	R 601,46	R598,42
60	8	Information related to condition / script	0	Pharmacist	4	R71,68	R82,43	R 86,99	R86,55
60	9	Application of Pharmaceutical care	0	Pharmacist	3	R60,89	R70,02	R 73,89	R73,52
60	10	PCDT	0	Pharmacist	8	R215,50	R247,82	R 261,53	R260,21
60	11	Review of patient's medication history and apply pharmaceutical care.	0	Pharmacist	4	R108,36	R124,62	R 131,52	R130,85
60	12	Blood glucose	55,8	Pharmacist	4	R81,39	R93,59	R 98,77	R98,27

60	13	Blood cholesterol and / or tri-glycerides	91	Pharmacist	7	R132,87	R152,80	R 161,25	R160,44
60	14	Urine analysis	0	Pharmacist	7	R121,47	R139,69	R 147,42	R146,67
60	15	Blood pressure monitoring	49,5	Pharmacist	4	R72,14	R82,97	R 87,56	R87,11
60	16	HIV and Aids pre-test counseling	78,7	Pharmacist	24	R576,82	R663,34	R 700,04	R696,51
60	17	HIV and AIDS testing and post-test counseling	116,9	Pharmacist	17	R410,95	R472,59	R 498,74	R496,22
60	18	Pregnancy screening	0	Pharmacist	7	R129,33	R148,73	R 156,96	R156,17
60	19	Peak Flow measurement	0	Pharmacist	4	R64,89	R74,63	R 78,76	R78,36
60	20	Reproductive health service	0	Pharmacist	5	R114,23	R131,36	R 138,63	R137,93
60	21	Administering of an intra-muscular or sub-cutaneous injection	51,1	Pharmacist	4	R78,93	R90,77	R 95,79	R95,31
60	22	Administration of immunization	33,4	Pharmacist	5	R88,79	R102,10	R 107,75	R107,21
60	23	Chronic Authorisation assistance	0	Pharmacist					
60	24	Call-out fee	0	Pharmacist					
60	25	Delivery Fee	0	Pharmacist					
60	26	After-hours fee	0	Pharmacist					
60	27	Emergency post-coital contraception (EPC)	0	Pharmacist	3	R60,11	R69,13	R 72,96	R72,59
60	28	Pharmacist Initiated Therapy (PIT)	0	Pharmacist	3	R56,88	R65,41	R 69,03	R68,68

Source of the information:

1. The Fees are based on the SAPC published fees.
https://www.pharmcouncil.co.za/Media/Default/Documents/Services%20for%20which%20a%20pharmacist%20can%20levy%20a%20Fee_2019.pdf
2. The published fees do not contain fees for tariff codes : 23, 24, 25, 26.

The following rules applies to the following tariffs:

Procedure Code	Procedure Description	Rule:
21	Administering of an intra-muscular or sub-cutaneous injection	Claiming of tariff code must be accompanied by a valid NAPPI code of the product/injection administered
22	Administering of an intra-muscular or sub-cutaneous injection	Claiming of tariff code must be accompanied by a valid NAPPI code of the product/injection administered

PHYSIOTHERAPISTS

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. **Tariffs are VAT**			
	REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)			
	SCHEDULE			
	General rules governing the scale of benefits			
1	Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged, but shall not be payable. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. Modifier 0001 to be quoted			
2	In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by the practitioner, the practitioner shall provide motivation for a higher fee and such higher fee as may be agreed upon with the practitioner may be charged			
3	Where a practitioner uses equipment which is not owned by that practitioner, a reduction of 15% of the relevant rate will be applicable. Modifier 0003 must be quoted when this rule is applied			
4	In the case of prolonged or costly treatment, the practitioner should first ascertain whether financial responsibility in respect of such treatment will be accepted.			
5	After a series of 20 treatments in respect of one patient for the same condition, the practitioner concerned shall report as soon as possible if further treatment is necessary. Payment for treatments in excess of the stipulated number may be granted after receipt of a letter from the practitioner concerned, motivating the need for such treatment			
6	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient in hospital; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a. "emergency treatment" means a bona fide, justifiable emergency physiotherapy procedure, where failure to provide the procedure immediately would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy; and b. "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
7	Practitioners are reminded that a lower fee than that appearing in the scale of benefits shall be charged if the customary fee in the area is less than that charged. Reduced fees shall also be charged where the practitioner would have reduced his/her fee in private practice in particular cases. Prolonged treatment or exceptional cases should also receive special consideration in accordance with the usual medical practice			
8	The fee in respect of more than one procedure (excluding evaluation and visiting items 407, 501, 502, 503, 507, 509, 701, 702, 703, 704, 705, 706, 707, 708, 801, 803, 901 and 903) performed at the same consultation or visit, shall be the fee for the major procedure plus half the fee in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 0008 must then be quoted after the appropriate code numbers for the additional code numbers for the additional procedures to indicate that this rule is applicable.			
9	When more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments and the diagnosis or diagnostic codes shall be stated. Modifier 0009 must then be quoted after the appropriate code number to indicate that this rule is applicable.			
10	When the treatment times of two completely separate and different conditions overlap, the fee shall be the full fee for one condition and 50% of the fee for the other condition. Both conditions must be specified. Modifier 0010 must then be quoted after the appropriate code number to indicate that this rule is applicable.			
11	Every Physiotherapist must acquaint himself with the provisions of the Medical Schemes Act, 1998 and the regulations promulgated under the Act in connection with the rendering accounts. Every account shall contain the following particulars : · The name and practice code number of the referring practitioner (where applicable). · The name of the patient. · The practice code number and name of practitioner · The nature and cost of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.			
12	NB: Rounding off does not apply to amounts occurring once the modifiers are used.			
13	Where the physiotherapist performs treatment away from the treatment rooms, travelling costs being more than 16 kilometres in total) to be charged according to the AA-rate. Modifier 0013 must be quoted after the appropriate code numbers to show that this rule is applicable.			
14	Physiotherapy services rendered in a nursing home or hospital. Modifier 0014 must be quoted after each code.			
16	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
	Modifiers			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
1	Appointment not kept			
3	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner			
6	Add 50% of the total fee for the treatment			
8	Only 50% of the fee for these additional procedures may be charged			
9	The full fee for the additional condition may be charged			
10	Only 50% of the fee for the second condition may be charged			
13	Travelling costs (being more than 16 kilometres in total) according to AA-rate.			
14	Physiotherapy services rendered to an in-patient in a nursing home or hospital.			
1	**RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY**			
1	Infra-red, Radiant heat, Wax therapy Hot packs	5	R72,62	R 76,64
5	Ultraviolet light	10	R145,76	R 153,83
6	Laser beam	15	R218,38	R 230,46
7	Cryotherapy	5	R72,62	R 76,64
2	**LOW FREQUENCY CURRENTS**			
103	Galvanism, Diodynamic current, Tens.	10	R145,76	R 153,83
105	Muscle and nerve stimulating currents.	12	R174,57	R 184,23
107	Interferential Therapy.	10	R145,76	R 153,83
3	**HIGH FREQUENCY CURRENTS**			
201	Shortwave diathermy.	5	R72,62	R 76,64
203	Ultrasound.	10	R145,76	R 153,83
205	Microwave.	5	R72,62	R 76,64

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
4	**PHYSICAL MODALITIES**			
300	Vibration	10	R145,76	R 153,83
301	Percussion	16,1	R234,43	R 247,40
302	Massage	10	R145,76	R 153,83
303	Myofacial release/soft tissue mobilisation, one or more body parts	20,09	R292,31	R 308,48
304	Acupuncture	15	R218,38	R 230,46
305	Re-education of movement/Exercises (excluding ante- and post-natal exercises)	10	R145,76	R 153,83
307	Pre- and post-operative exercises and/or breathing exercises	10	R145,76	R 153,83
308	Group exercises (excluding ante- and post-natal exercises - maximum of 10 in a group)	10	R145,76	R 153,83
309	Isokinetic treatment.	10	R145,76	R 153,83
310	Neural tissue mobilisation	20	R291,00	R 307,10
313	Ante and post natal exercises/counselling	10	R145,76	R 153,83
314	Lymph drainage	5	R72,62	R 76,64
315	Postural drainage.	10	R145,76	R 153,83
317	Traction.	10	R145,76	R 153,83
318	Upper respiratory nebulisation and/or lavage	10	R145,76	R 153,83
319	Nebulisation	10	R145,76	R 153,83
321	Intermittent positive pressure ventilation.	10	R145,76	R 153,83
323	Suction: Level 1 (including sputum specimen taken by suction)	5	R72,62	R 76,64
325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	20,09	R292,31	R 308,48
327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	5	R72,62	R 76,64
328	Dry needling	15	R218,38	R 230,46
5	**MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION**			
401	Spinal	15	R218,38	R 230,46
402	Pre meditated manipulation	10	R145,76	R 153,83
405	All other joints.	15	R218,38	R 230,46
407	Immobilisation (excluding materials). Rule 008 does not apply.	15	R218,38	R 230,46

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
6	**REHABILITATION**			
501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	25	R363,61	R 383,73
502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	25	R363,61	R 383,73
503	Rehabilitation for Central Nervous System disorders - condition to be clearly stated and fully documented (No other treatment modality may be charged in conjunction with this). Duration: 60min.	55	R800,37	R 844,66
504	EMG Biofeedback treatment	15	R218,38	R 230,46
505	Group rehabilitation. Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision, without individual attention for the whole treatment session, no charge may be levied by facility	12	R174,57	R 184,23
506	Stress management	20	R291,00	R 307,10
507	Respiratory Re-education and Training. Duration: 30min.	15	R218,38	R 230,46
509	Rehabilitation. Each additional full 15 mins. Where the pathology requires the undivided attention of the physiotherapist. (Rule 0008 does not apply.) Can only be used with codes 501, 502, 507 or 503 to indicate the completion of an additional 15 minutes. A maximum of two instances of this code may be charged per session.	15	R218,38	R 230,46
7	**EVALUATION**			
701	Evaluation/counselling at the first visit only (to be fully documented)	15	R218,38	R 230,46
702	Complex evaluation/counselling at the first visit only (to be fully documented).	30	R436,36	R 460,51
703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per episode of care.	15	R218,38	R 230,46
704	Lung function: Peak flow (once per treatment).	5	R72,62	R 76,64
705	Computerised/Electronic test for lung pathology	15	R218,38	R 230,46
706	Reports. To be used to motivate for therapy and/or give a progress report and/or a pre-authorisation report, where such a report is specifically required.	15	R218,38	R 230,46
707	Physical Performance test. Must be fully documented.	20	R291,00	R 307,10
708	Interview, guidance or consultation with the patient or his family. To be used only once per episode of care.	15	R218,38	R 230,46
720	Essential continuation of physiotherapy care, in an after-hours situation. (See general Rules on tariff codes 720 and 721)	20	R291,00	R 307,10
721	Emergency physiotherapy intervention (See general Rules on tariff codes 720 and 721)	30	R436,36	R 460,51
801	Electrical test for diagnostic purposes (including IT curve and Isokinetic tests) for a specific medical condition	35	R508,85	R 537,01
803	Effort test - multistage treadmill.	35	R508,85	R 537,01

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
8	**VISITING CODES**			
901	Treatment at a nursing home : Relevant fee plus (to be charged only once per day and not with every hospital visit	10	R145,76	R 153,83
903	Domicilliary treatments : Relevant fee plus.	20	R291,00	R 307,10
10	**OTHER**			
117	Appointment not kept		R0,00	
937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	10	R145,76	R 153,83
938	Bird or equivalent freestanding nebuliser excluding oxygen domicilliary per day.	10	R145,76	R 153,83
939	Cost of material: Items to be charged (exclusive of VAT) at net acquisition price plus -			
	26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands;			
	a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.			
940	Cost of appliances: Items to be charged (exclusive of VAT) at net acquisition price plus-	R0,00		
	26% of the net acquisition price where the net acquisition price of that appliance is less than one hundred rands;			
	a maximum of twenty six rands where the net acquisition price of that appliance is greater than or equal to one hundred rands.			
941	Hiring equipment: 1% of the current replacement value of the equipment per day. Total charge not to exceed 50% of replacement value. Description of equipment to be supplied.			
	By arrangement. Should be considered where cost savings can be achieved			
	"Indications for use of code 720 "essential continuation of physiotherapy care in after hours situation\"" This code may be used under the following circumstances where failure to provide the physiotherapy intervention might result in any or all of the following: a. Serious impairment to bodily functions b. serious dysfunction of a bodily organ or part c. reduced functional ability due to severe pain d. would place the patient's life in serious jeopardy e. increase of length of hospital stay f. prolongation of expected recovery time			
	Explanation and use of "after-hours situation" "After-hours situation" shall mean all physiotherapy interventions, where essential continuation of care is required in excess of ordinary working hours in the following circumstances:			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	a. Weekdays before 07:00 and after 17:00 b. Saturdays before and after the normal working hours of the practice c. Sundays and Public holidays			
	This code may not be charged in the following circumstances: a. Where the physiotherapy appointment is scheduled for the convenience of the patient. b. Where the physiotherapy appointment is scheduled for the convenience of the physiotherapist. c. Where the ordinary outpatient consulting hours for the practice fall outside the above parameters. d. In circumstances where the above criteria are not met the use of code 720 is not applicable.			
	Code 720 and 721 may not be charged together at the same single intervention.			
	CODE 721 – emergency physiotherapy intervention Explanation and indications for use:			
	Code 721 may only be used where an emergency physiotherapy intervention is provided. Emergency is defined as a sudden, and at the time, unexpected onset of a health condition or an unplanned event that requires immediate unscheduled physiotherapy intervention. Failure to provide the physiotherapy intervention immediately might result in any or all of the following: a. Serious impairment to bodily functions b. serious dysfunction of a bodily organ or part			
	c. reduced functional ability due to severe pain d. would place the patient's life in serious jeopardy In circumstances where the above criteria are not met the use of code 720 is not applicable.			

PHYTOTHERAPY

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	ITEMS			
	Consultations			
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counseling and/or preparation of medicines.			
130	Consultation (initial or follow up). Duration 1 - 15 mins	10	R 130,37	R 137,58
131	Consultation (initial or follow up). Duration 16 - 30 mins	22,5	R 293,63	R 309,88
132	Consultation (initial or follow up). Duration 31 - 45 mins	37,5	R 489,25	R 516,32
133	Consultation (initial or follow up). Duration 46 - 60 mins	52,5	R 684,87	R 722,76
134	Consultation, each additional full 15 mins, to a maximum of 60 mins	15	R 196,02	R 206,86
	Preparation and Dispensing of Medicaments			
	Medicaments			
	The amount charged in respect of proprietary medicines shall be at net acquisition price. In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.			
310	Tinctures, per 10 ml	2,7	R8,33	R 8,79
320	Tea mixes, per 10g	1	R3,05	R 3,22
330	Capsules/tablets, per capsule	3,4	R10,17	R 10,73
340	Creams/Ointments, per 10ml	20,1	R60,91	R 64,28
350	Syrups, per 10ml	2,8	R8,49	R 8,96
360	Medicinal oils, per 10ml		R3,74	R 3,95
390	Proprietary materials			
395	Proprietary medicines			

PODIATRY

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	General Rules			
A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the first name of the patient; . the name and practice number of the referring practitioner, if applicable.			
B	The rate in respect of more than one procedure performed at the same consultation or visit, shall be the full rate for the major procedure plus half the rate in respect of each additional procedure carried out in the treatment of any one condition.			
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
D	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus - * 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and * a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	Modifiers			
2	For procedures 021 to 031 carried out in a day clinic or unattached operating theatre unit, the rate shall be reduced to two-thirds.			
4	Consultation or treatment in a nursing facility/hospital			
6	Consultation or treatment at the patient's recidence			
	ITEMS			
	Modifier 0004 must be quoted for consultation or treatment rendered in a nursing home or hospital.			
	Modifier 0006 must be quoted for consultations or treatment rendered at the patient's residence.			
	CONSULTATIONS.			
301	Consultation (initial or follow up) 5-10 minutes	7,5	R165,63	R 174,79
302	Consultation (initial or follow up) 11-20 minutes	15	R331,65	R 350,00
303	Consultation (initial or follow up) 21-30 minutes	25	R552,39	R 582,96
304	Consultation (initial or follow up) 31-45 minutes	37,5	R828,66	R 874,51
6	More than one patient seen at a residence (See note below).	8,5	R169,70	R 179,09
	NOTE : This code is a blanket code for home visits away from the practitioners rooms where more than one but up to and including six patients are treated. The code may be used again if seven to twelve patients are seen.			
101	Appointments not kept.			
	INJECTIONS.			
9	Administration of injection, per administration	1,3	R26,18	R 27,63
	ROUTINE TREATMENTS.			
10	General podiatric care up to 15 minutes including the following: Trim nails, Debride and cut dystrophic nails; one to five, Evacuation of sub-ungual haematoma, Paring or cutting of benign hyperkeratotic lesion; single lesion, Drain paronychia; one nail and Nail spike removal; single	3,9	R 77,75	R 82,05
11	General podiatric care (30 minutes) including the following:	7,8	R155,76	R 164,38

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	Debride and cut dystrophic nails: six or more, Nail spike removal; two to four, Paring or cutting of benign hyperkeratotic lesion; two to four lesions, Paring or cutting of benign hyperkeratotic lesion; more than four lesions, Reduction of heel fissures, Enucleation of interdigital corns; more than two			
12	Extended care for chronic disease management or ulcer management (applicable to diabetes, arthritis and peripheral vascular diseases)	7,4	R147,87	R 156,05
13	General podiatric care more than 30 minutes (a combination of items 010 and 011)	11,8	R235,61	R 248,65
	VERRUCA TREATMENTS.			
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation			
14	Verruca Pedis (Chemotherapy first lesion) (consultation and treatment).	5,9	R117,87	R 124,39
15	Subsequent lesion.	2,9	R57,75	R 60,95
16	Cryotherapy first lesion (consultation and treatment).	7,8	R155,76	R 164,38
17	Subsequent lesion.	3,9	R77,75	R 82,05
18	Diathermy first lesion (consultation and treatment).	6,9	R138,00	R 145,64
19	Subsequent lesion.	3,5	R69,86	R 73,73
	Nail Surgery.			
	Note : No consultation fee shall be charged for the same session unless the procedure is performed at the time of the initial consultation			
21	Nail wedge resection with matrix phenolisation : one nail - one side (including consultation).	19,6	R391,37	R 413,03
22	Two nails - one side.	25,5	R508,98	R 537,14
24	Two nails - both sides.	36,4	R726,97	R 767,20
23	One nail - two sides (including consultation).	25,5	R508,98	R 537,14
25	Avulsion with matrix phenolisation (including consultation).	19,6	R391,37	R 413,03
31	Avulsion without matrix phenolisation (including consultation).	12,8	R255,48	R 269,62
	Other			
40	Infection control, per patient	1,2	R23,94	R 25,26
41	Remedial therapy.	4,9	R97,88	R 103,30
42	Sterile pack.	5,9	R117,87	R 124,39
44	Suturing (includes consultation).	7,8	R155,76	R 164,38

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
46	Incision Biopsy.	5,9	R117,87	R 124,39
47	Removal of foreign body.	8,9	R177,86	R 187,70
48	Suturing / Wound closure material : Cost of material plus 10%			
146	Excision biopsy.	8,9	R 177,86	R 187,70
201	Sterile Surgical Blades (maximum of 2 per patient)	1	R 19,73	R 20,82
203	Wound dressing material (maximum of 2 per patient)	2	R 39,86	R 42,07
205	Plaster of Paris bandage roll (maximum of 2 per patient). At net acquisition price.			
207	Moulded Orthotic material fee	11,8	R 235,61	R 248,65
209	Simple insole material fee	5,9	R 117,87	R 124,39
211	Local anaesthetic medication per ampoule (maximum of 5 per patient)	2	R 39,86	R 42,07
213	Injection medication fee (other than local anaesthetic). At net acquisition price.			
	Items 215, 217 or 219 may be used for corrective or supportive strapping or padding placed into footwear. The area of the foot must be specified.			
215	Padding and strapping : Digital, per foot	2,8	R56,17	R 59,28
217	Padding and strapping: Metatarsal, per foot	3,5	R69,86	R 73,73
219	Padding and strapping: Heel, per foot	3,5	R69,86	R 73,73
	Appliances and Orthotics			
	(By arrangement).			
43	Biomechanical examination.	15,7	R313,76	R 331,12
51	Neutral impression Plaster of Paris casting	8,5	R169,70	R 179,09
52	Orthotic repair.	12,8	R255,48	R 269,62
53	Temporary orthotic or corrective component.	12,8	R255,48	R 269,62
54	Prescription covering and soft tissue supplements.	8,9	R177,86	R 187,70
55	Silicone devices: Digital	5,4	R107,87	R 113,84
56	Computerised gait analysis	19,6	R391,37	R 413,03
57	Template measurement.	2,9	R57,75	R 60,95
58	Immobilisation casting	10,6	R211,93	R 223,66
59	Simple insole - one foot.	11,1	R221,80	R 234,07
61	Simple insoles - both feet.	20,1	R401,50	R 423,72
60	Silicone devices: metatarsal	10,7	R213,38	R 225,19

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
64	Silicone devices: heel	15,9	R317,70	R 335,28
	The rates for items 063 and 065 include the cost of instrinsic and extrinsic posting adjustments			
63	Prescription orthotic : one foot.	19,1	R381,24	R 402,34
65	Prescription orthotics : both feet.	38,3	R764,85	R 807,17
67	Preformed moulded insoles: Adult, both feet	22,1	R441,49	R 465,92
69	Preformed moulded insoles: Adult, one foot	11	R219,43	R 231,57
71	Preformed moulded insoles: Child, both feet	17	R339,54	R 358,33
73	Preformed moulded insoles: Child, one foot	8,5	R169,70	R 179,09
	CONSUMABLE LIST			
	STERILISING ITEMS			
	Cold Sterilant e.g. Cidex, Steri 101, Etc.			
	Ultraviolet Tubes (Replacements)			
	Autoclave Bags			
	WASTE DISPOSAL			
	Sharps Container			
	Medical Waste Bin			
	REGULARLY USED ITEMS			
	Disposable Hand Towels e.g. Kimdri			
	Disinfecting Handwash e.g. Hibiscrub			
	Linen Savers			
	Cotton Wool			
	Gloves: Non-Sterile			
	Sterile			
	Gauze: Non-Sterile			
	Sterile			
	Tube Gauze (Various Sizes)			
	Padding e.g. Semi Compressed Felt			
	Strapping e.g. Hapla, Zopla			
	Disinfecting Hand Gel e.g. Steri 601			
	Surface Disinfectant e.g. Steri 201			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	Tongue Depressors			
	Applicator Sticks			
	Friars Balsam			
	Silver Nitrate?			
	Hibitane Concentrate			
	Phenol			
	Silicone & Activator for Devices			
	Monochloracetic Acid			
	Salacylic Acid in Lanolin			
	Dental Needles			
	Xylotox Se Plain Solution for Injection			
	Emergency Drugs e.g. Adrenaline/Epipen			
	Penrose Drains / Tournicot			
	Hydrogen Peroxide			
	70% Alcohol			
	Hibicol			
	Acetone			
	Sterile Blades (Various Sizes)			
	Moores Discs			
	Sterile Dressing Trays			
	Sutures			
	Single Use Sterile Syringes			

PRIVATE HOSPITALS

		2019 Tariff			2020 Tariff		
	DESCRIPTION	**55700**	**55800**	**57700**	**55700**	**55800**	**57700**
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent.						
	GENERAL RULES						
	SCHEDULE						
B	The charges relating to each type of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.						
C	The charges indicated in Section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.						
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.						
E.1	Procedure for the classification of hospitals:						
E.1.1	Inspections private hospitals or unattached operating theatre units/day clinics having practice code numbers commencing with the digits 057, 058 or 077 will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to						
E.3.2	The provisions referred to in E.1.1 shall apply mutatis mutandis to all approved specialised intensive care units, specialised theatres, catheterisation laboratories and trauma unit.						
F.1	Procedures to consider applications by institutions to be classified as unattached operating theatre units having a practice code number commencing with the digits 77 and for the reclassification of unattached operating theatre units with 76 practice numb						
F.1.1	Inspections of new unattached theatre operating units and units having practice code numbers commencing with the digit 76, to be reclassified as approved unattached operating theatre units having practice numbers commencing with the digits 77 will be cond						
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code num						
H	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on reques						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
I	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.						
1	**ACCOMMODATION**						
	Ward fees						
	Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts. In the case of hospitals, the day admission fee (code 007) shall be charged in respect of all patients admitted as day patients and discharged before 23h00 on the same date. The following will be applicable to items 001 to 005, 015, 020, 200, 201, 202 and 215 to 218: On the day of admission: If accommodation is less than 12 hours from time of admission : half the daily rate If accommodation is more than 12 hours from time of admission: full daily rate Two half day fees would be applicable when a patient is transferred internally between any ward and any specialised unit. On day of discharge: If accommodation is less than 12 hours: half the daily rate If accommodation is more than 12 hours: full daily rate The items listed as non-recoverable in Annuxure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.						
1,1	**General Wards**						
1	Surgical cases: per day.	1418	1417,9		R 1 496,46	R 1 496,36	
2	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	1490	1489,7		R 1 572,45	R 1 572,13	
3	Psychiatric general ward fee, per day	1174	1173,9		R 1 238,96	R 1 238,86	
4	Medical and neurological cases: per day.	1418	1417,9		R 1 496,46	R 1 496,36	
5	Paediatric cases (under 14 years of age)	1750	1750,3		R 1 846,83	R 1 847,15	
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day						
7	Day admission (irrespective of type of ward patient is admitted to, i.e. general, neurosurgical or paediatric) which includes all patients discharged by 23h00 on date of admission	907	907,4	775,5	R 957,19	R 957,61	R 818,41
14	Overnight fee - Medical practitioner to pre-authorise all overnight admissions			341,7			R 360,61

	DESCRIPTION	55700	55800	57700	55700	55800	57700
19	Out-patients facility fee for ambulatory admission - chargeable for patients admitted for local anaesthetic procedures - No ward fees applicable. Note: Each account should be accompanied by a report from the practitioner indicating the nature of the compl Definition: Item 019 may only be used in conjunction with item 071 for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335	420	419,9	419,9	R 443,24	R 443,13	R 443,13
22	Out-patient wound care facility	207	207	207	R 218,45	R 218,45	R 218,45
	Maternity						
	1. The maternity fees are a fixed per diem fee and replace all other charges:						
	INCLUDING:						
	Charges such as multiple births (nursery fee for 2nd baby excluded);						
	After-hour deliveries (including caesareans);						
	Labour ward or other ward fees, nursery fees;						
	Incubators;						
	Phototherapy;						
	Theatre and equipment fees; and						
	Surgical items (see list under point 8).						
	But EXCLUDE						
	Sections 5.1 to 5.3;						
	Sections 5.7 to 5.8 (Gases); and						
	1. The costs of special treatment of newly born infants, e.g. circumcision certified as necessary by the attending practitioner, which shall be dealt with in accordance with the National Reference Price List for private hospitals.						
	2. If an epidural anaesthetic is given for either a vaginal delivery or a caesarean section, an additional fee (item 011) may be charged. This comprises of an epidural pack, all consumables used, as well as nursing time.						
	3. An uncomplicated stay in a nursery for routine observation is included in the maternity fee, as well as phototherapy and routine high care observation after delivery for the new born baby.						
	4. A neonate requiring specialised treatment in a ward, high care or ICU shall be considered to be a patient in its own right and, for that reason, the National Reference Price List shall be applied to such neonate and an account may be rendered on a fee						
	In such cases, the fixed fee per day remains applicable until the mother is discharged, but the amount of item 015, per day must be deducted from the fixed fee (comprising the nursery fee component).						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	5. If the mother is admitted into high care or ICU, the full account is rendered on a fee for service basis, as this is clearly not an uncomplicated delivery. The codes for the nursery fee (item 015) and the delivery room (item 016) must be used to cover						
	6. The first day fee includes the cost of admitting the mother, `prepping' and `staging' etc, admission into the delivery room, the delivery and post natal period up until midnight. This includes any cost incurred during the early stages of an uncomplicat						
	The second day is calculated as starting from midnight following the birth of the neonate on the day of the delivery.						
	If however, the mother needs admission for stabilisation or treatment of a medical condition such as diabetes, pre-eclampsia or urinary tract infection, such an admission falls outside the scope of the maternity fixed fee. An account will then be rendered						
	If however, the mother is admitted to ICU or high care the full account must be rendered on a fee for service basis. If the baby needs admission - see (4).						
	7. Admission for suppression of premature labour is not an uncomplicated delivery, and an account must be rendered on a fee for service basis.						
	8. The following list of surgicals (maternity basket) are included in the per diem fee. THEATRE SURGICALS FOR NORMAL VAGINAL DELIVERIES THEATRE CHARGES 1 X Amnihook 1 X Continue Flo 1 X Cord Clamp 3 X Gloves Surgical St 8 X Gloves Sterile 4 X I D Bands 0.5 X Jaques Catheter 1 X Jelco IV 1 X KY Jelly Sachet 20 X Maternity Pad 5 X Preptic Swabs 1 X Spiral Electrode 1 X Spinocan 1 X Suction Catheter St 1 X Swabbing Tray						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	1 X Tegaderm 1626						
	1 X Vaginal Plug						
	2 X Water for irrigation						
	1 X Stockinette						
	2 X Silicone Tubing						
	1 X Add a Line						
	SUTURES						
	0.25 X Suture W734						
	0.25 X Suture W758						
	0.25 X Suture W727						
	0.25 X Suture W734						
	0.25 X Suture W758						
	0.25 X Suture W770						
	0.25 X Suture W759						
	0.25 X Suture W441						
	SYRINGES						
	1 X Syringe 1ml						
	1 X Syringe 20ml						
	3 X Syringe 2ml						
	2 X Syringe 5ml						
	DRESSINGS						
	2 X Cotton Wool Balls L/s						
	THEATRE SURGICALS FOR CAESARS WITH GENERAL ANAESTHETIC						
	THEATRE CHARGES						
	1 X Amnihook						
	1 X Airway						
	1 X Sterile Tray						
	2 X Continue Flo						
	1 X Cord Clamp						
	1 X Diathermy Plate Dispo						
	1 X ET Tube						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	3 X Electrodes Red Dot 1 X Foley catheter 8 X Gloves Surgical St 5 X Gloves Sterile						
	4 X I D Bands 1 X Jelco IV 2 X KY Jelly Sachet 20 X Maternity Pad 10 X Preptic Swabs 1 X Sheet _ 1 X Spiral Electrode 1 X Spinocan 1 X Suction Catheter St 1 X Swabbing Tray 1.2 X Tegaderm 1626 1 X Urine Drn Bag 1 X Vent Pump Set 1 X Yankuer Suction 6 X Water for irrigation 1 X Stockinette 2 X Silicone Tubing 2 X Opticlude 1 X Add a Line SUTURES 0.06 X Suture W441 0.30 X Suture 8623G 0.11 Suture W791 0.30 X Suture W9999 2.20 X Suture W493 0.17 X Suture W795 0.17 X Suture W797						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	0.30 X Suture W439 0.17 X Suture W434 0.17 X Suture W445 1 X Suture W728						
	1 X Suture V518G 1 X Suture V486G 0.20 X Suture V523G 0.30 X Suture V523G SYRINGES 1 X Syringe 1ml 1 X Syringe 20ml 1 X Syringe 10ml 8 X Syringe 2ml 2 X Syringe 5ml DRAIN 1 X Corrugated Drain DRESSINGS 15 X Abominal Swabs 3 X Cotton Wool Balls L/s 5 X Gauze Sterile Xray 1 X Telfa Dressing 1 X Steripad 1 X Tegaderm 1627 5 X Paint Balls						
	Natural births						
9	First day (Day of confinement).	6860	6859,6		R 7 239,59	R 7 239,16	
10	Subsequent day(s).Per day	2363	2363		R 2 493,75	R 2 493,75	
17	Subsequent day(s) excluding nursery fee.	1719	1718,9		R 1 814,12	R 1 814,01	
	Caesarean						
12	First day (Day of confinement).	10655	10655,3		R 11 244,58	R 11 244,89	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
13	Subsequent day(s). Per day	2343	2342,8		R 2 472,65	R 2 472,43	
	Note: The following fees (items 015 and 016) are included in the above per diem fees, and may only be charged on a fee for service account						
15	Nursery fee.	666	665,5		R 702,85	R 702,32	
16	Delivery room.	2860	2860,3		R 3 018,25	R 3 018,57	
	This item is not applicable for deliveries by registered midwifes in private practice.						
18	Subsequent day(s) excluding nursery fee	1689	1689,4		R 1 782,46	R 1 782,88	
	Epidural fee						
11	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	1042	1042,1		R 1 099,66	R 1 099,76	
	Birthing Unit						
	The birthing unit fee may only be charged by an approved maternity unit in a hospital. It includes preparation, labour room, recovery ward fee for mother and baby and the maternity basket. The only additional charge that may be levied is for pharmaceutica This fee may not be charged for together with the per diem fees for maternity and is not applicable to medical practitioners or other professions.						
30	Global fee for a Birthing Unit (Accredited or Approved by BHF). This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient is discharged within 12 hours from birth.	4286	4285,8		R 4 523,16	R 4 522,95	
31	Global fee for a Birthing Unit (Accredited or Approved by BHF) This fee is chargeable when a nurse in private practice uses the labour ward in the hospital and the patient stay exceed 12 hours and is discharged within 24 hours from birth.	6649	6648,8		R 7 016,91	R 7 016,70	
32	Additional Birthing Unit fee chargeable for every additional 12 hours of patient stay beyond the 24 hours contemplated in code 031	1181	1180,6		R 1 246,35	R 1 245,93	
1.2	**Private Wards**						
20	Private ward Hospitals shall obtain a certificate motivating for the necessity for accommodation in a private ward, including reversed barrier nursing, from the attendant practitioner, and such certificate shall be forwarded for approval. General ward fees are applica	1833	1832,6		R 1 934,43	R 1 934,00	
21	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	1418	1417,9		R 1 496,46	R 1 496,36	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
1.3	**Special Care Units**						
	Specialised units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), Neonatal Intensive Care Unit (NICU), High Care (HC), Neonatal High Care (NHC), A & B.						
	Hospitals shall obtain a certificate stating the reason for accommodation in any specialised or other intensive care unit or in high care ward including neonatal intensive care and high care from the attending practitioner. Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF.						
200	Specialised ICU (As approved by BHF according to General Rule E.1.1) Per day	7671	7670,8		R 8 095,46	R 8 095,25	
	(Subject to a maximum of 1 day. Pre-authorisation required for every additional day thereafter. Item 201 will apply if no pre-authorisation is obtained. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neuro-surgery						
201	Intensive Care Unit: Per day.	5838	5838		R 6 161,04	R 6 161,04	
202	Neonatal Intensive Care Unit: Per day.	7269	7268,7		R 7 671,22	R 7 670,90	
	(The charges referred to under items 200, 201 and 202 include the use of all equipment except: Bennett MA, Servo and Bear ventilators or equivalent apparatus plus the cost of oxygen)						
215	High Care Ward, Per day.	3740	3739,6		R 3 946,95	R 3 946,52	
216	Neonatal High Care Ward `A' (Intensive nursing and monitoring)	4062	4062		R 4 286,76	R 4 286,76	
217	Neonatal High Care Ward `B' (Standard nursing and monitoring)	2656	2655,5		R 2 802,97	R 2 802,44	
218	Neonatal ward fee (Pre-discharge - This fee may not be charged for routine post-natal nursery care).	1750	1750,3		R 1 846,83	R 1 847,15	
	Note: Once the baby has been stabilised and no longer requires ICU care but is not ready to be returned to the general nursery, no additional equipment charges, eg phototherapy may be charged.						
105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by BHF	1803	1803,1		R 1 902,77	R 1 902,87	
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.						
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	414	414,1	414,1	R 436,91	R 437,01	R 437,01
	Note: The procedure room fee (071) cannot be charged in addition to 302						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
2.2	**THEATRE FEES**						
61	Excimer Laser Theatre fee, per minute	26	25,6	25,6	R 27,44	R 27,02	R 27,02
	The items listed as non-recoverable in Annuxure B shall be deemed to be included in theatre fees, and no charge in respect thereof may be levied.						
	Minor Theatre, regardless of type of theatre available, the incident is procedure driven and not facility driven						
	A facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and short or no general anaesthetic, are carried out. No Sophisticated monitoring is required but resuscitation equipment (trolley) must be availab						
	Time in minor theatre						
71	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	20	19,7	16,8	R 21,11	R 20,79	R 17,73
	The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows						
2.3	**Major theatre**						
	In addition to the theatre charge calculated as above, a surcharge (modifier 0002 and/or 0003) shall be allowed in cases where specialised theatres referred to in General Rule E.1.1 are utilised for the performance of any of the undermentioned procedures, Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF						
2	Modifier 0002: Orthopaedic, Neurosurgical and Vascular: · Joint replacements (only hip, knee, shoulder ankle or elbow) · Femoral popliteal bypasses · Carotid endarterectomies · Aortic Aneurysm repair and arterial grafts · Neurosurgery (Surgery on the brain and spinal cord only, excludes neurolysis)						
3	Modifier 0003: Cardiac surgery · All open heart surgery, with or without the insertion of a prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment (except item 513), no additional fees may be charged Time in Theatre The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	Specialised Theatre Modifiers						
3	**PROCEDURAL FEES**						
	The fees quoted for items 052, 053 and 055 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533, 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: Ward fees may however be chargeable together with items 053 and 055.						
3.1	**Procedures**						
52	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	564	563,9	563,9	R 595,21	R 595,10	R 595,10
53	Angiograms.	564	563,9		R 595,21	R 595,10	
55	Electroconvulsive therapy (ECT)	564	563,9	563,9	R 595,21	R 595,10	R 595,10
3.2	**Catheterisation laboratory procedures**						
	Note: A certificate indicating the level of the catheterisation laboratory used, should be signed by the relevant doctor, indicating the information.						
	The fees quoted for items 054, 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for items 515, 529, 533 and 535 and any items chargeable in terms of Section 4 and 5 hereof. NOTE: ward fees may however be chargeable together with items 054, 055, 056, 070 and 073.						
54	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue monoplane unit, and in a hospital NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.	2023	2022,8		R 2 134,94	R 2 134,73	
56	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised analogue bi-plane unit, and in a hospital	3811	3811,3		R 4 021,88	R 4 022,19	
70	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital bi-plane unit, and in a hospital e NB: EPS for cardiac ablations - items 529 must be charged additionally.	9901	9900,8		R 10 448,86	R 10 448,64	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
73	Cardiac angiography and catheterisation, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy when carried out in a facility equipped with a recognised digital monoplane unit, and in a hospital	7323	7322,6		R 7 728,21	R 7 727,78	
75	Catheterisation laboratory film price (once per procedure)	218	218,2		R 230,06	R 230,27	
3.3	**Radiation Oncology**						
	Simulation - Fixed custom made						
902	Simple - Simulation of a single area with either a single port or parallel opposed ports. Simple or no blocking or use of custom/home made simulation	600	600,2		R 633,20	R 633,41	
903	Intermediate - Simulation of three or more converging ports, two separate treatment areas or multiple blocks.	915	915,4		R 965,63	R 966,05	
904	Complex - Simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocks, custom shielding blocks, brachytherapy source verification, hyperthermia probe verification, any use of contrast	1200	1200,3		R 1 266,40	R 1 266,72	
905	Computerised Tomographic.	1200	1200,3		R 1 266,40	R 1 266,72	
	Treatment Planning						
906	Manual.						
907	Simple - Planning requiring single treatment area of interest in a single port or simple parallel opposed ports with simple or no blocking	566	565,6		R 597,32	R 596,90	
908	Computerised (intermediate) - Planning requiring three or more ports, two separate treatment areas, multiple blocks or special time dose constraints	863	862,7		R 910,75	R 910,44	
909	Computerised (complex) - Planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations or a combination of therapeut	1130	1130,2		R 1 192,53	R 1 192,74	
	Technical Aids						
910	Control films (As per radiology film price list).	103	103,1		R 108,70	R 108,80	
911	Dosimetric procedures.	33	32,9		R 34,83	R 34,72	
912	Artefacts: Simple - design and construction (simple block or bolus)	83	82,5		R 87,59	R 87,07	
913	Artefacts: intermediate - design and construction (multiple blocks, stents, bite blocks, special bolus).	224	224,4		R 236,39	R 236,82	
914	Artefacts: complex (specify) - design and construction (irregular blocks, special shields, compensators, wedges, molds or casts)	449	448,5		R 473,84	R 473,32	
	Linear accelerator treatment						
915	Photon treatment, single field.	877	876,5		R 925,53	R 925,00	
916	Photon treatment, multiple fields	1262	1262		R 1 331,83	R 1 331,83	
917	Electron treatment.	877	876,5		R 925,53	R 925,00	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
919	Brachytherapy - global fee per patient.	6660	6660,1		R 7 028,52	R 7 028,63	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
3.4	**Stereotactic radiosurgery**						
	Included in item 430						
	Stereotactic frames and attachments						
	Linear Accelerator						
	Specialised graphic planning, hardware and software						
	Simulator and dark rooms						
	10 dental films						
	Stereotactic masks						
	All disposables						
	4 to 20 Graphic transparencies (including 1 week of planning)						
	2 trained radiographers						
	Fixation and immobilisation						
	Nuclear Specialist Medical Physicist						
	Duration 1 - 4 hours						
	2 treatment radiographers						
	Excluded from fee						
	Other medical practitioners						
	CT & MRI						
399	Linear Accelerator radiosurgery - Global Fee	144812	144812,4		R152 824,93	R152 825,35	
	Item 399 is an all- inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all the professional providers of service inv						
430	Global fee for stereotactic radiosurgery	99109	99108,8		R104 593,03	R104 592,82	
4	**STANDARD CHARGES FOR EQUIPMENT**						
220	Ballistic Lithotripsy/Lithoclast: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	735	735,2	735,2	R 775,67	R 775,88	R 775,88
221	Ballistic Lithotripsy/Lithoclast: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	490	489,6	489,6	R 517,11	R 516,69	R 516,69
222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	4901	4900,7	4900,7	R 5 172,19	R 5 171,87	R 5 171,87

	DESCRIPTION	55700	55800	57700	55700	55800	57700
223	Laser Lithotripsy: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	3264	3264,3	3264,3	R 3 444,61	R 3 444,92	R 3 444,92
224	Stone basket (reusable) for the removal of kidney-, bladder- or gallstones: Per case	1976	1976,4	1976,4	R 2 085,34	R 2 085,76	R 2 085,76
225	Stereotactic equipment for use in neuro-surgical procedures, when used in conjunction with x-rays, MRI scans or CAT scans: Per case	1889	1888,6		R 1 993,52	R 1 993,10	
226	Continuous Passive Exerciser: Per day.	150	149,7	149,7	R 158,30	R 157,98	R 157,98
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	417	417,1	417,1	R 440,07	R 440,18	R 440,18
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	206	206,2	206,2	R 217,40	R 217,61	R 217,61
230	Patient-controlled analgesia pump, being a programmable reusable analgesia infusion system, providing patient control and/or continuous analgesia modes with mechanisms to limit self administration per time period and with lockout interval. Applicable only	158	158,1	158,1	R 166,74	R 166,85	R 166,85
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward - Major joint replacement - Severe burns - Thoracotomies (motivation by practitioner)						
231	Cardiac monitors - in private, general and high care wards only - not to be charged for routine ECG's: Per day or part thereof	172	171,8		R 181,52	R 181,31	
233	Croupettes (excluding oxygen): Per day or part thereof	35	35,2		R 36,94	R 37,15	
235	Oxygen tents (excluding oxygen): Per day or part thereof	57	57,2		R 60,15	R 60,37	
237	CUSA (plus CUSA pack as per section 5).	2666	2666,1		R 2 813,52	R 2 813,62	
238	Lasers - Argon or Holium (ophthalmic).	826	825,8	825,8	R 871,71	R 871,49	R 871,49
239	Lasers - CO2 (surgical).	1067	1067	1067	R 1 126,04	R 1 126,04	R 1 126,04
241	Lasers - Candella (Rates by arrangement)	0	-				
242	Occutomes.	351	351,2	351,2	R 370,42	R 370,63	R 370,63
243	Lasers - YAG (ophthalmic).	931	931,3	931,3	R 982,52	R 982,83	R 982,83
244	Lasers - YAG (surgical).	1160	1159,7	1159,7	R 1 224,19	R 1 223,87	R 1 223,87
245	First Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment for one or more stones in same kidney which are eliminated in one treatment.	10729	10728,8	10728,8	R 11 322,67	R 11 322,46	R 11 322,46
246	Second Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	7146	7145,6	7145,6	R 7 541,41	R 7 540,99	R 7 540,99

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	Note: The fees in respect of items 220 to 223, 245 to 246 and 339 to 341 are inclusive of all equipment and components but exclusive of theatre fees and items chargeable under Section 5. The C-arm (item 249) and screening table (item 251) are not chargeable with these equipment fees.						
249	C Arm (not chargeable when Modifiers 0002, 0003 or item 251 applies).	347	346,8	346,8	R 366,20	R 365,99	R 365,99
250	Ultrasonic imaging equipment.	580	579,5	579,5	R 612,09	R 611,57	R 611,57
	(Limited to real-time imaging equipment for transrectal applications with needle-biopsy capability or Doppler ultrasound for vascular anatomy and haemo-dynamics) Note: This can be used for infertility treatment						
251	Screening table - fixed base urology table (including all radiographic equipment) (See item 249) Note: May not be used in conjunction with items 220 to 223, 245 to 246 and 339 to 341.	782	781,8	781,8	R 825,27	R 825,06	R 825,06
252	Gastroscope (fibre optic/flexible only).	457	456,8	456,8	R 482,29	R 482,08	R 482,08
253	Colonoscope (fibre optic/flexible only)	511	510,8	510,8	R 539,28	R 539,06	R 539,06
254	Duodenoscope (fibre optic/flexible only).	484	484,1	484,1	R 510,78	R 510,89	R 510,89
255	Sigmoidoscope (fibre optic).	392	392,3	392,3	R 413,69	R 414,01	R 414,01
256	Bronchoscope (flexible/fibre optic, adults).	323	322,5	322,5	R 340,87	R 340,35	R 340,35
257	Laryngoscope (fibre optic/flexible excluding intubation)	188	188,3	188,3	R 198,40	R 198,72	R 198,72
258	Sinoscope (rigid only)	215	214,8	214,8	R 226,90	R 226,69	R 226,69
259	Oesophagoscope (rigid only)	107	107,1	107,1	R 112,92	R 113,03	R 113,03
261	Hysteroscope	135	134,8	134,8	R 142,47	R 142,26	R 142,26
262	Colposcope (Not chargeable when item 239 applies)	188	188,3	188,3	R 198,40	R 198,72	R 198,72
263	Cysto Urethroscope	162	161,6	161,6	R 170,96	R 170,54	R 170,54
264	Arthroscope (including basic reusable instruments and equipment)	440	440,3	440,3	R 464,35	R 464,66	R 464,66
	Note: The basic reusable instruments and equipment (which would always include the equivalent to the items named) are included in the fee of item 264 (see list below) : - Telescope, light source, cable - Monitor - Electrosurgical instrument - High frequency cord - Obturator - Camera						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	- Focussing camera coupler - Control console, footswitch - Probe, scissors, (hooked, parrot beak), grasper, forceps (punch basket, duckbill), camelback handle, powered arthroplasty system, handpiece.						
294	Transcranial Doppler	960	960		R 1 013,12	R 1 013,12	
295	Ultrasonic Cutting and Coagulating Devices (See section 5.3.3)	264	264,3	264,3	R 278,61	R 278,92	R 278,92
335	Excimer laser: Hire fee per eye	2913	2913,3	2913,3	R 3 074,19	R 3 074,50	R 3 074,50
337	Microkeratome used with an excimer laser, per operation.	535	535	535	R 564,60	R 564,60	R 564,60
339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	326	325,5	325,5	R 344,04	R 343,51	R 343,51
341	Ballistic lithotripsy magnetic: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically necessary)	217	217,1	217,1	R 229,01	R 229,11	R 229,11
343	Sigmoidoscope (rigid, adults)	81	80,7	80,7	R 85,48	R 85,17	R 85,17
345	Sigmoidoscope (rigid, paediatrics)	65	65,1	65,1	R 68,60	R 68,70	R 68,70
347	Bronchoscope (flexible/fibre optic, paediatrics)	323	322,5	322,5	R 340,87	R 340,35	R 340,35
	Note: For codes 252-256 and 343-347, reusable biopsy and polyp forceps are included in the fee.						
348	Bronchoscope (rigid, adults)	129	129,2	129,2	R 136,14	R 136,35	R 136,35
349	Bronchoscope (rigid, paediatrics)	188	188,3	188,3	R 198,40	R 198,72	R 198,72
360	Category 1 - Laparoscopy and thoracoscopy, per case. See Annexure A	1055	1054,8	1054,8	R 1 113,38	R 1 113,17	R 1 113,17
364	Category 2 - Interventional Laparoscopic and Thorascopic procedures, per case. See Annexure A	1253	1253	1253	R 1 322,33	R 1 322,33	R 1 322,33
507	Argon Beamer (See section 5.3.2)	107	106,9	106,9	R 112,92	R 112,82	R 112,82
	Note: The Argon Beamer will not apply where a standard electosurgery unit is used. It can only be used with surgery on internal organs and in neurosurgery.						
509	Endometrial Resection (Radio frequency)	646	645,8	645,8	R 681,75	R 681,53	R 681,53
511	Colour Doppler (external)	1933	1933,2	1933,2	R 2 039,96	R 2 040,17	R 2 040,17
513	Transoesphageal Colour Doppler. (May be charged together with Modifier 0003)	2333	2332,5	2332,5	R 2 462,09	R 2 461,57	R 2 461,57
515	Cardiorhythm Ablater. (May be charged in addition to the catheterisation Laboratory).	1271	1270,6	1270,6	R 1 341,33	R 1 340,91	R 1 340,91
517	Phaco emulsifier	684	684,2	684,2	R 721,85	R 722,06	R 722,06
519	Uretho Reno Fibroscope, per case	577	576,5	576,5	R 608,93	R 608,40	R 608,40
521	OAS Frameless Stereotaxy	6799	6798,7		R 7 175,21	R 7 174,89	
523	OPD Tacography (Includes paper)	110	110,1		R 116,09	R 116,19	

	DESCRIPTION	55700	55800	57700	55700	55800	57700
525	RFG3C Lesion Generator (Rhizotomy)	2201	2201,1		R 2 322,79	R 2 322,89	
527	Swift Lase Kit (Tonsillectomy)	429	428,9		R 452,74	R 452,63	
529	Bard Apparatus 1. For EPS studies the analogue monoplane unit (item 054) must be charged additionally. 2. EPS studies for cardiac ablations - the digital bi-plane unit (item 070) must be charged additionally.	1647	1646,6		R 1 738,13	R 1 737,71	
531	Densitometer	1015	1015		R 1 071,16	R 1 071,16	
533	Civus (Cardiac Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	2757	2757		R 2 909,55	R 2 909,55	
535	Ivus (Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	6056	6055,8		R 6 391,10	R 6 390,89	
537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery.	26	25,5		R 27,44	R 26,91	
	Disposable cover is non-chargeable. This item may not be charged together with any disposable monitoring style gel pads or when techniques other than electrosurgery are used. (e.g. not to be charged with the ultrasonic cutting and coagulating device or eq						
	Equipment fees for automated, stereotactic, digital imaged surgical breast biopsy (UNDER REVIEW)						
	Note: For the purpose of a 6 month trial cost analysis, the manufacturer of the ABBI equipment recommends that the total breast biopsy procedure, inclusive of all fees, disposables and professional charges should not exceed the current conventional open e						
540	Stereotactic guided digital imaged breast biopsy procedure	11117	11116,7		R 11 732,14	R 11 731,82	
541	Stereotactic guided digital imaged cover needle biopsy	6540	6539,7		R 6 901,88	R 6 901,56	
542	Stereotactic guided digital imaged vacuum assisted core needle biopsy.	6540	6539,7		R 6 901,88	R 6 901,56	
543	Stereotactic guided digital imaged fine needle aspiration	4580	4579,5		R 4 833,43	R 4 832,90	
544	Mammotome Stereotactic Driver - vacuum assisted core needle biopsy. (UNDER REVIEW)	0	-				
545	Mammotome Hand Held ultrasound vacuum assisted vacuum core needle biopsy. (UNDER REVIEW)	0	-				
550	Equipment fee for dynamic (non-frame based - StealthStation) stereotactic image guided referencing surgery and treatment planning used in conjunction with CT or MRI imaging in pre-authorised cranial, spinal cord and ENT procedures, per procedure	7108	7108		R 7 501,31	R 7 501,31	
560	Low pressure hyperbaric oxygen treatment protocol. (By arrangement) Only for Prescribed Minimum Benefits Code 277S: Anaerobic infections - life threatening (when no state facility is available)						
562	Standard pressure hyperbaric oxygen treatment protocol. (By arrangement).						
564	US Navy TT5 treatment protocol. (By arrangement)						
566	US Navy TT6 treatment protocol. (By arrangement)						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
568	US Navy TT6 extended treatment protocol. (By arrangement).						
570	Comes 30 treatment protocol. (By arrangement).						
572	US Navy Table 6A treatment protocol. (By arrangement)						
574	Pressure relieving mattress hire fee, per day	0	-				
576	Infrared Coagulator: per use						
578	Prostatic hyperthemia and thermotherapy: per case	10079	10078,6		R 10 636,70	R 10 636,28	
580	Sequential compression device, per case						
582	Selector ultrasonic aspirator						
584	Cryosurgery acuprobe						
594	Motility machine						
596	Ph recorder						
606	Epilepsy monitoring system						
608	Lynx ultrasound scanner						
610	Intra-operative multi-frequency probe						
612	Flexible laparoscopic probe						
5	**STANDARD DRUG, MATERIAL, CONSUMABLE AND DISPOSABLE CHARGES**						
	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.						
5.1	**STANDARD DRUG CHARGES**						
	(Only substances controlled by the Medicines and Related Substances Control Act, Act 101 of 1965, as amended/Medicine Control Council)						
5.1.1	Inpatients and day patients: Dispensed items including ampoules, over the counter and proprietary items issued to inpatients, day patients and TTO's						
	Not to be charged for consumable, disposable and surgical items						
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor). All items which patients take home as TTO's must be shown on accounts.						
272	Pharmacy						
273	To take out						
278	Ward stock						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
282	Theatre						
5.1.2	Emergency Room: Dispensed items including ampoules, over the counter and proprietary items and TTO's issued to patients treated in the emergency room (Items 301 and 302) when not admitted to a ward.						
	The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor). All items which patients take home as TTO's must be shown on accounts.						
	Not to be charged for consumable, disposable and surgical items						
407	Pharmacy						
411	Theatre						
413	To take out						
5.2	**Consumable, disposable, and surgical items used in ward, theatre or emergency room**						
	When used in ward or theatre Net acquisition price inclusive of VAT (unless the facility is not a registered VAT vendor). Items to be fully specified						
	See consumable and disposable list.						
266	Large disposable sterile trays - per tray (excluding theatre)						
267	Sterile disposable swabbing and ENT trays - per tray (excluding theatre)						
269	Soluble bags for barrier nursing only, limited to 2 per patient, per day						
415	Emergency room						
417	Pharmacy						
419	Ward stock						
421	Theatre						
5.3	**Fractional charges**						
	Net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor) to be charged per case at the fractional rates indicated below.						
	Note: Fractional charges can only apply to reusable and limited life reusable/resposable products.						
5.3.1	Drills, burrs, cutters, blades						
280	Neuro/Craniotomy						
432	Arthroscopy						
433	Orthopaedic						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
437	Mastoidectomy and major ear surgery						
439	Maxillo- Facial drills and burrs (not applicable to oral surgery, eg wisdom teeth)						
5.3.2	Surgical laser fibre optic leads, hand pieces and probes, scalpels, argon beamer instruments (Limited life re-usable components)						
	Hospitals/unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name.						
281	Vascular surgery						
443	General surgery						
445	Gynaecology						
447	Ophthalmic						
449	Urology						
451	ENT						
453	Orthopaedic						
5.3.3	Ultrasonic Cutting and Coagulating Devices (Limited life re-usable)						
	General surgery, Gynaecology, Cardio-Vascular and Urology						
455	Handpiece and Cable Assembly (one unit)						
456	Coagulating Shear (Laparoscopic/open)						
458	Coagulating Shear - Single use (Laparoscopic/open) Refer to Section 5.2						
457	Blades (sharp hook, dissecting hook, ball)						
459	Blades - Single use (sharp hook, dissecting hook, ball) Refer to 5.2						
5.3.4	Warm air blankets						
429	Warm air blanket may be charged in the following cases and limited to 1 per stay						
	- Infants						
	- Elderly patients over 65,						
	- Patients exposed for a long period of time in theatre longer than 2 hours						
	- Post traumatic hypothermia - one per stay						
	- Cardio-thoracic hypothermic patients in recovery and ICU - one per stay						
5.3.5	Diathermy pencils, laryngeal masks and fluoroshield gloves						
431	Diathermy pencils						
435	Laryngeal masks						
441	Fluoroshield gloves (1 pair per procedure)						

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	DESCRIPTION	55700	55800	57700	55700	55800	57700
5.7	**Gases**						
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified						
	Oxygen and Nitrous Oxide						
	For both gases together, per minute						
283	PWV area	4	4,33	4,3	R 4,22	R 4,57	R 4,54
701	Cape Town	6	5,93	5,9	R 6,33	R 6,26	R 6,23
702	Port Elizabeth	5	5,28	5,3	R 5,28	R 5,57	R 5,59
703	East London	6	5,86	5,9	R 6,33	R 6,18	R 6,23
704	Durban	5	5,44	5,4	R 5,28	R 5,74	R 5,70
705	Other areas	5	4,84	4,8	R 5,28	R 5,11	R 5,07
	Oxygen, ward use						
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex						
284	PWV area	6	6,36	6,4	R 6,33	R 6,71	R 6,75
710	Cape Town	11	10,5	10,5	R 11,61	R 11,08	R 11,08
711	Port Elizabeth	10	10,1	10,1	R 10,55	R 10,66	R 10,66
712	East London	10	9,74	9,7	R 10,55	R 10,28	R 10,24
713	Durban	8	8,26	8,3	R 8,44	R 8,72	R 8,76
714	Other areas	8	7,87	7,9	R 8,44	R 8,31	R 8,34
	Oxygen, recovery room or emergency room						
	Flat rate for oxygen per case						
720	PWV area	13	12,6	12,6	R 13,72	R 13,30	R 13,30
721	Cape Town	21	20,9	20,9	R 22,16	R 22,06	R 22,06
722	Port Elizabeth	20	20,1	20,1	R 21,11	R 21,21	R 21,21
723	East London	20	19,5	19,5	R 21,11	R 20,58	R 20,58
724	Durban	17	16,5	16,5	R 17,94	R 17,41	R 17,41
725	Other areas	16	15,8	15,8	R 16,89	R 16,67	R 16,67
	Oxygen in Theatre						
	Fee for oxygen per minute in the operating theatre when no other gas administered						
730	PWV area	0	0,39	0,4		R 0,41	R 0,42

	DESCRIPTION	55700	55800	57700	55700	55800	57700
731	Cape Town	1	0,7	0,7	R 1,06	R 0,74	R 0,74
732	Port Elizabeth	1	0,66	0,7	R 1,06	R 0,70	R 0,74
733	East London	1	0,66	0,7	R 1,06	R 0,70	R 0,74
734	Durban	1	0,52	0,5	R 1,06	R 0,55	R 0,53
735	Other areas	1	0,52	0,5	R 1,06	R 0,55	R 0,53
	Carbon Dioxide						
291	Per minute	1	0,79	0,8	R 1,06	R 0,83	R 0,84
	Laser Mix						
292	Per minute	15	15,1	15,1	R 15,83	R 15,94	R 15,94
	Entonox						
293	Per 30 minutes	144	144,3	144,3	R 151,97	R 152,28	R 152,28
5.8	**Inhalation anaesthetics**						
	Price increases: Should a change occur in the manufacturer's price of any item listed hereunder, the new price shall be as notified						
285	Halothane (Halothane): per minute	1	0,5	0,5	R 1,06	R 0,53	R 0,53
752	Ethrane (Enflurane): per minute	1	1,44	1,4	R 1,06	R 1,52	R 1,48
753	Forane (Isoflurane): per minute	2	1,6	1,6	R 2,11	R 1,69	R 1,69
754	Isofor (Isoflurane): per minute	2	1,6	1,6	R 2,11	R 1,69	R 1,69
755	Ultane (Sevoflurane): per minute	5	4,59	4,6	R 5,28	R 4,84	R 4,85
756	Suprane (Desflurane), per minute	4	3,93	3,9	R 4,22	R 4,15	R 4,12
757	Aerrane (Isoflurane): per minute	2	1,6	1,6	R 2,11	R 1,69	R 1,69
758	Alyrane (Enflurane): per minute	1	1,44	1,4	R 1,06	R 1,52	R 1,48
759	Fluothane (Halothane), per minute	0	0,34	0,3		R 0,36	R 0,32
5,9	Prostheses (Surgically implanted)						
286	A prosthesis shall mean a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral and nece						
	Hospitals/unattached operating theatre units shall show the name and reference number of each item. The manufacturer's name, and suppliers invoices should be attached to the account and the components should be specified on the account.						
	Net acquisition price on suppliers invoice, inclusive of VAT (unless the facility is not a registered VAT vendor), by prior arrangement.						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
5.1	**Medical artificial items (non-prostheses)**						
287	According to agreement. (Examples of items included hereunder shall be wheelchairs, crutches and excretion bags). Copies of invoices shall be supplied.		-				
5,14	Blood charges						
288	Emergency non-crossmatched blood ex hospital (i.e. on stand-by) - Number of units and nature of emergency to be specified and copy of invoice included.						
	This item is only chargeable when a private hospital supplies O-negative whole blood to a patient in an emergency situation. A motivation stating the reason for administering the O-negative blood must accompany the account and no mark-up is permitted on t						
289	Routine blood charges, when incurred in respect of blood or related products procured from a recognised blood bank for transfusion purposes, may be charged at R 14.70 per collection, plus R 3.09 per kilometre travelled. This fee is applicable to all modes						
297	Emergency blood collection. Claims for this item code must be supported by documentary evidence of the patient's condition	762	762,4		R 804,16	R 804,59	
5.15	**Incise drapes**						
298	Incise drapes (See Annexure B)						
299	Ophthalmic drapes. (See Annexure B)						
300	Non-incise drapes (isolation, fluid-collection and combination)						
	Chargeable in the following procedures:						
	Hip, knee, shoulder and elbow joint replacements						
	Open heart and cardiac bypass surgery						
	Vascular surgery (excluding catheterisation laboratory procedures)						
	Neuro-surgery (Brain and spinal cord)						
	Arthroscopy of hip, shoulder, knee or elbow joints						
	Spinal surgery						
	Note: The name, item number and cost must be shown.						
5.16	**Disposable Patient Controlled Analgesia Pump**						
	Not applicable in Specialised units, ICU and High Care units. 1 per patient for maximum of 48 hours in ward						
	- Severe burns						
	- Thoracotomies (motivation by practitioner)						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
6	**NON STANDARD ITEMS/SERVICES**						
290	Items/services e.g. telephone calls/hire, television hire, boarding, extra meals, dry cleaning of clothing, extra nursing in ward etc. The nature of each service shall be specified		-				
121	Benefits to be pre-authorised						
	ENDOSCOPIC (laparoscopic & thoracoscopic) GENERIC LIST						
	Comments						
	2. Harmonic scalpel shears and and blades – not to be charged together with disposable electrosurgical probes, argon beam coagulator, clip appliers, bipolar forceps and Tripolar forceps.						
	6. Specimen retrieval bags – to motivate use (used when specimen needs to be captured and removed to avoid site contamination); procedure related – histology report required.						
	LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES						
	Diagnostic laparoscopy (49320)						
	Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670)						
	Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771)						
	Hysteroscopy diagnostic (58555)						
	THORACOSCOPY, DIAGNOSTIC						
	THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy						
	THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy						
	Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673)						
	Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface, any method (58662)						
	Laparoscopy, surgical; with removal leiomyomata (58551)						
	Laparoscopy surgical; withenterolysis (freeing intestinal adhesion) (44200)						
	Laparoscopy, surgical; with retropritoneal node sampling (biopsy) (38570)						
	Laparoscopy,surgical, abdomen, peritoneum, omentum; with drainage lymphocele to peritoneal cavity (49323)						
	Laparoscopy, surgical; appendectomy (44970)						
	Laparoscopy, surgical, abdomen, peritoneum and omentum; with biopsy (49321)						
	Laparoscopy, surgical, abdominal, peritoneum and omentum; with aspiration of cavity or cyst (e.g. ovarian cyst) single or multiple (49322)						
	Laparoscopy, surgical; with removal of adnexal structures (partial or total oopherectomy and/or salpingectomy) (58661)						
	Laparoscopy, surgical; orchiopexy for intra-abdominal testis (54692)						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	Laparoscopy, surgical; ligation spermatic veins for varicocele (55550)						
	Laparoscopy, surgical; ablation of renal cysts (50541)						
	Laparoscopy, surgical; urethral suspension for stress incontinence (51990)						
	Laparoscopy, surgical; sling operation for stress incontinence (51992)						
	Hysteroscopy with lysis intra-uterine adhesions (58559)						
	Hysteroscopy with removal impacted foreign body (58562)						
	Hysteroscopy with removal leiomyomata \ (58561)						
	Hysteroscopy with endometrial ablation \ (58563)						
	Laparoscopic treatment of ectopic pregnancy, without salpingectomy and/or oopherectomy (59150)						
	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oopherectomy (59151)						
	Laparoscopy, surgical; with vaginal hysterectomy. (Lap assisted vag. Hyst) (58550)						
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy (38571)						
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) (38572)						
	Laparoscopy with adrenalectomy (60650)						
	Laparoscopy, surgical; pyeloplasty (50544)						
	Laparoscopy, surgical; nephrectomy (50540)						
	Laparoscopy, surgical; donor nephrectomy (50547)						
	Laparoscopically assisted nephroureterectomy (50548)						
	Laparoscopy, surgical, ureterolithotomy 50945)						
	Laparoscopy, surgical; transection of Vagus nerve, truncal (43651)						
	Laparoscopy, surgical; transection of Vagus nerves, selective or highly selective (43652)						
	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy (47560)						
	Laparoscopy, surgical; with guided transhepatic cholangiography, with biopsy (47561)						
	Laparoscopy, surgical; cholecystoenterostomy (47570)						
	Laparoscopy, surgical; cholecystectomy with cholangiography (47563)						
	Laparoscopy, surgical; cholecystectomy with explor, common bile duct (47564)						
	Laparoscopy, surgical; splenectomy (38120)						
	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g. Stamm procedure) (43653)						
	Laparoscopy, surgical; jejunostomy (44201)						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	Laparoscopy, surgical; intestinal resection, with anastomosis (44202)						
	Laparoscopy, surgical; oesophagogastric fundoplasty eg Nissen, Toupet procedures) (43280)						
	Unlisted laparoscopic procedure, uterus (58578)						
	Unlisted hysteroscopy procedure, uterus (58579)						
	Unlisted laparoscopic procedure, oviduct, ovary (58679)						
	Unlisted laparoscopic spleen procedure (38129)						
	Unlisted laparoscopic lymphatic procedure (38589)						
	Unlisted laparoscopic oesophagus procedure (43289)						
	Unlisted laparoscopic stomach procedure (43659)						
	Unlisted laparoscopic intestinal procedure (except rectum) (44209)						
	Unlisted laparoscopic appendix procedure (44979)						
	Unlisted laparoscopic biliary tract procedure (47579)						
	Unlisted laparoscopy procedure, abdomen, peritoneum & omentum (49329)						
	Unlisted laparoscopic hernia procedure (49659)						
	Unlisted laparoscopic renal procedure (50549)						
	Unlisted laparoscopic procedure, testis (54699)						
	Unlisted laparoscopic procedure, spermatic cord (55559)						
	Unlisted laparoscopic procedure, maternity care and delivery (59898)						
	Unlisted laparoscopic endocrine procedure (60659)						
	THORACOSCOPY, SURGICAL						
	THORACOSCOPY, SURGICAL pleurodesis						
	THORACOSCOPY, SURGICAL partial pulmonary decortication						
	THORACOSCOPY, SURGICAL total pulm. Decortication						
	THORACOSCOPY, SURGICAL removal interpleural foreign body						
	THORACOSCOPY, SURGICAL control traum. Haemorrhage						
	THORACOSCOPY, SURGICAL exc./plication bullae						
	THORACOSCOPY, SURGICAL parietal pleurectomy						
	THORACOSCOPY, SURGICAL wedge resection						
	THORACOSCOPY, SURGICAL removal clot/foreign body from pericardial space						
	THORACOSCOPY, SURGICAL creation pericardial window						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	THORACOSCOPY, SURGICAL total pericardectomy						
	THORACOSCOPY, SURGICAL exc pericard. Cyst, tumor, mass						
	THORACOSCOPY, SURGICAL exc mediastinal cyst, tumor, mass						
	THORACOSCOPY, SURGICAL lobectomy, total or segmental						
	THORACOSCOPY, SURGICAL with sympathectomy						
	THORACOSCOPY, SURGICAL with esophagomyotomy						
	New codes for Category 2						
	CPT42000 CPT4 2001						
	Laparoscopy, surgical; radical nephrectomy 50545						
	Laparoscopy, surgical; nephrectomy including partial ureterectomy 50546						
	Laparoscopy, surgical; nephrectomy with total ureterectomy 50548						
	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement 50948						
	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement 50948						
	Unlisted laparoscopic procedure, ureter 50949						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	APPENDIX B						
	PRINCIPLES						
	The following principles are applicable:						
	1. At all times best clinical practice must be adhered too.						
	2. Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be inclu						
	3. The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows:						
	¢ Items included in the per minute theatre fee.						
	¢ Items included in the per day ward or unit fee.						
	¢ Items are charged to the patient's account where reimbursement is not granted.						
	4. Any agreed difference on the basic interpretation of the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities list will be made in accordance with the approval of the duly a						
	5. Disposable items are single use only and must never be reused.						
	¢ Single use items will be charged at 100%.						
	¢ Hospitals will sign an ethical undertaking that single use items will only be used once. If a hospital does not conform it may be reported to the group head office. If an acceptable explanation is not supplied within 14 days, payment on that account may						
	6. Limited life re-usable products are products intended for multiple use and endorsed as such by the manufacturers. Such products will be charged according to the "Fractional" charges as detailed and are under continual review. The item will be considere						
	7. Where a hospital uses an excessively priced product, a review process with the parties as listed under 3 above should be conducted, and appropriate price adjustment made.						
	Key Indicators						
	The different key indicators in the Recommended Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities List are as follows:						
	Key Description						
	THR Theatre consumable and disposable items						
	WRD Ward consumable and disposable items						
	NR Item is non-recoverable						
	C Item is chargeable under certain circumstance						

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	DESCRIPTION	55700	55800	57700	55700	55800	57700
	R Item is recoverable						
	Disposable Means the manufacturer states one time use only.						

	DESCRIPTION	55700	55800	57700	55700	55800	57700
	APPENDIX C						
	Anthrax						
	Haemorrhagic fevers of Africa:						
	¢ Crimean-Congo Ebola						
	¢ Lassa						
	¢ Marburg						
	¢ Rift Valley						
	¢ Dengue						
	Herpes Zoster						
	HIV/AIDS						
	Legionnaires Disease						
	Measles:						
	¢ Rubeola						
	¢ Rubella						
	Meningococcal infections						
	Multi-drug Resistant Bacteria:						
	¢ MRSA						
	¢ VRE						
	¢ MRSE						
	Poliomyelitis						
	Pyrexia unknown origin						
	Rabies						
	Small Pox						
	Tuberculosis Pulmonary						
	Typhus Fever						
	Viral Hepatitis						
	Whooping Cough (Pertussis)						
	Note: The above is a general list and the clinical appropriate use of items for specific conditions is subject to Case Management.						
	APPENDIX D						
	Medically Prescribed Meals:						

PRIVATE SUB ACUTE FACILITY

Practice Type: Sub-Acute-Facilities		Code: 049		
Tariff code	**DESCRIPTION**	**UNITS**	**VALUE**	**2020 Tariff**
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	GENERAL RULES			
B	The charges are indicated in the relevant column opposite the item codes.			
C	Procedure for the classification of private sub-acute facilities: i) Inspections of private sub-acute facilities having practice code numbers commencing with the digits "049" will be conducted by an independent agency on behalf of BHF. Applications to be addressed in writing to BHF. ii) The provisions referred to in D.1.1 shall apply mutatis mutandis to all private sub-acute facilities such as post-natal units, rehabilitation units and psychiatric units.			
D	All accounts submitted by private sub-acute facilities shall comply with all of the requirements of Chapter 2, Regulation 5, promulgated in terms of the Medical Schemes Act, Act No. 131 of 1998. Such accounts shall also reflect the practice code number an			
E	All accounts containing items, which are subject to a discount in terms of the rates shall indicate such items individually and shall show separately the gross amount of the discount.			
	SCHEDULE			
1	**ACCOMMODATION**			
	Ward Fees			
	Private sub-acute facilities shall indicate the exact time of admission and discharge on all accounts.			
	Patients admitted as day patients shall be charged half daily rate if discharged before 23h00 on the same date:			
	The following will be applicable to items 001, 010, 013, 015, 017, 105 and 020			
	On the day of admission:			
	If accommodation is less than 12 hours from time of admission: half the daily rate.			
	If accommodation is more than 12 hours from time of admission: full daily rate.			
	On day of discharge:			
	If accommodation is less than 12 hours: half the daily rate.			
	If accommodation is more than 12 hours: full daily rate.			

Practice Type: Sub-Acute-Facilities		Code: 049		
Tariff code	**DESCRIPTION**	**UNITS**	**VALUE**	**2020 Tariff**
	Two half-day fees would be applicable when a patient is transferred internally between any ward and any sub-acute unit.			
1.1	**General Wards**			
1	Ward fee, per day	10	R2 090,26	R 2 205,92
1.2	**Rehabilitation units**			
	The following high function rehabilitation impairment categories will be treated in recognised and accredited specialised rehabilitation units of private sub-acute facilities: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunctio			
101	General ward/facility fee: under 5 hours stay	2,227	R465,83	R 491,61
105	General care (ward/supporting facilities and equipment)	10,286	R2 149,98	R 2 268,95
	Note: The maxima may be modified in individual cases on specific motivation from the doctor-in-charge.			
1.3	**Psychiatric Rehabilitation Unit**			
	The following psychiatric categories will be treated in recognised and accredited specialised psychiatric units of private sub-acute facilities: Depression, Bipolar mood disorder, Anxiety disorder, Organic mood disorder, Dementia, Psychological behavioura			
3	Ward fee: with overnight stay (specific motivation from the doctor-in-charge) (ward/supporting facilities and equipment)	10,43	R2 179,98	R 2 300,60
5	General ward fee: under 5 hours stay	2,26	R473,46	R 499,66
7	General ward fee: without overnight stay	5,392	R1 127,02	R 1 189,38
2	**STANDARD MATERIAL CHARGES**			
2.1	**Ward stock**			
	The amount charged in respect of dispensed medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of			
	In relation to other ward stock (materials and/or medicines), the amount charged shall not exceed the net acquisition price (inclusive of VAT) or the exit price as determined in terms of Act No 101 of 1965.			
419	Ward stock	0		
2.2	**Gases**			
	Oxygen, ward use			
	Fee for oxygen, per quarter hour of part thereof.To charged using the appropriate NAPPI code.			
284	PWV area	1	R0,00	
710	Cape Town	1	R0,00	

Practice Type: Sub-Acute-Facilities		Code: 049		
Tariff code	**DESCRIPTION**	**UNITS**	**VALUE**	**2020 Tariff**
711	Port Elizabeth	1	R0,00	
712	East London	1	R0,00	
713	Durban	1	R0,00	
714	Other areas	1	R0,00	

PSYCHOLOGY

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. **TARIFFS ARE VAT INCLUSIVE.**			
	GENERAL RULES			
B	Where emergency treatment is provided:			
	a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or			
	b. after working hours			
	the fee for such visits shall be the total fee plus 50%.			
	For purposes of this rule:			
	a. "emergency treatment" means a bona fide, justifiable emergency psychological procedure, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment			
	b. "working hours" means 8h00 to 17h00, Monday to Friday.			
	Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.			
C	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
D	Every account shall contain the following particulars: a) The surname, first name and other initials, if any, of the patient; b) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; c) The date on which each relevant health service was rendered; d) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.			
E	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required. Maximum billable time for such a report is 15 minutes.			
F	With the exception of compilation of reports as per Rule E, time charged in terms of the codes in this schedule only includes time spent in direct interaction with the patient.			
	MODIFIERS			
	Modifier governing the section Psychological Services			
3	Emergency treatments - Relevant fee plus 50%			
4	Psychology services rendered to an in-patient in a nursing home or hospital.			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	CONSULTATIVE AND THERAPEUTIC SERVICES			
7	Appointment not kept			
200	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	5	R124,70	R 131,60
201	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	15	R373,48	R 394,15
202	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	25	R622,51	R 656,96
203	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	35	R871,54	R 919,77
204	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	45	R1 120,57	R 1 182,57
205	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	55	R1 370,00	R 1 445,81
206	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	65	R1 618,90	R 1 708,48
207	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	75	R1 867,67	R 1 971,01
208	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	85	R2 116,83	R 2 233,96
209	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 91-100min.	95	R2 365,99	R 2 496,91
210	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 101-110min.	105	R2 615,29	R 2 760,00
211	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 111-120min.	115	R2 863,79	R 3 022,25
	This code would be used in addition to code 211.			
290	Extended assessment, consultation, counselling and/or therapy (individual or family) - per full 15 minutes in excess of 120 minutes	7,5	R186,81	R 197,15
	GROUP SERVICES			
300	Psychology group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	1	R24,73	R 26,10
301	Psychology group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	3	R74,46	R 78,58
302	Psychology group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	5	R124,58	R 131,47
303	Psychology group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	7	R174,44	R 184,09
304	Psychology group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	9	R224,04	R 236,44
305	Psychology group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	11	R273,76	R 288,91
306	Psychology group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	13	R323,62	R 341,53
307	Psychology group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	15	R373,48	R 394,15
308	Psychology group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	17	R423,34	R 446,76
309	Psychology group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	19	R473,20	R 499,38
310	Psychology group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	21	R523,06	R 552,00
311	Psychology group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	23	R572,79	R 604,48

PSYCHOMETRY

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. TARIFFS ARE VAT INCLUSIVE.			
	GENERAL RULES			
A	Every account shall contain the following particulars: a) The surname, first name and other initials, if any, of the patient; b) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; c) The date on which each relevant health service was rendered; d) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.			
B	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required. Maximum billable time for such a report is 15 minutes.			
	PSYCHOMETRIC SERVICES			
7	Appointment not kept			
200	Psychometric testing. Duration: 1-10min.	0,5	R62,22	R 65,66
201	Psychometric testing. Duration: 11-20min.	1,5	R186,81	R 197,15
202	Psychometric testing. Duration: 21-30min.	2,5	R311,26	R 328,48
203	Psychometric testing. Duration: 31-40min.	3,5	R435,71	R 459,82
204	Psychometric testing. Duration: 41-50min.	4,5	R560,16	R 591,16
205	Psychometric testing. Duration: 51-60min.	5,5	R684,47	R 722,34
206	Psychometric testing. Duration: 61-70min.	6,5	R809,45	R 854,24
207	Psychometric testing. Duration: 71-80min.	7,5	R933,77	R 985,44
208	Psychometric testing. Duration: 81-90min.	8,5	R1 058,35	R 1 116,91
209	Psychometric testing. Duration: 91-100min.	9,5	R1 182,93	R 1 248,39
210	Psychometric testing. Duration: 101-110min.	10,5	R1 307,38	R 1 379,72
211	Psychometric testing. Duration: 111-120min.	11,5	R1 432,09	R 1 511,33
290	Psychometric testing - per full 15 minutes in excess of 120 minutes.	0,75	R93,53	R 98,71

RADIOGRAPHY

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	DIAGNOSTIC PROCEDURES			
	Note : Items 015, 029, 031, 033, 037, 065, 071, 073, 075, 077, 079, 081, 083, 085, 087, 089, 091, 093, 095, 097, 099, 101, 115, 117, 119, 121, 129, 131, 133, 135, 137, 139, 141, 149, 167, 171 and 173 should be only be paid on condition that the radiographer submits the name of the supervising clinician and his/her BHF practice number.			
	GENERAL RULES			
1000	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
	MODIFIERS			
1	The specified call-out fee may be charged for any bona-fide, justifiable emergency occurring at any hour which requires the practitioner to travel to the patient. Motivation may be required	12,49		
21	Services rendered to hospital patients: Quote modifier 0021 on all accounts for services performed on hospital or day clinic patients.			
80	Multiple examinations: Full fees			
81	Repeat examinations: No reduction			
84	Films should be charged under code 300.			
1	**SKELETON**			
1.1	**LIMBS**			
1	Finger, toe	12,3	R 65,25	R 68,86
3	Limb per region, e.g. shoulder, elbow, knee, foot, hand, wrist or ankle (an adjacent part which does not require an additional set of views should not be added, e.g. wrist or hand)	16,2	R 86,04	R 90,80
5	Smith-Petersen or equivalent control, in theatre	134,6	R 714,21	R 753,73
7	Stress studies, e.g. joint	16,2	R 86,04	R 90,80

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
9	Length studies per right and left pair of long bones	16,2	R 86,04	R 90,80
11	Skeletal survey under 5 years	48,5	R 257,45	R 271,70
13	Skeletal survey over 5 years	52,3	R 277,58	R 292,94
15	Arthrography per joint	39,5	R 209,57	R 221,17
1.2	**SPINAL COLUMN**			
17	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	24,6	R 130,63	R 137,86
21	Stress studies	10	R 53,15	R 56,09
25	Scoliosis studies	39,3	R 208,64	R 220,18
27	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	17	R 90,38	R 95,38
	MYELOGRAPHY			
29	Lumbar	43,1	R 228,77	R 241,43
31	Thoracic	40,1	R 212,85	R 224,63
33	Cervical	59,4	R 315,33	R 332,78
35	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	0		
37	Discography	31,5	R167,07	R 176,31
1.3	**SKULL**			
39	Skull studies	32,3	R171,41	R 180,89
41	Paranasal sinuses	17	R90,38	R 95,38
43	Facial bones and/or orbits	34,9	R185,10	R 195,34
45	Mandible	26	R138,00	R 145,64
47	Nasal bone	16,2	R86,04	R 90,80
49	Mastoid: Bilateral	50	R265,34	R 280,02
	TEETH			
51	One quadrant	7,7	R40,78	R 43,04
53	Two quadrants	8,5	R45,12	R 47,62
55	Full mouth	10,8	R57,36	R 60,53
57	Rotation tomography of the teeth and jaws	14,6	R77,49	R 81,78

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
59	Temporo-mandibular joints: Per side	19,2	R101,82	R 107,45
61	Tomography: Per side	30,5	R161,81	R 170,76
63	Localisation of foreign body in the eye	30,7	R163,00	R 172,02
65	Ventriculography	37,4	R198,51	R 209,49
67	Post-nasal studies: Lateral neck	10	R53,15	R 56,09
69	Maxillo-facial cephalometry	26,9	R142,74	R 150,64
71	Dacryocystography	24,2	R128,53	R 135,64
2	**ALIMENTARY TRACT**			
73	Sialography (plus 80% for each additional gland)	24,6	R130,63	R 137,86
75	Pharynx and oesophagus	22,8	R120,90	R 127,59
77	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	31,5	R167,07	R 176,31
79	Small bowel meal (control film of abdomen included, except when part of item 081)	27,7	R146,95	R 155,08
81	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	47,2	R250,48	R 264,34
83	Barium enema (control film of abdomen included)	50,9	R270,08	R 285,02
85	Biliary tract: ERCP (choledogram and/or pancreatography screening included)	47	R249,43	R 263,23
87	Gastric/oesophageal/duodenal intubation control	20,8	R110,51	R 116,62
89	Hypotonic duodenography (077 included)	57,3	R304,15	R 320,98
3	**BILIARY TRACT**			
91	Oral cholecystography	47,8	R253,77	R 267,81
93	Intravenous	58,6	R310,99	R 328,20
95	Operative: First series	58,1	R308,36	R 325,42
97	Subsequent series	24	R127,21	R 134,25
99	Post-operative: T-tube	20,1	R106,69	R 112,59
101	Trans-hepatic, percutaneous	34,6	R183,52	R 193,67
103	Tomography of biliary tract: Add	21,5	R114,06	R 120,37
4	**CHEST**			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
105	Larynx (tomography included)	42,4	R224,96	R 237,41
107	Chest (item 167 included)	19,2	R101,82	R 107,45
109	Chest and cardiac studies (item 167 included)	23,1	R122,61	R 129,39
111	Ribs	19,2	R101,82	R 107,45
113	Sternum or sterno-clavicular joints	24,6	R130,63	R 137,86
	BRONCHOGRAPHY			
115	Unilateral	33,5	R177,73	R 187,56
117	Bilateral	56,5	R299,94	R 316,54
119	Pleurography	15,7	R83,27	R 87,88
121	Laryngography	15,7	R83,27	R 87,88
123	Thoracic inlet	15,7	R83,27	R 87,88
5	**ABDOMEN**			
125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	17	R90,38	R 95,38
127	Acute abdomen or equivalent studies	30,7	R163,00	R 172,02
6	**URINARY TRACT**			
129	Control film included and bladder views before and after micturition	270.3	355,59	R 375,27
133	Waterload test: Add	81.1	106,69	R 112,59
135	Cystography only or urethrography only (retrograde)	151.7	199,57	R 210,61
	CYSTO-URETHROGRAPHY			
137	Retrograde	33,1	R175,76	R 185,49
139	Retrograde-prograde pyelography	42,4	R224,96	R 237,41
141	Aspiration renal cyst	17	R90,38	R 95,38
143	Tomography of renal tract: Add	19,2	R101,82	R 107,45
7	**GYNAECOLOGY AND OBSTETRICS**			
145	Pregnancy	19,2	R101,82	R 107,45
147	Pelvimetry	35,5	R188,52	R 198,95

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
149	Hysterosalpingography	32	R169,70	R 179,09
8	**TOMOGRAPHY AND CINEMATOGRAPHY**			
151	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension, fees shall be charged for the additional investigation at 50% of the rate with a maximum of two additional investigations		0	
153	Tomography (multi-dimensional in motion): Add 150%		0	
9	**COMPUTED TOMOGRAPHY**			
155	Head, single examination, full series	262,7	R1 393,94	R 1 471,07
157	Head, repeat examination at the same visit, after contrast, full series	90,2	R478,72	R 505,21
159	Chest	303,7	R1 611,67	R 1 700,85
161	Abdomen (including base of chest and/or pelvis)	353	R1 873,19	R 1 976,84
163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	82,1	R435,71	R 459,82
165	Limbs and other limited examinations	82,1	R435,71	R 459,82
	MODIFIER GOVERNING THIS SPECIFIC SECTION OF THE TARIFFS			
89	The number of sections of each examination and the matrix number must be specified. A full series of sections would be 8 or more for brain examinations, 12 or more for chest examinations, and 16 or more for abdomen examinations. Fees for examinations on a matrix number of less than 250 shall be reduced by 50%			
10	**MISCELLANEOUS**			
167	Fluoroscopy: Per half hour: Add (not applicable to items 107 and 109)	21,4	R113,53	R 119,81
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	29,6	R157,08	R 165,77
171	Sinography	44,3	R235,09	R 248,10
173	Bone densitometry	80,9	R429,26	R 453,01
175	Mammography: Unilateral or bilateral	58,1	R308,36	R 325,42
177	Repeat mammography, unilateral or bilateral for localisation of tumour	58,1	R308,36	R 325,42
179	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except 005: Per 1/2 hour: Plus fee for examination performed	17,6	R93,40	R 98,57
181	Setting of sterile trays	3	R15,92	R 16,80
	Films are to be charged (exclusive of VAT) at net acquisition price plus -			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	* 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; and			
	* a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.			
300	X-Ray films			
	ATTENDANCE IN CATHETERISATION LABORATORY			
	Use codes 191 to 193 to charge for radiographer input where that is not included in cath lab facility fee			
191	Preparation in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures.	43	R228,25	R 240,88
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	43	R228,25	R 240,88
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
194	Right heart investigation of valve and venous system of the right heart	43	R228,25	R 240,88
195	PTCA per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
196	Left heart investigation of valve of the left heart and ventrical	43,1	R228,77	R 241,43
197	Stent procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
201	Temporary pacemaker procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
203	Permanent pacemaker procedure in catheterisation laboratory per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
205	Intra-aortic balloon pump procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
207	Electro-physiological studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
209	Bleomycine and other studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
211	Intra vascular ultrasound per 30 minutes of part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
213	Rotablator/Laser procedures per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43	R228,25	R 240,88
	RULES			
Z	No fee to be subject to more than one reduction			
11	**PORTABLE UNIT EXAMINATIONS**			

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
185	Where portable x-ray unit is used in the hospital or theatre: Add	19,4	R103,01	R 108,71
187	Theatre investigations with fixed installation : Add	8,3	R44,07	R 46,51

RADIOLOGY 5-DIGIT CODE STRUCTURE

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

This schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025"). "025" practices may only charge the codes with a 3rd digit of 9. "038" practices may charge all codes except

This schedule must be used in conjunction with the Radiological Society of S A Guidelines. Please refer to the PET guidelines

Code Structure Framework

a. The tariff code consists of 5 digits

i. 1st digit indicates the main anatomical region or procedural category.

- 0 = General (non specific)
- 1 = Head
- 2 = Neck
- 3 = Thorax
- 4 = Abdomen and Pelvis (soft tissue)
- 5 = Spine, Pelvis and Hips
- 6 = Upper limbs
- 7 = Lower limbs
- 8 = Interventional
- 9 = Soft tissue regions (nuclear medicine)
- eg "Head" = 1xxxx

ii. 2nd digit indicates the sub region within a main region or category eg.

- "Head / Skull and Brain" = 10xxx

iii. 3rd digit indicates modality

- 1 = General (Black and White) x-rays
- 2 = Ultrasound
- 3 = Computed Tomography
- 4 = Magnetic Resonance Imaging
- 5 = Angiography
- 6 = Interventional radiology
- 9 = Nuclear Medicine (Isotopes)

eg:

Guidelines for use of coding structure

- The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.
- Some codes may have multiple applications and their use is described in notes associated with each code
- Codes 00540 to 00570 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA.
- The machine codes 00540, 00560, 00570 may not be added to 60575, 70550.
- Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.

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Consumables

- Contrast Medium and consumables are to be priced as per current legislation
- Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90.
- The cost of film and hard copy images is included in the comprehensive procedure codes and is not billed for separately.
- Appropriate codes must be provided for consumables.

General Comments on Procedural Codes

- Code 00125 is a stnad plone study and may not be added to any other codes.
- Setting of sterile tray is included in all appropriate procedure codes, except for code 01047
- CT Angiography are stand alone studies and may not be added to the regional contrasted studies.
- Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies

Modifiers

00090	Consumables used in radiology procedures as per NAPPI code (where applicable, VAT sould be added to the above
00091	Radiology and nuclear medicine services rendered to hospital inpatients
00092	Radiology and nuclear medicine services rendered to outpatients

General Codes			2019 Tariff				2020 Tariff			
CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Equipment / Diagnostic									
00090	Consumables used in radiology procedures: cost price PLUS 31.5% (up to a maximum of R31,50). (Where applicable, VAT should be added to the above).				-	-				
	Appropriate code to be provided. See separate codes for contrast and isotopes									
00110	X-ray skeletal survey under five years				6,260	790,51				R 834,25
00115	X-ray skeletal survey over five years				10,400	1313,30				R 1 385,97
00120	X-ray sinogram any region				10,890	1375,26				R 1 451,36
00130	X-ray with mobile unit in other facility	+			1,900	239,95				R 253,23
	To be added to applicable procedure codes eg 30100.									
00135	X-ray control view in theatre any region				5,260	664,21				R 700,96

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
00140	X-ray fluoroscopy any region	+			2,260	285,34				R 301,13
	May only be added to the examination when fluoroscopy is not included in the standard procedure code. May not be added to: • any angiography, venography, lymphangiography or interventional codes. • any contrasted fluoroscopy examination.									
00145	X-ray fluoroscopy guidance for biopsy, any region	+			5,300	669,35				R 706,39
	Add to the procedure eg. 80600, 80605, 80610.									
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour				2,420	305,60				R 322,51
	Only to be used if equipment is owned by the radiologist.									
00155	X-ray C-arm fluoroscopy in theatre per half hour (procedure only)				2,300	290,34				R 306,41
00160	X-ray fixed theatre installation (equipment fee only)				2,260	285,34				R 301,13
	Only to be used if equipment is owned by the radiologist.									
00190	X-ray examination contrast material				-					
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.									
00210	Ultrasound with mobile unit in other facility	+			1,840	232,32				R 245,18
	Add to the relevant ultrasound examination codes eg 10200.									
00220	Ultrasound intra-operative study				7,320	924,30				R 975,44
	Covers all regions studied. Single code per operative procedure.									
00230	Ultrasound guidance	+			12,100	1528,26				R 1 612,82
	Comprehensive ultrasound code including regional study and guidance. Guided procedure code to be added eg. 80600, 80605, 80610.									
00240	Ultrasound guidance for tissue ablation				11,240	1419,60				R 1 498,15
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure									
00250	Ultrasound limited Doppler study any region				6,500	820,90				R 866,32
	Stand alone code may not be added to any other code.									
00290	Ultrasound examination contrast material				-					
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.									
00310	CT planning study for radiotherapy				21,370	2698,69				R 2 848,02
00591	Radiology prosthetic device									

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	To be used once per planning session for any region									
00320	CT guidance (separate procedure)				16,920	2136,83				R 2 255,07
	Comprehensive CT code including regional study and guidance. Guided procedure code to be added eg 80600, 80605, and 80610.									
00330	CT guidance, with diagnostic procedure	+			8,460	1068,35				R 1 127,47
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.									
00340	CT guidance and monitoring for tissue ablation				21,150	2670,94				R 2 818,73
	May only be used once per procedure for a region. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. If performed by radiologist, add procedural code 80620, or 80630.									
00390	CT examination contrast material				-					
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.									
00410	MR study of the whole body for metastases screening				70,400	8890,53				R 9 382,47
00420	MR Spectroscopy any region	+			28,900	3649,70				R 3 851,65
	May be added to the regional study, once only.									
00430	MR guidance for needle replacement	+			42,560	5374,76				R 5 672,16
	Comprehensive MRI code including region studied and guidance. Guided procedure code to be added eg 80600, 80605, 80610.									
00440	MR low field strength imaging of peripheral joint any region				12,000	1515,50				R 1 599,36
00450	MR planning study for radiotherapy or surgical procedure				38,000	4798,95				R 5 064,49
00455	MR planning study for radiotherapy or surgical procedure, with contrast				47,000	5935,57				R 6 264,00
00490	MR examination contrast material				-					
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.									
00510	Analogue monoplane screening table	+			41,010	5179,01				R 5 465,58
	A machine code may be added once per complete procedure / patient visit.									
00520	Analogue monoplane table with DSA attachment	+			47,500	5998,59				R 6 330,51
	A machine code may be added once per complete procedure / patient visit.									
00530	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.	+			47,500	5998,59				R 6 330,51

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	A machine code may be added once per complete procedure / patient visit.									
00540	Digital monoplane screening table	+			79,920	10092,80				R 10 651,27
	A machine code may be added once per complete procedure / patient visit.									
00550	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.	+			93,030	11748,41				R 12 398,49
	A machine code may be added once per complete procedure / patient visit.									
00560	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment.	+			125,000	15785,92				R 16 659,41
	A machine code may be added once per complete procedure / patient visit.									
00590	Angiography and interventional examination contrast material				-					
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.									
00900	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton		34,920	4342,06				R 4 582,32		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT		48,330	6009,24				R 6 341,75		
00906	Nuclear Medicine study - Venous thrombosis regional		21,540	2678,17				R 2 826,36		
00909	Nuclear Medicine study - Tumour whole body		34,150	4246,16				R 4 481,11		
00912	Nuclear Medicine study - Tumour whole body multiple studies		47,560	5913,47				R 6 240,68		
00915	Nuclear Medicine study - Tumour whole body and SPECT		47,560	5913,47				R 6 240,68		
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT		60,980	7582,23				R 8 001,78		
00921	Nuclear Medicine study – Infection whole body		31,450	3910,57				R 4 126,95		
00924	Nuclear Medicine study – infection whole body with SPECT		44,860	5577,75				R 5 886,39		
00927	Nuclear Medicine study – infection whole body multiple studies		44,860	5577,75				R 5 886,39		
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies		58,270	7245,32				R 7 646,23		
00933	Nuclear Medicine study - Bone marrow imaging limited area		24,100	2996,66				R 3 162,48		
00936	Nuclear Medicine study - Bone marrow imaging whole body		37,510	4663,98				R 4 922,05		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies		37,510	4663,98				R 4 922,05		
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies		50,920	6331,42				R 6 681,76		
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic		24,100	2996,66				R 3 162,48		
00960	Nuclear Medicine therapy – Hyperthyroidism		11,990	1490,77				R 1 573,26		
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases		6,470	804,58				R 849,10		
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy		6,470	804,58				R 849,10		
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy		6,470	804,58				R 849,10		
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate		6,470	804,58				R 849,10		
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy		6,470	804,58				R 849,10		
00990	Nuclear Medicine Isotope		-	-						
	Identification code for the use of isotope with a procedure. Appropriate codes to be supplied.									
00991	Nuclear Medicine Substrate		-	-						
00956	PET/CT scan whole body without contrast - by arrangement with Fund				165,130					
00957	PET/CT scan whole body with contrast - by arrangement with scheme				163,190					
00950	PET scan local - by arrangement with Fund				-					
00951	PET/CT local - by arrangement with Fund				120,000					
00952	PET/CT local with contrast - by arrangement with Fund				124,680					
00955	PET scan whole body - by arrangement with scheme				-					
Call and assistance										
	• Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. • Emergency call out code 01020 only t									
01010	Emergency call out fee, first case				3,000	378,87				R 399,83
01020	Emergency call out fee, subsequent cases same trip				2,000	252,45				R 266,42
01030	Radiologist assistance in theatre, per half hour				6,000	757,62				R 799,54

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
01040	Radiographer attendance in theatre, per half hour				1,600	202,07				R 213,25
01050	Written report on study done elsewhere, short				1,500	189,44				R 199,92
01055	Written report on study done elsewhere, extensive				4,200	530,29				R 559,63
01060	Written report for medico legal purposes, per hour				9,720	1227,40				R 1 295,32
01070	Consultation for pre-assessment of interventional procedure				4,860	613,83				R 647,80
01100	X-ray procedure after hours, per procedure				2,000	252,450				R 266,42
01200	Ultrasound procedure after hours, per procedure				4,000	505,170				R 533,12
01300	CT procedure after hours, per procedure				10,000	1262,780				R 1 332,65
01400	MR procedure after hours, per procedure				14,000	1768,080				R 1 865,91
01500	Angiography procedure after hours, per procedure				20,000	2525,830				R 2 665,59
01600	Interventional procedure after hours, per procedure				26,000	3283,450				R 3 465,13
01970	Consultation for nuclear medicine study		2,200	273,50				R 288,63		
	Monitoring									
	• ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.									
02010	ECG/pulse Oximeter monitoring				2,000	252,45				R 266,42
	Head									
	Skull and Brain									
	Codes 10100 (skull) and 10110 (tomography) may be combined.									
10100	X-ray of the skull				3,860	487,41				R 514,38
10110	X-ray tomography of the skull				4,300	543,05				R 573,10
10120	X-ray shuntogram for VP shunt				15,360	1939,76				R 2 047,09
10200	Ultrasound of the brain – Neonatal				7,380	932,06				R 983,63
10210	Ultrasound of the brain including doppler				13,220	1669,55				R 1 761,93
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler				15,040	1899,37				R 2 004,47
10300	CT Brain uncontrasted				22,650	2860,50				R 3 018,78

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
10310	CT Brain with contrast only				33,280	4202,88				R 4 435,44
10320	CT Brain pre and post contrast				40,480	5112,18				R 5 395,05
10325	CT brain pre and post contrast for perfusion studies				49,100	6200,65				R 6 543,75
	Stand alone code may not be added to any other CT studies of the brain, except for code 10330									
10330	CT angiography of the brain				77,580	9797,47				R 10 339,60
10335	CT of the brain pre and post contrast with angiography				97,910	12364,74				R 13 048,92
10340	CT brain for cranio-stenosis including 3D				34,160	4314,04				R 4 552,75
10350	CT Brain stereotactic localisation				19,360	2444,93				R 2 580,22
10360	CT base of skull coronal high resolution study for CSF leak				34,900	4407,45				R 4 651,33
10400	MR of the brain, limited study				43,560	5501,05				R 5 805,44
10410	MR of the brain uncontrasted				63,800	8057,14				R 8 502,97
10420	MR of the brain with contrast				75,940	9590,40				R 10 121,07
10430	MR of the brain pre and post contrast				104,040	13138,93				R 13 865,95
10440	MR of the brain pre and post contrast, for perfusion studies				107,440	13568,32				R 14 319,10
10450	MR of the brain plus angiography				92,200	11643,56				R 12 287,84
10460	MR of the brain pre and post contrast plus angiography				121,230	15309,70				R 16 156,84
10470	MR angiography of the brain uncontrasted				58,500	7387,80				R 7 796,59
10480	MR angiography of the brain contrasted				74,020	9347,68				R 9 864,92
10485	MR of the brain, with diffusion studies				79,000	9976,64				R 10 528,68
10490	MR of the brain, pre and post contrast, with diffusion studies,				110,640	13972,32				R 14 745,46
10492	MR study of the brain plus angiography plus diffusion, uncontrasted				95,000	11997,18				R 12 661,02
10495	MR of the brain pre and post contrast plus angiography and diffusion				125,440	15841,44				R 16 718,00
10500	Arteriography of intracranial vessels: 1 - 2 vessels				48,600	6137,51				R 6 477,12
10510	Arteriography of intracranial vessels: 3 - 4 vessels				82,330	10397,09				R 10 972,40
10520	Arteriography of extra-cranial (non-cervical) vessels				48,440	6117,25				R 6 455,74
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels				118,090	14913,20				R 15 738,40
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography				97,570	12321,85				R 13 003,66
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography				37,290	4709,23				R 4 969,81
10560	Venography of dural sinuses				52,230	6595,97				R 6 960,95
10900	Nuclear Medicine study – Bone regional, static		21,500	2673,17				R 2 821,09		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
10905	Nuclear Medicine study – Bone regional, static, with flow		27,530	3423,16				R 3 612,57		
10910	Nuclear Medicine study – Bone regional, static with SPECT		34,920	4342,06				R 4 582,32		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT		40,940	5090,34				R 5 372,01		
10920	Nuclear Medicine study – Brain, planar, complete, static		16,920	2103,68				R 2 220,08		
10925	Nuclear Medicine study – Brain complete static with vascular flow		22,950	2853,53				R 3 011,43		
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT		30,330	3771,38				R 3 980,06		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT		36,360	4521,11				R 4 771,28		
10940	Nuclear Medicine study - CSF flow imaging cisternography		21,600	2685,67				R 2 834,28		
10945	Nuclear Medicine study – Ventriculography		13,410	1667,44				R 1 759,71		
10950	Nuclear Medicine study - Shunt evaluation static, planar		13,410	1667,44				R 1 759,71		
10955	Nuclear Medicine study - CFS leakage detection and		13,410	1667,44				R 1 759,71		
10960	Nuclear medicine study - CSF SPECT		13,410	1667,44				R 1 759,71		
10970	PET scan of the brain - by arrangement with scheme									
10971	PET/CT scan of the brain uncontrasted - by arrangement with Fund				110,120					
10972	PET/CT of the brain contrasted - by arrangement with Fund				116,110					
10980	PET perfusion scan of the brain - by arrangement with Fund				-					
10981	PET/CT perfusion scan of the brain - by arrangement with Fund				131,070					

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Facial bones and nasal bones									
	Codes 11100 (facial bones) and 11110 (tomography) may be combined									
11100	X-ray of the facial bones				3,930	496,35				R 523,81
11110	X-ray tomography of the facial bones				4,300	543,05				R 573,10
11120	X-ray of the nasal bones				2,390	301,92				R 318,63
11300	CT of the facial bones				20,960	2646,99				R 2 793,46
11310	CT of the facial bones with 3D reconstructions				30,400	3839,13				R 4 051,56
11320	CT of the facial bones/soft tissue, pre and post contrast				41,260	5210,58				R 5 498,90
11400	MR of the facial soft tissue				62,400	7880,20				R 8 316,24
11410	MR of the facial soft tissue pre and post contrast				100,600	12704,54				R 13 407,52
11420	MR of the facial soft tissue plus angiography, with contrast				110,300	13929,44				R 14 700,20
11430	MR angiography of the facial soft tissue				74,020	9347,68				R 9 864,92
	Orbits, lacrimal glands and tear ducts									
	Code 12130 (tomography) may be added to 12100 or 12110 or 12120 (orbits) or 12140 (dacrocystography).									
12100	X-ray orbits less than three views				3,560	449,52				R 474,39
12110	X-ray of the orbits, three or more views, including foramina				5,300	669,35				R 706,39
12120	X-ray of the orbits for foreign body				3,560	449,52				R 474,39
12130	X-ray tomography of the orbits				4,300	543,05				R 573,10
12140	X-ray dacrocystography				11,200	1414,47				R 1 492,74
12200	Ultrasound of the orbit/eye				5,130	647,90				R 683,75
12210	Ultrasound of the orbit/eye including doppler				10,970	1385,26				R 1 461,91
12300	CT of the orbits single plane				15,700	1982,78				R 2 092,49
12310	CT of the orbits, more than one plane				20,590	2600,16				R 2 744,04
12320	CT of the orbits pre and post contrast single plane				36,030	4550,05				R 4 801,82
12330	CT of the orbits pre and post contrast multiple planes				39,700	5013,51				R 5 290,92
12400	MR of the orbits				62,460	7887,96				R 8 324,43
12410	MR of the orbitae, pre and post contrast				100,640	12709,54				R 13 412,80
12900	Nuclear Medicine study – Dacrocystography		20,770	2582,40				R 2 725,29		
	Paranasal sinuses									
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).									

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
13100	X-ray of the paranasal sinuses, single view				2,740	345,99				R 365,13
13110	X-ray of the paranasal sinuses, two or more views				3,660	462,28				R 487,86
13120	X-ray tomography of the paranasal sinuses				4,300	543,05				R 573,10
13130	X-ray of the naso-pharyngeal soft tissue				2,740	345,99				R 365,13
13300	CT of the paranasal sinuses single plane, limited study				7,200	909,30				R 959,61
13310	CT of the paranasal sinuses, two planes, limited study				12,400	1566,02				R 1 652,67
13320	CT of the paranasal sinuses, any plane, complete study				15,420	1947,39				R 2 055,15
13330	CT of the paranasal sinuses, more than one plane, complete study				20,770	2622,92				R 2 768,05
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast				34,740	4387,32				R 4 630,09
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast				41,010	5179,01				R 5 465,58
13400	MR of the paranasal sinuses				60,270	7611,17				R 8 032,32
13410	MR of the paranasal sinuses, pre and post contrast				96,590	12198,06				R 12 873,02
	Mandible, teeth and maxilla									
	Code 14110 (orthopantomogram) may be combined with 14100 (mandible) if two separate studies are performed. Code 14110 (orthopantomogram) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14160 (tomograph									
14100	X-ray of the mandible				3,660	462,28				R 487,86
14110	X-ray orthopantomogram of the jaws and teeth				4,060	512,66				R 541,03
14120	X-ray maxillofacial cephalometry				2,770	349,80				R 369,16
14130	X-ray of the teeth single quadrant				2,000	252,45				R 266,42
14140	X-ray of the teeth more than one quadrant				2,530	319,68				R 337,37
14150	X-ray of the teeth full mouth				3,620	457,15				R 482,45
14160	X-ray tomography of the teeth per side				3,230	407,95				R 430,52
14300	CT of the mandible				22,280	2813,67				R 2 969,36
14310	CT of the mandible, pre and post contrast				41,260	5210,58				R 5 498,90
14320	CT mandible with 3D reconstructions				30,400	3839,13				R 4 051,56
14330	CT for dental implants in the mandible				27,450	3466,57				R 3 658,39
14340	CT for dental implants in the maxilla				27,450	3466,57				R 3 658,39
14400	MR of the mandible/maxilla				63,800	8057,14				R 8 502,97
14410	MR of the mandible/maxilla, pre and post contrast				98,640	12457,09				R 13 146,38

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	TM Joints									
	Code 15100 (TM joint) and 15120 (tomography) may be combined. Code 15110 (TM joint) and 15130 (tomography) may be combined. Code 15140 (arthrography) and 15120 (tomography) may be combined. Code 15150 (arthrography) and 15130 (tomography)may be combined.									
15100	X-ray tempero-mandibular joint, left				3,560	449,52				R 474,39
15110	X-ray tempero-mandibular joint, right				3,560	449,52				R 474,39
15120	X-ray tomography tempero-mandibular joint, left				4,300	543,05				R 573,10
15130	X-ray tomography tempero-mandibular joint, right				4,300	543,05				R 573,10
15140	X-ray arthrography of the tempero-mandibular joint, left				15,410	1946,07				R 2 053,75
15150	X-ray arthrography of the tempero-mandibular joint, right				15,410	1946,07				R 2 053,75
15200	Ultrasound tempero-mandibular joints, one or both sides				6,560	828,39				R 874,23
15300	CT of the tempero-mandibular joints				25,380	3205,18				R 3 382,53
15310	CT of the tempero-mandibular joints plus 3D reconstructions				34,500	4356,93				R 4 598,01
15320	CT arthrogram of the tempero-mandibular joints				35,960	4541,24				R 4 792,52
15400	MR of the tempero-mandibular joints				63,800	8057,14				R 8 502,97
15410	MR of the tempero-mandibular joints, pre and post contrast				100,840	12734,80				R 13 439,46
15420	MR arthrogram of the tempero-mandibular joints				74,710	9434,90				R 9 956,96
	Mastoids and internal auditory canal									
	Code 16100 (mastoids) and 16120 (tomography) may be combined. Code 16110 (mastoids bilat) and 16130 (tomography) may be combined. Code 16140 (IAM's) and 16150 (tomography) may be combined.									
16100	X-ray of the mastoids, unilateral				3,590	453,47				R 478,56
16110	X-ray of the mastoids, bilateral				7,180	906,67				R 956,84
16120	X-ray tomography of the petro-temporal bone, unilateral				4,300	543,05				R 573,10
16130	X-ray tomography of the petro-temporal bone, bilateral				8,600	1085,98				R 1 146,07
16140	X-ray internal auditory canal, bilateral				5,230	660,53				R 697,08

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
16150	X-ray tomography of the internal auditory canal, bilateral				4,300	543,05				R 573,10
16300	CT of the mastoids				12,600	1591,27				R 1 679,32
16310	CT of the internal auditory canal				21,470	2711,32				R 2 861,35
16320	CT of the internal auditory canal, pre and post contrast				34,200	4319,04				R 4 558,03
16330	CT of the ear structures, limited study				13,400	1692,31				R 1 785,95
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes				43,350	5474,48				R 5 777,40
16400	MR of the internal auditory canals, limited study				43,560	5501,05				R 5 805,44
16410	MR of the internal auditory canals, pre and post contrast, limited study				68,930	8705,04				R 9 186,72
16420	MR of the internal auditory canals, pre and post contrast, complete study				102,640	12961,99				R 13 679,22
16430	MR of the ear structures				64,400	8132,92				R 8 582,94
16440	MR of the ear structures, pre and post contrast				102,640	12961,99				R 13 679,22
	Sella turcica									
	Code 17100 (sella) and 17110 (tomography) may be combined.									
17100	X-ray of the sella turcica				3,080	389,00				R 410,52
17110	X-ray tomography of the sella turcica				4,300	543,05				R 573,10
17300	CT of the sella turcica/hypophysis				17,450	2203,66				R 2 325,60
17310	CT of the sella turcica/hypophysis, pre and post contrast				42,260	5336,87				R 5 632,18
17400	MR of the hypophysis				43,560	5501,05				R 5 805,44
17410	MR of the hypophysis, pre and post contrast				74,030	9349,00				R 9 866,31
	Salivary glands and floor of the mouth									
	Code 18100 (calculus) and 18110 (open mouth) may be combined. Codes 18120 (sialography) and 18320 (CT sialography) include introduction of contrast and fluoroscopy (00140 may not be added).									
18100	X-ray of the salivary glands and ducts for calculus				2,840	358,62				R 378,46
18110	X-ray of the salivary ducts, open mouth for calculus				1,900	239,95				R 253,23
18120	X-ray sialography, per gland				14,080	1778,21				R 1 876,60
18200	Ultrasound of the salivary glands/floor of the mouth				6,560	828,39				R 874,23
18300	CT of the salivary glands, uncontrasted				12,600	1591,27				R 1 679,32
18310	CT of the salivary glands/floor of the mouth, pre and post				42,100	5316,75				R 5 610,94
18320	CT sialography				26,280	3318,84				R 3 502,48
18400	MR of the salivary glands/floor of the mouth				63,200	7981,37				R 8 423,01

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
18410	MR of the salivary glands/floor of the mouth, pre and post				100,840	12734,80				R 13 439,46
18900	Nuclear Medicine study - Salivary gland imaging		20,770	2582,40				R 2 725,29		
	Soft Tissue									
19900	Nuclear Medicine study - Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
19905	Nuclear Medicine study - Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
19910	Nuclear Medicine study - Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
19915	Nuclear Medicine study - Tumour localisation planar, static, multiple studies and SPECT		47,560	5913,47				R 6 240,68		
19920	Nuclear medicine study - Infection localisation planar, static		18,040	2243,12				R 2 367,24		
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies		31,450	3910,57				R 4 126,95		
19930	Nuclear medicine study - Infection localisation planar, static and SPECT		31,450	3910,57				R 4 126,95		
19935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT		44,860	5577,75				R 5 886,39		
	Neck									
	Code 20120 (laryngography) includes fluoroscopy (00140 may not be added). Code 20130 (speech) includes tomography and cinematography (00140 may not be added). Code 20450 (MR Angiography) may be combined with 10410 (MR brain).									
20100	X-ray of soft tissue of the neck				2,740	345,99				R 365,13
20110	X-ray of the larynx including tomography				9,390	1185,83				R 1 251,45
20120	X-ray laryngography				8,280	1045,59				R 1 103,45
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording				8,300	1048,09				R 1 106,08
20200	Ultrasound of the thyroid				6,560	828,39				R 874,23
20210	Ultrasound of soft tissue of the neck				6,560	828,39				R 874,23
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler				15,000	1894,37				R 1 999,19
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler				21,840	2758,16				R 2 910,78
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler				10,800	1363,82				R 1 439,28

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
20300	CT of the soft tissues of the neck				18,250	2304,69				R 2 432,22
20310	CT of the soft tissues of the neck, with contrast				38,150	4817,89				R 5 084,48
20320	CT of the soft tissues of the neck, pre and post contrast				43,810	5532,76				R 5 838,91
20330	CT angiography of the extracranial vessels in the neck				79,360	10022,16				R 10 576,72
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain				107,500	13575,82				R 14 327,02
20350	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain plus a pre and post contrast study of the brain				124,430	15713,83				R 16 583,33
20400	Mr of the soft tissue of the neck				63,600	8031,75				R 8 476,17
20410	MR of the soft tissue of the neck, pre and post contrast				102,040	12886,35				R 13 599,39
20420	MR of the soft tissue of the neck and uncontrasted angiography				92,600	11694,21				R 12 341,29
20430	MR angiography of the extracranial vessels in the neck, without contrast				59,600	7526,85				R 7 943,34
20440	MR angiography of the extracranial vessels in the neck, with contrast				74,020	9347,68				R 9 864,92
20450	MR angiography of the extra and intracranial vessels with contrast				116,050	14655,61				R 15 466,55
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast				135,170	17070,15				R 18 014,70
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast				156,050	19707,15				R 20 797,61
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels				44,430	5611,03				R 5 921,51
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels				50,730	6406,54				R 6 761,04
20520	Arteriography of cervical vessels: carotid and vertebral				77,630	9803,52				R 10 345,98
20530	Arteriography of aortic arch and cervical vessels				91,970	11614,62				R 12 257,30
20540	Arteriography of aortic arch, cervical and intracranial vessels				108,870	13748,81				R 14 509,58
20550	Venography of jugular and vertebral veins				48,950	6181,71				R 6 523,76

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
Thyroid (Nuclear Medicine)										
21900	Nuclear Medicine study - Thyroid, single uptake		9,680	1203,59				R 1 270,19		
21910	Nuclear medicine study - Thyroid, multiple uptake		14,690	1826,62				R 1 927,69		
21920	Nuclear medicine study - Thyroid imaging with uptake		17,720	2203,26				R 2 325,17		
21930	Nuclear medicine study - Thyroid imaging		12,720	1581,54				R 1 669,05		
21940	Nuclear medicine study - Thyroid imaging with vascular flow		18,740	2330,08				R 2 459,01		
21950	Nuclear medicine study - Thyroid suppression/stimulation		12,720	1581,54				R 1 669,05		
21960	PET scan of the thyroid - by arrangement with Fund				-	-				
Parathyroid (Nuclear Medicine)										
22900	Nuclear Medicine study - Parathyroid, planar, static		16,520	2054,08				R 2 167,74		
22910	Nuclear medicine study - Parathyroid, planar, static, multiple		28,910	3594,84				R 3 793,75		
22920	Nuclear medicine study - Parathyroid, planar, static with subtraction technique		21,880	2720,53				R 2 871,07		
22930	Nuclear medicine study - Parathyroid SPECT		13,410	1667,44				R 1 759,71		
22940	PET scan of the parathyroid - by arrangement with Fund				-	-				
Soft Tissue										
29900	Nuclear Medicine study - Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
29905	Nuclear medicine study - Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
29910	Nuclear medicine study - Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
29915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT		47,560	5913,47				R 6 240,68		
29920	Nuclear medicine study - Tumour localisation planar, static		18,040	2243,12				R 2 367,24		
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies		31,450	3910,57				R 4 126,95		
29930	Nuclear medicine study - Infection localisation planar, static and SPECT		31,450	3910,57				R 4 126,95		
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT		44,860	5577,75				R 5 886,39		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
29940	Nuclear medicine study - Regional lymph node mapping, static, planar		24,100	2996,66				R 3 162,48		
29945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple		36,490	4537,03				R 4 788,08		
29950	Nuclear medicine study – Lymph node localisation with gamma probe		12,390	1540,76				R 1 626,02		
29960	PET scan of the soft tissue of the neck - by arrangement with scheme				-	-				
29961	PET/CT scan of the soft tissue of the neck uncontrasted - by arrangement with Fund				105,870	-				
29962	PET/CT scan of the soft tissue of the neck contrasted - by arrangement with Fund				111,690	-				

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Thorax									
	Chest wall, pleura, lungs and mediastinum									
	Code 30345 (high resolution) is a stand alone study.									
30100	X-ray of the chest, single view				3,040	384,01				R 405,26
30110	X-ray of the chest two views, PA and lateral				3,840	484,91				R 511,74
30120	X-ray of the chest complete with additional views				4,240	535,56				R 565,19
30130	X-ray of the chest complete including fluoroscopy				4,480	565,68				R 596,98
30140	X-ray tomography of the chest				4,300	543,05				R 573,10
30150	X-ray of the ribs				4,790	605,02				R 638,50
30155	X-ray of the chest and ribs				6,420	810,63				R 855,48
30160	X-ray of the thoracic inlet				2,560	323,23				R 341,12
30170	X-ray of the sterno-clavicular joints				4,210	531,74				R 561,16
30175	X-ray tomography of the sterno-clavicular joint				4,300	543,05				R 573,10
30180	X-ray of the sternum				4,210	531,74				R 561,16
30185	X-ray tomography of the sternum				4,300	543,05				R 573,10
30200	Ultrasound of the chest wall, any region				6,560	828,39				R 874,23
30210	Ultrasound of the pleural space				6,560	828,39				R 874,23
30220	Ultrasound of the mediastinal structures				6,560	828,39				R 874,23
30300	CT of the chest, limited study				9,500	1199,64				R 1 266,02
30310	CT of the chest uncontrasted				26,600	3359,23				R 3 545,11
30320	CT of the chest contrasted				42,430	5358,18				R 5 654,67
30330	CT of the chest, pre and post contrast				45,700	5771,26				R 6 090,60
30340	CT of the chest, limited high resolution study				11,200	1414,47				R 1 492,74
30350	CT of the chest, complete high resolution study				24,010	3032,18				R 3 199,96
30355	CT of the chest, complete high resolution study with additonal prone and expiratory studies				33,300	4205,38				R 4 438,08
30360	CT of the chest for pulmonary embolism				57,120	7213,62				R 7 612,77
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs				80,280	10138,32				R 10 699,31
30400	MR of the chest				63,600	8031,75				R 8 476,17
30410	MR of the chest with uncontrasted angiography				92,600	11694,21				R 12 341,29
30420	MR of the chest, pre and post contrast				102,040	12886,35				R 13 599,39

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
30900	Nuclear Medicine study - Lung perfusion		21,540	2678,17				R 2 826,36		
30910	Nuclear Medicine study - Lung ventilation, aerosol		21,500	2673,17				R 2 821,09		
30920	Nuclear Medicine study - Lung perfusion and ventilation		42,030	5225,97				R 5 515,14		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas		14,170	1761,90				R 1 859,39		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas		34,690	4313,25				R 4 551,92		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic		26,510	3296,21				R 3 478,60		
30960	Nuclear medine study - alveolar permeabillity		26,510	3296,21				R 3 478,60		
	Stand alone code. Not to be combined with 30910.									
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation		6,020	748,54				R 789,96		
	Stand alone code. Not to be combined with 30920.									
30980	PET scan of the chest - by arrangement with scheme				-	-				
30981	PET/CT scan of the chest uncontrasted - by arrangement with Fund				111,440	-				
30982	PET/CT scan of the chest contrasted - by arrangement with Fund				117,420	-				
30983	PET/CT scan of the chest pre and post contrast - by arrangement with Fund				148,320	-				

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Oesophagus									
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).									
31100	X-ray barium swallow				6,600	833,39				R 879,50
31105	Xray 3 phase dynamic contrasted swallow				12,600	1591,27				R 1 679,32
31110	X-ray barium swallow, double contrast				7,920	1000,07				R 1 055,41
31120	X-ray barium swallow with cinematography				10,070	1271,73				R 1 342,10
	Aorta and large vessels									
	Codes 32210 and 32220 (Ivus) may be combined									
32200	Ultrasound intravascular arterial or venous assessment for intervention, once per complete procedure				4,200	530,29				R 559,63
32210	Ultrasound intravascular (IVUS) first vessel				8,440	1065,85				R 1 124,83
32220	Ultrasound intravascular (IVUS) subsequent vessels				5,300	669,35				R 706,39
32300	CT angiography of the aorta and branches				79,080	9986,90				R 10 539,51
32305	CT angiography of the thoracic and abdominal aorta and branches				105,500	13323,37				R 14 060,60
32310	CT angiography of the pulmonary vasculature				79,080	9986,90				R 10 539,51
32400	MR angiography of the aorta and branches				78,500	9913,63				R 10 462,18
32410	MR angiography of the pulmonary vasculature				105,270	13294,16				R 14 029,77
32500	Arteriography of thoracic aorta				28,260	3568,79				R 3 766,26
32510	Arteriography of bronchial intercostal vessels alone				50,150	6333,26				R 6 683,70
32520	Arteriography of thoracic aorta, bronchial and intercostal				67,430	8515,61				R 8 986,81
32530	Arteriography of pulmonary vessels				63,270	7990,18				R 8 432,30
32540	Arteriography of heart chambers, coronary arteries				44,270	5590,77				R 5 900,13
32550	Venography of thoracic vena cava				28,380	3583,92				R 3 782,23
32560	Venography of vena cava, azygos system				56,310	7111,27				R 7 504,76
32570	Venography patency of A-port or other central line				19,640	2480,31				R 2 617,55

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Heart									
	Codes 33300 (CT anatomy / function) and 33310 (CT Angiography) may be done as stand alone studies or as additive studies if both are performed at the same time.									
33205	Ultrasound study of the heart for foetal or paediatric cases including doppler				12,300	1553,39				R 1 639,34
	Code 33205 is a stand alone study and may not be added to 33200 or 33210. This code is intended for paediatric and foetal cases only									
33200	Ultrasound study of the heart, including Doppler				8,200	1035,46				R 1 092,76
33210	Ultrasound study of the heart trans-oesophageal				10,520	1328,69				R 1 402,21
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel				5,200	656,72				R 693,06
33300	CT anatomical/functional study of the heart				34,610	4370,87				R 4 612,72
33310	CT angiography of heart vessels				81,280	10264,74				R 10 832,72
33400	MR of the heart, anatomical study				62,200	7855,07				R 8 289,72
33410	MR of the heart, anatomical and functional study				69,000	8713,73				R 9 195,89
33420	MR of the heart, pre and post contrast				103,040	13012,64				R 13 732,67
33430	MR angiography of the heart vessels				70,710	8929,74				R 9 423,85
33440	MR of the heart, anatomical, functional and coronary angiography				106,840	13492,55				R 14 239,14
33900	Nuclear Medicine study - Cardiac shunt detection		21,500	2673,17				R 2 821,09		
33905	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion single study		26,510	3296,21				R 3 478,60		
33910	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion multiple studies		34,920	4342,06				R 4 582,32		
33915	Nuclear Medicine study - Cardiac blood pool imaging, gated SPECT		13,410	1667,44				R 1 759,71		
33920	Nuclear medicine study - Cardiac blood pool imaging, first pass technique		26,510	3296,21				R 3 478,60		
33925	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi) planar, non gated		16,520	2054,08				R 2 167,74		
33930	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi) planar, non gated		16,520	2054,08				R 2 167,74		
33935	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (non gated)		16,520	2054,08				R 2 167,74		
33940	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT non gated		16,520	2054,08				R 2 167,74		

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
33945	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (gated)		28,910	3594,84				R 3 793,75		
33950	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT (gated)		28,910	3594,84				R 3 793,75		
33955	Nuclear medicine study - Plus wall movement and ejection fraction, SPECT		6,020	748,54				R 789,96		
33960	Nuclear medicine study - Cardiac hot spot imaging (infarction) planar		21,500	2673,17				R 2 821,09		
33965	Nuclear medicine study - Cardiac hot spot imaging (infarction) SPECT		13,410	1667,44				R 1 759,71		
33970	Nuclear Medicine study - Multi stage treadmill ECG test		6,660	828,13				R 873,95		
33980	PET scan of the heart - by arrangement with Fund				-	-				
33981	PET/CT scan of the heart - by arrangement with Fund					-				
	Breast									
	Codes 34110 (localization), 34120 (stereo-tactic localization) and 34130 (stereo-tactic biopsy) may not be combined. Code 34130 (stereo-tactic biopsy). Add procedural code 80610 (cutting needle) or 34150 (mammotome) Code 34205 (U/S FNA) includes the proce									
34100	X-ray mammography including ultrasound				10,440	1318,30				R 1 391,25
34101	X-Ray mammography unilateral, including ultrasound				8,352	1054,80				R 1 113,17
	Code 34100 may not be combined with 34205 when these two procedures are done in the same sitting. Code 34100 includes ultrasound. In this situation use code 80605 (fine needle aspiration) with 34100									
34105	X-ray mammography galactography				9,400	1187,01				R 1 252,69
	Once off fee per visit. May be added to 34100									
34110	X-ray mammography study for localisation				7,240	914,30				R 964,89
34120	X-ray stereotactic mammography – localisation				10,400	1313,30				R 1 385,97
34130	X-ray stereotactic mammography – biopsy				11,600	1464,98				R 1 546,04
34140	X-ray of biopsy specimen of the mamma				2,740	345,99				R 365,13
34150	X-ray Mammotome hand held biopsy apparatus				9,800	1237,53				R 1 306,01
34200	Ultrasound study of the breast				7,900	997,57				R 1 052,77
34205	Ultrasound guided aspiration FNA/localisation of the breast				12,100	1528,26				R 1 612,82
34300	Computer assisted diagnosis for mammography				1,400	176,81				R 186,59
34400	MR study of the breast				62,600	7905,59				R 8 343,03
34410	MR study of the breast pre and post contrast				100,840	12734,80				R 13 439,46
34900	PET scan of the breast/mamma - by arrangement with scheme				-	-				

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Soft Tissue									
39900	Nuclear medicine study - Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
39905	Nuclear medicine study - Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
39910	Nuclear medicine study - Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
39915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT		47,560	5913,47				R 6 240,68		
39920	Nuclear medicine study - Infection localisation planar, static		18,040	2243,12				R 2 367,24		
39925	Nuclear medicine study - Infection localisation planar, static, multiple studies		31,450	3910,57				R 4 126,95		
39930	Nuclear medicine study - Infection localisation planar, static and SPECT		31,450	3910,57				R 4 126,95		
39935	Nuclear medicine study - Infection localisation planar, static, multiple studies, SPECT		44,860	5577,75				R 5 886,39		
39940	Nuclear medicine study - Regional lymph node mapping, static, planar		24,100	2996,66				R 3 162,48		
39945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple		36,490	4537,03				R 4 788,08		
39950	Nuclear medicine study – Lymph node localisation with gamma probe		12,390	1540,76				R 1 626,02		

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Abdomen and Pelvis									
	Abdomen/stomach/bowel									
	Code 40120 (tomography) may be combined with 40100 or 40105 or 40110 (abdomen). Codes 40140 to 40190 (barium studies) include fluoroscopy (00140 may not be added). Code 40190 (intussusception) is a stand alone code and may not be combined with 40160 or 40165 (00140 may not be added)									
40100	X-ray of the abdomen				3,320	419,26				R 442,46
40105	X-ray of the abdomen supine and erect, or decubitus				5,360	676,84				R 714,29
40110	X-ray of the abdomen multiple views including chest				8,100	1022,96				R 1 079,56
40120	X-ray tomography of the abdomen				4,300	543,05				R 573,10
40140	X-ray barium meal single contrast				8,870	1120,18				R 1 182,16
40143	X-ray barium meal double contrast				11,990	1514,18				R 1 597,96
40147	X-ray barium meal double contrast with follow through				15,800	1995,28				R 2 105,69
40150	X-ray small bowel enteroclysis (meal)				25,450	3213,99				R 3 391,83
	Code 40150 excludes duodenal intubation and 40175 (Duodenal intubation) may be added.									
40153	X-ray small bowel meal follow through single contrast				19,550	2468,87				R 2 605,48
40157	X-ray small bowel meal with pneumocolon				25,630	3236,75				R 3 415,85
40160	X-ray large bowel enema single contrast				12,970	1637,98				R 1 728,61
40165	X-ray large bowel enema double contrast				19,630	2479,00				R 2 616,17
40170	X-ray guided gastro oesophageal intubation				1,600	202,07				R 213,25
40175	X-ray guided duodenal intubation				2,800	353,62				R 373,19
40180	X-ray defaecogram				12,970	1637,98				R 1 728,61
40190	X-ray guided reduction of intussusception				16,270	2054,61				R 2 168,30
40200	Ultrasound study of the abdominal wall				5,540	699,60				R 738,31
40210	Ultrasound study of the whole abdomen including the pelvis				8,240	1040,46				R 1 098,03
40300	CT study of the abdomen				26,410	3335,28				R 3 519,83
40310	CT study of the abdomen with contrast				44,820	5660,23				R 5 973,43
40313	CT study of the abdomen pre and post contrast				52,990	6691,88				R 7 062,16
40320	CT of the pelvis				26,130	3300,03				R 3 482,63

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
40323	CT of the pelvis with contrast				47,480	5996,09				R 6 327,87
40327	CT of the pelvis pre and post contrast				53,870	6803,04				R 7 179,47
40330	CT of the abdomen and pelvis				38,500	4861,96				R 5 130,99
40333	CT of the abdomen and pelvis with contrast				62,170	7851,13				R 8 285,56
40337	CT of the abdomen and pelvis pre and post contrast				67,430	8515,61				R 8 986,81
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast				74,110	9359,13				R 9 877,00
40345	CT of the chest, abdomen and pelvis without contrast				70,120	8855,15				R 9 345,13
40350	CT of the chest, abdomen and pelvis with contrast				88,350	11157,60				R 11 774,99
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast				93,050	11750,91				R 12 401,13
40360	CT of the base of skull to symphysis pubis with contrast				102,730	12973,44				R 13 691,30
40365	CT colonoscopy				34,780	4392,32				R 4 635,36
	Stand alone study, may not be added to any code between 40300 and 40360									
40400	MR of the abdomen				64,580	8155,54				R 8 606,81
40410	MR of the abdomen pre and post contrast				100,840	12734,80				R 13 439,46
40420	MR of the pelvis, soft tissue				64,580	8155,54				R 8 606,81
40430	MR of the pelvis, soft tissue, pre and post contrast				102,040	12886,35				R 13 599,39
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying		21,500	2673,17				R 2 821,09		
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies		34,920	4342,06				R 4 582,32		
40910	Nuclear Medicine study - Gastro intestinal protein loss		21,500	2673,17				R 2 821,09		
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies		34,920	4342,06				R 4 582,32		
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic		21,500	2673,17				R 2 821,09		
40925	Nuclear medicine study – Acute GIT bleed multiple studies		34,920	4342,06				R 4 582,32		
40930	Nuclear medicine study - Meckel's localisation		20,770	2582,40				R 2 725,29		
40935	Nuclear medicine study - Gastric mucosa imaging		20,770	2582,40				R 2 725,29		
40940	Nuclear medicine study - colonic transit multiple studies		44,860	5577,75				R 5 886,39		
	Stand alone code									

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
40950	PET scan of the abdomen and pelvis - by arrangement with scheme				-	-				
40951	PET/CT scan of the abdomen and pelvis uncontrasted - by arrangement with Fund				119,530	-				
40952	PET/CT scan of the abdomen and pelvis contrasted - by arrangement with Fund				129,310	-				
40953	PET/CT scan of the abdomen and pelvis pre and post contrast - by arrangement with Fund				140,500	-				
	Liver, spleen, gall bladder and pancreas									
	Code 41110, 41120 and 41130 (cholangiography) include fluoroscopy (00140 may not be added).									
41100	X-ray ERCP including screening				18,900	2386,78				R 2 518,85
41105	X-ray ERCP reporting on images done in theatre				2,400	303,10				R 319,87
41110	X-ray cholangiography intra-operative				8,450	1067,03				R 1 126,07
41120	X-ray T-tube cholangiography post operative				14,050	1774,27				R 1 872,45
41130	X-ray transhepatic percutaneous cholangiography				32,340	4084,09				R 4 310,08
41200	Ultrasound study of the upper abdomen				7,000	883,91				R 932,82
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis				9,800	1237,53				R 1 306,01
	Code 41210 is a stand alone study and may not be added to 40200, 40210, 41200 or 42200									
41300	CT of the abdomen triphasic study – liver				54,900	6933,28				R 7 316,92
41400	MR study of the liver/pancreas				64,780	8180,80				R 8 633,47
41410	MR study of the liver/pancreas pre and post contrast				100,840	12734,80				R 13 439,46
41420	MRCP				49,200	6213,28				R 6 557,08
41430	MR study of the abdomen with MRCP				92,980	11742,09				R 12 391,82
41440	MR study of the abdomen pre and post contrast with MRCP				133,600	16871,90				R 17 805,48
41900	Nuclear Medicine study - Liver and spleen, planar views only		21,500	2673,17				R 2 821,09		
41905	Nuclear Medicine study - Liver and spleen, with flow study		27,530	3423,16				R 3 612,57		
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT		34,920	4342,06				R 4 582,32		
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT		40,940	5090,34				R 5 372,01		
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic		21,500	2673,17				R 2 821,09		
41925	Nuclear Medicine study – hepatobiliary tract including flow		26,510	3296,21				R 3 478,60		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies		34,920	4342,06				R 4 582,32		
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies		39,920	4963,52				R 5 238,17		
41940	Nuclear medicine study - Gall bladder ejection fraction		6,020	748,54				R 789,96		
41945	Nuclear medicine study – Biliary gastric reflux study		20,770	2582,40				R 2 725,29		
	Renal tract									
42100	X-ray tomography of the renal tract				4,300	543,05				R 573,10
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP). Codes 42115 (IVP), 42120 (cystography), 42130 (urethography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).									
42110	X-ray excretory urogram including tomography				24,860	3139,40				R 3 313,11
42115	X-ray excretory urogram including tomography with micturating study				32,860	4149,86				R 4 379,49
42120	X-ray cystography				15,050	1900,56				R 2 005,72
42130	X-ray urethrography				15,370	1940,94				R 2 048,34
42140	X-ray micturating cysto-urethrography				19,300	2437,30				R 2 572,16
42150	X-ray retrograde/prograde pyelography				12,530	1582,33				R 1 669,89
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre				2,410	304,42				R 321,26
42160	X-ray prograde pyelogram – percutaneous				32,670	4125,79				R 4 354,08
42200	Ultrasound study of the renal tract including bladder				7,420	937,06				R 988,91
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney				3,800	479,91				R 506,47
	Code 42205 is a stand alone study and may not be added to 42200									
42210	Ultrasound study of the renal arteries including Doppler				10,600	1338,56				R 1 412,63
42300	CT of the renal tract for a stone				25,150	3176,23				R 3 351,98
42400	MR of the renal tract for obstruction				47,000	5935,57				R 6 264,00
42410	MR of the kidneys without contrast				64,580	8155,54				R 8 606,81
42420	MR of the kidneys pre and post contrast				102,240	12911,61				R 13 626,05
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)		21,940	2728,16				R 2 879,12		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow		27,960	3476,57				R 3 668,94		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT		35,350	4395,34				R 4 638,55		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT		41,370	5144,15				R 5 428,79		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow		26,510	3296,21				R 3 478,60		
42930	Nuclear Medicine study – Renovascular study, baseline		26,510	3296,21				R 3 478,60		
42940	Nuclear Medicine study – Renovascular study, with intervention		26,510	3296,21				R 3 478,60		
42950	Nuclear medicine study - indirect voiding cystogram		6,020	748,54				R 789,96		
	Reproductive system									
	Codes 43120 and 43130 (hystero-salpingography) include fluoroscopy (00140 may not be added). Codes 43230 (U/S ova aspiration) and 43240 (amniocentesis) are complete procedure codes and may not be combined with 00230 (ultrasound guidance) or 80605 (fine needle aspiration). Code 43240 may be combined with 43260 (second trimester), 43270 (third trimester follow up)									
43100	X-ray pelvimetry single				4,000	505,17				R 533,12
43110	X-ray pelvimetry multiple views				5,800	732,36				R 772,88
43120	X-ray hystero-salpingography				10,030	1266,60				R 1 336,69
43130	X-ray hystero-salpingography with introduction of contrast				13,530	1708,75				R 1 803,30
43200	Ultrasound study of the pelvis transabdominal				5,700	719,73				R 759,56
43205	Ultrasound study of the female pelvis transvaginal				7,210	910,48				R 960,86
43210	Ultrasound study of the prostate transrectal				7,380	932,06				R 983,63
43215	Ultrasound transrectal prostate volume for brachytherapy				10,400	1313,30				R 1 385,97
43220	Ultrasound study of the testes				7,380	932,06				R 983,63
43225	Ultrasound study for male impotence including doppler and injection of vaso contrictor				15,000	1894,37				R 1 999,19
	Code 43225 is a stand alone study and may not be added to 43200, 43210, 43220 or 44200									
43230	Ultrasound guided transvaginal aspiration for ova				13,500	1704,94				R 1 799,28
43240	Ultrasound guided amniocenthesis				5,840	737,49				R 778,30
43250	Ultrasound study of the pregnant uterus, first trimester				4,200	530,29				R 559,63
43260	Ultrasound study of the pregnant uterus, second trimester				6,360	803,14				R 847,58
43270	Ultrasound study of the pregnant uterus, third trimester, first				6,360	803,14				R 847,58
43273	Ultrasound study of the pregnant uterus, third trimester, follow-up visit				4,200	530,29				R 559,63

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
43277	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit				8,170	1031,91				R 1 089,01
43280	Ultrasound doppler of the umbilical cord for resistive index				3,800	479,91				R 506,47
	Code 43280 is a stand alone study and may not be added to the following codes: 43250, 43260, 43270, 43273 or 43277									
43300	CT pelvimetry – Topogram				6,580	830,89				R 876,87
43400	MR study of pelvic reproductive organs - limited study				47,600	6011,22				R 6 343,84
43405	MR study for pelvimetry				20,000	2525,83				R 2 665,59
43410	MR study of pelvic reproductive organs - complete – uncontrasted				64,580	8155,54				R 8 606,81
43420	MR study of pelvic reproductive organs - complete – pre and post contrast				102,240	12911,61				R 13 626,05
43950	Nuclear medicine study - Radio pharmaceutical voiding cystogram		21,500	R 2 673,17				R 2 821,09		
43960	Nuclear medicine study - Testicular imaging		26,510	R 3 296,21				R 3 478,60		
43961	PET scan of the testis - by arrangement with scheme				-	-				
43970	Nuclear medicine study - hystero-salpingography		26,510	3296,21				R 3 478,60		
	Aorta and vessels									
	Code 44400 (MR Angiography) may be combined with 40400 (MR abdomen).									
44200	Ultrasound study of abdominal aorta and branches including doppler				18,320	2313,50				R 2 441,51
44205	Ultrasound study of the IVC and pelvic veins including Doppler				14,000	1768,08				R 1 865,91
	This is a stand alone code and may not be added to 44200.									
44300	CT angiography of abdominal aorta and branches				76,720	9688,67				R 10 224,78
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen				94,320	11911,27				R 12 570,36
44310	CT angiography of the pelvis				78,640	9931,26				R 10 480,79
44320	CT angiography of the abdominal aorta and pelvis				89,540	11307,70				R 11 933,39
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis				119,150	15046,99				R 15 879,59
44330	CT portogram				74,400	9395,70				R 9 915,60
44400	MR angiography of abdominal aorta and branches				76,640	9678,54				R 10 214,09
44500	Arteriography of abdominal aorta alone				28,120	3551,03				R 3 747,52
44503	Arteriography of aorta plus coeliac, mesenteric branches				75,630	9551,07				R 10 079,56
44505	Arteriography of aorta plus renal, adrenal branches				63,010	7957,29				R 8 397,59

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
44507	Arteriography of aorta plus non-visceral branches				60,790	7676,95				R 8 101,74
44510	Arteriography of coeliac, mesenteric vessels alone				64,350	8126,47				R 8 576,13
44515	Arteriography of renal, adrenal vessels alone				49,490	6249,99				R 6 595,82
44517	Arteriography of non-visceral abdominal vessels alone				54,910	6934,33				R 7 318,03
44520	Arteriography of internal and external iliac vessels alone				56,720	7162,97				R 7 559,32
44525	Venography of internal and external iliac veins alone				62,110	7843,63				R 8 277,64
44530	Corpora cavernosography				25,060	3164,79				R 3 339,91
44535	Vasography, vesciculography				29,190	3686,27				R 3 890,24
44540	Venography of inferior vena cava				26,120	3298,58				R 3 481,10
44543	Venography of hepatic veins alone				53,770	6790,54				R 7 166,28
44545	Venography of inferior vena cava and hepatic veins				68,910	8702,54				R 9 184,08
44550	Venography of lumbar azygos system alone				43,890	5542,62				R 5 849,31
44555	Venography of inferior vena cava and lumbar azygos veins				65,460	8266,71				R 8 724,13
44560	Venography of renal, adrenal veins alone				43,990	5555,25				R 5 862,64
44565	Venography of inferior vena cava and renal/adrenal veins				68,390	8636,77				R 9 114,67
44570	Venography of spermatic, ovarian veins alone				40,390	5100,73				R 5 382,97
44573	Venography of inferior vena cava, renal, spermatic, ovarian				73,990	9344,00				R 9 861,03
44580	Venography indirect splenoportogram				48,670	6146,32				R 6 486,42
44583	Venography direct splenoportogram				31,590	3989,37				R 4 210,12
44587	Venography transhepatic portogram				66,750	8429,70				R 8 896,14
	Soft Tissue									
49900	Nuclear Medicine study – Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
49905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
49910	Nuclear Medicine study – Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
49915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT		47,560	5913,47				R 6 240,68		
49920	Nuclear medicine study – Infection localisation planar, static		18,040	2243,12				R 2 367,24		
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies		31,450	3910,57				R 4 126,95		
49940	Nuclear medicine study – Infection localisation planar, static and SPECT		31,450	3910,57				R 4 126,95		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT		44,860	5577,75				R 5 886,39		
49960	Nuclear medicine study – Regional lymph node mapping dynamic		5,010	623,04				R 657,51		
49965	Nuclear medicine study – Regional lymph node mapping, static, planar		24,100	2996,66				R 3 162,48		
49970	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple		37,510	4663,98				R 4 922,05		
49975	Nuclear medicine study – Regional lymph node mapping SPECT		13,410	1667,44				R 1 759,71		
49980	Nuclear medicine study – Lymph node localisation with gamma probe		13,410	1667,44				R 1 759,71		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Spine, Pelvis and Hips									
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventional myelography codes viz. 51160, 52150, 53160									
	General									
50100	X-ray of the spine scoliosis view AP only				7,000	883,91				R 932,82
50105	X-ray of the spine scoliosis view AP and lateral				12,000	1515,50				R 1 599,36
50110	X-ray of the spine scoliosis view AP and lateral including stress views				18,540	2341,39				R 2 470,95
50120	X-ray bone densitometry				11,520	1454,98				R 1 535,49
50130	X-ray guided lumbar puncture				4,800	606,07				R 639,61
50140	X-ray guided cisternal puncture cisternogram				22,980	2902,08				R 3 062,66
50300	CT quantitive bone mineral density				11,830	1493,92				R 1 576,58
50500	Arteriogram of the spinal column and cord, all vessels				127,230	16067,45				R 16 956,52
50510	Venography of the spinal, paraspinal veins				58,450	7381,35				R 7 789,78
	Cervical									
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51160 (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51340 (CT myelography) - post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).									
51100	X-ray f the cervical spine, stress views only				4,140	522,79				R 551,72
51110	X-ray of the cervical spine, one or two views				3,010	380,19				R 401,23
51120	X-ray of the cervical spine, more than two views				4,280	540,55				R 570,46
51130	X-ray of the cervical spine, more than two views including stress				7,580	957,19				R 1 010,15
51140	X-ray Tomography cervical spine				4,300	543,05				R 573,10
51160	X-ray myelography of the cervical spine				27,460	3467,76				R 3 659,64
51170	X-ray discography cervical spine per level				25,170	3178,73				R 3 354,62
51300	CT of the cervical spine limited study				9,500	1199,64				R 1 266,02
51310	CT of the cervical spine – regional study				13,910	1756,64				R 1 853,84
51320	CT of the cervical spine – complete study				37,130	4689,10				R 4 948,56
51330	CT of the cervical spine pre and post contrast				58,850	7432,00				R 7 843,24
51340	CT myelography of the cervical spine				47,190	5959,52				R 6 289,28
51350	CT myelography of the cervical spine following myelogram				21,690	2739,34				R 2 890,92
51400	MR of the cervical spine, limited study				44,400	5607,08				R 5 917,34

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
51410	MR of the cervical spine and cranio-cervical junction				64,820	8185,93				R 8 638,88
51420	MR of the cervical spine and cranio-cervical junction pre and				102,140	12898,98				R 13 612,72
51900	Nuclear Medicine study – Bone regional cervical		21,500	2673,17				R 2 821,09		
51910	Nuclear Medicine study – Bone tomography regional cervical		13,410	1667,44				R 1 759,71		
51920	Nuclear Medicine study – with flow		6,020	748,54				R 789,96		
	Thoracic									
	Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).									
52100	X-ray of the thoracic spine, one or two views				3,210	405,45				R 427,88
52110	X-ray of the thoracic spine, more than two views				4,000	505,17				R 533,12
52120	X-ray tomography thoracic spine				4,300	543,05				R 573,10
52140	X-ray of the thoracic spine, more that two views including stress				6,640	838,52				R 884,92
52150	X-ray myelography of the thoracic spine				18,620	2351,39				R 2 481,50
52300	CT of the thoracic spine limited study				9,500	1199,64				R 1 266,02
52305	CT of the thoracic spine – regional study				13,910	1756,64				R 1 853,84
52310	CT of the thoracic spine complete study				35,780	4518,61				R 4 768,64
52320	CT of the thoracic spine pre and post contrast				58,850	7432,00				R 7 843,24
52330	CT myelography of the thoracic spine				48,090	6073,05				R 6 409,09
52340	CT myelography of the thoracic spine following myelogram				20,370	2572,40				R 2 714,74
52400	MR of the thoracic spine, limited study				46,600	5884,93				R 6 210,56
52410	MR of the thoracic spine				64,340	8125,29				R 8 574,89
52420	MR of the thoracic spine pre and post contrast				101,420	12808,07				R 13 516,78
52900	Nuclear Medicine study – Bone regional dorsal		21,500	2673,17				R 2 821,09		
52910	Nuclear Medicine study – Bone tomography regional dorsal		13,410	1667,44				R 1 759,71		
52920	Nuclear Medicine study – with flow		6,020	748,54				R 789,96		

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Lumbar									
	Code 53100 (stress) is a stand alone study and may not be added to 53115, 53135 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added) Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).									
53100	X-ray of the lumbar spine – stress study only				4,140	522,79				R 551,72
53110	X-ray of the lumbar spine, one or two views				3,560	449,52				R 474,39
53120	X-ray of the lumbar spine, more than two views				4,460	563,18				R 594,34
53130	X-ray of the lumbar spine, more that two views including stress				7,520	949,69				R 1 002,24
53140	X-ray tomography lumbar spine				4,300	543,05				R 573,10
53160	X-ray myelography of the lumbar spine				23,940	3023,24				R 3 190,53
53170	X-ray discography lumbar spine per level				25,170	3178,73				R 3 354,62
53300	CT of the lumbar spine limited study				9,500	1199,64				R 1 266,02
53310	CT of the lumbar spine – regional study				13,910	1756,64				R 1 853,84
53320	Ct of the lumbar spine complete study				37,640	4753,56				R 5 016,59
53330	CT of the lumbar spine pre and post contrast				58,850	7432,00				R 7 843,24
53340	CT myelography of the lumbar spine				49,110	6201,97				R 6 545,15
53350	CT myelography of the lumbar spine following myelogram				23,460	2962,72				R 3 126,66
53400	MR of the lumbar spine, limited study				46,200	5834,41				R 6 157,25
53410	MR of the lumbar spine				64,320	8122,79				R 8 572,25
53420	MR of the lumbar spine pre and post contrast				103,290	13044,08				R 13 765,85
53900	Nuclear medicine study – Bone regional lumbar		21,500	2673,17				R 2 821,09		
53910	Nuclear medicine study – Bone tomography regional lumbar		13,410	1667,44				R 1 759,71		
53920	Nuclear medicine study – with flow		6,020	748,54				R 789,96		
	Sacrum									
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints). Code 54300 (CT) limited study - limited to single sacral vertebral body. Code 54310 (CT) complete study - an extensive study of the sacral spine.									
54100	X-ray of the sacrum and coccyx				3,580	452,02				R 477,03
54110	X-ray of the sacro-iliac joints				4,100	517,80				R 546,45
54120	X-ray tomography – sacrum and/or coccyx				4,300	543,05				R 573,10
54300	CT of the sacrum – limited study				7,600	959,68				R 1 012,78
54310	CT of the sacrum – complete study – uncontrasted				25,610	3234,25				R 3 413,21
54320	CT of the sacrum with contrast				46,930	5926,76				R 6 254,71

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
54330	CT of the sacrum pre and post contrast				52,970	6689,38				R 7 059,53
54400	MR of the sacrum				65,000	8208,69				R 8 662,90
54410	MR of the sacrum pre and post contrast				101,040	12760,06				R 13 466,12
	Pelvis									
	Codes 55110 (tomography) and 55100 (pelvis) may be combined. Code 55300 (CT) limited study – limited to a small region of interest of the pelvis eg. ascetabular roof or pubic ramus.									
55100	X-ray of the pelvis				3,660	462,28				R 487,86
55110	X-ray tomography – pelvis				4,300	543,05				R 573,10
55300	CT of the bony pelvis limited				9,500	1199,64				R 1 266,02
55310	CT of the bony pelvis complete uncontrasted				25,610	3234,25				R 3 413,21
55320	CT of the bony pelvis complete 3D recon				37,470	4731,99				R 4 993,83
55330	CT of the bony pelvis with contrast				46,930	5926,76				R 6 254,71
55340	CT of the bony pelvis – pre and post contrast				52,970	6689,38				R 7 059,53
55400	MR of the bony pelvis				65,000	8208,69				R 8 662,90
55410	MR of the bony pelvis pre and post contrast				102,240	12911,61				R 13 626,05
55900	Nuclear medicine study – Bone regional pelvis		21,500	2673,17				R 2 821,09		
55910	Nuclear medicine study – Bone tomography regional pelvis		13,410	1667,44				R 1 759,71		
55920	Nuclear medicine study – with flow		6,020	748,54				R 789,96		
	Hips									
	Code 56130 (tomography) may be combined with 56100 or 56110 or 56120 (hip). Code 56140 (stress) may be combined with 56100 or 56110 or 56120 (hip). Code 56150 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 56160 (introduction of contrast into hip joint) to be used with 56310 (CT hip) and 56410 (MR hip) and includes fluoroscopy. The combination of 56150 and 56310 and 56410 is not supported except in exceptional circumstances with motivation. Code 56300 (CT) study limited to small region of interest eg part of femur head.									
56100	X-ray of the left hip				3,180	401,50				R 423,72
56110	X-ray of the right hip				3,180	401,50				R 423,72
56120	X-ray pelvis and hips				6,020	760,25				R 802,32
56130	X-ray tomography – hip				4,300	543,05				R 573,10
56140	X-ray of the hip/s – stress study				4,380	553,18				R 583,79
56150	X-ray arthrography of the hip joint including introduction contrast				15,750	1989,09				R 2 099,15
56160	X-ray guidance and introduction of contrast into hip joint only				7,410	935,74				R 987,52
56200	Ultrasound of the hip joints				6,500	820,90				R 866,32
56300	CT of hip – limited				9,500	1199,64				R 1 266,02

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
56310	CT of hip – complete				27,370	3456,57				R 3 647,83
56320	CT of hip – complete with 3D recon				39,780	5023,77				R 5 301,75
56330	CT of hip with contrast				43,260	5463,16				R 5 765,45
56340	CT of hip pre and post contrast				47,880	6046,61				R 6 381,19
56400	MR of the hip joint/s, limited study				44,900	5670,23				R 5 983,98
56410	MR of the hip joint/s				64,100	8095,03				R 8 542,95
56420	MR of the hip joint/s, pre and post contrast				101,640	12835,83				R 13 546,08
56900	Nuclear medicine study – Bone regional pelvis		21,500	2673,17				R 2 821,09		
56910	Nuclear medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
56920	Nuclear medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
Upper limbs										
General										
	Code 60100 (stress only) is a stand alone study and may not be combined with other codes. Code 60200 (U/S) may only be used once per visit									
60100	X-ray upper limbs - any region - stress studies only				4,520	570,68				R 602,26
60110	X-ray upper limbs - any region – tomography				4,300	543,05				R 573,10
60200	Ultrasound upper limb – soft tissue - any region				7,380	932,06				R 983,63
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler				13,640	1722,56				R 1 817,87
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler				13,640	1722,56				R 1 817,87
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis				12,540	1583,64				R 1 671,27
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler				17,260	2179,71				R 2 300,32
60300	CT of the upper limbs limited study				9,500	1199,64				R 1 266,02
60310	CT angiography of the upper limb				78,280	9885,74				R 10 432,75
60400	MR of the upper limbs limited study, any region				44,800	5657,73				R 5 970,79
60410	MR angiography of the upper limb				74,660	9428,46				R 9 950,17
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral				45,670	5767,58				R 6 086,72
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral				82,670	10439,97				R 11 017,65
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral				56,750	7166,79				R 7 563,35
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral				88,110	11127,21				R 11 742,92

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
60540	Venography, antegrade of upper limb veins, unilateral				26,120	3298,58				R 3 481,10
60550	Venography, antegrade of upper limb veins, bilateral				49,430	6242,49				R 6 587,91
60560	Venography, retrograde of upper limb veins, unilateral				31,010	3916,09				R 4 132,78
60570	Venography, retrograde of upper limb veins, bilateral				54,810	6921,83				R 7 304,84
60580	Venography, shuntogram, dialysis access shunt				23,790	3004,42				R 3 170,66
60900	Nuclear medicine study – Venogram upper limb		37,120	4615,43				R 4 870,82		
	Shoulder									
	Code 61160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 61170 (introduction of contrast into the shoulder joint) may be combined with 61300 and 61305 (CT), or 61400 and 61405 (MR). The combination of 61160 (arthrography) and 61300 and 61305 (CT) or 61400 and 61405 (MR) is not supported except in exceptional circumstances with motivation									
61100	X-ray of the left clavicle				3,040	384,01				R 405,26
61105	X-ray of the right clavicle				3,040	384,01				R 405,26
61110	X-ray of the left scapula				3,040	384,01				R 405,26
61115	X-ray of the right scapula				3,040	384,01				R 405,26
61120	X-ray of the left acromio-clavicular joint				3,140	396,50				R 418,44
61125	X-ray of the right acromio-clavicular joint				3,140	396,50				R 418,44
61128	X-ray of acromio-clavicular joints plus stress studies bilateral				7,680	969,81				R 1 023,47
61130	X-ray of the left shoulder				3,480	439,39				R 463,70
61135	X-ray of the right shoulder				3,480	439,39				R 463,70
61140	X-ray of the left shoulder plus subacromial impingement views				5,920	747,62				R 788,99
61145	X-ray of the right shoulder plus subacromial impingement views				5,920	747,62				R 788,99
61150	X-ray of the left subacromial impingement views only				3,240	409,13				R 431,77
61155	X-ray of the right subacromial impingement views only				3,240	409,13				R 431,77
61160	X-ray arthrography shoulder joint including introduction of				15,830	1999,09				R 2 109,71
61170	X-ray guidance and introduction of contrast into shoulder joint only				7,410	935,74				R 987,52
61200	Ultrasound of the left shoulder joint				6,500	820,90				R 866,32
61210	Ultrasound of the right shoulder joint				6,500	820,90				R 866,32
61300	CT of the left shoulder joint – uncontrasted				24,360	3076,38				R 3 246,61
61305	CT of the right shoulder joint – uncontrasted				24,360	3076,38				R 3 246,61
61310	CT of the left shoulder – complete with 3D recon				37,660	4756,06				R 5 019,23
61315	CT of the right shoulder – complete with 3D recon				37,660	4756,06				R 5 019,23
61320	CT of the left shoulder joint - pre and post contrast				48,630	6141,32				R 6 481,14
61325	CT of the right shoulder joint - pre and post contrast				48,630	6141,32				R 6 481,14

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
61400	MR of the left shoulder				64,640	8163,17				R 8 614,87
61405	MR of the right shoulder				64,640	8163,17				R 8 614,87
61410	MR of the left shoulder pre and post contrast				101,040	12760,06				R 13 466,12
61415	MR of the right shoulder pre and post contrast				101,040	12760,06				R 13 466,12
	Humerus									
62100	X-ray of the left humerus				2,940	371,24				R 391,78
62105	X-ray of the right humerus				2,940	371,24				R 391,78
62300	CT of the left upper arm				24,360	3076,38				R 3 246,61
62305	CT of the right upper arm				24,360	3076,38				R 3 246,61
62310	CT of the left upper arm contrasted				39,970	5047,72				R 5 327,03
62315	CT of the right upper arm contrasted				39,970	5047,72				R 5 327,03
62320	CT of the left upper arm pre and post contrast				48,580	6135,01				R 6 474,48
62325	CT of the right upper arm pre and post contrast				48,580	6135,01				R 6 474,48
62400	MR of the left upper arm				64,200	8107,53				R 8 556,15
62405	MR of the right upper arm				64,200	8107,53				R 8 556,15
62410	MR of the left upper arm pre and post contrast				102,040	12886,35				R 13 599,39
62415	MR of the right upper arm pre and post contrast				102,040	12886,35				R 13 599,39
62900	Nuclear medicine study – Bone limited/regional static		21,500	2673,17				R 2 821,09		
62905	Nuclear medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
62910	Nuclear medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
	Elbow									
	Code 63120 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 63130 (introduction of contrast) may be combined with 63300 and 63305 (CT) or 63400 and 63405 (MR). The combination of 63120 (arthrography) and 63300 and 63305 or 63400 and 63405 (MR) is not supported except in exceptional circumstances with motivation.									
63100	X-ray of the left elbow				3,140	396,50				R 418,44
63105	X-ray of the right elbow				3,140	396,50				R 418,44
63110	X-ray of the left elbow with stress				4,340	548,05				R 578,38
63115	X-ray of the right elbow with stress				4,340	548,05				R 578,38
63120	X-ray arthrography elbow joint including introduction of contrast				15,890	2006,72				R 2 117,76
63130	X-ray guidance and introduction of contrast into elbow joint only				7,410	935,74				R 987,52
63200	Ultrasound of the left elbow joint				6,500	820,90				R 866,32

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
63205	Ultrasound of the right elbow joint				6,500	820,90				R 866,32
63300	CT of the left elbow				24,360	3076,38				R 3 246,61
63305	CT of the right elbow				24,360	3076,38				R 3 246,61
63310	CT of the left elbow – complete with 3D recon				37,660	4756,06				R 5 019,23
63315	CT of the right elbow – complete with 3D recon				37,660	4756,06				R 5 019,23
63320	CT of the left elbow contrasted				39,970	5047,72				R 5 327,03
63325	CT of the right elbow contrasted				39,970	5047,72				R 5 327,03
63330	CT of the left elbow pre and post contrast				48,630	6141,32				R 6 481,14
63335	CT of the right elbow pre and post contrast				48,630	6141,32				R 6 481,14
63400	MR of the left elbow				64,640	8163,17				R 8 614,87
63405	MR of the right elbow				64,640	8163,17				R 8 614,87
63410	MR of the left elbow pre and post contrast				101,040	12760,06				R 13 466,12
63415	MR of the right elbow pre and post contrast				101,040	12760,06				R 13 466,12
63905	Nuclear medicine study – Bone limited/regional static		21,500	2673,17				R 2 821,09		
63910	Nuclear medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
63915	Nuclear medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
	Forearm									
64100	X-ray of the left forearm				2,940	371,24				R 391,78
64105	X-ray of the right forearm				2,940	371,24				R 391,78
64110	X-ray peripheral bone densitometry				1,960	247,45				R 261,14
64300	CT of the left forearm				24,360	3076,38				R 3 246,61
64305	CT of the right forearm				24,360	3076,38				R 3 246,61
64310	CT of the left forearm contrasted				39,970	5047,72				R 5 327,03
64315	CT of the right forearm contrasted				39,970	5047,72				R 5 327,03
64320	CT of the left forearm pre and post contrast				48,580	6135,01				R 6 474,48
64325	CT of the right forearm pre and post contrast				48,580	6135,01				R 6 474,48
64400	MR of the left forearm				64,200	8107,53				R 8 556,15
64405	MR of the right forearm				64,200	8107,53				R 8 556,15
64410	MR of the left forearm pre and post contrast				98,040	12381,05				R 13 066,13
64415	MR of the right forearm pre and post contrast				98,040	12381,05				R 13 066,13
64900	Nuclear medicine study – Bone limited/regional static		21,500	2673,17				R 2 821,09		
64905	Nuclear medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
64910	Nuclear medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Hand and Wrist									
	Code 65120 (finger) may not be combined with 65100 or 65105 (hands). Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done. Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added).									
65100	X-ray of the left hand				3,080	389,00				R 410,52
65105	X-ray of the right hand				3,080	389,00				R 410,52
65110	X-ray of the left hand – bone age				3,080	389,00				R 410,52
65120	X-ray of a finger				2,670	337,17				R 355,83
65130	X-ray of the left wrist				3,180	401,50				R 423,72
65135	X-ray of the right wrist				3,180	401,50				R 423,72
65140	X-ray of the left scaphoid				3,300	416,76				R 439,82
65145	X-ray of the right scaphoid				3,300	416,76				R 439,82
65150	X-ray of the left wrist, scaphoid and stress views				7,560	954,69				R 1 007,52
65155	X-ray of the right wrist, scaphoid and stress views				7,560	954,69				R 1 007,52
65160	X-ray arthrography wrist joint including introduction of contrast				15,930	2011,72				R 2 123,04
65170	X-ray guidance and introduction of contrast into wrist joint only				7,410	935,74				R 987,52
65200	Ultrasound of the left wrist				6,500	820,90				R 866,32
65210	Ultrasound of the right wrist				6,500	820,90				R 866,32
65300	CT of the left wrist and hand				24,360	3076,38				R 3 246,61
65305	CT of the right wrist and hand				24,360	3076,38				R 3 246,61
65310	CT of the left wrist and hand - complete with 3D recon				37,660	4756,06				R 5 019,23
65315	CT of the right wrist and hand - complete with 3D recon				37,660	4756,06				R 5 019,23
65320	CT of the left wrist and hand contrasted				39,970	5047,72				R 5 327,03
65325	CT of the right wrist and hand contrasted				39,970	5047,72				R 5 327,03
65330	CT of the left wrist and hand pre and post contrast				48,630	6141,32				R 6 481,14
65335	CT of the right wrist and hand pre and post contrast				48,630	6141,32				R 6 481,14
65400	MR of the left wrist and hand				64,640	8163,17				R 8 614,87
65405	MR of the right wrist and hand				64,640	8163,17				R 8 614,87
65410	MR of the left wrist and hand pre and post contrast				101,040	12760,06				R 13 466,12
65415	MR of the right wrist and hand pre and post contrast				101,040	12760,06				R 13 466,12
65900	Nuclear Medicine study – bone limited/regional static		21,500	2673,17				R 2 821,09		
65905	Nuclear Medicine study – bone limited static plus flow		27,530	3423,16				R 3 612,57		
65910	Nuclear Medicine study – bone tomography regional		13,410	1667,44				R 1 759,71		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Soft Tissue									
69900	Nuclear medicine study – Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT		47,560	5913,47				R 6 240,68		
69920	Nuclear medicine study – Infection localisation planar, static		18,040	2243,12				R 2 367,24		
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies		31,450	3910,57				R 4 126,95		
69930	Nuclear medicine study – Infection localisation planar, static and SPECT		31,450	3910,57				R 4 126,95		
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT		44,860	5577,75				R 5 886,39		
69940	Nuclear medicine study – Regional lymph node mapping dynamic		6,020	748,54				R 789,96		
69945	Nuclear medicine study – Regional lymph node mapping, static, planar		24,100	2996,66				R 3 162,48		
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple		37,510	4663,98				R 4 922,05		
69955	Nuclear medicine study – Regional lymph node mapping SPECT		13,410	1667,44				R 1 759,71		
69960	Nuclear medicine study – Lymph node localisation with gamma probe		13,410	1667,44				R 1 759,71		

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PART 4 OF 4

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Lower Limbs									
	General									
	Code 70100 (stress) is a stand alone study and may not be combined with other codes. Code 70200 (U/S) may be billed once per visit Code 70310 and 70320 (CT Angiography) may not be combined Code 70410 and 70420 (MR Angiography) may not be combined									
70100	X-ray lower limbs - any region- stress studies only				4,520	570,68				R 602,26
70110	X-ray lower limbs - any region-tomography				4,300	543,05				R 573,10
70120	X-ray of the lower limbs full length study				6,460	815,90				R 861,05
70200	Ultrasound lower limb – soft tissue - any region				7,380	932,06				R 983,63
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler				13,640	1722,56				R 1 817,87
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler				13,640	1722,56				R 1 817,87
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis				13,640	1722,56				R 1 817,87
70240	Ultrasound peripheral venous system lower limbs including pulse and colour doppler in erect and supine position including all compression and reflux manoeuvres, deep and superficial systems bilaterally				19,660	2482,81				R 2 620,19
70300	CT of the lower limbs limited study				9,500	1199,64				R 1 266,02
70310	CT angiography of the lower limb				79,430	10030,97				R 10 586,02
70320	CT angiography abdominal aorta and outflow lower limbs				98,340	12418,94				R 13 106,12
70400	MR of the lower limbs limited study				46,400	5859,80				R 6 184,04
70410	MR angiography of the lower limb				76,660	9681,04				R 10 216,72
70420	MR angiography of the abdominal aorta and lower limbs				118,860	15010,42				R 15 841,00
70500	Angiography of pelvic and lower limb arteries unilateral				40,590	5125,99				R 5 409,63
70505	Angiography of pelvic and lower limb arteries bilateral				75,920	9587,51				R 10 118,02
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral				61,230	7732,47				R 8 160,33
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral				85,660	10817,67				R 11 416,25
70520	Angiography translumbar aorta with full peripheral study				45,680	5768,76				R 6 087,96
70530	Venography, antegrade of lower limb veins, unilateral				25,460	3215,31				R 3 393,22
70535	Venography, antegrade of lower limb veins, bilateral				49,430	6242,49				R 6 587,91

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
70540	Venography, retrograde of lower limb veins, unilateral				31,170	3936,48				R 4 154,30
70545	Venography, retrograde of lower limb veins, bilateral				56,790	7171,78				R 7 568,62
70560	Lymphangiography, lower limb, unilateral				51,040	6445,61				R 6 802,27
70565	Lymphangiography, lower limb, bilateral				83,970	10604,29				R 11 191,06
70900	Nuclear medicine study – Venogram lower limb		37,120	4615,43				R 4 870,82		
	Femur									
71100	X-ray of the left femur				2,940	371,24				R 391,78
71105	X-ray of the right femur				2,940	371,24				R 391,78
71300	CT of the left femur				24,520	3096,51				R 3 267,85
71305	CT of the right femur				24,520	3096,51				R 3 267,85
71310	CT of the left upper leg contrasted				41,830	5282,54				R 5 574,84
71315	CT of the right upper leg contrasted				41,830	5282,54				R 5 574,84
71320	CT of the left upper leg pre and post contrast				49,710	6277,75				R 6 625,12
71325	CT of the right upper leg pre and post contrast				49,710	6277,75				R 6 625,12
71400	MR of the left upper leg				64,800	8183,43				R 8 636,25
71405	MR of the right upper leg				64,800	8183,43				R 8 636,25
71410	MR of the left upper leg pre and post contrast				102,040	12886,35				R 13 599,39
71415	MR of the right upper leg pre and post contrast				102,040	12886,35				R 13 599,39
71900	Nuclear Medicine study – bone limited/regional static		21,500	2673,17				R 2 821,09		
71905	Nuclear Medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
71910	Nuclear Medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
	Knee									
	Codes 72140 and 72145 (patella) may not be added to 72101, 72106, 72130, 72115, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added).									
72100	X-ray of the left knee one or two views				2,770	349,80				R 369,16
72105	X-ray of the right knee one or two views				2,770	349,80				R 369,16
72110	X-ray of the left knee, more than two views				3,320	419,26				R 442,46
72115	X-ray of the right knee, more than two views				3,320	419,26				R 442,46
72120	X-ray of the left knee including patella				4,620	583,44				R 615,72
72125	X-ray of the right knee including patella				4,620	583,44				R 615,72
72130	X-ray of the left knee with stress views				5,820	734,99				R 775,66
72135	X-ray of the right knee with stress views				5,820	734,99				R 775,66

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
72140	X-ray of left patella				2,770	349,80				R 369,16
72145	X-ray of right patella				2,770	349,80				R 369,16
72150	X-ray both knees standing – single view				2,800	353,62				R 373,19
72160	X-ray arthrography knee joint including introduction of contrast				15,810	1996,59				R 2 107,07
72170	X-ray guidance and introduction of contrast into knee joint only				7,410	935,74				R 987,52
72200	Ultrasound of the left knee joint				6,500	820,90				R 866,32
72205	Ultrasound of the right knee joint				6,500	820,90				R 866,32
72300	CT of the left knee				24,520	3096,51				R 3 267,85
72305	CT of the right knee				24,520	3096,51				R 3 267,85
72310	CT of the left knee complete study with 3D reconstructions				35,930	4537,55				R 4 788,63
72315	CT of the right knee complete study with 3D reconstructions				35,930	4537,55				R 4 788,63
72320	CT of the left knee contrasted				41,830	5282,54				R 5 574,84
72325	CT of the right knee contrasted				41,830	5282,54				R 5 574,84
72330	CT of the left knee pre and post contrast				49,760	6283,93				R 6 631,64
72335	CT of the right knee pre and post contrast				49,760	6283,93				R 6 631,64
72400	MR of the left knee				64,100	8095,03				R 8 542,95
72405	MR of the right knee				64,100	8095,03				R 8 542,95
72410	MR of the left knee pre and post contrast				100,840	12734,80				R 13 439,46
72415	MR of the right knee pre and post contrast				100,840	12734,80				R 13 439,46
72900	Nuclear Medicine study – Bone limited/regional static		21,500	2673,17				R 2 821,09		
72905	Nuclear Medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
72910	Nuclear Medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
	Lower Leg									
73100	X-ray of the left lower leg				2,940	371,24				R 391,78
73105	X-ray of the right lower leg				2,940	371,24				R 391,78
73300	CT of the left lower leg				24,520	3096,51				R 3 267,85
73305	CT of the right lower leg				24,520	3096,51				R 3 267,85
73310	CT of the left lower leg contrasted				41,830	5282,54				R 5 574,84
73315	CT of the right lower leg contrasted				41,830	5282,54				R 5 574,84
73320	CT of the left lower leg pre and post contrast				49,710	6277,75				R 6 625,12
73325	CT of the right lower leg pre and post contrast				49,710	6277,75				R 6 625,12
73400	MR of the left lower leg				64,200	8107,53				R 8 556,15
73405	MR of the right lower leg				64,200	8107,53				R 8 556,15
73410	MR of the left lower leg pre and post contrast				102,040	12886,35				R 13 599,39

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
73415	MR of the right lower leg pre and post contrast				102,040	12886,35				R 13 599,39
73900	Nuclear Medicine study – bone limited/regional static		21,500	2673,17				R 2 821,09		
73905	Nuclear Medicine study – bone limited static plus flow		27,530	3423,16				R 3 612,57		
73910	Nuclear Medicine study – bone tomography regional		13,410	1667,44				R 1 759,71		
	Ankle and Foot									
	Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added)									
74100	X-ray of the left ankle				3,320	419,26				R 442,46
74105	X-ray of the right ankle				3,320	419,26				R 442,46
74110	X-ray of the left ankle with stress views				4,520	570,68				R 602,26
74115	X-ray of the right ankle with stress views				4,520	570,68				R 602,26
74120	X-ray of the left foot				2,800	353,62				R 373,19
74125	X-ray of the right foot				2,800	353,62				R 373,19
74130	X-ray of the left calcaneus				2,740	345,99				R 365,13
74135	X-ray of the right calcaneus				2,740	345,99				R 365,13
74140	X-ray of both feet – standing – single view				2,800	353,62				R 373,19
74145	X-ray of a toe				2,670	337,17				R 355,83
74150	X-ray of the sesamoid bones one or both sides				2,800	353,62				R 373,19
74160	X-ray arthrography ankle joint including introduction of contrast				15,910	2009,22				R 2 120,40
74170	X-ray guidance and introduction of contrast into ankle joint				7,410	935,74				R 987,52
74210	Ultrasound of the left ankle				6,500	820,90				R 866,32
74215	Ultrasound of the right ankle				6,500	820,90				R 866,32
74220	Ultrasound of the left foot				6,500	820,90				R 866,32
74225	Ultrasound of the right foot				6,500	820,90				R 866,32
74290	Ultrasound bone densitometry				2,040	257,71				R 271,97
74300	CT of the left ankle/foot				24,520	3096,51				R 3 267,85
74305	CT of the right ankle/foot				24,520	3096,51				R 3 267,85
74310	CT of the left ankle/foot – complete with 3D recon				37,810	4774,88				R 5 039,09

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
74315	CT of the right ankle/foot – complete with 3D recon				37,810	4774,88				R 5 039,09
74320	CT of the left ankle/foot contrasted				41,830	5282,54				R 5 574,84
74325	CT of the right ankle/foot contrasted				41,830	5282,54				R 5 574,84
74330	CT of the left ankle/foot pre and post contrast				49,710	6277,75				R 6 625,12
74335	CT of the right ankle/foot pre and post contrast				49,710	6277,75				R 6 625,12
74400	MR of the left ankle				64,100	8095,03				R 8 542,95
74405	MR of the right ankle				64,100	8095,03				R 8 542,95
74410	MR of the left ankle pre and post contrast				100,640	12709,54				R 13 412,80
74415	MR of the right ankle pre and post contrast				100,640	12709,54				R 13 412,80
74420	MR of the left foot				64,200	8107,53				R 8 556,15
74425	MR of the right foot				64,200	8107,53				R 8 556,15
74430	MR of the left foot pre and post contrast				102,040	12886,35				R 13 599,39
74435	MR of the right foot pre and post contrast				102,040	12886,35				R 13 599,39
74900	Nuclear Medicine study – Bone limited/regional static		21,500	2673,17				R 2 821,09		
74905	Nuclear Medicine study – Bone limited static plus flow		27,530	3423,16				R 3 612,57		
74910	Nuclear Medicine study – Bone tomography regional		13,410	1667,44				R 1 759,71		
	Soft Tissue									
79900	Nuclear Medicine study – Tumour localisation planar, static		20,740	2578,98				R 2 721,68		
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies		35,170	4373,11				R 4 615,09		
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT		34,150	4246,16				R 4 481,11		
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT		47,560	5913,47				R 6 240,68		
79920	Nuclear Medicine study – Infection localisation planar, static		18,430	2291,67				R 2 418,48		
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies		31,840	3958,98				R 4 178,04		
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT		31,840	3958,98				R 4 178,04		
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT		45,250	5626,29				R 5 937,61		
79940	Nuclear Medicine study – Regional lymph node mapping dynamic		6,020	748,54				R 789,96		

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar		24,100	2996,66				R 3 162,48		
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies		37,510	4663,98				R 4 922,05		
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT		13,410	1667,44				R 1 759,71		
79960	Nuclear Medicine study – Lymph node localisation with gamma probe		13,410	1667,44				R 1 759,71		
	Intervention									
	General									
	Intervention codes (aspiration/biopsy/ablations/cyst drainage, etc,) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00540, 00550, 00560 and 00570 may not be combined with these codes. If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00540, 00550, 00560 and 00570), it may be coded separately. Codes 80640, 80645, 87682, 87683 include fluoroscopy, Machine codes may not be added. All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.									
80600	Percutaneous abscess, cyst drainage, any region				9,370	1183,33				R 1 248,81
80605	Fine needle aspiration biopsy, any region				4,220	532,79				R 562,27
80610	Cutting needle, trochar biopsy, any region				6,360	803,14				R 847,58
80620	Tumour/cyst ablation chemical				25,370	3203,86				R 3 381,14
80630	Tumour ablation radio frequency, per lesion				21,210	2678,43				R 2 826,64
80640	Insertion of CVP line in radiology suite				8,990	1135,31				R 1 198,13
80645	Peripheral central venous line insertion				12,120	1530,76				R 1 615,46
80650	Infiltration of a peripheral joint, any region				6,400	808,13				R 852,85
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.									
	Neuro intervention									
81600	Intracranial aneurysm occlusion, direct				214,520	27091,00				R 28 590,04
81605	Intracranial arteriovenous shunt occlusion				254,820	32180,42				R 33 961,07
81610	Dural sinus arteriovenous shunt occlusion				264,330	33381,24				R 35 228,34
81615	Extracranial arteriovenous shunt occlusion				157,280	19862,38				R 20 961,43
81620	Extracranial arterial embolisation (head and neck)				163,120	20599,87				R 21 739,73
81625	Caroticocavernous fistula occlusion				192,290	24283,64				R 25 627,33

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CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
81630	Intracranial angioplasty for stenosis, vasospasm				126,920	16028,38				R 16 915,28
81632	Intracranial stent placement (including PTA)				133,720	16887,03				R 17 821,45
81635	Temporary balloon occlusion test				83,420	10534,82				R 11 117,75
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.									
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)				178,180	22501,74				R 23 746,84
81645	Intracranial aneurysm occlusion with balloon remodelling				216,350	27322,14				R 28 833,97
81650	Intracranial aneurysm occlusion with stent assistance				230,450	29102,72				R 30 713,07
81655	Intracranial thrombolysis, catheter directed				58,940	7443,31				R 7 855,17
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650									
81660	Nerve block, head and neck, per level				7,660	967,31				R 1 020,83
81665	Neurolysis, head and neck, per level				20,140	2543,46				R 2 684,20
81670	Nerve block, head and neck, radio frequency, per level				19,040	2404,54				R 2 537,59
81680	Nerve block, coeliac plexus or other regions, per level				9,280	1172,01				R 1 236,86
	Thorax									
82600	Chest dain insetion				8,820	1 113.73				
82605	Tachial, bonchial stent insetion				30,360	3 834.13				
	Gastointestinal									
83600	Oesophageal stent insetion				31,220	3 942.53				
83605	GIT balloon dilation				24,360	3 076.38				
83610	GIT stent insetion (non-oesophageal)				32,020	4 043.70				
83615	Pecutaneous gastostomy, jejunostomy				25,360	3 202.68				
	Hepatobiliay									
84600	Pecutaneous biliay dainage, extenal				33,980	4 291.28				
84605	Pecutaneous extenal/intenal biliay dainage				37,210	4 699.10				
84610	Pemanent biliay stent insetion				51,220	6 468.37				
84615	Dainage tube eplacement				20,220	2 553.46				
84620	Pecutaneous bile duct stone o foeign object emoval				49,980	6 311.82				
84625	Pecutaneous gall bladde dainage				29,580	3 735.47				

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
84630	Pecutaneous gallstone emoval, including dainage				69,250	8 745.43				
84635	Tansjugula live biopsy				24,930	3 148.34				
84640	Tansjugula intahepatic Potosystemic shunt				119,470	15 087.37				
84645	Tanshepatic Potogam including venous sampling, pessue studies				81,890	10 341.57				
84650	Tanshepatic Potogam with embolisation of vaices				100,810	12 730.98				
84655	Pecutaneous hepatic tumou ablation				15,680	1 980.28				
84660	Pecutaneous hepatic abscess, cyst dainage				13,200	1 667.05				
84665	Hepatic chemoembolisation				59,440	7 506.46				
84670	Hepatic ateial infusion cathete placement				60,300	7 615.12				
	Uogenital									
85600	Pecutaneous nephostomy, extenal dainage				29,970	3784,80				R 3 994,23
85605	Pecutaneous double J stent insetion including access				40,820	5155,07				R 5 440,32
85610	Pecutaneous enal stone, foeign body emoval including access				66,790	8434,70				R 8 901,42
85615	Pecutaneous nephostomy tact establishment				29,270	3696,53				R 3 901,07
85620	Change of nephostomy tube				15,900	2008,04				R 2 119,15
85625	Pecutaneous cystostomy				16,520	2086,31				R 2 201,75
85630	Uethal balloon dilatation				14,240	1798,34				R 1 897,85
85635	Uethal stent insetion				31,220	3942,53				R 4 160,68
85640	enal cyst ablation				11,920	1505,37				R 1 588,67
85645	enal abscess, cyst dainage				15,160	1914,50				R 2 020,44
85655	Fallopian tube ecanalisation				45,060	5690,49				R 6 005,36
	Spinal									
86600	Spinal vascula malfomation embolisation				275,160	34749,14				R 36 671,93
86605	Veteboplasty pe level				22,300	2816,17				R 2 972,00
86610	Facet joint block pe level, uni- o bilateal				9,540	1204,64				R 1 271,30
	Code 86610 may only be billed once pe level, and not pe left and ight side pe level									
86615	Spinal neve block pe level, uni- o bilateal				8,160	1030,46				R 1 087,48
86620	Epidual block				9,420	1189,51				R 1 255,33
86625	Chemonucleolysis, including discogam				18,320	2313,50				R 2 441,51
86630	Spinal neve ablation pe level				11,600	1464,98				R 1 546,04

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
	Vascula									
	Code 87654 (Thombolysis follow up) may only be used on the days following the initial pocedue, 87650 (thombolysis). If a balloon angioplasty and / o stent placement is pefomed at moe that one defined anatomical site at the same sitting the elevant codes may be combined. Howeve multple balloon dilations o stent placements at one defined site will only attact one pocedue code.									
87600	Pecutaneous tansluminal angioplasty: aota, IVC				56,560	7142,84				R 7 538,08
87601	Pecutaneous tansluminal angioplasty: iliac				55,760	7041,81				R 7 431,46
87602	Pecutaneous tansluminal angioplasty: femoopopliteal				60,160	7597,36				R 8 017,75
87603	Pecutaneous tansluminal angioplasty: subpopliteal				73,340	9261,78				R 9 774,27
87604	Pecutaneous tansluminal angioplasty: bachiocephalic				67,120	8476,27				R 8 945,29
87605	Pecutaneous tansluminal angioplasty: subclavian, axillay				60,160	7597,36				R 8 017,75
87606	Pecutaneous tansluminal angioplasty: extacanial caotid				71,620	9044,58				R 9 545,05
87607	Pecutaneous tansluminal angioplasty: extacanial vetebal				73,300	9256,78				R 9 768,99
87608	Pecutaneous tansluminal angioplasty: enal				87,690	11073,93				R 11 686,69
87609	Pecutaneous tansluminal angioplasty: coeliac, mesenteic				87,690	11073,93				R 11 686,69
87620	Aota stent-gaft placement				120,750	15249,19				R 16 092,98
87621	Stent insetion (including PTA): aota, IVC				73,870	9328,74				R 9 844,93
87622	Stent insetion (including PTA): iliac				76,370	9644,47				R 10 178,13
87623	Stent insetion (including PTA): femoopopliteal				77,970	9846,54				R 10 391,38
87624	Stent insetion (including PTA): subpopliteal				84,550	10677,43				R 11 268,25
87625	Stent insetion (including PTA): bachiocephalic				98,470	12435,51				R 13 123,61
87626	Stent insetion (including PTA): subclavian, axillay				86,690	10947,64				R 11 553,41
87627	Stent insetion (including PTA): extacanial caotid				106,990	13511,36				R 14 258,99
87628	Stent insetion (including PTA): extacanial vetebal				100,550	12698,09				R 13 400,72
87629	Stent insetion (including PTA): enal				98,590	12450,64				R 13 139,58
87630	Stent insetion (including PTA): coeliac, mesenteic				98,590	12450,64				R 13 139,58
87631	Stent-gaft placement: iliac				76,370	9644,47				R 10 178,13
87632	Stent-gaft placement: femoopopliteal				77,970	9846,54				R 10 391,38
87633	Stent-gaft placement: bachiocephalic				98,470	12435,51				R 13 123,61
87634	Stent-gaft placement: subclavian, axillay				82,770	10452,74				R 11 031,12
87635	Stent-gaft placement: extacanial caotid				120,430	15208,80				R 16 050,35
87636	Stent-gaft placement: extacanial vetebal				114,730	14488,80				R 15 290,51
87637	Stent-gaft placement: enal				98,590	12450,64				R 13 139,58
87638	Stent-gaft placement: coeliac, mesenteic				98,590	12450,64				R 13 139,58

CODE	DESCRIPTION	ADD	Nuclear Medicine		Radiology		Nuclear Medicine		Radiology	
			Units	Value	Units	Value	Units	Value	Units	Value
87650	Thombolysis in angiogaphy suite, pe 24 hous				45,820	5786,52				R 6 106,71
	Code 87650 may be combined with any of the elevant non neuo inteventional angiogaphy and inteventional codes 10520, 20500, 20510, 20520, 20530, 20540,32500,32530,44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87609.									
87651	Aspiation, heolytic thombectomy				77,670	9808,78				R 10 351,53
87652	Atheectomy, pe vessel				91,890	11604,62				R 12 246,74
87653	Pecutaneous tunnelled / subcutaneous ateial o venous cental o othe line insetion				28,150	3554,98				R 3 751,69
87654	Thombolysis follow-up				23,570	2976,67				R 3 141,38
87655	Pecutaneous scleotheapy, vascula malfomation				21,100	2664,62				R 2 812,06
87660	Embolisation, mesenteic				100,430	12682,97				R 13 384,76
87661	Embolisation, enal				99,360	12547,73				R 13 242,04
87662	Embolisation, bonchial, intecostal				108,340	13681,99				R 14 439,06
87663	Embolisation, pulmonay ateiovenous shunt				103,220	13035,27				R 13 756,55
87664	Embolisation, abdominal, othe vessels				101,440	12810,57				R 13 519,42
87665	Embolisation, thoacic, othe vessels				97,600	12325,40				R 13 007,41
87666	Embolisation, uppe limb				90,920	11481,88				R 12 117,21
87667	Embolisation, lowe limb				92,140	11636,06				R 12 279,92
87668	Embolisation, pelvis, non-uteine				117,120	14790,59				R 15 609,00
87669	Embolisation, uteus				113,880	14381,46				R 15 177,23
87670	Embolisation, spematic, ovaia veins				85,820	10837,92				R 11 437,62
87680	Infeio vena cava filte placement				61,840	7809,69				R 8 241,83
87681	Intavascula foeign body emoval				85,030	10738,08				R 11 332,25
87682	evision of access pot (tunnelled o implantable)				14,120	1783,21				R 1 881,88
87683	emoval of access pot (tunnelled o implantable)				11,120	1404,20				R 1 481,90
87690	Supeio petosal venous sampling				73,010	9220,21				R 9 730,39
87691	Panceatic stimulation test				89,790	11339,28				R 11 966,72
87692	Tanspotal venous sampling				76,950	9717,74				R 10 255,45
87693	Adenal venous sampling				55,010	6946,96				R 7 331,36
87694	Paathyoid venous sampling				86,660	10944,09				R 11 549,66
87695	enal venous sampling				55,010	6946,96				R 7 331,36

REGISTERED COUNSELLORS

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.			
	GENERAL RULES			
A	Every account shall contain the following particulars: a) The surname, first name and other initials, if any, of the patient; b) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the c) The date on which each relevant health service was rendered; d) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.			
B	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required. Maximum billable time for such a report is 15 minutes.			
	SERVICES RENDERED BY REGISTERED COUNSELLORS			
300	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	0,5	R62,22	R 65,66
301	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	1,5	R186,81	R 197,15
302	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	2,5	R311,26	R 328,48
303	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	3,5	R435,71	R 459,82
304	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	4,5	R560,16	R 591,16
305	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	5,5	R684,47	R 722,34
306	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	6,5	R809,45	R 854,24
307	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	7,5	R933,77	R 985,44
308	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	8,5	R1 058,35	R 1 116,91
400	Group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	0,1	R12,39	R 13,08
401	Group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	0,3	R37,36	R 39,43
402	Group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	0,5	R62,22	R 65,66
403	Group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	0,7	R87,09	R 91,91
404	Group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	0,9	R111,95	R 118,14
405	Group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	1,1	R136,95	R 144,53
406	Group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	1,3	R161,94	R 170,90
407	Group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	1,5	R186,81	R 197,15
408	Group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	1,7	R211,93	R 223,66
409	Group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	1,9	R236,53	R 249,62
410	Group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2,1	R261,53	R 276,00
411	Group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2,3	R286,39	R 302,24
490	Extended group consultation, counselling and/or therapy - per patient per full 15 minutes in excess of 120 minutes	0,15	R5,66	R 5,97

REHABILITATION HOSPITALS

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated,

	GENERAL RULES		
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.		
B.1	Procedure for the classification of hospitals:		
B.1.1	Inspections of sub-acute facilities, private hospitals, rehabilitation hospitals or sub-acute facilities having practice code numbers commencing with the digits 059 will be conducted by an independent agency on behalf of BHF. Applications to be addressed		
C	Where possible, accounts shall reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.		
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on reques		
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.		
F	Accommodation fees includes the services listed below:		
	A. The minimum services that are required are items 3, 5 and 6.		
	B. It any of the other services included in this list are requested, no additional charge may be levied by the hospital.		
	1 Pre-authorisation (up to the date of admission) of:		
	· length of stay		
	· level of care		
	· theatre procedures		
	2 Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation		
	3 Notification of admission		
	4 Immediate notification of changes to:		
	· length of stay		
	· level of care		
	· theatre procedures		
	5 Reporting of length of stay and level of care		
	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.		
	6 Discharge ICD-10 and CPT-4 coding		

REHABILITATION HOSPITALS

	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.		
	· Including coding of complications and co-morbidity. To be done as accurately as practically possible by the hospital.		
	7 Case management by means of standard documentation and liaisn with hospital appointed case managers		
	· Liaison means communication and sharing of information between case managers, but does not include active case management by the hospital.		
	SCHEDULE	**Tariff**	**2020**
7	GLOBAL FEE FOR REHABILITATION WITH A PRACTICE NUMBER COMMENCING WITH "59"		
	The following rehabilitation categories will be treated in recognised and accredited rehabilitation hospitals: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replace		
	This section is only applicable to facilities registered as Physical Rehabilitation Hospitals and not Sub-acute facilities.		
	Rehabilitation		
100	Out patients, 3 hours per day (maximum 18 days)	R761,96	R 804,12
101	Out patients, 6 hours per day (maximum 18 days)	R1 607,46	R 1 696,40
105	General care (maximum 27 days)	R3 200,18	R 3 377,25
107	High care (maximum 36 days)	R3 772,17	R 3 980,90
109	Rehabilitation ICU (maximum 7 days)	R6 779,75	R 7 154,90

SOCIAL WORKERS				
Tariff code	**DESCRIPTION**	**UNITS**	**VALUE**	**2020 Tariff**
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.TARIFFS ARE VAT INCLUSIVE.			
	GENERAL RULES			
5	Every practitioner shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars: a) The surname, first name and other initials, if any, of the patient; b) The practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; c) the relevant diagnostic and such other item code numbers that relates to such relevant health service; d) The date on which each relevant health service was rendered; e) The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.			
6	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.			
7	Where emergency treatment is provided: a. during working hours, and the provision of such treatment requires the practitioner to leave her or his practice to attend to the patient at another venue; or b. after working hours the fee for such visits shall be the total fee plus 50%. For purposes of this rule: a) "emergency treatment" means a bona fide, justifiable emergency social work service, where failure to provide the service immediately would result in serious or irreparable psychological or functional impairment b) "working hours" means 8h00 to 17h00, Monday to Friday. Modifier 0003 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.			
8	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required. Maximum billable time for such a report is 15 minutes.			
	Modifiers			
3	Add 50% of the total fee for the treatment			
21	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.			
22	Services rendered at patients residence: Quote modifier 0022 on all accounts for services performed at the patients residence.			

Road Accident Fund Tariff 2020 / 2021

Tariff code	DESCRIPTION	UNITS	VALUE	2020 Tariff
	ITEMS			
107	Appointment not kept	0	R0,00	
200	Social worker consultation, counselling and/or therapy. Duration: 1-10min.	0,5	R65,78	R 69,42
201	Social worker consultation, counselling and/or therapy. Duration: 11-20min.	1,5	R197,59	R 208,52
202	Social worker consultation, counselling and/or therapy. Duration: 21-30min.	2,5	R329,81	R 348,06
203	Social worker consultation, counselling and/or therapy. Duration: 31-40min.	3,5	R461,62	R 487,16
204	Social worker consultation, counselling and/or therapy. Duration: 41-50min.	4,5	R593,57	R 626,41
205	Social worker consultation, counselling and/or therapy. Duration: 51-60min.	5,5	R725,12	R 765,24
206	Social worker consultation, counselling and/or therapy. Duration: 61-70min.	6,5	R857,34	R 904,78
207	Social worker consultation, counselling and/or therapy. Duration: 71-80min.	7,5	R989,02	R 1 043,75
208	Social worker consultation, counselling and/or therapy. Duration: 81-90min.	8,5	R1 121,10	R 1 183,13
209	Social worker consultation, counselling and/or therapy. Duration: 91-100min.	9,5	R1 253,05	R 1 322,39
210	Social worker consultation, counselling and/or therapy. Duration: 101-110min.	10,5	R1 384,87	R 1 461,50
211	Social worker consultation, counselling and/or therapy. Duration: 111-120min.	11,5	R1 516,55	R 1 600,47
	Group consultation, counselling or therapy			
	Group consultation, counselling and/or therapy items are chargeable to a maximum of 12 patients.			
300	Social worker group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	0,1	R13,29	R 14,03
301	Social worker group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	0,3	R39,47	R 41,65
302	Social worker group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	0,5	R65,78	R 69,42
303	Social worker group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	0,7	R92,35	R 97,46
304	Social worker group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	0,9	R118,66	R 125,23
305	Social worker group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	1,1	R145,37	R 153,41
306	Social worker group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	1,3	R171,55	R 181,04
307	Social worker group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	1,5	R197,59	R 208,52
308	Social worker group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	1,7	R224,04	R 236,44
309	Social worker group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	1,9	R250,74	R 264,61
310	Social worker group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2,1	R277,05	R 292,38
311	Social worker group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2,3	R303,23	R 320,01

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SPEECH THERAPISTS AND AUDIOLOGISTS

Tariff code	SPEECH THERAPISTS AND AUDIOLOGISTS	Practice Type: Speech Therapy		Practice Type: Audiology Code: 082					
		UNITS	VALUE	UNITS	VALUE				
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.								
	General Rules								
A	All accounts must be presented with the following information clearly stated: · name of practitioner · qualifications of the practitioner; · BHF practice number; · postal address and telephone number; · date on which service(s) were provided; · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered; · the first name of the patient; . the name and practice number of the referring practitioner, if applicable.								
B	The rate in respect of more than one evaluation under item 029 shall be the full rate for the first evaluation plus half the rate in respect of each additional evaluation, but under no circumstances may fees be charged for more than three evaluations carried out.								
D	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.								
E	Materials used in treatment shall be charged (exclusive of VAT) at net acquisition price plus – - 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands; - a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands. Use item 300 for this purpose.								
	ITEMS								
1	**Assessment, Consultation & Treatment**	**2019 Tariff**				**2020 Tariff**			
	The time used to conduct any diagnostic or treatment procedure claimed in addition to the codes in this section, can not be considered in determining the duration of the assessment, consultation or treatment claimed	**Practice Type: Speech Therapy Code: 082**		**Practice Type: Audiology Code: 082**		**Practice Type: Speech Therapy Code: 082**		**Practice Type: Audiology Code: 082**	
1.1	**Consultations**	**UNITS**	**VALUE**	**UNITS**	**VALUE**	**UNITS**	**VALUE**	**UNITS**	**VALUE**
1.1.1	**Audiology Consultations**								
1010	Audiology consultation. Duration 1 - 15 mins			10	R151,16				R 159,52
1011	Audiology consultation. Duration 16 - 30 mins			22,5	R339,67				R 358,47
1012	Audiology consultation. Duration 31 - 45 mins			37,5	R566,47				R 597,81
1013	Audiology consultation. Duration 46 - 60 mins			52,5	R793,27				R 837,16
1015	Prolonged audiology consultation, each additional full 15 mins, to a maximum of 60 mins			15	R226,67				R 239,21
1.1.2	**Speech Therapy Consultations**								
1020	Speech therapy consultation. Duration 1 - 15 mins	10	R151,16				R 159,52		
1021	Speech therapy consultation. Duration 16 - 30 mins	22,5	R339,67				R 358,47		
1022	Speech therapy consultation. Duration 31 - 45 mins	37,5	R566,47				R 597,81		
1023	Speech therapy consultation. Duration 46 - 60 mins	52,5	R793,27				R 837,16		
1,2	**Assessment & Treatment**								
1.2.1	**Speech Therapy Assessment & Treatment**								
1050	Speech therapy assessment and treatment. Duration 1 - 15 mins	10	R151,16				R 159,52		
1051	Speech therapy assessment and treatment. Duration 16 - 30 mins	22,5	R339,67				R 358,47		
1052	Speech therapy assessment and treatment. Duration 31 - 45 mins	37,5	R566,47				R 597,81		
1053	Speech therapy assessment and treatment. Duration 46 - 60 mins	52,5	R793,27				R 837,16		
2	**Speech, Voice and Language Disorder**								
7	Group therapy: per patient at rooms (Maximum of 3 patients per therapy)	15	R226,67				R 239,21		
	Note: Professional Group Consultations - no fee to be charged.								
9	Preparation of a home programme	15	R226,67				R 239,21		
	Note: This category is to prepare the home programme prior to consultation with patient or care giver								
20	Report writing	30	R453,20	30	R453,20		R 478,28		R 478,28
107	Appointment not kept	0	R0,00	0	R0,00				

3	**Audiology**								
A.	**Peripheral Hearing Evaluation**								
1100	Pure Tone Audiogram (Air conduction) (3273)			15	R259,16				R 273,50
1105	Pure Tone Audiogram (Bone conduction) (3274)			12	R207,33				R 218,80
1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277)			15	R259,16				R 273,50
1115	Speech audiogram screening			5	R86,69				R 91,49
1120	Visual reinforcement audiometry and/or combined play audiometry employed in a sound field environment to assess peripheral hearing			40	R706,71				R 745,81
1121	Conditioning play audiometry			40	R706,71				R 745,81
1122	Select picture audiometry			40	R706,71				R 745,81
1125	Tinnitus Evaluation			15	R259,16				R 273,50
B.	**Middle Ear Function Evaluation**								
1200	Tympanometry			8	R130,76				R 138,00
1205	Immittance Measurements - Impedance / Stapedial reflex (3276): Limited reflex spectrum (eg : 1-2 frequencies)			4	R65,51				R 69,13
1210	Immittance Measurements - Impedance / Stapedial reflex (3276): Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies)			12	R196,28				R 207,14
1215	Immittance Measurements - Impedance / High Frequency Tympanometry (for peadiatric population)			8	R130,76				R 138,00
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral			12	R196,28				R 207,14
1225	Rinné & Weber tests			4	R69,07				R 72,89
C.	**Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology**								
1300	Tone Decay (for retro cochlear pathology)			8	R138,39				R 146,05
1305	Reflex decay (for retro cochlear pathology)			8	R130,76				R 138,00
1310	Short Increment Sensitivity Index (SISI)			5	R86,69				R 91,49
1315	Air conduction MCL (Most comfortable levels) & UCL (Uncomfortable levels)			8	R138,39				R 146,05
1320	Speech thresholds MCL (Most comfortable levels) & UCL (Uncomfortable levels)			4	R69,07				R 72,89
1325	Test for functional hearing loss			10	R172,86				R 182,42
1331	Stenger test - pure tone			5	R86,69				R 91,49
1332	Stenger test - speech			5	R86,69				R 91,49
1335	Fistula test - (for peri-lymph fluid leakage)			15	R259,16				R 273,50
D.	**Auditory Processing (AP) and Central Auditory Processing Tests (CAP)**								
	Only tests appropriate to the recommendations of the HPCSA Taskforce on CAPD should be administered i.e. low-linguistically loaded tests are tests of choice. No more than two tests from each category below can be administered. Repeat item 1400 for each test done. Deviations from this billing guideline requires motivation.								
	PRELIMINARY TEST BATTERY								
	·Scan-C								
	· Scan-A								
	·PSI								
	DIFFERENTIAL DIAGNOSIS BETWEEN CAPD AND ADHD								
	·Selective Auditory Attention Test								
	·Auditory Continuous Performance Test								
	TESTS OF MONAURAL LOW REDUNDANCY								
	·Low Pass Filtered Speech - Ivey								
	·Low Pass Filtered Speech - NU-6 Lists 500Hz, 750Hz And 1000Hz								
	·Time Compressed Speech/Time Compressed Speech with Reverberation								
	SPEECH IN NOISE TESTS								
	·SPIN								
	·SSI-ICM								
	·BKB-SIN								
	·SIN								
	·QuickSIN								
	DICHOTIC SPEECH TESTS								
	·Dichotic Digits Test								
	·Dichotic Consonant Vowel								
	·SSI-CCM								
	·Staggered Spondaic Word Test								
	·Competing Sentences Test								
	·Dichotic Rhyme Test								
	· Dichotic Sentence Identification Test								
	TEMPORAL PROCESSING TESTS								
	·Random Gap Detection Test								
	TEMPORAL PATTERNING TESTS								
	·Frequency Pattern (Pitch Pattern) Sequence Test								
	·Duration Pattern Sequence Test								
	BINAURAL INTERACTION TESTS								

	·Masking Level Difference for Speech								
	·Binaural Fusion Test (Ivey, NU-6 or CVC Fusion)								
1400	Central Auditory Processing Disorders test, test to be specified.			13	R229,69				R 242,40

E.	**Electro-Physiological Examinations/ Auditory Evoked Potentials (AEP)**								
1500	Diagnostic Neurological short latency ABR (Auditory Brainstem Response) Bilateral; single decibel (2692)			60	R1 059,80				R 1 118,44
1505	AABR - Bilateral (Automated Auditory Brainstem Response). Cannot be charged with 1510			30	R490,04				R 517,16
1510	Screening ABR - Bilateral (Auditory Brainstem Response) . Cannot be charged with 1505			20	R326,78				R 344,86
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli			60	R1 059,80				R 1 118,44
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli			80	R1 412,89				R 1 491,07
	Combinations of items 1531 to 1534 cannot be billed together.								
1531	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at: 1 frequency			30	R530,03				R 559,36
1532	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies			60	R1 059,80				R 1 118,44
1533	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies			90	R1 589,83				R 1 677,80
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies			120	R2 119,73				R 2 237,02
	Combinations of items 1541 to 1544 cannot be billed together.								
1541	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 1 frequency			25	R441,76				R 466,20
1542	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies			50	R883,52				R 932,41
1543	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies			75	R1 324,75				R 1 398,05
1544	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses(2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies			100	R1 766,50				R 1 864,25
	Combinations of items 1551 to 1554 cannot be billed together.								
1551	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 1 frequency			30	R530,03				R 559,36
1552	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 2 frequencies			40	R706,71				R 745,81
1553	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 3 frequencies			60	R1 059,80				R 1 118,44
1554	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 4 frequencies			80	R1 412,89				R 1 491,07
1560	P300 Cognitive AEP (Auditory Evoked Potential) or MMN (Mismatch Negativity)			35	R618,30				R 652,51
1565	Electrocochleography: unilateral (2699). Cannot be charged with item 1570.			45	R794,72				R 838,69
1570	Electrocochleography: bilateral (2700). Cannot be charged with item 1565.			90	R1 589,83				R 1 677,80
1575	Cochlear nerve function test - intra-operative monitoring - per 30min			30	R530,03				R 559,36
1580	OAE (Oto-acoustic emissions) - limited frequencies (transient or distortion product) for hearing screening of neonatal and pediatric population.			15	R235,61				R 248,65
1581	OAE (Oto-acoustic emissions) - comprehensive diagnostic evaluation			30	R490,04				R 517,16
F.	**Balance/Vestibular Examinations and Treatment**								
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253). Cannot use with item 1605.			55	R971,66				R 1 025,43
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG). Cannot use with item 1600.			55	R1 022,57				R 1 079,15
1610	Eye Visualization – spontaneous and positional nystagmus – monocular			35	R550,42				R 580,88
1615	Eye Visualization – spontaneous and positional nystagmus – binocular			35	R572,00				R 603,65
1620	Oculo-motor/central tests using electro-nystagmography (ENG). Cannot be used with item 1625.			25	R464,91				R 490,64
1625	Oculo-motor/central tests using video-nystagmography (VNG). Cannot be used with item 1620.			25	R464,91				R 490,64
1630	DVA (Dynamic Visual Acuity) test using Video-nystagmography (VNG)			10	R186,15				R 196,45
1635	Caloric test using ENG electro-nystagmography (3255). Cannot be used with item 1640.			50	R929,56				R 981,00
1640	Caloric test using VNG electro-nystagmography (3255). Cannot be used with item 1635.			50	R929,56				R 981,00
1645	Posturography			25	R464,91				R 490,64
1650	Rotational Chair test			15	R245,22				R 258,79
1655	Otolith repositioning/canalith maneuvre			25	R377,56				R 398,45
1660	Vestibular rehabilitation (neuromuscular) re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception			25	R377,56				R 398,45
G.	**Cochlear Implant Tests**								
1700	Cochlear Implants: Pre-implant round window promontory testing.			45	R735,25				R 775,93

1710	Cochlear Implants : Electrode mapping : per 15min (max 120min)			15	R278,76				R 294,18
1720	Cochlear Implants : Implant test : Four test modes : intra- or post-operatively			5	R86,69				R 91,49
1725	Cochlear Implants : Neural Response Telemetry : intra-operatively (during cochlear implant surgery)			20	R371,90				R 392,48
1730	Cochlear Implants : Neural Response Telemetry : post-operatively (after cochlear implant surgery)			55	R950,87				R 1 003,48
1735	Cochlear Implants : Electrical Stapedius Reflex Thresholds : intra-operatively only			13	R241,66				R 255,03
1740	Cochlear Implants : Comprehensive speech perception testing, pre- and post-cochlear implant, per 15min (max 45min)			15	R264,69				R 279,34
H.	**Hearing Amplification / Hearing Aids**								
1800	Hearing aid evaluation - per ear			15	R235,61				R 248,65
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading)			13	R229,69				R 242,40
1810	Insertion gain measurement, per ear			10	R163,78				R 172,84
1815	Re-programming of hearing aid, per ear			10	R157,34				R 166,05
1820	Technical adjustment of hearing aid/device, per ear.			6	R94,72				R 99,96
1825	Repairs to hearing aids			0	R0,00				
1830	Global charge for supply and fitting of hearing aid and follow-up (By arrangement).			0	R0,00				
I.	**Occupational Health / Industrial Hearing Assessment**								
1900	Pure Tone Audiogram (Air conduction). (3237)			15	R226,67				R 239,21
1905	Pure Tone Audiogram (Bone conduction) (3274)			12	R181,15				R 191,17
1910	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels (3277)			15	R226,67				R 239,21
1915	Speech audiogram screening			5	R75,51				R 79,69
1920	Immittance Measurements (Impedance) (Tympanometry)			4	R60,51				R 63,86
1925	Immittance Measurements (Impedance) (Stapedial reflex) (3276)			12	R181,15				R 191,17
4	**Material**								
300	Medication			0	R0,00				
301	Material			0	R0,00				

Accredited Blood and Blood Product Couriers

Tariff code	TISSUE TRANSPORTATION	NUMBER OF UNITS	Tariff Value	2020 Tariff
	GENERAL RULES			
1	Items in the section on blood transportation are only chargeable by providers with a "003" practice number (Accredited Blood and Blood Product Couriers)			
1	**BLOOD TRANSPORTATION**			
700	Routine compat collection: Collection of patient's blood compat by courier from hospital / clinic, other than as an emergency. Compat to be delivered to blood bank for cross match.	0		
710	Routine blood / blood product collection: Collection and delivery of cross-matched blood/blood produce by courier from blood bank, other than as an emergency. Blood/blood product to be taken to hospital/clinic for patient.	0		
720	Emergency blood / blood product collection: Collection of blood/blood product (without a full cross-match) where the driver has to wait for the blood/blood product and deliver it to the hospital (i.e. ROUND TRIP).	0		
	May require verification of emergency and determine the nature of such required verification. May not be billed with 700, 710 or 730.	0		
730	Emergency blood / blood product collection following change of status of request: Collection of blood/blood product (with or without a full cross-match) where, after the original request was delivered to the blood bank by the courier as a routine request, the status of the request was subsequently changed by the hospital or clinic to an emergency necessitating a non-routine collection by the courier. Blood/blood product to be taken to hospital/clinic for patient.	0		
	May require verification of change of status and determine the nature of such required verification. Typically billed with 700. May not be billed with 710.	0		
740	Long distance: Additional per km fee for collections further than 50km. This fee applies only to those kilometres in excess of 50 km. Supporting documentation required, illustrating distance traveled.	0		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.		
	GENERAL RULES		**2020 Tariff**
A	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed if the appropriate code is supplied on the account.		
C	All accounts submitted by unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Medical Schemes Act, Act No. 131 of 1999. Where possible, such accounts shall also reflect the practice code numbers and names of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.		
D	All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as all the procedures performed. Photocopies of all other documents pertaining to the patients account must be provided on request.		
E	All accounts containing items which are subject to a discount in terms of the recommended benefit shall indicate such items individually and shall show separately the gross amount of the discount.		
F	Accommodation fees includes the services listed below:		
	A. The minimum services that are required are items 3, 5 and 6.		
	B. No additional charge may be levied by the hospital for other services required that are on this list.		
	1 Pre-authorisation (up to the date of admission) of:		
	· length of stay		
	· level of care		
	· theatre procedures		
	2 Provision of ICD-10 and CPT-4 codes when requesting pre-authorisation		
	3 Notification of admission		
	4 Immediate notification of changes to:		
	· length of stay		
	· level of care		
	· theatre procedures		
	5 Reporting of length of stay and level of care		
	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'				
	6 Discharge ICD-10 and CPT-4 coding			
	· In standard format for purposes of creating a minimum dataset of information to be used in defining an alternative reimbursement system.			
	· Including coding of complications and co-morbidity. To be done as accurately as practically possible by the hospital.			
	7 Case management by means of standard documentation and liaison with hospital appointed case managers			
	· Liaison means communication and sharing of information between case managers, but does not include active case management by the hospital.			
	SCHEDULE			
9	UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
5	Local anaesthetic theatre, Per minute	11,4	R	12,03
10	General anaesthetic theatre, Per minute	35,7	R	37,68
15	Dental anaesthetic theatre (Applicable to units registered for dental procedures only), Per minute	24,1	R	25,43
61	Excimer laser theatre fee, per minute	25,7	R	27,12
	Ward fees (including recovery room)			
19	Out-patients facility fee for ambulatory admission - chargeable for patients NOT requiring general anaesthetic- No ward fees applicable.	419,9	R	443,13
	Definition: Item 019 may only be used in conjunction with item 071 which is for pre-booked patients and may not be used in conjunction with items 301, 302, 061 and 335.			
25	Day rate.	481,5	R	508,14
	Emergency units			
35	Theatre drugs The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No	0		
301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	0		
302	For all consultations which require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	414,1	R	437,01
	Non-chargeable items (1)			
40	Theatre items: Refer to Appendix B.	0		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'				
	Non chargeable items (2)			
60	Wards: Refer to Appendix B.	0		
	THE CHARGE FOR A MONITOR HAS BEEN INCLUDED IN THE THEATRE FEE. NO EXTRA CHARGE IS PAYABLE			
	STANDARD CHARGES FOR EQUIPEMENT AND MATERIALS			
227	Operating microscope - motorised. This is applicable to a binocular operating microscope with motorised focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	417,1	R	440,18
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	206,3	R	217,72
335	Excimer laser: Hire fee per eye	2913,2	R	3 074,40
337	Microkeratome used with an excimer laser, per operation	535	R	564,60
	GASES			
	Oxygen and Nitrous Oxide			
	For both gases together, per minute			
283	PWV area	4,34	R	4,58
701	Cape Town	5,95	R	6,28
702	Port Elizabeth	5,31	R	5,60
703	East London	5,85	R	6,17
704	Durban	5,44	R	5,74
705	Other areas	4,84	R	5,11
	Oxygen, ward use			
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex			
284	PWV area	6,35	R	6,70
710	Cape Town	10,6	R	11,19
711	Port Elizabeth	10,1	R	10,66
712	East London	9,74	R	10,28
713	Durban	8,25	R	8,71
714	Other areas	7,87	R	8,31
	Oxygen, recovery room and emergency units			
	Flat rate for oxygen per case			

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'				
720	PWV area	12,6	R	13,30
721	Cape Town	20,9	R	22,06
722	Port Elizabeth	20	R	21,11
723	East London	19,5	R	20,58
724	Durban	16,5	R	17,41
725	Other areas	15,8	R	16,67
	Oxygen in Theatre			
	Fee for oxygen per minute in the operating theatre when no other gas administered.			
730	PWV area	0,38	R	0,40
731	Cape Town	0,7	R	0,74
732	Port Elizabeth	0,66	R	0,70
733	East London	0,66	R	0,70
734	Durban	0,54	R	0,57
735	Other areas	0,5	R	0,53
	Carbon Dioxide			
291	Per minute	0,78	R	0,82
	Laser			
292	Per minute	15,1	R	15,94
	Entonox			
293	Per 30 minutes	144,3	R	152,28
	Inhalation anaesthetics			
285	Halothane (Halothane): per minute	0,34	R	0,36
752	Ethrane (Enflurane): per minute	1,44	R	1,52
753	Forane (Isoflurane): per minute	1,6	R	1,69
754	Isofor (Isoflurane); per minute	1,6	R	1,69
755	Ultane (Sevoflurane): per minute	4,59	R	4,84
756	Suprane (Desflurane); per minute	3,93	R	4,15
757	Aerrane (Isoflurane): per minute	1,6	R	1,69
758	Alyrane (enflurane): per minute	1,44	R	1,52
759	Fluothane (Halothane): per minute	0,34	R	0,36

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	ANNEXURES		
	APPENDIX A		
	LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES		
	CATEGORY 1 (CPT4 2000 code numbers included where possible)		
	Diagnostic laparoscopy (49320)		
	Laparoscopy, surgical; with fulgeration of oviducts (with/without transection) (58670)		
	Laparoscopy, surgical; with occlusion of oviducts (e.g.band, clip, Falope ring) (58771)		
	Hysteroscopy diagnostic (58555)		
	Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C (58558)		
	THORACOSCOPY, DIAGNOSTIC		
	THORACOSCOPY, DIAGNOSTIC with biopsy		
	THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy		
	THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy		
	THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy		
	THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy		
	THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy		
	CATEGORY 2		
	Laparoscopy, surgical; with salpingostomy (salpingoneostomy) (58673)		
	Laparoscopy, surgical; with fimbrioplasty (58672)		
	Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface, any method (58662)		
	Laparoscopy, surgical; with lysis of adhesions (changed 1998 to salpigolysis, ovariolysis) (58660)		
	Laparoscopy, surgical; with removal leiomyomata (58551)		
	Laparoscopy surgical; withenterolysis (freeing intestinal adhesion) (44200)		
	Laparoscopy, surgical; with retropritoneal node sampling (biopsy) (38570)		
	Laparoscopy,surgical, abdomen, peritoneum, omentum; with drainage lymphocele to peritoneal cavity (49323)		
	Laparoscopy, surgical; appendectomy (44970)		
	Laparoscopy, surgical, abdomen, peritoneum and omentum; with biopsy (49321)		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	Laparoscopy, surgical, abdominal, peritoneum and omentum; with aspiration of cavity or cyst (e.g. ovarian cyst) single or multiple (49322)		
	Laparoscopy, surgical; with removal of adnexal structures (partial or total oopherectomy and/or salpingectomy) (58661)		
	Laparoscopy, surgical; orchiopexy for intra-abdominal testis (54692)		
	Laparoscopy, surgical; ligation spermatic veins for varicocele (55550)		
	Laparoscopy, surgical; ablation of renal cysts (50541)		
	Laparoscopy, surgical; urethral suspension for stress incontinence (51990)		
	Laparoscopy, surgical; sling operation for stress incontinence (51992)		
	Hysteroscopy with lysis intra-uterine adhesions (58559)		
	Hysteroscopy with removal impacted foreign body (58562)		
	Hysteroscopy with removal leiomyomata \ (58561)		
	Hysteroscopy with endometrial ablation \ (58563)		
	Laparoscopic treatment of ectopic pregnancy, without salpingectomy and/or oopherectomy (59150)		
	Laparoscopic treatment of ectopic pregnancy; with salpingectomy and/or oopherectomy (59151)		
	Laparoscopy, surgical; with vaginal hysterectomy. (Lap assisted vag. Hyst) (58550)		
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy (38571)		
	Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy) (38572)		
	Laparoscopy with adrenalectomy (60650)		
	Laparoscopy, surgical; pyeloplasty (50544)		
	Laparoscopy, surgical; nephrectomy (50540)		
	Laparoscopy, surgical; donor nephrectomy (50547)		
	Laparoscopically assisted nephroureterectomy (50548)		
	Laparoscopy, surgical, ureterolithotomy 50945)		
	Laparoscopy, surgical; transection of Vagus nerve, truncal (43651)		
	Laparoscopy, surgical; transection of Vagus nerves, selective or highly selective (43652)		
	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy (47560)		
	Laparoscopy, surgical; with guided transhepatic cholangiography, with biopsy (47561)		
	Laparoscopy, surgical; cholecystoenterostomy (47570)		
	Laparoscopy, surgical; cholecystectomy with cholangiography (47563)		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	Laparoscopy, surgical; cholecystectomy with explor, common bile duct (47564)		
	Laparoscopy, surgical; splenectomy (38120)		
	Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g. Stamm procedure) (43653)		
	Laparoscopy, surgical; jejunostomy (44201)		
	Laparoscopy, surgical; intestinal resection, with anastomosis (44202)		
	Laparoscopy, surgical; oesophagogastric fundoplasty eg Nissen, Toupet procedures) (43280)		
	Unlisted laparoscopic procedure, uterus (58578)		
	Unlisted hysteroscopy procedure, uterus (58579)		
	Unlisted laparoscopic procedure, oviduct, ovary (58679)		
	Unlisted laparoscopic spleen procedure (38129)		
	Unlisted laparoscopic lymphatic procedure (38589)		
	Unlisted laparoscopic oesophagus procedure (43289)		
	Unlisted laparoscopic stomach procedure (43659)		
	Unlisted laparoscopic intestinal procedure (except rectum) (44209)		
	Unlisted laparoscopic appendix procedure (44979)		
	Unlisted laparoscopic biliary tract procedure (47579)		
	Unlisted laparoscopy procedure, abdomen, peritoneum & omentum (49329)		
	Unlisted laparoscopic hernia procedure (49659)		
	Unlisted laparoscopic renal procedure (50549)		
	Unlisted laparoscopic procedure, testis (54699)		
	Unlisted laparoscopic procedure, spermatic cord (55559)		
	Unlisted laparoscopic procedure, maternity care and delivery (59898)		
	Unlisted laparoscopic endocrine procedure (60659)		
	THORACOSCOPY, SURGICAL		
	THORACOSCOPY, SURGICAL pleurodesis		
	THORACOSCOPY, SURGICAL partial pulmonary decortication		
	THORACOSCOPY, SURGICAL total pulm. Decortication		
	THORACOSCOPY, SURGICAL removal interpleural foreign body		
	THORACOSCOPY, SURGICAL control traum. Haemorrhage		
	THORACOSCOPY, SURGICAL exc./plication bullae		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	THORACOSCOPY, SURGICAL parietal pleurectomy		
	THORACOSCOPY, SURGICAL wedge resection		
	THORACOSCOPY, SURGICAL removal clot/foreign body from pericardial space		
	THORACOSCOPY, SURGICAL creation pericardial window		
	THORACOSCOPY, SURGICAL total pericardectomy		
	THORACOSCOPY, SURGICAL exc pericard. Cyst, tumor, mass		
	THORACOSCOPY, SURGICAL exc mediastinal cyst, tumor, mass		
	THORACOSCOPY, SURGICAL lobectomy, total or segmental		
	THORACOSCOPY, SURGICAL with sympathectomy		
	THORACOSCOPY, SURGICAL with esophagomyotomy		
	New codes for Category 2		
	CPT42000 CPT4 2001		
	Laparoscopy, surgical; radical nephrectomy 50545		
	Laparoscopy, surgical; nephrectomy including partial ureterectomy 50546		
	Laparoscopy, surgical; nephrectomy with total ureterectomy 50548		
	Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement 50948		
	Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement 50948		
	Unlisted laparoscopic procedure, ureter 50949		
	APPENDIX B		
	PRINCIPLES		
	The following principles are applicable:		
	1. At all times best clinical practice must be adhered too.		
	2. Items listed in the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only. Photocopies of all documents pertaining to the patients account must be provided on request. The right to inspect the original source documentation at the hospital/sameday surgical facilities concerned is reserved. The Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Sub-Acute Facilities, Private Hospitals and Sameday Surgery Facilities will be reviewed half-yearly.		
	3. The cost of consumable and disposable items used on a patient in a hospital must be recovered by means of a charge mechanism as follows:		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	¢ Items included in the per minute theatre fee.		
	¢ Items included in the per day ward or unit fee.		
	¢ Items are charged to the patient's account where reimbursement is not granted.		
	4. Any agreed difference on the basic interpretation of the Recommended Guide to Reimbursement for Consumable and Disposable Items Charged by Private Hospitals and Same Day Surgery Facilities list will be made in accordance with the approval of the duly appointed representatives of the individual contractor, MCO and representatives of private hospitals. Such approval shall be ratified in writing and circulated to all parties concerned. Where the hospital uses an excessively priced product, a review process should be conducted, and appropriate price adjustment made.		
	5. Disposable items are single use only and must never be reused.		
	¢ Single use items will be charged at 100%.		
	¢ Hospitals will sign an ethical undertaking that single use items will only be used once. If a hospital does not conform it may be reported to the group head office. If an acceptable explanation is not supplied within 14 days, payment on that account may be withheld.		
	6. Limited life re-usable products are products intended for multiple use and endorsed as such by the manufacturers. Such products will be charged according to the "Fractional" charges as detailed and are under continual review. The item will be considered life re-usable (limited multiple use) if it can re re-used less than 100 times (endorsed as such by the manufacturer).		
	7. Where a hospital uses an excessively priced product, a review process with the parties as listed under 3 above should be conducted, and appropriate price adjustment made.		
	Key Indicators		
	The different key indicators in the Recommended Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities List are as follows:		
	Key Description		
	THR Theatre consumable and disposable items		
	WRD Ward consumable and disposable items		
	NR Item is non-recoverable		
	C Item is chargeable under certain circumstance		
	R Item is recoverable		
	P Item is recoverable from patient		
	F Fractional (re-usable) and is charged out on a pro-rata basis (as per 5.5.1-5.5.4).		
	N/A Not used/not applicable		
	Disposable Means the manufacturer states one time use only.		

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	S/U(Single use) Item =Payable 100%		
	Medical Prescribed Meals See List		
	Practice Code References to the NRPL-HS includes 57/58, 76 and 77		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	APPENDIX C		
	Infectious Diseases		
	CONDITION		
	Acute Flaccid Paralysis		
	Anthrax		
	Chicken Pox		
	Diptheria		
	Haemophyllis Influenza		
	Haemorrhagic fevers of Africa:		
	¢ Crimean-Congo Ebola		
	¢ Lassa		
	¢ Marburg		
	¢ Rift Valley		
	¢ Dengue		
	Herpes Zoster		
	HIV/AIDS		
	Legionnaires Disease		
	Measles:		
	¢ Rubeola		
	¢ Rubella		
	Meningococcal infections		
	Multi-drug Resistant Bacteria:		
	¢ MRSA		
	¢ VRE		
	¢ MRSE		
	Poliomyelitis		
	Pyrexia unknown origin		
	Rabies		
	Small Pox		
	Tuberculosis Pulmonary		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	Typhus Fever		
	Viral Hepatitis		
	Whooping Cough (Pertussis)		
	Note: The above is a general list and the clinical appropriate use of items for specific conditions is subject to Case Management.		
	APPENDIX D		
	Medically Prescribed Meals:		
	ORAL SUPPLEMENTS Standard Ensure		
	(oral and tube feeds) Fortisip		
	Fresubin Original drink (Vanilla)		
	Standard & Fibre Ensure with Fibre		
	Isotonic Fresubin Original		
	Jevity		
	Low Residue Modulen N		
	Peptamen & Peptamen Jnr		
	(Lemon, Banana, Chocolate & Capuchino)		
	(Strawberry & Vanilla)		
	TUBE FEEDS Semi-Elemental Alitraq		
	Peptamen & Peptamen Jnr RTH		
	Peptisorb		
	Survimed OPD (Liquid)		
	Vital		
	Standard Nutren RTH		
	Nutrison		
	Nutrison Energy		
	Nutrison Paediatric		
	High Energy & High Protein Fresubin 750 MCT(HP Energy)		
	Semi-Elemental High Protein Perative,		
	And High Fibre		
	Nutren Fibre RTH		
	DISEASE SPECIFIC MaximumGlucose Tolerance Fresubin Diabetes		

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'			
	Glucerna		
	Nutren Diabetes		
	Pulmonary Insufficiency Pulmocare		
	Supportan		
	Renal Failure Suplena		
	HIV/Aids Advera		
	Survimed OPD		
	Supportan		
	Cancer Patients Supportan drink (Milk Coffee), Stresson Multi Fibre, Peptisorb		
	MODULAR Protein Promod		
	Protifar		
	MCT Oil MCT Oil		
	Fresubin 750MCT(HP Energy)		
	Glutamine Glutapack-10		
	Dipeptiven 50ml & 100ml		
	Food thickener Thick & Easy		
	Carbohydrate Fantomalt		
	Polycose		
	Note: Or generic equivalents. All tubes feeds subject to Case Management		