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Contents

GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF TRANSPORT

NO. 4036 **7 November 2023**

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

ROAD ACCIDENT FUND MEDICAL TARIFFS, 2023

The Minister of Transport, in terms of section 26 of the Road Accident Fund Act, 1996 (Act No. 56 of 1996) hereby publishes the draft Medical Tariffs, 2023 for comments and inputs.

All interested persons are requested to submit written comments and inputs on the draft Medical Tariffs within 30 days from the date of publication hereof to the Director- General, Department of transport.

Comments may be sent to the following postal or e-mail address for the attention of the following persons:

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ROAD ACCIDENT FUND MEDICAL TARIFFS 2023/2024

Road Accident Fund Tariff

Table of Content

General Information
These tariffs are applicable from 01 April 2023 until 31 March 2024
Reimbursement is subject to clinical appropriateness.

The following information is applicable to all disciplines:

* 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.

* All prices are VAT inclusive

* Guidelines for information required on each account :
· Name of service provider
· BHF & HPCSA practice number
· Address of the practice
· Telephone number
· Link number
· The name of the patient
· The date on which the service was rendered.
· Diagnosis and ICD 10 codes of patient's condition
· Procedures performed/Services rendered
· Response vehicle: Details of vehicle driver and intervention undertaken on patient

* The RAF is not liable for any consultation/service fee in cases where the appointment was not kept.

Medication:
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 19 June 2020, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965).

(a) where the single exit price of a medicine or scheduled substance is less than one hundred and thirteen rand and seventy two cents (R113.72), the dispensing fee shall not exceed R15.95 plus 46% of the single exit price in respect of that medicine or scheduled substance;

(b) where the single exit price of a medicine or scheduled substance is greater than or equal to one hundred and thirteen rand and seventy two cents (R113.72), but less than three hundred and three rand and thirty two cents (R303.32), the dispensing fee shall not exceed R29.07 plus 33% of the single exit price in respect of that medicine or scheduled substance;

(c) where the single exit price of a medicine or scheduled substance is greater than or equal to three hundred and three rand and thirty two cents (R303.32), but less than one thousand and sixty one rand and sixty two cents (R1061.62), the dispensing fee shall not exceed R82.77 plus 15% of the Single Exit Price in respect of that medicine or scheduled substance;

(d) where the single exit price of a medicine or scheduled substance is greater than or equal to one thousand and sixty one rand and sixty two cents (R1061.62), the dispensing fee shall not exceed R190.68 plus 5% of the Single Exit Price in respect of that medicine or scheduled substance.

Traveling Fees:
Traveling fees, where applicable and when approved by the RAF, will be covered at appropriate AA rates.

BIOKINETICS (PR 091)

GENERAL RULES

91002	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.
91003	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.
91004	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.
91005	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.
91011	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:
1	**Consultations / Patient Education / Counseling**		
91901	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)	16.7	R 177.96
91903	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	11.7	R 124.79
91905	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	16.7	R 177.96
91922	Patient education (based upon the evaluation outcomes)	16.3	R 149.05
91936	Health promotion and lifestyle modifications		
2	**Evaluation / Diagnostic Procedures**		
91908	Simple evaluation at the first visit only (to be fully documented)	10	R 91.56
91909	Complex evaluation at the first visit only (to be fully documented).	16.7	R 152.54
91912	Anthropometric/body composition assessment	10	R 91.56
91913	Ergological testing evaluation of body segment, limb or joint	28.5	R 260.55
91914	Neurological patients: Ergological evaluation	16.7	R 152.54
91915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	16.7	R 152.54
91916	Perceptual motor evaluation (perception and gross motor function)	16.7	R 152.54
91917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) / Musculoskeletal assessment (strength, endurance, range of motion, posture)	28.5	R 260.55
91918	Physical work capacity with full ECG	28.5	R 260.55
91920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	28.5	R 260.55
91921	Isokinetic testing by means of specialised electronic equipment	28.5	R 260.55
3	**Therapeutic Procedures (Physical Rehabilitation)**		
	Maximum of 3 modalities, per diagnosis, may be charged per visit		
91923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	16.3	R 293.61
91925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the Biokineticist	16.3	R 149.05
91926	Exercise on Isokinetic apparatus/Isotonic/Isometric resistance equipment.	16.3	R 149.05
91927	Posture, gait and activities of daily living (ADL), with/without equipment use	16.3	R 149.05
91928	A rehabilitative exercise prescription	16.3	R 149.05
91929	Callisthenics exercises	16.3	R 149.05
91930	Group session with high risk patients, per patient (maximum 10 patients)	8.8	R 80.42
91931	Passive and active range of motion exercise therapy	16.3	R 293.61
91933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, Low-Back pain/ Lumbago etc.		R 150.05
91934	Group exercise sessions, per patient	8.8	R 80.42

Road Accident Fund Tariff

CHIROPRACTORS (PR 004)

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 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 6 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 by the Fund after receipt of a letter from the practitioner concerned, motivating the need for such treatment.
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.

Code:	Descripion:	Units:	Value:
1	**Consultations**		
301	Consultation	25.00	R 271.68
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 232.30
312	Two diagnostic procedures	37.50	R 348.28
313	Three diagnostic procedures	50.00	R 464.43
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 92.89
322	Two instances of immobilization or therapeutic exercises	15.00	R 139.41
4	**Treatment (therapeutic procedures)**		
	Only a single item from this section may be charged per patient encounter		
331	Single treatment procedure	10.00	R 92.89
332	Two treatment procedures	15.00	R 139.41
333	Three treatment procedures	20.00	R 185.77
334	Four treatment procedures	25.00	R 232.30
335	Five treatment procedures	30.00	R 278.49
336	Six treatment procedures	35.00	R 325.18
5	**Consumables**		
	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS		
100	Medication / material: Charge for medication or material, identified by the appropriate Nappi code.		
110	X-Ray films		

CLINICAL PATHOLOGY (PR 052)

GENERAL RULES

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**	**Units**	**Value**
3705	Alkali resistant haemoglobin	4.50	R 104.18
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	3.65	R 84.08
3710	Antibody titration	7.20	R 166.16
3711	Arneth count	2.25	R 41.60
3712	Antibody identification	8.45	R 195.25
3713	Bleeding time (does not include the cost of the simplate device)	6.94	R 160.68
3714	Blood volume, dye method	7.20	R 166.16
3715	Buffy layer examination	19.90	R 459.78
3716	Mean Cell Volume	2.25	R 27.42
3718	Quantitative reverse transcriptase polymerase chain reaction (QR-PCR) for monitoring minimal residual disease (MRD) in leukaemia patients	183.68	R 2 826.30
3717	Bone marrow cytological examination only	19.90	R 459.78
3719	Bone marrow: Aspiration	8.40	R 154.60
3720	Bone marrow trephine biopsy	32.60	R 599.60
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	36.80	R 676.70
3722	Capillary fragility: Hess	2.02	R 46.70
3723	Circulating anticoagulants	5.85	R 134.92
3724	Coagulation factor inhibitor assay	57.56	R 1 328.99
3726	Activated protein C resistance	26.00	R 600.69
3727	Coagulation time	3.16	R 72.62
3728	Anti-factor Xa Activity	53.60	R 985.30
3729	Cold agglutinins	3.60	R 83.41
3730	Protein S: Functional	37.50	R 865.72
3731	Compatibility for blood transfusion	3.60	R 83.41
3732	Cryoglobulin	3.60	R 83.41
3734	Protein C (chromogenic)	30.29	R 699.22
3735	Anti-thrombin III (chromogenic)	22.00	R 508.29
3736	Plasminogen (chromogenic)	61.65	R 1 423.86
3737	Lupus Russel Viper method	17.00	R 392.81
3738	Lupus Kaolin Exner method	25.00	R 577.59
3739	Erythrocyte count	2.25	R 51.67
3740	Factors V and VII: Qualitative	7.20	R 166.16
3741	Coagulation factor assay: Functional	9.45	R 218.34

Road Accident Fund Tariff

3742	Coagulation factor assay: Immunological	4.50	R -
3743	Erythrocyte sedimentation rate	3.00	R 68.79
3744	Fibrin stabilizing factor (urea test)	4.50	R 104.18
3746	Fibrin monomers	2.70	R 62.47
3748	Plasminogen activator inhibitor (PAI-I)	65.95	R -
3750	Tissue plasminogen Activator (tPA)	67.79	R -
3751	Osmotic fragility (screen)	2.25	R -
3752	Osmotic fragility test: Quantitative	10.00	R -
3753	Osmotic fragility (before and after incubation)	18.00	R 416.07

Road Accident Fund Tariff

Code	Description	Units	Value
3754	ABO Reverse Group	5.50	R 69.13
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	10.50	R 242.77
3756	Full cross match	7.20	R 166.16
3757	Coagulation factors: Quantitative	32.20	R 743.75
3758	Factor VIII related antigen	60.46	R 1 396.11
3759	Coagulation factor correction study	11.72	R 270.84
3761	Factor XIII related antigen	61.11	R -
3762	Haemoglobin estimation	1.80	R 41.71
3763	Contact activated product assay	16.20	R 374.04
3764	Grouping: A B and O antigens	3.60	R 83.41
3765	Grouping: Rh antigen	3.60	R 83.41
3766	PIVKA	43.49	R 590.71
3767	Euglobulin Lysis time	25.58	R 346.45
3768	Haemoglobin A2 (column chromatography)	15.00	R 619.13
3769	Haemoglobin electrophoresis	26.82	R 83.41
3770	Haemoglobin-S (solubility test)	3.60	R 83.41
3771	Factor III-availability test	5.85	
3772	Haptoglobin: Quantitative	9.45	R 218.34
3773	Ham's acidified serum test	8.00	R 184.61
3775	Heinz bodies	2.25	R 51.67
3776	Haemosiderin in urinary sediment	2.25	R 51.67
3781	Heparin tolerance	7.20	R 132.20
3783	Leucocyte differential count	6.20	R 143.23
3785	Leucocytes: Total count	1.80	R 41.71
3786	QBC malaria concentration and fluorescent staining	25.00	R 577.59
3787	LE-cells	8.30	R 191.75
3789	Neutrophil alkaline phosphatase	28.00	R 646.88
3791	Packed cell volume: Haematocrit	1.80	R 41.71
3792	Plasmodium falciparum: Monoclonal immunological identification	9.00	R 207.70
3793	Plasma haemoglobin	6.75	R 155.70
3794	Platelet sensitivities	18.64	R 342.80
3795	Platelet aggregation per aggregant	12.14	R 280.48
3796	Platelet antibodies: Agglutination	5.40	R 99.00
3797	Platelet count	2.25	R 51.67
3799	Platelet adhesiveness	4.50	R 104.18
3801	Prothrombin consumption	5.85	R 134.92
3803	Prothrombin determination (two stages)	5.85	R 134.92
3805	Prothrombin index	6.00	R 138.91
3806	Therapeutic drug level: Dosage	4.50	R 104.18

3807	Recalcification time	2.25	R 41.60
3809	Reticulocyte count	3.00	R 68.79
3810	Schumm's test	3.60	R 83.41
3811	Sickling test	2.25	R 51.67
3814	Sucrose lysis test for PNH	3.60	R 83.41
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	21.10	R 487.20
3820	Thrombo - Elastogram	26.00	R 600.69
3825	Fibrinogen titre	3.60	R 83.41
3828	Soluble urokrinase Plasminogen Activator Receptor (suPAR) ELISA	36.13	
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	8.00	R 184.61
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	16.00	R 369.88
3832	Red cell pyruvate kinase: Quantitative	16.00	R 369.88
3834	Red cell Rhesus phenotype	9.90	R 228.97
3835	Haemoglobin F in blood smear	5.85	R 134.92

Code	Description	Units	Value
3837	Partial thromboplastin time	5.85	R 134.92
3841	Thrombin time (screen)	7.16	R 165.34
3843	Thrombin time (serial)	7.65	R 176.79
3847	Haemoglobin H	2.25	R 51.67
3851	Fibrin degeneration products (diffusion plate)	10.35	R 239.12
3853	Fibrin degeneration products (latex slide)	4.50	R 104.18
3854	XDP (Dimer test or equivalent latex slide test)	8.50	R 196.07
3855	Haemagglutination inhibition	9.90	R 228.97
3856	D-Dimer (quantitative)	27.52	R 552.16
3857	Ristocetin Cofactor	35.53	R -
3858	Heparin removal	28.88	R -
2	**Microscopic and miscellaneous tests**		
3863	Autogenous vaccine	12.60	R 290.79
3864	Entomological examination	20.70	R 478.05
3865	Parasites in blood smear	5.60	R 129.11
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	4.90	R 113.00
3868	Fungus identification	8.30	R 191.75
3869	Faeces (including parasites)	4.90	R 113.00
3872	Automated urine microscopy	8.72	
3873	Transmission electron microscopy	85.00	R 1 562.80
3874	Scanning electron microscopy	100.00	R 1 838.50
3875	Inclusion bodies	4.50	R 104.18
3878	Crystal identification polarized light microscopy	4.50	R 104.18
3879	Campylobacter in stool: Fastidious culture	9.90	R 228.97

3880	Antigen detection with polyclonal antibodies	4.50	R 104.18
3881	Mycobacteria	3.00	R 68.79
3882	Antigen detection with monoclonal antibodies	10.80	R 249.75
3883	Concentration techniques for parasites	3.00	R 68.79
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	6.30	R 145.72
3885	Cytochemical stain	5.45	R 125.96
3	**Bacteriology**		
4650	Antibiotic MIC per organism per antibiotic	8.00	R 184.61
4651	Non-radiometric automated blood cultures	13.90	R 320.86
4652	Rapid automated bacterial identification per organism	15.00	R 346.45
4653	Rapid automated antibiotic susceptibility per organism	17.00	R 392.81
4654	Rapid automated MIC per organism per antibiotic	17.00	R 392.81
3887	Antibiotic susceptibility test: Per organism	8.00	R 184.61
3888	Adhesive tape preparation	2.70	R 62.47
3889	Clostridium difficile toxin: Monoclonal immunological	12.40	R 286.14
3890	Antibiotic assay of tissues and fluids	13.90	R 320.86
3891	Blood culture: Aerobic	5.85	R 134.92
3892	Blood culture: Anaerobic	5.85	R 134.92
3893	Bacteriological culture: Miscellaneous	6.30	R 145.72
3894	Radiometric blood culture	10.80	R 249.75
3895	Bacteriological culture: Fastidious organisms	9.90	R 228.97
3896	In vivo culture: Bacteria	16.00	R 369.88
3897	In vivo culture: Virus	16.00	R 369.88
3898	Bacterial exotoxin production (in vitro assay)	4.50	
3899	Bacterial exotoxin production (in vivo assay)	20.70	R 478.05
3900	Cytomegalovirus (CMV) pp65 antigen detection assay	59.20	R -
3901	Fungal culture	4.50	R 104.18
3902	Clostridium difficile (cytotoxicity neutralisation)	30.00	R 692.91

Code	Description	Units	Value
3903	Antibiotic level: Biological fluids	11.70	R 270.52
3904	Rotavirus latex slide test	5.62	R 129.95
3905	Identification of virus or rickettsia	20.70	R 478.05
3906	Identification: Chlamydia	16.00	R 369.88
3907	Culture for staphylococcus aureus		R 51.67
3908	Anaerobe culture: Comprehensive	9.90	R 228.97
3909	Anaerobe culture: Limited procedure	4.50	R 104.18
3911	Beta-lactamase assay	4.50	R 104.18
3914	Sterility control test: Biological method	4.50	R 104.18
3915	Mycobacterium culture	4.50	R 104.18

3916	Radiometric tuberculosis culture	10.80	R 249.75
3917	Mycoplasma culture: Limited	2.25	R 41.60
3918	Mycoplasma culture: Comprehensive	9.90	R 228.97
3919	Identification of mycobacterium	9.90	R 228.97
3920	Mycobacterium: Antibiotic sensitivity	9.90	R 228.97
3921	Antibiotic synergistic study	20.70	R 478.05
3922	Viable cell count	1.35	R 31.07
3923	Biochemical identification of bacterium: Abridged	3.15	R 72.45
3924	Biochemical identification of bacterium: Extended	12.50	R 288.79
3925	Serological identification of bacterium: Abridged	3.15	R 72.45
3926	Serological identification of bacterium: Extended	10.20	R 235.29
3927	Grouping for streptococci	7.30	R 168.82
3928	Antimicrobic substances	3.80	R 87.73
3929	Radiometric mycobacterium identification	14.00	R 323.19
3930	Radiometric mycobacterium antibiotic sensitivity	25.00	R 577.59
3931	Helicobacter: Monoclonal immunological	12.40	R 286.14
4655	Mycobacteria: MIC determination - E Test	16.50	R 303.10
4656	Mycobacteria: Identification HPLC	35.00	R 643.90
4657	Mycobacteria: Liquefied, concentrated, fluorochrome stain	9.90	R 182.00
4	**Serology**		
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	14.10	R 325.51
3933	IgE: Total: EMIT or ELISA	11.70	R 270.52
3934	Auto antibodies by labelled antibodies	16.00	R 369.88
3935	Sperm antibodies	16.00	R 369.88
3936	Virus neutralisation test: First antibody	75.00	R 1 732.59
3937	Virus neutralisation test: Each additional antibody	15.00	R 346.45
3938	Precipitation test per antigen	4.50	R 104.18
3939	Agglutination test per antigen	5.50	R 126.95
3940	Haemagglutination test: Per antigen	9.90	R 228.97
3941	Modified Coombs' test for brucellosis	4.50	R 104.18
3942	Hepatitis Rapid Viral Ab	12.24	R 248.08
3943	Antibody titer to bacterial exotoxin	3.60	R 83.41
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	12.40	R 286.14
3945	Complement fixation test	5.85	R 134.92
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	14.05	R 324.35
3947	C-reactive protein	10.84	R 250.74
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	12.95	R 298.94
3949	Qualitative Kahn, VDRL or other flocculation	2.25	R 51.67
3950	Neutrophil phagocytosis	25.20	R 582.41
3951	Quantitative Kahn, VDRL or other flocculation	3.60	R 83.41
3952	Neutrophil chemotaxis	67.95	R 1 569.76

3953	Tube agglutination test	4.15	R 96.21
3955	Paul Bunnell: Presumptive	2.25	R 51.67

Code	Description	Units	Value
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	8.50	R 196.07
3957	Paul Bunnell: Absorption	4.50	R -
3958	Anti Gad/Ia2 Ab	67.95	R -
3959	Rose Waaler agglutination test	4.50	R 1 364.38
3960	Gonococcal, listeria or echinococcus agglutination	9.50	R 104.18
3961	Slide agglutination test	2.63	R 219.34
3962	Rebuck skin window	5.40	R 60.82
3963	Serum complement level: Each component	3.15	R 72.45
3965	Anti Ia2 Antibodies	36.00	R 722.65
3966	Anti Gad Antibodies	36.00	
3967	Auto-antibody: Sensitized erythrocytes	4.50	R 104.18
3968	Herpes virus typing: Monoclonal immunological	20.69	R 477.89
3969	Western blot technique	74.00	R 1 708.83
3970	Epstein-Barr virus antibody titer		R 155.70
3971	Immuno-diffusion test: Per antigen	3.15	R 72.45
3972	Respiratory syncytial virus (ELISA technique)	35.00	R 808.06
3973	Immuno electrophoresis: Per immune serum	9.45	R 218.34
3974	Polymerase chain reaction	75.00	R 1 732.59
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	12.00	R 277.00
3977	Counter immuno-electrophoresis	6.75	R -
3978	Lymphocyte transformation	51.70	R 1 193.56
3980	Bilharzia Ag Serum/Urine	14.50	R 180.46
3982	Histone Ab	16.00	
3984	Quantiferon TB assay	44.80	
3986	Anti R7-V	59.59	
4600	Anti-CCP	17.46	R 350.44
4601	Panel typing: Antibody detection: Class I	36.00	R 831.32
4602	Panel typing: Antibody detection: Class II	44.00	R 1 016.26
4603	HLA test for specific locus/antigen - serology	27.00	R 623.61
4604	HLA typing: Class I - serology	52.00	R 1 200.87
4605	HLA typing: Class II - serology	52.00	R 1 200.87
4606	HLA typing: Class I & II - serology	90.00	R 2 078.88
4607	Cross matching T-cells (per tray)	18.00	R 416.07
4608	Cross matching B-cells	38.00	R 877.68
4609	Cross matching T- & B-cells	48.00	R 1 108.82
4610	Helicobacter: Pylori antigen test	34.60	R 694.56

4611	Erythropoietin	20.00	R 367.80
4612	HTLV I/II	20.00	R -
4613	Anti-Gm1 Antibody Assay	75.00	R -
4614	HIV Ab - Rapid Test	12.00	R 240.93
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	R 104.18
3993	Abnormal pigments: Quantitative	9.00	R 207.70
3995	Acid phosphate	5.18	R 119.80
3996	Serum Amyloid A	8.28	
3997	Acid phosphatase fractionation	1.80	
3998	Amino acids Quantitative (Post derivatisation HPLC)	78.12	R 1 804.72
3999	Albumin	4.80	R 110.84
4000	Alcohol	12.40	R 286.14

Code	Description	Units	Value
4001	Alkaline phosphatase	5.18	R 119.80
4002	Alkaline phosphatase-iso-enzymes	11.70	R 270.52
4003	Ammonia: Enzymatic	7.71	R 178.13
4004	Ammonia: Monitor	4.50	R 104.18
4005	Alpha-1-antitrypsin: Total	7.20	R 166.16
4006	Amylase	5.18	R 119.80
4007	Arsenic in blood, hair or nails	36.25	R 837.30
4008	Bilirubin - Reflectance	4.77	
4009	Bilirubin: Total	4.77	R 110.33
4010	Bilirubin: Conjugated	3.62	R 83.74
4011	Breath Hydrogen Test	21.56	R -
4012	CSF Nicotinic Acid	12.42	R -
4013	CSF Glutamine	11.25	R -
4014	Cadmium: Atomic absorption	18.12	R 418.23
4016	Calcium: Ionized	6.75	R 155.70
4017	Calcium: Spectrophotometric	3.62	R 83.74
4018	Calcium: Atomic absorption	7.25	R 166.99
4019	Carotene	2.25	R 51.67
4020	Carnitine (Total or free) in biological fluid: Each	11.69	R 270.19
4021	Carnitine (Total or free) in muscle: Each	23.38	R 540.03
4022	Acyl Carnitine	23.38	R 540.03
4023	Chloride	2.59	R 59.98

Road Accident Fund Tariff

4025	Chol/HDL/LDL/Trig	27.07	R 543.52
4026	LDL cholesterol (chemical determination)	6.90	R 159.19
4027	Cholesterol total	5.34	R 123.29
4028	HDL cholesterol	6.90	R 159.19
4029	Cholinesterase: Serum or erythrocyte: Each	7.48	R 172.98
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	9.00	R 207.70
4031	Total CO2	5.18	R 119.80
4032	Creatinine	3.62	R 83.74
4033	CSF-Immunoglobulin G	9.45	R -
4034	C1-Esterase Inhibitor	9.45	R 189.59
4035	CSF-Albumin	9.45	R 189.59
4036	CSF-IgG Index	22.05	
4038	Glutamic acid	29.06	
4040	Homocysteine (random)	15.30	R 353.43
4041	Homocysteine (after Methionine load)	18.10	R 417.91
4042	D-Xylose absorption test: Two hours	13.15	R 303.58
4045	Fibrinogen: Quantitative	3.60	R 83.41
4047	Hollander test	24.75	
4049	Glucose tolerance test (2 specimens)	8.97	R 207.37
4050	Glucose strip-test with photometric reading	1.80	R 41.71
4051	Galactose	11.25	R 259.72
4052	Glucose tolerance test (3 specimens)	13.17	R 303.91
4053	Glucose tolerance test (4 specimens)	17.37	R 401.12
4057	Glucose: Quantitative	3.62	R 83.74
4061	Glucose tolerance test (5 specimens)	21.56	R 498.00
4062	Galactose-1-phosphate uridyl transferase	16.00	R 369.88
4063	Fructosamine	7.20	R 166.16
4064	Glycated haemoglobin:Chromatography/HbA1C	14.25	R 329.17
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	46.88	R 1 083.06
4067	Lithium: Flame ionisation	5.18	R 119.80
4068	Lithium: Atomic absorption	7.48	R 172.98
4071	Iron	6.75	R 155.70

Code	Description	Units	Value
4073	Iron-binding capacity	7.65	R 176.79
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	R 383.84
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	6.75	R 155.70
4079	Ketones in plasma: Qualitative	2.25	R 51.67
4080	Everolimus assay	63.95	
4081	Drug level-biological fluid: Quantitative	10.80	R 249.75
4082	Tacrolimus assay	20.10	

Road Accident Fund Tariff

4083	Lysosomal enzyme assay	36.56	R	844.45
4084	Thymidine kinase	20.00		
4085	Lipase	5.18	R	119.80
4086	Lactate	16.00		
4091	Lipoprotein electrophoresis	9.00	R	207.70
4092	Orosmucoid	9.45		
4093	Osmolality: Serum or urine	6.75	R	155.70
4094	Magnesium: Spectrophotometric	3.62	R	83.74
4095	Magnesium: Atomic absorption	7.25	R	166.99
4096	Mercury: Atomic absorption	18.12	R	418.23
4098	Copper: Atomic absorption	18.12	R	418.23
4105	Protein electrophoresis	9.00	R	207.70
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	20.00	R	462.10
4109	Phosphate	3.62	R	83.74
4111	Phospholipids	3.15		
4113	Potassium	3.62	R	83.74
4114	Sodium	3.62	R	83.74
4117	Protein: Total	3.11	R	71.95
4121	pH, pCO2 or pO2: Each	6.75	R	155.70
4123	Pyruvic acid	4.50	R	104.18
4125	Salicylates	4.50	R	104.18
4126	Secretin-pancreozymin response	26.10		
4127	Caeruloplasmin	4.50	R	104.18
4128	Phenylalanine: Quantitative	11.25	R	259.72
4129	Glutamate dehydrogenase (GDH)	5.40		
4130	Aspartate aminotransferase (AST)	5.40	R	124.63
4131	Alanine aminotransferase (ALT)	5.40	R	124.63
4132	Creatine kinase (CK)	5.40	R	124.63
4133	Lactate dehidrogenase (LD)	5.40	R	124.63
4134	Gamma glutamyl transferase (GGT)	5.40	R	124.63
4135	Aldolase	5.40	R	124.63
4136	Angiotensin converting enzyme (ACE)	9.00	R	207.70
4137	Lactate dehydrogenase isoenzyme	10.80	R	249.75
4138	CK-MB: Immunoinhibition/precipitation	10.80	R	249.75
4139	Adenosine deaminase	5.40	R	124.63
4142	Red cell enzymes: Each	7.80		
4143	Serum/plasma enzymes	5.40	R	124.63
4144	Transferrin	11.70	R	270.52
4146	Lead: Atomic absorption	15.00	R	346.45
4147	Triglyceride	7.93	R	183.45
4148	Tay - Sachs Study	36.56		
4149	Red cell magnesium	11.70	R	270.52
4151	Urea	3.62	R	83.74
4152	CK-MB: Mass determination: Quantitative (Automated)	12.40	R	286.14
4153	CK-MB: Mass determination: Quantitative (Not automated)	17.47	R	403.61
4154	Myoglobin quantitative: Monoclonal immunological	12.40	R	286.14
4155	Uric acid	3.78	R	87.41

Road Accident Fund Tariff

4156	Vitamin D3	12.42	R 251.91

Code	Description	Units	Value
4157	Vitamin A-saturation test	15.30	R 353.43
4158	Vitamin E (tocopherol)	3.60	R 83.41
4159	Vitamin A	6.30	R 145.72
4160	Vitamin C (ascorbic acid)	2.25	
4161	Troponin isoforms: Each	20.00	R 462.10
4163	Apoprotein AI: Turbidometric method	8.28	R 191.42
4165	Apoprotein AII: Turbidometric method	8.28	R 191.42
4167	Apoprotein B: Turbidometric method	8.28	R 191.42
4170	Lipoprotein (a)(Lp(a)) assay	12.42	R 286.96
4171	Sodium + potassium + chloride + CO2 + urea	15.84	R 365.89
4172	ELISA/EMIT technique	12.42	R 286.96
4173	Sirolimus Assay	78.00	
4181	Quantitative protein estimation: Mancini method	7.76	R 179.30
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	8.28	R 191.42
4183	Quantitative protein estimation: Labelled antibody	12.42	R 286.96
4184	C-reactive protein (Ultra sensitive)	11.68	R 234.45
4185	Lactose	10.80	R 249.75
4186	Vitamin B6	15.30	R 307.40
4187	Zinc: Atomic absorption	18.12	R 418.23
7	**Biochemical tests: Urine**		
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	1.50	R 34.90
4189	Abnormal pigments	4.50	R 104.18
4193	Alkapton test: Homogentisic acid	4.50	R 104.18
4194	Amino acids: Quantitative (Post derivatisation HPLC)	78.12	R 1 804.72
4195	Amino laevulinic acid	18.00	R 416.07
4197	Amylase	5.18	R 119.80
4198	Arsenic	18.12	R 418.23
4199	Ascorbic acid	2.25	R 51.67
4201	Bence-Jones protein	2.70	R 62.47
4203	Phenol	3.60	
4204	Calcium: Atomic absorption	7.25	R 166.99
4205	Calcium: Spectrophotometric	3.62	R 83.74
4206	Calcium: Absorption and excretion studies	25.00	
4209	Lead: Atomic absorption	15.00	R 346.45
4210	Urine collagen telopeptides	36.50	
4211	Bile pigments: Qualitative	2.25	R 51.67

Road Accident Fund Tariff

4213	Protein: Quantitative	2.25	R 51.67
4216	Mucopolysaccharides: Qualitative	3.60	R 83.41
4217	Oxalate	9.38	R 216.68
4218	Glucose: Quantitative	2.25	R 51.67
4219	Steroids: Chromatography (each)	7.20	R 166.16
4220	Klinolab Newborn Screen	36.56	
4221	Creatinine	3.62	R 83.74
4223	Creatinine clearance	7.65	R 176.79
4227	Electrophoresis: Qualitative	4.50	R 104.18
4228	Foetal Lung Maturity	36.56	R 672.20
4229	Uric acid clearance	7.65	
4230	Urine/Fluid - Specific Gravity	0.90	R 18.11
4231	Metabolites HPLC (High Pressure Liquid Chromatography	37.50	R -
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	46.80	R -
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	37.50	R -

Code	Description	Units	Value
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	46.80	R -
4235	Inborn errors of metabolism (IEM) screening test by Tandem Mass Spectrometry for the detection of aminoacidopathies and cacylcamtine metabolic defects	70.86	R -
4237	5-Hydroxy-indole-acetic acid: Screen test	2.70	R 62.47
4238	5HIAA (Hplc)	78.12	
4239	5-Hydroxy-indole-acetic acid: Quantitative	6.75	
4247	Ketones: Excluding dip-stick method	2.25	R 51.67
4248	Reducing substances	1.80	R 41.71
4251	Metanephrines: Column chromatography	22.05	R 509.29
4252	Metanephrine (Hplc)	78.12	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	27.00	R 623.61
4254	Nitrosonaphtol test for tyrosine	2.25	R 51.67
4255	Orotic Acid - Urine	9.45	
4256	Very long Chain Fatty Acids	129.38	
4261	Micro Albumin: Quantitative	12.42	R 249.41
4262	Micro Albumin: Qualitative	4.50	R 90.40
4263	pH: Excluding dip-stick method	0.90	R 20.77
4265	Thin layer chromatography: One way	6.75	R 155.70
4266	Thin layer chromatography: Two way	11.25	R 259.72
4267	Total organic matter screen: Infrared	31.25	
4268	Organic acids: Quantitative: GCMS	109.38	R 2 526.36
4269	Phenylpyruvic acid: Ferric chloride	2.25	R 51.67
4270	Chromium Total Urine	18.12	R -
4271	Phosphate excretion index	22.05	R 509.29

4272	Porphobilinogen qualitative screen: Urine	5.00	R 115.48
4273	Porphobilinogen/ALA: Quantitative each	15.00	R 346.45
4283	Magnesium: Spectrophotometric	3.62	R 83.74
4284	Magnesium: Atomic absorption	7.25	R 166.99
4285	Identification of carbohydrate	7.65	R 176.79
4287	Identification of drug: Qualitative	4.50	R 104.18
4288	Identification of drug: Quantitative	10.80	R 249.75
4293	Urea clearance	5.40	R 124.63
4297	Copper: Spectrophotometric	3.62	R 83.74
4298	Copper: Atomic absorption	18.12	R 418.23
4300	Indican or indole: Qualitative	3.15	R -
4301	Chloride	2.59	R 59.98
4307	Ammonium chloride loading test	22.05	R -
4309	Urobilinogen: Quantitative	6.75	R 155.70
4313	Phosphates	3.62	R 83.74
4315	Potassium	3.62	R 83.74
4316	Sodium	3.62	R 83.74
4319	Urea	3.62	R 83.74
4321	Uric acid	3.62	R 83.74
4322	Fluoride	5.18	
4323	Total protein and protein electrophoresis	11.25	R 259.72
4325	VMA: Quantitative	11.25	R 259.72
4326	Catecholamines (HPLC)	78.12	R 1 804.72
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	46.88	R 1 083.06
4328	Immunoglobulin D	9.45	
4335	Cystine: Quantitative	12.60	R 290.79
4336	Dinitrophenol hydrazine test: Ketoacids	2.25	R 51.67
4337	Hydroxyproline: Quantitative	18.90	

Code	Description	Units	Value
8	**Biochemical tests: Faeces**		
4339	Chloride	2.59	R 59.98
4343	Fat: Qualitative	3.15	R 72.45
4345	Fat: Quantitative	22.05	R 509.29
4347	Ph	0.90	R 20.77
4350	M2 Pyruvate Kinase quantitative ELISA	63.35	
4351	Occult blood: Chemical test	2.25	R 51.67
4352	Occult blood: Monoclonal antibodies	10.00	R 230.80
4357	Potassium	3.62	R 83.74
4358	Sodium	3.62	R 83.74

4359	Secretory IgA	9.45	
4361	Stercobilin	2.25	
4362	Elastase quantitative ELISA	47.00	R 1 085.55
4363	Stercobilinogen: Quantitative	6.75	R 155.70
4364	Chymotrypsin determination: Enzymatic	7.47	
9	**Biochemical tests: Miscellaneous**		
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	5.00	R 115.48
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	20.00	R 462.10
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	20.00	R 462.10
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	30.00	R 692.91
4370	Drug level in biological fluid: Monoclonal immunological	12.40	R 286.14
4371	Amylase in exudate	5.18	R 119.80
4372	Fluoride in biological fluids and water	15.62	R 360.57
4373	Breast milk analysis	6.75	
4374	Trace metals in biological fluid: Atomic absorption	18.13	R 418.40
4375	Calcium in fluid: Spectrophotometric	3.62	R 83.74
4376	Calcium in fluid: Atomic absorption	7.25	R 166.99
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	21.88	R 505.48
4378	Urea breath test	58.00	
4380	Lecithin in amniotic fluid: L/S ratio	27.00	R 623.61
4381	Lamellar body count in amniotic fluid	10.00	R -
4382	Bilirubin in amniotic fluid: Spectrophotometric essay	9.45	R -
4386	Oestrogen/Progesterone receptors: Fluorescent method	20.70	R -
4387	Oestrogen/Progesterone receptors: Cytosol radio-isotope technique	230.00	R -
4388	Gastric contents: Maximal stimulation test	27.00	R -
4389	Gastric fluid: Total acid per specimen	2.25	R -
4390	Foam test: Amniotic fluid	3.15	R 72.45
4391	Renal calculus: Chemistry	5.40	R 124.63
4392	Renal calculus: Crystallography	16.25	R 375.37
4393	Saliva: Potassium	3.62	
4394	Saliva: Sodium	3.62	
4395	Sweat: Sodium	3.62	R 83.74
4396	Sweat: Potassium	3.62	R 83.74
4397	Sweat: Chloride	2.59	R 59.98
4399	Sweat collection by iontophoresis (excluding collection material)	4.50	R 104.18
4400	Tryptophane loading test	22.05	R 509.29

Code	Description	Units	Value
10	**Cerebrospinal fluid**		

4401	Cell count	3.45	R 79.93
4407	Cell count, protein, glucose and chloride	7.65	R 176.79
4409	Chloride	2.59	R 59.98
4415	Potassium	3.62	
4416	Sodium	3.62	R 83.74
4417	Protein: Qualitative	0.90	R 20.77
4419	Protein: Quantitative	3.11	R 71.95
4421	Glucose	3.62	R 83.74
4423	Urea	3.62	R 83.74
4425	Protein electrophoresis	12.60	R 290.79
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	R -
4426	HLA typing low resolution Class I DNA-PCR per locus	100.00	R -
4427	HLA typing low resolution Class II DNA-PCR per locus	74.00	R -
4428	HLA typing high resolution Class I or II DNA-PCR per locus	66.00	R -
4429	Quantitative PCR (DNA/RNA)	84.30	R 1 749.22
4430	Recombinant DNA technique	25.00	R 577.59
4431	Ribosomal RNA targeting for bacteriological identification	35.00	R 808.06
4432	Ribosomal RNA amplification for bacteriological identification	75.00	R 1 732.59
4433	Bacteriological DNA identification (LCR)	25.00	R 577.59
4434	Bacteriological DNA identification (PCR)	75.00	R 1 732.59
11.2	**RNA/DNA based tests and andrology: Andrology**		
4435	Mixed antiglobulin reaction: Semen	6.60	R 152.54
4436	Friberg test: Semen	14.50	R 334.98
4437	Kremer test: Semen	3.60	R 83.41
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	150.00	R 3 010.56
4440	Semen analysis: Cell count	7.65	R 176.79
4441	Semen analysis: Cytology	7.20	R 166.16
4442	Semen analysis: Viability + motility - 6 hours	6.00	R 138.91
4443	Semen analysis: Supravital stain	5.44	R 125.79
4445	Seminal fluid: Alpha glucosidase	20.00	R 462.10
4446	Seminal fluid fructose	3.15	R 72.45
4447	Seminal fluid: Acid phosphatase	5.18	R 119.80
12	**Immunology**		
4448	HCG: Latex agglutination: Qualitative (side room)	4.00	R 92.38
4449	HCG: Latex agglutination: Semi-quantitative (side room)	9.31	R 215.34
4450	HCG: Monoclonal immunological: Qualitative	10.00	R 230.80
4451	HCG: Monoclonal immunological: Quantitative	12.40	R 286.14

4452	Bone Specific Alk Phosphatase	20.00	
4455	Anti IgE receptor antibody test (10 samples and dilution)	161.56	R 3 731.55
4456	Eosinophil cationic protein	27.81	R 642.56
4457	Mast cell tryptase	96.87	R 2 237.24
4458	Micro-albuminuria: Radio-isotope method	12.42	R 286.96
4459	Acetyl choline receptor antibody	158.12	R 3 651.96
4460	CA-199 tumour marker	20.00	R 462.10
4461	Nuclear Matrix Protein 22	35.00	
4462	CA-125 tumour marker	20.00	R 462.10

Code	Description	Units	Value
4463	C6 complement functional essay	45.00	R 1 039.36
4464	House dust mite antigen ELIZA	20.31	
4466	Beta-2-microglobulin	12.42	R 286.96
4467	Chromograqnin A	47.00	R 943.31
4468	CA-549	20.00	R 462.10
4469	Tumour markers: Monoclonal immunological (each)	20.00	R 462.10
4470	CA-195 tumour marker	20.00	R 462.10
4471	Carcino-embryonic antigen	20.00	R 462.10
4472	MCA antigen tumour marker	20.00	
4473	TSH Receptor Ab	17.48	
4474	Cast Per Allergen	27.81	R 556.15
4475	CA-724	20.00	R 401.45
4476	Neopterin	20.00	
4477	Neuron specific enolase	20.00	R 462.10
4478	Osteocalcin	31.40	R 630.42
4479	Vitamin B12-absorption: Shilling test	11.70	R 270.52
4480	Serotonin	18.75	R 433.19
4482	Free thyroxine (FT4)	17.48	R 403.78
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	37.08	R 744.58
4485	Insulin	12.42	R 286.96
4486	C-Peptide	12.42	R 249.41
4487	Calcitonin	18.90	R 379.52
4488	B-Type Natriuretic Peptide	47.04	R 944.48
4490	Releasing hormone response	50.00	R 1 154.84
4491	Vitamin B12	12.42	R 286.96
4492	Vitamin D3: Calcitroil (RIA)	75.00	R 1 732.59
4493	Drug concentration: Quantitative	12.42	R 286.96
4494	Free hormone assay	17.48	R 403.78
4495	Growth hormone	12.42	R 286.96

Road Accident Fund Tariff

4496	Hormone concentration: Quantitative	12.42	R 286.96
4497	Carbohydrate deficient transferrin	29.06	R 671.14
4499	Cortisol	12.42	R 286.96
4500	DHEA sulphate	12.42	R 286.96
4501	Testosterone	12.42	R 286.96
4502	Free testosterone	17.48	R 403.78
4503	Oestradiol	12.42	R 286.96
4504	Anti-mullerian hormone	49.65	R -
4505	Oestriol	10.80	R 249.75
4506	Multiple antigen specific IgE screening test for Atopy	37.26	R 860.73
4507	Thyrotropin (TSH)	19.60	R 452.97
4508	Combined antigen specific IgE	24.48	R 565.62
4509	Free tri-iodothyronine (FT3)	17.48	R 403.78
4511	Renin activity	18.90	R -
4512	Parathormone	17.08	R 394.64
4513	IgE: Total	12.42	R 286.96
4514	Antigen specific IgE	12.42	R 286.96
4515	Aldosterone	12.42	R 286.96
4516	Follitropin (FSH)	12.42	R 286.96
4517	Lutropin (LH)	12.42	R 286.96
4518	Soluble transferrin receptor	11.25	R -
4519	Prostate specific antigen	14.49	R 334.82
4520	17 Hydroxy progesterone	12.42	R 286.96
4521	Progesterone	12.42	R 286.96
4522	Alpha-feto protein	12.42	R 286.96

Code	Description	Units	Value
4523	ACTH	21.74	R 502.15
4524	Free PSA	20.00	R 401.45
4526	Sex hormone binding globulin	12.42	R 286.96
4527	Gastrin	12.42	R 286.96
4528	Ferritin	12.42	R 286.96
4529	Anti-DNA antibodies	12.42	R 286.96
4530	Antiplatelet antibodies	15.30	R 353.43
4531	Hepatitis: Per antigen or antibody	14.49	R 334.82
4532	Transcobalamine	12.42	R 286.96
4533	Folic acid	12.42	R 286.96
4534	Prostatic acid phosphatase	12.42	R 286.96
4536	Erythrocyte folate	17.48	R 403.78
4537	Prolactin	12.42	R 286.96
4538	Procalcitonin: Semi-quantitative	32.00	R 642.72
4539	Procalcitonin: Quantitative	46.00	R 923.87
4540	HCG: Quantitative as used for Down's screen	15.00	R 346.45
4546	First trimester Downs screen	53.50	R 1 073.92
4552	Second Trimester Down's screen	38.22	R 675.29

4553	Thyroglubulin	20.00	R 401.45
4554	SCC marker	20.00	R -
13	**Clinical pathology: Miscellaneous**		
4544	Attendance in theatre	27.00	R 623.61
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		R 366.89
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	Units	Value
	ANATOMICAL PATHOLOGY		
1	**Exfoliative cytology**		
4559	Cytology preparation using approved liquid bases cytology method: First unit	27.32	
4560	Cytology preparation using approved liquid bases cytology method: Each additional unit	9.00	
4561	Sputum, all body fluids and tumour aspirates: First unit	13.40	R 357.09
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	7.80	R 207.70
4564	Performance of fine-needle aspiration for cytology	15.00	R 399.63
4565	Examination of fine needle aspiration in theatre	90.00	R 2 396.75
4566	Vaginal or cervical smears, each	11.00	R 293.28
2	**Hystology**		
4567	Histology per sample/specimen each	20.00	
4571	Histology per additional block, each	11.60	
4575	Histology and frozen section in laboratory	22.70	
4577	Histology and frozen section in theatre	403.50	
4578	Second and subsequent frozen sections, each	97.50	
4579	Attendance in theatre - no frozen section performed	45.00	
4582	Serial step sections (including item 4567)	23.30	
4584	Serial step sections per additional block, each	13.50	
4587	Histology consultation	10.10	
4589	Special stains	6.70	

4590	Special procedures (special procedures are confined to polarization, decalcification and submission of blocks for radiological examination to identify microcalcifications)	6.70	
4591	Immunofluorescence studies	20.70	
4592	Immunoperoxidase studies	40.00	
4593	Electron microscopy	94.00	
4595	Foetal autopsy excluding histology	73.00	

HUMAN GENETICS

1	Cytogenic		
4750	Cell culture: Lymphocytes, cord blood	15.00	R 354.60
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	45.00	R 1 064.28
4752	Cell culture: Chorionic villi	60.00	R 1 419.04
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	135.00	R 3 192.68
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	270.00	R 6 385.53
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	70.00	R 1 655.33
4760	FISH procedure, including cell culture	115.00	R 2 719.61
4761	FISH analysis per probe system	35.00	R 827.34

Code	Description	Units	Value
2	DNA-testing		
4763	Blood: DNA extraction	45.00	R 1 064.28
4764	Blood: Genotype per person: Southern blotting	89.00	R 2 104.80
4765	Blood: Genotype per person: PCR	60.00	R 1 419.04
4766	HIV Drug Resistance Testing	513.00	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	90.00	R 2 128.56
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	188.00	R 4 445.89
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	120.00	R 2 837.42

CLINICAL TECHNOLOGY (PR 075)

GENERAL RULES

75001	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:
1.	**Surgical Support**		
75010	Ablations	219.70	R 3 965.34
75011	Preparation of extra-corporeal equipment for surgical procedures.	196.70	R 3 550.27
75012	Operation of heart laser during myocardial revascularisation	219.70	R 3 965.34
75013	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 366.39
75014	Radiofrequency Catheter Ablations	219.70	R 3 965.34
	Not to be charged with item 012		
75015	Preparation and operation of pre-operative, intra-operative or post operative physiological monitoring per patient, per admission	19.40	R 350.27
	May only submit once in theatre and once in catheterisation laboratory		
75017	Standby with extra-corporeal equipment for surgery within hospital	58.80	R 1 061.46
	Cannot be used with 011		
75019	Standby within the hospital for coronary angioplasty.	19.40	R 350.27
75021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory.	58.80	R 1 061.46
75085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time.	10.00	R 180.45
75023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit.	196.70	R 3 550.27
75027	Preparation and operation of a pre- and post-operative blood salvage device.	19.40	R 350.27
75029	Preparation and operation of an autotransfusion cell washing system.	77.10	R 1 391.63
75031	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 1 113.63
75033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography.	14.60	R 263.70
75034	Lymph compression treatment.	22.50	R 405.94
75116	Preparation and operation of an artificial heart (Berlin-Heart)	219.70	R 3 965.34
75118	Daily monitoring of artificial heart, per hour	33.40	R 602.68
75157	Standby with extra corporeal equipment (maximum 4 hours) (per event).	26.30	R 474.73
2.	**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.		
75035	Nebulisation (per one procedure).	12.30	R 222.00
75037	Measurement of Lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography.	24.20	R 436.68
75039	Flow-volume determinations.	30.60	R 552.16
75041	Flow-volume (Pre-post B-D).	50.80	R 916.89
75043	Airways resistance and conductance measurements using plethysmograph or similar apparatus.	24.20	R 436.68
75045	Gas distribution measurements.	24.20	R 436.68
75047	Diffusion determinations.	24.20	R 436.68
75049	Exercise testing (EIA).	17.10	R 308.73
75050	ECMO change-out and re-establishment.	46.30	R 835.64

75051	Exercise testing with recording of : VT, VO2, HR, RR, ECG and Oximetry	24.20	R 436.68
75053	Allergy tests.	11.40	R 205.88
75055	If RAST included add (per allergen).	11.40	R 205.88
75057	Bronchial provocation testing.	40.80	R 736.44
75059	Compliance measurements.	24.20	R 436.68
75061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR.	6.00	R 108.34
3.	**Cardiology**		
75062	Assist in preparations and operations of Rotablator Procedures	29.90	R 539.70
75063	Cardiac catheterisation for the first hour.	40.30	R 727.47
75065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	10.00	R 180.45
75064	Intravascular Ultrasound (IVUS)	25.70	R 463.93
	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		
75068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	10.00	R 180.45
75066	Cardiac Cath Right Heart Studies	56.00	R 1 010.61
75067	Cardiac Electro physiology and related procedures for first FOUR hours.	67.90	R 1 225.63
75069	Temporary and single Pacemaker procedures.	40.30	R 727.47

Code:	Description:	Units:	Value:
75070	Permanent and dual Pacemaker procedures or implantation and testing of ICD devices.	46.30	R 835.64
	Not to be charged in conjunction with items 063 or 065		R -
75071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time.	10.00	R 180.45
75072	Multisite Pacing (Bi-ventricular pacing)	46.30	R 835.64
75073	Dilatation procedures and stents.	55.40	R 999.98
75074	Wavemap - Measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	10.00	R 180.45
75075	Pacemaker checking and/or reprogramming.	14.00	R 252.74
75077	24 Hour Holter ambulatory monitoring.	55.40	R 999.98
75079	Cardiac exercise stress testing.	29.10	R 525.25
75081	Recording of twelve lead ECG.	7.70	R 138.91
75087	M Mode echocardiogram.	16.60	R 299.76
75089	2D echocardiogram.	29.40	R 530.56
75091	Doppler flow.	32.20	R 582.90
75093	Colour imaging.	32.20	R 582.90
75095	ECG signal averaging (Hi-Res).	53.70	R 969.24
75097	Ambulatory bloodpressure monitoring.	18.60	R 335.65
75099	Vector cardiogram.	55.40	R 999.98
75111	Transoesophageal echocardiogram.	43.10	R 777.98
4.	**Neurology**		
	Preparation, recording and analyses/technical report of:		
75178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	74.10	R 1 337.62
75179	Auditory evoked potentials, full audiological examination, bilateral	74.10	R 1 337.62
75180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	37.11	R 669.81
75181	Somatosensory evoked potentials, unilateral, upper limb	37.11	R 669.81
75182	Somatosensory evoked potentials, unilateral, lower limb	37.11	R 669.81
75115	Additional 2 nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	14.90	R 268.85

75117	Electroretinography (ERG) - unilateral or Electro-oculography (EOG)	43.10	R 777.98
75183	Electronystagmography for spontaneous and positional nystagmus (3253)	24.15	R 435.85
75184	Caloric test done with electronystagmography (3255)	67.57	R 1 219.65
75119	Sleep EEG.	31.40	R 566.79
75185	Overnight polysomnography	264.83	R 4 780.05
75186	Obstructive sleep apnea screening	137.17	R 2 475.85
75187	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 2 488.81
75188	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 4 780.05
75125	Multiple sleep latency test (MSLT)	111.10	R 2 005.27
75127	Overnight CPAP titration.	104.20	R 1 880.81
75132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	17.42	R 314.55
75133	EEG with special activation.	49.40	R 891.64
75135	Electromyography : Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of 5.	14.90	R 268.85
75137	Intra-operative evoked potentials for the 1st hour	55.40	R 999.98
75139	Each additional hour or part thereof provided that such part comprises 50% or more of the time.	37.10	R 669.64
75141	Intra-operative EEG (carotid endarterectomy).	26.30	R 474.73
75143	Transcranial or Carotid Doppler (bilateral).	39.40	R 711.18
5.	**Dialysis**		
75145	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 835.64
75146	Chronic haemodialysis (acetate dialysate)	149.40	R 2 696.51
75148	Chronic haemodialysis (bicarbonate dialysate)	159.60	R 2 880.79
	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		
75147	Peritoneal dialysis, per day	16.80	R 303.25
	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;		
	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.		
75176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period.	1 700.00	R 30 683.73
75177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period.	2 360.00	R 42 596.04
75149	Treatment procedure per 1 hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	33.40	R 602.68
75150	Acute haemodialysis	317.20	R 5 725.19

Code:	Description:	Units:	Value:
	Emergency dialysis treatment in hospital; includes dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to 5 hours treatment time, equipment rental		
75151	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 447.48
75152	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 896.95
75154	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 1 344.60
75156	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 1 792.08
75153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24	16.60	R 299.76
75155	hours) 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 525.25
6.	**Reproductive Health**		
75159	Post Vasectomy semen analysis.	10.00	R 180.45
75161	Complete semen analysis.	31.70	R 571.94

75163	Semen wash for A I.	30.30	R 547.01
75165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	368.70	R 6 654.71
	Cannot be used with items 161, 163, 167 and 169		R -
75167	Ovum and embryo freezing.	131.30	R 2 370.00
75169	Semen freezing.	30.30	R 547.01
7.	**Miscellaneous**		
75171	Travelling per km in excess of 16km (in own car).	0.67	
75173	Equipment hire (By arrangement).		
75175	Medication / Material		
	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS		

Dental Practitioners	
General Dental Practitioners: PR 054 Maxillofacial and Oral Surgery: PR 062; Orthodontics: PR 064 Periodontics: PR 092; Prosthodontics: PR 094	
	I. INTRODUCTION
A.	**ADMINISTRATIVE AND INVOICING RULES**
001	Invoices:
	a. A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.
	b. An invoice shall contain the following particulars: i. The surname and initials of the member; ii. The first name of the patient;iii. The name of the scheme; iv. The membership number of the member; v. The practice number; vi. The date on which every service was rendered; vii. The code number, description and fee/benefit of the procedure or service; viii. The name of the dentist rendering the service; ix. The name of the general dental practitioner/specialist assistant (when applicable); x. The appropriate ICD-10 code(s) for the procedures performed.
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.
002	Cost of direct materials:
	The expenses incurred for direct materials identified in the
	Schedule may be billed in addition to the procedure code.
	These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use Modifier 8025 for handling fee.
003	Dental laboratory services:
	Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code.
	The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by of the dentist and a copy (or the original) shall be filed by the dentist for record purposes.
	Electronic submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 - Dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code
005	8099. Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/Funder may be billed. Use Modifier 8011 with a narrative description. Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.
B.	**GENERAL CODING RULES**
006	The schedule does not prescribe the scope of practice of a particular category of Oral Health Care Provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of Oral Health Care Provider are customary fees, should the procedure or service be rendered by that provider category.
	Specialists are however encouraged to confine their practice to the speciality or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25).
	Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being "by arrangement" until such fees are listed.
007	Procedures not listed in the Dental Schedule
	When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the RPL for medical practitioners may be reported.
	Unlisted procedures. Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 - Unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined "by arrangement" with the patient and/or Funder.
C.	**SERVICES RULES**
008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed.
	The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – Treatment plan completed. Oral diagnosis defined. The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist.
	Treatment plan defined. The treatment plan is the sequential guide for the patient's care as determined by the dentist's guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or maintenance of optimal oral health.
009	Surgery guidelines:
	1. Follow-up care for therapeutic surgical procedures: The fee/benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.
	2. Multiple Procedures (Maxillo-facial and oral surgery): The fee/benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (Modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/benefit for the major operation plus: 75% for the second procedure/operation (Modifier 8009). 50% for the third and subsequent procedures/operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (Modifier 8006).
	3. Assistant Surgeon (Maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 (of the fee of the practitioner performing the procedure (Modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% (of the fee of the practitioner performing the procedure (Modifier 8007). The patient must be informed beforehand that another dentist/specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.

	4. Surgical team (Maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (Modifier 8008).

010	Orthodontic guidelines: 1. The documentation and first invoice to the patient/Funder regarding orthodontic services will include the following information: a. The treatment plan and type of treatment (treatment code number); b. A diagnostic code (ICD-10) and c. An orthodontic payment plan indicating the following: i. The total fee that will be levied for the treatment; ii. The total months of orthodontic treatment (retention period excluded); iii. The initial fee payable by the patient (approximately 20% of the total fee); and iv. The monthly payments of the balance of the fee.
	2. The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and 5 oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).
	3. The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).
	4. When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.
	5. The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.
	6. When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding - when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed. The balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (Orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to motivation.
	7. When an established orthodontic patient requires retreatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (Orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the Fund
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at Court at the request of an advocate or attorney. Use code 8111 (Dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.

D.	MODIFIERS
012	Modifiers should be used with procedures identified throughout the RPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. A service or procedure was performed by more than one practitioner. b. A service or procedure has been increased or reduced. c. Only part of a service was performed. d. An adjunctive service was performed. e. A service or procedure was provided more than once. f. The fee/benefit was altered due to a financial agreement.

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)					
8005	Maximum multiple procedures (same incision) - MFO surgeon					
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)					
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)					
8008	Emergency surgery - after hours (PLU Emergency surgery - after hours (PLUS 25% of the appropriate benefit)S 25% of the					
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)					
8010	Open reduction (PLUS 75% of the appropriate benefit)					
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/FUND)					
8012	Reduced services (benefit MINUS X % as determined by the practitioner)					
8013	Multiple modifiers					
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)					
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)					

E.	EXPLANATIONS
	Tooth identification and designation of areas of the oral cavity:

	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.
	Treatment categories:
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows: • Basic dentistry - designated as (B) in the treatment category column • Advanced dentistry - designated as (A) in the treatment category column • Surgery - designated as (S) in the treatment category column
	Abbreviations used in Dental Coding
	DM Direct Material Column • +D Add fee/benefit for denture • +L Add laboratory fee • +M Add material fee

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	MP Mouth Part Column • M Maxilla/Mandible • Q Quadrant • S Sextant • T Tooth					
	TC Treatment Category Column • A Advanced dentistry • B Basic dentistry • S Surgery					
	II. DENTAL PROCEDURES AND SERVICES					
A.	**DIAGNOSTIC SERVICES**					
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required.					
	CLINICAL ORAL EXAMINATIONS					
	The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented. Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.					
8103	Extensive oral examination – condition focused combined consultation for complex treatment planning	R 696.27	R 696.27	R 696.27	R 696.27	R 696.27
8105	Case presentation – extensive treatment planning Use this code for the presentation of a treatment plan to a patient as a result of an extensive oral examination (Code 8103) and treatment planning (e.g. orthognathic case presentation to the patient and family). This code may not be reported on the same day as the examination or any other procedure	R -	R -	R -	R -	R -
8893	Telephonic/electronic consultation	R -	R -	R -	R -	R -
8894	Consultation without the patient (with family for consent or writing of special reports, or preparation of quotations)	R -	R -	R -	R -	R -
8895	Examination under general anaesthesia	R 636.97	R -	R -	R -	R -
	GENERAL DENTAL PRACTITIONER					
8101	Oral examination	R 570.66	R -	R -	R -	R -
8102	Comprehensive oral examination	R 920.87	R -	R -	R -	R -
8104	Limited oral examination	R 276.24	R -	R -	R -	R -
8189	Re-examination - existing condition	R 276.24	R -	R -	R -	R -
8190	Consultation - second opinion or advice	R 570.66	R -	R -	R -	R -
	MAXILLO FACIAL SURGEON					
8901	Consultation - MFOS	R -	R 726.98	R -	R -	R -
8902	Consultation - MFOS (detailed)	R -	R 1 902.77	R -	R -	R -
	ORTHODONTIST					
	PERIODONTIST/ORAL MEDICINE					
	PROSTHODONTIST					
8501	Consultation - Prosthodontis	R -	R -	R -	R -	R 726.98
8507	Comprehensive consultation - Prosthodontist	R -	R -	R -	R -	R 1 166.94
8506	Detailed consultation - Prosthodontist	R -	R -	R -	R -	R 1 902.77
	ORAL PATHOLOGIST					

	RADIOGRAPHS/DIAGNOSTIC IMAGING					
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders. A complete series of intra-oral radiographs/images for diagnostic purposes is required once per treatment plan only. A second series may be required in exceptional cases e.g., following periodontal surgery. The same applies to panoramic films, where additional films may be required for follow-up/re-evaluation purposes. Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical practice.					
8107	Intraoral radiograph - periapical	R 230.99	R 230.99	R 221.24	R 230.99	R 230.99
8108	Intraoral radiographs - complete series	R 1 787.88	R 1 787.88	R 1 712.36	R 1 787.88	R 1 787.88
8112	Intraoral radiograph - bitewing	R 230.99	R 230.99	R 221.24	R 230.99	R 230.99
8113	Intraoral radiograph - occlusal	R 397.36	R 397.36	R 380.58	R 397.36	R 397.36
8115	Extraoral radiograph - panoramic	R 923.26	R 923.26	R 884.26	R 923.26	R 923.26
8118	Extraoral radiograph - skull/facial bone	R 923.26	R 923.26	R 884.26	R 923.26	R 923.26
8121	Oral and/or facial image (digital/conventional)	R 248.47	R 248.47	R 237.97	R 248.47	R 248.47
8601	Computerised implant planning	R -	R -		R -	R -
8602	Computer Generated Surgical Guide	R -	R -		R -	R -
8483	Cost of CT Scan DICOM conversion	R -	R -		R -	R -
8485	Cost of the production of a computer generated surgical guide using rapid prototyping. Systems using computer generated laboratory techniques (e.g. Med 3-D) can use laboratory technician codes.(8099)	R -	R -		R -	R -
8193	Three-dimensional reconstruction of cone beam volumetric image using existing data (includes multiple images)	R -	R -		R -	R -
8194	CBCT capture and interpretation with limited field of view –less than one whole jaw	R -	R -		R -	R -

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
8195	CBCT capture and interpretation with limited field of view of one full dental arch -mandible	R -	R -		R -	R -
8196	CBCT capture and interpretation with limited field of view of one full dental arch – maxilla without orbits and/or cranium	R -	R -		R -	R -
8199	CBCT capture and interpretation with limited field of view of one full dental arch – maxilla with orbits and/or cranium	R -	R -		R -	R -
8197	CBCT capture and interpretation with limited field of view of both dental arches –without orbits and or cranium	R -	R -		R -	R -
8200	CBCT capture and interpretation with field of view of both dental arches –with orbits and/or cranium	R -	R -		R -	R -
8217	CBCT capture and interpretation for the visualisation of sinuses	R -	R -		R -	R -
8198	CBCT capture and interpretation for TMJ series including two or more exposures.	R -	R -		R -	R -
8205	CBCT image capture with limited field of view –less than one whole jaw	R -	R -		R -	R -
8206	CBCT image capture with limited field of view of one full dental arch -mandible	R -	R -		R -	R -
8207	CBCT image capture with limited field of view of one full dental arch – maxilla without orbits and or cranium	R -	R -		R -	R -
8210	CBCT image capture with limited field of view of one full dental arch – maxilla with orbits and/or cranium	R -	R -		R -	R -
8208	CBCT capture with limited field of view of both dental arches –without orbits and or cranium	R -	R -		R -	R -
8211	CBCT capture with field of view of both dental arches –with orbits and/or cranium	R -	R -		R -	R -
8218	CBCT capture for the visualisation of sinuses	R -	R -		R -	R -
8209	CBCT capture for TMJ series including two or more exposures.	R -	R -		R -	R -
8203	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including the report	R -	R -		R -	R -
8212	Interpretation of diagnostic image by a practitioner associated with capture of the image, including the report	R -	R -		R -	R -

8219	Report by a third party on pathology, implant measurements, endodontics, orthodontic measurements, nerve proximities etc	R -	R -		R -	R -
	OTHER DIAGNOSTIC PROCEDURES					
8117	Diagnostic models	R 248.47	R 248.47	R 248.47	R 248.47	R 248.47
8119	Diagnostic models mounted	R 624.04	R 624.04	R 624.04	R 624.04	R 624.04
8126	Digital Diagnostic Models	R 624.04	R 624.04	R 624.04	R 624.04	R 624.04
8124	Pulp tests	R 68.22	R -	R -	R -	R -
8125	Pulp tests – more than 3 teeth. See Code 8124 for descriptor	R -	R -	R -	R -	R -
8503	Occlusion analysis mounted	R 777.00	R -	R -	R -	R 1 166.94
8505	Pantographic recording	R 1 128.64	R -	R -	R -	R 1 693.56
8508	Electrognathographic recording	R 1 208.59	R -	R -	R -	R 1 812.53
8509	Electrognathographic recording with computer analysis	R 2 006.42	R -	R -	R -	R 3 010.35
8811	Tracing and analysis of extra-oral film	R 107.48	R 107.48	R 107.48	R 107.48	R 107.48
B.	**PREVENTIVE SERVICES**					
	Services/procedures intended to eliminate or reduce the need for future dental treatment.					
	DENTAL PROPHYLAXIS					
8159	Prophylaxis - complete dentition	R 688.68	R -	R -	R 971.37	R 688.68
8160	Removal of gross calculus	R -	R -	R -	R -	R -
8179	Polishing - complete dentition (periodontally compromised patient)	R 402.15	R -	R -	R -	R -
8180	Prophylaxis - complete dentition (periodontally compromised patient)	R 747.80	R -	R -	R -	R -
	TOPICAL FLUORIDE TREATMENT					
	SPACE MAINTENANCE (PASSIVE APPLIANCES)					
	OTHER PREVENTIVE PROCEDURES					
C.	**RESTORATIVE SERVICES**					
	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/ procedures intend to restore the function of a natural tooth. Anterior teeth include incisors and canines. Posterior teeth include premolars and molars. The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved. Limitations on amalgam and resin-based composite restorations: (1) The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the same day and may require the reporting of a MOD restoration instead of a separate MO and DO restoration. (2) The current NHRPL rates include direct pulp capping (code 8301) and rubber dam application (code 8304).					
	AMALGAM RESTORATIONS					
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately. See codes 8345, 8347 and 8348 for post and/or pin retention."					
8341	Amalgam - one surface	R 697.29	R -	R -	R -	R -
8342	Amalgam - two surfaces	R 858.63	R -	R -	R -	R -
8343	Amalgam - three surfaces	R 1 047.26	R -	R -	R -	R -
8344	Amalgam - four or more surfaces	R 1 166.94	R -	R -	R -	R -

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8346	Restorative Material Factor	R -	R -		R -	R -
	RESIN-BASED COMPOSITE RESTORATIONS					
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays" If pins are used, they should be reported in addition to these codes - See codes 8345, 8347 and 8348 for post and/or pin retention."					
8350	Resin crown - anterior primary tooth (direct)	R 1 520.74	R -	R -	R -	R -
8351	Resin - one surface, anterior	R 764.80	R -	R -	R -	R -
8352	Resin - two surfaces, anterior	R 962.76	R -	R -	R -	R -
8353	Resin - three surfaces, anterior	R 1 149.71	R -	R -	R -	R -
8354	Resin - four or more surfaces, anterior	R 1 282.56	R -	R -	R -	R -
8367	Resin - one surface, posterior	R 829.43	R -	R -	R -	R -
8368	Resin - two surfaces, posterior	R 1 026.19	R -	R -	R -	R -

8369	Resin - three surfaces, posterior	R 1 240.19	R -	R -	R -	R -
8370	Resin - four or more surfaces, posterior	R 1 333.78	R -	R -	R -	R -
	INLAY/ONLAY RESTORATIONS					
	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.					
	METAL INLAYS/ONLAYS					
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers. Metal components include structures manufactured by means of conventional casting and/or electroforming. The benefits provided for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.					
8360	Temporary inlay/onlay	R -	R -	R -	R -	R -
8361	Inlay - metal - one surface	R 1 065.21	R -	R -	R -	R 2 099.06
8362	Inlay/onlay - metal - two surfaces	R 1 556.40	R -	R -	R -	R 3 044.10
8363	Inlay/onlay - metal - three surfaces	R 2 595.28	R -	R -	R -	R 4 720.67
8364	Inlay/onlay - metal - four or more surfaces	R 3 138.89	R -	R -	R -	R 4 720.67
	PORCELAIN/CERAMIC INLAYS/ONLAYS					
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers. Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. TO BE CONFIRMED: When computer generated (CADCAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.					
8371	Inlay - porcelain - one surface	R 1 282.56	R -	R -	R -	R 2 535.91
8372	Inlay/onlay - porcelain - two surfaces	R 1 893.68	R -	R -	R -	R 3 651.87
8373	Inlay/onlay - porcelain - three surfaces	R 3 121.42	R -	R -	R -	R 5 673.85
8374	Inlay/onlay - porcelain - four or more surfaces	R 3 780.41	R -	R -	R -	R 5 673.85
	Procedures utilizing computer generated restorations					
	Fabrication of computer generated restorations					
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic restoration by the dental practitioner. This includes the design, milling, and finishing of the resin or ceramic restoration and replace the laboratory codes used when resin or ceramic restorations are made by conventional means in a dental laboratory. The codes 8560 and 8570 are currently used. Please use codes 8519 -8526 for fabrication and 8527 and 8528 for direct cost of material. Code 8304 (isolation of tooth/teeth) may be levied in addition to these codes.					
8519	Fabrication of computer generated 1-3 surface resin or ceramic inlay or onlay	R 1 893.68	R -	R -	R -	R 3 651.87
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic restoration by the dental practitioner. See Code 8527, 8528 for cost of materials. Practitioners will use this code and not the usual laboratory fees (8099)	R -				R -
8520	Fabrication of computer generated 4 or more surface resin or ceramic inlay or onlay	R 3 780.41	R -	R -	R -	R 5 673.85
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic inlay or onlay by the dental practitioner. See Code, 8527, 8528 for cost of materials. Practitioners will use this code and not the usual laboratory fees (8099)	R -	R -	R -	R -	R -
8521	Fabrication of computer generated resin or ceramic crown	R 4 002.07	R -	R -	R -	R 5 892.16
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic crown by the dental practitioner. See Code 8527, 8528 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)	R -	R -	R -	R -	R -
8522	Fabrication of computer generated resin or ceramic crown retainer, per unit as part of bridge framework	R 4 002.07	R -	R -	R -	R 5 892.16
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic crown retainer by the dental practitioner. See Code 8527, 8528 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)	R -	R -	R -	R -	R -
8523	Fabrication of computer generated resin or ceramic pontic, per unit as part of bridge framework	R 4 002.07	R -	R -	R -	R 5 892.16
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic pontic by the dental practitioner. See Code, 8527, 8528 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)	R -	R -	R -	R -	R -
8524	Fabrication of computer generated resin or ceramic veneer for bridge framework, per unit	R 2 687.68	R -	R -	R -	R 4 031.76

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	This procedure involves the fabrication of a computer generated (CAD-CAM) resin or ceramic veneer for bridge framework by the dental practitioner. See code, 8527 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)					

	This procedure involves the fabrication of a computer generated (CAD-CAM) ceramic restoration by the dental practitioner. See Code 8527, 8528 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)					
	This procedure involves the fabrication of a computer generated (CAD-CAM) ceramic restoration by the dental practitioner. See Code 8527, 8528 for the cost of direct materials. Practitioners will use this code and not the usual laboratory fees (8099)					
	Direct cost of materials in the fabrication of computer generated restorations					
8525	Fabrication of computer generated ceramic implant supported restoration, per unit	R -	R -		R -	R -
8526	Fabrication of a computer generated ceramic implant abutment, per unit	R -	R -		R -	R -
8527	Direct Cost of material in the fabrication of computer generated resin restoration.	R -	R -		R -	R -
8528	Direct Cost of material in the fabrication of computer generated ceramic restoration.	R -	R -		R -	R -
8560	Cost of ceramic block	R -	R -		R -	R -
8570	Fabrication of computer generated ceramic restoration	R -	R -		R -	R -
	RESIN-BASED INLAYS/ONLAYS					
	Resin based inlays/onlays usually utilise the indirect technique. Fees for the application of a rubber dam (8304) may be levied in addition to these codes. When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting Modifier 8023 in addition to these codes.					
8381	Inlay - resin - one surface	R 1 282.56	R -	R -	R -	R 2 535.91
8382	Inlay/onlay - resin - two surfaces	R 1 893.68	R -	R -	R -	R 3 651.87
8383	Inlay/onlay - resin - three surfaces	R 3 121.42	R -	R -	R -	R 5 673.85
8384	Inlay/onlay - resin - four or more surfaces	R 3 780.41	R -	R -	R -	R 5 673.85
8385	Fabrication of Indirect resin inlay/onlay restoration	R -	R -		R -	R -
	CROWNS – SINGLE RESTORATIONS					
	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants. Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming. Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations. TO BE CONFIRMED: When computer generated (CADCAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply.					
8400	Report codes 8570 (Fabrication of computer generated ceramic restoration) and 8560 for restTemporary crown	R -	R -	R -	R -	R -
8401	Crown - full cast metal	R 4 002.07	R -	R -	R -	R 5 892.16
8403	Crown - 3/4 cast metal	R 4 002.07	R -	R -	R -	R 5 892.16
8404	Crown - 3/4 porcelain/ceramic	R 3 779.94	R -	R -	R -	R 5 673.85
8405	Crown - resin laboratory	R 3 779.94	R -	R -	R -	R 5 673.85
8406	Crown – three-quarter resin (indirect)	R -	R -	R -	R -	R -
8407	Crown - resin with metal	R 4 002.07	R -	R -	R -	R 5 892.16
8409	Crown - porcelain/ceramic	R 4 002.07	R -	R -	R -	R 5 892.16
8411	Crown - porcelain with metal	R 4 002.07	R -	R -	R -	R 5 892.16
8410	Provisional crown	R 777.00	R -	R -	R 777.00	R 1 166.94
	VENEERS					
	TEMPORARY RESTORATIONS					
8137	Emergency crown (chair-side)	R 1 201.41	R -	R -	R -	R 1 201.41
8357	Prefabricated metal crown	R 714.77	R -	R -	R -	R 714.77
8480	Cost of Prefabricated metal restoration	R -	R -	R -	R -	R -
8375	Prefabricated resin crown	R 714.77	R -	R -	R -	R 714.77
8481	Cost of prefabricated resin crown	R -	R -	R -	R -	R -
8380	Cost of Prefabricated non metal restoration	R -	R -	R -	R -	R -
	OTHER RESTORATIVE PROCEDURES					
	Pin Retention and Cores					
8345	Prefabricated post retention, per post (in addition to restoration)	R 688.68	R -	R -	R -	R -
8347	Pin retention - first pin (in addition to restoration)	R 345.89	R -	R -	R -	R -
8348	Pin retention - each additional pin (in addition to restoration)	R 320.52	R -	R -	R -	R -
8366	Pin retention as part of cast restoration (any number of pins)	R 517.52	R -	R -	R -	R 701.60
8376	Core build-up with prefabricated posts	R 1 906.36	R -	R -	R -	R 1 906.36
8379	Cost of prefabricated posts	R -	R -	R -	R -	R -
8391	Cast core with single post	R 804.29	R -	R -	R -	R -

8392	Cast post (each additional)	R	478.75	R	-	R	-	R	-
8397	Cast core with pins (any number of pins)	R	1 282.56	R	-	R	-	R	1 667.47
8396	Coping – metal	R	522.07	R	-	R	-	R	974.97
8398	Core build-up with or without pins	R	1 556.40	R	-	R	-	R	1 556.40
8581	Cast core with single post	R	-	R	-	R	-	R	1 188.25
8582	Cast core with double post	R	-	R	-	R	-	R	1 693.56
8583	Cast core with triple post	R	-	R	-	R	-	R	2 099.06

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	UNCLASSIFIED RESTORATIVE PROCEDURES					
8133	Recement inlay, onlay, crown or veneer	R 349.96	R -	R -	R -	R 444.28
8142	Recement inlay/onlay/veneer	R 349.96	R -	R -	R -	R 444.28
8134	Recement cast core or post	R 349.96	R -	R -	R -	R 444.28
8135	Remove inlay, onlay or crown R	R 697.29	R -	R -	R -	R 697.29
8156	Removal of inlay/onlay/Veneer	R 697.29	R -	R -	R -	R 697.29
8138	Remove retention post (prefabricated or cast)	R 456.72	R -	R -	R -	R -
8146	Resin bonding for restorations	R -	R -	R -	R -	R -
8228	ART restorations	R -	R -	R -	R -	R -
8157	Re-burnishing and polishing of restorations - complete dentition	R 349.96	R -	R -	R -	R -
8349	Carve restoration to accommodate existing removable prosthesis	R 141.23	R -	R -	R -	R -
8413	Repair crown (permanent or provisional)	R 777.00	R -	R -	R -	R 777.00
8414	Additional fee for provision of crown within an existing clasp or rest	R 230.99	R -	R -	R -	R -
D.	**ENDODONTIC SERVICES**					
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.					
	PULP CAPPING					
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.					
8301	Pulp cap - direct	R 466.30	R -	R -	R -	R -
8303	Pulp cap - indirect	R 466.30	R -	R -	R -	R -
	PULPOTOMY	R -	R -	R -	R -	R -
8307	Pulp amputation (pulpotomy)	R 456.72	R -	R -	R -	R -
8132	Pulp removal (pulpectomy)	R 572.82	R -	R -	R -	R -
	ENDODONTIC THERAPY					
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report code 8304 (application of a rubber dam) in addition to these codes.					
	PREPARATORY VISITS					
8332	Root canal preparatory visit - single canal tooth	R 349.96	R -	R -	R -	R -
8333	Root canal preparatory visit - multi canal tooth	R 490.95	R -	R -	R -	R -
8317	Root canal preparation, each additional canal	R 650.14	R -	R -	R -	R -
	Preparation of the canal. May require further appointments to prepare the canal. Obturation is done in a subsequent appointment.	R -	R -		R -	R -
8318	Irrigation and medication per tooth at a separate visit	R 140.03	R -	R -	R -	R -
	OBTUATION OF CANALS					
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).					
8335	Root canal obturation - anteriors and premolars - first canal	R 1 590.39	R -	R -	R -	R -
8328	Root canal obturation - anteriors and premolars - each additional canal	R 650.14	R -	R -	R -	R -
8336	Root canal obturation - posteriors - first canal	R 2 188.82	R -	R -	R -	R -
8337	Root canal obturation - posteriors - each additional canal	R 650.14	R -	R -	R -	R -
	COMPLETE THERAPY					
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).					
8338	Root canal therapy - anteriors and premolars - first canal	R 2 433.70	R -	R -	R -	R -

8329	Root canal therapy - anteriors and premolars - each additional canal	R	812.19	R	-	R	-	R	-	R	-
8339	Root canal therapy - posteriors - first canal	R	3 343.32	R	-	R	-	R	-	R	-
8340	Root canal therapy - posteriors - each additional canal	R	812.19	R	-	R	-	R	-	R	-
8631	Root canal therapy - first canal	R	-	R	-	R	-	R	-	R	4 130.14
8633	Root canal therapy - each additional canal	R	-	R	-	R	-	R	-	R	1 038.88
8639	Endodontic instruments per patient per completed treatment	R	-	R	-			R	-	R	-
	ENDODONTIC RETREATMENT										
8334	Re-preparation of previously obturated root canal	R	517.52	R	-	R	-	R	-	R	624.04
8323	Retreatment of previously completed root canal therapy, each additional canal – anterior or premolar"	R	517.52	R	-	R	-	R	-	R	624.04
8324	Retreatment of previously completed root canal therapy, each additional canal – molar	R	517.52	R	-	R	-	R	-	R	624.04
	APEXIFICATION/RECALCIFICATION PROCEDURES										
8634	Apexification/ apexogenesis /revascularisation - initial visit	R	466.30	R	-	R	-	R	-	R	688.68
8635	Apexification/recalcification – per visit	R	466.30	R	-	R	-	R	-	R	688.68
	PERIRADICULAR PROCEDURES										
9015	Apicectomy - anteriors (including retrograde filling)	R	1 728.27	R	2 291.28	R	-	R	2 291.28	R	2 291.28
8637	Apicectomy/ periradicular surgery, first root – premolar	R	2 073.93	R	2 749.67	R	-	R	2 749.67	R	2 749.67
8638	Apicectomy/ periradicular surgery, each additional root – anteriors and premolars	R	864.14	R	1 145.64	R	-	R	1 145.64	R	1 145.64
9016	Apicectomy - posteriors (including retrograde filling)	R	3 046.98	R	4 571.54	R	-	R	4 571.54	R	4 571.54
8642	Apicectomy/ periradicular surgery, each additional root – molars	R	3 046.98	R	4 571.54	R	-	R	4 571.54	R	4 571.54

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	OTHER ENDODONTIC PROCEDURES					
8330	Removal of root canal obstruction	R 456.72	R -	R -	R -	R -
8331	Repair of perforation defects	R 456.72	R -	R -	R -	R -
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	R 312.62	R -	R -	R -	R -
8640	Removal of fractured post or instrument from root canal	R -	R -	R -	R -	R 1 214.34
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	R 1 528.16	R -	R -	R 2 291.28	R 2 291.28
8792	Vestibuloplasty with teeth per sextant	R 8 384.03	R 12 576.88	R -	R 12 576.88	R -
8793	Vestibuloplasty in an edentulous area per sextant	R 6 986.81	R 10 480.70	R -	R 10 480.70	R -
8794	Alveoplasty with implant therapy 1-3 teeth	R -	R -	R -	R -	R -
8795	Alveoplasty with implant therapy 4 or more teeth	R -	R -	R -	R -	R -
8796	Repair of oronasal opening	R 3 548.94	R 5 323.65	R -	R -	R -
E.	**PERIODONTIC SERVICES**					
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.					
	SURGICAL SERVICES					
	Surgical services includes usual postoperative care.					
	NON-SURGICAL PERIODONTAL SERVICES					
8723	Provisional splinting - extracoronal (wire) - per sextant	R 650.14	R -	R -	R 974.97	R 974.97
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	R 944.09	R -	R -	R 1 414.93	R 1 414.93
8727	Provisional splinting - intracoronal - per tooth	R 296.34	R -	R -	R 444.28	R 444.28
F.	**REMOVABLE PROSTHODONTICS**					
	"The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable. Removable prosthodontic services include routine postoperative care."					
	COMPLETE DENTURES					
8231	Complete dentures - maxillary and mandibular	R 5 652.55	R -	R -	R -	R 11 801.32
8232	Complete denture - maxillary or mandibular	R 3 484.79	R -	R -	R -	R 8 256.68
8244	Immediate denture - maxillary	R 3 484.79	R -	R -	R -	R 5 227.42
8245	Immediate denture - mandibular	R 3 484.79	R -	R -	R -	R 5 227.42

8246	Immediate denture – Partial	R 2 439.21	R -	R -	R -	R 3 659.29
8643	Complete dentures - maxillary and mandibular (with major complications)	R -	R -	R -	R -	R 15 315.55
8646	Immediate denture – maxillary or mandibular Only for Prosthodontist	R -	R -	R -	R -	R 8 677.74
8647	Immediate denture – maxillary or mandibular (with major complications) Only for Prosthodontist	R 5 784.68	R -	R -	R -	R 8 677.74
8649	Complete denture - maxillary or mandibular (with complications)	R 5 784.68	R -	R -	R -	R 9 423.39
8651	Complete denture - maxillary or mandibular (with major complications)	R -	R -	R -	R -	R 10 599.43
	PARTIAL DENTURES					
8233	Partial denture - resin base - one tooth	R 1 620.31	R -	R -	R -	R -
8234	Partial denture - resin base - two teeth	R 1 620.31	R -	R -	R -	R -
8235	Partial denture - resin base - three teeth	R 2 424.61	R -	R -	R -	R -
8236	Partial denture - resin base - four teeth	R 2 424.61	R -	R -	R -	R -
8237	Partial denture - resin base - five teeth	R 2 424.61	R -	R -	R -	R -
8238	Partial denture - resin base - six teeth	R 3 215.97	R -	R -	R -	R -
8239	Partial denture - resin base - seven teeth	R 3 215.97	R -	R -	R -	R -
8240	Partial denture - resin base - eight teeth	R 3 215.97	R -	R -	R -	R -
8241	Partial denture - resin base - nine or more teeth	R 3 215.97	R -	R -	R -	R -
8281	Partial denture - cast metal framework only	R 3 780.41	R -	R -	R -	R -
8283	Partial denture – Flexidenture framework	R -	R -	R -	R -	R -
8284	Full denture –Flexidenture framework	R -	R -	R -	R -	R -
8671	Partial denture - cast metal framework with resin denture base	R -	R -	R -	R -	R 9 423.39
	ADJUSTMENTS TO DENTURES					
8275	Adjust complete or partial denture	R 256.37	R -	R -	R -	R 256.37
8662	Adjust complete or partial dentures (remounting)	R 907.22	R -	R -	R -	R 1 360.36
	REPAIRS TO DENTURES					
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.					
8269	Repair denture or other intra-oral appliance	R 444.28	R -	R -	R -	R 478.75
8270	Add clasp to existing partial denture	R 320.52	R -	R -	R -	R -
8271	Add tooth to existing partial denture	R 320.52	R -	R -	R -	R -
8273	Impression to repair or modify a denture or other intra-oral appliance	R 256.37	R -	R -	R -	R 256.37
	DENTURE REBASE PROCEDURES					
	Rebase – The partial or complete removal and replacement of the denture base.					
8259	Rebase complete or partial denture (laboratory)	R 1 321.10	R -	R -	R -	R 1 906.36
8261	Remodel complete or partial denture	R 2 121.08	R -	R -	R -	R -

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	DENTURE RELINE PROCEDURES					
	Reline - The addition of material to the fitting surface of a denture base.	R -	R -	R -	R -	R -
8263	Reline complete or partial denture (chair-side)	R 838.52	R -	R -	R -	R 1 047.26
8267	Reline complete or partial denture (laboratory)	R 1 928.87	R -	R -	R -	R 1 928.87
	INTERIM DENTURES					
	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.					
8658	Interim complete denture	R 3 484.79	R -	R -	R -	R 5 226.94
8659	Interim partial denture	R 2 787.26	R -	R -	R -	R 4 182.08
8661	Diagnostic dentures (including tissue conditioning)	R -	R -	R -	R -	R 9 423.39
	OTHER REMOVABLE PROSTHETIC PROCEDURES					
8251	Clasp or rest - cast gold	R 320.52	R -	R -	R -	R -
8253	Clasp or rest - wrought gold	R 320.52	R -	R -	R -	R -
8255	Clasp or rest - stainless steel	R 337.75	R -	R -	R -	R -
8257	Bar - lingual or palatal	R 397.36	R -	R -	R -	R -
8265	Tissues conditioning per arch (including soft self-cure reline)	R 547.68	R -	R -	R -	R 701.60

8277	Inlay in denture	R	-	R	-	R	-	R	-	R	-
8597	Locks and milled rests	R	319.32	R	-	R	-	R	-	R	478.75
8599	Precision attachment (removable denture)	R	777.00	R	-	R	-	R	-	R	1 166.94
8652	Overdenture - complete	R	6 282.34	R	-	R	-	R	-	R	9 423.39
8653	Overdenture - partial	R	5 026.11	R	-	R	-	R	-	R	7 539.28
8657	Replacement of precision attachment	R	444.28	R	-	R	-	R	-	R	478.75
8663	Metal base to complete denture	R	1 892.48	R	-	R	-	R	-	R	2 838.72
8664	Remount crown or bridge for prosthetics	R	907.22	R	-	R	-	R	-	R	1 420.68
8667	Soft base to denture (heat cured)	R	1 892.48	R	-	R	-	R	-	R	2 838.72
8672	Altered cast technique (in addition to partial denture)	R	242.48	R	-	R	-	R	-	R	363.61
8674	Additive partial denture	R	2 850.45	R	-	R	-	R	-	R	4 276.15
G.	**MAXILLO-FACIAL PROSTHETICS**										
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect. Where "+D" appears the practitioner will charge the relevant fee/benefit for the dentures in the Schedule plus the fee/benefit indicated										
9196	Planning for Craniofacial Reconstruction – Simple	R	1 641.86	R	2 462.91	R	2 358.88	R	-	R	-
9197	Planning for Craniofacial Reconstruction – Complex	R	25 379.26	R	-	R	36 460.27	R	-	R	-
	MAXILLIARY PROSTHESIS										
9101	Obturator prosthesis, surgical - modified denture	R	467.97	R	-	R	-	R	-	R	701.60
9102	Obturator prosthesis, surgical - continuous base	R	1 268.44	R	-	R	-	R	-	R	1 902.77
9103	Obturator prosthesis, surgical - split base	R	1 889.61	R	-	R	-	R	-	R	2 834.89
9104	Obturator prosthesis, interim - on existing denture	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9105	Obturator prosthesis, interim - on new denture	R	8 802.93	R	-	R	-	R	-	R	13 204.04
9106	Obturator prosthesis, definitive - open/hollow box	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9107	Obturator prosthesis, definitive - silicone glove	R	5 504.62	R	-	R	-	R	-	R	8 256.68
	Obturator prosthesis modification	R	-	R	-	R	-	R	-	R	-
8685	Modification of obturator prostheses per visit	R	319.32	R	-	R	-	R	-	R	478.75
	MANDIBULAR RESECTION PROSTHESES										
9108	Mandibular resection prosthesis w/ guide flange	R	6 761.56	R	-	R	-	R	-	R	10 142.46
9109	Mandibular resection prosthesis w/o guide flange	R	6 282.34	R	-	R	-	R	-	R	9 423.39
9110	Mandibular resection prosthesis, palatal augmentation	R	1 268.44	R	-	R	-	R	-	R	1 902.77
	INTERMEDIATE/DEFINITIVE PROSTHESES										
9125	Speech aid/obturator prosthesis - palatal alteration	R	1 271.55	R	-	R	-	R	-	R	1 906.36
9126	Speech aid/obturator prosthesis - velar alteration	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9127	Speech aid/obturator prosthesis - pharyngeal alteration	R	6 282.34	R	-	R	-	R	-	R	9 423.39
9128	Speech aid/obturator prosthesis - modification	R	319.32	R	-	R	-	R	-	R	478.75
9129	Speech aid/obturator prosthesis - surgical	R	2 522.99	R	-	R	-	R	-	R	3 784.96
	SPEECH APPLIANCES										
9130	Speech aid appliance - palatal lift	R	1 268.44	R	-	R	-	R	-	R	1 902.77
9131	Speech aid appliance - palatal stimulating	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9132	Speech aid appliance - bulb	R	6 282.34	R	-	R	-	R	-	R	9 423.39
9133	Speech aid appliance - modification	R	319.32	R	-	R	-	R	-	R	478.75
9134	Unspecified speech aid appliance	R	-	R	-			R	-	R	-
	EXTRA-ORAL APPLIANCES										
9135	Auricular prosthesis - simple	R	7 867.46	R	-	R	-	R	-	R	11 801.32
9136	Auricular prosthesis - complex	R	10 265.02	R	-	R	-	R	-	R	15 315.55
9137	Nasal prosthesis - simple	R	7 867.46	R	-	R	-	R	-	R	11 801.32
9138	Nasal prosthesis - complex	R	10 265.02	R	-	R	-	R	-	R	15 315.55
9139	Ocular prosthesis - interim	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9140	Ocular prosthesis - modified stock appliance	R	7 072.27	R	-	R	-	R	-	R	10 608.76
9141	Ocular prosthesis - custom appliance	R	10 265.02	R	-	R	-	R	-	R	15 315.55
9142	Orbital prosthesis - simple	R	7 072.27	R	-	R	-	R	-	R	10 608.76
9143	Orbital prosthesis - complex	R	10 265.02	R	-	R	-	R	-	R	15 315.55
9144	Facial prosthesis, combination - small	R	-	R	-	R	-	R	-	R	-

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)

9145	Facial prosthesis, combination - medium	R	-	R	-	R	-	R	-	R	-
9146	Facial prosthesis, combination - large	R	-	R	-	R	-	R	-	R	-
9147	Facial prosthesis, combination - complex	R	-	R	-	R	-	R	-	R	-
9148	Unspecified body prosthesis - simple	R	7 072.27	R	-	R	-	R	-	R	10 608.76
9149	Unspecified body prosthesis - complex	R	10 265.02	R	-	R	-	R	-	R	15 315.55
9150	Facial prosthesis, surgical - simple	R	5 504.62	R	-	R	-	R	-	R	8 256.68
9151	Facial prosthesis, surgical - complex	R	7 072.27	R	-	R	-	R	-	R	10 608.76
9152	Extraoral appliance - additional prosthesis	R	-	R	-	R	-	R	-	R	-
9153	Extraoral appliance - replacement prosthesis	R	-	R	-	R	-	R	-	R	-
9155	Cranial prosthesis	R	2 850.45	R	-	R	-	R	-	R	4 276.15
	CUSTOM IMPLANTS										
9156	Cranial implant prosthesis, custom made	R	3 441.22	R	-	R	-	R	-	R	5 160.64
9157	Facial implant prosthesis, custom made - simple	R	1 718.94	R	-	R	-	R	-	R	2 577.33
9158	Facial implant prosthesis, custom made - complex	R	3 441.22	R	-	R	-	R	-	R	5 160.64
9159	Ocular implant prosthesis, custom made	R	1 718.94	R	-	R	-	R	-	R	2 577.33
9160	Body implant prosthesis - custom made	R	7 651.07	R	-	R	-	R	-	R	11 476.49
	SURGICAL APPLIANCES										
9154	Cost of Surgical Splint	R	-	R	-	R	-	R	-	R	-
9161	Surgical splint - simple	R	777.00	R	-	R	-	R	-	R	1 166.94
9162	Surgical splint - complex	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9163	Surgical template - simple	R	777.00	R	-	R	-	R	-	R	1 166.94
9164	Surgical template - complex	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9165	Surgical conformer - simple	R	777.00	R	-	R	-	R	-	R	1 166.94
9166	Surgical conformer - complex	R	2 850.45	R	-	R	-	R	-	R	4 276.15
	TRISMUS APPLIANCES										
9167	Trismus appliance (simple)	R	319.32	R	-	R	-	R	-	R	478.75
9168	Trismus appliance (complex)	R	2 850.45	R	-	R	-	R	-	R	4 276.15
9169	Orthoses appliance	R	6 282.34	R	-	R	-	R	-	R	9 423.39
9170	Facial palsy appliance	R	1 889.61	R	-	R	-	R	-	R	2 834.89
9171	Commissure splint	R	777.00	R	-	R	-	R	-	R	1 166.94
9172	Oral retractor, dynamic - per arm	R	777.00	R	-	R	-	R	-	R	1 166.94
9173	Hand splint	R	-	R	-	R	-	R	-	R	-
9174	Unspecified burn appliance	R	-	R	-	R	-	R	-	R	-
	ATTENDANCE IN THEATRE										
9175	Theatre attendance (MaxFac prosthod) /hour	R	1 051.09	R	-	R	-	R	-	R	1 578.18
H.	**IMPLANT SERVICES**										
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.										
	SURGICAL IMPLANT PROCEDURES										
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.										
9180	Surgical placement of sub-periosteal implant - preparatory stage	R	4 612.23	R	6 919.55	R	-	R	-	R	-
9181	Surgical placement of sub-periosteal implant - placement stage	R	4 612.23	R	6 919.55	R	-	R	-	R	-
9182	Surgical placement of endosteal implant plate	R	2 308.99	R	3 463.48	R	-	R	3 463.48	R	-
8216	CBCT of plaster models or impressions for the purpose of creating virtual models for use in planning software	R	-	R	-	R	-	R	-	R	-
9183	Surgical placement of endosteal implant - first per jaw	R	3 249.25	R	4 417.15	R	-	R	4 417.15	R	-
9184	Surgical placement of endosteal implant - second per jaw	R	2 433.70	R	3 313.64	R	-	R	3 313.64	R	-
9185	Surgical placement of endosteal implant - third and subsequent per jaw	R	1 628.69	R	2 219.70	R	-	R	2 219.70	R	-
9190	Surgical placement of abutment - first per jaw	R	1 205.72	R	1 632.04	R	-	R	1 632.04	R	1 632.04
9191	Surgical placement of abutment - second per jaw	R	906.27	R	1 227.74	R	-	R	1 227.74	R	1 227.74
9192	Surgical placement of abutment - third and subsequent per jaw	R	606.81	R	825.84	R	-	R	825.84	R	825.84
	IMPLANT SUPPORTED PROSTHETICS										
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.										
	ABUTMENTS AND BARS										

	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g., healing abutments/collars, temporary abutments, caps, cylinders, etc.Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant. See Codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.					
8584	Connector bar - implant supported	R 6 282.34	R -	R -	R -	R 9 423.39
8669	Crown cemented on a screw-retained implant-supported superstructure.	R 650.14	R -	R -	R -	R 974.97
8578	Prefabricated abutment	R 2 964.15	R -	R -	R -	R 4 447.07
8579	Custom abutment	R -	R -	R -	R -	R -
8580	Modification of prefabricated abutment	R -	R -	R -	R -	R -

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
	REMOVABLE DENTURES					
8533	Implant supported removable complete overdenture	R 6 282.34	R -	R -	R -	R 9 423.39
8534	Implant supported removable partial overdenture	R 5 026.11	R -	R -	R -	R 7 539.28
8654	Implant supported fixed-detachable complete overdenture	R 7 066.76	R -	R -	R -	R 10 599.43
8550	Retainer-Implant/Abutment Supported	R -	R -	R -	R -	R -
8655	Implant supported fixed-detachable partial overdenture	R 5 652.79	R -	R -	R -	R 7 263.53
8660	Additional fee to implant supported fixed-detachable denture - per implant	R 974.97	R -	R -	R -	R 974.97
	CROWNS - SINGLE RESTORATIONS					
8536	Crown - implant/abutment supported - porcelain/ceramic	R 5 195.11	R -	R -	R -	R 6 871.19
8537	Crown - implant/abutment supported - porcelain with metal	R 5 195.11	R -	R -	R -	R 6 871.19
8538	Crown - implant/abutment supported - cast metal	R 5 195.11	R -	R -	R -	R 6 871.19
8539	Crown-Implant / abutment supported crown – resin veneered to metal	R -	R -	R -	R -	R -
8541	Implant supported temporary crown – cemented	R -	R -	R -	R -	R -
8542	Implant supported temporary crown – screw retained	R -	R -	R -	R -	R -
8543	Implant supported provisional crown – cemented	R -	R -	R -	R -	R -
8544	Implant supported provisional crown – screw retained	R -	R -	R -	R -	R -
8592	Crown - implant/abutment supported	R -	R -	R -	R -	R 6 871.19
	BRIDGE RETAINERS - CROWNS					
8546	Crown retainer - implant/abutment supported - porcelain/ ceramic	R 5 195.11	R -	R -	R -	R 6 871.19
8547	Crown retainer - implant/abutment supported - porcelain with metal	R 5 195.11	R -	R -	R -	R 6 871.19
8548	Crown retainer - implant/abutment supported - cast metal	R 5 195.11	R -	R -	R -	R 6 871.19
8549	Implant supported crown retainer – resin veneered to metal	R -	R -	R -	R -	R -
8571	Implant supported temporary retainer – cemented	R -	R -	R -	R -	R -
8572	Implant supported temporary crown retainer – screw retained	R -	R -	R -	R -	R -
8573	Implant supported provisional crown retainer – cemented	R -	R -	R -	R -	R -
8574	Implant supported provisional crown retainer – screw retained	R -	R -	R -	R -	R -
	OTHER IMPLANT SERVICES					
8665	Mini screw implants	R -	R -	R -	R -	R -
8666	Immediate loading of implant	R -	R -	R -	R -	R -
8668	Metal base for implant supported denture - complete	R -	R -	R -	R -	R -
8621	Metal base for implant supported denture – Partial	R -	R -	R -	R -	R -
8670	Implant screw access closure	R -	R -	R -	R -	R -
8590	Implant maintenance procedures - per implant	R 287.73	R -	R -	R -	R 431.83
8591	Removal of implant supported prosthesis	R -	R -	R -	R -	R -
8593	Repair of implant supported resin prosthesis	R -	R -	R -	R -	R -
8594	Repair of implant supported prosthesis	R 319.32	R -	R -	R -	R 478.75
8595	Repair of implant abutment	R 319.32	R -	R -	R -	R 478.75
8596	Repair of implant supported ceramic or ceramometal crown, retainer or pontic	R -	R -	R -	R -	R -
8598	Repair of implant supported Provisional Prosthesis	R -	R -	R -	R -	R -
8600	Cost of implant components	R -	R -	R -	R -	R -
9187	Cost of endosteal implant body	R -	R -	R -	R -	R -
9188	Cost of prefabricated abutment	R -	R -	R -	R -	R -
9189	Cost of other implant compnts	R -	R -	R -	R -	R -
9193	Report as an additional code for the placement of endosseus implant into fresh extraction socket	R -	R -	R -	R -	R -
9194	Surgical placement of one-piece trans mucosal endosseus implant	R -	R -	R -	R -	R -

9195	Additional code for the surgical placement of single phase endosseus implant	R -	R -	R -	R -	R -
8607	Skeletal anchorage - screw, plate or implant	R -	R -	R -	R -	R -
8608	Removal of non-integrated implant	R -	R -	R -	R -	R -
8609	Flap operation with modification of the implant surface, including bone surgery-one to three implants per quadrant	R -	R -	R -	R -	R -
8610	Flap operation with modification of the implant surface, including bone surgery-four or more implants per quadrant	R -	R -	R -	R -	R -
8612	Skeletal anchorage - removal	R -	R -	R -	R -	R -
9198	Surgical removal of implant	R 1 501.82	R 2 253.22	R -	R 2 253.22	R -
I.	**FIXED PROSTHODONTICS**					
	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable. A prosthetic retainer (e.g., crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge. Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics. Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.					
	PONTICS					
	Comment: Codes 8415, 8416, 8417and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.					
8415	Pontic - porcelain/ceramic	R 3 266.72	R -	R -	R -	R -
8416	Pontic - resin with metal	R 2 595.28	R -	R -	R -	R -

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
8418	Pontic - porcelain fused to metal	R 3 266.72	R -	R -	R -	R -
8419	Provisional pontic	R 777.00	R -	R -	R -	R 1 166.94
8420	Pontic – resin based composite (indirect)	R -	R -	R -	R -	R -
8423	Ovate pontic design	R -	R -	R -	R -	R -
8611	Pontic - sanitary	R -	R -	R -	R -	R 3 561.39
8613	Pontic - posterior	R -	R -	R -	R -	R 4 357.78
8615	Pontic - anterior/premolar	R -	R -	R -	R -	R 4 707.98
8421	Temporary pontic	R -	R -	R -	R -	R -
	BRIDGE RETAINERS – INLAYS/ONLAYS					
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlayed to be considered an onlay. See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.					
8431	Temporary inlay/onlay retainer Emergency inlay/onlay retainer. An emergency inlay/onlay retainer temporary is a custom made retainer to maintain the space and tissue until the definitive prosthesis can be placed. This code is to be used when the patient has to have a prosthesis fabricated as an emergency when the previous definitive prosthesis has failed and cannot be recemented.	R -	R -	R -	R -	R -
8432	Inlay/onlay retainer - metal - two surfaces	R 1 556.40	R -	R -	R -	R 3 044.10
8433	Inlay/onlay retainer - metal - three surfaces	R 2 595.28	R -	R -	R -	R 4 720.67
8434	Inlay/onlay retainer - metal - four or more surfaces	R 3 138.89	R -	R -	R -	R 4 720.67
8436	Inlay/onlay retainer - porcelain - two surfaces	R 1 893.68	R -	R -	R -	R 3 651.87
8437	Inlay/onlay retainer - porcelain - three surfaces	R 3 121.42	R -	R -	R -	R 5 673.85
8438	Inlay/onlay retainer - porcelain - four or more surfaces	R 3 780.41	R -	R -	R -	R 5 673.85
8617	Retainer cast metal (Maryland type retainer)	R 1 556.40	R -	R -	R -	R 3 044.10
8618	Retainer – ceramic for resin bonded bridge	R -	R -		R -	R -
	BRIDGE RETAINERS – CROWNS					
	A crown retainer for a bridge that gains retention, support and stability from a tooth.					
8440	Temporary crown retainer	R -	R -		R -	R -
8441	Crown retainer - full cast metal	R 4 002.07	R -	R -	R -	R 5 892.16
8442	Crown retainer - 3/4 cast metal	R 4 002.07	R -	R -	R -	R 5 892.16
8443	Crown retainer - porcelain/ceramic	R 4 002.07	R -	R -	R -	R 5 892.16
8444	Crown retainer - 3/4 porcelain/ceramic	R 4 002.07	R -	R -	R -	R 5 892.16
8445	Crown retainer - porcelain with metal	R 4 002.07	R -	R -	R -	R 5 892.16
8446	Crown retainer - resin with metal	R 4 002.07	R -	R -	R -	R 5 892.16
8448	Crown retainer – resin based composite (indirect)	R -	R -	R -	R -	R -
8447	Provisional crown retainer	R 777.00	R -	R -	R -	R 1 166.94

	OTHER FIXED PROSTHODONTIC PROCEDURES					
	See "other restorative services" for procedures related to fixed prosthesis not listed in this sub-section.					
8514	Recement bridge	R 349.96	R -	R -	R -	R 444.28
8515	Sectioning of a bridge	R 697.29	R -	R -	R -	R 697.29
8516	Remove bridge	R 697.29	R -	R -	R -	R 697.29
8518	Repair bridge	R 777.00	R -	R -	R -	R 777.00
8585	Connector bar	R 6 282.34	R -	R -	R -	R 9 423.39
8586	Stress breaker	R 2 343.22	R -	R -	R -	R 3 514.71
8587	Coping metal	R 522.07	R -	R -	R -	R 974.97
J.	**ORAL AND MAXILLO-FACIAL SURGERY**					
	The branch of dentistry using surgery to treat disorders/ diseases of the mouth. Surgical procedures include routine postoperative care.					
	EXTRACTIONS					
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	R 349.96	R 525.66	R -	R -	R -
8202	Extraction - each additional tooth or exposed tooth roots	R 141.23	R 212.08	R -	R -	R -
8204	Minimally traumatic tooth/root removal	R -	R -		R -	R -
	SURGICAL EXTRACTIONS					
	Report code 8220 when sutures are provided by the practitioner.					
8213	Surgical removal of residual roots, first tooth - per tooth	R 1 514.03	R -	R -	R -	R -
8214	Surgical removal of residual roots, second and subsequent teeth's roots	R 1 166.94	R -	R -	R -	R -
8937	Surgical removal of tooth	R 1 514.03	R 2 043.53	R -	R -	R -
8941	Surgical removal of impacted tooth - first tooth	R 2 510.06	R 3 301.43	R -	R -	R -
8943	Surgical removal of impacted tooth - second tooth	R 1 346.47	R 1 778.30	R -	R -	R -
8945	Surgical removal of impacted tooth - third and subsequent teeth	R 764.80	R 1 009.20	R -	R -	R -
8953	Surgical removal of residual roots, first tooth - per tooth	R -	R 2 043.53	R -	R -	R -
	DISTRACTION OSTEOGENESIS					
9067	Distraction osteogenesis – across one to two tooth sites	R 6 781.19	R 10 171.67	R -	R -	R -
9068	Distraction of the alveolar ridge -across three to five tooth sites	R 6 781.19	R 10 171.67	R -	R -	R -
9070	Distraction of the alveolar ridge -full arch	R 6 781.19	R 10 171.67	R -	R -	R -
9073	Distraction for the reconstruction of the mandibular body (per side)	R 6 781.19	R 10 171.67	R -	R -	R -
9078	Distraction for the reconstruction of the mandibular condyle and tempero-mandibular joint	R 6 781.19	R 10 171.67	R -	R -	R -
9080	Distraction for the reconstruction of the midface (internal distractor)	R 6 781.19	R 10 171.67	R -	R -	R -

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
9082	Distraction for the reconstruction of the midface (external distractor)	R 6 781.19	R 10 171.67	R -	R -	R -
9084	Removal of an internal or external distractor device	R 1 302.67	R 1 954.48	R -	R -	R -
	OTHER SURGICAL PROCEDURES					
8517	Reimplantation of avulsed tooth (include stabilisation)	R 810.04	R -	R -	R -	R 1 214.34
8909	Oral antral fistula closure	R 3 548.94	R 5 323.65	R -	R -	R -
9247	Bicoronal approach	R -	R -	R -	R -	R -
9249	Blephro-approach	R -	R -	R -	R -	R -
9251	Transconjunctival/subcilliary approach	R -	R -	R -	R -	R -
9253	Mandibular swing approach for access to the skullbase	R -	R -	R -	R -	R -
9255	Geniohyoidotomy (mandibular split)	R -	R -	R -	R -	R -
9257	Midfacial deglove, including nasal skeleton	R -	R -	R -	R -	R -
8916	Preauriculo-temporal approach	R -	R -	R -	R -	R -
8912	Transmasseteric antero-parotid approach	R -	R -	R -	R -	R -
8913	Condylar Risdon / submandibular approach	R -	R -	R -	R -	R -
8914	Endoscopic or intra-oral approach to the condyle	R -	R -	R -	R -	R -
8915	Intra-oral circum-oral mandibular approach	R -	R -	R -	R -	R -
8911	Caldwell-Luc procedure	R 1 389.08	R 2 082.78	R -	R -	R -

8918	Brush biopsy	R	1 362.27	R	2 043.53	R	-	R	-	R	-
8919	Biopsy of bone - needle	R	1 362.27	R	2 043.53	R	-	R	-	R	-
8920	Exfoliative cytological specimen collection	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8923	Aspiration biopsy (FNA)	R	1 362.27	R	2 043.53	R	-	R	-	R	-
8924	Open biopsy of a single lymph node in the neck	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8932	Biopsy of soft tissue – intraoral superficial, with suturing	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8934	Biopsy of soft tissue– intraoral deep or intramuscular, requiring suturing in multiple layers	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8921	Biopsy – extra-oral bone/soft tissue	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8925	Biopsy of soft tissue –extra oral deep or intramuscular, requiring suturing in multiple layers	R	2 229.28	R	3 343.32	R	-	R	-	R	-
8966	Repair of oronasal fistula (local flaps)	R	4 238.81	R	6 358.70	R	-	R	-	R	-
8896	Cost of materials required to aid eruption	R	-	R	-	R	-	R	-	R	-
8983	Corticotomy - first tooth	R	2 023.42	R	3 035.73	R	-	R	-	R	-
8984	Corticotomy - each additional tooth	R	1 026.19	R	1 539.17	R	-	R	-	R	-
8994	Placement of Zygomaticus implant	R	-	R	-	R	-	R	-	R	-
8996	Placement of a second Zygomaticus implant	R	-	R	-	R	-	R	-	R	-
8998	Craniofacial transcutaneous endosseus implant	R	2 308.99	R	3 463.48	R	-	R	-	R	-
8999	Craniofacial trans mucosal endosseus implant	R	2 308.99	R	3 463.48	R	-	R	-	R	-
8606	Placement of implant fixtures outside the oral cavity	R	2 308.99	R	3 463.48	R	-	R	-	R	-
	ALVEOLOPLASTY										
8955	Alveoplasty or alveolectomy in conjunction with extractionsper quadrant	R	1 858.97	R	2 787.74	R	-	R	-	R	-
8956	Alveoplasty or alveolectomy not in conjunction with extractions – per quadrant	R	1 858.97	R	2 787.74	R	-	R	-	R	-
8957	Alveolotomy or alveolectomy (including extractions)	R	1 858.97	R	2 787.74	R	-	R	-	R	-
9003	Reposition mental foramen and nerve - per side	R	4 233.07	R	6 350.32	R	-	R	-	R	-
9004	Lateralization of inferior dental nerve	R	6 820.69	R	10 232.47	R	-	R	-	R	10 480.70
	VESTIBULOPLASTY										
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.										
8997	Sulcoplasty / Vestibuloplasty	R	6 986.81	R	10 480.70	R	-	R	10 480.70	R	10 480.70
	SURGICAL EXCISION OF SOFT TISSUE LESIONS	R	-	R	-	R	-	R	-	R	-
8910	Vermillionectomy	R	-	R	4 338.63	R	-	R	-	R	-
	REPAIR/RECONSTRUCTIVE PROCEDURES										
8990	Repair by primary suture	R	1 728.27	R	2 291.28	R	-	R	-	R	-
8992	Repair by skin graft or local flap	R	1 728.27	R	2 291.28	R	-	R	-	R	-
9006	Lip reconstruction following an injury or tumour removal: primary closure	R	-	R	12 485.68	R	-	R	-	R	-
9018	Lip reconstruction following an injury or tumour removal: simple advancement, rotation flap (Abbe or Estlander) (first stage)	R	-	R	9 417.64	R	-	R	-	R	-
9020	Lip reconstruction following an injury or tumour removal: simple advancement, rotation flap (Abbe or Estlander) (subsequent stages)	R	-	R	9 417.64	R	-	R	-	R	-
9022	Lip reconstruction following an injury or tumour removal: Total complicated reconstruction with a complicated advancement flap (Bernard flap)	R	-	R	4 754.66	R	-	R	-	R	-
	SURGICAL INCISION										
8731	Incision & drainage of abscess - intra-oral	R	558.70	R	6 944.44	R	-	R	-	R	-
8908	Surgical removal of roots from maxillary antrum	R	4 629.47	R	1 299.55	R	-	R	-	R	-
9011	Incision & drainage of abscess - intra-oral (pyogenic)	R	866.77	R	1 778.30	R	-	R	-	R	-
9013	Incision & drainage of abscess - extra-oral (pyogenic)	R	1 185.13	R	2 134.01	R	-	R	-	R	-
9100	Multiple extra-oral incision & drainages (eg. Ludiwig's angina)	R	1 422.11	R	1 600.21	R	-	R	-	R	-

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9299	Abscess - Retropharyngeal or equivalent	R	-	R	-	R	-	R	-	R	-
9017	Decortication, saucerisation and sequestrectomy	R	6 274.44	R	9 410.70	R	-	R	-	R	-
9019	Sequestrectomy - intra oral per sextant and or ramus	R	1 362.27	R	2 043.53	R	-	R	-	R	-
	TREATMENT OF FRACTURES										
	ALVEOLUS FRACTURES										

9024	Dento-alveolar fracture - per sextant	R	1 528.16	R	2 291.28	R	-	R	-	R	-
	MANDIBULAR FRACTURES										
9025	Mandible fracture - closed reduction	R	3 384.49	R	5 075.42	R	-	R	-	R	-
9027	Mandible fracture - compound, with eyelet wiring	R	4 752.51	R	7 127.80	R	-	R	-	R	-
9029	Mandible fracture - splints	R	5 262.13	R	7 892.84	R	-	R	-	R	-
9031	Mandible fracture - open reduction	R	7 799.48	R	11 698.86	R	-	R	-	R	-
	MAXILLIARY FRACTURES										
9035	Maxilla fracture - Le Fort I or Guerin	R	4 760.65	R	7 140.97	R	-	R	-	R	-
9036	Open treatment of maxillary fracture – Le Fort I	R	4 760.65	R	7 140.97	R	-	R	-	R	-
9037	Maxilla fracture - Le Fort II or middle third face	R	7 799.48	R	11 698.86	R	-	R	-	R	-
9038	Open treatment of maxillary fracture – II or middle third of face	R	7 799.48	R	11 698.86	R	-	R	-	R	-
9039	Maxilla fracture - Le Fort III or craniofacial disjunction	R	11 186.37	R	16 779.07	R	-	R	-	R	-
	ZYGOMA/ORBITAL/ANTRAL FRACTURES										
9041	Zygomatic arch fracture - closed reduction	R	3 384.49	R	5 075.42	R	-	R	-	R	-
9043	Zygomatic arch fracture - open reduction	R	6 781.19	R	10 171.67	R	-	R	-	R	-
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)	R	10 159.46	R	15 238.95	R	-	R	-	R	-
9291	Zygomatic fracture-open reduction with fixation at two sites	R	6 781.19	R	10 171.67	R	-	R	-	R	-
8944	Zygomatic fracture-open reduction with fixation at three or more sites	R	6 781.19	R	10 171.67	R	-	R	-	R	-
9293	Zygomatic fracture-closed reduction	R	3 384.49	R	5 075.42	R	-	R	-	R	-
8946	Zygomatic reconstruction (osteotomy or onlay)	R	14 218.50	R	21 328.59	R	-	R	-	R	-
8947	Anthrostomy for the placement of a sinuspack in order to reduce a zygomatic fracture	R	-	R	2 953.38	R	-	R	-	R	-
9046	Placement of Zygomaticus fixture, per fixture	R	6 711.05	R	10 066.10	R	-	R	-	R	-
9273	Open treatment of an orbital wall fracture	R	-	R	6 492.03	R	-	R	-	R	-
9275	Major orbital reconstruction (comminuted orbital fractures)	R	-	R	6 492.03	R	-	R	-	R	-
9277	Secondary reconstruction of orbital defect	R	-	R	6 492.03	R	-	R	-	R	-
9279	Eyelid surgery for facial paralysis including tarsoraphy (excludes material)	R	-	R	8 550.39	R	-	R	-	R	-
9281	Full thickness eyelid repair (tumor or trauma surgery)	R	-	R	6 241.17	R	-	R	-	R	-
9283	Repair by superior rectus, levator or frontalis muscle operation	R	-	R	8 687.08	R	-	R	-	R	-
9285	Ptosis: By lesser procedure e.g. sling operation	R	-	R	6 291.43	R	-	R	-	R	-
9287	Dacrocystorhinostomy	R	-	R	9 601.24	R	-	R	-	R	-
	NASAL FRACTURES										
9280	Open reduction and fixation of nasal fractures	R	-	R	-			R	-	R	-
9282	Manipulation and immobilisation of nasal fracture	R	-	R	-			R	-	R	-
	TEMPOROMANDIBULAR JOINT										
	Procedures which are an integral part of a primary procedure should not be reported separately.										
8170	Cost of Mouth protector	R	407.65	R	-	R	-	R	-	R	-
8172	Cost of orthotic appliance	R	-	R	-	R	-	R	-	R	-
8850	Treatment of MPDS - first visit	R	536.19	R	-	R	770.32	R	-	R	770.32
8851	Treatment of MPDS - subsequent visit	R	281.98	R	-	R	405.34	R	-	R	405.34
8852	Occlusal orthotic appliance	R	1 346.47	R	1 774.47	R	1 699.52	R	1 699.52	R	1 699.52
8951	Trigger point injection (local anesthesia)	R	396.16	R	594.36	R	-	R	-	R	-
8952	Pain point injection (alcohol, phenol, etc)	R	396.16	R	594.36	R	-	R	-	R	-
8954	Laser treatment for facial pain	R	396.16	R	594.36	R	-	R	-	R	-
9053	Coronoidectomy (intra-oral approach)	R	4 230.91	R	6 345.29	R	-	R	-	R	-
9074	Tmj arthroscopy diagnostic	R	3 366.30	R	5 049.81	R	-	R	-	R	-
9075	Condylectomy, coronoidectomy or both	R	8 457.52	R	12 686.76	R	-	R	-	R	-
9076	TMJ artrocentesis	R	1 858.97	R	2 787.74	R	-	R	-	R	-
9077	TMJ intra-articular injection	R	507.47	R	761.68	R	-	R	-	R	-
9079	Trigger point injection	R	396.16	R	594.36	R	-	R	-	R	-
9081	Condylectomy (Ward/Kostecka)	R	3 384.49	R	5 075.42	R	-	R	-	R	-
9083	TMJ srthroplasty	R	8 457.52	R	12 686.76	R	-	R	-	R	-
9085	Reduction of TMJ disloc w/o anaesthetic	R	672.40	R	1 009.20	R	-	R	-	R	-
9087	Reduction of TMJ disloc w/ anaesthetic	R	1 362.27	R	2 043.53	R	-	R	-	R	-
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	R	3 384.49	R	5 075.42	R	-	R	-	R	-
9091	Reduction of TMJ dislocation - open reduction	R	8 457.52	R	12 686.76	R	-	R	-	R	-

9092	Joint reconstruction	R	22 579.79	R	33 869.33	R	-	R	-	R	-
8929	Removal of temperomandibular joint prosthesis	R	1 302.67	R	1 954.48	R	-	R	-	R	-
8930	Design meeting and / or planning for a custom prosthesis / tempero-mandibular joint, charge per joint/prosthesis designed	R	1 902.77	R	-	R	-	R	-	R	-
	REPAIR OF TRAUMATIC WOUNDS										
8192	Suture - minor	R	1 728.27	R	-	R	-	R	-	R	-

Tariff	Description	General Dental Practice (54)		Maxillo-Facial & Oral Surgery (62)		Orthodontics (64)		Periodontics (92)		Prostodontics (94)	
	COMPLICATED SUTURING										
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.										
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)	R	1 728.27	R	2 291.28	R	-	R	-	R	-
9023	Suture - reconstruction, major (excludes closure of surgical incisions)	R	3 215.97	R	4 823.36	R	-	R	-	R	-
	OTHER REPAIR PROCEDURES										
8958	Emergency tracheotomy	R	1 561.91	R	2 342.98	R	-	R	-	R	-
8959	Pharyngostomy	R	1 561.91	R	2 342.98	R	-	R	-	R	-
9289	Frenulotomy	R	-	R	-	R	-	R	-	R	-
8962	Harvest iliac crest graft	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9208	Harvest iliac crest graft - monocortical	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9209	Harvest iliac crest graft - bicortical	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9210	Harvest tibial bone - spongiosa	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9211	Harvest iliac crest graft - bicortical	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9212	Harvest rib graft - bone	R	1 288.54	R	1 932.94	R	-	R	-	R	-
9213	Harvest rib graft - cartilage	R	1 288.54	R	1 932.94	R	-	R	-	R	-
8963	Harvest rib graft	R	1 288.54	R	1 932.94	R	-	R	-	R	-
8964	Harvest cranium graft	R	1 009.20	R	1 514.03	R	-	R	-	R	-
9214	Harvest auricular cartilage graft	R	1 288.54	R	1 932.94	R	-	R	-	R	-
8977	Surgical repair of maxilla or mandible - major	R	7 118.23	R	10 676.74	R	-	R	-	R	-
9001	Augmentation of alveolar ridge using block graft / split ridge technique – across one to two tooth sites	R	7 123.49	R	10 685.84	R	-	R	10 685.84	R	-
9002	Augmentation of alveolar ridge using block graft / split ridge technique – across three to five tooth sites. See code 9001 for descriptor.	R	4 484.41	R	6 725.66	R	-	R	-	R	-
8979	Harvesting of autogenous grafts (intra-oral)	R	586.70	R	880.89	R	-	R	880.89	R	-
8980	Intraoral harvesting of bone-coagulum/bone-scraping, not per site	R	1 288.54	R	1 932.94	R	-	R	-	R	-
9215	Intra-oral harvesting of particulate bone	R	1 288.54	R	1 932.94	R	-	R	-	R	-
9216	Harvest fascia lata	R	1 124.09	R	1 380.46	R	-	R	-	R	-
9217	Harvest of free fat	R	1 124.09	R	1 380.46	R	-	R	-	R	-
8985	Frenulectomy/frenulotomy	R	1 858.97	R	2 787.74	R	-	R	2 787.74	R	-
9005	Alveolar ridge augmentation - total (by bone graft)	R	7 123.49	R	10 685.84	R	-	R	10 685.84	R	-
9007	Alveolar ridge augmentation - total (by alloplastic material)	R	4 484.41	R	6 725.66	R	-	R	-	R	-
9008	Alveolar ridge augmentation - one to two tooth sites	R	1 385.97	R	2 535.91	R	-	R	-	R	-
9009	Alveolar ridge augmentation - three across 3 or more tooth sites	R	3 081.21	R	4 621.57	R	-	R	-	R	-
9010	Sinus lift procedure	R	4 629.47	R	6 944.44	R	-	R	-	R	-
9012	Maxillary sinus floor bone augmentation, buccal-approach, limited	R	-	R	-	R	-	R	-	R	-
9014	Osteotome sinus floor bone augmentation	R	-	R	-	R	-	R	-	R	-
9032	Reduction of masseter muscle and bone - extra-oral approach	R	-	R	11 698.86	R	-	R	-	R	-
9033	Reduction of masseter muscle and bone - intra-oral approach	R	-	R	-	R	-	R	-	R	-
8940	Endoscopic management of a condylar fracture – report per side	R	3 384.49	R	5 075.42	R	-	R	-	R	-
9048	Surgical removal of internal fixation devices, per site	R	1 302.67	R	1 954.48	R	-	R	-	R	-
	FUNCTIONAL CORRECTION OF MALOCCLUSION										
	For Codes 9047 to 9072 the full fee may be charged	R	-	R	-	R	-	R	-	R	-
9206	Surgical removal of reconstruction plate	R	1 302.67	R	1 954.48	R	-	R	-	R	-
9218	Nerve repair: 1st Fasciculus	R	-	R	9 235.24	R	-	R	-	R	-
9219	Nerve repair: 2nd and additonal Fasciculus	R	-	R	2 286.49	R	-	R	-	R	-
9225	Nerve repair: entubelation	R	-	R	10 241.08	R	-	R	-	R	-

9047	Osteotomy - open with stabilisation	R	14 218.50	R	21 328.59	R	-	R	-	R	-
9049	Osteotomy - mandible body, anterior segmental	R	11 850.15	R	17 774.62	R	-	R	-	R	-
9050	Osteotomy - total subapical	R	21 675.68	R	32 513.28	R	-	R	-	R	-
9051	Genioplasty	R	6 781.19	R	10 171.67	R	-	R	-	R	-
9204	Sandwich osteotomy - for placement of an interpositional bone graft to increase the alveolar ridge height, may also be reported if utilized in the maxilla	R	14 218.50	R	21 328.59	R	-	R	-	R	-
9052	Midfacial exposure	R	10 735.63	R	16 102.61	R	-	R	-	R	-
9055	Osteotomy - segmented, posterior	R	10 735.63	R	17 774.62	R	-	R	-	R	-
9057	Osteotomy - segmented, anterior	R	10 735.63	R	17 774.62	R	-	R	-	R	-
9059	Reconstruct maxilla - Le Fort I osteotomy, one piece	R	22 297.33	R	33 445.88	R	-	R	-	R	-
9060	Reconstruct maxilla - Le Fort I osteotomy w/ repositioning and graft	R	25 031.45	R	37 546.10	R	-	R	-	R	-
9061	Palatal osteotomy	R	7 799.48	R	11 698.86	R	-	R	-	R	-
9062	Reconstruct maxilla - Le Fort I osteotomy, multiple segments	R	28 463.34	R	42 694.29	R	-	R	-	R	-
9063	Reconstruct maxilla - Le Fort 2 osteotomy (facial and posttraumatic deformities)	R	28 477.94	R	42 715.83	R	-	R	-	R	-
9065	Reconstruct maxilla - Le Fort 3 osteotomy (severe congenital deformities)	R	42 678.49	R	64 017.61	R	-	R	-	R	-
9229	Choanal artesia repair through a palatal osteotomy	R	-	R	8 870.44	R	-	R	-	R	-
9227	Turbinectomy	R	-	R	2 862.18	R	-	R	-	R	-

Tariff	Description	General Dental Practice (54)		Maxillo-Facial & Oral Surgery (62)		Orthodontics (64)		Periodontics (92)		Prostodontics (94)	
9066	Surgical expansion - maxilliary or mandibular	R	6 781.19	R	10 171.67	R	-	R	-	R	-
9069	Glossectomy - partial	R	5 079.01	R	7 619.00	R	-	R	-	R	-
9071	Geniohyoidotomy	R	3 046.98	R	4 571.54	R	-	R	-	R	-
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	R	22 297.33	R	33 445.88	R	-	R	-	R	-
	SALIVARY GLANDS										
8960	Salivary duct dilatation or canalization	R	-	R	456.48	R	-	R	-	R	-
8948	Endoscopic procedure: Wharton's duct	R	-	R	456.48	R	-	R	-	R	-
8949	Endoscopic procedure: Stenson's duct	R	-	R	456.48	R	-	R	-	R	-
8950	Excision of a ranula (marsupealization)	R	-	R	3 913.98	R	-	R	-	R	-
9093	Removal of salivary stone (Sialolithotomy)	R	1 528.16	R	2 291.28	R	-	R	-	R	-
9095	Excision of sublinglual salivary gland	R	3 765.57	R	5 648.24	R	-	R	-	R	-
9096	Excision of salivary gland - extra oral approach	R	5 578.58	R	8 367.75	R	-	R	-	R	-
9202	Excision of submandibular salivary gland with any type of neck dissection	R	-	R	16 093.03	R	-	R	-	R	-
9186	Closure of salivary fistula	R	-	R	4 159.82	R	-	R	-	R	-
9176	Local resection of parotid tumour (lumpectomy)	R	-	R	7 753.28	R	-	R	-	R	-
9177	Superficial parotidectomy	R	-	R	14 172.78	R	-	R	-	R	-
9178	Total parotidectomy with preservation of facial nerve	R	-	R	16 391.05	R	-	R	-	R	-
9179	Total parotidectomy without preservation of facial nerve	R	-	R	16 391.05	R	-	R	-	R	-
	PEDICLE FLAPS										
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post –cancer/ trauma/ tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.										
9284	Musculofascial flap	R	-	R	-			R	-	R	-
9286	Musculocranial flap	R	-	R	-			R	-	R	-
9288	Buccal fat pad (major repair)	R	-	R	-			R	-	R	-
9241	Simple local flap (eg. Advancement or rotation flap)	R	-	R	-			R	-	R	-
9242	Complex local flap	R	-	R	-			R	-	R	-
9243	Regional flap (eg pectoral, deltoid or lattisimus dorsi flap)	R	-	R	-			R	-	R	-
9244	Tongue flap - 2 procedures	R	-	R	-			R	-	R	-
	REPAIR OF FRONTAL BONES										
	The use of codes 9274, 9275 and 9278 imply the bicoronal/hemicoronal approach.										
9274	Repair anterior table, frontal sinus and/or supraorbital rim	R	-	R	-	R	-	R	-	R	-

9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus	R	-	R	-	R	-	R	-	R	-
9278	Repair medial canthal ligament (canthopexy), per side	R	-	R	-	R	-	R	-	R	-
9200	Cranioplasty	R	-	R	12 802.37	R	-	R	-	R	-
9233	Obliteration of the frontal sinus	R	-	R	13 309.13	R	-	R	-	R	-
K.	**SUPPLEMENTARY SERVICES**										
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.										
	ANAESTHESIA										
8499	General anaesthetic	R	-	R	-	R	-	R	-	R	-
8141	Inhalation sedation - first 15 minutes or part thereof	R	256.37	R	-	R	-	R	-	R	-
8143	Inhalation sedation - each addnl 15 minutes	R	132.13	R	-	R	-	R	-	R	-
8144	Intravenous sedation	R	153.92	R	-	R	-	R	-	R	-
8145	Local anaesthetic - per visit	R	222.86	R	-	R	-	R	-	R	-
8471	Procedural sedation or General anaesthesia- Assessment	R	726.98	R	-	R	-	R	-	R	-
8472	Procedural sedation - first 30 minutes	R	512.74	R	-	R	-	R	-	R	-
8473	Procedural sedation- each additional 15 minutes or part thereof	R	132.13	R	-	R	-	R	-	R	-
8147	Monitoring equipment for intravenous sedation	R	547.68	R	-	R	-	R	-	R	-
8474	Procedure room for Sedation	R	3 021.84	R	3 021.84	R	3 021.84	R	3 021.84	R	3 021.84
9239	Surgical facility for surgical procedures in consulting rooms	R	-	R	-	R	-	R	-	R	-
	PROFESSIONAL VISITS	R	-	R	-	R	-	R	-	R	-
8129	Office/hospital visit – after regularly scheduled hours	R	858.63	R	-	R	-	R	-	R	-
8140	House/extended care facility/hospital call	R	569.23	R	-	R	-	R	569.23	R	-
8903	House/Hosp/Nursing home consultation - MFOS	R	-	R	636.97	R	-	R	-	R	-
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	R	-	R	423.21	R	-	R	-	R	-
8905	After regularly hours consultation - MFOS	R	-	R	932.84	R	-	R	-	R	-
8906	Post-op visit in hospital for Neoplasm/ Trauma/CLP (2x/day for duration of hospitalization), reported visit."	R	-	R	-	R	-	R	-	R	-
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	R	-	R	1 060.18	R	-	R	-	R	-
9203	House/Hosp/Nursing home consultation - Oral pathologist	R	-	R	-	R	-	R	-	R	-
9207	After hours visit - Oral pathologist	R	-	R	-	R	-	R	-	R	-
	DRUGS, MEDICAMENTS AND MATERIALS										
8109	Infection control/barrier techniques	R	51.94	R	-	R	-	R	-	R	-
8110	Sterilized instrumentation	R	132.13	R	-	R	-	R	-	R	-
8183	Therapeutic drug injection	R	153.92	R	-	R	-	R	-	R	-
8220	Cost of suture material	R	-	R	-	R	-	R	-	R	-
8304	Rubber dam per arch	R	273.84	R	-	R	-	R	-	R	-

Tariff	Description	General Dental Practice (54)	Maxillo-Facial & Oral Surgery (62)	Orthodontics (64)	Periodontics (92)	Prostodontics (94)
8306	Cost of MTA	R -	R -	R -	R -	R -
9259	Distraction device for alveolar bone	R -	R -	R -	R -	R -
9261	Internal distraction device for maxilla or mandible	R -	R -	R -	R -	R -
9263	Transport distraction device	R -	R -	R -	R -	R -
9265	External distraction device for maxilla or mandible	R -	R -	R -	R -	R -
9267	Temperomandibular joint prosthesis (stock or custom)	R -	R -	R -	R -	R -
9269	Custom prosthesis for facial reconstruction	R -	R -	R -	R -	R -
9271	Cost of impression material (only to be used with code 8215)	R -	R -	R -	R -	R -
8310	Supply of bleaching materials	R -	R -	R -	R -	R -
	Equipment					
	ADMINISTRATIVE AND LABORATORY SERVICES					
8099	Dental laboratory service	R -	R -	R -	R -	R -
8106	Special report	R 585.98	R 585.98	R 585.98	R 585.98	R 585.98
8111	Dental testimony	R -	R -	R -	R -	R -
8120	Treatment plan completed	R -	R -	R -	R -	R -
8139	Appointment not kept /30min	R -	R -	R -	R -	R -
L.	**MISCELLANEOUS SERVICES**					

	Palliative Treatment										
8131	Emergency dental treatment	R	349.96	R	-	R	-	R	-	R	714.77
8166	Application of desensitising resin, per tooth	R	230.99	R	-	R	-	R	-	R	-
8167	Application of desensitising medicament, per visit	R	269.53	R	-	R	-	R	-	R	-
8165	Sedative filling	R	349.96	R	-	R	-	R	-	R	-
	Post Surgical Complications										
8931	Treatment of post-extraction haemorrhage	R	256.37	R	1 539.17	R	-	R	-	R	-
8933	Treatment of haemorrhage (blood dyscracias)	R	3 548.94	R	5 323.65	R	-	R	-	R	-
9235	Severe nasal bleeding - anterior pack	R	-	R	1 828.57	R	-	R	-	R	-
9236	Severe nasal bleeding - anterior + posterior pack or cauterization	R	-	R	2 743.21	R	-	R	-	R	-
9237	Management of a patient on anti-coagulatives for the performance of a surgical procedure. This code is reported along with the appropriate surgical codes	R	-	R	-	R	-	R	-	R	-
9223	Ligation of maxillary artery	R	-	R	8 960.68	R	-	R	-	R	-
8935	Treatment of septic socket	R	256.37	R	402.15	R	-	R	-	R	-
	BLEACHING										
8308	External bleaching - per arch	R	-	R	-	R	-	R	-	R	-
8309	Home bleaching - instructions and applicator	R	-	R	-	R	-	R	-	R	-
8311	Home bleaching - subsequent visit	R	-	R	-	R	-	R	-	R	-
8325	Internal bleaching - per tooth	R	829.43	R	-	R	-	R	-	R	1 244.50
8327	Internal bleaching - each additional visit	R	397.36	R	-	R	-	R	-	R	596.76
	UNCLASSIFIED TREATMENT										
8158	Enamel microabrasion	R	320.52	R	-	R	-	R	-	R	-
8168	Behavior management	R	-	R	-	R	-	R	-	R	-
8551	Occlusal adjustment - major	R	2 217.31	R	-	R	3 185.83	R	-	R	3 326.32
8553	Occlusal adjustment - minor	R	773.65	R	-	R	1 015.40	R	1 060.18	R	1 060.18
9099	Unlisted dental procedure or service (By report) R	R	-	R	-	R	-	R	-	R	-
	MODIFIERS										
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)	R	-	R	-			R	-	R	-
8005	Maximum multiple procedures (same incision) - MFO surgeon	R	-	R	-			R	-	R	-
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)	R	-	R	-			R	-	R	-
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)	R	-	R	-			R	-	R	-
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)	R	-	R	-			R	-	R	-
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)	R	-	R	-			R	-	R	-
8010	Open reduction (PLUS 75% of the appropriate benefit)	R	-	R	-			R	-	R	-
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)	R	-	R	-			R	-	R	-
8012	Reduced services (benefit MINUS X % as determined by the practitioner)	R	-	R	-			R	-	R	-
8013	Multiple modifiers	R	-	R	-			R	-	R	-
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)	R	-	R	-			R	-	R	-
8025	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 19 June 2020, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). SEE GENERAL INFORMATION FOR DETAILS.	R	-	R	-			R	-	R	-

DENTAL TECHNICIANS (PR 093)			
Code:	**Description:**	**Units:**	**Value:**
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 47.69
9303	Casting and trimming of model in superhard stone(diestone) per model	3.857	R 67.63
9305	Casting and trimming of study model, per model	7.143	R 125.29
9307	Casting and trimming of gnathostatic model, per model..	9.286	R 163.01
9309	New trimmed base to supplied model, per model	3.286	R 57.49
9311	Trimming of supplied model, per model	2.000	R 35.23
9312	Gingival tissue mask per implant	15.429	R 270.68
9313	Duplicating model, per model	8.286	R 145.56
9314	Refractory model, per unit	8.143	R 142.90
9315	Models and duplicate models (virgin model) for crown and bridge (work inclusive of one removable die)	11.286	R 197.90
9317	Sectional models for crown and bridge (work inclusive of one removable die)	10.000	R 175.47
9319	Each additional removable die for items 9315 and 9317 per die	2.571	R 45.03
9320	Pindex or indexed model tray per die (not more than 9319)	2.571	R 45.03
9321	Occlusion block, per block	9.857	R 172.98
9323	Occlusion block on baseplate, per block	12.429	R 218.17
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	1.857	R 32.57
9329	Fit and supply of disposable articulator	4.857	R 85.24
9330	Delivery charge per completed procedure (invoiced)	5.143	R 90.23
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 2 326.13
9333	Full upper or lower denture	77.571	R 1 361.06
9335	Set-up and waxing of full upper and lower dentures	45.714	R 802.07
9337	Set-up and waxing of full upper or lower denture	30.571	R 536.38
9339	Waxing and finishing of full upper and lower dentures	81.286	R 1 426.19
9341	Waxing and finishing of full upper or lower denture	45.429	R 797.26
9343	Additional fee for dentures on fully adjustable articulator at request of dentist	129.429	R 2 271.13
9345	Additional fee for immediate dentures, or tooth socketed	1.857	R 32.57
9346	Additional fee for immediate dentures, per tooth not socketed..	1.000	R 17.61
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 516.44
B	**PARTIAL DENTURES**		
9351	Set-up and finish of one-tooth denture	35.571	R 624.11
9352	Set-up and finish of two-tooth denture	37.857	R 664.16
9353	Set-up and finish of three-tooth denture	40.571	R 711.85
9354	Set-up and finish of four-tooth denture	42.857	R 751.89
9355	Set-up and finish of five-tooth denture	46.286	R 812.21
9356	Set-up and finish of six-tooth denture	55.286	R 970.07
9357	Set-up and finish of seven-tooth denture	65.714	R 1 153.01

9358	Set-up and finish of eight-tooth denture	69.714	R 1 223.30
9359	Set-up and finish nine or more tooth denture	71.429	R 1 253.38
9361	Set-up and waxing of one-tooth denture	10.143	R 177.96
9362	Set-up and waxing of two-tooth denture	12.286	R 215.68
9363	Set-up and waxing of three-tooth denture	14.000	R 245.59
9364	Set-up and waxing of four-tooth denture	16.286	R 285.80
9365	Set-up and waxing of five-tooth denture	18.000	R 315.71
9366	Set-up and waxing of six-tooth denture	21.286	R 373.54
9367	Set-up and waxing of seven-tooth denture	23.429	R 411.09
9368	Set-up and waxing of eight-tooth denture	25.143	R 441.17
9369	Set-up and waxing of nine or more tooth denture	26.857	R 471.41
9371	Waxing and finishing of one-tooth denture	27.857	R 488.69
9372	Waxing and finishing of two-tooth denture	28.429	R 498.66
9373	Waxing and finishing of three-tooth denture	28.857	R 506.30
9374	Waxing and finishing of four-tooth denture	29.429	R 516.44
9375	Waxing and finishing of five-tooth denture	30.571	R 536.38
9376	Waxing and finishing of six-tooth denture	31.714	R 556.48

Code:	Description:	Units:	Value:
9377	Waxing and finishing of seven-tooth denture	39.571	R 694.40
9378	Waxing and finishing of eighth-tooth denture	41.143	R 721.82
9379	Waxing and finishing of nine or more tooth denture	43.429	R 762.03
9383	Additional fee for finishing denture in tooth colour material, per tooth	6.857	R 120.47
9385	Additional fee for supplying finished denture on duplicate model	13.000	R 228.14
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 395.97
9393	Additional charge for each additional fracture, or tooth, or clasp	7.000	R 122.96
9395	Additional fee for using wire strengthener	8.000	R 140.41
9397	Additional fee for using pre-formed strengthener	8.571	R 150.21
9398	Additional fee for using mesh strengthener in repair procedure	13.571	R 238.28
D	**Additional Services**		
9401	Clear base	10.000	R 175.47
9403	Dox grinding of upper and lower dentures	12.714	R 222.99
9405	Inlay to artificial tooth, one surface only, per inlay	21.857	R 383.34
9406	Inlay to artificial tooth, multisurfaces e.g. horseshoe or L-type inlay, per inlay	28.000	R 491.35
9407	Heka base technique per upper or lower denture	30.000	R 526.41
9409	Frego frame	13.000	R 228.14
9410	Bleaching tray	14.429	R 253.07
9411	Template per upper or lower denture	35.857	R 629.10
9413	Reline/rebase of single denture	45.143	R 792.27
9415	Remodel of single denture	69.429	R 1 218.15
9417	Soft base reline per denture	114.000	R 2 000.29
9419	Soft base to new denture, per denture	114.000	R 2 000.29
9421	Gum tinting per denture	21.143	R 370.88
9423	Lingual or palatal bar	17.000	R 298.43
9425	Cleaning and polishing of existing denture, per denture	13.857	R 243.26

9427	Mesh strengthener	11.857	R 208.04
9429	Theatre/ Consultation out of Laboratory per hour or part thereof	29.429	R 516.44
9431	Special Tray, acrylic, each	11.143	R 195.58
9432	Special Tray Light Cure each	12.143	R 213.19
9433	Special Tray in base plate material, each	11.429	R 200.56
9435	Provision of single arm clasp, to partial denture	5.857	R 102.86
9437	Provision of double arm clasp, to partial denture	10.143	R 177.96
9439	Provision of single arm clasp with rest, to partial denture	13.143	R 230.64
9441	Provision of double arm clasp with rest, to partial denture	17.714	R 311.06
9443	Provision of preformed Roach clasp, to partial denture	7.571	R 132.93
9445	Provision of rest only to partial denture	7.571	R 132.93
9447	Cast Clasp	26.571	R 466.26
9448	Casting and trimming of Model from impression inside occlusion block or wax try in	4.857	R 85.24
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	10.143	R 177.96
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 1 596.67
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 1 396.28
9455	Additional charge for each one arm clasp	3.286	R 57.49
9457	Additional charge for each Roach clasp	5.571	R 97.87
9459	Additional charge for each rest	3.000	R 52.84
9461	Additional charge for continuous clasp, per tooth	3.286	R 57.49
9463	Additional charge for lingual bar, per tooth passed	7.714	R 135.26
9465	Additional charge for palatal bar	12.286	R 215.68
9467	Additional charge for onlay	32.714	R 573.93
9469	Additional charge for saddle with finishing line, per tooth	5.429	R 95.38
9471	Additional charge for saddle without finishing line, per tooth	3.143	R 55.17
9473	Additional charge for horseshoe saddle, per tooth	5.429	R 95.38
9475	Additional charge for fitting of tooth to metal backing, per tooth	3.714	R 65.14

Code:	Description:	Units:	Value:
9479	Additional charge for fitting one distal-extension hinge	11.000	R 193.08
9480	Additional charge per milled edge per tooth	9.571	R 167.99
9481	Additional charge for each soldering joint	13.429	R 235.62
9483	Additional charge for soldering retention	16.286	R 285.80
9485	Additional charge for each additional retention soldering joint	5.000	R 87.73
9487	Additional charge for each welding joint	16.429	R 288.30
9489	Additional charge for fitting swing lock	13.429	R 235.62
9491	Additional charge for each backing cast	13.143	R 230.64
9493	Additional charge for each Steels backing or pontic cast (Plastic work to be charged in addition)	14.286	R 250.74
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 363.40

9497	Basic fee if a new section is to be fabricated and where item 9495 does not apply (9301)	23.571	R 413.58
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	R 1 586.71
9502	Ceramic metal substitute coping	73.000	R 1 280.96
9505	Porcelain veneer crown or pontic	119.429	R 2 095.33
9507	Post-solder invested joint, per joint	24.429	R 428.54
9511	Inlay in porcelain veneer crown	39.429	R 691.74
9512	Ceramic, inlay/onlay, bridge retainer	92.714	R 1 626.75
9515	Porcelain shoulder per unit (not applicable to pontics)	8.000	R 140.41
9520	Addition fee for crown- & bridge work performed on a movable condyle articulator per unit	3.857	R 67.63
9521	Full metal crown, MOD, three-quarter crown	73.857	R 1 296.08
9524	Indirect Composite Resin inlay	20.000	R 350.94
9525	Class IV, MO, DO, cervical/occlusal inlay	60.857	R 1 067.77
9526	Additional fee for one piece casting of crown or inlay on post.	18.571	R 325.85
9531	Pin-ledge inlay	69.000	R 1 210.84
9533	Full metal pontic	54.571	R 957.60
9535	Coping or abutment thimble cast	51.143	R 897.45
9537	Precision lock and rest cast	72.571	R 1 273.49
9538	Lock and rest cast	34.714	R 609.16
9539	Casting of rest only	20.714	R 363.40
9541	Metal inlay or post, cast direct	22.000	R 386.00
9543	Gold/pre-solder invested joint	21.857	R 383.34
9545	Cast post with thimble, indirect	36.429	R 639.24
9546	Multiple Post	60.286	R 1 057.80
9547	Manufacture cast post and core to existing crown	47.571	R 834.81
9549	C.S.P. attachment (Steiger)	160.571	R 2 817.49
9550	Milling milled edge per unit	51.143	R 897.45
9551	Telescope crown	126.000	R 2 210.81
9553	Composite/acrylic veneer crown/pontic, indirect	100.714	R 1 767.15
9557	Composite/acrylic jacket crown, indirect	71.143	R 1 248.39
9559	Composite/acrylic veneer post crown	99.571	R 1 747.06
9560	Indirect Composite Resin Veneer	42.143	R 739.43
9561	Composite/acrylic jacket crown, direct	48.571	R 852.09
9563	Temporary acrylic/composite crown per unit	34.714	R 609.16
9564	Heat formed template supplied to dentist for the manufacture of temporary restorations	17.429	R 305.91
9565	Composite/acrylic-facing replaced	40.429	R 709.35
9566	Porcelain/ Ceromor facing replaced	73.286	R 1 285.78
9569	Waxing of crown to existing denture	28.571	R 501.16
9570	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	29.429	R 516.44

Code:	Description:	Units:	Value:
5	**Orthodontic Appliances**		

	The tariffs under this section excludes the tariff for models. The following section includes consumables, however it excludes materials.		
A.1	**Orthodontic Services**		
9571	Basic charge which includes acrylic base	36.143	R 634.25
9572	Basic charge non acrylic base	17.429	R 305.91
9573	Additional charge for fitting first expansion screw	6.857	R 120.47
9575	Additional fee for fitting subsequent expansion screws	5.857	R 102.85
9576	Additional fee for full aclusal bite plate	20.286	R 356.09
9577	Additional fee for bite plate anterior	6.857	R 120.47
9578	Additional fee for bite plate posterior	6.857	R 120.47
9579	Additional fee for fitting tongue guard	8.571	R 150.21
9581	Additional fee for flat or inclined plane	5.286	R 92.72
9583	Additional fee for Adams Crib	6.286	R 110.33
9585	Additional fee for Jackson Crib	6.571	R 115.32
9587	Additional fee for ball clasp	7.429	R 130.28
9589	Additional fee for single arm clasp	5.714	R 100.20
9591	Additional fee for double arm clasp	10.000	R 175.47
9593	Additional fee for fitting single loop finger spring	4.714	R 82.58
9595	Additional fee for fitting double loop finger spring	5.571	R 97.88
9597	Additional fee for fitting Buccal retraction spring	4.143	R 72.78
9599	Additional fee for fitting apron spring	10.714	R 188.10
9603	Additional fee for fitting coffin spring	10.286	R 180.46
9605	Additional fee for fitting Quad Helix	11.429	R 200.57
9607	Additional fee for fitting flapper or "T"-spring	8.571	R 150.21
9609	Additional fee for fitting all springs with tubing, each	9.571	R 167.99
A.2	**Arches**		
9611	Additional fee for fitting labial arch	5.429	R 95.38
9613	Additional fee for fitting buccal arch	6.429	R 112.66
9615	Additional fee for fitting Roberts retractor	12.000	R 210.53
9617	Invisible Retainer	15.857	R 278.16
9619	Additional fee for fitting twinwire arch extra-oral arch	15.000	R 263.37
9620	Additional fee Lip bumper	6.286	R 110.33
9621	Additional fee for fitting extra-oral arch	14.286	R 250.74
9622	Additional fee for fitting space maintainer arch	6.286	R 110.33
A.3	**Welding and Soldering**		
9623	Additional fee for each spot-welding joint	2.857	R 50.18
9625	Additional fee for each soldering joint	4.571	R 80.26
9627	Additional fee for each invested soldering joint	12.714	R 223.00
9629	Additional fee for each hook for elastic traction	4.143	R 72.78
B	**Mouth Protectors and MYO Functional Appliances**		
9631	Gum guard	26.857	R 471.41
9633	Oral Screen	33.000	R 579.08
9635	Andresen or Norwegian appliance	59.000	R 1 035.20
9637	Tooth positioner	68.000	R 1 193.06
9639	Gunning splint	90.571	R 1 589.19
9641	Frankel appliance	87.429	R 1 534.02

9643	Chin cap	29.000	R 508.96
9645	Bionator	59.143	R 1 037.86
9646	Diagnostic set-up	56.857	R 997.65
9647	Snoring Appliance	53.714	R 942.48
C	**Fixed Appliances**		
9651	Pinched or swaged band with welded attachment (excluding	17.429	R 305.91
9653	Pinched or swaged band with soldered attachment	22.857	R 401.12
D	**Additional Services**		
9662	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate of		R 516.44

Code:	Description:	Units:	Value:
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 -
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	R 789.61
9782	Positioning and soldering of complete (male and female) precision attachment	37.571	R 659.17
9783	Implant stent per unit	34.714	R 609.16
9784	Alignment of dolder bar and clips	47.429	R 832.15
9786	Triming, waxing and finishing of implant abutment - crown and bridge work only, per abutment	20.429	R 358.25
9787	Waxing, milling and finishing of a custom abutment	39.857	R 699.39
9788	Implant superstructure (edentulous cases) including placing of preformed parts, per section cast	217.857	R 3 822.60
9789	Finishing of prosthesis on implant structure per arch	79.571	R 1 396.28

DENTAL THERAPY (PR 095)

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.
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:
8109	Infection control/barrier techniques	1.73	R 24.59
8110	Sterilized instrumentation	4.46	R 63.14
8120	Treatment plan completed		
1	**Diagnostic services**		
8101	Oral examination	10.00	R 141.57
8102	Comprehensive oral examination	16.15	R 228.64
8104	Limited oral examination	7.79	R 110.33
8189	Re-examination - existing condition	7.79	R 110.33
8129	Office/hospital visit – after regularly scheduled hours	24.00	R 339.97
8140	House/extended care facility/hospital call	15.88	R 224.98
8190	Consultation - second opinion or advice		
2	**Radiographs/diagnostic imaging**		
8107	Intraoral radiograph - periapical	7.50	R 106.18
8108	Intraoral radiographs - complete series	60.19	R 852.26
8112	Intraoral radiograph - bitewing	7.50	R 106.18
8113	Intraoral radiograph - occlusal	12.89	R 182.62
8114	Extraoral radiograph - hand-wrist		
8115	Extraoral radiograph - panoramic	30.00	R 424.88
8116	Extraoral radiograph - cephalometric	30.00	R 424.88
8118	Extraoral radiograph - skull/facial bone		
8121	Oral and/or facial image (digital/conventional)	8.04	R 113.82
3	**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	7.85	R 111.33
8153	Oral hygiene instruction - each additional visit	5.75	R 81.42
8155	Polishing - complete dentition	9.60	R 135.92
8159	Prophylaxis - complete dentition	17.49	R 247.76
8161	Topical application of fluoride - child	9.60	R 135.92
8162	Topical application of fluoride - adult	9.60	R 135.92
8163	Dental sealant	7.11	R 100.86
	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		
4	**Extractions during a single visit.**		
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	11.20	R 158.52
8202	Extraction - each additional tooth or exposed tooth roots	4.32	R 61.31
8145	Local anaesthetic - per visit	1.70	R 24.26
8220	Cost of suture material		

8931	Treatment of post-extraction haemorrhage	7.30	R 103.35
8935	Treatment of septic socket	7.30	R 103.35
9011	Incision & drainage of abscess - intra-oral (pyogenic)	13.79	R 195.24
8303	Pulp cap - indirect	14.20	R 201.22
	Amalgam restorations (including polishing).		
8341	Amalgam - one surface	20.49	R 290.12
8342	Amalgam - two surfaces	25.26	R 357.76
8343	Amalgam - three surfaces	30.80	R 436.18
8344	Amalgam - four or more surfaces	34.30	R 485.70
	Only one of the above items may be charged per tooth within a year.		

Road Accident Fund Tariff

Code:	Description:	Units:	Value:
5	**Resin restorations (using resin bonding technique)**		
8351	Resin - one surface, anterior	24.80	R 351.10
8352	Resin - two surfaces, anterior	31.17	R 441.34
8367	Resin - one surface, posterior	26.88	R 380.52
8369	Resin - three surfaces, posterior	40.16	R 568.62
8370	Resin - four or more surfaces, posterior	43.20	R 611.98
8368	Resin - two surfaces, posterior	33.25	R 471.07
8353	Resin - three surfaces, anterior	37.24	R 527.40
8354	Resin - four or more surfaces, anterior	41.57	R 588.71
8350	Resin crown - anterior primary tooth (direct)	44.68	R 632.92
	Note: Only one of the above codes may be charged per tooth within a year.		
6	**Palliative Treatment**		
8131	Emergency dental treatment	10.00	R 141.57
8165	Sedative filling	10.00	R 141.57
8166	Application of desensitising resin, per tooth	6.60	R 93.38
8167	Application of desensitising medicament, per visit	7.69	R 109.00

DIETICIANS (PR 084)

GENERAL RULES

84003	Dietary services are per individual patient.
84005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.
84010	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.
84011	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 preauthorisation 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:**
1	**INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT**		
84200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	0.50	R 67.18
84201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	1.50	R 201.56
84202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	2.50	R 335.93
84203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	3.50	R 470.25
84204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	4.50	R 537.71
84205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	5.50	R 632.09
84206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	6.50	R 747.08
84207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	7.50	R 862.06
84208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	8.50	R 977.22
84209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	9.50	R 1 092.03
84210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	10.50	R 1 206.84
84211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	11.50	R 1 321.84
2	**GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT**		
	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.		
84300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	0.10	R 13.46
84301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	0.30	R 40.22
84302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	0.50	R 67.13
84303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	0.70	R 94.38
84304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	0.90	R 107.51
84305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	1.10	R 126.45
84306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	1.30	R 149.39
84307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	1.50	R 172.31
84308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	1.70	R 195.25
84309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	1.90	R 218.50
84310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	2.10	R 241.44
84311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	2.30	R 264.36

EMERGENCY MEDICAL SERVICES	
1. AMBULANCE SERVICES	
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.
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.
	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.				
1.1	**BASIC LIFE SUPPORT**				
	Metropolitan Area:				
Code:	**Description:**	**EMS Primary Response**		**Interhospital transfer**	
		Units:	**Value:**	**Units:**	**Value:**
100	Up to 45 minutes		R 2 277.62		R 1 767.50
102	Up to 60 minutes		R 3 034.16		R 2 354.70
103	Every 15 minutes thereafter or part thereof, where specially motivated		R 759.21		R 589.20
	Long distance		R -		
111	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		R 37.89		R 29.40
112	Per km (> 100 km) (BLS return - non patient carrying kilometres) to a maximum of **R 1800**		R 13.29		R 10.40
104	Call out fee (under 100km travel to scene)				R 674.50
113	Non patient carrying rate per km up to a maximum of R1800 (Subject to motivation)				R 10.10
1.2	**INTERMEDIATE LIFE SUPPORT**				
	Metropolitan Area:				
Code:	**Description:**	**EMS Primary Response**		**Interhospital transfer**	
		Units:	**Value:**	**Units:**	**Value:**
125	Up to 45 minutes		R 3 075.03		R 2 386.40
127	Every 15 minutes thereafter or part thereof, where specially motivated		R 1 025.07		R 795.70
	Long distance				
129	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		R 51.34		R 39.60
130	Per km (> 100 km) (ILS return - non patient carrying kilometres) to a maximum of R		R 13.29		R 10.40
126	Call out fee (under 100km travel to scene)				R 1 011.60
128	Non patient carrying rate per km up to a maximum of R1800 (Subject to motivation)				R 10.10
1.3	**ADVANCED LIFE SUPPORT/INTENSIVE CARE UNIT**				
	Metropolitan Area:				
Code:	**Description:**	**EMS Primary Response**		**Interhospital transfer**	

		Units:	Value:	Units:	Value:
131	Up to 60 minutes		R 5 407.66		R 4 196.70
133	Every 15 minutes thereafter or part thereof, where specially motivated		R 1 351.91		R 1 049.10
	Long distance				
141	Per km (>100 km) DISTRANCE TRAVELLED BY PATIENT		R 67.46		R 52.20
142	Per km (> 100 km) (ALS return - non patient carrying kilometres)		R 13.29		R 10.40
143	Non patient carrying rate per km up to a maximum of R1800 (Subject to motivation)		R 10.99		
1.4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**				
Code:	**Description:**	**EMS Primary Response**		**Interhospital transfer**	
		Units:	**Value:**	**Units:**	**Value:**
151	Resuscitation fee, per incident		R 6 037.41		R 4 571.20
153	Doctor per hour		R 1 728.61		
	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.				

	2. AEROMEDICAL TRANSFERS				
	ROTOR WING RATES				
	Definitions: 1. Helicopter rates are determined according to aircraft type. 2. Day light operations are defined from Sunrise to Sunset (and night operations from Sunset to Sunrise) 3. If flying time is mostly in night time (as per definition above), then bill night time operation rates (type C) 4. Call out charge includes Basic Call Cost plus other flying time incurred. Staff and consumables cost can only be charged if a patient has been treated. 5. Flying time is billed for minimum of 30 minutes and thereafter in 15 minute increments. 6. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients) 7. Rates are calculated according to time; from throttle open, to throttle closed. 8. Group A - C must fall within the Cat 138 Ops as determined by Civil Aviation. 9. Hot loads restricted to 8 minutes grount time and must be denoted.				
	AIRCRAFT TYPE A (RA): HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119 (when used for rescue purposes), AIRCRAFT TYPE B (RB) & Ca (DAY OPERATIONS) (RC) BO105, 206CT, AS355, A109, HB222, HB230, HB430 AIRCRAFT TYPE Cb (NIGHT OPERATIONS) (RC) HB222, HB230, HB212 / 412, AS365, A119, S76, HB427, MD900, BK117, EC135, BO105, HB430 AIRCRAFT TYPE D (RESCUE) H500, HB206B, AS350, AS315, FH1100, A119				
		EMS Primary Response			
		Units:	**Value:**		
2.1	**Rotorwing Type A** **(Single Engine - Daylight Operations or where otherwise approved by SACAA)**				
700	Basic Call Cost (Start-up)		R29 898.45		
701	Flying time: cost per minute up to 120 minutes		R357.59		

	Minimum cost for 30 minutes applicable. Supply motivation for not using fixed wing air ambulance if time exceeds 120 minutes				
702	Hot load (per minute) - maximum 8 minutes		R238.29		
2.2	**Rotorwing Type B and Ca (Twin Engine Daylight Operations)**				
710	Basic Call Cost (Start-up)		R39 493.25		
711	Flying time: cost per minute up to 120 minutes		R546.84		
	Minimum cost for 30 minutes applicable. Supply motivation for not using fixed wing air ambulance if time exceeds 120 minutes				
712	Hot load (per minute) - maximum 8 minutes		R616.74		
2.3	**Rotorwing Type Cb (Twin Engine Night Operations)**				
720	Basic Call Cost (Start-up)		R56 173.79		
	Bell 222		R56 173.79		
	Bell Long Ranger L 4		R 38 943.10		
	Bell Jet Ranger		R 38 943.10		
	Eurocopter		R56 173.79		
	Agusta Westland AW 119		R56 173.79		
721	Flying time: cost per minute up to 120 minutes		R616.74		
	Minimum cost for 30 minutes applicable. Supply motivation for not using fixed wing air ambulance if time exceeds 120 minutes				
722	Hot load (per minute) - maximum 8 minutes		R616.74		
2.4	**Rotorwing Type A, B and C (staff and consumables)**				
730	Staff and consumables: 1 - 30 minutes		R3 320.83		
731	Staff and consumables: 31 - 60 minutes		R7 073.36		
732	Staff and consumables: 61 - 90 minutes		R10 610.04		
733	Staff and consumables: more than 90 minutes		R14 146.11		
2.5	**Other Costs**				
595	Winching: Per lift		R6 167.72		

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.

Road Accident Fund Tariff

HEARING AID ACOUSTICIANS (PR 083)

GENERAL RULES

83003	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.
83005	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:
83001	First consultation (comprehensive)	15.70	R 189.93
83003	Consultation (screening interview)	10.00	R 120.97
83021	Test - air conduction	10.00	R 120.97
83023	Test - bone conduction	10.00	R 120.97
83025	Test - speech hearing tests	14.00	R 169.36
83027	Test - free field	12.80	R 161.68
83029	Test - insertion gain (per ear)	10.90	R 137.68
83031	Test - binaural loudness balance test, per ear	12.80	R 161.68
83051	Global charge for supply and fitting of hearing aid and follow-up (By arrangement)		
83053	Hearing Aid Evaluation, per ear (refer to General Rule 003)	12.80	R 154.85
83055	Technical adjustment or replacement of earmolds	21.10	R 255.26
83057	Repairs/service per instrument (3 X services/4 year cycle)		
83059	Tympanogram	10.00	R 120.97
83061	Reflex test (stapedial reflex)	10.00	R 120.97

HOMEOPATHY (PR 008) (Subject to preauthorisation)

GENERAL RULES

Definition: Consultations

Road Accident Fund Tariff

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.

Road Accident Fund Tariff

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.

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

SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS

Code:	Description:	Units:	Value:
1	**Consultations**		
301	Consultation (initial or follow up). Duration 1 - 15 mins	10.00	R 117.32
302	Consultation (initial or follow up). Duration 16 - 30 mins	22.50	R 263.71
303	Consultation (initial or follow up). Duration 31 - 45 mins	37.50	R 439.34
304	Consultation (initial or follow up). Duration 46 - 60 mins	52.50	R 615.14
004	Consultation, each additional full 15 mins, to a maximum of 60 mins	15.00	R 175.80
003	Hospital visit (BY ARRANGEMENT)		
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)	0.10	R 2.49
203	Non-proprietary Homoeopathic Medicine - Liquid drops (per ml)	0.23	R 5.65
204	Non-proprietary Homoeopathic Medicine - Pillules & granules (per ml)	0.23	R 5.65
	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)	0.10	R 2.49
223	Non-proprietary (compounded and administered) homeopathic medicine – Liquid drops (per ml)	0.23	R 5.65
224	Non-proprietary (compounded and administered) homeopathic medicine – Pillules & granules (per ml)	0.23	R 5.65
209	Proprietary materials		

Code:	Description:	Units:	Value:
2.2	**Unlicensed practitioner or licensed practitioner in unlicensed area**		

Road Accident Fund Tariff

	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)		

Road Accident Fund Tariff

HOSPICE OR SIMILAR APPROVED FACILITIES (PR 079)			
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:**
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 1 596.17
955	Home health care, per visit		R 522.42
960	Global fee for a terminally ill patient - By arrangement		

MEDICAL PRACTITIONERS

RULES GOVERNING THE CODING STRUCTURE:

	Fees calculated: Relative Value Unit (RVU) x Rand Conversion Factor (RCF):	**2023**		
	Consultation fees: General practitioners	**R 38.29**		
	Consultation fees: Specialists	**R 76.59**		
	Procedural fees	**R 36.49**		
	Psychiatrists	**R 91.61**		
	Anaesthetic	**R 253.46**		
	Radiology Ultrasound	**R 18.43**		
	Radiology	**R 27.40**		

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, 0173-0175, 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 Fund 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 Fund 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
L.	respect of specimens sent to pathologists. **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.
AA.	Procedures to exclude cost of isotope
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.	**Cystosopy:** (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).

MODIFIERS GOVERNING THE STRUCTURE									
Code	**Description**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
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 performed in doctor's own procedure rooms. (d) Please note that Modifier 0004 may not be used in conjunction with Modifier 0074 and 0075.		Not Applicable						
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.		Not Applicable	Adjust for multiple procedures		Adjust for multiple procedures			
	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		Not Applicable						
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.		Procedural fees	15.00	R 547.30	15.00	R 547.30		R -
0008	**Specialist surgeon assistant:** Where a procedure requires a registered specialist surgeon assistant, the fee is 40% of the fee for the specialist surgeon. CALCULATION: [Add up total allowable amounts across procedures, then calculate 40% thereof for this modifier to be recorded in the "Allowable Amount" column		Not Applicable						
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. CALCULATION: [Add up total allowable amounts across procedures, then calculate 20% thereof for this modifier to be recorded in the "Allowable Amount" column]		Not Applicable						

Code	**Description**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**

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.		Procedural fees	7.00	R 255.41	7.00	R 255.41	7.00	R 255.41
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)		Procedural fees		R -				R -
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		Not Applicable						
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.		Not Applicable	Submit Motivation Letter		Submit Motivation Letter			
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		Not Applicable						
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.		Not Applicable						
0017	**Injections administered by medical doctors:** When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the medical doctor him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections as part of a planned series of injections for the same condition should be coded to item 0131 (not to be coded together with a consultation item).		Consultation fees	7.50	R 574.40	7.50	R 287.20		R -
0018	**Surgical modifier for persons with a BMI of higher than 35** (calculated according to kg/m2 = weight in kilograms divided by height in metres squared rounded off to the first decimal): Units for the procedure (including appropriate modifiers, except for modifier 0011) + 50% of the units for the surgeons; and for the anaesthesiologists/anaesthetists + 50% increase in anaesthetic time units only. SURGEON CALCULATION: [Add up total allowable amounts across procedures, then take 50% thereof for the 0018 modified to be recorded in the "Allowable Amount" column.] ANAESTHETIST CALCULATION: [Calculate 50% of total allowable amount for 0023 and record in the "Allowable Amount" column.]		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value

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.		Not Applicable						
0020	**Conscious sedation:** Any case that is conducted outside of a theatre hospital suite shall be coded with the relevant procedure code. To identify these cases, the modifier 0020 should be used to indicate to the Fund that there will be no hospital/theatre account.		Not Applicable						
0021	**Determination of anaesthetic fees:** (a) 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 [refer to Modifier 0027 for more than one procedure under the same anaesthetic]) PLUS the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see Modifiers 0026 and 0037-0044). (b) 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. (c) The appropriate physical status modifier (refer to modifiers 5431 - 5436) should be added.		Anaesthetic		R -				R -
0023	The basic anaesthetic units are laid down in the structure 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.		Anaesthetic		R -				R -
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.		Consultation fees		R -		R -		R -
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.		Not Applicable						
0026	**One lung ventilation:** Utilisation of one lung ventilation: Add 3.00 anaesthetic units		Anaesthetic		R -			3.00	R 760.39
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 operation/procedure with the highest number of anaesthetic units.		Not Applicable						
0028	**Indicator for use of low flow anaesthetic technique less than 1 litre/minute:** Fresh gas flow of less than 1 litre/ minute. (No additional units to be added.)		Anaesthetic		R -				R -
0029	**Assistant anaesthesiologists**: When it is required by the scope of the anaesthesia, an assistant anaesthesiologist/anaesthetist may be employed. The units for the assistant anaesthesiologist/anaesthetist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic		Anaesthetic		R -				R -
0030	**Indicator for use of low flow anaesthetic technique 1-2 litre/minute:** Fresh gas flow of 1 to 2 litre/minute. (No additional units to be added.)		Anaesthetic		R -				R -
0031	**Intravenous drips and transfusions:** Treatment with intravenous drips and transfusions rendered either prior to, or during actual theatre or operating time, is considered part of the normal treatment treatment in administering an anaesthetic.		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0032	**Patients in prone position:** Anaesthesia administered to patients in the prone position shall have a minimum of 5,00 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 5,00 or more, no extra units should be added.		Anaesthetic		R -			2.00	R 506.93
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.		Anaesthetic		R -				R -
0034	**Head, neck and shoulder girdle procedures**: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head, neck and shoulder girdle shall have a minimum of 5,00 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 5,00 or more, no extra units should be added.		Anaesthetic		R -			2.00	R 506.93
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).		Anaesthetic		R -				R -
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.		Anaesthetic		R -				R -
0037	**Body hypothermia: Utilisation of total body hypothermia:** Add 3,00 anaesthetic units.		Anaesthetic		R -			3.00	R 760.39
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.		Anaesthetic		R -			4.00	R 1 013.85
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.		Anaesthetic		R -				R -
0040	**Phaeochromocytoma:** The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units		Anaesthetic		R -				R -
0041	**Hyperbaric pressurisation:** Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units		Anaesthetic		R -			3.00	R 760.39
0042	**Extracorporeal circulation:** Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units		Anaesthetic		R -			3.00	R 760.39
0043	**Anaesthesia for patients under one year of age or over 70 years of age:** 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		Anaesthetic		R -			3.00	R 760.39
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, if appropriate.		Anaesthetic		R -			3.00	R 760.39

0045	**Post-operative alleviation of pain:** (a) When a regional or nerve block procedure is performed in theatre for post-operative pain relief, the appropriate procedure item (items 2799 - 2804) will be coded, provided that it was not the primary anaesthetic technique. (b) When a regional or nerve block procedure is performed in the ward or nursing facility, the appropriate procedure items (items 2799 - 2804) will be coded, provided that it was not the primary anaesthetic technique. (c) When a second medical practitioner has administered the regional or nerve block for postoperative alleviation of pain in the ward or nursing facility, it will be coded 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. (d) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drugs).		Not Applicable						
5431	Physical status modifier: Normal helath patient, ASA 1: Add 0.00 anaesthetic units		Anaesthetic		R -				R -
5432	Physical status modifier: A patient with mild systemic disease, ASA 2: Add 0.00 anaesthetic units		Anaesthetic		R -				R -
5433	Physical status modifier: A patient with severe systemic disease, ASA 3: Add 1.00 anaesthetic unit		Anaesthetic		R -			1.00	R 253.46

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
5434	Physical status modifier:A patient with severe systemic disease that is a constant threat to life, ASA 4: Add 2 anaesthetic units		Anaesthetic		R -			2.00	R 506.93
5435	Physical status modifier:A moribund patient who is not expected to survive without the operation, ASA 5: Add 3 anaesthetic units		Anaesthetic		R -			3.00	R 760.39
5436	Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes, ASA 6: Add 0.00 anaesthetic units		Anaesthetic		R -				R -
	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		Anaesthetic		R -			1.00	R 253.46
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		Anaesthetic		R -			2.00	R 506.93
5443	**Maxillary and orbital bones:** Add three (3,00) anaesthetic units		Anaesthetic		R -			3.00	R 760.39
5444	**Shaft of femur:** Add four (4,00) anaesthetic units		Anaesthetic		R -			4.00	R 1 013.85
5445	**Spine (except coccyx), pelvis, hip, neck of femur**: Add five (5,00) anaesthetic units		Anaesthetic		R -			5.00	R 1 267.31
5448	**Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach:** Add eight (8,00) anaesthetic units		Anaesthetic		R -			8.00	R 2 027.70
0100	**Intra-aortic balloon pump:** Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, the addition of 75,00 clinical procedure units under modifier 0100, is applicable.		Procedural fees		R -			75.00	R 2 736.49

0046	Where in the treatment of a specific fracture or dislocation (compound [open]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.		Not Applicable						
0047	A fracture NOT requiring reduction shall be charged on a per service basis.		Not Applicable						
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 units for such subsequent reductions will be 27,00 clinical procedure units (not including aftercare)		Procedural fees	27.00	R 985.14	27.00	R 985.14		R -
0049	Except where otherwise specified, in cases of compound [open] fractures, the units for modifier 0049 are to be added to the units for the fractures (debridement included)		Procedural fees	126.20	R 4 604.60	120.00	R 4 378.38		R -
0051	Except where otherwise specified, fracture (traumatic or surgical, i.e. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixation/and or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as fractures/osteotomies of hands and feet (refer to modifier 0052) for specialists and general practitioners for LONG BONE or PELVIS fracture/osteotomy: Add to the appropriate procedure		Procedural fees	124.20	R 4 531.63	120.00	R 4 378.38		R -
0052	code Except where otherwise specified, fracture (traumatic or surgical, i.e. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixation/and or bone grafting (excluding fixation with Kirschner wires (refer to Modifier 0053) as well as long bone or pelvis fracture/osteotomy (refer to Modifier 0051) for specialist and general practitioner for HAND or FOOT fracture/osteotomy: Add to the appropriate procedure code.		Procedural fees	81.10	R 2 959.06	81.10	R 2 959.06		R -
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.		Procedural fees	32.00	R 1 167.57	32.00	R 1 167.57		R -
0055	**Dislocation requiring open reduction:** Units for the specific joint plus 77,00 clinical procedure units for specialists and general practitioners.		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46		R -
0057	**Multiple procedures on feet:** In multiple procedures on feet, the units for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate units for the second foot in the same way. The total units for the second foot are reduced by 25% of the units for the first foot. Add to the total units for the first foot.		Not Applicable						
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)		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered 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.		Not Applicable						

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 units 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).		Not Applicable						
0063	Where two specialists work together on a replantation procedure, each shall be entitled to twothirds of the units for the procedure.		Not Applicable						
0064	Where the replantation is unsuccessful, no further code is payable for amputation of the nonviable parts.		Not Applicable						
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of the units for the lesser procedure, except where otherwise specified elsewhere		Not Applicable						
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 units.		Not Applicable						
0067	**Microsurgery of the larynx:** Add 25% to the units of the operation performed.		Not Applicable						
0069	**When endoscopic instruments are used during intranasal surgery:** Add 10% of the units of the procedure performed. This is only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.		Not Applicable						
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope.		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89		R -
0072	**Non invasive peripheral vascular tests:** The number of tests in a single case are restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.		Not Applicable						
0076	Assistant paediatric cardiologist: The units for a paediatric cardiologist acting as an assistant is 50% of the units of the procedures performed.		Procedural fees		R -				R -
0074	**Endoscopic procedures performed with own equipment:** The value of modifier 0074 = 33.33% (1/3) of the procedure fee (plus "+" codes excluded), where endoscopic procedures are performed with own equipment.		Not Applicable						
0075	**Endoscopic procedures performed in own procedure room:** (a) The units for the procedure plus 21.00 clinical procedure units will apply where endoscopic procedures are performed in own rooms . (b) This modifier is used by medical doctors who own or rent the facility. (c) Modifier 0075 may not be used in conjuction with modifier 0004. (d) Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the structure.		Procedural fees	21.00	R 766.22	21.00	R 766.22		R -
0077	**Physical treatment:** When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments which should be coded separately. (Only applicable if services are provided by a specialist in physical medicine)		Not Applicable						
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure		Not Applicable						
0079	When a first or follow-up consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, both the consultation/isit and the psychotherapy codes (item 2957, 2974 or 2975) may be coded. Please note: When adding psychotherapy items after a first or follow-up consultation, the clinician must ensure that the time stipulated for the psychotherapy items are adhered to (i.e. item 2957 - minimum 10 minutes, item 2974 - minimum 30 minutes, and item 2975 - minimum 50 minutes).		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0080	**Multiple examinations:** No reduction in units.		Not Applicable						
0081	**Repeat examinations:** No reduction		Not Applicable						

0082	Plus "+" means that this item is complementary to a preceding item and is therefore not subject to reduction. The procedures marked with "+" must not be added to the units for the definitive item and must appear on a separate line on the account.		Not Applicable						
0083	A reduction of 33,33% (1/3) in the units will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.		Not Applicable						
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 magnetic 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.)		Not Applicable						
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		Not Applicable						
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 increase in terms of modifier 0080: Multiple examinations.		Not Applicable						
6300	If a procedure lasts less than 30 minutes, only 50% of the technical component (equipment) fees for items 3536-3550 will be allowed (specify time of procedure on account).		Not Applicable						
6302	When the procedure is performed by a non-radiologist, the units will be reduced by 40% (i.e. 60% of the units will be used).		Not Applicable						
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.		Not Applicable						
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)*		Not Applicable						
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.*		Not Applicable						
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.*		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
5104	**Ultrasound in pregnancy, multiple gestation, after twenty weeks:** Units for part examined plus 50% of the units.		Not Applicable						
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).		Not Applicable						
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).		Not Applicable						
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).		Not Applicable						
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.		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered 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.		Not Applicable						
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the units are applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.		Not Applicable						
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the units are 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.		Not Applicable						
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the units are applicable specifying that it is a “flow sensitive series”		Not Applicable						

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
I. CONSULTATIVE SERVICES									
I.	**Consultative services: General information:**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
I.a	**New and established patients: Consultations/visits by Psychiatrists (22) only**								
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/ visit by psychiatrist - refer to items 0166-0169).		Psychiatrists	15.00	R 1 374.12				R -
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).		Psychiatrists	27.50	R 2 519.22				R -
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).		Psychiatrists	40.00	R 3 664.33				R -
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 01660169).		Psychiatrists	52.50	R 4 809.43				R -
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.		Psychiatrists	15.00	R 1 374.12				R -
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.		Psychiatrists	27.50	R 2 519.22				R -
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.		Psychiatrists	40.00	R 3 664.33				R -
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.		Psychiatrists	52.50	R 4 809.43				R -
I.b.	**General Practitioner and Specialist services**								
	NOTE: Items 0190-0193 and items 0173-0175 (as appropriate) should be used by all medical doctors, except or psychiatrists who should use items 7021-7032 (as appropriate) for new consultation/treatment (therapy)(C/T).								
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 coordination 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.		Consultation fees	15.00	R 1 148.80	15.00	R 574.40		R -
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.		Consultation fees	30.00	R 2 297.61	30.00	R 1 148.80		R -

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.		Consultation fees	45.00	R 3 446.41	45.00	R 1 723.20		R -
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.		Consultation fees	63.60	R 4 870.92	63.60	R 2 435.46		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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.		Consultation fees	15.00	R 1 148.80	15.00	R 574.40		R -
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.		Consultation fees	30.00	R 2 297.61	30.00	R 1 148.80		R -
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.		Consultation fees	45.00	R 3 446.41	45.00	R 1 723.20		R -
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for postoperative 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 7021 - 7032.		Consultation fees	15.00	R 1 148.80	15.00	R 574.40		R -
0178	Hospital follow-up visit patient in ward or nursing facility with a duration of 31 - 60 minutes: ADD only to item 0109, as appropriate. (Psychiatrists (Pr "22") refer to items 7021 - 7032)	+	Consultation fees		R -		R -		R -
0179	Prolonged face-to-face attendance to a patient in ward or nursing facility: ADD to either item 0178 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 (please state duration of visit on account in minutes)	+	Consultation fees		R -		R -		R -
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.		Consultation fees	22.50	R 1 723.20		R -		R -
I.d	**Add-on consultative services:**								
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 7021 - 7032, or item 0109, as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof.	+	Consultation fees	6.00	R 459.52	6.00	R 229.76		R -
0146	For an EMERGENCY consultation/visit AT the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 7021-7032, or items 0151-0153 as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof.	+	Consultation fees	8.00	R 612.69	8.00	R 306.35		R -
0126	For an UNSCHEDULED consultation/visit AT the doctor's home or rooms: ADD only to the consultation/visit items 0190-0192, items 7021-7032, or items 0151-0153 as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof.	+	Consultation fees		R -		R -		R -
0147	For an emergency OR unscheduled consultation/visit AWAY from the medical doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 7021-7032, or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.	+	Consultation fees	14.00	R 1 072.22	14.00	R 536.11	14.00	R 1 072.22
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, 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).	+	Consultation fees	15.00	R 1 148.80	15.00	R 574.40		R -

I.e	Emergency department								
	An emergency department is defined as a facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. Emergency diagnosis and treatment of illness or injury is provided. The facility must be available 24 hours a day.								
7060	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: (a) problem focused history (b) problem focused examination (c) straightforward medical decission making. Counselling and/or co-ordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are self-limited or minor		Consultation fees		R -		R -		R -
7061	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: (a) expanded problem focused history (b) expanded problem focused examination (c) medical decission making of low complexity. Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of low or moderate severity		Consultation fees		R -		R -		R -
7062	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: (a) expanded problem focused history (b) expanded problem focused examination (c) medical decission making of moderate complexity. Counselling and/or co-ordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of moderate severity		Consultation fees		R -		R -		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
7063	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: (a) a detailed history (b) a detailed examination (c) medical decission making of moderate complexity. Counselling and/or co-ordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity, and require urgent evaluation by the medical practitioner but do not pose an imediate significant threat to life or physiologic function.		Consultation fees		R -		R -		R -
7064	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: (a) comprehensive history (b) comprehensive examination (c) medical decission making of high complexity. Counselling and/or co-ordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) are of high severity, and require urgent evaluation by the medical practitioner and pose an imediate significant threat to life or physiologic function.		Consultation fees		R -		R -		R -
I.f	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.		Consultation fees	16.00	R 225.39 1	16.00	R 612.69	16.00	R 225.39 1
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.		Consultation fees	32.00	R 450.78 2	32.00	R 225.39 1		R -
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.		Consultation fees	45.00	R 446.41 3	45.00	R 723.20 1		R -
I.g.	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*		Consultation fees	33.00	R 527.37 2	33.00	R 263.68 1		R -

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)		Consultation fees	45.00	R 3 446.41	45.00	R 1 723.20		R -
I.h.	**Consultative services: Miscellaneous**								
0130	Telephone consultation (all hours)		Consultation fees	12.00	R 919.04	12.00	R 459.52		R -
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 consultation item.		Consultation fees	7.50	R 574.40	7.50	R 287.20		R -
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)		Consultation fees	5.00	R 382.93	5.00	R 191.47	5.00	R 382.93
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		Consultation fees	9.00	R 689.28	9.00	R 344.64	9.00	R 689.28
0137	Patient and/or family education and/or guidance for a specific condition for 20 minutes, supported by the appropriate ICD10 code(s). ICD 10 codes to be added for this service. This item may be added to a consultation if done in addition to the consultation (specific items from consultative services structure will be added in the working of the description.)		Consultation fees	15.00	R 1 148.80		R -		R -
0138	Patient and/or family education and/or guidance for a specific condition for 40 minutes, supported by the appropriate ICD10 code(s). ICD 10 codes to be added for this service. This item may be added to a consultation if done in addition to the consultation (specific items from consultative services structure will be added in the working of the description.)		Consultation fees	30.00	R 2 297.61		R -		R -
0139	Patient and/or family education and/or guidance for a specific condition for 41 minutes and longer, supported by the appropriate ICD10 code(s). ICD 10 codes to be added for this service. This item may be added to a consultation if done in addition to the consultation (specific items from consultative services structure will be added in the working of the description.)		Consultation fees	45.00	R 3 446.41		R -		R -
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		Consultation fees	21.43	R 1 641.26	21.43	R 820.63	21.43	R 1 641.26

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
II. Medicine, material, supplies and use of own equipment									
II.a	**Medicine codes**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
II.a.1	**Dispensing of medicine by licensed dispensing medical practitioners**								
	2020 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 R128 the fee must not exceed 30% of the SEP. b. Where SEP is equal to or greater than R128 the fee must not exceed R38,40 in respect of that medicine or scheduled substance								
0197	**Licensed dispensing medical doctors:** To be used for dispensed items where the practice is a licensed dispensing doctor's practice. This code will be used for medicine, material and/or unregistered/unscheduled products that are dispensed. The pricing of these items will be dependent on whatever the relevant legislation at the time specified e.g. schedule based and where not governed by legislation, then it is up to the medical doctor to determine an appropriate handling fee. The appropriate NAPPI code(s), where applicable, must be provided.		Not Applicable						
II.a.2	**Once-off administration of medicine used during a consultation**								
0198	**Once-off dispensing of medicine, material and unregistered/unscheduled products:** To be used for the once-off dispensing of medicine, material and/or unregistered/unscheduled products as a once-off occurrence in the event of an emergency where the practice is not a licensed dispensing practice. The pricing of these items will be dependent on whatever the relevant legislation at the time specified e.g. schedule based and where not governed by legislation at the time, then it is up to the medical doctor to determine an appropriate handling fee. The appropriate NAPPI code(s), where applicable, must be provided.		Not Applicable						
II.b	**Material codes**								
II.b.1	**Material used during a consultation**								

0201	Medicine, material and/or unregistered/unscheduled products used during treatment: To be used for all medicine, material and/or unregistered/unscheduled products using in treatment. The appropriate NAPPI code(s), where appicable, must be provided.		Not Applicable						
II.b.2	**Setting of sterile tray**								
0202	**Setting of sterile tray:** Where a sterile procedure is perfromed in the rooms, 10.00 clinical procedure units will be appropriate for setting of the sterile tray. Cost of stitching material, if applicable, shall be coded for according to item 0201 (Cost of material used in treatment), as appropriate.		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
II.c	**Own equipment used in treatment**								
II.c.1	**Laser equipment**								
5930	Surgical laser apparatus: Hire fee for own equipment		Procedural fees	109.00	R 3 977.03	109.00	R 3 977.03		R -
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement)		Not Applicable						
II.c.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.*								

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered 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		Not Applicable						
1. General									
1.1	**Injections, Infusions and Inhalation Sedation Treatment**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
0204	Inhalation sedation: Per additional quarter-hour or part thereof		Procedural fees	3.00	R 109.46	3.00	R 109.46		R -
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - applicable once per calender day		Procedural fees	12.00	R 437.84	12.00	R 437.84		R -
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula by medical doctor personally - applicable once per calender day.		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula by medical doctor personally - applicable once per calender day		Procedural fees	8.00	R 291.89	8.00	R 291.89		R -
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
0209	Umbilical artery cannulation at birth		Procedural fees	18.00	R 656.76	18.00	R 656.76		R -

0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)		Procedural fees	3.25	R 118.58	3.25	R 118.58		R -
0211	Exchange transfusion: First and subsequent (including after-care)		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92		R -
	Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Medical doctors are entitled to code according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once per calendar day). Managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, is regarded as part of the services the doctor renders during consultations. Item 0205: Intravenous infusions (cutdown or push-in)(patients under three years old) may be coded daily for managing the infusion in addition to daily hospital visit item or daily Intensive Care Unit (ICU) items.								
2. Integumentary System									
2.1	**Allergy**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
0217	Allergy: Patch tests: First patch		Procedural fees	4.00	R 145.95	4.00	R 145.95		R -
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs		Procedural fees	2.80	R 102.16	2.80	R 102.16		R -
0219	Allergy: Patch tests: Each additional patch		Procedural fees	2.00	R 72.97	2.00	R 72.97		R -
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens		Procedural fees	1.90	R 69.32	1.90	R 69.32		R -
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen		Procedural fees	2.80	R 102.16	2.80	R 102.16		R -
2.2	**Skin (general)**								
0222	Intralesional injection into areas of pathology e.g. Keloid: Single		Procedural fees	4.00	R 145.95	4.00	R 145.95		R -
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple		Procedural fees	8.00	R 291.89	8.00	R 291.89		R -
0228	PUVA Treatment: Maximum of 21 treatments		Procedural fees	20.00	R 729.73	20.00	R 729.73		R -
0229	PUVA: Follow-up or maintenance therapy once a week		Procedural fees	20.00	R 729.73	20.00	R 729.73		R -
0230	UVR-Treatment		Procedural fees	20.00	R 729.73	20.00	R 729.73		R -
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		Procedural fees	5.50	R 200.68	5.50	R 200.68		R -
0232	Biopsy of superficial soft tissue: Back or flank		Procedural fees	47.40	R 1 729.46	47.40	R 1 729.46	5,00T	R 1 267.31
0233	Biopsy without suturing: First lesion		Procedural fees	6.00	R 218.92	6.00	R 218.92	3,00T	R 760.39
0234	Biopsy without suturing: Subsequent lesions (each)	+	Procedural fees	3.00	R 109.46	3.00	R 109.46	3,00T	R 760.39
0235	Biopsy without suturing: Maximum for multiple additional lesions		Procedural fees	18.00	R 656.76	18.00	R 656.76	3,00T	R 760.39

0236	Biopsy of superficial soft tissue: Shoulder area		Procedural fees	49.10	R 1 791.49	49.10	R 1 791.49	3,00T	R 760.39
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing		Procedural fees	12.00	R 437.84	12.00	R 437.84	3,00T	R 760.39
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		Procedural fees	49.10	R 1 791.49	49.10	R 1 791.49	3,00T	R 760.39
0239	Biopsy of superficial soft tissue: Forearm and/or wrist		Procedural fees	48.50	R 1 769.60	48.50	R 1 769.60	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0240	Biopsy of superficial soft tissue: Leg or ankle area		Procedural fees	48.30	R 1 762.30	48.30	R 1 762.30	3,00T	R 760.39
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion		Procedural fees	6.00	R 218.92	6.00	R 218.92	3,00T	R 760.39
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	+	Procedural fees	3.00	R 109.46	3.00	R 109.46	3,00T	R 760.39
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	+	Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	3,00T	R 760.39
0244	Repair of nail bed		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	3,00T	R 760.39
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion		Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	+	Procedural fees	7.00	R 255.41	7.00	R 255.41	3,00T	R 760.39
0247	Biopsy of superficial soft tissue: Pelvis and hip area		Procedural fees	58.30	R 2 127.16	58.30	R 2 127.16	3,00T	R 760.39
0248	Biopsy of superficial soft tissue: Thigh or knee area		Procedural fees	52.30	R 1 908.24	52.30	R 1 908.24	3,00T	R 760.39
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	3,00T	R 760.39
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	+	Procedural fees	15.00	R 547.30	15.00	R 547.30	3,00T	R 760.39
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
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		Procedural fees	87.00	R 3 174.33	87.00	R 3 174.33	3,00T	R 760.39
0258	Incision/removal of foreign body: subcutaneous tissue, simple		Procedural fees	31.00	R 1 131.08	31.00	R 1 131.08	3,00T	R 760.39
0259	Removal of foreign body : Muscle or tendon sheath, simple		Procedural fees	43.70	R 1 594.46	43.70	R 1 594.46	3,00T	R 760.39
0260	Incision/removal of foreign body: subcutateous tissue, complicated		Procedural fees	55.50	R 2 025.00	55.50	R 2 025.00	3,00T	R 760.39
0261	Removal of foreign body: Muscle of tendon sheath, deep/complicated		Procedural fees	74.20	R 2 707.30	74.20	R 2 707.30	3,00T	R 760.39

0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax; less than 3 cm		Procedural fees	90.10	R 3 287.44	90.10	R 3 287.44	5,00T	R 1 267.31
0263	Excision tumour of subcutaneous soft tissue: Shoulder area; less than 3 cm		Procedural fees	84.20	R 3 072.16	84.20	R 3 072.16	3,00T	R 760.39
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area; less than 3 cm		Procedural fees	94.50	R 3 447.98	94.50	R 3 447.98	3,00T	R 760.39
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area; less than 3 cm		Procedural fees	94.70	R 3 455.27	94.70	R 3 455.27	3,00T	R 760.39
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger; less than 1,5 cm		Procedural fees	99.30	R 3 623.11	99.30	R 3 623.11	3,00T	R 760.39
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area; less than 3 cm		Procedural fees	111.60	R 4 071.90	111.60	R 4 071.90	3,00T	R 760.39
0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area; less than 3 cm		Procedural fees	92.10	R 3 360.41	92.10	R 3 360.41	3,00T	R 760.39
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area; less than 3 cm		Procedural fees	92.60	R 3 378.65	92.60	R 3 378.65	3,00T	R 760.39
0270	Excision tumour of subcutaneous soft tissue: Foot or toe; less than 1,5 cm		Procedural fees	78.30	R 2 856.89	78.30	R 2 856.89	3,00T	R 760.39
0279	Surgical treatment for axillary hyperhidrosis		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	4,00T	R 1 013.85
0280	Laser treatment for small skin lesions: First lesion		Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	+	Procedural fees	7.00	R 255.41	7.00	R 255.41	3,00T	R 760.39
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions		Procedural fees	56.00	R 2 043.25	56.00	R 2 043.25	3,00T	R 760.39
0283	Laser treatment for large skin lesions: Limited area		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	4,00T	R 1 013.85
0284	Laser treatment for large skin lesions: Extensive area		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	4,00T	R 1 013.85
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
2.3	**Major plastic repair**								
0288	Harvesting of graft: Fascia lata graft, complex or sheet.		Procedural fees	127.40	R 4 648.38	120.00	R 4 378.38	4,00T	R 1 013.85
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts		Procedural fees	234.00	R 8 537.85	187.20	R 6 830.28	4,00T	R 1 013.85
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fasciocutaneous flap		Procedural fees	410.00	R 14 959.47	328.00	R 11 967.58	4,00T	R 1 013.85
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis		Procedural fees	800.00	R 29 189.22	640.00	R 23 351.37	4,00T	R 1 013.85
0292	Distant flaps: First stage		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
0293	Contour grafts (excluding cost of material)		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85

0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses		Procedural fees	1 200.00	R 43 783.82	960.00	R 35 027.06	6,00T	R 1 520.78
0295	Local skin flaps (large, complicated)		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0296	Other procedures of major technical nature		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
0297	Subsequent major procedures for repair of same lesion		Procedural fees	104.00	R 3 794.60	104.00	R 3 794.60	4,00T	R 1 013.85
0298	Lower abdominal dermo-lipectomy		Procedural fees	170.00	R 6 202.71	136.00	R 4 962.17	5,00T	R 1 267.31
0299	Major abdominal lipectomy with repositioning of umbilicus		Procedural fees	275.00	R 10 033.79	220.00	R 8 027.03	5,00T	R 1 267.31
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)		Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	+	Procedural fees	7.00	R 255.41	7.00	R 255.41	3,00T	R 760.39
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	4,00T	R 1 013.85
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	4,00T	R 1 013.85
0304	Major debridement of wound, sloughectomy or secondary suture		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	3,00T	R 760.39
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		Procedural fees	13.90	R 507.16	13.90	R 507.16	3,00T	R 760.39
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof	+	Procedural fees	5.30	R 193.38	5.30	R 193.38	3,00T	R 760.39
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51	5,00T	R 1 267.31
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof	+	Procedural fees	11.20	R 408.65	11.20	R 408.65	5,00T	R 1 267.31
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		Procedural fees	62.50	R 2 280.41	62.50	R 2 280.41	6,00T	R 1 520.78
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof		Procedural fees	19.50	R 711.49	19.50	R 711.49	6,00T	R 1 520.78
0305	Needle biopsy - soft tissue		Procedural fees	25.00	R 912.16	25.00	R 912.16	3,00T	R 760.39
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude		Procedural fees	27.00	R 985.14	27.00	R 985.14	3,00T	R 760.39
0308	Each additional small procedure done at the same time	+	Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
0306	Excision subcutaneous mass <2cm: Head and neck, e.g. lipoma, cyst		Procedural fees	96.70	R 3 528.25	96.70	R 3 528.25	5,00T	R 1 267.31

0318	Excision subcutaneous mass <2cm involving muscle/subgaleal: Head and neck, e.g. lipoma, cyst		Procedural fees	101.90	R 3 717.98	101.90	R 3 717.98	5,00T	R 1 267.31
0309	Excision subcutaneous mass >2cm: Head and neck, e.g. lipoma, cyst		Procedural fees	149.40	R 5 451.09	120.00	R 4 378.38	5,00T	R 1 267.31
0312	Excision subcutaneous mass >2cm involving muscle/subgaleal: Head and neck, e.g. lipoma, cyst		Procedural fees	157.20	R 5 735.68	125.76	R 4 588.54	5,00T	R 1 267.31
0310	Radical excision of nailbed		Procedural fees	38.00	R 1 386.49	38.00	R 1 386.49	3,00T	R 760.39
0313	Extensive resection for malignant soft tissue tumour including muscle		Procedural fees	283.90	R 10 358.52	227.12	R 8 286.82	4,00T	R 1 013.85
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude		Procedural fees	104.00	R 3 794.60	104.00	R 3 794.60	4,00T	R 1 013.85
0315	Requiring repair by small skin graft or small local flap or other procedures of similar		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76	3,00T	R 760.39
4940	magnitude Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) <= 0.5 cm		Procedural fees	22.50	R 820.95	22.50	R 820.95	3,00T	R 760.39
4941	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 0.6-1.0 cm		Procedural fees	29.70	R 1 083.65	29.70	R 1 083.65	3,00T	R 760.39
4942	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 1.1-2.0 cm		Procedural fees	32.80	R 1 196.76	32.80	R 1 196.76	3,00T	R 760.39
4943	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 2.1-3.0 cm		Procedural fees	41.80	R 1 525.14	41.80	R 1 525.14	3,00T	R 760.39
4944	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 3.1-4.0 cm		Procedural fees	46.30	R 1 689.33	46.30	R 1 689.33	3,00T	R 760.39
4945	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) > 4.0 cm		Procedural fees	69.80	R 2 546.76	69.80	R 2 546.76	3,00T	R 760.39
4950	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia <0.5 cm		Procedural fees	23.50	R 857.43	23.50	R 857.43	5,00T	R 1 267.31
4951	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 0.6-1.0 cm		Procedural fees	32.10	R 1 171.22	32.10	R 1 171.22	5,00T	R 1 267.31
4952	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 1.1-2.0 cm		Procedural fees	38.90	R 1 419.33	38.90	R 1 419.33	5,00T	R 1 267.31
4953	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 2.1-3.0 cm		Procedural fees	45.30	R 1 652.84	45.30	R 1 652.84	5,00T	R 1 267.31
4954	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 3.1-4.0 cm		Procedural fees	51.80	R 1 890.00	51.80	R 1 890.00	5,00T	R 1 267.31
4955	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia > 4.0 cm		Procedural fees	79.00	R 2 882.44	79.00	R 2 882.44	5,00T	R 1 267.31
4960	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane <0.5 cm		Procedural fees	29.20	R 1 065.41	29.20	R 1 065.41	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
4961	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 0.6- 1.0 cm		Procedural fees	37.80	R 1 379.19	37.80	R 1 379.19	5,00T	R 1 267.31

4962	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 1.1-2.0 cm		Procedural fees	42.10	R 536.08	1	42.10	R 536.08	1	5,00T	R 267.31	1
4963	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 2.1-3.0 cm		Procedural fees	51.70	R 886.35	1	51.70	R 886.35	1	5,00T	R 267.31	1
4964	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 3.1-4.0 cm		Procedural fees	65.90	R 404.46	2	65.90	R 404.46	2	5,00T	R 267.31	1
4965	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane > 4.0 cm		Procedural fees	94.00	R 429.73	3	94.00	R 429.73	3	5,00T	R 267.31	1
4856	Split thickness autograft of the trunk, arms and/or legs <=100² cm (1% of body area for infants and children)		Procedural fees	153.60	R 604.33	5	153.60	R 604.33	5	5,00T	R 267.31	1
4857	Split thickness autograft of the trunk, arms and/or legs; each additional 100² cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)	+	Procedural fees	31.50	R 149.33	1	31.50	R 149.33	1	5,00T	R 267.31	1
4858	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100² cm (1% of body area for infants and children)		Procedural fees	172.00	R 275.68	6	172.00	R 275.68	6	5,00T	R 267.31	1
4859	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100² cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)	+	Procedural fees	51.60	R 882.70	1	51.60	R 882.70	1	5,00T	R 267.31	1
4862	Full thickness graft of the trunk, free graft including direct closure of donor site: <=20cm²		Procedural fees	136.50	R 980.41	4	120.00	R 378.38	4	5,00T	R 267.31	1
4863	Full thickness graft of the trunk, free graft including direct closure of donor site, each additional 20cm² (modifier 0005 not applicable)	+	Procedural fees	25.60	R 934.05		25.60	R 934.05		5,00T	R 267.31	1
4864	Full thickness graft of the scalp, arms and/or legs, free graft including direct closure of donor site: <=20cm²		Procedural fees	140.30	R 119.06	5	120.00	R 378.38	4	5,00T	R 267.31	1
4865	Full thickness graft of the scalp, arms and/or legs, free graft including direct closure of donor site; each additional 20cm² (modifier 0005 not applicable)	+	Procedural fees	23.00	R 839.19		23.00	R 839.19		5,00T	R 267.31	1
4866	Full thickness graft of the face, neck, axilla, genitalia, hands and/or feet, free graft including direct closure of donor site: <=20cm²		Procedural fees	163.40	R 961.90	5	130.72	R 769.52	4	5,00T	R 267.31	1
4867	Full thickness graft of the face, neck, axilla, genitalia, hands and/or feet, free graft including direct closure of donor site; each additional 20cm² (modifier 0005 not applicable)	+	Procedural fees	36.20	R 320.81	1	36.20	R 320.81	1	5,00T	R 267.31	1
4868	Full thickness graft of the nose, ears, eyelids and/or lips, free graft including direct closure of donor site: <=20cm²		Procedural fees	183.50	R 695.28	6	146.80	R 356.22	5	5,00T	R 267.31	1
4869	Full thickness graft of the nose, ears, eyelids and/or lips, free graft including direct closure of donor site; each additional 20cm² (modifier 0005 not applicable)	+	Procedural fees	43.10	R 572.57	1	43.10	R 572.57	1	5,00T	R 267.31	1
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100² cm (1% of body area for infants and children)		Procedural fees	66.30	R 419.06	2	66.30	R 419.06	2	5,00T	R 267.31	1
4873	Acellular dermal allograft of the trunk, arms and/or legs; each additional 100² cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)	+	Procedural fees	15.30	R 558.24		15.30	R 558.24		5,00T	R 267.31	1
4874	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100² cm (1% of body area for infants and children)		Procedural fees	74.00	R 700.00	2	74.00	R 700.00	2	5,00T	R 267.31	1
4875	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100² cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)	+	Procedural fees	21.80	R 795.41		21.80	R 795.41		5,00T	R 267.31	1
4880	Biopsy soft tissue: Neck or thorax		Procedural fees	46.60	R 700.27	1	46.60	R 700.27	1	5,00T	R 267.31	1
4881	Biopsy of soft tissue: Deep: Back or flank		Procedural fees	100.40	R 663.25	3	100.40	R 663.25	3	5,00T	R 267.31	1
4882	Biopsy of soft tissue: Deep: Shoulder area		Procedural fees	117.60	R 290.81	4	117.60	R 290.81	4	5,00T	R 267.31	1
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular): Upper arm or elbow area		Procedural fees	117.60	R 290.81	4	117.60	R 290.81	4	3,00T	R 760.39	

4884	Biopsy of soft tissue: Deep (subfascial or intramuscular): Forearm and/or wrist		Procedural fees	106.60	R 3 889.46	106.60	R 3 889.46	3,00T	R 760.39
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular): Thigh or knee area		Procedural fees	112.90	R 4 119.33	112.90	R 4 119.33	4,00T	R 1 013.85
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular): Leg or ankle area		Procedural fees	119.50	R 4 360.14	119.50	R 4 360.14	3,00T	R 760.39
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular): Pelvis and hip area		Procedural fees	197.70	R 7 213.39	197.70	R 7 213.39	4,00T	R 1 013.85
2.5	**Breasts**								
0316	Fine needle aspiration for soft tissue (all areas)		Procedural fees	15.00	R 547.30	15.00	R 547.30		R -
0317	Aspiration of cyst or tumour		Procedural fees	9.00	R 328.38	9.00	R 328.38	3,00T	R 760.39
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant		Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	3,00T	R 760.39
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma		Procedural fees	94.20	R 3 437.03	94.20	R 3 437.03	3,00T	R 760.39
0323	Subareolar cone excision of ducts of wedge excision of breast		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	3,00T	R 760.39
0324	Wedge excision of breast and axillary dissection		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	5,00T	R 1 267.31
0325	Total mastectomy		Procedural fees	155.00	R 5 655.41	124.00	R 4 524.33	5,00T	R 1 267.31
0327	Total mastectomy with axillary gland biopsy		Procedural fees	185.00	R 6 750.01	148.00	R 5 400.00	5,00T	R 1 267.31
0329	Total mastectomy with axillary gland dissection		Procedural fees	275.00	R 10 033.79	220.00	R 8 027.03	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0330	Nipple and areola reconstruction		Procedural fees	95.00	R 3 466.22	95.00	R 3 466.22	4,00T	R 1 013.85
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral		Procedural fees	234.00	R 8 537.85	187.20	R 6 830.28	4,00T	R 1 013.85
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral		Procedural fees	410.00	R 14 959.47	328.00	R 11 967.58	4,00T	R 1 013.85
0334	Removal of breast implant by means of capsulectomy: Per breast		Procedural fees	234.00	R 8 537.85	187.20	R 6 830.28	4,00T	R 1 013.85
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	4,00T	R 1 013.85
0336	Breast reconstruction: Lattisimus dorsi flap, without prosthetic implant.		Procedural fees	378.80	R 13 821.09	303.04	R 11 056.88	5,00T	R 1 267.31
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral		Procedural fees	234.00	R 8 537.85	187.20	R 6 830.28	5,00T	R 1 267.31

0338	Breast reconstruction; Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, suture of donor site included		Procedural fees	467.30	R 17 050.15	373.84	R 13 640.12	5,00T	R 1 267.31
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral		Procedural fees	410.00	R 14 959.47	328.00	R 11 967.58	5,00T	R 1 267.31
0340	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, with microvascular anastomosis (supercharging)(suture of donor site included)		Procedural fees	555.50	R 20 268.26	444.40	R 16 214.61	5,00T	R 1 267.31
0341	Gynaecomastia: Unilateral		Procedural fees	92.00	R 3 356.76	92.00	R 3 356.76	3,00T	R 760.39
0343	Gynaecomastia: Bilateral		Procedural fees	161.00	R 5 874.33	128.80	R 4 699.46	3,00T	R 760.39
2.6	**Burns**								
0345	Minor burns		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	Per service	
0347	Moderate burns		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	Per service	
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)		Procedural fees	276.00	R 10 070.28	220.80	R 8 056.22	5,00T	R 1 267.31
0353	Tangential excision and grafting: Small		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	5,00T	R 1 267.31
0354	Tangential excision and grafting: Large		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	5,00T	R 1 267.31
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		Procedural fees	147.40	R 5 378.11	120.00	R 4 378.38	4,00T	R 1 013.85
0357	Small skin graft in acute hand injury		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	3,00T	R 760.39
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
0361	Z-plasty		Procedural fees	220.10	R 8 030.68	176.08	R 6 424.55	3,00T	R 760.39
0363	Local flap and skin graft		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	3,00T	R 760.39
0365	Cross finger flap (all stages)		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
0367	Palmar flap (all stages)		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
0369	Distant flap: First stage		Procedural fees	158.00	R 5 764.87	126.40	R 4 611.90	3,00T	R 760.39
0371	Distant flap: Subsequent stage (not subject to general modifier 0005)		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	3,00T	R 760.39
0373	Transfer neurovascular island flap		Procedural fees	230.50	R 8 410.14	184.40	R 6 728.11	3,00T	R 760.39
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)		Procedural fees	242.40	R 8 844.33	193.92	R 7 075.47	3,00T	R 760.39

0375	Dupuytren's contracture: Fasciotomy		Procedural fees	51.00	R 1 860.81	51.00	R 1 860.81	3,00T	R 760.39
0376	Dupuytren's contracture: Fasciectomy		Procedural fees	218.00	R 7 954.06	174.40	R 6 363.25	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered 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		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
0378	Laser acupuncture using more than 6 points		Procedural fees	14.00	R 510.81	14.00	R 510.81		R -
0379	Electro-acupuncture		Procedural fees	14.00	R 510.81	14.00	R 510.81		R -
0380	Scalp acupuncture		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
0381	Micro-acupuncture (ear, hand)		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
3. Musculo-Skeletal System									
3.1	**Bones**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
3.1.1	**Bones: Fractures (Reduction under general anaesthetic - refer to modifier 0047)**								
0383	Fracture: Scapula (reduction under general anaesthetic)		Procedural fees	112.30	R 4 097.44	112.30	R 4 097.44	3,00TM	R 760.39
0384	Fracture: Scapula: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable).		Procedural fees	284.20	R 10 369.47	227.36	R 8 295.58		R -
0386	Fracture: Clavicle: Open reduction and internal fixation (Modifier 0051, 0052 not applicable).		Procedural fees	209.40	R 7 640.28	167.52	R 6 112.22		R -
0387	Fracture: Clavicle (reduction under general anaesthetic)		Procedural fees	93.80	R 3 422.44	93.80	R 3 422.44	3,00TM	R 760.39
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure (Modifiers not applicable).		Procedural fees	216.10	R 7 884.74	172.88	R 6 307.79	3,00TM	R 760.39
0389	Fracture: Humerus: (reduction under general anaesthetic)		Procedural fees	129.60	R 4 728.65	129.60	R 4 728.65	3,00TM	R 760.39

0390	Fracture: Humerus: Open reduction and internal fixation (Modifier 0051 not applicable).		Procedural fees	255.30	R 9 315.01	204.24	R 7 452.01	3,00TM	R 760.39
0391	Fracture: Radius and/or Ulna: (reduction under general anaesthetic)		Procedural fees	135.70	R 4 951.22	120.00	R 4 378.38	3,00TM	R 760.39
0392	Fracture: Radius or Ulna: Open reduction and internal fixation (Modifier 0051 not applicable).		Procedural fees	193.50	R 7 060.14	154.80	R 5 648.11	3,00TM	R 760.39
0401	Fracture: Carpal bone: Open reduction and internal fixation (Modifier 0052 not applicable)		Procedural fees	208.70	R 7 614.74	166.96	R 6 091.79	3,00TM	R 760.39
0402	Fracture: Carpal bone: (reduction under general anaesthetic)		Procedural fees	119.30	R 4 352.84	119.30	R 4 352.84	3,00TM	R 760.39
0403	Fracture/Dislocation: Bennett fracture: (reduction under general anaesthetic)		Procedural fees	84.50	R 3 083.11	84.50	R 3 083.11	3,00TM	R 760.39
0404	Fracture: Bennet fracture/dislocation: Open reduction and internal fixation (Modifiers 0051, 0052, 0055 not applicable)		Procedural fees	179.80	R 6 560.28	143.84	R 5 248.22	3,00TM	R 760.39
0405	Fracture: Metacarpal bone (reduction under general anaesthesia)		Procedural fees	75.40	R 2 751.08	75.40	R 2 751.08	3,00TM	R 760.39
0406	Fracture: Metacarpal bone: Open reduction and intenal fixation (Modifier 0052 not applicable)		Procedural fees	163.60	R 5 969.19	130.88	R 4 775.36	3,00TM	R 760.39
0409	Fracture: Finger phalanx: Distal, Simple: (reduction under general anaesthetic)		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	3,00TM	R 760.39
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (Modifier 0052 not applicable.)		Procedural fees	141.10	R 5 148.25	120.00	R 4 378.38	3,00TM	R 760.39
0413	Fracture: Finger phalanx, proximal or middle (reduction under general anaesthetic.)		Procedural fees	50.50	R 1 842.57	50.50	R 1 842.57	3,00TM	R 760.39
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifier 0052 not applicable)		Procedural fees	169.90	R 6 199.06	135.92	R 4 959.25	3,00TM	R 760.39
0417	Fracture: Pelvis closed (reduction under general anaesthetic)		Procedural fees	132.70	R 4 841.76	120.00	R 4 378.38	3,00TM	R 760.39
0419	Fracture: Pelvis: Open reduction and internal fixation (Modifier 0051 not applicable)		Procedural fees	354.49	R 12 934.11	283.59	R 10 347.21	3,00TM	R 760.39
0420	Fracture: Acetabulum: Open reduction and internal fixation (Modifier 0051 not applicable)		Procedural fees	560.00	R 20 432.45	448.00	R 16 345.96	3,00TM	R 760.39
0421	Fracture: Femur: Neck or Shaft: (reduction under general anaesthetic)		Procedural fees	279.10	R 10 183.39	223.28	R 8 146.71	3,00TM	R 760.39
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (Modifier 0051 not applicable		Procedural fees	392.30	R 14 313.66	313.84	R 11 450.93	3,00TM	R 760.39
0425	Fracture: Patella (reduction under general anaesthetic)		Procedural fees	82.50	R 3 010.14	82.50	R 3 010.14	3,00TM	R 760.39
0429	Fracture: Tibia with or without fibula (reduction under general anaesthetic)		Procedural fees	143.40	R 5 232.17	120.00	R 4 378.38	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value

0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (Modifier 0051 not applicable)		Procedural fees	293.20	R 10 697.85	234.56	R 8 558.28	3,00TM	R 760.39
0433	Fracture: Fibula shaft (reduction under general anaesthetic)		Procedural fees	112.40	R 4 101.08	112.40	R 4 101.08	3,00TM	R 760.39
0434	Fracture:Fibula shaft: Open reduction and internal fixation (modifier 0051 not applicable)		Procedural fees	207.00	R 7 552.71	165.60	R 6 042.17		R -
0435	Fracture: Ankle malleolus (reduction under general anaesthetic)		Procedural fees	126.80	R 4 626.49	120.00	R 4 378.38	3,00TM	R 760.39
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)		Procedural fees	207.10	R 7 556.36	165.68	R 6 045.09	3,00TM	R 760.39
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00TM	R 760.39
0438	Fracture: Talus: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable.		Procedural fees	311.60	R 11 369.20	249.28	R 9 095.36	3,00TM	R 760.39
0439	Fracture: Tarsal bones (excluding talus and calcaneus) (reduction under general anaesthetic)		Procedural fees	76.60	R 2 794.87	76.60	R 2 794.87	3,00TM	R 760.39
0440	Fracture: Calcaneus fracture: Open reduction with internal fixation (Modifiers 0051, 0052 not applicable)		Procedural fees	403.50	R 14 722.31	322.50	R 11 766.90	3,00TM	R 760.39
0441	Fracture: Metatarsal bones (reduction under general anaesthetic)		Procedural fees	66.80	R 2 437.30	66.80	R 2 437.30	3,00TM	R 760.39
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (Modifiers 0052 not applicable)		Procedural fees	154.70	R 5 644.46	123.76	R 4 515.57	3,00TM	R 760.39
0443	Fracture: Toe phalanx: Distal Simple (reduction under general anaesthetic)		Procedural fees	66.80	R 2 437.30	66.80	R 2 437.30	3,00TM	R 760.39
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (Modifiers 0052 not applicable)		Procedural fees	144.50	R 5 272.30	120.00	R 4 378.38	3,00TM	R 760.39
0447	Fracture (reduction under general anaesthetic): Other: Simple		Procedural fees	26.00	R 948.65	26.00	R 948.65	3,00TM	R 760.39
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00T	R 760.39
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest		Procedural fees	230.00	R 8 391.90	184.00	R 6 713.52	3,00TM	R 760.39
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00TM	R 760.39
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00TM	R 760.39
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00TM	R 760.39
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00TM	R 760.39
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.		Procedural fees	288.00	R 10 508.12	230.40	R 8 406.49	3,00TM	R 760.39

0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (Modifier 0052 not applicable)		Procedural fees	210.90	R 7 695.01	168.72	R 6 156.01	3,00TM	R 760.39
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)		Procedural fees	43.00	R 1 568.92	43.00	R 1 568.92	3,00TM	R 760.39
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna		Procedural fees	328.20	R 11 974.88	262.56	R 9 579.90	3,00TM	R 760.39
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones		Procedural fees	181.00	R 6 604.06	144.80	R 5 283.25	3,00TM	R 760.39
3.1.1.2	**Bones: Radical resection of bone tumours**								
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		Procedural fees	415.00	R 15 141.91	332.00	R 12 113.52	10TM	R 2 534.63
0481	Radical resection of bone tumour: Fibula		Procedural fees	240.10	R 8 760.41	192.08	R 7 008.33	4,00TM	R 1 013.85
0482	Radical resection of bone tumour: Femur or knee		Procedural fees	371.80	R 13 565.69	297.44	R 10 852.55	5,00TM	R 1 267.31
0483	Radical resection of malignant bone tumour: Scapula		Procedural fees	237.70	R 8 672.85	190.16	R 6 938.28	6,00TM	R 1 520.78
0484	Radical resection of bone tumour: Clavicle		Procedural fees	413.80	R 15 098.12	331.04	R 12 078.50	6,00TM	R 1 520.78
0485	Radical resection of bone tumour: Metatarsal		Procedural fees	185.00	R 6 750.01	148.00	R 5 400.00	4,00TM	R 1 013.85
3.1.2	**Bony operations**								
3.1.2.1	**Bony operations: Bone grafting**								
0497	Resection of bone or tumour with or without grafting (benign)		Procedural fees	282.00	R 10 289.20	225.60	R 8 231.36	3,00TM	R 760.39
0499	Grafts to cysts: Large bones		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00TM	R 760.39
0501	Grafts to cysts: Small bones		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00TM	R 760.39
0503	Grafts to cysts: Cartilage graft		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	3,00TM	R 760.39
0505	Grafts to cysts: Inter-metacarpal bone graft		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	3,00TM	R 760.39
0506	Harvesting of graft: Cartilage graft, costochondral		Procedural fees	91.10	R 3 323.92	91.10	R 3 323.92	6T	R 1 520.78
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3.1.2.2	**Bony operations: Acute or chronic osteomyelitis**								
0509	Acute or chronic osteomyelitis: Conservative treatment		Procedural fees	Per service	RCF Missing	Per service	RCF Missing		R -

0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care		Procedural fees	Per service	RCF Missing	Per service	RCF Missing		R -
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including FOUR weeks after-care		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00TM	R 760.39
3.1.2.3	**Bony operations: Osteotomy**								
0516	Osteotomy: Pelvic		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
0521	Osteotomy: Femoral: Proximal (Modifier 0051 is applicable)		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
0527	Osteotomy: Knee region (Modifier 0051 is applicable)		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
0528	Osteotomy: Os Calcis (Dwyer operation) (Modifier 0051 is applicable)		Procedural fees	115.00	R 4 195.95	115.00	R 4 195.95	3,00TM	R 760.39
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation (Modifier 0051 is applicable)		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	3,00TM	R 760.39
0531	Rotational osteotomy of tibia and fibula - stand alone procedure		Procedural fees	278.90	R 10 176.09	223.12	R 8 140.87	3,00TM	R 760.39
0532	Rotation osteotomy of the Radius, Ulna or Humerus (Modifier 0051 is applicable)		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0533	Osteotomy: Single metatarsal (Modifier 0051 is applicable)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	3,00TM	R 760.39
0534	Osteotomy: Multiple metatarsal osteotomies (Modifier 0051 is applicable)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	3,00TM	R 760.39
3.1.2.4	**Bony operations: Exostosis**								
0535	Exostosis: Excision: Readily accessible sites		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	3,00TM	R 760.39
0537	Exostosis: Excision: Less accessible sites		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39
3.1.2.5	**Bony operations: Biopsy**								
0539	Needle Biopsy: Spine (no after-care) (Modifier 0005 not applicable)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	4,00TM	R 1 013.85
0541	Needle Biopsy: Other sites (no after-care) (Modifier 0005 not applicable)		Procedural fees	32.00	R 1 167.57	32.00	R 1 167.57	4,00TM	R 1 013.85
0543	Biopsy: Open (Modifier 0005 not applicable): Readily accessible site Anaesthetic: as per bone.		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	As per bone	
0545	Biopsy: Open (Modifier 0005 not applicable): Less accessible site Anaesthetic: as per bone.		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	As per bone	
3.2	**Joints**								
3.2.1	**Joints: Dislocations**								
0547	Dislocation: Clavicle either end		Procedural fees	96.50	R 3 520.95	96.50	R 3 520.95	3,00TM	R 760.39
0549	Dislocation: Shoulder		Procedural fees	112.10	R 4 090.14	112.10	R 4 090.14	3,00TM	R 760.39

0551	Dislocation: Elbow		Procedural fees	133.60	R 4 874.60	120.00	R 4 378.38	3,00TM	R 760.39
0552	Dislocation: Wrist		Procedural fees	115.50	R 4 214.19	115.50	R 4 214.19	3,00TM	R 760.39
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation		Procedural fees	130.00	R 4 743.25	120.00	R 4 378.38	3,00TM	R 760.39
0555	Dislocation: Lunate		Procedural fees	136.30	R 4 973.11	120.00	R 4 378.38	3,00TM	R 760.39
0556	Dislocation: Carpo-metacarpo dislocation, with manipulation		Procedural fees	117.20	R 4 276.22	117.20	R 4 276.22	3,00TM	R 760.39
0557	Dislocation: Metacarpo-phalangeal or interphalangeal (hand)		Procedural fees	107.30	R 3 915.00	107.30	R 3 915.00	3,00TM	R 760.39
0559	Dislocation: Hip		Procedural fees	220.50	R 8 045.28	176.40	R 6 436.22	3,00TM	R 760.39
0561	Dislocation: Knee, with manipulation		Procedural fees	181.20	R 6 611.36	144.96	R 5 289.09	3,00TM	R 760.39
0563	Dislocation: Patella		Procedural fees	136.90	R 4 995.00	120.00	R 4 378.38	3,00TM	R 760.39
0565	Dislocation: Ankle		Procedural fees	98.60	R 3 597.57	98.60	R 3 597.57	3,00TM	R 760.39
0567	Dislocation: Sub-Talar dislocation		Procedural fees	92.00	R 3 356.76	92.00	R 3 356.76	3,00TM	R 760.39
0569	Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	3,00TM	R 760.39
0571	Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)		Procedural fees	39.41	R 1 437.93	39.41	R 1 437.93	3,00TM	R 760.39
3.2.2	**Joints: Operations for dislocations**								
0578	Operations for dislocations: Recurrent dislocation of shoulder		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	3,00TM	R 760.39
0579	Operations for dislocations: Recurrent dislocation of all other joints		Procedural fees	161.00	R 5 874.33	128.80	R 4 699.46	3,00TM	R 760.39
3.2.3	**Joints: Capsular operations**								
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)		Procedural fees	51.00	R 1 860.81	51.00	R 1 860.81	3,00TM	R 760.39
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0585	Capsulectomy digital joint		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	3,00TM	R 760.39
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	3,00TM	R 760.39

0587	Release of digital joint contracture		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00TM	R 760.39
3.2.4	**Joints: Synovectomy**								
0589	Synovectomy: Digital joint		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	3,00TM	R 760.39
0592	Synovectomy: Large joint		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0593	Tendon synovectomy		Procedural fees	203.70	R 7 432.30	162.96	R 5 945.84	3,00TM	R 760.39
3.2.5	**Joints: Arthrodesis**								
0597	Arthrodesis: Shoulder		Procedural fees	224.00	R 8 172.98	179.20	R 6 538.38	3,00TM	R 760.39
0598	Arthrodesis: Elbow		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
0599	Arthrodesis: Wrist		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
0600	Arthrodesis: Digital joint		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00TM	R 760.39
0601	Arthrodesis: Hip		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
0602	Arthrodesis: Knee		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
0603	Arthrodesis: Ankle		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
0604	Arthrodesis: Sub-talar		Procedural fees	130.00	R 4 743.25	120.00	R 4 378.38	3,00TM	R 760.39
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
0607	Arthrodesis: Mid-tarsal wedge resection		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	3,00TM	R 760.39
3.2.6	**Joints: Arthroplasty**								
0614	Arthroplasty: Debridement large joints		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0615	Arthroplasty: Excision medial or lateral end of clavicle		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44	3,00TM	R 760.39
0617	Shoulder: Acromioplasty		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00TM	R 760.39
0619	Shoulder: Partial replacement		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00TM	R 1 267.31
0620	Shoulder: Total replacement		Procedural fees	416.00	R 15 178.39	332.80	R 12 142.71	5,00TM	R 1 267.31
0621	Elbow: Excision head of radius		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39

0622	Elbow: Excision		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00TM	R 760.39
0623	Elbow: Partial replacement		Procedural fees	188.00	R 6 859.47	150.40	R 5 487.57	3,00TM	R 760.39
0624	Elbow: Total replacement		Procedural fees	282.00	R 10 289.20	225.60	R 8 231.36	3,00TM	R 760.39
0625	Wrist: Excision distal end of ulna		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39
0626	Wrist: Excision single bone		Procedural fees	110.00	R 4 013.52	110.00	R 4 013.52	3,00TM	R 760.39
0627	Wrist: Excision proximal row		Procedural fees	166.00	R 6 056.76	132.80	R 4 845.41	3,00TM	R 760.39
0631	Wrist: Total replacement		Procedural fees	249.00	R 9 085.14	199.20	R 7 268.11	3,00TM	R 760.39
0635	Digital Joint: Total replacement		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00TM	R 760.39
0637	Hip: Total replacement		Procedural fees	416.00	R 15 178.39	332.80	R 12 142.71	3,00TM	R 760.39
0641	Hip: Prosthetic replacement of femoral head		Procedural fees	288.00	R 10 508.12	230.40	R 8 406.49	3,00TM	R 760.39
0643	Hip: Girdlestone		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
0645	Knee: Partial replacement		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	3,00TM	R 760.39
0646	Knee: Total replacement		Procedural fees	416.00	R 15 178.39	332.80	R 12 142.71	3,00TM	R 760.39
0649	Ankle: Total replacement		Procedural fees	290.40	R 10 595.69	232.32	R 8 476.55	3,00TM	R 760.39
0650	Ankle: Astragalectomy		Procedural fees	154.00	R 5 618.92	123.20	R 4 495.14	3,00TM	R 760.39
3.2.7	**Joints: Miscellaneous (joints)**								
0658	Aspiration and/or injection: Small joint, bursa (e.g. fingers,toes) (excluding aftercare, Modifier 0005 not applicable)		Procedural fees	11.40	R 415.95	11.40	R 415.95	3,00T	R 760.39
0659	Aspiration and/or injection: Intermediate joint, bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa)(excluding aftercare, Modifier 0005 not applicable)		Procedural fees	12.00	R 437.84	12.00	R 437.84	3,00T	R 760.39
0660	Aspiration and/or injection: Major joint, bursa (e.g. shoulder, hip, knee joint, subacromial bursa)(excluding aftercare, Modifier 0005 not applicable.)		Procedural fees	14.60	R 532.70	14.60	R 532.70	4,00T	R 1 013.85
0661	Aspiration of joint or intra-articular injection (not including after-care) (Modifier 0005 not applicable)		Procedural fees	9.00	R 328.38	9.00	R 328.38	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (Modifier 0005 not applicable): First joint		Procedural fees	7.50	R 273.65	7.50	R 273.65	3,00T	R 760.39

0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (Modifier 0005 not applicable): Additional (each)	+	Procedural fees	4.00	R 145.95	4.00	R 145.95	3,00T	R 760.39
0667	Arthroscopy (excluding after-care) (Modifiers 0005 and 0013 not applicable)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	3,00T	R 760.39
0669	Manipulation large joint under general anaesthetic (not including after-care) (Modifier 0005 not applicable) - Anaesthetic: Knee/Shoulder.		Procedural fees	43.10	R 1 572.57	43.10	R 1 572.57	3,00T	R 760.39
0669a	Manipulation large joint under general anaesthetic (not including after-care) (Modifier 0005 not applicable) - Anaesthetic: Hip		Procedural fees		R -			4,00T	R 1 013.85
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Knee/Shoulder		Procedural fees	Per service	RCF Missing	Per service	RCF Missing	3,00T	R 760.39
0670a	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthaetic: Hip		Procedural fees		R -			4,00T	R 1 013.85
0673	Meniscectomy or operation for other internal derangement of knee: Medial OR Lateral		Procedural fees	185.70	R 6 775.55	148.56	R 5 420.44	4,00TM	R 1 013.85
3.2.8	**Joints: Joint ligament reconstruction or suture**								
0675	Joint ligament reconstruction or suture: Ankle: Collateral		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0676	Joint ligament reconstruction or suture: Ankle: (e.g. Watson-Jones type)		Procedural fees	191.50	R 6 987.17	153.20	R 5 589.73	3,00TM	R 760.39
0677	Joint ligament reconstruction or suture: Knee: Collateral		Procedural fees	196.80	R 7 180.55	157.44	R 5 744.44	4,00TM	R 1 013.85
0678	Joint ligament reconstruction or suture: Knee: Cruciate		Procedural fees	277.60	R 10 128.66	182.08	R 6 643.47	4,00TM	R 1 013.85
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee		Procedural fees	324.40	R 11 836.23	259.52	R 9 468.98	4,00TM	R 1 013.85
0680	Joint ligament reconstruction or suture: Digital joint ligament		Procedural fees	229.80	R 8 384.60	183.84	R 6 707.68	3,00TM	R 760.39
3.3	**Amputations**								
3.3.1	**Amputations: Specific Amputations**								
0682	Amputation: Fore-quarter		Procedural fees	397.80	R 14 514.34	318.24	R 11 611.47	15,00TM	R 3 801.94
0683	Amputation: Through shoulder		Procedural fees	323.00	R 11 785.15	258.40	R 9 428.12	9,00TM	R 2 281.17
0681	Amputation Humerus: Includes primary closure		Procedural fees	211.60	R 7 720.55	169.28	R 6 176.44	4,00TM	R 1 013.85
0684	Amputation: Forearm		Procedural fees	213.50	R 7 789.87	170.48	R 6 220.22	3,00TM	R 760.39
0687	Amputation: Metacarpal: One Ray		Procedural fees	206.10	R 7 519.87	164.88	R 6 015.90	3,00TM	R 760.39
0691	Amputation: Finger or Thumb		Procedural fees	189.30	R 6 906.90	146.60	R 5 348.92	3,00TM	R 760.39
0693	Amputation Hindquarter		Procedural fees	470.70	R 17 174.20	376.56	R 13 739.36	15,00TM	R 3 801.94
0695	Amputation: Through hip		Procedural fees	373.10	R 13 613.12	298.48	R 10 890.50	10,00TM	R 2 534.63

0697	Amputation: Through thigh		Procedural fees	245.00	R 8 939.20	196.00	R 7 151.36	5,00TM	R 1 267.31
0699	Amputation: Below knee, through knee or Syme		Procedural fees	277.20	R 10 114.06	221.76	R 8 091.25	4,00TM	R 1 013.85
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		Procedural fees	204.10	R 7 446.90	163.28	R 5 957.52	4,00TM	R 1 013.85
0688	Amputation: Foot, Midtarsal (Chopart type)		Procedural fees	165.70	R 6 045.82	132.00	R 4 816.22	3,00TM	R 760.39
0701	Amputation: Foot, Trans-metatarsal		Procedural fees	223.80	R 8 165.68	179.04	R 6 532.55	3,00TM	R 760.39
0705	Amputation: Toe		Procedural fees	167.10	R 6 096.90	133.68	R 4 877.52	3,00TM	R 760.39
3.3.2	**Amputations: Post-amputation reconstruction**								
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		Procedural fees	150.70	R 5 498.52	120.56	R 4 398.81	3,00TM	R 760.39
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		Procedural fees	173.90	R 6 345.01	139.12	R 5 076.00	3,00TM	R 760.39
0696	Re-amputation: Thigh, through femur, any level		Procedural fees	217.30	R 7 928.52	173.84	R 6 342.82	3,00TM	R 760.39
0698	Re-amputation: Leg, through tibia and fibula		Procedural fees	198.20	R 7 231.63	158.56	R 5 785.30	3,00TM	R 760.39
0706	Finger or thumb: Local advancement flaps (V-Y Plasty), with neurectomy, any joint.		Procedural fees	186.30	R 6 797.44	149.04	R 5 437.95	3,00TM	R 760.39
0707	Krukenberg reconstruction		Procedural fees	331.70	R 12 102.58	265.36	R 9 682.06	3,00TM	R 760.39
0711	Pollicisation of the finger (to include all stages)		Procedural fees	455.90	R 16 634.20	364.72	R 13 307.36	3,00TM	R 760.39
0712	Post-amputation reconstruction: Toe to thumb transfer		Procedural fees	800.00	R 29 189.22	640.00	R 23 351.37	3,00TM	R 760.39
0700	Scar revision/secondary closure: Amputated shoulder		Procedural fees	128.10	R 4 673.92	120.00	R 4 378.38	3,00TM	R 760.39
0702	Scar revision/secondary closure: Amputated humerus		Procedural fees	163.10	R 5 950.95	130.48	R 4 760.76	3,00TM	R 760.39
0704	Scar revision/secondary closure: Amputated forearm		Procedural fees	184.10	R 6 717.17	147.28	R 5 373.73	3,00TM	R 760.39
0708	Re-amputation: Humerus		Procedural fees	223.10	R 8 140.14	178.48	R 6 512.11	6,00TM	R 1 520.78
0710	Re-amputation: Through forearm		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3.4	**Muscles, tendons and fasciae**								
3.4.1	**Muscles, tendons and fasciae: Investigations**								

0713	Electromyography (per region)		Procedural fees	75.00	R 2 736.49	75.00	R 2 736.49	3,00T	R 760.39
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730) - Anaesthetic: if required.		Procedural fees	57.00	R 2 079.73	57.00	R 2 079.73	3,00T	R 760.39
0715	Strength duration curve per session - Anaesthetic: if required.		Procedural fees	10.50	R 383.11	10.50	R 383.11	3,00T	R 760.39
0717	Electrical examination of single nerve or muscle - Anaesthetic: if required.		Procedural fees	9.00	R 328.38	9.00	R 328.38	3,00T	R 760.39
0718	Oxidative study for mitochondrial function		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14		
0721	Voltage integration during isometric contraction - Anaesthetic: if required.		Procedural fees	12.00	R 437.84	12.00	R 437.84	3,00T	R 760.39
0723	Tonometry with edrophonium - Anaesthetic: if required.		Procedural fees	8.00	R 291.89	8.00	R 291.89	3,00T	R 760.39
0725	Isometric tension studies with edrophonium - Anaesthetic: if required.		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral - Anaesthetic: if required.		Procedural fees	8.00	R 291.89	8.00	R 291.89		
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral - Anaesthetic: if required.		Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
0729	Tendon reflex time - Anaesthetic: if required.		Procedural fees	7.00	R 255.41	7.00	R 255.41	3,00T	R 760.39
0730	Limb brain somatosensory studies (per limb)		Procedural fees	49.00	R 1 787.84	49.00	R 1 787.84		
0731	Vision and audio-sensory studies		Procedural fees	49.00	R 1 787.84	49.00	R 1 787.84		
0733	Motor nerve conduction studies (single nerve)		Procedural fees	26.00	R 948.65	26.00	R 948.65		
0735	Examinations of sensory nerve conduction by sweep averages (single nerve) - Anaesthetic: if required.		Procedural fees	31.00	R 1 131.08	31.00	R 1 131.08	3,00T	R 760.39
0737	Biopsy for motor nerve terminals and end plates - Anaesthetic: if required.		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
0739	Combined muscle biopsy with end plates and nerve terminal biopsy - Anaesthetic: if required.		Procedural fees	34.00	R 1 240.54	34.00	R 1 240.54	3,00T	R 760.39
0740	Muscle fatigue studies - Anaesthetic: if required.		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
0741	Muscle biopsy - Anaesthetic: if required.		Procedural fees	20.00	R 729.73	20.00	R 729.73	8,00T	R 2 027.70
0742	Global fee for all muscle studies, including histochemical studies		Procedural fees	262.00	R 9 559.47				
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase		Procedural fees	20.25	R 738.85				
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase		Procedural fees	33.30	R 1 215.00				

4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase		Procedural fees	5.70	R 207.97				
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase		Procedural fees	1.60	R 58.38				
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase		Procedural fees	9.90	R 361.22				
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase		Procedural fees	13.70	R 499.87				
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase		Procedural fees	25.90	R 945.00				
4715	Biochemical estimations on muscle biopsy specimens: Enolase		Procedural fees	32.70	R 1 193.11				
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase		Procedural fees	37.70	R 1 375.54				
4719	Biochemical estimations on muscle biopsy specimens: Aldolase		Procedural fees	15.75	R 574.66				
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase		Procedural fees	11.06	R 403.54				
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase		Procedural fees	34.70	R 1 266.08				
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase		Procedural fees	40.30	R 1 470.41				
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase		Procedural fees	28.80	R 1 050.81				
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study		Procedural fees	43.00	R 1 568.92				
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation		Procedural fees	82.00	R 2 991.89				
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia		Procedural fees	143.00	R 5 217.57				
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy		Procedural fees	75.00	R 2 736.49				
4731	H-response study (per nerve)		Procedural fees	14.00	R 510.81				
4733	F-waves (per nerve)		Procedural fees	20.00	R 729.73				
4735	Single fibre studies		Procedural fees	71.00	R 2 590.54				
4737	Somatosensory study (limb-spine)		Procedural fees	69.00	R 2 517.57				

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value

3.4.2	Muscles, tendons and fasciae: Decompression Operations								
5550	Decompression faciotomy: Buttock compartments:(unilateral)		Procedural fees	243.00	R 8 866.22	194.40	R 7 092.98	5,00TM	R 1 267.31
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		Procedural fees	151.90	R 5 542.30	121.50	R 4 433.11	3,00TM	R 760.39
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		Procedural fees	253.10	R 9 234.74	202.50	R 7 388.52	3,00TM	R 760.39
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/ or nerve		Procedural fees	123.70	R 4 513.38	120.00	R 4 378.38	3,00TM	R 760.39
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/ or nerve		Procedural fees	162.10	R 5 914.46	129.70	R 4 732.30	3,00TM	R 760.39
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		Procedural fees	130.80	R 4 772.44	120.00	R 4 378.38	3,00TM	R 760.39
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		Procedural fees	171.50	R 6 257.44	137.20	R 5 005.95	3,00TM	R 760.39
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		Procedural fees	137.30	R 5 009.60	120.00	R 4 378.38	4,00TM	R 1 013.85
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe		Procedural fees	86.60	R 3 159.73	86.60	R 3 159.73	3,00TM	R 760.39
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		Procedural fees	226.30	R 8 256.90	181.00	R 6 604.06	3,00TM	R 760.39
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		Procedural fees	354.50	R 12 934.47	283.60	R 10 347.58	3,00TM	R 760.39
5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		Procedural fees	166.80	R 6 085.95	133.40	R 4 867.30	3,00TM	R 760.39
5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		Procedural fees	321.10	R 11 715.82	256.90	R 9 373.39	3,00TM	R 760.39
5563	Decompression Faciotomy: Fingers and/or hand		Procedural fees	165.60	R 6 042.17	132.50	R 4 834.46	3,00TM	R 760.39
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair								
0745	Muscle and tendon repair: Biceps humeri		Procedural fees	109.00	R 3 977.03	109.00	R 3 977.03	3,00T	R 760.39
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39
0747	Muscle and tendon repair: Rotator cuff		Procedural fees	134.00	R 4 889.19	120.00	R 4 378.38	4,00T	R 1 013.85
0748	Muscle and tendon repair: Debridement rotator cuff		Procedural fees	139.70	R 5 097.17	120.00	R 4 378.38	4,00T	R 1 013.85
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure		Procedural fees	271.90	R 9 920.68	217.52	R 7 936.55	4,00T	R 1 013.85
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00T	R 760.39

0757	Muscle and tendon repair: Achilles tendon repair		Procedural fees	197.60	R 7 209.74	158.08	R 5 767.79	4,00T	R 1 013.85
0759	Muscle and tendon repair: Other single tendon		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	3,00T	R 760.39
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (modifier 0005 applicable)		Procedural fees	220.30	R 8 037.98	176.24	R 6 430.38	3,00T	R 760.39
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (modifier 0005 applicable)		Procedural fees	249.60	R 9 107.04	199.68	R 7 285.63	3,00T	R 760.39
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (modifier 0005 applicable)		Procedural fees	191.30	R 6 979.87	153.04	R 5 583.90	3,00T	R 760.39
0763	Muscle and tendon repair: Tendon or ligament injection		Procedural fees	9.00	R 328.38	9.00	R 328.38	3,00T	R 760.39
0764	Hand: Flexor tendon repair: Secondary, Zone 1		Procedural fees	243.90	R 8 899.06	195.12	R 7 119.25	3,00T	R 760.39
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)		Procedural fees	249.60	R 9 107.04	199.68	R 7 285.63	3,00T	R 760.39
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)		Procedural fees	190.60	R 6 954.33	152.48	R 5 563.46	3,00T	R 760.39
0768	Repair: Intrinsic muscles of hand (each) (modifier 0005 applicable)		Procedural fees	125.30	R 4 571.76	100.24	R 3 657.41	3,00T	R 760.39
0771	Extensor tendon suture: Primary (per tendon)		Procedural fees	164.80	R 6 012.98	131.84	R 4 810.38	3,00T	R 760.39
0773	Extensor tendon suture: Secondary (per tendon)		Procedural fees	170.00	R 6 202.71	136.00	R 4 962.17	3,00T	R 760.39
0774	Boutonniere or Mallet finger repair (each)(Modifier 0005 applicable)		Procedural fees	216.60	R 7 902.98	173.28	R 6 322.38	3,00T	R 760.39
3.4.4	**Muscles, tendons and fasciae: Tendon graft**								
0775	Free tendon graft		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00T	R 760.39
0776	Reconstruction of pulley for flexor tendon (each)(Modifier 0005 applicable)		Procedural fees	180.20	R 6 574.87	144.16	R 5 259.90	3,00T	R 760.39
0777	Tendon graft: Finger: Flexor		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
0779	Tendon graft: Finger: Extensor		Procedural fees	122.00	R 4 451.36	120.00	R 4 378.38	3,00T	R 760.39
0780	Two stage flexor tendon graft using silastic rod		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3.4.5	**Muscles, tendons and fasciae: Tendolysis**								
0781	Tendon freeing operation, except where specified elsewhere		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	3,00T	R 760.39

0782	Carpal tunnel syndrome		Procedural fees	123.00	R 4 487.84	120.00	R 4 378.38	3,00T	R 760.39
0783	Tenolysis: De Quervain		Procedural fees	38.00	R 1 386.49	38.00	R 1 386.49	3,00T	R 760.39
0784	Trigger finger		Procedural fees	38.00	R 1 386.49	38.00	R 1 386.49	3,00T	R 760.39
0785	Flexor tendon freeing operation following free tendon graft or suture in finger, hand or forearm (each tendon)(Modifier 0005 applicable)		Procedural fees	276.10	R 10 073.93	220.88	R 8 059.14	3,00T	R 760.39
0787	Extensor tendon freeing operation following free tendon graft or suture in finger, hand or forearm (each tendon)(Modifier 0005 applicable)		Procedural fees	212.20	R 7 742.44	170.00	R 6 202.71	3,00T	R 760.39
0788	Intrinsic tendon release per finger		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	3,00T	R 760.39
0789	Central tendon tenotomy for Boutonniere deformity		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14	3,00T	R 760.39
3.4.6	**Muscles, tendons and fasciae: Tenodesis**								
0790	Tenodesis: Digital joint (each)(Modifier 0005 applicable)		Procedural fees	176.20	R 6 428.92	140.96	R 5 143.14	3,00T	R 760.39
3.4.7	**Muscles, tendons and fasciae: Muscle tendon and facia transfer**								
0791	Single tendon transfer		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00T	R 760.39
0792	Multiple tendon transfer		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00T	R 760.39
0793	Hamstring to quadriceps transfer		Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	3,00T	R 760.39
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	5,00T	R 1 267.31
0795	Tendon transfer at elbow		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44	3,00T	R 760.39
0802	Radial club hand repair - stand alone procedure		Procedural fees	360.30	R 13 146.09	288.24	R 10 516.87	3,00T	R 760.39
0803	Hand tendons: Single tendon transfer (each)(Modifier 0005 applicable)		Procedural fees	216.20	R 7 888.39	172.96	R 6 310.71	3,00T	R 760.39
0809	Hand tendons: Substitution for intrinsic paralysis and hand/hand tendon (all four fingers)		Procedural fees	330.60	R 12 062.44	264.48	R 9 649.95	3,00T	R 760.39
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)		Procedural fees	220.60	R 8 048.93	176.48	R 6 439.14	3,00T	R 760.39
3.4.8	**Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening**								
0812	Percutaneous Tenotomy: All sites		Procedural fees	140.50	R 5 126.36	120.00	R 4 378.38	3,00T	R 760.39
0813	Torticollis		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	5,00T	R 1 267.31
0815	Scalenotomy		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	5,00T	R 1 267.31

0817	Scalenotomy with excision of first rib		Procedural fees	190.00	R 6 932.44	152.00	R 5 545.95	3,00TM	R 760.39
0821	Tennis elbow		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00T	R 760.39
0822	Open release elbow (Mitals) - stand alone procedure		Procedural fees	278.20	R 10 150.55	222.56	R 8 120.44	3,00TM	R 760.39
0823	Excision or slide for Volkmann's Contracture		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
0825	Hip: Open muscle release		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44	7,00T	R 1 774.24
0829	Knee: Quadriceps plasty		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00T	R 760.39
0831	Knee: Open tenotomy		Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	3,00T	R 760.39
0835	Calf		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	4,00T	R 1 013.85
0837	Open elongation tendon Achilles		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	4,00T	R 1 013.85
0838	Percutaneous "Hoke" elongation tendo Achilles		Procedural fees	79.30	R 2 893.38	79.30	R 2 893.38	4,00T	R 1 013.85
0845	Foot: Plantar fasciotomy		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	3,00T	R 760.39
0846	Foot: Postero-medial release for club-foot		Procedural fees	192.00	R 7 005.41	153.60	R 5 604.33	3,00T	R 760.39
3.5	**Bursae and ganglia**								
0847	Excision: Semimembranosus		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	4,00T	R 1 013.85
0849	Excision: Prepatellar		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	3,00T	R 760.39
0851	Excision: Olecranon		Procedural fees	81.80	R 2 984.60	81.80	R 2 984.60	3,00T	R 760.39
0853	Excision: Small bursa or ganglion		Procedural fees	80.90	R 2 951.76	80.90	R 2 951.76	3,00T	R 760.39
0855	Excision: Compound palmar ganglion or synovectomy		Procedural fees	128.00	R 4 670.27	120.00	R 4 378.38	3,00T	R 760.39
0857	Bursae and ganglia: Aspiration or injection (no after-care) (Modifier 0005 not applicable)		Procedural fees	9.00	R 328.38	9.00	R 328.38	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3.6	**Musculo-skeletal system: Miscellaneous**								
3.6.1	**Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis**								

0883	Removal: Implant, e.g. buried wire/pin/rod, superficial		Procedural fees	44.40	R 620.00 1	44.40	R 620.00 1	3,00T	R 760.39
0884	Removal: Implant, e.g. buried wire/pin/screw/metal band/nail/rod/plate, deep		Procedural fees	127.00	R 633.79 4	75.50	R 754.73 2	5,00T	R 267.31 1
0885	Removal of prosthesis for infection soon after operation - Anaesthetic: As per bone (specify) + M.		Procedural fees	128.00	R 670.27 4	120.00	R 378.38 4	As per bone (Specify) + M	
0886	Late removal of infected or not infected total joint replacement prosthesis (including FOUR weeks after-care): ADD to the item for total joint replacement of the specific joint	+	Procedural fees	64.00	R 335.14 2	64.00	R 335.14 2	6,00TM	R 520.78 1
3.6.1.1	**Musculo-skeletal system: Miscellaneous: Removal of foreign bodies.**								
0644	Removal of foreign body: Shoulder, subcutaneous		Procedural fees	49.70	R 813.38 1	49.70	R 813.38 1	3,00T	R 760.39
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous		Procedural fees	41.70	R 521.49 1	41.70	R 521.49 1	3,00T	R 760.39
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular		Procedural fees	109.00	R 977.03 3	109.00	R 977.03 3	3,00T	R 760.39
0651	Exploration with removal of deep foreign body: Forearm or wrist		Procedural fees	122.80	R 480.54 4	122.80	R 480.54 4	3,00T	R 760.39
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue		Procedural fees	45.30	R 652.84 1	45.30	R 652.84 1	6,00T	R 520.78 1
0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular		Procedural fees	186.90	R 819.33 6	149.52	R 455.46 5	6,00T	R 520.78 1
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular		Procedural fees	120.60	R 400.27 4	120.00	R 378.38 4	4,00T	R 013.85 1
0655	Removal of foreign body: Foot, subcutaneous		Procedural fees	40.00	R 459.46 1	40.00	R 459.46 1	3,00T	R 760.39
0656	Removal of foreign body: Foot, deep		Procedural fees	94.20	R 437.03 3	94.20	R 437.03 3	3,00T	R 760.39
0657	Removal of foreign body: Foot, complicated		Procedural fees	110.50	R 031.76 4	110.50	R 031.76 4	3,00T	R 760.39
3.7	**Plasters (exclusive of after-care)**								
0887	Application of long leg cast (femur to toes, humerus) (excludig aftercare) (first cast included in procedure)		Procedural fees	29.50	R 076.35 1	29.50	R 076.35 1	3,00T	R 760.39
0888	Application of short limb cast (forearm, lower leg) (excluding aftercare) (first cast included in procedure)		Procedural fees	18.40	R 671.35	18.40	R 671.35	3,00T	R 760.39
0889	Application of spica, plaster jacket or hinged cast brace (excluding aftercare) (first cast included in procedure)		Procedural fees	32.00	R 167.57 1	32.00	R 167.57 1	4,00T	R 013.85 1
0891	Application of turnbuckle cast for scoliosis (excluding after-care) (first cast NOT included in procedure)		Procedural fees	49.30	R 798.79 1	49.30	R 798.79 1	5,00T	R 267.31 1
0892	Application of cast: Revision (walker, window, bivalve) (excluding aftercare)		Procedural fees	18.90	R 689.60	18.90	R 689.60	5,00T	R 267.31 1
3.8	**Musculo-skeletal system: Special areas**								
3.8.1	**Special areas: Foot and Ankle**								
0900	Excision tarsal coalition - stand alone procedure		Procedural fees	141.50	R 162.84 5	120.00	R 378.38 4	3,00TM	R 760.39

0901	Tenotomy: Single tendon		Procedural fees	63.30	R 2 309.60	63.30	R 2 309.60	3,00TM	R 760.39
0903	Hammer toe: One toe		Procedural fees	99.50	R 3 630.41	99.50	R 3 630.41	3,00TM	R 760.39
0905	Filleting of toe or Ruiz-Mora procedure		Procedural fees	99.50	R 3 630.41	99.50	R 3 630.41	3,00TM	R 760.39
0906	Arthrodesis Hallux		Procedural fees	148.00	R 5 400.00	120.00	R 4 378.38	3,00TM	R 760.39
0907	Silver bunionectomy or similar for Hallux Valgus		Procedural fees	126.20	R 4 604.60	120.00	R 4 378.38	3,00TM	R 760.39
0909	Excision arthroplasty		Procedural fees	145.20	R 5 297.84	120.00	R 4 378.38	3,00TM	R 760.39
0910	Cheilectomy or metatarsophangeal implant Hallux		Procedural fees	183.00	R 6 677.03	146.40	R 5 341.63	3,00TM	R 760.39
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure		Procedural fees	189.20	R 6 903.25	151.36	R 5 522.60	3,00TM	R 760.39
5730	Hallux Valgus double osteotomy etc.		Procedural fees	182.60	R 6 662.44	146.08	R 5 329.95	3,00TM	R 760.39
5731	Distal soft tissue procedure for Hallux Valgus		Procedural fees	173.60	R 6 334.06	138.88	R 5 067.25	3,00TM	R 760.39
5732	Aitkin procedure or similar		Procedural fees	166.80	R 6 085.95	133.44	R 4 868.76	3,00T	R 760.39
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)		Procedural fees	91.99	R 3 356.39	91.00	R 3 320.27	3,00TM	R 760.39
5735	Repair angular deformity toe (lesser toes)		Procedural fees	97.20	R 3 546.49	97.20	R 3 546.49	3,00TM	R 760.39
5736	Sesamoidectomy		Procedural fees	97.80	R 3 568.38	97.80	R 3 568.38	3,00TM	R 760.39
5737	Repair major foot tendons e.g. Tib Post		Procedural fees	147.30	R 5 374.46	120.00	R 4 378.38	3,00TM	R 760.39
5738	Repair of dislocating peroneal tendons		Procedural fees	173.20	R 6 319.47	138.56	R 5 055.57	3,00T	R 760.39
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot		Procedural fees	202.30	R 7 381.22	161.84	R 5 904.98	3,00TM	R 760.39
5740	Steindler strip - plantar fascia		Procedural fees	97.20	R 3 546.49	97.20	R 3 546.49	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
5741	Kelikian syndactilly (one web space)		Procedural fees	97.20	R 3 546.49	97.20	R 3 546.49	3,00T	R 760.39
5742	Tendon transfer foot		Procedural fees	172.00	R 6 275.68	137.60	R 5 020.55	3,00T	R 760.39

5743	Capsulotomy metatarsophalangeal joints: Foot		Procedural fees	86.80	R 3 167.03	86.80	R 3 167.03	3,00T	R 760.39
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		Procedural fees	730.00	R 26 635.16	584.00	R 21 308.13	3,00TM	R 760.39
0913	Replantation of thumb		Procedural fees	670.00	R 24 445.97	536.00	R 19 556.77	3,00TM	R 760.39
0914	Replantation of a single digit (to be motivated), for multiple digits (Modifier 0005 applicable)		Procedural fees	580.00	R 21 162.18	464.00	R 16 929.75	3,00TM	R 760.39
0915	Replantation operation through the palm		Procedural fees	270.00 1	R 46 337.88	016.00 1	R 37 070.30	3,00TM	R 760.39
3.8.4	**Special areas: Hands: (Note: Skin: See Integumentary System)**								
0919	Tumours: Epidermoid cysts		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00TM	R 760.39
0920	Tumours: Ganglion or fibroma		Procedural fees	77.50	R 2 827.71	77.50	R 2 827.71	3,00TM	R 760.39
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)		Procedural fees	86.00	R 3 137.84	86.00	R 3 137.84	3,00TM	R 760.39
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		Procedural fees	37.00	R 1 350.00	37.00	R 1 350.00	3,00TM	R 760.39
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		Procedural fees	110.00	R 4 013.52	110.00	R 4 013.52	3,00TM	R 760.39
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic		Procedural fees	16.00	R 583.78	16.00	R 583.78	3,00TM	R 760.39
3.8.5	**Special areas: Spine**								
	Notes regarding the 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 additionally. 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)		Procedural fees	207.00	R 7 552.71	165.60	R 6 042.17	3,00TM	R 760.39
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	+	Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	3,00TM	R 760.39
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)		Procedural fees	339.00	R 12 368.93	271.20	R 9 895.14	3,00TM	R 760.39
0930	Posterior osteotomy of spine: One vertebral segment		Procedural fees	339.00	R 12 368.93	339.00	R 12 368.93	3,00TM	R 760.39
0931	Posterior spinal fusion: One level		Procedural fees	385.00	R 14 047.31	308.00	R 11 237.85	3,00TM	R 760.39
0932	Posterior osteotomy of spine: Each additional vertebral segment	+	Procedural fees	103.00	R 3 758.11	103.00	R 3 758.11	3,00TM	R 760.39

0933	Anterior spinal osteotomy with disc removal: One vertebral segment		Procedural fees	315.00	R 11 493.25	252.00	R 9 194.60	3,00TM	R 760.39
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	+	Procedural fees	103.00	R 3 758.11	103.00	R 3 758.11	3,00TM	R 760.39
0938	Anterior fusion base of skull to C2		Procedural fees	449.00	R 16 382.45	359.20	R 13 105.96	4,00TM	R 1 013.85
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	3,00TM	R 760.39
0941	Anterior interbody fusion: One level		Procedural fees	360.00	R 13 135.15	288.00	R 10 508.12	3,00TM	R 760.39
0942	Anterior interbody fusion: Each additional level	+	Procedural fees	102.00	R 3 721.63	102.00	R 3 721.63	3,00TM	R 760.39
0944	Posterior fusion: Occiput to C2		Procedural fees	390.00	R 14 229.74	312.00	R 11 383.79	4,00TM	R 1 013.85
0946	Posterior spinal fusion: Each additional level	+	Procedural fees	111.00	R 4 050.00	111.00	R 4 050.00	3,00TM	R 760.39
0948	Posterior interbody lumbar fusion: One level		Procedural fees	364.00	R 13 281.09	291.20	R 10 624.87	3,00TM	R 760.39
0950	Posterior interbody lumbar fusion: Each additional interspace	+	Procedural fees	95.00	R 3 466.22	95.00	R 3 466.22	3,00TM	R 760.39
0959	Excision of coccyx		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00TM	R 760.39
0961	Costo-transversectomy		Procedural fees	198.00	R 7 224.33	158.40	R 5 779.46	3,00TM	R 760.39
0963	Antero-lateral decompression of spinal cord or anterior debridement		Procedural fees	326.00	R 11 894.61	260.80	R 9 515.68	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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).								
3.8.7	**Special areas: All spinal problems**								
0960	Posterior non-segmental instrumentation		Procedural fees	167.00	R 6 093.25	133.60	R 4 874.60	5,00TM	R 1 267.31
0962	Posterior segmental instrumentation: 2 to 6 vertebrae		Procedural fees	176.00	R 6 421.63	140.80	R 5 137.30	5,00TM	R 1 267.31
0964	Posterior segmental instrumentation: 7 to 12 vertebrae		Procedural fees	201.00	R 7 333.79	160.80	R 5 867.03	5,00TM	R 1 267.31
0966	Posterior segmental instrumentation:13 or more vertebrae		Procedural fees	245.00	R 8 939.20	196.00	R 7 151.36	5,00TM	R 1 267.31
0968	Anterior instrumentation: 2 to 3 vertebrae		Procedural fees	159.00	R 5 801.36	127.20	R 4 641.09	5,00TM	R 1 267.31
0970	Anterior instrumentation: 4 to 7 vertebrae		Procedural fees	185.00	R 6 750.01	148.00	R 5 400.00	5,00TM	R 1 267.31

0972	Anterior instrumentation: 8 or more vertebrae		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	5,00TM	R 1 267.31
0974	Additional pelvic fixation of instrumentation other than sacrum		Procedural fees	108.00	R 3 940.54	108.00	R 3 940.54	5,00TM	R 1 267.31
5750	Reinsertion of instrumentation		Procedural fees	276.00	R 10 070.28	220.80	R 8 056.22	6,00TM	R 1 520.78
5751	Removal of posterior non-segmental instrumentation		Procedural fees	173.00	R 6 312.17	138.40	R 5 049.73	6,00TM	R 1 520.78
5752	Removal of posterior segmental instrumentation		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	6,00TM	R 1 520.78
5753	Removal of anterior instrumentation		Procedural fees	204.00	R 7 443.25	163.20	R 5 954.60	6,00TM	R 1 520.78
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels		Procedural fees	295.00	R 10 763.52	236.00	R 8 610.82	3,00TM	R 760.39
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)		Procedural fees	304.00	R 11 091.90	243.20	R 8 873.52	3,00TM	R 760.39
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels		Procedural fees	321.00	R 11 712.17	256.80	R 9 369.74	3,00TM	R 760.39
0943	Laminectomy with decompression of nerve roots and disc removal: One level		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	3,00TM	R 760.39
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	+	Procedural fees	63.00	R 2 298.65	63.00	R 2 298.65	3,00TM	R 760.39
5759	Laminectomy for decompression diskectomy, etc. revision operation		Procedural fees	352.00	R 12 843.26	281.60	R 10 274.60	3,00TM	R 760.39
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level		Procedural fees	301.00	R 10 982.44	240.80	R 8 785.95	3,00TM	R 760.39
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	+	Procedural fees	68.00	R 2 481.08	68.00	R 2 481.08	3,00TM	R 760.39
5763	Anterior disc removal and spinal decompression cervical: One level		Procedural fees	344.00	R 12 551.36	275.20	R 10 041.09	3,00TM	R 760.39
5764	Anterior disc removal and spinal decompression cervical: Each additional level	+	Procedural fees	81.00	R 2 955.41	81.00	R 2 955.41	3,00TM	R 760.39
5765	Vertebral corpectomy for spinal decompression: One level		Procedural fees	466.00	R 17 002.72	372.80	R 13 602.17	3,00TM	R 760.39
5766	Vertebral corpectomy for spinal decompression: Each additional level	+	Procedural fees	88.00	R 3 210.81	88.00	R 3 210.81	3,00TM	R 760.39
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)		Procedural fees	71.00	R 2 590.54	71.00	R 2 590.54		R -
0969	Skull or skull-femoral traction including two weeks after-care		Procedural fees	64.00	R 2 335.14	64.00	R 2 335.14		R -
0971	Halo-splint and POP jacket including two weeks after-care		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44		R -
3.9	**Facial bone procedures**								
	Note: Modifiers 0046 to 0058 are not applicable to section 3.9: Facial bone procedures of the Coding Structure.								
0987	Repair of orbital floor (blowout fracture)		Procedural fees	184.60	R 6 735.41	147.68	R 5 388.33	4,00TM	R 1 013.85

0988	Genioplasty		Procedural fees	263.00	R 9 595.95	210.40	R 7 676.76	4,00TM	R 1 013.85
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I		Procedural fees	202.20	R 7 377.57	161.76	R 5 902.06	4,00TM	R 1 013.85
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II		Procedural fees	302.00	R 11 018.93	241.60	R 8 815.14	4,00TM	R 1 013.85
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III		Procedural fees	433.00	R 15 798.66	346.40	R 12 638.93	4,00TM	R 1 013.85
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy		Procedural fees	970.00	R 35 391.92	776.00	R 28 313.54	4,00TM	R 1 013.85
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy		Procedural fees	302.00	R 11 018.93	241.61	R 8 815.51	4,00TM	R 1 013.85
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)		Procedural fees	1 103.00	R 40 244.63	882.40	R 32 195.71	4,00TM	R 1 013.85
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)		Procedural fees	1 654.00	R 60 348.70	1 323.20	R 48 278.96	4,00TM	R 1 013.85
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement		Procedural fees	*	RCF Missing	*	RCF Missing		R -
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation		Procedural fees	302.00	R 11 018.93	241.60	R 8 815.14	3,00TM	R 760.39
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation		Procedural fees	184.00	R 6 713.52	147.20	R 5 370.82	3,00TM	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
0998	Excision mandible bone, e.g. osteomyelitis, abscess		Procedural fees	219.30	R 8 001.49	175.44	R 6 401.20	3,00TM	R 760.39
1000	Excision facial bone, e.g. osteomyelitis, abscess		Procedural fees	144.30	R 5 265.00	120.00	R 4 378.38	5,00TM	R 1 267.31
1001	Temporo-mandibular joint: Reconstruction for dysfunction		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00TM	R 1 013.85
1002	Harvesting: Bone for contouring of benign bony growths (e.g. fibrous dysplasia)		Procedural fees	189.20	R 6 903.25	151.36	R 5 522.60	5,00TM	R 1 267.31
1003	Manipulation: Immobilisation and follow-up of fractured nose		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00TM	R 760.39
1005	Nasal fracture without manipulation		Procedural fees	*	RCF Missing	*	RCF Missing		R -
1006	Fracture: Nose and septum, open reduction		Procedural fees	177.40	R 6 472.71	141.92	R 5 178.17	5,00TM	R 1 267.31
1007	Mandibulectomy		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	5,00TM	R 1 267.31
1008	Excision: Torus Mandibularis		Procedural fees	84.10	R 3 068.52	84.10	R 3 068.52	5,00TM	R 1 267.31

1009	Maxillectomy or excision zygoma		Procedural fees	521.60	R 19 031.37	317.44	R 11 582.28	5,00TM	R 1 267.31
1010	Excision: Torus Palatinus		Procedural fees	83.30	R 3 039.33	83.30	R 3 039.33	5,00TM	R 1 267.31
1011	Bone graft to mandible		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00TM	R 1 013.85
1012	Adjustment of occlusion by ramisection		Procedural fees	227.00	R 8 282.44	181.60	R 6 625.95	4,00TM	R 1 013.85
1013	Fracture of arch of zygoma without displacement		Procedural fees	*	RCF Missing	*	RCF Missing		R -
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)		Procedural fees	131.00	R 4 779.73	120.00	R 4 378.38	3,00TM	R 760.39
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)		Procedural fees	262.00	R 9 559.47	209.60	R 7 647.57	3,00TM	R 760.39
4. Respiratory System		**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
4.1	**Nose and Sinuses**								
1018	Flexible nasopharyngolaryngoscope examination		Procedural fees	51.94	R 1 895.11	51.94	R 1 895.11		
1019	ENT endoscopy in rooms with rigid endoscope		Procedural fees	12.00	R 437.84				
1020	Repair of perforated septum: Any method		Procedural fees	141.90	R 5 177.44	120.00	R 4 378.38	4,00T	R 1 013.85
1021	Intranasal dermatoplasty septum or lateral (Graft harvesting not included). Unilateral		Procedural fees	182.50	R 6 658.79	146.00	R 5 327.03	4,00T	R 1 013.85
1022	Functional reconstruction of nasal septum		Procedural fees	184.40	R 6 728.11	147.52	R 5 382.49	4,00T	R 1 013.85
1023	Harvesting of graft: Cartlage graft of nasal septum		Procedural fees	124.80	R 4 553.52	112.80	R 4 115.68	5,00T	R 1 267.31
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	4,00T	R 1 013.85
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)		Procedural fees	64.60	R 2 357.03	64.60	R 2 357.03	4,00T	R 1 013.85
1026	Biopsy: Intranasal		Procedural fees	14.70	R 536.35	14.70	R 536.35	4,00T	R 1 013.85
1027	Dacrocystorhinostomy		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	5,00T	R 1 267.31
1028	Lysis: Intranasal synechia		Procedural fees	21.60	R 788.11	21.60	R 788.11	5,00T	R 1 267.31
1029	Inferior Turbinectomy, partial or total. Unilateral, any method (modifier 0005 to apply to opposite side of nose)		Procedural fees	112.80	R 4 115.68	112.80	R 4 115.68	4,00T	R 1 013.85
1030	Endoscopic turbinectomy: Laser or microdebrider		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	4,00T	R 1 013.85

1031	Removal of single nasal polyp at rooms (at initial consultation only)		Procedural fees	25.40	R 926.76	25.40	R 926.76		
1033	Removal of multiple polyps in hospital under general anaesthetic (Unilateral)		Procedural fees	81.80	R 2 984.60	81.80	R 2 984.60	4,00T	R 1 013.85
1034	Autogenous nasal bone transplant: Bone removal included		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	4,00T	R 1 013.85
1035	Functional endoscopic sinus surgery: Unilateral		Procedural fees	219.90	R 8 023.39	175.92	R 6 418.71	4,00T	R 1 013.85
1036	Functional endoscopic sinus surgery: Bilateral		Procedural fees	384.80	R 14 040.01	307.84	R 11 232.01	4,00T	R 1 013.85
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic		Procedural fees	8.00	R 291.89	8.00	R 291.89		
1038	Hypophysectomy or excision of pituitary tumour: Transnasal/transseptal approach (total procedure)		Procedural fees	461.40	R 16 834.88	369.12	R 13 467.90	11,00T	R 2 788.09
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	4,00T	R 1 013.85
1040	Repair of CSF leak: Ethmoid region, transnasal endoscopic approach (Modifier 0069 not applicable)		Procedural fees	343.50	R 12 533.12	274.80	R 10 026.50	5,00T	R 1 267.31
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging (Unilateral)		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	6,00T	R 1 520.78
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach (Modifier 0069 not applicable)		Procedural fees	365.50	R 13 335.82	292.40	R 10 668.66	5,00T	R 1 267.31
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging (Unilateral)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	6,00T	R 1 520.78

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1044	Transnasal endoscopic decompression: Transnasal endoscopic optic nerve (Modifier 0069 does not apply)		Procedural fees	368.30	R 13 437.99	294.64	R 10 750.39	5,00T	R 1 267.31
1045	Ligation anterior ethmoidal artery		Procedural fees	135.40	R 4 940.27	120.00	R 4 378.38	6,00T	R 1 520.78
1047	Caldwell-Luc operation: Unilateral		Procedural fees	137.30	R 5 009.60	120.00	R 4 378.38	4,00T	R 1 013.85
1048	Endonasal frontal sinus drainage, with or without removal of tissue (Modifier 0069 not applicable)		Procedural fees	152.20	R 5 553.25				
1049	Ligation internal maxillary artery		Procedural fees	196.00	R 7 151.36	156.80	R 5 721.09	6,00T	R 1 520.78
1050	Vidian neurectomy (transantral or transnasal)		Procedural fees	113.00	R 4 122.98	113.00	R 4 122.98	4,00T	R 1 013.85
1051	Removal nasopharyngeal fibroma		Procedural fees	285.00	R 10 398.66	228.00	R 8 318.93	6,00T	R 1 520.78
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	4,00T	R 1 013.85

1053	Frontal sinus drainage, trephine operation (Unilateral)		Procedural fees	93.10	R 3 396.90	93.10	R 3 396.90	4,00T	R 1 013.85
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)		Procedural fees	37.30	R 1 360.95				
1055	External frontal sinus surgery, unilateral		Procedural fees	228.40	R 8 333.52	182.72	R 6 666.82	4,00T	R 1 013.85
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)		Procedural fees	741.60	R 27 058.40	593.28	R 21 646.72	11,00T	R 2 788.09
1057	External ethmoidectomy and/or sphenoidectomy (Unilateral)		Procedural fees	263.40	R 9 610.55	210.72	R 7 688.44	4,00T	R 1 013.85
1058	Sublabial transseptal sphenoidotomy		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	4,00T	R 1 013.85
1059	Craniectomy: For osteomyelitis (total procedure)		Procedural fees	341.60	R 12 463.80	273.28	R 9 971.04	11,00T	R 2 788.09
1060	Obliteration of frontal sinus		Procedural fees	291.10	R 10 621.23	232.88	R 8 496.98	4,00T	R 1 013.85
1061	Lateral rhinotomy		Procedural fees	164.00	R 5 983.79	131.20	R 4 787.03	4,00T	R 1 013.85
1062	Excision nasolabial cyst		Procedural fees	186.10	R 6 790.14	148.88	R 5 432.11	4,00T	R 1 013.85
1063	Removal of foreign bodies from nose: At rooms		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
1065	Removal of foreign body from nose: Under general anaesthetic		Procedural fees	38.60	R 1 408.38	38.60	R 1 408.38	4,00T	R 1 013.85
1067	Proof puncture at rooms: Unilateral		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
1069	Proof puncture, uni- or bilateral under general anaesthetic		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	4,00T	R 1 013.85
1071	Proetz treatment (consultation fee only to be charged for first treatment)		Procedural fees	4.00	R 145.95	4.00	R 145.95		
1077	Septum abscess: At rooms, including after-care		Procedural fees	8.00	R 291.89	8.00	R 291.89		
1079	Septum abscess: Under general anaesthetic		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03		
1081	Oro-antral fistula (without Caldwell-Luc)		Procedural fees	111.80	R 4 079.19	111.80	R 4 079.19	4,00T	R 1 013.85
1083	Choanal atresia: Intranasal approach		Procedural fees	113.00	R 4 122.98	113.00	R 4 122.98	5,00T	R 1 267.31
1084	Choanal atresia: Transpalatal approach		Procedural fees	194.00	R 7 078.38	155.20	R 5 662.71	7,00T	R 1 774.24
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip		Procedural fees	403.30	R 14 715.01	322.64	R 11 772.01	5,00T	R 1 267.31
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction		Procedural fees	398.60	R 14 543.53	318.88	R 11 634.82	5,00T	R 1 267.31

1088	Reconstruction vestibular stenosis and/or nasal valve collapse (spreader grafts or similar procedure, lateral cartilage grafts or similar implants, unilateral or bilateral)		Procedural fees	285.40	R 10 413.25	228.32	R 8 330.60	5,00T	R 1 267.31
1089	Forehead rhinoplasty (all stages): Total		Procedural fees	552.00	R 20 140.56	441.60	R 16 112.45	5,00T	R 1 267.31
1091	Forehead rhinoplasty (all stages): Partial		Procedural fees	414.00	R 15 105.42	331.20	R 12 084.34	5,00T	R 1 267.31
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
1099	Columella reconstruction or lengthening		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
4890	Endoscopy: Sinus/nasal, with maxillary antrostomy		Procedural fees	64.60	R 2 357.03	64.60	R 2 357.03	5,00T	R 1 267.31
4891	Endoscopy: Sinus/nasal, with maxillary antrostomy and removal of tissue		Procedural fees	103.00	R 3 758.11	103.00	R 3 758.11	5,00T	R 1 267.31
4892	Endoscopy: Sinus/nasal, with partial anterior ethmoidectomy		Procedural fees	170.50	R 6 220.95	136.40	R 4 976.76	5,00T	R 1 267.31
4893	Endoscopy: Sinus/nasal, with medial or inferior orital wall decompression		Procedural fees	280.60	R 10 238.12	224.48	R 8 190.49	5,00T	R 1 267.31
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision		Procedural fees	214.10	R 7 811.76	179.28	R 6 541.30	7,00T	R 1 774.24
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision		Procedural fees	247.50	R 9 030.41	198.00	R 7 224.33	7,00T	R 1 774.24
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision		Procedural fees	275.10	R 10 037.44	220.08	R 8 029.95	7,00T	R 1 774.24
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision		Procedural fees	291.10	R 10 621.23	232.88	R 8 496.98	7,00T	R 1 774.24
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision		Procedural fees	245.70	R 8 964.74	196.56	R 7 171.79	7,00T	R 1 774.24
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision		Procedural fees	244.30	R 8 913.66	195.44	R 7 130.93	7,00T	R 1 774.24

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
4902	Intranasal sinus surgery, unilateral, 3 or more sinuses operated one side: frontal, maxilla, ethmoid, sphenoid.		Procedural fees	303.40	R 11 070.01	242.72	R 8 856.01	5,00T	R 1 267.31
4.2	**Throat**								
1100	Control of oropharyngeal haemorrhage with secondary surgical intervention, primary or secondary (e.g. post tonsillectomy)		Procedural fees	136.80	R 4 991.36	136.80	R 4 991.36	10,00T	R 2 534.63
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)		Procedural fees	168.30	R 6 140.68	134.64	R 4 912.55	5,00T	R 1 267.31
1107	Opening of quinsy: At rooms		Procedural fees	12.00	R 437.84	12.00	R 437.84	6,00T	R 1 520.78
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		Procedural fees	85.00	R 3 101.35	85.00	R 3 101.35	5,00T	R 1 267.31

1109	Opening of quinsy: Under general anaesthetic		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	6,00T	R 1 520.78
1110	Ludwig's Angina: Drainage		Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	9,00T	R 2 281.17
1096	Removal of foreign body: Pharynx		Procedural fees	40.50	R 1 477.70	40.50	R 1 477.70	5,00T	R 1 267.31
1112	Pharyngeal pouch operation		Procedural fees	231.80	R 8 457.58	185.44	R 6 766.06	5,00T	R 1 267.31
1098	Resection: Lateral pharyngeal wall or pyriform sinus, closure by advancement of lateral and posterio pharangeal walls		Procedural fees	286.90	R 10 467.98	229.52	R 8 374.39	6,00T	R 1 520.78
1113	Retropharyngeal abscess: Internal approach		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	6,00T	R 1 520.78
1115	Retropharyngeal abscess: External approach		Procedural fees	85.00	R 3 101.35	85.00	R 3 101.35	6,00T	R 1 520.78
1114	Pharyngectomy: Partial		Procedural fees	237.90	R 8 680.14	190.32	R 6 944.11	7,00T	R 1 774.24
1116	Functional reconstruction of palate and uvula		Procedural fees	168.30	R 6 140.68	134.64	R 4 912.55	5,00T	R 1 267.31
4.3	**Larynx**								
1117	Laryngeal intubation		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
1120	Intubation, endotracheal, emergency procedure		Procedural fees	34.00	R 1 240.54	34.00	R 1 240.54		R -
1118	Laryngeal stroboscopy with video capture		Procedural fees	39.00	R 1 422.97	39.00	R 1 422.97	6,00T	R 1 520.78
1121	Stroboscopy - equipment cost		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65		R -
1122	Laryngeal function studies		Procedural fees	11.60	R 423.24	11.60	R 423.24		R -
1119	Laryngectomy: without neck node dissection, including tracheostomy, skin flaps for access and tracheal stoma		Procedural fees	592.30	R 21 610.97	473.84	R 17 288.77	7,00T	R 1 774.24
4904	Laryngectomy: Total, with radical unilateral neck dissection, including submandibular salivary gland, tracheostomy, skin flaps for access and tracheal stoma		Procedural fees	732.90	R 26 740.97	586.32	R 21 392.78	7,00T	R 1 774.24
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection		Procedural fees	434.80	R 15 864.34	347.84	R 12 691.47	7,00T	R 1 774.24
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection		Procedural fees	563.20	R 20 549.21	450.56	R 16 439.37	7,00T	R 1 774.24
4907	Laryngectomy: Hemilaryngectomy, horisontal		Procedural fees	429.70	R 15 678.26	343.76	R 12 542.61	7,00T	R 1 774.24
4908	Laryngectomy: Hemilaryngectomy, laterovertical		Procedural fees	391.00	R 14 266.23	312.80	R 11 412.98	7,00T	R 1 774.24
4909	Laryngectomy: Hemilaryngectomy, anterovertical		Procedural fees	405.10	R 14 780.69	324.08	R 11 824.55	7,00T	R 1 774.24

4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical		Procedural fees	414.20	R 15 112.72	331.36	R 12 090.17	7,00T	R 1 774.24
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)		Procedural fees	35.00	R 1 277.03				
1124	Arytenoidectomy/arytenoidopexy: External approach		Procedural fees	115.70	R 4 221.49	115.70	R 4 221.49	8,00T	R 2 027.70
1125	Operative laryngoscopy - excision of lesion/polyp		Procedural fees	103.30	R 3 769.06	103.30	R 3 769.06	6,00T	R 1 520.78
1126	Post laryngectomy for voice restoration		Procedural fees	139.50	R 5 089.87	120.00	R 4 378.38	9,00T	R 2 281.17
1127	Tracheotomy		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	9,00T	R 2 281.17
1128	Endolaryngeal operations		Procedural fees	75.00	R 2 736.49	75.00	R 2 736.49	8,00T	R 2 027.70
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure		Procedural fees	294.40	R 10 741.63	235.52	R 8 593.31	8,00T	R 2 027.70
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)		Procedural fees	41.40	R 1 510.54	41.40	R 1 510.54	6,00T	R 1 520.78
1131	Direct laryngoscopy plus foreign body removal		Procedural fees	64.60	R 2 357.03	64.60	R 2 357.03	6,00T	R 1 520.78
4913	Pharyngolaryngectomy: with radical neck dissection, without reconstruction		Procedural fees	571.10	R 20 837.45	456.88	R 16 669.96	7,00T	R 1 774.24
4914	Pharyngolaryngectomy: with radical neck dissection, with reconstruction		Procedural fees	667.50	R 24 354.75	534.00	R 19 483.80	7,00T	R 1 774.24
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal		Procedural fees	275.60	R 10 055.68	220.48	R 8 044.55	8,00T	R 2 027.70
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy		Procedural fees	427.60	R 15 601.64	342.08	R 12 481.31	9,00T	R 2 281.17
4918	Laryngoplasty: Open reduction of fracture		Procedural fees	367.20	R 13 397.85	293.76	R 10 718.28	8,00T	R 2 027.70
4919	Laryngoplasty: Cricoid split		Procedural fees	230.30	R 8 402.85	184.24	R 6 722.28	8,00T	R 2 027.70

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
4922	Tracheostoma: Revision, without flap rotation, simple		Procedural fees	102.40	R 3 736.22	102.40	R 3 736.22	9,00T	R 2 281.17
4923	Tracheostoma: Revision, with flap rotation, complex		Procedural fees	167.30	R 6 104.19	133.84	R 4 883.36	9,00T	R 2 281.17
4926	Tracheostomy: Fenestration with skin flaps		Procedural fees	180.40	R 6 582.17	144.32	R 5 265.73	9,00T	R 2 281.17
4927	Tracheostomy: Revision of scar		Procedural fees	104.50	R 3 812.84	104.50	R 3 812.84	9,00T	R 2 281.17

4928	Tracheostomy/fistula: Closure, without plastic repair		Procedural fees	104.50	R 3 812.84	104.50	R 3 812.84	9,00T	R 2 281.17
4929	Tracheostomy/fistula: Closure, with plastic repair		Procedural fees	149.80	R 5 465.68	120.00	R 4 378.38	9,00T	R 2 281.17
4932	Tracheobronchoscopy: Through established tracheostomy incision		Procedural fees	37.70	R 1 375.54	37.70	R 1 375.54	6,00T	R 1 520.78
4933	Tracheoplasty: Cervical		Procedural fees	260.10	R 9 490.14	208.08	R 7 592.12	8,00T	R 2 027.70
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage		Procedural fees	329.00	R 12 004.07	263.20	R 9 603.25	8,00T	R 2 027.70
4.4	**Bronchial procedures**								
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy								
1132	Bronchoscopy: Diagnostic bronchoscopy		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	6,00T	R 1 520.78
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	8,00T	R 2 027.70
1134	Bronchoscopy: Bronchoscopy with laser		Procedural fees	75.00	R 2 736.49			8,00T	R 2 027.70
1136	Nebulisation in rooms (inhalants not included)		Procedural fees	12.00	R 437.84	12.00	R 437.84	12,00c	R 437.84
1137	Bronchial lavage		Procedural fees		R -			8,00T	R 2 027.70
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	12,00T	R 3 041.55
4.5	**Pleura**								
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	3,00T	R 760.39
1141	Insertion of intercostal catheter (under water drainage)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	6,00T	R 1 520.78
1142	Intra-pleural block		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51	36,00c	R 1 313.51
1143	Paracentesis chest: Diagnostic		Procedural fees	8.00	R 291.89	8.00	R 291.89	3,00T	R 760.39
1145	Paracentesis chest: Therapeutic		Procedural fees	13.00	R 474.32	13.00	R 474.32	3,00T	R 760.39
1147	Pneumothorax: Induction (diagnostic)		Procedural fees	25.00	R 912.16	25.00	R 912.16		
1149	Pleurectomy		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	11,00T	R 2 788.09
1151	Decortication of lung		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	11,00T	R 2 788.09
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76	3,00T	R 760.39

CONTINUES ON PAGE 130 OF BOOK 2

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4.6	Pulmonary procedures								
4.6.1	Pulmonary procedures: Surgical								
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)		Procedural fees	32.00	R 1 167.57	32.00	R 1 167.57	5,00T	R 1 267.31
1157	Pneumonectomy		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	11,00T	R 2 788.09
1159	Pulmonary lobectomy		Procedural fees	389.50	R 14 211.50	311.60	R 11 369.20	11,00T	R 2 788.09
1161	Segmental lobectomy		Procedural fees	365.00	R 13 317.58	292.00	R 10 654.06	11,00T	R 2 788.09
1163	Excision tracheal stenosis/cricotracheal resection. Includes graft insertion and removal of cricoid cartilage preserving cricoarytenoid joint.		Procedural fees	490.80	R 17 907.58	392.64	R 14 326.07	8,00T	R 2 027.70
1164	Excision tracheal stenosis: Intra thoracic		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	12,00T	R 3 041.55
1167	Thoracoplasty associated with lung resection or done by the same surgeon within FOUR weeks		Procedural fees	215.00	R 7 844.60	172.00	R 6 275.68	12,00T	R 3 041.55
1168	Thoracoplasty: Complete		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	11,00T	R 2 788.09
1169	Thoracoplasty: Limited (osteoplastic)		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	11,00T	R 2 788.09
1171	Drainage empyema (including FOUR weeks after treatment)		Procedural fees	170.00	R 6 202.71	136.00	R 4 962.17	11,00T	R 2 788.09
1173	Drainage of lung abscess (including FOUR weeks after treatment)		Procedural fees	170.00	R 6 202.71	136.00	R 4 962.17	11,00T	R 2 788.09
1175	Thoracotomy (limited): For lung or pleural biopsy		Procedural fees	115.00	R 4 195.95	115.00	R 4 195.95	11,00T	R 2 788.09
1179	Thoracoscopy		Procedural fees	89.00	R 3 247.30	89.00	R 3 247.30	11,00T	R 2 788.09
1181	Lung transplant: Unilateral		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	15,00T	R 3 801.94
1182	Harvesting donor lung: Unilateral		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	5,00T	R 1 267.31
1183	Excision or plication of emphysematous cyst: Unilateral		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	11,00T	R 2 788.09
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)		Procedural fees	438.00	R 15 981.10	350.40	R 12 784.88	11,00T	R 2 788.09
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
4.6.2	Pulmonary function tests								
1186	Flow volume test: Inspiration/expiration		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60

1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation - thereafter item 1186 applies)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	50,00c	R 1 824.33
1187	Exhaled nitric oxide detemination (not to children under 4 years of age)		Procedural fees	6.10	R 222.57	6.10	R 222.57		R -
1189	Forced expirogram only		Procedural fees	10.00	R 364.87	10.00	R 364.87	10,00c	R 364.87
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry		Procedural fees	45.31	R 1 653.20				R -
1191	N2 single breath distribution		Procedural fees	10.00	R 364.87	10.00	R 364.87	10,00c	R 364.87
1192	Peak expiratory flow only		Procedural fees	5.00	R 182.43	5.00	R 182.43	5,00c	R 182.43
1197	Compliance and resistance, using oesophageal balloon		Procedural fees	24.00	R 875.68	24.00	R 875.68	24,00c	R 875.68
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		Procedural fees	55.89	R 2 039.23	55.89	R 2 039.23		R -
1199	Pulmonary stress testing: For determination of VO2 max		Procedural fees	96.50	R 3 520.95	96.50	R 3 520.95		R -
1201	Maximum inspiratory/expiratory pressure		Procedural fees	5.00	R 182.43	5.00	R 182.43	5,00c	R 182.43
4.6.2.2	**Pulmonary function tests: Specialised services Pulmonologist ('17') and Practitioners accredited to the SA Thoracic Society**								
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method		Procedural fees	37.76	R 1 377.73				R -
1195	Thoracic gas volume		Procedural fees	37.93	R 1 383.93				R -
1196	Determination of resistance to airflow, oscillary or plethysmographic methods		Procedural fees	45.31	R 1 653.20				R -
1200	Carbon monoxide diffusing capacity, any method		Procedural fees	38.06	R 1 388.68				R -
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		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	40,00c	R 1 459.46
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		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60
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**		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	100,00c	R 3 648.65
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**		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	50,00c	R 1 824.33
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**		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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)		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	137,00c	R 4 998.65
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)		Procedural fees	58.00	R 2 116.22	58.00	R 2 116.22	58,00c	R 2 116.22
1210	Intensive care: Category 3: Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	50,00c	R 1 824.33
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.		Procedural fees		R -				R -
1212	Ventilation: First day		Procedural fees	75.00	R 2 736.49	75.00	R 2 736.49	75,00c	R 2 736.49
1213	Ventilation: Subsequent days, per calendar day		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	50,00c	R 1 824.33
1214	Ventilation: After two weeks, per calendar day		Procedural fees	25.00	R 912.16	25.00	R 912.16	25,00c	R 912.16
1215	Insertion of arterial pressure cannula		Procedural fees	25.00	R 912.16	25.00	R 912.16	25,00c	R 912.16
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	50,00c	R 1 824.33
1217	Insertion of central venous line via peripheral vein		Procedural fees	10.00	R 364.87	10.00	R 364.87	10,00c	R 364.87
1218	Insertion of central venous line via subclavian or jugular veins		Procedural fees	25.00	R 912.16	25.00	R 912.16	25,00c	R 912.16
1219	Hyperalimentation (daily tariff)		Procedural fees	15.00	R 547.30	15.00	R 547.30	15,00c	R 547.30

1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60
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)		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60
4.7.4	**Extracorporeal membrance oxygenation (ECMO)/ Extracorporeal life support (ECLS)**								
4785	Extracorporeal membrance oxygenation (ECMO) / Extracorporeal life support (ECLS) management provided by medical doctor: First day, veno-venous		Procedural fees	R 179.80	R 6 560.28				R -
4786	Extracorporeal membrance oxygenation (ECMO) / Extracorporeal life support (ECLS) management provided by medical doctor: First day, veno-arterial		Procedural fees	R 179.80	R 6 560.28				R -
4787	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Daily management, each subsequent day, veno-venous		Procedural fees	R 103.65	R 3 781.83				R -
4788	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Daily management, each subsequent day, veno-arterial		Procedural fees	R 103.65	R 3 781.83				R -
4789	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Percutaneous insertion of arterial and/or venous cannula(e): Birth through 5 years of age		Procedural fees	R 376.00	R 13 718.93			5,00T	R 1 267.31
4790	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Percutaneous insertion of arterial and/or venous cannula(e): 6 years of age and older		Procedural fees	R 338.40	R 12 347.04			5,00T	R 1 267.31
4791	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Open insertion of arterial and/or venous cannula(e): Birth through 5 years of age		Procedural fees	R 413.60	R 15 090.82			5,00T	R 1 267.31
4792	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Open insertion of arterial and/or venous cannula(e): 6 years of age and older		Procedural fees	R 372.24	R 13 581.74			5,00T	R 1 267.31
4793	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Sternotomy and/or thoracotomy insertion of cetral (arterial and/or venous) cannula(e): Birth through 5 years of age		Procedural fees	R 564.00	R 20 578.40			15,00T	R 3 801.94
4794	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Sternotomy and/or thoracotomy insertion of cetral (arterial and/or venous) cannula(e): 6 years of age and older		Procedural fees	R 507.60	R 18 520.56			15,00T	R 3 801.94
4795	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Repositioning percutaneous or open peripheral (arterial and/or venous) cannula(e): Birth through 5 years of age		Procedural fees	R 57.70	R 2 105.27			5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
4796	Extracorporeal membrane oxygenation (ECMO)/ Extracorporeal life support (ECLS) provided by medical doctor: Repositioning percutaneous or open peripheral (arterial and/or venous) cannula(e): 6 years of age and older		Procedural fees	R 57.70	R 2 105.27			5,00T	R 1 267.31
4797	Extracorporeal membrane oxygenation (ECMO) repositioning central (arterial and/or venous) cannula(e) by sternotomy or thoracotomy; birth through 5 years of age		Procedural fees	R 86.55	R 3 157.91			15,00T	R 3 801.94
4798	Extracorporeal membrane oxygenation (ECMO) - repositioning central (arterial and/or venous) cannula(e) by sternotomy or thoracotomy; 6 years of age and older		Procedural fees	R 86.55	R 3 157.91			15,00T	R 3 801.94
4799	Arterial exposure with creation of graft conduit (e.g. chimney graft) to facilitate arterial perfusion for ECMO/ECLS	+	Procedural fees	R 61.60	R 2 247.57				R -
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). m. Cerebral abscesses								
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60		R -
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT		Procedural fees	101.13	R 3 689.88	101.13	R 3 689.88		R -
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): Routine HBO table (2-2,5 ATA x 90-120 min): PROFESSIONAL COMPONENT		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19		R -
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT		Procedural fees	131.26	R 4 789.22	131.26	R 4 789.22		R -
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): Emergency HBO table (2,5-3 ATA x 90-120 min): PROFESSIONAL COMPONENT		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92		R -
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT		Procedural fees	131.26	R 4 789.22	131.26	R 4 789.22		R -
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT5 (2,8 ATA x 135 min): PROFESSIONAL COMPONENT		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79		R -
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT		Procedural fees	214.18	R 7 814.68	214.18	R 7 814.68		R -
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6 (2,8 ATA x 285 min): PROFESSIONAL COMPONENT		Procedural fees	190.00	R 6 932.44	190.00	R 6 932.44		R -
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT		Procedural fees	386.42	R 14 099.12	386.42	R 14 099.12		R -
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes prehyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min): PROFESSIONAL COMPONENT		Procedural fees	327.00	R 11 931.09	327.00	R 11 931.09		R -
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		Procedural fees	680.85	R 24 841.85	680.85	R 24 841.85		R -
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		Procedural fees	678.28	R 24 748.08	678.28	R 24 748.08		R -
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		Procedural fees	671.85	R 24 513.47	671.85	R 24 513.47		R -
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 procedure units (Please indicate time in minutes and not per half hour)		Procedural fees		R -				R -
5. Mediastinal Procedures									
1222	Mediastinal tumours		Procedural fees	285.00	R 10 398.66	228.00	R 8 318.93	11,00T	R 2 788.09

1223	Mediastinoscopy		Procedural fees	95.00	R 3 466.22	95.00	R 3 466.22	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1224	Mediastinotomy		Procedural fees	115.00	R 4 195.95	115.00	R 4 195.95	11,00T	R 2 788.09
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	11,00T	R 2 788.09
1226	Removal of single rib with a lesion		Procedural fees	282.00	R 10 289.20	225.60	R 8 231.36	11,00T	R 2 788.09

6. Cardiovascular System

6.1	Cardiovascular system: General	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1227	Prolonged neonatal resuscitation		Procedural fees	20.00	R 729.73	20.00	R 729.73	20.00	R 729.73
	NOTE: Items 1228 and 1229 professional component for performing of the ECG. The consultation/visit item should be added.								
1228	General Practitioner's technical component for performing an ECG only: Without effort: ½ (item 1232)		Procedural fees		R -	4.50	R 164.19		R -
1229	General Practitioner's technical component for performing an ECG only: Without and with effort: ½ (item 1233)		Procedural fees		R -	6.50	R 237.16		R -
	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.		Procedural fees	6.00	R 218.92				R -
1231	Professional component for a physician interpreting an ECG: With and without effort.		Procedural fees	10.00	R 364.87				R -
1232	Electrocardiogram: Without effort (Interpretation included)		Procedural fees	9.00	R 328.38	9.00	R 328.38		R -
1233	Electrocardiogram: With and without effort (Interpretation included)		Procedural fees	13.00	R 474.32	13.00	R 474.32		R -
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus (interpretation included)		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46		R -
1235	Multi-stage treadmill test (Interpretation included)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19		R -
1236	Electrocardiogram without effort: Under 4 years old (Interpretation included)		Procedural fees	18.00	R 656.76	18.00	R 656.76		R -
1237	24 Hour ambulatory blood pressure: Equipment hire		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60		R -
1238	24 Hour ambulatory ECG monitoring (holter): Equipment fee		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76		R -

1239	24 Hour ambulatory ECG monitoring (holter): Interpretation		Procedural fees	27.00	R 985.14	27.00	R 985.14		R -
1240	Signal averaged electrocardiogram (Interpretation included)		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92		R -
1241	X-ray Screening: Chest		Procedural fees	4.00	R 145.95	4.00	R 145.95		R -
1242	X-ray screening: Prosthetic valves		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
1243	Two week event triggered ambulatory ECG monitoring: Equipment hire		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76		R -
1244	Two week event triggered ambulatory ECG monitoring: Interpretation		Procedural fees	25.00	R 912.16	25.00	R 912.16		R -
1245	Angiography cerebral: First two series		Procedural fees	34.30	R 1 251.49	34.30	R 1 251.49	4,00T	R 1 013.85
1246	Angiography peripheral: Per limb		Procedural fees	25.00	R 912.16	25.00	R 912.16	4,00T	R 1 013.85
1247	Cardioversion for arrhythmias (any method) with doctor in attendance		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	6,00T	R 1 520.78
1248	Paracentesis of pericardium		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	9,00T	R 2 281.17
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing		Procedural fees	51.00	R 1 860.81	51.00	R 1 860.81		R -
6.2	**Invasive Cardiology**								
6.2.1	**Invasive cardiology: Cardiac catheterisation**								
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)		Procedural fees	140.00	R 5 108.11			9,00T	R 2 281.17
1250	Endomyocardial biopsy		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	9,00T	R 2 281.17
1251	Transeptal puncture		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	9,00T	R 2 281.17
1252	Left heart catheterisation with coronary angiography (with or without biopsy)		Procedural fees	140.00	R 5 108.11			9,00T	R 2 281.17
1253	Right heart catheterisation (with or without biopsy)		Procedural fees	70.00	R 2 554.06			9,00T	R 2 281.17
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	9,00T	R 2 281.17
1255	Tilt test		Procedural fees		R -				R -
6.2.2	**Invasive cardiology: Electrophysiological study**								
1256	Ventricular stimulation study		Procedural fees	160.00	R 5 837.84			9,00T	R 2 281.17
1257	Full electrophysiological study		Procedural fees	300.00	R 10 945.96			9,00T	R 2 281.17

1262	Electrophysiological mapping		Procedural fees	500.00	R 18 243.26	400.00	R 14 594.61		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
6.2.3	**Invasive cardiology: Pacemakers**								
1258	Pacemaker/Pulse generator/Neurostimulator: Permanent - single chamber		Procedural fees	155.00	R 5 655.41	124.00	R 4 524.33	9,00T	R 2 281.17
1259	Pacemaker/Pulse generator/Neurostimulator: Permanent - dual chamber		Procedural fees	230.00	R 8 391.90	184.00	R 6 713.52	9,00T	R 2 281.17
1272	Coronary sinus lead implantation (add to either item 1258: Pacemaker: Permanent - single chamber or item 1259: Pacemaker: Permanent - dual chamber)	+	Procedural fees	120.60	R 4 400.27	120.00	R 4 378.38	4,00T	R 1 013.85
1260	AV nodal ablation		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	9,00T	R 2 281.17
1261	Accessory pathway ablation		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	9,00T	R 2 281.17
1263	Insertion transvenous implantable defibrillator		Procedural fees	212.00	R 7 735.14	169.60	R 6 188.11	15,00T	R 3 801.94
1264	Test for implantable transvenous defibrillator		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	15,00T	R 3 801.94
1265	Renewal of pacemaker/pulse generator/neurostimulator unit only, team fee		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	9,00T	R 2 281.17
1266	Resiting pacemaker generator		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92		R -
1267	Repositioning of catheter electrode		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	9,00T	R 2 281.17
1268	Threshold testing: Own equipment		Procedural fees	15.00	R 547.30				R -
1269	Threshold testing: Hospital equipment		Procedural fees	11.00	R 401.35				R -
1270	Programming of atrio-ventricular sequential pacemaker/pulse generator/neurostimulator		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33		R -
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	9,00T	R 2 281.17
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts		Procedural fees	260.00	R 9 486.50	208.00	R 7 589.20		R -
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	9,00T	R 2 281.17
1296	Fractional flow reserve (FFR): First vessel (add on code)	+	Procedural fees	28.00	R 1 021.62	28.00	R 1 021.62		R -
1298	Fractional flow reserve (FFR): Each addisional vessel (add on code)	+	Procedural fees	22.40	R 817.30	22.40	R 817.30		R -
1300	Renal denervation (RDN), per artery, (Modifier 0005 applicable)		Procedural fees	223.00	R 8 136.49	178.40	R 6 509.20		R -

6.2.4	Invasive cardiology: Percutaneous translumical angioplasty								
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion		Procedural fees	260.00	R 9 486.50	208.00	R 7 589.20	13,00T	R 3 295.02
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	13,00T	R 3 295.02
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	13,00T	R 3 295.02
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	13,00T	R 3 295.02
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	13,00T	R 3 295.02
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	13,00T	R 3 295.02
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty		Procedural fees	260.00	R 9 486.50	208.00	R 7 589.20	15,00T	R 3 801.94
1283	Use of balloon procedure as in item 1282: Second cardiologist		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	15,00T	R 3 801.94
1284	Atherectomy: Single lesion: First cardiologist		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76		
1285	Atherectomy: Single lesion: Second cardiologist		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06		
1286	Insertion of intravascular stent: First cardiologist		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65		
1287	Insertion of intravascular stent: Second cardiologist		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33		
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		Procedural fees	300.00	R 10 945.96			15,00T	R 3 801.94
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)		Procedural fees	160.00	R 5 837.84				
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation								
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		Procedural fees	276.50	R 10 088.52			6,00T	R 1 520.78
5992	Closure interatrial communication (Fontan fenestration etc)		Procedural fees	310.80	R 11 340.01			10,00T	R 2 534.63
5995	Rapid right ventricular pacing for percutaneous procedure		Procedural fees	51.00	R 1 860.81			10,00T	R 2 534.63
5996	Removal of embolised device/materials		Procedural fees	80.60	R 2 940.81			6,00T	R 1 520.78

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
6.3	Cardiac surgery								

1295	Pericardiectomy for constrictive pericarditis		Procedural fees	400.00	R 14 594.61	320.00	R 11 675.69	15,00T	R 3 801.94
1299	Systemo-pulmonary anastomosis		Procedural fees	425.00	R 15 506.77	340.00	R 12 405.42	15,00T	R 3 801.94
1305	Operative implantation of cardiac pacemaker by thoracotomy		Procedural fees	220.00	R 8 027.03	176.00	R 6 421.63	15,00T	R 3 801.94
1307	Re-exploration after cardiac surgery		Procedural fees	215.00	R 7 844.60	172.00	R 6 275.68	15,00T	R 3 801.94
1311	Pericardial drainage		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	13,00T	R 3 295.02
6.3.1	**Cardiac surgery: Open heart surgery**								
1312	Evaluation of coronary angiogram by cardiothoracic surgeon		Procedural fees	25.00	R 912.16				
1320	Repeat open heart surgery (additional fee above procedure fee)		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	15,00T	R 3 801.94
1321	Stand-by fee for coronary angioplasty		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	30,00c	R 1 094.60
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour		Procedural fees	20.00	R 729.73				
6.3.1.1	**Cardiac surgery: Open heart surgery: Acquired conditions**								
1360	Closure: Left atrial appendage (LAA)		Procedural fees	828.00	R 30 210.84	662.40	R 24 168.67		
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		Procedural fees	397.50	R 14 503.39	318.00	R 11 602.71		
1339	Mitral valve replacement		Procedural fees	657.00	R 23 971.64	525.60	R 19 177.31	15,00T	R 3 801.94
1340	Mitral valvuloplasty		Procedural fees	688.00	R 25 102.73	550.40	R 20 082.18	15,00T	R 3 801.94
1341	Aortic valve replacement		Procedural fees	623.80	R 22 760.29	499.04	R 18 208.23	15,00T	R 3 801.94
1342	Tricuspid annulo plasty		Procedural fees	188.00	R 6 859.47	150.40	R 5 487.57	15,00T	R 3 801.94
1343	Double valve replacement		Procedural fees	968.90	R 35 351.79	775.12	R 28 281.43	15,00T	R 3 801.94
1344	Acute dissecting aneurysm repair		Procedural fees	750.00	R 27 364.89	600.00	R 21 891.91	15,00T	R 3 801.94
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest		Procedural fees	1 000.00	R 36 486.52	800.00	R 29 189.22	15,00T	R 3 801.94
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65		
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11		
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins		Procedural fees	750.00	R 27 364.89	600.00	R 21 891.91	15,00T	R 3 801.94

1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery		Procedural fees	781.00	R 28 495.97	624.80	R 22 796.78	15,00T	R 3 801.94
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery		Procedural fees	813.00	R 29 663.54	650.40	R 23 730.83	15,00T	R 3 801.94
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm		Procedural fees	875.00	R 31 925.71	700.00	R 25 540.56	15,00T	R 3 801.94
1352	Cardiac aneurysm		Procedural fees	563.00	R 20 541.91	450.40	R 16 433.53	15,00T	R 3 801.94
1353	Ascending/descending thoracic aortic aneurysm repair		Procedural fees	625.00	R 22 804.08	500.00	R 18 243.26	15,00T	R 3 801.94
1354	Arrhythmia surgery		Procedural fees	688.00	R 25 102.73	550.40	R 20 082.18	15,00T	R 3 801.94
1355	Cardiac tumour		Procedural fees	625.00	R 22 804.08	500.00	R 18 243.26	15,00T	R 3 801.94
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)		Procedural fees	188.00	R 6 859.47	150.40	R 5 487.57	15,00T	R 3 801.94
1358	Harvesting of radial artery		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11		
6.4	**Peripheral vascular system**								
6.4.1	**Peripheral vascular system: Investigations**								
1357	Skin temperature test: Response to reflex heating		Procedural fees	15.00	R 547.30	15.00	R 547.30		R -
1359	Skin temperature test: Response to reflex cooling		Procedural fees	15.00	R 547.30	15.00	R 547.30		R -
1361	Cold sensitivity test		Procedural fees	17.00	R 620.27	17.00	R 620.27		R -
1363	Oscillometry test		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
1365	Sweating test		Procedural fees	17.00	R 620.27	17.00	R 620.27		R -
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site		Procedural fees	26.30	R 959.60	26.30	R 959.60		R -
1367	Doppler blood tests		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
5369	Doppler arterial pressures		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
5371	Doppler arterial pressures with exercise		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
5373	Doppler segmental pressures and wave forms		Procedural fees	12.00	R 437.84	12.00	R 437.84		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value

5375	Venous doppler examination (both limbs)		Procedural fees	9.00	R 328.38	9.00	R 328.38		R -
5377	Venous plethysmography		Procedural fees	16.00	R 583.78	16.00	R 583.78		R -
5379	Supra-orbital doppler test		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
5381	Carotid non-invasive complex tests		Procedural fees	39.00	R 1 422.97	39.00	R 1 422.97		R -
6.4.2	**Peripheral vascular system: Arterio-venous abnormalities**								
1369	Fistula or aneurysm (as for grafting of various arteries)		Procedural fees		RCF Missing				R -
6.4.3	**Arteries**								
6.4.3.1	**Peripheral vascular system: Arteries: Aorta-iliac and major branches**								
1372	Abdominal aorta and iliac artery: Unruptured		Procedural fees	540.00	R 19 702.72	432.00	R 15 762.18	15,00T	R 3 801.94
1373	Abdominal aorta and iliac artery: Ruptured		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	15,00T	R 3 801.94
1375	Grafting and/or thrombo-endarterectomy for thrombosis		Procedural fees	444.00	R 16 200.01	355.20	R 12 960.01	15,00T	R 3 801.94
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis		Procedural fees	594.00	R 21 672.99	475.20	R 17 338.39	15,00T	R 3 801.94
6.4.3.2	**Peripheral vascular system: Arteries: Iliac artery**								
1379	Prosthetic grafting and/or thrombo-endarterectomy		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	13,00T	R 3 295.02
6.4.3.3	**Peripheral vascular system: Arteries: Peripheral**								
1385	Prosthetic grafting		Procedural fees	255.00	R 9 304.06	204.00	R 7 443.25	5,00T	R 1 267.31
1387	Vein grafting proximal to knee joint		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	5,00T	R 1 267.31
1388	Vein grafting distal to knee joint		Procedural fees	444.00	R 16 200.01	355.20	R 12 960.01	5,00T	R 1 267.31
1389	Endarterectomy when not part of another specified procedure		Procedural fees	264.00	R 9 632.44	211.20	R 7 705.95	5,00T	R 1 267.31
1390	Carotid endarterectomy		Procedural fees	321.00	R 11 712.17	256.80	R 9 369.74	15,00T	R 3 801.94
1393	Embolectomy: Peripheral embolectomy transfemoral		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	5,00T	R 1 267.31
1395	Miscellaneous arterial procedures: Arterial suture: Trauma		Procedural fees	125.00	R 4 560.82	100.00	R 3 648.65	5,00T	R 1 267.31
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 because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure) - Anaesthetic: Except where a specific code already exist elsewhere.		Procedural fees	264.00	R 9 632.44	211.20	R 7 705.95	15,00T	R 3 801.94

1397	Profundoplasty		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	5,00T	R 1 267.31
1399	Distal tibial (ankle region)		Procedural fees	456.00	R 16 637.85	364.80	R 13 310.28	5,00T	R 1 267.31
1401	Femoro-femoral		Procedural fees	254.00	R 9 267.58	203.20	R 7 414.06	5,00T	R 1 267.31
1402	Carotid-subclavian		Procedural fees	288.00	R 10 508.12	230.40	R 8 406.49	8,00T	R 2 027.70
1403	Axillo-femoral: (Bifemoral + 50%of the units)		Procedural fees	288.00	R 10 508.12	230.40	R 8 406.49	8,00T	R 2 027.70
6.4.4	**Peripheral vascular system: Veins**								
1407	Ligation of saphenous vein		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	3,00T	R 760.39
1408	Placement of Hickman catheter or similar		Procedural fees	91.00	R 3 320.27	91.00	R 3 320.27	4,00T	R 1 013.85
1410	Litigation of inferior vena cava: Abdominal		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	8,00T	R 2 027.70
1412	Umbrella operation on inferior vena cava: Abdominal		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	8,00T	R 2 027.70
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral		Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	3,00T	R 760.39
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral		Procedural fees	247.00	R 9 012.17	197.60	R 7 209.74	3,00T	R 760.39
1417	Extensive sub-fascial ligation of perforating veins		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	3,00T	R 760.39
1419	Lesser varicose vein procedures		Procedural fees	31.00	R 1 131.08	31.00	R 1 131.08	3,00T	R 760.39
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9 injections per leg (excluding cost of material)		Procedural fees	9.00	R 328.38	9.00	R 328.38		
1422	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: First vein		Procedural fees	96.20	R 3 510.00	96.20	R 3 510.00	5,00T	R 1 267.31
1424	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: subsequent veins (Modifier 0005 is not applicable)		Procedural fees	47.00	R 1 714.87	47.00	R 1 714.87	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	11,00T	R 2 788.09
1427	Thrombectomy: Illio-femoral		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	6,00T	R 1 520.78
6.4.5	**Peripheral vascular system: Portal hypertension**								
1429	Porto-caval shunt		Procedural fees	500.00	R 18 243.26	400.00	R 14 594.61	11,00T	R 2 788.09

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		Procedural fees	12.00	R 437.84	12.00	R 437.84		R -
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
	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.								

7. Lympho Reticular System

7.1	Spleen	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1435	Splenectomy (in all cases)		Procedural fees	221.30	R 8 074.47	177.04	R 6 459.57	9,00T	R 2 281.17
1436	Splenorrhaphy		Procedural fees	231.80	R 8 457.58	185.44	R 6 766.06	9,00T	R 2 281.17
7.2	**Lymph nodes and lymphatic channels**								
1439	Excision of lymph node for biopsy: Neck or axilla		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	4,00T	R 1 013.85
1441	Excision of lymph node for biopsy: Groin		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	3,00T	R 760.39
1442	Lymphadenectomy: Modified radical neck dissection, cervical		Procedural fees	310.50	R 11 329.06	248.40	R 9 063.25	5,00T	R 1 267.31
1443	Simple excision of lymph nodes for tuberculosis		Procedural fees	91.00	R 3 320.27	91.00	R 3 320.27	3,00T	R 760.39
1445	Radical excision of lymph nodes of neck: Total: Unilateral		Procedural fees	315.00	R 11 493.25	252.00	R 9 194.60	5,00T	R 1 267.31
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral		Procedural fees	235.00	R 8 574.33	188.00	R 6 859.47	5,00T	R 1 267.31
1449	Radical excision of lymph nodes of axilla		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	4,00T	R 1 013.85
1451	Radical excision of lymph nodes of groin: Ilio-inguinal		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	4,00T	R 1 013.85
1453	Radical excision of lymph nodes of groin: Inguinal		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	4,00T	R 1 013.85
7.3	**Bone marrow and stem cell transplantation and harvesting.**								
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells		Procedural fees	58.00	R 2 116.22	58.00	R 2 116.22	5,00T	R 1 267.31
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)		Procedural fees	39.00	R 1 422.97	39.00	R 1 422.97	5,00T	R 1 267.31
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis		Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	5,00T	R 1 267.31
1457	Bone marrow biopsy: By trephine		Procedural fees	13.00	R 474.32	13.00	R 474.32	3,00T	R 760.39

1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula		Procedural fees	8.00	R 291.89	8.00	R 291.89		R -
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)		Procedural fees	28.10	R 1 025.27	28.10	R 1 025.27		R -
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		Procedural fees	36.90	R 1 346.35	36.90	R 1 346.35		R -
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		Procedural fees	36.80	R 1 342.70	36.80	R 1 342.70		R -
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		Procedural fees	23.50	R 857.43	23.50	R 857.43		R -
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		Procedural fees	23.80	R 868.38	23.80	R 868.38		R -
1448	Bone marrow harvesting for transplant - PROFESSIONAL COMPONENT (refer to item 5934 for calculation of own equipment cost)		Procedural fees	101.00	R 3 685.14	101.00	R 3 685.14	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
8. Digestive System									
8.1	**Oral cavity**								
1461	All dental procedures		Anaesthetic		R -			4,00T	R 1 013.85
1463	Surgical biopsy of tongue or palate: Under general anaesthetic		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	4,00T	R 1 013.85
1465	Surgical biopsy of tongue or palate: Under local anaesthetic		Procedural fees	15.00	R 547.30	15.00	R 547.30	4,00T	R 1 013.85
1467	Drainage of intra-oral abscess		Procedural fees	31.00	R 1 131.08	31.00	R 1 131.08	4,00T	R 1 013.85
1469	Local excision of mucosal lesion of oral cavity		Procedural fees	23.00	R 839.19	23.00	R 839.19	4,00T	R 1 013.85
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	6,00T	R 1 520.78
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)		Procedural fees	227.00	R 8 282.44	181.60	R 6 625.95	6,00T	R 1 520.78
1480	Repair of oronasal fistula (large) e.g. distant flap		Procedural fees	227.00	R 8 282.44	181.60	R 6 625.95	6,00T	R 1 520.78
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
1482	Repair of oronasal fistula (large): Second stage		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
1483	Alveolar periosteal or other flaps for arch closure		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	4,00T	R 1 013.85

1486	Closure of anterior nasal floor		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
1462	Removal of embedded foreign body: Vestibule of mouth, simple		Procedural fees	41.10	R 1 499.60	41.10	R 1 499.60	5,00T	R 1 267.31
1464	Removal of embedded foreign body: Vestibule of mouth, complicated		Procedural fees	73.10	R 2 667.16	73.10	R 2 667.16	5,00T	R 1 267.31
1466	Removal of embedded foreign body: Dentoalveolar structures, soft tissues		Procedural fees	52.80	R 1 926.49	52.80	R 1 926.49	5,00T	R 1 267.31
8.2	**Lips**								
1497	Vermilionectomy		Procedural fees	94.90	R 3 462.57	94.90	R 3 462.57	4,00T	R 1 013.85
1499	Lip reconstruction following an injury: Direct repair		Procedural fees	105.60	R 3 852.98	105.60	R 3 852.98	4,00T	R 1 013.85
1501	Lip reconstruction following an injury or tumour removal: Flap repair		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)		Procedural fees	104.00	R 3 794.60	104.00	R 3 794.60	4,00T	R 1 013.85
8.3	**Tongue**								
1505	Partial glossectomy		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	6,00T	R 1 520.78
1507	Local excision of lesion of tongue		Procedural fees	27.00	R 985.14	27.00	R 985.14	4,00T	R 1 013.85
8.4	**Palate, uvula and salivary glands**								
1509	Wide excision of lesion of palate		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	5,00T	R 1 267.31
1511	Radical resection of palate (including skin graft)		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	7,00T	R 1 774.24
1513	Excision of ranula		Procedural fees	85.60	R 3 123.25	85.60	R 3 123.25	5,00T	R 1 267.31
1515	Excision of sublingual salivary gland		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	4,00T	R 1 013.85
1517	Excision of submandibular salivary gland		Procedural fees	146.00	R 5 327.03	120.00	R 4 378.38	4,00T	R 1 013.85
1519	Excision of submandibular salivary gland: With suprahyoid dissection		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	5,00T	R 1 267.31
1521	Excision of submandibular salivary gland: With radical neck dissection		Procedural fees	352.00	R 12 843.26	281.60	R 10 274.60	6,00T	R 1 520.78
1523	Local resection of parotid tumour		Procedural fees	169.60	R 6 188.11	135.68	R 4 950.49	5,00T	R 1 267.31
1525	Partial parotidectomy		Procedural fees	310.00	R 11 310.82	248.00	R 9 048.66	5,00T	R 1 267.31

1526	Total parotidectomy with preservation of facial nerve		Procedural fees	358.50	R 13 080.42	286.80	R 10 464.33	5,00T	R 1 267.31
1527	Total parotidectomy		Procedural fees	358.50	R 13 080.42	286.80	R 10 464.33	5,00T	R 1 267.31
1529	Parotidectomy: Extracapsular		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	5,00T	R 1 267.31
1531	Drainage of parotid abscess		Procedural fees	25.00	R 912.16	25.00	R 912.16	4,00T	R 1 013.85
1533	Closure of salivary fistula		Procedural fees	91.00	R 3 320.27	91.00	R 3 320.27	4,00T	R 1 013.85
1535	Dilatation of salivary duct		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
1537	Operative removal of salivary calculus		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76	4,00T	R 1 013.85
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated		Procedural fees	58.50	R 2 134.46	58.50	R 2 134.46	5,00T	R 1 267.31
1539	Salivary duct: Meatotomy		Procedural fees	20.00	R 729.73	20.00	R 729.73	5,00T	R 1 267.31
1541	Branchial cyst and/or fistula: Excision		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1543	Excision of cystic hygroma		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	5,00T	R 1 267.31
1544	Ludwig's Angina: Drainage		Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	9,00T	R 2 281.17
8.5	**Oesophagus**								
1545	Oesophagoscopy with rigid instrument: First and subsequent		Procedural fees	47.00	R 1 714.87	47.00	R 1 714.87	4,00T	R 1 013.85
1549	Oesophagoscopy with dilatation of stricture		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	4,00T	R 1 013.85
1550	Oesophagoscopy with removal of foreign body		Procedural fees	70.00	R 2 554.06	70.00	R 2 554.06	4,00T	R 1 013.85
1551	Oesophagoscopy with insertion of indwelling oesophageal tube		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	4,00T	R 1 013.85
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	4,00T	R 1 013.85
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	4,00T	R 1 013.85
1555	Repair of tracheal oesophageal fistula and oesophageal atresia		Procedural fees	400.00	R 14 594.61	320.00	R 11 675.69	15,00T	R 3 801.94
1557	Oesophageal dilatation		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	4,00T	R 1 013.85

1559	Oesophagectomy: Two stage		Procedural fees	500.00	R 18 243.26	400.00	R 14 594.61	11,00T	R 2 788.09
1560	Oesophagectomy: Three stage		Procedural fees	550.00	R 20 067.59	440.00	R 16 054.07	11,00T	R 2 788.09
1561	Thoraco-abdominal oesophagogastrectomy		Procedural fees	500.00	R 18 243.26	400.00	R 14 594.61	11,00T	R 2 788.09
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)	+	Procedural fees	80.60	R 2 940.81	80.60	R 2 940.81	5,00T	R 1 267.31
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure		Procedural fees	243.10	R 8 869.87	194.48	R 7 095.90	11,00T	R 2 788.09
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	11,00T	R 2 788.09
1566	Private fee: Gastroplasty		Procedural fees	325.00	R 11 858.12	260.00	R 9 486.50	8,00T	R 2 027.70
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair		Procedural fees	375.00	R 13 682.45	300.00	R 10 945.96	11,00T	R 2 788.09
1569	Oesophagomyotomy: Laparotomy, with fundoplication if performed (Heller type procedure)		Procedural fees	280.80	R 10 245.41	224.64	R 8 196.33	7,00T	R 1 774.24
1575	Insertion of indwelling oesophageal tube by laparotomy		Procedural fees	142.00	R 5 181.09	120.00	R 4 378.38	6,00T	R 1 520.78
1578	Anorectal manometry and physiological assessment		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	4,00T	R 1 013.85
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach		Procedural fees	400.00	R 14 594.61	320.00	R 11 675.69	11,00T	R 2 788.09
1580	Oesophageal manometry 4-6 channel		Procedural fees	110.00	R 4 013.52	110.00	R 4 013.52	4,00T	R 1 013.85
1581	Removal of benign oesophageal tumours		Procedural fees	285.00	R 10 398.66	228.00	R 8 318.93	11,00T	R 2 788.09
1582	Advanced oesophageal function assessment (impedance or provocative test or high definition 3D rendering)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	4,00T	R 1 013.85
1583	Excision of intrathoracic oesophageal diverticulum		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	11,00T	R 2 788.09
1584	Ambulatory oesophageal or gastric pH or bile or impedance studies: Hire cost (item 0201 applicable for disposable or semi-disposable devices)		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76		R -
1585	Ambulatory oesophageal or gastric pH or bile or impedance studies: Interpretation		Procedural fees	27.00	R 985.14	27.00	R 985.14		R -
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		Procedural fees	357.10	R 13 029.34	258.68	R 9 438.33	7,00T	R 1 774.24
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic (Item 1807 may not be added to this item.)		Procedural fees	314.70	R 11 482.31	251.76	R 9 185.85	7,00T	R 1 774.24
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): ADD to major procedure (modifier 0005 does not apply)	+	Procedural fees	48.30	R 1 762.30	48.30	R 1 762.30	7,00T	R 1 774.24
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		Procedural fees	348.20	R 12 704.61	278.56	R 10 163.69	7,00T	R 1 774.24

5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		Procedural fees	378.10	R 13 795.55	302.48	R 11 036.44	7,00T	R 1 774.24
5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		Procedural fees	382.20	R 13 945.15	305.76	R 11 156.12	15,00T	R 3 801.94

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		Procedural fees	411.80	R 15 025.15	329.44	R 12 020.12	15,00T	R 3 801.94
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracoabdominal approach (not applicable to neonatal surgery)		Procedural fees	451.20	R 16 462.72	360.96	R 13 170.17	15,00T	R 3 801.94
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		Procedural fees	492.50	R 17 969.61	394.00	R 14 375.69	15,00T	R 3 801.94
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)		Procedural fees	463.60	R 16 915.15	370.88	R 13 532.12	7,00T	R 1 774.24
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)		Procedural fees	520.90	R 19 005.83	416.72	R 15 204.66	7,00T	R 1 774.24
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure) (item 1807 may not be added to this item)		Procedural fees	377.70	R 13 780.96	302.16	R 11 024.77	7,00T	R 1 774.24
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		Procedural fees	313.10	R 11 423.93	250.48	R 9 139.14	15,00T	R 3 801.94
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		Procedural fees	389.80	R 14 222.45	311.84	R 11 377.96	7,00T	R 1 774.24
8.6	**Stomach**								
1587	Upper gastro-intestinal endoscopy with hospital equipment (including biopsy) (refer to Modifier 0074 for use of own equipment)		Procedural fees	48.75	R 1 778.72	48.75	R 1 778.72	4,00T	R 1 013.85
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587) or small bowel endoscopy (item 1626) as appropriate, per lesion)	+	Procedural fees	25.00	R 912.16	25.00	R 912.16	4,00T	R 1 013.85
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)	+	Procedural fees	34.00	R 1 240.54	34.00	R 1 240.54	6,00T	R 1 520.78
1591	Plus removal of foreign bodies (stomach or small bowel): ADD to gastro-intestinal endoscopy (Item 1587) or small bowel endoscopy (item 1626)	+	Procedural fees	25.00	R 912.16	25.00	R 912.16	4,00T	R 1 013.85
1593	Augmented histamine test: Gastric intubation with x-ray screening		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
1597	Gastrostomy or Gastrotomy		Procedural fees	147.50	R 5 381.76	120.00	R 4 378.38	6,00T	R 1 520.78
1598	Gastrotomy with suture repair of bleeding ulcer		Procedural fees	251.20	R 9 165.41	200.00	R 7 297.30	6,00T	R 1 520.78
1599	Pyloromyotomy (Rammstedt)		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44	6,00T	R 1 520.78
1601	Local excision of ulcer or benign neoplasm		Procedural fees	195.60	R 7 136.76	156.48	R 5 709.41	6,00T	R 1 520.78

1603	Vagotomy: Abdominal		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	6,00T	R 1 520.78
1604	Vagotomy: Thoracic		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	11,00T	R 2 788.09
1605	Truncal or selective with drainage procedures		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	6,00T	R 1 520.78
1607	Vagotomy and antrectomy		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	6,00T	R 1 520.78
1609	Highly selective vagotomy		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	6,00T	R 1 520.78
1611	Pyloroplasty		Procedural fees	180.20	R 6 574.87	144.16	R 5 259.90	6,00T	R 1 520.78
1613	Gastroenterostomy		Procedural fees	203.60	R 7 428.66	162.88	R 5 942.92	6,00T	R 1 520.78
1615	Suture of perforated gastric or duodenal ulcer or wound or injury		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	7,00T	R 1 774.24
1617	Partial gastrectomy		Procedural fees	328.30	R 11 978.52	262.64	R 9 582.82	7,00T	R 1 774.24
1619	Total gastrectomy		Procedural fees	384.43	R 14 026.51	307.54	R 11 221.06	7,00T	R 1 774.24
1621	Revision of gastrectomy or gastro-enterostomy		Procedural fees	375.00	R 13 682.45	300.00	R 10 945.96	7,00T	R 1 774.24
1625	Gastro-esophageal operation for portal hypertension (Tanner)		Procedural fees	375.00	R 13 682.45	300.00	R 10 945.96	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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)		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	6,00T	R 1 520.78
1627	Duodenal intubation (under X-ray screening)		Procedural fees	8.00	R 291.89				R -
1629	Duodenal intubation with biliary drainage after gall bladder stimulation		Procedural fees	21.00	R 766.22				R -
1631	Duodenal intubation: Under 3 years of age		Procedural fees	15.00	R 547.30				R -
8.8	**Intestines**								
1632	H2 breath test (intestines)		Procedural fees	9.00	R 328.38	9.00	R 328.38		R -
1633	Complete test using lactose or lactulose		Procedural fees	27.00	R 985.14	27.00	R 985.14		R -
1634	Enterotomy or Enterostomy		Procedural fees	202.60	R 7 392.17	162.08	R 5 913.74	6,00T	R 1 520.78

1637	Operation for relief of intestinal obstruction		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	7,00T	R 1 774.24
1639	Resection of small bowel with enterostomy or anastomosis		Procedural fees	244.90	R 8 935.55	195.92	R 7 148.44	6,00T	R 1 520.78
1641	Entero-enterostomy or entero-colostomy for bypass		Procedural fees	213.10	R 7 775.28	170.48	R 6 220.22	6,00T	R 1 520.78
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)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38		R -
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79		R -
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury		Procedural fees	185.20	R 6 757.30	148.16	R 5 405.84	6,00T	R 1 520.78
1647	Closure of intestinal fistula		Procedural fees	258.00	R 9 413.52	206.40	R 7 530.82	6,00T	R 1 520.78
1649	Excision of Meckel's diverticulum		Procedural fees	179.80	R 6 560.28	143.84	R 5 248.22	6,00T	R 1 520.78
1651	Excision of lesion of mesentery		Procedural fees	171.60	R 6 261.09	137.28	R 5 008.87	4,00T	R 1 013.85
1652	Laparotomy for mesenteric thrombosis		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	8,00T	R 2 027.70
1653	Total colonoscopy with hospital equipment (including biopsy) (refer to Modifier 0074 for use of own equipment		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	4,00T	R 1 013.85
1654	PLUS Polypectomy: ADD to colonoscopy (Item 1653 or item 1656): per lesion	+	Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	4,00T	R 1 013.85
1656	Left-sided colonoscopy		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	4,00T	R 1 013.85
1657	Right or left hemicolectomy or segmental colectomy		Procedural fees	325.00	R 11 858.12	260.00	R 9 486.50	6,00T	R 1 520.78
1658	Reconstruction of colon after Hartman's procedure		Procedural fees	359.40	R 13 113.26	287.52	R 10 490.60	6,00T	R 1 520.78
1661	Colotomy: Including removal of tumour or foreign body		Procedural fees	205.70	R 7 505.28	164.56	R 6 004.22	6,00T	R 1 520.78
1663	Total colectomy		Procedural fees	390.00	R 14 229.74	312.00	R 11 383.79	6,00T	R 1 520.78
1665	Colostomy or ileostomy isolated procedure		Procedural fees	233.80	R 8 530.55	187.04	R 6 824.44	6,00T	R 1 520.78
1666	Continent ileostomy pouch (all types)		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	6,00T	R 1 520.78
1667	Colostomy: Closure		Procedural fees	179.10	R 6 534.74	143.28	R 5 227.79	5,00T	R 1 267.31
1668	Revision of ileostomy pouch		Procedural fees	375.00	R 13 682.45	300.00	R 10 945.96	6,00T	R 1 520.78
1669	Total proctocolectomy and ileostomy		Procedural fees	480.00	R 17 513.53	384.00	R 14 010.82	7,00T	R 1 774.24

1670	Restorative proctocolectomy with ileal pouch - anal anastomosis		Procedural fees	565.20	R 20 622.18	452.16	R 16 497.74	7,00T	R 1 774.24
1671	Colomyotomy (Reilly operation)		Procedural fees	185.00	R 6 750.01	148.00	R 5 400.00	6,00T	R 1 520.78
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (Paediatric surgeons add Modifier 0016)		Procedural fees	20.50	R 747.97	20.50	R 747.97	4,00T	R 1 013.85
1659	Surgeon present assisting with air enema for reduction of inussuception (Paediatric surgeons add Modifier 0016)		Procedural fees	60.60	R 2 211.08	60.60	R 2 211.08		R -
1636	Oral food challenge test		Procedural fees	14.10	R 514.46	14.10	R 514.46		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
8.9	**Appendix**								
1673	Drainage of appendix abscess		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	5,00T	R 1 267.31
1675	Appendicectomy		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	4,00T	R 1 013.85
8.10	**Rectum and anus**								
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.		Procedural fees	48.75	R 1 778.72	48.75	R 1 778.72	3,00T	R 760.39
1677	Sigmoidoscopy: First and subsequent, with or without biopsy		Procedural fees	13.00	R 474.32	13.00	R 474.32	3,00T	R 760.39
1688	Total mesorectal excision with colo-anal anastomosis with or without proximal diverting stoma		Procedural fees	432.70	R 15 787.72	346.16	R 12 630.17	7,00T	R 1 774.24
	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		Procedural fees	409.30	R 14 933.93	327.44	R 11 947.15	7,00T	R 1 774.24
1692	Abdomino-perineal resection of rectum: Perineal surgeon		Procedural fees	158.50	R 5 783.11	126.80	R 4 626.49		R -
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	4,00T	R 1 013.85
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	6,00T	R 1 520.78
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	6,00T	R 1 520.78
1701	Repair of prolapsed rectum: Perineal		Procedural fees	236.60	R 8 632.71	189.28	R 6 906.17	5,00T	R 1 267.31
1703	Repair of prolapsed rectum: Thierisch suture		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	4,00T	R 1 013.85
1705	Incision and drainage of peri-anal abscess		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	3,00T	R 760.39

1707	Drainage of submucous abscess		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	3,00T	R 760.39
1709	Drainage of ischio-rectal abscess		Procedural fees	87.00	R 3 174.33	87.00	R 3 174.33	3,00T	R 760.39
1711	Excision of pelvi-rectal fistula		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	5,00T	R 1 267.31
1713	Excision of fistula-in-ano		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	3,00T	R 760.39
1715	Operation for fissure-in-ano		Procedural fees	66.80	R 2 437.30	66.80	R 2 437.30	3,00T	R 760.39
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
1721	Sclerosing injection for haemorrhoids: Per injection		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
1723	Haemorrhoidectomy		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	3,00T	R 760.39
1725	Drainage of external thrombosed pile		Procedural fees	12.50	R 456.08	12.50	R 456.08	3,00T	R 760.39
1727	Multiple procedures (haemorrhoids, fissure, etc.)		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	3,00T	R 760.39
1733	Anoplasty: Y-V-plasty		Procedural fees	41.00	R 1 495.95	41.00	R 1 495.95	3,00T	R 760.39
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79		
1735	Anal sphincteroplasty for incontinence		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	3,00T	R 760.39
1737	Dilation of ano-rectal stricture		Procedural fees	12.50	R 456.08	12.50	R 456.08	3,00T	R 760.39
1739	Closure of recto-vesical fistula		Procedural fees	241.00	R 8 793.25	192.80	R 7 034.60	5,00T	R 1 267.31
1741	Closure of recto-urethral fistula		Procedural fees	241.00	R 8 793.25	192.80	R 7 034.60	5,00T	R 1 267.31
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor		Procedural fees	27.00	R 985.14	27.00	R 985.14		

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
8.11	**Liver**								
1743	Needle biopsy of liver		Procedural fees	30.30	R 1 105.54	30.30	R 1 105.54	3,00T	R 760.39
1745	Biopsy of liver by laparotomy		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	4,00T	R 1 013.85
1744	Extensive debridement, haemostatis and packing of liver wound or injury		Procedural fees	483.80	R 17 652.18	387.04	R 14 121.74	13,00T	R 3 295.02

1746	Re-exploration of liver wound for removal of packing		Procedural fees	192.90	R 7 038.25	154.32	R 5 630.60	13,00T	R 3 295.02
1747	Drainage of liver abscess or cyst		Procedural fees	179.10	R 6 534.74	143.28	R 5 227.79	7,00T	R 1 774.24
1748	Body composition measured by bio-electrical impedance		Procedural fees	3.00	R 109.46	3.00	R 109.46		
1749	Hemi-hepatectomy: Right		Procedural fees	564.00	R 20 578.40	451.20	R 16 462.72	9,00T	R 2 281.17
1751	Hemi-hepatectomy: Left		Procedural fees	521.10	R 19 013.13	416.88	R 15 210.50	9,00T	R 2 281.17
1752	Extended right or left hepatectomy		Procedural fees	570.90	R 20 830.15	456.72	R 16 664.12	9,00T	R 2 281.17
1753	Partial or segmental hepatectomy		Procedural fees	378.00	R 13 791.90	302.40	R 11 033.52	9,00T	R 2 281.17
1754	Hepatico-jejunostomy		Procedural fees	369.20	R 13 470.82	295.36	R 10 776.66	9,00T	R 2 281.17
1757	Simple suture of liver wound or injury		Procedural fees	214.20	R 7 815.41	171.36	R 6 252.33	13,00T	R 3 295.02
1758	Complex suture of liver wound or injury, including hepatic artery ligation		Procedural fees	296.60	R 10 821.90	237.28	R 8 657.52	13,00T	R 3 295.02
8.12	**Biliary tract**								
1759	Cholecystostomy		Procedural fees	171.60	R 6 261.09	137.28	R 5 008.87	6,00T	R 1 520.78
1761	Cholecystectomy		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	6,00T	R 1 520.78
1762	Cholecystectomy and operative cholangiogram		Procedural fees	255.00	R 9 304.06	204.00	R 7 443.25	6,00T	R 1 520.78
1763	With exploration of common bile duct		Procedural fees	264.50	R 9 650.68	211.60	R 7 720.55	6,00T	R 1 520.78
1765	Exploration of common bile duct: Secondary operation		Procedural fees	327.70	R 11 956.63	262.16	R 9 565.31	6,00T	R 1 520.78
1767	Reconstruction of common bile duct		Procedural fees	371.70	R 13 562.04	297.36	R 10 849.63	6,00T	R 1 520.78
1766	Resection bile duct tmour: Intrahepatic		Procedural fees	407.40	R 14 864.61	324.92	R 11 855.20	7,00T	R 1 774.24
1768	Resection bile duct tumour: Extrahepatic		Procedural fees	327.70	R 11 956.63	262.16	R 9 565.31	7,00T	R 1 774.24
1769	Cholecysto-enterostomy or gastrostomy		Procedural fees	236.30	R 8 621.76	189.04	R 6 897.41	6,00T	R 1 520.78
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	+	Procedural fees	25.60	R 934.05	25.60	R 934.05	6,00T	R 1 520.78
1773	Transduodenal sphincteroplasty		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	6,00T	R 1 520.78
1774	Balloon dilatation of common bile duct strictures		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	6,00T	R 1 520.78

1775	Excision choledochal cyst with reconstruction		Procedural fees	327.70	R 11 956.63	262.16	R 9 565.31	6,00T	R 1 520.78
1777	Porto-enterostomy for biliary atresia		Procedural fees	400.00	R 14 594.61	320.00	R 11 675.69	11,00T	R 2 788.09
8.13	**Pancreas**								
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus		Procedural fees	105.90	R 3 863.92	105.90	R 3 863.92	4,00T	R 1 013.85
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	+	Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	6,00T	R 1 520.78
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	+	Procedural fees	15.82	R 577.22	15.82	R 577.22	4,00T	R 1 013.85
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	+	Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	4,00T	R 1 013.85
1780	Gastric and duodenal intubation		Procedural fees	8.00	R 291.89	8.00	R 291.89		
1781	Procedure (excluding laboratory tests)		Procedural fees	21.00	R 766.22	21.00	R 766.22		
1783	Drainage of pancreatic abscess		Procedural fees	239.30	R 8 731.22	191.44	R 6 984.98	6,00T	R 1 520.78
1784	Debridement pancreatic necrosis		Procedural fees	348.40	R 12 711.90	278.72	R 10 169.52	6,00T	R 1 520.78
1785	Internal drainage of pancreatic cyst		Procedural fees	250.60	R 9 143.52	200.48	R 7 314.82	6,00T	R 1 520.78
1786	Internal drainage of pancreatic cyst with Roux-Y		Procedural fees	306.80	R 11 194.06	245.44	R 8 955.25	6,00T	R 1 520.78
1787	Operative pancreatogram: ADD	+	Procedural fees	10.00	R 364.87	10.00	R 364.87		
1788	Biopsy of pancreas		Procedural fees	177.70	R 6 483.65	142.16	R 5 186.92	6,00T	R 1 520.78
1789	Pancreatico-duodenectomy		Procedural fees	704.80	R 25 715.70	563.84	R 20 572.56	8,00T	R 2 027.70
1791	Local, partial or subtotal pancreatectomy		Procedural fees	351.30	R 12 817.71	281.04	R 10 254.17	8,00T	R 2 027.70
1792	Near-total pancreatectomy (with preservation of duodenum)		Procedural fees	415.90	R 15 174.74	332.72	R 12 139.79	8,00T	R 2 027.70
1793	Distal pancreatectomy with internal drainage		Procedural fees	377.40	R 13 770.01	301.92	R 11 016.01	8,00T	R 2 027.70
1794	Total pancreatectomy		Procedural fees	421.50	R 15 379.07	337.20	R 12 303.25	8,00T	R 2 027.70

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
8.14	**Peritoneal cavity**								
1797	Pneumo-peritoneum: First		Procedural fees	13.00	R 474.32	13.00	R 474.32	4,00T	R 1 013.85

1799	Pneumo-peritoneum: Repeat		Procedural fees	6.00	R 218.92	6.00	R 218.92	4,00T	R 1 013.85
1800	Peritoneal lavage		Procedural fees	20.00	R 729.73	20.00	R 729.73		
1801	Diagnostic paracentesis: Abdomen		Procedural fees	8.00	R 291.89	8.00	R 291.89		
1803	Therapeutic paracentesis: Abdomen		Procedural fees	13.00	R 474.32	13.00	R 474.32		
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	+	Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	5,00T	R 1 267.31
1808	Omentectomy - stand alone procedure		Procedural fees	189.20	R 6 903.25	151.36	R 5 522.60	6,00T	R 1 520.78
1809	Laparotomy		Procedural fees	196.00	R 7 151.36	156.80	R 5 721.09	4,00T	R 1 013.85
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and presacral)		Procedural fees	344.00	R 12 551.36	275.20	R 10 041.09	10,00T	R 2 534.63
1811	Suture of burst abdomen		Procedural fees	188.30	R 6 870.41	150.64	R 5 496.33	7,00T	R 1 774.24
1812	Laparotomy for control of surgical haemorrhage		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	9,00T	R 2 281.17
1813	Drainage of sub-phrenic abscess		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	7,00T	R 1 774.24
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal		Procedural fees	248.40	R 9 063.25	198.72	R 7 250.60	5,00T	R 1 267.31
1817	Drainage of pelvic abscess: (Transrectal approach)		Procedural fees	74.80	R 2 729.19	74.80	R 2 729.19	5,00T	R 1 267.31
9. Herniae		**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
1819	Inguinal or femoral hernia: Adult		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	4,00T	R 1 013.85
1821	Inguinal or femoral hernia: Child under 14 years		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	4,00T	R 1 013.85
1823	Inguinal hernia: Infant under one year		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	4,00T	R 1 013.85
1825	Recurrent inguinal or femoral hernia		Procedural fees	155.00	R 5 655.41	124.00	R 4 524.33	4,00T	R 1 013.85
1827	Strangulated hernia or femoral hernia		Procedural fees	238.00	R 8 683.79	190.00	R 6 932.44	7,00T	R 1 774.24
1829	Epigastric hernia		Procedural fees	93.30	R 3 404.19	93.30	R 3 404.19	4,00T	R 1 013.85
1831	Umbilical hernia: Adult		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	4,00T	R 1 013.85
1833	Umbilical hernia: Child under 14 years		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	4,00T	R 1 013.85

1835	Incisional hernia		Procedural fees	166.80	R 6 085.95	133.44	R 4 868.76	4,00T	R 1 013.85
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)	+	Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	4,00T	R 1 013.85
1837	Repair of omphalocele in new-born (one or more procedures)		Procedural fees	275.00	R 10 033.79	220.00	R 8 027.03	7,00T	R 1 774.24

10. Urinary System

10.1	Kidney	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1839	Renal biopsy: Per kidney: Open		Procedural fees	71.00	R 2 590.54	71.00	R 2 590.54	5,00T	R 1 267.31
1841	Renal biopsy: Needle		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	3,00T	R 760.39
1843	Peritoneal dialysis: First day		Procedural fees	33.00	R 1 204.06	33.00	R 1 204.06		R -
1845	Peritoneal dialysis: Every subsequent day (per calendar day)		Procedural fees	33.00	R 1 204.06	33.00	R 1 204.06		R -
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)		Procedural fees	21.00	R 766.22	21.00	R 766.22		R -
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)		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79		R -
1851	Chronic haemodialysis: Per week (in general ward or out-patient dialysis unit)		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76		R -
1852	Continuous haemodialysis per calender day in intensive or high care unit		Procedural fees	33.00	R 1 204.06	33.00	R 1 204.06		R -
1853	Nephrectomy: Primary nephrectomy		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	5,00T	R 1 267.31
1855	Nephrectomy: Secondary nephrectomy		Procedural fees	267.00	R 9 741.90	213.00	R 7 771.63	5,00T	R 1 267.31
1859	Nephrectomy: Partial		Procedural fees	267.00	R 9 741.90	213.60	R 7 793.52	5,00T	R 1 267.31
1860	Laparoscopic nephrectomy, partial (Item 1807 may not be added to this item)		Procedural fees	374.90	R 13 678.80	299.92	R 10 943.04	7,00T	R 1 774.24
1862	Laparoscopic nephrectomy, includes partial ureterectomy (Item 1807 may not be added to this item)		Procedural fees	301.20	R 10 989.74	240.96	R 8 791.79	7,00T	R 1 774.24
1863	Nephro-ureterectomy		Procedural fees	305.00	R 11 128.39	244.00	R 8 902.71	5,00T	R 1 267.31
1865	Nephrotomy with drainage nephrostomy		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	6,00T	R 1 520.78

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1873	Suture renal laceration (renorraphy)		Procedural fees	193.00	R 7 041.90	154.40	R 5 633.52	6,00T	R 1 520.78

1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy		Procedural fees	34.00	R 1 240.54	34.00	R 1 240.54	3,00T	R 760.39	
1878	Ablation of renal tumour: Cryotherapy, percutaneous, unilateral		Procedural fees	132.50	R 4 834.46	106.00	R 3 867.57	7,00T	R 1 774.24	
1877	Operation for renal cyst: Marsupialisation or excision		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	
1879	Closure renal fistula		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	
1880	Laparoscopic ablation of renal mass or lesion(s) (item 1807) may not be added to this item)		Procedural fees	294.90	R 10 759.87	235.92	R 8 607.90	7,00T	R 1 774.24	
1881	Pyeloplasty		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	5,00T	R 1 267.31	
1882	Pyeloplasty, complicated.(Secondary procedure for congenital kidney abnormality or solitary kidney)		Procedural fees	409.60	R 14 944.88	327.68	R 11 955.90	7,00T	R 1 774.24	
1883	Pyelostomy		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	
1885	Pyelolithotomy		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)		Procedural fees	223.00	R 8 136.49	178.40	R 6 509.20	5,00T	R 1 267.31	
1889	Nephrectomy for Allograft: Living or dead		Procedural fees	255.00	R 9 304.06	204.00	R 7 443.25	5,00T	R 1 267.31	
1891	Perinephric abscess or renal abscess: Drainage		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	7,00T	R 1 774.24	
1892	Laparoscopic drainage of lymphocele to peritoneal cavity (item 1897 may not be added to this item)		Procedural fees	161.80	R 5 903.52	129.44	R 4 722.82	6,00T	R 1 520.78	
1893	Aberrant renal vessels: Repositioning with pyeloplasty		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	5,00T	R 1 267.31	
1894	Auto transplantation of kidney		Procedural fees	420.00	R 15 324.34	336.00	R 12 259.47	10,00T	R 2 534.63	
1895	Allo transplantation of kidney		Procedural fees	420.00	R 15 324.34	336.00	R 12 259.47	10,00T	R 2 534.63	
10.2	**Ureter**									
1897	Ureterorraphy: Suture of ureter		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	5,00T	R 1 267.31	
1898	Ureterorraphy: Lumbar approach		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	
1899	Ureteroplasty		Procedural fees	181.00	R 6 604.06	144.80	R 5 283.25	5,00T	R 1 267.31	
1901	Ureterolysis		Procedural fees	118.00	R 4 305.41	118.00	R 4 305.41	5,00T	R 1 267.31	
1902	Ureterolysis: Lumbar approach		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31	

1903	Ureterectomy only		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
1904	Ureterectomy with bladder cuff - stand-alone procedure		Procedural fees	294.80	R 10 756.23	235.84	R 8 604.98	7,00T	R 1 774.24
1905	Ureterolithotomy		Procedural fees	265.80	R 9 698.12	212.64	R 7 758.49	5,00T	R 1 267.31
1907	Cutaneous ureterostomy: Unilateral		Procedural fees	108.00	R 3 940.54	108.00	R 3 940.54	5,00T	R 1 267.31
1909	Cutaneous ureterostomy: Bilateral		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31
1911	Uretero-enterostomy: Unilateral		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
1913	Uretero-enterostomy: Bilateral		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	5,00T	R 1 267.31
1915	Uretero-ureterostomy		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
1917	Transuretero-ureterostomy		Procedural fees	155.00	R 5 655.41	124.00	R 4 524.33	5,00T	R 1 267.31
1919	Closure of ureteric fistula		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	5,00T	R 1 267.31
1921	Immediate deligation of ureter		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	5,00T	R 1 267.31
1923	Ureterolysis for retrocaval ureter with anastomosis		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	5,00T	R 1 267.31
1924	Ureterocalicostomy		Procedural fees	331.10	R 12 080.69	264.88	R 9 664.55	7,00T	R 1 774.24
1925	Uretero-pyelostomy		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	5,00T	R 1 267.31
1927	Uretero-neo-cystostomy: Unilateral		Procedural fees	316.10	R 11 533.39	252.88	R 9 226.71	5,00T	R 1 267.31
1929	Uretero-neo-cystostomy: Bilateral		Procedural fees	444.15	R 16 205.49	379.32	R 13 840.07	5,00T	R 1 267.31
1931	Uretero-neo-cystostomy: With Boariplasty		Procedural fees	351.80	R 12 835.96	281.44	R 10 268.77	5,00T	R 1 267.31
1932	Laparoscopic uretero-neocystostomy, excludes cystoscopy and urethral stent insertion (item 1807 may not be added to this item)		Procedural fees	382.30	R 13 948.80	305.84	R 11 159.04	6,00T	R 1 520.78
1933	Uretero-sigmoidostomy with rectal bladder and colostomy		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	5,00T	R 1 267.31
1935	Uretero-ileal conduit		Procedural fees	388.00	R 14 156.77	310.40	R 11 325.42	5,00T	R 1 267.31
1936	Contrast injection for ileal conduit visualisation		Procedural fees	15.70	R 572.84	15.70	R 572.84	4,00T	R 1 013.85
1937	Replacement of ureter by bowel segment: Unilateral		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00T	R 1 267.31

1939	Replacement of ureter by bowel segment: Bilateral		Procedural fees	485.00	R 17 695.96	388.00	R 14 156.77	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
1941	Ureterostomy-in-situ: Unilateral		Procedural fees	100.00	R 3 648.65	100.00	R 3 648.65	5,00T	R 1 267.31
1943	Ureterostomy-in-situ: Bilateral		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	5,00T	R 1 267.31
10.3	**Bladder**								
1945	Instillation of radio-opaque material for cystography or urethrocystography		Procedural fees	5.00	R 182.43	5.00	R 182.43	3,00T	R 760.39
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydrodilatation of bladder		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
1949	Cystoscopy: Hospital equipment		Procedural fees	44.00	R 1 605.41	44.00	R 1 605.41	3,00T	R 760.39
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	+	Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
1952	J J Stent catheter	+	Procedural fees	44.00	R 1 605.41	44.00	R 1 605.41	3,00T	R 760.39
1953	With hydrodilatation of the bladder for interstitial cystitis	+	Procedural fees	5.00	R 182.43	5.00	R 182.43	3,00T	R 760.39
1954	Uretroscopy	+	Procedural fees	35.00	R 1 277.03			3,00T	R 760.39
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	+	Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00T	R 760.39
1957	With dilatation of the ureter or ureters	+	Procedural fees	25.00	R 912.16	25.00	R 912.16	3,00T	R 760.39
1959	With manipulation of ureteral calculus	+	Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
1961	With removal of foreign body or calculus from urethra or bladder	+	Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
1963	With fulguration or treatment of minor lesions, with or without biopsy	+	Procedural fees	15.00	R 547.30	15.00	R 547.30	3,00T	R 760.39
1964	And control of haemorrhage and blood clot evacuation	+	Procedural fees	15.00	R 547.30	15.00	R 547.30	3,00T	R 760.39
1965	And catheterisation of the ejaculatory duct	+	Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
1967	With ureteric meatotomy: Unilateral or bilateral	+	Procedural fees	15.00	R 547.30	15.00	R 547.30	3,00T	R 760.39
1969	And cold biopsy	+	Procedural fees	15.00	R 547.30	15.00	R 547.30	3,00T	R 760.39
1971	With cryosurgery for bladder or prostatic disease	+	Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76	3,00T	R 760.39
1973	With incision, fulguration or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	+	Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00T	R 760.39
1976	Optic urethrotomy		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	3,00T	R 760.39
1977	Transurethral resection of ejaculatory duct		Procedural fees	60.70	R 2 214.73	60.70	R 2 214.73	3,00T	R 760.39
1979	Internal urethrotomy: Female		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	3,00T	R 760.39
1981	Internal urethrotomy: Male		Procedural fees	76.20	R 2 780.27	76.20	R 2 780.27	3,00T	R 760.39

1985	Transurethral resection of bladder neck: Female or child		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	5,00T	R 1 267.31
1986	Transurethral resection of bladder neck: Male		Procedural fees	125.00	R 4 560.82	120.00	R 4 378.38	5,00T	R 1 267.31
1987	Litholapaxy		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	5,00T	R 1 267.31
1989	Cystometrogram		Procedural fees	25.00	R 912.16	25.00	R 912.16	3,00T	R 760.39
1991	Flometric bladder, studies with videocystograph		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	3,00T	R 760.39
1992	Flometric bladder, studies without videocystograph		Procedural fees	25.00	R 912.16	25.00	R 912.16	3,00T	R 760.39
1993	Voiding cysto-urethrogram		Procedural fees	21.00	R 766.22	21.00	R 766.22	3,00T	R 760.39
1994	Rigiscan examination		Procedural fees	66.00	R 2 408.11	66.00	R 2 408.11		R -
1995	Percutaneous aspiration of bladder		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
1996	Bladder catheterisation: Male (not at operation)		Procedural fees	6.00	R 218.92	6.00	R 218.92	3,00T	R 760.39
1997	Bladder catheterisation: Female (not at operation)		Procedural fees	3.00	R 109.46	3.00	R 109.46		R -
1999	Percutaneous cystostomy		Procedural fees	24.00	R 875.68	24.00	R 875.68	3,00T	R 760.39
2001	Total cystectomy: After previous urinary diversion		Procedural fees	294.00	R 10 727.04	235.20	R 8 581.63	8,00T	R 2 027.70
2003	Total cystectomy: With conduit construction and ureteric anastomosis		Procedural fees	554.70	R 20 239.07	443.76	R 16 191.26	8,00T	R 2 027.70
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone		Procedural fees	650.00	R 23 716.24	520.00	R 18 972.99	8,00T	R 2 027.70
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)		Procedural fees	700.00	R 25 540.56	560.00	R 20 432.45	8,00T	R 2 027.70
2007	Partial cystectomy		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	6,00T	R 1 520.78
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	8,00T	R 2 027.70
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters		Procedural fees	462.00	R 16 856.77	369.90	R 13 496.36	8,00T	R 2 027.70
2010	Reversion of temporary conduit		Procedural fees	360.00	R 13 135.15	288.00	R 10 508.12	8,00T	R 2 027.70
2011	Partial cystectomy with uretero-neo-cystostomy		Procedural fees	202.00	R 7 370.28	161.60	R 5 896.22	6,00T	R 1 520.78
2012	Reversion of conduit with major urinary tract reconstruction		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	8,00T	R 2 027.70

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2013	Diverticulectomy (independent procedure): Multiple or single		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
2014	Closure of cystostomy - stand-alone procedure		Procedural fees	134.10	R 4 892.84	120.00	R 4 378.38	6,00T	R 1 520.78
2015	Suprapubic cystostomy		Procedural fees	67.00	R 2 444.60	67.00	R 2 444.60	5,00T	R 1 267.31
2016	Abdomino-neo-urethrostomy		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	5,00T	R 1 267.31
2017	Open loop fulguration or excision of bladder tumour		Procedural fees	101.00	R 3 685.14	101.00	R 3 685.14	5,00T	R 1 267.31
2019	Operation for vesico-vaginal or urethra-vaginal fistula		Procedural fees	155.00	R 5 655.41	124.00	R 4 524.33	5,00T	R 1 267.31
2020	Repair of vesico vaginal fistula: Abdominal approach		Procedural fees	255.00	R 9 304.06	204.00	R 7 443.25	5,00T	R 1 267.31
2021	Vesico-plication (Hamilton Stewart)		Procedural fees	118.00	R 4 305.41	118.00	R 4 305.41	5,00T	R 1 267.31
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach		Procedural fees	195.00	R 7 114.87	156.00	R 5 691.90	5,00T	R 1 267.31
2025	Vesico-urethropexy with rectus sling		Procedural fees	229.40	R 8 370.01	183.52	R 6 696.01	5,00T	R 1 267.31
2027	Open operation for ureterocele: Unilateral		Procedural fees	118.00	R 4 305.41	118.00	R 4 305.41	5,00T	R 1 267.31
2029	Open operation for ureterocele: Bilateral		Procedural fees	207.00	R 7 552.71	165.60	R 6 042.17	5,00T	R 1 267.31
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial		Procedural fees	264.00	R 9 632.44	211.20	R 7 705.95	8,00T	R 2 027.70
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent		Procedural fees	53.00	R 1 933.79	53.00	R 1 933.79	8,00T	R 2 027.70
2034	Appendico-vesicostomy, cutaneous		Procedural fees	264.30	R 9 643.39	211.44	R 7 714.71	6,00T	R 1 520.78
2035	Cutaneous vesicostomy		Procedural fees	118.00	R 4 305.41	118.00	R 4 305.41	5,00T	R 1 267.31
2036	Revision of urinary-cutaneous anastomosis, includes repair of fascial defect and hernia		Procedural fees	210.10	R 7 665.82	168.08	R 6 132.65	7,00T	R 1 774.24
2037	Cystoplasty, cysto-urethraplasty, vesicolysis		Procedural fees	126.00	R 4 597.30	120.00	R 4 378.38	5,00T	R 1 267.31
2039	Operation for ruptured bladder		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	6,00T	R 1 520.78
2042	Enterocystoplasty plus bowel anastomosis		Procedural fees	419.90	R 15 320.69	335.92	R 12 256.55	5,00T	R 1 267.31

2043	Cysto-lithotomy		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	5,00T	R 1 267.31
2045	Excision of patent-urachus or urachal cyst		Procedural fees	112.00	R 4 086.49	112.00	R 4 086.49	5,00T	R 1 267.31
2047	Drainage of perivesical or prevesical abscess		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	5,00T	R 1 267.31
2049	Evacuation of clots from bladder: Other than post-operative		Procedural fees	132.10	R 4 819.87	120.00	R 4 378.38	3,00T	R 760.39
2050	Evacuation of clots from bladder: Post-operative		Procedural fees		R -			4,00T	R 1 013.85
2051	Simple bladder lavage: Including catheterisation		Procedural fees	12.00	R 437.84	12.00	R 437.84	3,00T	R 760.39
2053	Bladder neck plasty: Male		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
2057	Bladder neck plasty: Female		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
10.4	**Urethra**								
2059	Open biopsy of urethra: Male		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	3,00T	R 760.39
2061	Open biopsy of urethra: Female		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	3,00T	R 760.39
2063	Dilatation of urethra stricture: By passage sound: Initial (male)		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
2069	Dilatation of female urethra		Procedural fees	5.00	R 182.43	5.00	R 182.43	3,00T	R 760.39
2070	Transvaginal urethrolysis, includes cystoscopy		Procedural fees	193.00	R 7 041.90	154.40	R 5 633.52	4,00T	R 1 013.85
2071	Urethrorraphy: Suture of urethral wound or injury		Procedural fees	139.00	R 5 071.63	120.00	R 4 378.38	4,00T	R 1 013.85
2073	External urethrotomy: Pendulous urethra (anterior)		Procedural fees	67.00	R 2 444.60	67.00	R 2 444.60	3,00T	R 760.39
2075	Urethraplasty: Pendulous urethra: First stage		Procedural fees	71.00	R 2 590.54	71.00	R 2 590.54	4,00T	R 1 013.85
2077	Urethraplasty: Pendulous urethra: Second stage		Procedural fees	145.00	R 5 290.55	120.00	R 4 378.38	4,00T	R 1 013.85
2079	Reconstruction of female urethra		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	4,00T	R 1 013.85
2081	Reconstruction or repair of male anterior urethra (one stage)		Procedural fees	261.60	R 9 544.87	209.28	R 7 635.90	4,00T	R 1 013.85

2083	Reconstruction or repair of prostatic or membranous urethra: First stage		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	6,00T	R 1 520.78
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	6,00T	R 1 520.78
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage		Procedural fees	294.00	R 10 727.04	235.20	R 8 581.63	6,00T	R 1 520.78
2087	Urethral diverticulectomy: Male or female		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units		Procedural fees	86.00	R 3 137.84	86.00	R 3 137.84		
2089	Marsupialisation of urethral diverticula: Male or female		Procedural fees	115.10	R 4 199.60	115.10	R 4 199.60	4,00T	R 1 013.85
2091	Total urethrectomy: Female		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	5,00T	R 1 267.31
2093	Total urethrectomy: Male		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31
2095	Drainage of simple localised perineal urinary extravasation		Procedural fees	128.80	R 4 699.46	120.00	R 4 378.38	5,00T	R 1 267.31
2097	Drainage of extensive perineal and/or abdominal urinary extravasation		Procedural fees	137.00	R 4 998.65	120.00	R 4 378.38	5,00T	R 1 267.31
2099	Fulguration for urethral caruncle or polyp		Procedural fees	53.60	R 1 955.68	53.60	R 1 955.68	3,00T	R 760.39
2101	Excision of urethral caruncle		Procedural fees	53.60	R 1 955.68	53.60	R 1 955.68	3,00T	R 760.39
2103	Simple urethral meatotomy		Procedural fees	26.30	R 959.60	26.30	R 959.60	3,00T	R 760.39
2105	Incision of deep peri-urethral abscess: Female		Procedural fees	123.10	R 4 491.49	120.00	R 4 378.38	3,00T	R 760.39
2107	Incision of deep peri-urethral abscess: Male		Procedural fees	123.10	R 4 491.49	120.00	R 4 378.38	3,00T	R 760.39
2104	Debridement of external genitalia and perineum (Fournier's gangrene)		Procedural fees	148.80	R 5 429.19	120.00	R 4 378.38	4,00T	R 1 013.85
2106	Debridement of external genitalia, perineum and abdominal wall (Fournier's gangrene)		Procedural fees	187.40	R 6 837.57	149.92	R 5 470.06	7,00T	R 1 774.24
2109	Badenoch pull-through for intractable stricture or incontinence		Procedural fees	181.00	R 6 604.06	144.80	R 5 283.25	5,00T	R 1 267.31
2108	Sling operation for male urinary incontinence (fascia or synthetic)		Procedural fees	211.20	R 7 705.95	168.96	R 6 164.76	6,00T	R 1 520.78
2110	Removal/Revision: Sling for male urinary incontinence		Procedural fees	145.20	R 5 297.84	120.00	R 4 378.38	6,00T	R 1 520.78

2111	External sphincterotomy		Procedural fees	108.00	R 3 940.54	108.00	R 3 940.54	5,00T	R 1 267.31
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff		Procedural fees	272.00	R 9 924.33	217.60	R 7 939.47	6,00T	R 1 520.78
2113	Drainage of Skene gland abscess or cyst		Procedural fees	42.30	R 1 543.38	42.30	R 1 543.38	3,00T	R 760.39
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff		Procedural fees	178.10	R 6 498.25	142.48	R 5 198.60	6,00T	R 1 520.78
2115	Operation for correction of male urinary incontinence with or without introduction of prosthesis (excluding cost of prosthesis)		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	5,00T	R 1 267.31
2116	Urethral meatoplasty		Procedural fees	101.50	R 3 703.38	101.50	R 3 703.38	3,00T	R 760.39
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)		Procedural fees	150.30	R 5 483.92	120.24	R 4 387.14	3,00T	R 760.39
2121	Closure of urethrovaginal fistula: Including diversionary procedures		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	5,00T	R 1 267.31
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff		Procedural fees	193.00	R 7 041.90	154.40	R 5 633.52	6,00T	R 1 520.78
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff		Procedural fees	225.30	R 8 220.41	123.52	R 4 506.81	6,00T	R 1 520.78
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridement of infected tissue		Procedural fees	347.70	R 12 686.36	278.16	R 10 149.09	6,00T	R 1 520.78

11. Male Genital System

11.1	Penis	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2123	Biopsy of penis (independent procedure)		Procedural fees	52.10	R 1 900.95	52.10	R 1 900.95	3,00T	R 760.39
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses		Procedural fees	101.00	R 3 685.14	101.00	R 3 685.14	3,00T	R 760.39
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra		Procedural fees	188.60	R 6 881.36	150.88	R 5 505.09	3,00T	R 760.39
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce		Procedural fees	224.60	R 8 194.87	179.68	R 6 555.90	3,00T	R 760.39
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	3,00T	R 760.39
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	3,00T	R 760.39
2153	Reconstructive operation for epispadias with incontinence		Procedural fees	168.00	R 6 129.74	134.40	R 4 903.79	3,00T	R 760.39
2154	Induction of artificial erection		Procedural fees	16.00	R 583.78	16.00	R 583.78	3,00T	R 760.39
2155	Hypospadias: Urethral reconstruction		Procedural fees	187.00	R 6 822.98	149.60	R 5 458.38	3,00T	R 760.39

2157	Hypospadias: Subsequent procedures for repair of urethra: Total		Procedural fees	84.00	R 3 064.87	84.00	R 3 064.87	3,00T	R 760.39
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	3,00T	R 760.39
2161	Total amputation of penis: Without gland dissection		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	4,00T	R 1 013.85
2163	Total amputation of penis: With gland-dissection		Procedural fees	336.00	R 12 259.47	268.80	R 9 807.58	6,00T	R 1 520.78
2165	Partial amputation of penis: With gland-dissection		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	6,00T	R 1 520.78
2167	Partial amputation of penis: Without gland-dissection		Procedural fees	84.00	R 3 064.87	84.00	R 3 064.87	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2168	Excision: Penile plaque (Peyronie disease), <= 5cm in length		Procedural fees	235.20	R 8 581.63	188.16	R 6 865.30	3,00T	R 760.39
2170	Excision: Penile plaque (Peyronie disease), >5cm in length		Procedural fees	274.90	R 10 030.14	219.92	R 8 024.12	3,00T	R 760.39
2172	Removal of foreign body: Deep penile tissue (e.g. plastic implant)		Procedural fees	123.10	R 4 491.49	120.00	R 4 378.38	3,00T	R 760.39
2169	Injection procedure for Peyronie's disease		Procedural fees	14.00	R 510.81	14.00	R 510.81	3,00T	R 760.39
2171	Priapism operation: Irrigation of corpora cavernosa for priapism		Procedural fees	42.00	R 1 532.43	42.00	R 1 532.43	3,00T	R 760.39
2173	Priapism operation: Shunt procedure: Any type		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	4,00T	R 1 013.85
2174	Priapism operation: Stab shunt		Procedural fees	114.40	R 4 174.06	114.40	R 4 174.06	4,00T	R 1 013.85
11.2	**Testis and epididymis**								
2175	Testis biopsy: Needle (independent procedure)		Procedural fees	18.50	R 675.00	18.50	R 675.00	3,00T	R 760.39
2177	Testis biopsy: Incisional: Independent procedure: Unilateral		Procedural fees	58.90	R 2 149.06	58.90	R 2 149.06	3,00T	R 760.39
2179	Testis biopsy: Incisional: Independent procedure: Bilateral		Procedural fees	58.90	R 2 149.06	58.90	R 2 149.06	3,00T	R 760.39
2181	Epididymis biopsy: Needle		Procedural fees	86.10	R 3 141.49	86.10	R 3 141.49	3,00T	R 760.39
2183	Puncture aspiration hydrocele with or without injection of medication		Procedural fees	10.00	R 364.87	10.00	R 364.87	3,00T	R 760.39
2187	Operation for torsion appendix testis		Procedural fees	119.20	R 4 349.19	119.20	R 4 349.19	4,00T	R 1 013.85
2189	Operation for torsion testis with fixation of contralateral testis		Procedural fees	119.20	R 4 349.19	119.20	R 4 349.19	4,00T	R 1 013.85

2191	Orchidectomy (total or subcapsular): Unilateral		Procedural fees	98.00	R 3 575.68	98.00	R 3 575.68	3,00T	R 760.39	
2193	Orchidectomy (total or subcapsular): Bilateral		Procedural fees	147.00	R 5 363.52	120.00	R 4 378.38	3,00T	R 760.39	
2194	Laparoscopic orchiectomy (item 1807 may not be added to this item)		Procedural fees	187.60	R 6 844.87	150.08	R 5 475.90	6,00T	R 1 520.78	
2196	Laparoscopic orchiopexy: Intra-abdominal testis (item 1897 may not be added to this item)		Procedural fees	193.10	R 7 045.55	154.48	R 5 636.44	6,00T	R 1 520.78	
2198	Diagnostic laparoscopy (excluding after-care) (item 1897 may not be added to this item)		Procedural fees	94.40	R 3 444.33	94.40	R 3 444.33	6,00T	R 1 520.78	
2197	Operation for hydrocele or spermatocele		Procedural fees	99.80	R 3 641.35	99.80	R 3 641.35	4,00T	R 1 013.85	
2199	Varicocelectomy		Procedural fees	106.10	R 3 871.22	106.10	R 3 871.22	4,00T	R 1 013.85	
2201	Abdominal ligation of spermatic vein for varicocele		Procedural fees	112.80	R 4 115.68	112.80	R 4 115.68	4,00T	R 1 013.85	
2203	Epididymectomy: Unilateral		Procedural fees	114.40	R 4 174.06	114.40	R 4 174.06	3,00T	R 760.39	
2205	Epididymectomy: Bilateral		Procedural fees	158.20	R 5 772.17	126.56	R 4 617.73	3,00T	R 760.39	
2209	Vasotomy: Unilateral or bilateral		Procedural fees	70.40	R 2 568.65	70.40	R 2 568.65	3,00T	R 760.39	
2210	Vasogram, seminal vesiculogram: Unilateral		Procedural fees	58.10	R 2 119.87	58.10	R 2 119.87	3,00T	R 760.39	
2211	Vasogram, seminal vesiculogram: Bilateral		Procedural fees	58.10	R 2 119.87	58.10	R 2 119.87	3,00T	R 760.39	
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)		Procedural fees	91.20	R 3 327.57	91.20	R 3 327.57	4,00T	R 1 013.85	
2213	Suture or repair of testicular injury		Procedural fees	110.30	R 4 024.46	110.30	R 4 024.46	4,00T	R 1 013.85	
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma		Procedural fees	90.00	R 3 283.79	90.00	R 3 283.79	4,00T	R 1 013.85	
2217	Excision of local lesion of testis or epididymis		Procedural fees	90.80	R 3 312.98	90.80	R 3 312.98	4,00T	R 1 013.85	
2219	Vaso-vasostomy: Unilateral		Procedural fees	67.00	R 2 444.60	67.00	R 2 444.60	3,00T	R 760.39	
2221	Vaso-vasostomy: Bilateral		Procedural fees	117.00	R 4 268.92	117.00	R 4 268.92	3,00T	R 760.39	
2223	Epididymo-vasostomy: Unilateral		Procedural fees	67.00	R 2 444.60	67.00	R 2 444.60	3,00T	R 760.39	
2225	Epididymo-vasostomy: Bilateral		Procedural fees	117.00	R 4 268.92	117.00	R 4 268.92	3,00T	R 760.39	
2227	Incision and drainage of scrotal wall abscess		Procedural fees	42.70	R 1 557.97	42.70	R 1 557.97	3,00T	R 760.39	

2228	Removal of foreign body: Scrotum		Procedural fees	104.90	R 3 827.44	104.90	R 3 827.44	3,00T	R 760.39
2229	Excision of Mullerian duct cyst		Procedural fees	189.00	R 6 895.95	151.20	R 5 516.76	4,00T	R 1 013.85
2231	Excision of lesion of spermatic cord		Procedural fees	84.00	R 3 064.87	84.00	R 3 064.87	3,00T	R 760.39
2233	Seminal Vesiculectomy		Procedural fees	220.00	R 8 027.03	176.00	R 6 421.63	5,00T	R 1 267.31
11.3	**Prostate**								
2235	Biopsy prostate: Needle or punch, single or multiple, any approach		Procedural fees	23.30	R 850.14	23.30	R 850.14	3,00T	R 760.39
2237	Biopsy prostate: Incisional, any approach		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	4,00T	R 1 013.85
2236	Interstitial device(s): Single or multiple placement (via needl, any approach), or for radiation therapy guidance (e.g. fiducial markers, dosimeter), prostate		Procedural fees	29.10	R 1 061.76	29.10	R 1 061.76	3,00T	R 760.39
2239	Transurethral drainage of prostatic abscess		Procedural fees	117.40	R 4 283.52	117.40	R 4 283.52	4,00T	R 1 013.85
2241	Perineal drainage of prostatic abscess		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2243	Trans-urethral cryo-surgical removal of prostate		Procedural fees	126.00	R 4 597.30	120.00	R 4 378.38	6,00T	R 1 520.78
2245	Trans-urethral resection of prostate		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	6,00T	R 1 520.78
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer		Procedural fees	126.00	R 4 597.30	120.00	R 4 378.38	6,00T	R 1 520.78
2249	Trans-urethral resection of post-operative bladder neck contracture		Procedural fees	126.00	R 4 597.30	120.00	R 4 378.38	5,00T	R 1 267.31
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing (item 1807 may not be added to this item		Procedural fees	501.80	R 18 308.94	401.44	R 14 647.15	8,00T	R 2 027.70
2251	Prostatectomy: Perineal: Sub-total		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	6,00T	R 1 520.78
2253	Prostatectomy: Perineal: Radical		Procedural fees	336.00	R 12 259.47	268.80	R 9 807.58	8,00T	R 2 027.70
2254	Pelvic lymph adenectomy		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	8,00T	R 2 027.70
2255	Supra-pelvic, transversical		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	6,00T	R 1 520.78
2257	Retropubic: Sub-total		Procedural fees	252.00	R 9 194.60	201.60	R 7 355.68	6,00T	R 1 520.78
2259	Retropubic: Radical		Procedural fees	336.00	R 12 259.47	268.80	R 9 807.58	8,00T	R 2 027.70

2260	Prostate brachytherapy		Procedural fees	230.00	R 8 391.90	184.00	R 6 713.52	8,00T	R 2 027.70
2265	Cryosurgical ablation of the prostate, includes utrasound guidance		Procedural fees	311.40	R 11 361.90	249.12	R 9 089.52	6,00T	R 1 520.78
2266	Transrectal high-intensity focused ultrasound (HIFU)		Procedural fees	336.60	R 12 281.36	268.80	R 9 807.58	5,00T	R 1 267.31

12. Female Genital System

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
12.1	**Vulva and introitus**								
2278	Perineoplasty, non-obstetrical - stand-alone procedure		Procedural fees	67.00	R 2 444.60	67.00	R 2 444.60	6,00T	R 1 520.78
2279	Colpoperineorraphy: Repair secondary perineal tear, suture of injury of vagina and/or perineum		Procedural fees	42.80	R 1 561.62	42.80	R 1 561.62	6,00T	R 1 520.78
2280	Colpoperineorraphy: Repair third degree tear, including anal sphincter repair, suture of injury of vagina and/or perineum		Procedural fees	104.30	R 3 805.54	104.30	R 3 805.54	6,00T	R 1 520.78
2282	Incision and drainage obstetrical/postpartum of vaginal haematoma		Procedural fees	49.80	R 1 817.03	49.80	R 1 817.03	4,00T	R 1 013.85
2284	Incision and drainage non-obstetrical of vaginal haematoma (e.g. post-trauma, spontaneous bleeding)		Procedural fees	88.00	R 3 210.81	88.00	R 3 210.81	4,00T	R 1 013.85
2287	Clitoris repair for injury: Including skin graft, if required		Procedural fees	72.30	R 2 637.98	72.30	R 2 637.98	4,00T	R 1 013.85
2293	Vulva and introitus: Drainage of abscess		Procedural fees	30.90	R 1 127.43	30.90	R 1 127.43	3,00T	R 760.39
12.2	**Vaginal procedures and operations**								
2312	Artificial insemination (intravaginal and intracervical)		Procedural fees	13.90	R 507.16	13.90	R 507.16		R -
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure		Procedural fees	30.80	R 1 123.78	30.80	R 1 123.78	3,00T	R 760.39
2314	Intrauterine insemination		Procedural fees	16.70	R 609.32	16.70	R 609.32		R -
2315	Semen analysis, presence and/or motility of sperm including Huhner test (post coital)		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
2321	Drainage of vaginal abscess		Procedural fees	27.80	R 1 014.33	27.80	R 1 014.33	3,00T	R 760.39
2322	Pudendal nerve block		Procedural fees	23.30	R 850.14	23.30	R 850.14		R -
2324	Revision of prosthetic vaginal graft or mesh: Vaginal approach (removal included)		Procedural fees	135.70	R 4 951.22	120.00	R 4 378.38	5,00T	R 1 267.31
2326	Revision of prosthetic vaginal graft or mesh: Abdominal approach (removal included)		Procedural fees	266.70	R 9 730.95	213.36	R 7 784.76	6,00T	R 1 520.78
2320	Revision of prosthetic vaginal graft or mesh: laparoscopic revision (including removal)		Procedural fees	239.70	R 8 745.82	191.76	R 6 996.66	6,00T	R 1 520.78

2325	Construction of artificial vagina: Labial fusion without graft, after stenosis		Procedural fees	150.10	R 5 476.63	120.08	R 4 381.30	4,00T	R 1 013.85
2327	Construction of artificial vagina with graft (skin or bowel)		Procedural fees	232.60	R 8 486.76	186.08	R 6 789.41	5,00T	R 1 267.31
2328	Paravaginal/site specific defect repair (including repair of cystocele, if performed, laparoscopic approach)		Procedural fees	259.40	R 9 464.60	207.52	R 7 571.68	6,00T	R 1 520.78
2330	Fitting/insertion of pessary or other intravaginal support device		Procedural fees	13.40	R 488.92	13.40	R 488.92	4,00T	R 1 013.85
2333	Sacrocolpopexy: Abdominal approach with use of mesh		Procedural fees	271.70	R 9 913.39	217.36	R 7 930.71	4,00T	R 1 013.85
2337	Colpopexy: Vaginal, extra-peritoneal approach (sacrospinous, iliococcygeus)		Procedural fees	142.40	R 5 195.68	113.92	R 4 156.54	5,00T	R 1 267.31
2338	Colpopexy: Vaginal, intra-peritoneal approach (uretrosacral, levator myorrhaphy)		Procedural fees	195.90	R 7 147.71	156.72	R 5 718.17	6,00T	R 1 520.78
2340	Sacrocolpopexy: Laparoscopic with use of mesh		Procedural fees	276.30	R 10 081.23	221.04	R 8 064.98	6,00T	R 1 520.78
2339	Colpotomy: Diagnostic (excluding after-care)		Procedural fees	20.00	R 729.73	20.00	R 729.73	4,00T	R 1 013.85
2341	Colpotomy: Therapeutic, includes draining of pelvic abscess		Procedural fees	123.60	R 4 509.73	120.00	R 4 378.38	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2343	Vaginal hysterectomy: Without repair		Procedural fees	234.60	R 8 559.74	187.68	R 6 847.79	6,00T	R 1 520.78
2344	Vaginal hysterectomy with unilateral/bilateral salpingectomy and/or oophorectomy, without repair		Procedural fees	261.80	R 9 552.17	209.44	R 7 641.74	6,00T	R 1 520.78
2345	Vaginal hysterectomy with enterocele/apical repair, without salpingectomy and/or oophorectomy		Procedural fees	250.50	R 9 139.87	200.40	R 7 311.90	6,00T	R 1 520.78
2346	Vaginal hysterectomy, laparoscopy assisted (LAVH) with/without bilateral salpingooophorectomy		Procedural fees	281.10	R 10 256.36	224.88	R 8 205.09	6,00T	R 1 520.78
2357	Vaginal hysterectomy and enterocele/apical repair with unilateral or bilateral salpingooophorectomy		Procedural fees	280.90	R 10 249.06	224.72	R 8 199.25	6,00T	R 1 520.78
2361	Vaginal hysterectomy, for uterus larger than 250g, including colpourethrocystopexy, with or without endoscopic control		Procedural fees	297.90	R 10 869.33	238.32	R 8 695.47	6,00T	R 1 520.78
2354	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele		Procedural fees	191.10	R 6 972.57	152.88	R 5 578.06	5,00T	R 1 267.31
2355	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy		Procedural fees	192.20	R 7 012.71	153.76	R 5 610.17	5,00T	R 1 267.31
2358	Anteroposterior colporrhaphy without enterocele/apical repair, with or without perineorrhaphy		Procedural fees	236.70	R 8 636.36	189.36	R 6 909.09	6,00T	R 1 520.78
2359	Anteroposterior colporrhaphy with enterocele/apical repair, with or without perineorrhaphy		Procedural fees	259.40	R 9 464.60	207.52	R 7 571.68	6,00T	R 1 520.78

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)	+	Procedural fees	73.10	R 667.16 2	73.10	R 667.16 2	6,00T	R 520.78 1
2362	Enterocele repair, vaginal approach		Procedural fees	137.70	R 024.19 5	120.00	R 378.38 4	5,00T	R 267.31 1
2363	Amputation of cervic and shortening of support ligaments of uterus for uterine prolapse (Fothergill-Mancehster)		Procedural fees	125.20	R 568.11 4	120.00	R 378.38 4	5,00T	R 267.31 1
2364	Enterocele repair, abdominal approach		Procedural fees	238.30	R 694.74 8	120.00	R 378.38 4	5,00T	R 267.31 1
2368	Uterovesical fistula repair		Procedural fees	226.00	R 245.95 8	180.80	R 596.76 6	5,00T	R 267.31 1
2369	Vesico- or urethro-vaginal fistula		Procedural fees	179.00	R 531.09 6	143.20	R 224.87 5	5,00T	R 267.31 1
2370	Vesico or urethro-vaginal fistula - Obestetric or radiation		Procedural fees	232.00	R 464.87 8	185.60	R 771.90 6	5,00T	R 267.31 1
2371	Closure of uretero-vaginal fistula with reimplantation of ureter to bladder		Procedural fees	318.50	R 620.96 11	254.80	R 296.77 9	5,00T	R 267.31 1
2373	Closure of recto-vaginal fistula, vaginal or transanal approach		Procedural fees	268.60	R 800.28 9	214.88	R 840.22 7	5,00T	R 267.31 1
2374	Closure of recto-vaginal fistula, abdominal approach		Procedural fees	160.90	R 870.68 5	128.72	R 696.54 4	5,00T	R 267.31 1
2375	Colpocleisis (any method)		Procedural fees	144.60	R 275.95 5	120.00	R 378.38 4	4,00T	R 013.85 1
2379	Vaginal hysterectomy, radical (Schauta type operation)		Procedural fees	410.40	R 974.07 14	328.32	R 979.25 11	8,00T	R 027.70 2
2380	Vaginectomy; simple, partial: Removal of vaginal wall		Procedural fees	141.30	R 155.55 5	120.00	R 378.38 4	8,00T	R 027.70 2
2381	Vaginectomy; simple, complete: Removal of vaginal wall		Procedural fees	254.00	R 267.58 9	203.20	R 414.06 7	8,00T	R 027.70 2
2382	Radical vaginectomy, complete removal of vaginal wall, with removal of para-vaginal tissue		Procedural fees	462.30	R 867.72 16	369.84	R 494.17 13	8,00T	R 027.70 2
2385	Vaginal laceration or trauma: Repair		Procedural fees	86.20	R 145.14 3	86.20	R 145.14 3	4,00T	R 013.85 1
2386	Paravaginal/site specific defect repair (including repair of cystocele, if performed, abdominal approach		Procedural fees	216.00	R 881.09 7	172.80	R 304.87 6	6,00T	R 520.78 1
2387	Paravaginal /site specific defect repair (including repair of cystocele, if performed), vaginal approach		Procedural fees	191.50	R 987.17 6	153.20	R 589.73 5	5,00T	R 267.31 1
12.3	**Cervix**							x	
2389	Paracervical (pelvis) nerve block		Procedural fees	23.80	R 868.38	23.80	R 868.38		
2391	Trachelorraphy, repair of uterine cervix/cervical canal, vaginal approach		Procedural fees	147.00	R 363.52 5	120.00	R 378.38 4	3,00T	R 760.39
2409	Cerclage of cervic, during pregnancy; vaginal		Procedural fees	44.30	R 616.35 1	44.30	R 616.35 1		

2410	Cervical cerclage, any route, non-obstetrical (Add 1807 if done by laparoscopy)		Procedural fees	89.10	R 3 250.95	89.10	R 3 250.95	3,00T	R 760.39
2413	Cerclage of cervix, during pregnancy, abdominal		Procedural fees	70.40	R 2 568.65	70.40	R 2 568.65	3,00T	R 760.39
2416	Removal of cervical cerclage under anaesthesia, other than local anaesthesia		Procedural fees	38.90	R 1 419.33	38.90	R 1 419.33	3,00T	R 760.39
2421	Removal of cervical stump, vaginal approach		Procedural fees	115.20	R 4 203.25	115.20	R 4 203.25	5,00T	R 1 267.31
2422	Removal of cervical stump, vaginal approach; with enterocele/apical repair		Procedural fees	160.60	R 5 859.74	128.48	R 4 687.79		
2423	Removal of cervical stump, abdominal approach		Procedural fees	240.50	R 8 775.01	192.40	R 7 020.01	5,00T	R 1 267.31
2424	Removall of cervical stump, abdominal approach, with enterocele/apical repair		Procedural fees	237.80	R 8 676.49	190.24	R 6 941.20	5,00T	R 1 267.31
2429	Colposcopy of vulva and/or vagina and/or cervix (excluding aftercare)		Procedural fees	26.40	R 963.24	26.40	R 963.24	3,00T	R 760.39
12.4	**Uterus**							x	
2433	Embryo transfer		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	4,00T	R 1 013.85
2434	Endometrial sampling/biopsy, any method (excluding aftercare)		Procedural fees	25.00	R 912.16	25.00	R 912.16	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2435	Catheterisation and introduction of saline or contrast material for saline infusion sonohysterography (SIS) or hysterosalpingography (excluding aftercare)		Procedural fees	16.60	R 605.68	16.60	R 605.68	3,00T	R 760.39
2436	Diagnostic hysteroscopy (excluding aftercare) - stand alone procedure		Procedural fees	44.00	R 1 605.41	44.00	R 1 605.41	3,00T	R 760.39
2437	Hysteroscopy and sampling of the endometrium and/or polypectomy, with or without D & C		Procedural fees	67.20	R 2 451.89	67.20	R 2 451.89	3,00T	R 760.39
2439	Hysteroscopy with lysis of intrauterine adhesions (any method) (excluding aftercare)		Procedural fees	82.80	R 3 021.08	82.80	R 3 021.08	3,00T	R 760.39
2443	Dilation and curettage (D & C) (Excluding aftercare)		Procedural fees	62.40	R 2 276.76	62.40	R 2 276.76	3,00T	R 760.39
2447	Treatment of incomplete abortion, any trimester, completed surgically		Procedural fees	85.40	R 3 115.95	85.40	R 3 115.95	4,00T	R 1 013.85
2455	Evacuation and curettage uterus postpartum		Procedural fees	50.10	R 1 827.97	50.10	R 1 827.97	6,00T	R 1 520.78
2469	Subtotal abdominal hysterectomy with or without unilateral or bilateral salpingectomy, and/or oophorectomy		Procedural fees	190.00	R 6 932.44	152.00	R 5 545.95	6,00T	R 1 520.78
2470	Laparoscopy: Subtotal abdominal hysterectomy, with or without removal of tube(s), with or without removal of ovary(s)		Procedural fees	232.70	R 8 490.41	186.16	R 6 792.33	6,00T	R 1 520.78
2471	Total abdominal hysterectomy; with or without unilateral or bilateral salpingectomy, and/or oophorectomy		Procedural fees	290.10	R 10 584.74	232.08	R 8 467.79	6,00T	R 1 520.78

2472	Laparoscopy, total abdominal hysterectomy; with or without unilateral or bilateral salpingectomy, and/or oopherectomy.		Procedural fees	256.40	R 9 355.14	205.10	R 7 483.39	6,00T	R 1 520.78
12.5	**Fallopian tubes**							x	
2493	Diagnostic laparoscopy (excluding aftercare)		Procedural fees	94.10	R 3 433.38	94.10	R 3 433.38	5,00T	R 1 267.31
2499	Laparoscopy (diagnostic) with biopsy (single or multiple) (excluding aftercare)		Procedural fees	99.70	R 3 637.71	99.70	R 3 637.71	5,00T	R 1 267.31
12.6	**Ovaries**							x	
2529	Salpingo-oophorectomy, unilateral or bilateral - stand alone procedure		Procedural fees	210.80	R 7 691.36	168.64	R 6 153.09	4,00T	R 1 013.85
12.7	**Miscellaneous procedures**							x	
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)		Procedural fees	194.40	R 7 092.98	155.52	R 5 674.38	6,00T	R 1 520.78
2544	Laparoscopic vaginal suspension for stress incontinence (Item 1807 may not be added to this item)		Procedural fees	216.90	R 7 913.93	173.52	R 6 331.14	5,00T	R 1 267.31
2545	Surgery for stress incontinence: Vesicourethropexy/urethropexy; abdominal approach		Procedural fees	189.30	R 6 906.90	151.44	R 5 525.52	5,00T	R 1 267.31
2548	Surgery for stress incontinence: Use of tape/fascia		Procedural fees	204.30	R 7 454.20	163.44	R 5 963.36	5,00T	R 1 267.31
2550	Surgery for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach		Procedural fees	168.40	R 6 144.33	134.72	R 4 915.46	5,00T	R 1 267.31
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)		Procedural fees		R -				
2570	Ligation of internal iliac vessels (when not part of another procedure)		Procedural fees	255.00	R 9 304.06	180.00	R 6 567.57	8,00T	R 2 027.70

13. Obstetric Procedures

13.1	Pre-natal care and procedures	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
13.2	**Confinements**							x	
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 postpartum visit (6 weeks visit)		Procedural fees		R -				R -
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)		Procedural fees		R -				R -
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)		Procedural fees	190.00	R 6 932.44	152.00	R 5 545.95		R -
	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								

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
	o Drainage of vulval haematoma								
	o Repair third degree tear								
	o Repair second degree tear								
	o Repair episiotomy								
	o Resuscitation of newborn by obstetrician								
	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)**							x	
2653	Subtotal or total hysterectomy after Caesarean section (List seperately in addition to item 2615)	+	Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	9,00T	R 2 281.17
2657	Post-partum hysterectomy with or without removal of tube(s), with or without removal of ovary(s)		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	8,00T	R 2 027.70
2669	Abdominal operation for ruptured gravid uterus: Repair (laparotomy: hysterorrhaphy of ruptured uterus)		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	9,00T	R 2 281.17

14. Nervous System

14.1	Diagnostic procedures	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2680	Haemodynamic and authonomic nervous system testing with 'Task Force'system - PROFESSIONAL COMPONENT		Procedural fees	29.00	R 1 058.11				R -
2681	Visual evoked potentials (VEP): Unilateral		Procedural fees	50.00	R 1 824.33				R -
2682	Visual evoked potentials (VEP): Bilateral		Procedural fees	88.00	R 3 210.81				R -
2683	Electro-retinography (Ganzfeld method): Unilateral		Procedural fees	60.00	R 2 189.19				R -
2684	Electro-retinography (Ganzfeld method): Bilateral		Procedural fees	105.00	R 3 831.08				R -
2685	Electro-oculography: Unilateral		Procedural fees	30.00	R 1 094.60				R -
2686	Electro-oculography: Bilateral		Procedural fees	53.00	R 1 933.79				R -
2687	VEP stable condition (photic drive): Unilateral		Procedural fees	50.00	R 1 824.33				R -
2689	VEP stable condition (photic drive): Bilateral		Procedural fees	88.00	R 3 210.81				R -
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP		Procedural fees	150.00	R 5 472.98				R -
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex		Procedural fees	48.00	R 1 751.35				R -
2704	Neurostimulation, percutaneous: Sacral nerve		Procedural fees	120.80	R 4 407.57				R -
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming		Procedural fees	8.80	R 321.08				R -
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment		Procedural fees	6.00	R 218.92	6.00	R 218.92		R -
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus		Procedural fees	80.00	R 2 918.92				R -

2709	Full spinogram including bilateral median and posterior-tibial studies		Procedural fees	140.00	R 5 108.11				R -
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)		Procedural fees		R -				R -
2711	Electro-encephalography (EEG): 20-40 minutes record: Equipment cost for taking of record (Technical component) (refer to item 2712 for interpretation and report)		Procedural fees	105.60	R 3 852.98	105.60	R 3 852.98		R -
2712	Clinical interpretation and report of item 2711: Electro-encephalogram (EEG): 20-40 minutes record (Professional component)		Procedural fees	16.60	R 605.68	16.60	R 605.68		R -
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)		Procedural fees	294.60	R 10 748.93	235.68	R 8 599.14		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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)		Procedural fees	128.60	R 4 692.17	120.00	R 4 378.38		R -
6030	Electro-encephalogram (EEG): Monitoring (41-60 minutes): Equipment cost for taking of record (Technical component)(refer to item 6020 for interpretation and report)		Procedural fees	116.80	R 4 261.63	116.80	R 4 261.63		R -
6020	Clinical interpretation and report of item 6030: Electro-encephalogram (EEG): Monitoring (4160 minutes)(Professional component)		Procedural fees	16.40	R 598.38	16.40	R 598.38		R -
6031	Electro-encephalogram (EEG): Monitoring (> 60 minutes): Equipment cost for taking of record (Technical component)(refer to item 6020 for interpretation and report)		Procedural fees	126.80	R 4 626.49	120.00	R 4 378.38		R -
6021	Clinical interpretation and report of item 6031: Electro-encephalogram (EEG): Monitoring (> 60 minutes)(Professional component)		Procedural fees	26.30	R 959.60	26.30	R 959.60		R -
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)		Procedural fees	222.30	R 8 110.95	177.84	R 6 488.76		R -
6023	Clinical interpretation and report of item 6033: Electro-encephalogram (EEG): Overnight recording (8-16 hours)(Professional component)		Procedural fees	16.50	R 602.03	16.50	R 602.03		R -
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		Procedural fees	423.20	R 15 441.10				R -
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)		Procedural fees	34.00	R 1 240.54	34.00	R 1 240.54		R -
6000	Clinical interpretation and report of item 5999: Actigraphy: Patient monitored for a minimum of 72 hours (Professional component)		Procedural fees	13.80	R 503.51	13.80	R 503.51		R -
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications		Procedural fees	18.40	R 671.35	18.40	R 671.35	3,00T	R 760.39
2714	Cisternal or lateral cervical (C1-C2) puncture: without injection - stand-alone procedure		Procedural fees	32.00	R 1 167.57	32.00	R 1 167.57	5,00T	R 1 267.31
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation		Procedural fees		R -				R -
2719	Overnight polysomnogram and sleep staging: Equipment Hire		Procedural fees	125.00	R 4 560.82				R -
2720	Overnight polysomnogram and sleep staging: Interpretation		Procedural fees	23.00	R 839.19				R -

2721	Daytime polysomnogram: Equipment Hire		Procedural fees	125.00	R 560.82	4			R -
2722	Daytime polysomnogram: Interpretation		Procedural fees	17.00	R 620.27				R -
6014	Sleep testing: Multiple sleep latency test (Technical component)		Procedural fees	71.50	R 608.79	2			R -
2723	Multiple sleep latency test: Interpretation		Procedural fees	125.00	R 560.82	4			R -
6016	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation (no EEG) (Technical component)		Procedural fees	35.60	R 298.92	1			R -
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)		Procedural fees	22.40	R 817.30				R -
2724	Overnight continuous positive airways pressure (CPAP) titration		Procedural fees	155.00	R 655.41	5	124.00	R 524.33	4		R -
2728	Unattended overnight home-based polysomnogram: Interpretation		Procedural fees	24.50	R 893.92				R -
2732	Overnight home-based polysomnogram: Interpretation		Procedural fees	24.50	R 893.92				R -
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with item 0714)		Procedural fees	60.00	R 189.19	2			R -
2734	Wada activation test for hemispheric function: Includes electroencephalographic (EEG) monitoring		Procedural fees	172.50	R 293.92	6	138.00	R 035.14	5	13,00T	R 295.02	3
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician		Procedural fees	31.50	R 149.33	1					
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen		Procedural fees	7.00	R 255.41		7.00	R 255.41			
2739	Ventricular puncture: Fontanelle, suture or implanted ventricular catheter/reservoir, without injection, through excising burr hole		Procedural fees	41.80	R 525.14	1	41.80	R 525.14	1	5,00T	R 267.31	1
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		Procedural fees	38.80	R 415.68	1	38.80	R 415.68	1	5,00T	R 267.31	1
2743	Subdural tap, initial, infant unilateral or bilateral: Through fontanelle or suture		Procedural fees	34.60	R 262.43	1	34.60	R 262.43	1	5,00T	R 267.31	1
2745	Subdural tap(s), subsequent, infant, unilateral or bilateral: Through fontanelle or suture		Procedural fees	33.40	R 218.65	1	33.40	R 218.65	1	5,00T	R 267.31	1
2746	Biopsy: Temporal artery		Procedural fees	91.00	R 320.27	3	91.00	R 320.27	3			
2679	Cisternal or lateral cervical (C1-C2) puncture: Injection of medication/other substance, diagnosis/treatment		Procedural fees	40.50	R 477.70	1						
2688	Shunt tubing or reservoir puncture: For aspiration or injection procedure		Procedural fees	25.90	R 945.00		25.90	R 945.00		5,00T	R 267.31	1
2701	Drainage of cererospinal fluid (CSF): by needle or catheter, therapeutic interstitial devices, spinal puncture		Procedural fees	25.10	R 915.81		25.10	R 915.81		5,00T	R 267.31	1

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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		Procedural fees	84.50	R 3 083.11	84.50	R 3 083.11		R -
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)	+	Procedural fees	73.20	R 2 670.81	73.20	R 2 670.81		R -
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		Procedural fees	21.10	R 769.87	21.10	R 769.87		R -
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		Procedural fees	73.50	R 2 681.76	73.50	R 2 681.76		R -
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	+	Procedural fees	31.50	R 1 149.33	31.50	R 1 149.33		R -
14.2	**Introduction of burr holes for**							x	
2747	Burr hole(s): Ventricular puncture, includes injection of gas, contrast media, dye or radioactive material		Procedural fees	223.80	R 8 165.68	179.04	R 6 532.55	9,00T	R 2 281.17
2749	Burr hole(s): Implantation of ventricular catheter/reservoir/EEG electrode(s)/pressure recording device or other cerebral monitoring device - stand-alone procedure		Procedural fees	108.60	R 3 962.44	108.60	R 3 962.44	9,00T	R 2 281.17
2751	Burr hole(s) or trephine: Includes biopsy of brain or intracranial lesion (total procedure)		Procedural fees	376.60	R 13 740.82	301.28	R 10 992.66	9,00T	R 2 281.17
2753	Burr hole(s):Includes evacuation and/or drainage of haematoma: extradural or subdural		Procedural fees	379.40	R 13 842.99	303.52	R 11 074.39	9,00T	R 2 281.17
2755	Burr hole(s): Includes aspiration of haematoma or cyst, intracerebral (total procedure)		Procedural fees	369.90	R 13 496.36	295.92	R 10 797.09	9,00T	R 2 281.17
2756	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for leng term seizure monitoring		Procedural fees	305.40	R 11 142.98	244.32	R 8 914.39	9,00T	R 2 281.17
2757	Burr hole(s) or trephine: Includes drainage of brain abscess or cyst (total procedure)		Procedural fees	402.80	R 14 696.77	322.24	R 11 757.42	9,00T	R 2 281.17
2748	Twist drill hole: Subdural or ventricular puncture		Procedural fees	139.40	R 5 086.22	120.00	R 4 378.38	9,00T	R 2 281.17
2750	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for implanting ventricular catheter pressure recording device or other intracerebral monitoring device		Procedural fees	92.90	R 3 389.60	92.90	R 3 389.60	9,00T	R 2 281.17
2752	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for evacuation and/or drainage of subdural haematoma		Procedural fees	272.20	R 9 931.63	217.76	R 7 945.30	9,00T	R 2 281.17
2754	Burr hole(s): or trephine: Includes subsequent tapping (aspiration) of intracranial abscess or cyst		Procedural fees	296.40	R 10 814.60	237.12	R 8 651.68	9,00T	R 2 281.17
2758	Insertion: Subcutaneous reservoir, pump/continuous infusion system, includes connection to ventricular catheter		Procedural fees	152.10	R 5 549.60	121.68	R 4 439.68	5,00T	R 1 267.31
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery		Procedural fees	255.90	R 9 336.90	204.72	R 7 469.52	9,00T	R 2 281.17
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral		Procedural fees	218.90	R 7 986.90	175.12	R 6 389.52	9,00T	R 2 281.17

14.3	Nerve procedures							x	
2759	Nerve biopsy: Peripheral		Procedural fees	37.00	R 1 350.00	37.00	R 1 350.00	4,00T	R 1 013.85
2763	Nerve biopsy: Cranial nerves: Extra-cranial		Procedural fees	20.00	R 729.73	20.00	R 729.73	4,00T	R 1 013.85
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)		Procedural fees	26.00	R 948.65	26.00	R 948.65	4,00T	R 1 013.85
2766	Insertion of deep brain stimulotor for movement disorders and pain - first side		Procedural fees	352.50	R 12 861.50	282.00	R 10 289.20	9,00T	R 2 281.17
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)		Procedural fees	25.00	R 912.16				R -
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)		Procedural fees	30.00	R 1 094.60				R -
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)		Procedural fees	35.00	R 1 277.03				R -
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)		Procedural fees	35.00	R 1 277.03				R -
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)		Procedural fees	50.00	R 1 824.33				R -
14.3.1	Nerve procedures: Nerve repair or suture							x	
2767	Suture brachial plexus (see also items 2837 and 2839)		Procedural fees	379.00	R 13 828.39	303.20	R 11 062.71	5,00T	R 1 267.31
2769	Suture: Large nerve: Primary		Procedural fees	297.70	R 10 862.04	238.16	R 8 689.63	3,00T	R 760.39
2771	Suture: Large nerve: Secondary		Procedural fees	202.00	R 7 370.28	161.60	R 5 896.22	5,00T	R 1 267.31
2773	Suture: Digital nerve: Primary		Procedural fees	199.00	R 7 260.82	159.20	R 5 808.65	3,00T	R 760.39
2775	Suture: Digital nerve: Secondary		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2777	Nerve graft: Simple		Procedural fees	309.00	R 11 274.33	247.20	R 9 019.47	4,00T	R 1 013.85
2779	Fascicular: First fasciculus		Procedural fees	202.00	R 7 370.28	161.60	R 5 896.22	4,00T	R 1 013.85
2781	Fascicular: Each additional fasciculus		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33	4,00T	R 1 013.85
2783	Fascicular: Nerve flap: To include all stages		Procedural fees	224.00	R 8 172.98	179.20	R 6 538.38	4,00T	R 1 013.85
2782	Nerve pedicle transfer: First stage (not to be used together with item 2783)		Procedural fees	309.10	R 11 277.98	247.28	R 9 022.39	4,00T	R 1 013.85

2784	Nerve pedicle transfer: Second stage (not to be used together with item 2783)		Procedural fees	338.30	R 12 343.39	270.64	R 9 874.71	4,00T	R 1 013.85
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis		Procedural fees	124.00	R 4 524.33	120.00	R 4 378.38	6,00T	R 1 520.78
2787	Fascicular: Grafting of facial nerve		Procedural fees	215.00	R 7 844.60	172.00	R 6 275.68	5,00T	R 1 267.31
14.3.2	**Nerve procedures: Neurectomy**							x	
2789	Destruction by neurolytic agent: Trigeminal nerve, second and third division branches at foramen ovale (includes radiological monitoring)(total procedure)		Procedural fees	143.80	R 5 246.76	120.00	R 4 378.38	8,00T	R 2 027.70
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)		Procedural fees	45.50	R 1 660.14	45.50	R 1 660.14	5,00T	R 1 267.31
2796	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, each additional level (unilateral or bilateral)	+	Procedural fees	16.30	R 594.73	16.30	R 594.73	5,00T	R 1 267.31
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)		Procedural fees	44.00	R 1 605.41	44.00	R 1 605.41	5,00T	R 1 267.31
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)	+	Procedural fees	15.60	R 569.19	15.60	R 569.19	5,00T	R 1 267.31
2799	Procedures for pain relief: Intrathecal injections for pain		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51	4,00T	R 1 013.85
2800	Procedures for pain relief: Plexus nerve block		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51	36,00c	R 1 313.51
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 procedure units should be coded and not the anaesthetic units		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51		
2802	Procedures for pain relief: Peripheral nerve block		Procedural fees	25.00	R 912.16	25.00	R 912.16	25,00c	R 912.16
2803	Alcohol injection in peripheral nerves for pain: Unilateral		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
2804	Inserting an indwelling nerve catheter (includes removal of catheter) To be used only with items 2799, 2800, 2801 or 2802	+	Procedural fees	10.00	R 364.87	10.00	R 364.87	10,00c	R 364.87
2805	Alcohol injection in peripheral nerves for pain: Bilateral		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00T	R 760.39
2809	Peripheral nerve section for pain		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89	3,00T	R 760.39
2811	Pudendal neurectomy: Bilateral		Procedural fees	116.00	R 4 232.44	116.00	R 4 232.44	3,00T	R 760.39
2813	Obturator or Stoffels		Procedural fees	96.00	R 3 502.71	96.00	R 3 502.71	3,00T	R 760.39
2815	Interdigital		Procedural fees	82.30	R 3 002.84	82.30	R 3 002.84	3,00T	R 760.39
2825	Excision: Neuroma: Peripheral		Procedural fees	213.00	R 7 771.63	170.40	R 6 217.30	4,00T	R 1 013.85
14.3.3	**Nerve procedures: Other nerve procedures**							x	
2827	Transposition of ulnar nerve		Procedural fees	170.00	R 6 202.71	136.00	R 4 962.17	3,00T	R 760.39

2829	Neurolysis: Minor		Procedural fees	51.00	R 1 860.81	51.00	R 1 860.81	3,00T	R 760.39
2831	Neurolysis: Major		Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	3,00T	R 760.39
2833	Neurolysis: Digital		Procedural fees	141.00	R 5 144.60	120.00	R 4 378.38	3,00T	R 760.39
2835	Scalenotomy		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	6,00T	R 1 520.78
2834	Neuroplasty: Sciatic nerve		Procedural fees	168.80	R 6 158.92	135.04	R 4 927.14	3,00T	R 760.39
2837	Brachial plexus, suture or neurolysis (item 2767)		Procedural fees	223.00	R 8 136.49	178.40	R 6 509.20	5,00T	R 1 267.31
2839	Total brachial plexus exposure with graft, neurolysis and transplantation		Procedural fees	895.20	R 32 662.73	716.16	R 26 130.19	6,00T	R 1 520.78
2843	Lumbar sympathectomy: Unilateral		Procedural fees	153.00	R 5 582.44	122.40	R 4 465.95	4,00T	R 1 013.85
2845	Lumbar sympathectomy: Bilateral		Procedural fees	268.00	R 9 778.39	214.40	R 7 822.71	6,00T	R 1 520.78
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)		Procedural fees		R -			11,00T	R 2 788.09
2847	Cervical sympathectomy: Unilateral		Procedural fees	153.00	R 5 582.44	122.40	R 4 465.95	4,00T	R 1 013.85
2848	Cervical sympathectomy: Bilateral		Procedural fees	268.00	R 9 778.39	214.40	R 7 822.71	6,00T	R 1 520.78
2849	Sympathetic block: Other levels: Unilateral		Procedural fees	20.00	R 729.73	20.00	R 729.73	3,00T	R 760.39
2851	Sympathetic block: Other levels: Bilateral		Procedural fees	35.00	R 1 277.03	35.00	R 1 277.03	3,00T	R 760.39

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion		Procedural fees	20.00	R 729.73	20.00	R 729.73	4,00T	R 1 013.85
2854	Insertion of vagus nerve stimulator		Procedural fees	127.30	R 4 644.73	120.00	R 4 378.38	9,00T	R 2 281.17
14.4	**Skull procedures**							x	
2855	Craniectomy: Includes excision of tumour or other bone lesion of skull (total procedure)		Procedural fees	396.50	R 14 466.91	317.30	R 11 577.17	11,00T	R 2 788.09
2857	Excision, intra and extracranial: Benign tumour of cranial bone (e.g. fibrous dysplasia), without optic nerve decompression (total procedure)		Procedural fees	587.20	R 21 424.88	469.76	R 17 139.91	11,00T	R 2 788.09
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)		Procedural fees	377.90	R 13 788.26	302.32	R 11 030.60	9,00T	R 2 281.17
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)		Procedural fees	307.10	R 11 205.01	245.68	R 8 964.01	9,00T	R 2 281.17

2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debrdeent of brain (total procedure)		Procedural fees	455.10	R 16 605.02	364.08	R 13 284.01	11,00T	R 2 788.09
2863	Cranioplasty: Skull defect =< 5cm diameter: with/without prosthesis		Procedural fees	309.10	R 11 277.98	247.28	R 9 022.39	9,00T	R 2 281.17
2864	Cranioplasty: Repair of encephalocele, skull vault (total procedure)		Procedural fees	501.00	R 18 279.75	400.80	R 14 623.80	11,00T	R 2 788.09
2865	Craniectomy: Craniosynostosis, sinle cranial suture (total procedure)		Procedural fees	279.00	R 10 179.74	223.20	R 8 143.79	11,00T	R 2 788.09
2867	Craniectomy: Craniosynostosis, muliple cranial sutures (total procedure)		Procedural fees	313.70	R 11 445.82	250.96	R 9 156.66	11,00T	R 2 788.09
6035	Craniotomy: Craniosynostosis, frontal or parietal bone flap (total procedure)		Procedural fees	506.00	R 18 462.18	404.80	R 14 769.74	11,00T	R 2 788.09
6036	Craniotomy: Craniosynostosis, bifrontal bone flap (total procedure)		Procedural fees	499.90	R 18 239.61	399.92	R 14 591.69	11,00T	R 2 788.09
6037	Craniectomy: Extensive for multiple cranial suture craniosynostosis (e.g. cloverleaf skull); not requiring bone grafts (total procedure)		Procedural fees	475.50	R 17 349.34	380.40	R 13 879.47	11,00T	R 2 788.09
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)		Procedural fees	537.40	R 19 607.86	429.92	R 15 686.28	11,00T	R 2 788.09
6039	Excision of beign tumour of cranial bone (e.g. fibrous dysplasia), intra and extracranial, with decompression of optic nerve		Procedural fees	643.30	R 23 471.78	514.64	R 18 777.42	11,00T	R 2 788.09
6040	Craniomegalic skull: Reduction (e.g. treated hydrocephalus) not requiring bone grafts or cranioplasty (total procedure)		Procedural fees	371.30	R 13 547.44	297.04	R 10 837.96	11,00T	R 2 788.09
6042	Craniomegalic skull: Reduction (e.g. treated hydrocephalus), requiring craniotomy and reconstruction with or without bone graft (includes obtaining grafts)(total procedure)		Procedural fees	465.40	R 16 980.83	372.32	R 13 584.66	11,00T	R 2 788.09
6043	Cranioplasty: Skull defect > 5 cm diameter		Procedural fees	340.80	R 12 434.61	272.64	R 9 947.68	9,00T	R 2 281.17
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		Procedural fees	264.90	R 9 665.28	211.92	R 7 732.22	9,00T	R 2 281.17
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)		Procedural fees	311.40	R 11 361.90	249.12	R 9 089.52	9,00T	R 2 281.17
6046	Cranioplasty: Skull defect, with reparative brain surgery: with/without prosthesis		Procedural fees	421.70	R 15 386.37	337.36	R 12 309.09	11,00T	R 2 788.09
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =< 5cm diameter (total procedure)		Procedural fees	271.40	R 9 902.44	297.12	R 10 840.87	9,00T	R 2 281.17
6048	Cranioplasty: Includes autograft and obtaining bone grafts; > 5cm diameter (total procedure)		Procedural fees	432.70	R 15 787.72	346.16	R 12 630.17	9,00T	R 2 281.17
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure	+	Procedural fees	37.30	R 1 360.95	37.30	R 1 360.95		R -
14.5	**Shunt procedures and Neuroendoscopy**							x	
2869	Ventriculo-cisternostomy: From the third ventricle to the cisterna magna (total procedure)		Procedural fees	409.00	R 14 922.99	327.20	R 11 938.39	10,00T	R 2 534.63
2871	Creation of shunt: Ventriculo-atrial, -jugular, -auricular		Procedural fees	307.20	R 11 208.66	245.76	R 8 966.93	10,00T	R 2 534.63

2873	Creation of shunt: Ventriculo-peritoneal, -pleural, other terminus		Procedural fees	315.40	R 11 507.85	252.32	R 9 206.28	10,00T	R 2 534.63
2875	Creation of shunt: Subarachnoid-peritoneal, -pleural, or other; percutaneous, lumbar, not requiring laminectomy		Procedural fees	192.80	R 7 034.60	154.24	R 5 627.68	8,00T	R 2 027.70
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure	+	Procedural fees	56.00	R 2 043.25	56.00	R 2 043.25	8,00T	R 2 027.70
6056	Neuroendoscopy: Intracranial, with dissection of adhesions, fenestration of septum pellucidim or intraventricular cysts (includes placement, replacement or removal of ventricular catheter)		Procedural fees	451.30	R 16 466.37	361.04	R 13 173.09	11,00T	R 2 788.09
6057	Neuroendoscopy: Intracranial with fenestration or excision of colloid cyst (includes placement of external ventricular catheter for drainage)		Procedural fees	561.00	R 20 468.94	448.80	R 16 375.15	11,00T	R 2 788.09
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body		Procedural fees	364.80	R 13 310.28	291.84	R 10 648.23	11,00T	R 2 788.09
6059	Neuroendoscopy: Intracranial, with excision of brain tumour (includes placement of external ventricular catheter for drainage)		Procedural fees	620.70	R 22 647.18	496.56	R 18 117.75	11,00T	R 2 788.09
6060	Neuroendoscopy: Intracranial, includes excision of pituitary tumour, transnasal or transsphenoidal approach		Procedural fees	459.10	R 16 750.96	367.28	R 13 400.77	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered 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)		Procedural fees	290.80	R 10 610.28	232.64	R 8 488.22	10,00T	R 2 534.63
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (total procedure)		Procedural fees	111.40	R 4 064.60	111.40	R 4 064.60	10,00T	R 2 534.63
6063	Ventriculocisternostomy of the third ventricle: Stereotactic neuroendoscopic method (under CT guidance for stereotactic positioning) (item 6055 and 6148 may not be added.)		Procedural fees	358.80	R 13 091.36	287.04	R 10 473.09	10,00T	R 2 534.63
6064	Replacement/irrigation: Previously placed intraoperatve ventricular catheter		Procedural fees	158.30	R 5 775.82	126.64	R 4 620.65	10,00T	R 2 534.63
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		Procedural fees	252.30	R 9 205.55	201.84	R 7 364.44	10,00T	R 2 534.63
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit		Procedural fees	26.00	R 948.65	26.00	R 948.65	10,00T	R 2 534.63
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	10,00T	R 2 534.63
6068	Cerebospinal fluid (CSF) shunt system: Complete removal with replacement by similar or other shunt at same operation		Procedural fees	335.50	R 12 241.23	268.40	R 9 792.98	10,00T	R 2 534.63
14.6	**Aneurysm repair**							x	
2876	Carotid aneurysm: Surgery, intracranial, intracranial approach, simple (<15 millimetres) with no calcifications or critical perforating vessels at the aneurysm neck		Procedural fees	1 011.20	R 36 895.17	808.96	R 29 516.14	15,00T	R 3 801.94
2877	Anastomosis: Arterial and extracranial-intracranial arteries (e.g. middle cerebral/cortical), including craniotomy (total procedure)		Procedural fees	773.20	R 28 211.38	618.56	R 22 569.10	15,00T	R 3 801.94
2878	Intracranial arteriovenous malformation (IAM): Surgery, infratentorial, simple		Procedural fees	842.20	R 30 728.95	673.76	R 24 583.16	15,00T	R 3 801.94
6075	Intracranial arteriovenous malformation (IAM): Surgery, supratentorial, complex		Procedural fees	1 236.50	R 45 115.58	989.20	R 36 092.47	15,00T	R 3 801.94

6076	Intracranial arteriovenous malformation (IAM): Surgery, infratentorial, complex		Procedural fees	1 330.30	R 48 538.02	1 064.24	R 38 830.41	15,00T	R 3 801.94
6077	Intracranial arteriovenous malformation (IAM): Surgery, dural, simple		Procedural fees	648.50	R 23 661.51	518.80	R 18 929.21	15,00T	R 3 801.94
6078	Intracranial arteriovenous malformation (IAM): Surgery, dural, complex		Procedural fees	1 082.60	R 39 500.31	866.08	R 31 600.25	15,00T	R 3 801.94
6079	Intracranial aneurysm: Complex, intracranial approach, carotid circulation		Procedural fees	1 249.10	R 45 575.31	999.28	R 36 460.25	15,00T	R 3 801.94
6080	Intrracranial aneurysm: Surgical, complex, intracranial approach, vertebrobasilar circulation		Procedural fees	1 369.90	R 49 982.88	1 095.92	R 39 986.31	15,00T	R 3 801.94
6081	Intracranial aneurysm: Surgical, simple, open posterior cranial fossa approach, vertebrobasilar circulation		Procedural fees	1 190.80	R 43 448.15	952.64	R 34 758.52	15,00T	R 3 801.94
6082	Intracranial aneurysm: Surgical, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)		Procedural fees	404.20	R 14 747.85	323.36	R 11 798.28	15,00T	R 3 801.94
6083	Aneurysm: Surgical, for vascular malformation or carotid-carvenous fistula with intracranial and cervical occlusion of carotid artery		Procedural fees	770.80	R 28 123.81	616.64	R 22 499.05	15,00T	R 3 801.94
14.7	**Craniectomy or Craniotomy**							x	
2879	Craniectomy: Suboccipital: Includes exploration or decompression of cranial nerves (Middle cranial fossa approach)(total procedure)		Procedural fees	596.00	R 21 745.97	476.80	R 17 396.77	13,00T	R 3 295.02
2881	Internal auditory canal: Decompression, middle cranial fossa approach (total procedure)		Procedural fees	577.60	R 21 074.61	462.08	R 16 859.69	11,00T	R 2 788.09
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)		Procedural fees	652.10	R 23 792.86	521.68	R 19 034.29	13,00T	R 3 295.02
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)		Procedural fees	570.20	R 20 804.61	456.16	R 16 643.69	11,00T	R 2 788.09
2892	Micro vascular deompression of cranial nerve (suboccipital)		Procedural fees	553.00	R 20 177.05	442.00	R 16 127.04	6,00T	R 1 520.78
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		Procedural fees	1 106.80	R 40 383.28	885.44	R 32 306.62	13,00T	R 3 295.02
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		Procedural fees	819.70	R 29 908.00	655.76	R 23 926.40	13,00T	R 3 295.02
2893	Craniectom for excision of brain abscess: Infratentorial or posterior fossa for excision of brain abscess		Procedural fees	648.30	R 23 654.21	518.64	R 18 923.37	13,00T	R 3 295.02
6085	Craniectomy/craniotomy: with exploration of the infratentorial area (below the tentorium of the cerebellum), posterior fossa (total procedure)		Procedural fees	596.40	R 21 760.56	477.12	R 17 408.45	13,00T	R 3 295.02
6086	Craniectomy/craniotomy: with evacuation of infratentorial, intracerebellar haematoma (total procedure)		Procedural fees	614.30	R 22 413.67	491.44	R 17 930.94	13,00T	R 3 295.02
6087	Craniectomy/craniotomy: with drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)		Procedural fees	631.80	R 23 052.18	505.44	R 18 441.75	13,00T	R 3 295.02
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)		Procedural fees	605.10	R 22 077.99	484.08	R 17 662.39	13,00T	R 3 295.02
6090	Craniectomy at base of skull (suboccipital): with freeing and section of one or more cranial nerves (total procedure)		Procedural fees	624.00	R 22 767.59	499.20	R 18 214.07	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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)		Procedural fees	494.10	R 18 027.99	395.28	R 14 422.39	11,00T	R 2 788.09
6092	Craniectomy: with excision of meningioma(neoplasm of meninges) from infratentorial structures or posterior fossa (total procedure)		Procedural fees	873.40	R 31 867.33	698.72	R 25 493.86	11,00T	R 2 788.09
6093	Craniectomy: with excision of midline brain tumour at base of skull; using posterior auricular or transmastoid approach (total procedure)		Procedural fees	942.10	R 34 373.95	753.68	R 27 499.16	13,00T	R 3 295.02
6094	Craniectomy: with excision or fenestration (creating opening for draining) of cyst in the infratentorium or posterior fossa (total procedure)		Procedural fees	617.60	R 22 534.07	494.08	R 18 027.26	13,00T	R 3 295.02
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)		Procedural fees	1 079.60	R 39 390.85	863.68	R 31 512.68	11,00T	R 2 788.09
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)		Procedural fees	910.30	R 33 213.68	728.24	R 26 570.94	13,00T	R 3 295.02
2899	Craniectomy/craniotomy: with evacuation of infratentorial haematoma, subdural or extradural		Procedural fees	543.10	R 19 815.83	434.48	R 15 852.66	13,00T	R 3 295.02
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)		Procedural fees	625.50	R 22 822.32	500.40	R 18 257.85	11,00T	R 2 788.09
2916	Craniotomy: with intra-cranial hypophysectomy or excision of pituitary tumour (total procedure)		Procedural fees	683.60	R 24 942.19	546.88	R 19 953.75	11,00T	R 2 788.09
14.8	**Craniotomy for**							x	
2901	Craniectomy/trephination (bone flap craniotomy): with excision of supratentorial meningioma		Procedural fees	756.70	R 27 609.35	605.36	R 22 087.48	11,00T	R 2 788.09
2902	Craniotomy for subdural implantation of strip- and grid electrodes for seizure monitoring and brain mapping		Procedural fees	398.10	R 14 525.28	311.28	R 11 357.52	9,00T	R 2 281.17
2903	Craniectomy/trephination or bone flap craniotomy: with excision of supratentorial brain tumour, excluding meningioma (total procedure)		Procedural fees	650.00	R 23 716.24	520.00	R 18 972.99	11,00T	R 2 788.09
2904	Craniectomy/craniotomy: with evacuation of supratentorial, intracerebral haematoma		Procedural fees	590.20	R 21 534.34	472.16	R 17 227.48	11,00T	R 2 788.09
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery		Procedural fees	489.00	R 17 841.91	391.20	R 14 273.53	11,00T	R 2 788.09
2906	Craniotomy: skull based repair of encephalocele (total procedure)		Procedural fees	493.50	R 18 006.10	394.80	R 14 404.88	11,00T	R 2 788.09
2907	Craniotomy with elevation of bone flap: with lobectomy of temporal lobe, without electrocorticography during the surgery (total procedure)		Procedural fees	730.00	R 26 635.16	584.24	R 21 316.88	11,00T	R 2 788.09
2909	Craniotomy: Repair of dural /cerebrospinal fluid (CSF) leak. Includes surgery for rhinorrhea/otorrhea		Procedural fees	474.60	R 17 316.50	379.68	R 13 853.20	11,00T	R 2 788.09
2910	Arteriovenous malformation (AVM): Surgery, intracranial supratentorial, simple		Procedural fees	671.40	R 24 497.05	537.12	R 19 597.64	15,00T	R 3 801.94
6115	Craniectomy/craniotomy: Supratentorial exploration		Procedural fees	487.10	R 17 772.58	389.68	R 14 218.07	11,00T	R 2 788.09
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		Procedural fees	25.90	R 945.00	25.90	R 945.00		

6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)		Procedural fees	564.70	R 20 603.94	451.76	R 16 483.15	11,00T	R 2 788.09
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		Procedural fees	705.10	R 25 726.65	564.05	R 20 580.22	11,00T	R 2 788.09
6119	Decompressive craniectomy/craniotomy: With or without duraplasty, for treating intracranial hypertension without evacuation of associated intraparenchymal haematoma, with lobectomy		Procedural fees	706.50	R 25 777.73	565.20	R 20 622.18	11,00T	R 2 788.09
6120	Decompression of (roof of) orbit only: Transcranial approach (total procedure)		Procedural fees	548.60	R 20 016.50	438.88	R 16 013.20	11,00T	R 2 788.09
6121	Exploration of orbit: Transcranial approach with biopsy (total procedure)		Procedural fees	561.00	R 20 468.94	448.80	R 16 375.15	11,00T	R 2 788.09
6123	Cranial decompression: Subtemporal (pseudotumour cerebri, slit ventricle syndrome)		Procedural fees	430.00	R 15 689.20	344.00	R 12 551.36	11,00T	R 2 788.09
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess		Procedural fees	566.20	R 20 658.67	452.96	R 16 526.93	11,00T	R 2 788.09
6126	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision/fenestration of cyst		Procedural fees	550.90	R 20 100.42	440.72	R 16 080.34	11,00T	R 2 788.09
6127	Implantation, chemotherapy agent: Intracavity, brain intracavitary. ADD to main procedure	+	Procedural fees	25.70	R 937.70	25.70	R 937.70		
6128	Implantation, subdural: Strip electrodes through 1 or more burr/trephine hole(s). Long-term seizure monitoring		Procedural fees	364.50	R 13 299.34	291.60	R 10 639.47	11,00T	R 2 788.09
6129	Craniotomy with elevation of bone flap: Subdural implantation of an electrode array. Long-term seizure monitoring		Procedural fees	453.50	R 16 546.64	362.80	R 13 237.31	11,00T	R 2 788.09
6130	Craniotomy with elevation of bone flap: Excision of cerebral epileptogenic focus, Including electrocorticography during surgery (includes removal of electrode array)		Procedural fees	298.60	R 10 894.87	238.88	R 8 715.90	11,00T	R 2 788.09
6131	Craniotomy with elevation of bone flap: Lobectomy, temporal lobe, without electrocorticography during surgery(includes removal of electrode array)		Procedural fees	763.70	R 27 864.76	610.96	R 22 291.80	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
6132	Craniotomy with elevation of bone flap: Lobectomy, temporal lobe with electrocorticography during surgery		Procedural fees	789.70	R 28 813.40	631.76	R 23 050.72	11,00T	R 2 788.09
6133	Craniotomy with elevation of bone flap: Lobectomy, other than temporal lobe, partial or total, with electrocorticography during surgery		Procedural fees	699.40	R 25 518.67	559.52	R 20 414.94	11,00T	R 2 788.09
6134	Craniotomy with elevation of bone flap: Lobectomy, other than temporal lobe, partial or total, without electrocorticography during surgery		Procedural fees	647.20	R 23 614.08	517.76	R 18 891.26	11,00T	R 2 788.09
6135	Craniotomy with elevation of bone flap: Transection of corpus callosum		Procedural fees	637.10	R 23 245.56	509.68	R 18 596.45	11,00T	R 2 788.09
6136	Craniotomy with elevation of bone flap: Partial or subtotal (functional) hemispherectomy		Procedural fees	643.90	R 23 493.67	515.12	R 18 794.94	11,00T	R 2 788.09
6137	Craniotomy with elevation of bone flap: Excision or coagulation of choroid plexus		Procedural fees	507.90	R 18 531.50	406.32	R 14 825.20	11,00T	R 2 788.09
6138	Craniotomy with elevation of bone flap: Excision of craniopharyngioma		Procedural fees	943.20	R 34 414.09	754.56	R 27 531.27	11,00T	R 2 788.09

6139	Craniotomy with elevation of bone flap: Selective amygdalohippocampectomy		Procedural fees	666.20	R 24 307.32	532.96	R 19 445.86	11,00T	R 2 788.09
6140	Craniotomy with elevation of bone flap: Multiple subpial transections, with electrocorticography during surgery		Procedural fees	759.80	R 27 722.46	607.84	R 22 177.97	11,00T	R 2 788.09
6141	Craniectomy/craniotomy: Excision of foreign body from brain		Procedural fees	554.30	R 20 224.48	443.44	R 16 179.58	11,00T	R 2 788.09
6142	Craniectomy/craniotomy: Treatment of penetrating wound of brain		Procedural fees	589.90	R 21 523.40	471.92	R 17 218.72	11,00T	R 2 788.09
14.8.1	**Stereotaxis; Stereotactic Radiosurgery (Cranial): Neurostimulators (Intracranial)**							x	
2911	Stereotactic biopsy, aspiration, or excision (includes burr hole(s): Intracranial lesion. Includes computed tomography (CT) and/or magnetic resonance (MRI) guidance		Procedural fees	409.30	R 14 933.93	327.44	R 11 947.15	11,00T	R 2 788.09
2915	Transnasal hypophysectomy		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	11,00T	R 2 788.09
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)		Procedural fees		R -				
6143	Creation of lesion: Globus pallidus or thalamus, stereotactic, includes burr hole(s) and localising and recording techniques, single or multiple stages		Procedural fees	377.80	R 13 784.61	302.24	R 11 027.69	11,00T	R 2 788.09
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		Procedural fees	472.20	R 17 228.93	377.76	R 13 783.15	11,00T	R 2 788.09
6145	Biopsy, stereotactic: Aspiration/excision for intracranial lesion. Includes burr hole(s)		Procedural fees	417.80	R 15 244.07	334.24	R 12 195.25	11,00T	R 2 788.09
6146	Implantation, stereotactic: Depth electrodes into the cerebrum for long-term seizure monitoring		Procedural fees	469.10	R 17 115.83	375.28	R 13 692.66	11,00T	R 2 788.09
6147	Localisation, stereotactic: Insertion of catheter(s) or probe(s) for placement of radiation source. Includes burr hole(s)		Procedural fees	480.40	R 17 528.12	384.32	R 14 022.50	9,00T	R 2 281.17
6148	Stereotactic computer-assisted (navigational) procedure: Cranial, intradural. ADD to main procedure	+	Procedural fees	69.00	R 2 517.57	69.00	R 2 517.57		
6149	Stereotactic computer-assisted (navigational) procedure: Cranial, extradural. ADD to main procedure	+	Procedural fees	56.40	R 2 057.84	56.40	R 2 057.84		
6150	Stereotactic computer-assisted (navigational) procedure: Spinal. ADD to main procedure	+	Procedural fees	69.10	R 2 521.22	69.10	R 2 521.22		
6151	Creation of lesion: Gasserian ganglion, stereotactic, percutaneous, by neurolytic agent (e.g. alcohol, thermal, electrical, radiofrequency)		Procedural fees	260.20	R 9 493.79	208.16	R 7 595.03	6,00T	R 1 520.78
6152	Creation of lesion: Trigeminal medullary tract, stereotactic method, percutaneous, by neurolytic agent (e.g. alcohol, thermal, electrical, radiofrequency)		Procedural fees	331.40	R 12 091.63	265.12	R 9 673.31	6,00T	R 1 520.78
6153	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): 1 cranial lesion, simple		Procedural fees	298.80	R 10 902.17	239.04	R 8 721.74		
6154	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): Each additional cranial lesion, simple. ADD to main procedure	+	Procedural fees	64.10	R 2 338.79	64.10	R 2 338.79		
6155	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): 1 cranial lesion, complex		Procedural fees	407.30	R 14 860.96	325.84	R 11 888.77		
6156	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator): Each additional cranial lesion, complex. ADD to main procedure	+	Procedural fees	88.50	R 3 229.06	88.50	R 3 229.06		

6157	Stereotactic radiosurgery: Application of stereotactic headframe. ADD to main procedure	+	Procedural fees	45.10	R 1 645.54	45.10	R 1 645.54		
6158	Implantation of neurostimulator electrodes: Cortical, twist drill or burr hole(s)		Procedural fees	292.60	R 10 675.96	234.08	R 8 540.76	9,00T	R 2 281.17
6159	Craniectomy/craniotomy: Implantation of neurostimulator electrodes, cerebral, cortical		Procedural fees	464.40	R 16 944.34	371.52	R 13 555.47	11,00T	R 2 788.09
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		Procedural fees	447.40	R 16 324.07	357.92	R 13 059.26	11,00T	R 2 788.09
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	+	Procedural fees	83.80	R 3 057.57	83.80	R 3 057.57		
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		Procedural fees	676.60	R 24 686.78	541.28	R 19 749.42	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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	+	Procedural fees	147.50	R 5 381.76	120.00	R 4 378.38		
6164	Craniectomy: Implantation of neurostimulator electrodes, cerebellar, cortical		Procedural fees	352.10	R 12 846.90	281.68	R 10 277.52	11,00T	R 2 788.09
6166	Revision/removal: Neurostimulator electrodes, intracranial		Procedural fees	171.60	R 6 261.09	137.28	R 5 008.87	11,00T	R 2 788.09
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		Procedural fees	156.30	R 5 702.84	125.04	R 4 562.27	5,00T	R 1 267.31
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		Procedural fees	255.20	R 9 311.36	204.16	R 7 449.09	5,00T	R 1 267.31
6169	Revision/removal: Neurostimulator pulse generator/receiver, cranial		Procedural fees	117.00	R 4 268.92	117.00	R 4 268.92	3,00T	R 760.39
14.8.2	**Surgery of Skull Base**							x	
14.8.2.1	**Approach Procedures**							x	
14.8.2.1.1	**Anterior Cranial Fossa**							x	
6170	Transoral approach: Skull base, brain stem or upper spinal cord for biopsy, decompression/excision of lesion and tracheostomy		Procedural fees	742.00	R 27 073.00	593.60	R 21 658.40	11,00T	R 2 788.09
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		Procedural fees	1 020.80	R 37 245.44	816.64	R 29 796.35	11,00T	R 2 788.09
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		Procedural fees	804.60	R 29 357.05	643.68	R 23 485.64	11,00T	R 2 788.09
6173	Craniofacial approach procedure: with exposure of the anterior cranial fossa to treat an extradural lesion/defect at the skull base which require unilateral or bifrontal craniotomy (included in the approach procedure) with elevation of frontal lobe(s)		Procedural fees	919.30	R 33 542.06	735.44	R 26 833.65	11,00T	R 2 788.09
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		Procedural fees	866.30	R 31 608.27	693.04	R 25 286.62	11,00T	R 2 788.09

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		Procedural fees	852.80	R 31 115.70	682.24	R 24 892.56	11,00T	R 2 788.09
6176	Anterior cranial fossa: Orbitocranial approach, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s), with orbital exenteration		Procedural fees	967.20	R 35 289.76	773.76	R 28 231.81	11,00T	R 2 788.09
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		Procedural fees	739.50	R 26 981.78	591.60	R 21 585.43	11,00T	R 2 788.09
14.8.2.1.2	**Middle Cranial Fossa**							x	
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		Procedural fees	911.40	R 33 253.81	729.12	R 26 603.05	11,00T	R 2 788.09
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		Procedural fees	923.80	R 33 706.25	739.04	R 26 965.00	11,00T	R 2 788.09
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		Procedural fees	948.00	R 34 589.22	758.40	R 27 671.38	11,00T	R 2 788.09
14.8.2.1.3	**Posterior Cranial Fossa**							x	
2897	Resection/excision of neoplastic, vascular or infectious lesion: Base of posterior cranial fossa/jugular foramen/foramen magnum or C1-C3 vertebral bodies, extradural		Procedural fees	674.70	R 24 617.46	539.76	R 19 693.96	13,00T	R 3 295.02
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		Procedural fees	708.50	R 25 850.70	566.80	R 20 680.56	11,00T	R 2 788.09
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		Procedural fees	732.50	R 26 726.38	586.00	R 21 381.10	11,00T	R 2 788.09

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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		Procedural fees	861.50	R 31 433.14	689.20	R 25 146.51	11,00T	R 2 788.09
6184	Posterior cranial fossa: Transpetrosal approach to clivus/foramen magnum, includes ligation of superior petrosal sinus and/or sigmoid sinus		Procedural fees	848.50	R 30 958.81	678.80	R 24 767.05	11,00T	R 2 788.09
14.8.2.2	**Definitive Procedures**							x	
	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**							x	
6185	Resection/excision neoplastic/vascular/infectious lesion: Base of anterior cranial fossa, extradural		Procedural fees	640.30	R 23 362.32	512.24	R 18 689.86	11,00T	R 2 788.09
6186	Resection/excision of neoplastic, vascular or infectious lesion of base of anterior cranial fossa (includes dural repair, with/without graft), intradural		Procedural fees	716.70	R 26 149.89	573.36	R 20 919.91	11,00T	R 2 788.09
14.8.2.2.2	**Base of Middle Cranial Fossa**							x	
6187	Resection/excision of neoplastic/vascular/ infectious lesion: Infratemporal fossa, parapharyngeal space, petrous apex, extradural		Procedural fees	651.30	R 23 763.67	521.04	R 19 010.94	11,00T	R 2 788.09
6188	Resection/excision of neoplastic/vascular/infectious lesion: Infratemporal fossa, parapharyngeal space, petrous apex, includes dural repair, with/without graft, intradural		Procedural fees	891.60	R 32 531.38	713.28	R 26 025.10	11,00T	R 2 788.09
6189	Resection/excision of neoplastic, vascular or infectious lesion: Parasellar area, cavernous sinus, clivus or midline skull base, extradural		Procedural fees	857.60	R 31 290.84	686.08	R 25 032.67	11,00T	R 2 788.09

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		Procedural fees	967.40	R 35 297.06	773.92	R 28 237.65	11,00T	R 2 788.09
6192	Transection/ligation: Carotid artery in cavernous sinus, with repair by anastomosis/graft. ADD to main procedure	+	Procedural fees	553.40	R 20 191.64	442.72	R 16 153.31		
6193	Transection or ligation, carotid artery in petrous canal; without repair. ADD to main procedure		Procedural fees	109.30	R 3 987.98	109.30	R 3 987.98		
6194	Transection or ligation, carotid artery in petrous canal; with repair by anastomosis or graft. ADD to main procedure	+	Procedural fees	410.80	R 14 988.66	328.64	R 11 990.93		
6195	Destruction of carotid aneurysm/arteriovenous malformation (AVM) or carotid-cavernous fistula by dissection within cavernous sinus		Procedural fees	977.50	R 35 665.57	782.00	R 28 532.46	15,00T	R 3 801.94
14.8.2.2.3	**Base of Posterior Cranial Fossa**							x	
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		Procedural fees	989.60	R 36 107.06	791.68	R 28 885.65	13,00T	R 3 295.02
14.8.2.2.4	**Repair and/or Reconstruction of Surgical Defects of Skull Base**							x	
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)		Procedural fees	388.70	R 14 182.31	310.96	R 11 345.85	11,00T	R 2 788.09
6197	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary anterior, 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)		Procedural fees	437.80	R 15 973.80	350.24	R 12 779.04	11,00T	R 2 788.09
14.9	**Spinal operations**							x	
	Note: See section 3.8.7 for laminectomy procedures								
2923	Chordotomy: Unilateral		Procedural fees	178.00	R 6 494.60	142.40	R 5 195.68	3,00TM	R 760.39
2925	Chordotomy: Open		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	3,00TM	R 760.39
2927	Rhizotomy: Extradural, but intraspinal		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	3,00TM	R 760.39
2928	Rhizotomy: Intradural		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	3,00TM	R 760.39
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach		Procedural fees	700.00	R 25 540.56	560.00	R 20 432.45	8,00T	R 2 027.70
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach		Procedural fees	700.00	R 25 540.56	560.00	R 20 432.45	8,00T	R 2 027.70
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	3,00TM	R 760.39
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach		Procedural fees	350.00	R 12 770.28	280.00	R 10 216.23	8,00T	R 2 027.70
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	7,00T	R 1 774.24
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	3,00T	R 760.39
2937	Repair of meningocele, involving nerve tissue		Procedural fees	250.00	R 9 121.63	200.00	R 7 297.30	9,00T	R 2 281.17

2938	Simple		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	9,00T	R 2 281.17

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
2939	Excision of arterial vascular malformations and cysts of the spinal cord		Procedural fees	700.00	R 25 540.56	560.00	R 20 432.45	9,00T	R 2 281.17
2940	Lumbar osteophyte removal		Procedural fees	187.00	R 6 822.98	149.40	R 5 451.09	3,00TM	R 760.39
2941	Cervical or thoracic osteophyte removal		Procedural fees	285.00	R 10 398.66	228.00	R 8 318.93	3,00TM	R 760.39
14.10	**Arterial ligations**							x	
2951	Carotis: Trauma		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	8,00T	R 2 027.70
2953	Carotis: For aneurysm (AV anomaly)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	8,00T	R 2 027.70
2955	Removal of carotid body tumour (without vascular reconstruction)		Procedural fees	335.60	R 12 244.88	268.48	R 9 795.90	8,00T	R 2 027.70
14.11	**Medical psychotherapy**							x	
2957	Psychotherapy (specific psychotherapy with approved evidence based method): Per short session (10-20 minutes)		Psychiatrists	16.00	R 1 465.73	16.00	R 1 465.73		R -
2974	Psychotherapy (specific psychotherapy with approved evidence based method): Per intermediate session (21-40 minutes)		Psychiatrists	32.00	R 2 931.46	32.00	R 2 931.46		R -
2975	Psychotherapy (specific psychotherapy with approved evidence based method): Per extended session (41 minutes and longer)		Psychiatrists	48.00	R 4 397.19	48.00	R 4 397.19		R -
2968	Group therapy: Adults (specify number): Code per person per 80-minute session; Children (specify number): Code per person per 80-minute session		Psychiatrists	8.00	R 732.87	8.00	R 732.87		R -
14.12	**Physical treatment methods**								
2970	Electro-convulsive treatment (ECT): Each time; inpatient (may be combined with Consultation/Treatment (Therapy)(C/T) codes if both performed on the same day)		Psychiatrists	17.00	R 1 557.34	17.00	R 1 557.34		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
15. Endocrine System									
15.1	**Thyroid**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
2983	Lobectomy: Partial		Procedural fees	198.10	R 7 227.98	158.48	R 5 782.38	5,00T	R 1 267.31
2985	Lobectomy: Total		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	5,00T	R 1 267.31
2987	Thyroidectomy: Subtotal		Procedural fees	266.00	R 9 705.41	212.80	R 80 737.37	5,00T	R 1 267.31
2989	Thyroidectomy: Total		Procedural fees	279.00	R 10 179.74	223.20	R 8 143.79	5,00T	R 1 267.31
2991	Thyroglossal cyst or fistula excision		Procedural fees	126.20	R 4 604.60	120.00	R 4 378.38	5,00T	R 1 267.31
15.2	**Parathyroid**								
2993	Parathyroid: Exploration of parathyroid glands for hyperparathyroidism including removal		Procedural fees	280.10	R 10 219.87	224.08	R 8 175.90	6,00T	R 1 520.78
2990	Parathyroid: Re-exploration for hyperparathyroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		Procedural fees	335.30	R 12 233.93	268.24	R 9 787.14	6,00T	R 1 520.78
2992	Parathyroid: Re-exploration for hyperparathyroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		Procedural fees	370.70	R 13 525.55	296.56	R 10 820.44	12,00T	R 3 041.55
2994	Parathyroid: Autotransplantation of parathyriod: ADD to major procedure (modifier 0005 does not apply)	+	Procedural fees	70.50	R 2 572.30	70.50	R 2 572.30	6,00T	R 1 520.78
15.3	**Adrenals**								
2995	Adrenalectomy: Unilateral		Procedural fees	225.00	R 8 209.47	180.00	R 6 567.57	9,00T	R 2 281.17
2997	Bilateral exploration of adrenal glands: Including removal		Procedural fees	394.00	R 14 375.69	315.20	R 11 500.55	11,00T	R 2 788.09
15.4	**Hypophysis**								
2999	Transethmoidal hypophysectomy		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	11,00T	R 2 788.09
3000	Transnasal hypophysectomy (see also item 2915)		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	11,00T	R 2 788.09
15.5	**Endocrine system: General**								
3001	Implantation of pellets (excluding cost of material) (excluding after-care)		Procedural fees	3.00	R 109.46	3.00	R 109.46		R -
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		Procedural fees	48.90	R 1 784.19	48.90	R 1 784.19		R -
2998	Ambulatory continuous glucose monitoring: Interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours (includes interpretation and report)		Procedural fees	12.30	R 448.78	12.30	R 448.78		R -

16. Eye		Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
	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		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3006	Keratometry		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
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	+	Procedural fees	11.68	R 426.16				R -
3012	Pre-surgical retinal examination before retinal surgery		Procedural fees	32.00	R 167.57 1	32.00	R 167.57 1		R -
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		Procedural fees	19.60	R 715.14	19.60	R 715.14		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
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		Procedural fees	45.00	R 641.89 1	45.00	R 641.89 1		R -
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3021	Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations		Procedural fees	9.00	R 328.38	9.00	R 328.38		R -
16.1.2	**Special eye investigations**								
3005	Endothelial cell count		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3007	Potential acuity measurement		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3008	Contrast sensitivity test		Procedural fees	7.00	R 255.41	7.00	R 255.41		R -
3010	Orthoptics consultation		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -

3011	Orthoptic subsequent sessions		Procedural fees	5.00	R 182.43	5.00	R 182.43		R -
3015	Charting of visual field with manual perimeter		Procedural fees	28.00	R 1 021.62	28.00	R 1 021.62		R -
3016	Retinal threshold test without storage facilities		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60		R -
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs		Procedural fees	74.00	R 2 700.00	74.00	R 2 700.00		R -
3018	Retinal threshold trend evaluation (additional to item 3017)		Procedural fees	16.00	R 583.78	16.00	R 583.78		R -
3019	Ocular muscle function with Hess screen or perimeter		Procedural fees	16.00	R 583.78	16.00	R 583.78		R -
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery		Procedural fees	46.00	R 1 678.38	46.00	R 1 678.38		R -
3022	Digital fluorescein video angiography		Procedural fees	68.00	R 2 481.08	68.00	R 2 481.08	9,00T	R 2 281.17
3023	Digital indocyanine video angiography		Procedural fees	110.00	R 4 013.52	110.00	R 4 013.52	9,00T	R 2 281.17
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039		Procedural fees	12.00	R 437.84	12.00	R 437.84		R -
3025	Electronic tonography		Procedural fees	19.00	R 693.24	19.00	R 693.24		R -
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum		Procedural fees	19.30	R 704.19	19.30	R 704.19		R -
3027	Fundus photography		Procedural fees	21.00	R 766.22	21.00	R 766.22		R -
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye		Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46		R -
3029	Anterior segment microphotography		Procedural fees	21.00	R 766.22	21.00	R 766.22		R -
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)		Procedural fees	45.00	R 1 641.89	45.00	R 1 641.89		R -
3032	Eyelid and orbit photography		Procedural fees	9.00	R 328.38	9.00	R 328.38		R -
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians		Procedural fees	16.00	R 583.78	16.00	R 583.78		R -
3034	Determination of lens implant power per eye		Procedural fees	15.00	R 547.30	15.00	R 547.30		R -
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		Procedural fees	22.00	R 802.70	22.00	R 802.70		R -
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)		Procedural fees	36.00	R 1 313.51	36.00	R 1 313.51		R -
3040	Femtosecond Laser: Equipment hire. For one or both eyes done in one session		Procedural fees		R -				R -

16.2	Retina								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy		Procedural fees	306.90	R 11 197.71	245.52	R 8 958.17	6,00T	R 1 520.78
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye (aftercare excluded)		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	6,00T	R 1 520.78
3041	Pan retinal photocoagulation (per eye): Done in one sitting (aftercare excluded)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	6,00T	R 1 520.78
3044	Removal of encircling band and/or buckling material		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	6,00T	R 1 520.78
16.3	Cataract								
3045	Cataract: Intra-capsular		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	7,00T	R 1 774.24
3047	Cataract: Extra-capsular (including capsulotomy)		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	7,00T	R 1 774.24
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)		Procedural fees	57.00	R 2 079.73	57.00	R 2 079.73	7,00T	R 1 774.24
3050	Repositioning of intra ocular lens		Procedural fees	171.10	R 6 242.84	136.88	R 4 994.27	7,00T	R 1 774.24
3051	Needling or capsulotomy		Procedural fees	130.00	R 4 743.25	120.00	R 4 378.38	4,00T	R 1 013.85
3052	Laser capsulotomy (aftercare excluded)		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3057	Removal of lenticulus		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	7,00T	R 1 774.24
3058	Exchange of intra ocular lens		Procedural fees	236.00	R 8 610.82	188.80	R 6 888.65	7,00T	R 1 774.24
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	7,00T	R 1 774.24
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)		Procedural fees	4.00	R 145.95				
16.4	Glaucoma								
3061	Drainage operation		Procedural fees	247.60	R 9 034.06	198.08	R 7 227.25	6,00T	R 1 520.78
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)		Procedural fees	60.00	R 2 189.19	60.00	R 2 189.19	6,00T	R 1 520.78
3063	Cyclocryotherapy or cyclodiathermy		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	6,00T	R 1 520.78
3064	Laser trabeculoplasty		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	6,00T	R 1 520.78
3065	Removal of blood from anterior chamber		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	4,00T	R 1 013.85

3067	Goniotomy		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	7,00T	R 1 774.24
16.5	**Intra-ocular foreign body**								
3071	Intra-ocular foreign body: Anterior to Iris		Procedural fees	127.00	R 4 633.79	120.00	R 4 378.38	4,00T	R 1 013.85
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	6,00T	R 1 520.78
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)		Procedural fees	20.00	R 729.73	20.00	R 729.73		
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles		Procedural fees	175.60	R 6 407.03	140.48	R 5 125.63	5,00T	R 1 267.31
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84	5,00T	R 1 267.31
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles		Procedural fees	120.00	R 4 378.38	120.00	R 4 378.38	5,00T	R 1 267.31
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	5,00T	R 1 267.31
16.7	**Globe**								
3079	Transcleral biopsy		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85
3080	Examination of eyes under general anaesthetic where no surgery is done		Procedural fees	80.00	R 2 918.92	80.00	R 2 918.92	4,00T	R 1 013.85
3081	Treatment of minor perforating injury		Procedural fees	161.60	R 5 896.22	129.28	R 4 716.98	6,00T	R 1 520.78
3083	Treatment of major perforating injury		Procedural fees	267.50	R 9 760.14	214.00	R 7 808.12	6,00T	R 1 520.78
3085	Enucleation or Evisceration		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	5,00T	R 1 267.31
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis		Procedural fees	160.00	R 5 837.84	128.00	R 4 670.27	5,00T	R 1 267.31
3088	Hydroxyapetite insertion (additional to item 3087)	+	Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46	5,00T	R 1 267.31
3089	Subconjunctival injection if not done at time of operation		Procedural fees	10.00	R 364.87	10.00	R 364.87	5,00T	R 1 267.31
3090	Intra vitreal injection drug		Procedural fees	47.60	R 1 736.76	47.60	R 1 736.76	4,00T	R 1 013.85
3091	Retrobulbar injection (if not done at time of operation)		Procedural fees	16.00	R 583.78	16.00	R 583.78	4,00T	R 1 013.85
3092	External laser treatment for superficial lesions		Procedural fees	53.00	R 1 933.79	53.00	R 1 933.79		
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation		Procedural fees	209.00	R 7 625.68	167.20	R 6 100.55	6,00T	R 1 520.78
3094	Implantation of intra vitreal drug delivery system		Procedural fees	247.60	R 9 034.06	198.08	R 7 227.25	4,00T	R 1 013.85

3095	Biopsy of vitreous body or anterior chamber contents		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	6,00T	R 1 520.78
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy		Procedural fees	130.00	R 4 743.25	120.00	R 4 378.38	7,00T	R 1 774.24
3097	Anterior vitrectomy		Procedural fees	280.00	R 10 216.23	224.00	R 8 172.98	6,00T	R 1 520.78
3098	Removal of silicon from globe		Procedural fees	280.00	R 10 216.23	224.00	R 8 172.98	6,00T	R 1 520.78
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement		Procedural fees	419.00	R 15 287.85	335.20	R 12 230.28	6,00T	R 1 520.78
3100	Lensectomy done at time of posterior vitrectomy		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	7,00T	R 1 774.24

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
16.8	**Orbit**								
3101	Drainage of orbital abscess		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	5,00T	R 1 267.31
3103	Orbit: Removal of tumour		Procedural fees	240.00	R 8 756.76	192.00	R 7 005.41	5,00T	R 1 267.31
3104	Removal orbital prosthesis		Procedural fees	212.70	R 7 760.68	170.16	R 6 208.55	5,00T	R 1 267.31
3105	Orbit: Exenteration		Procedural fees	275.00	R 10 033.79	220.00	R 8 027.03	5,00T	R 1 267.31
3107	Orbitotomy requiring bone flap		Procedural fees	393.00	R 14 339.20	314.40	R 11 471.36	5,00T	R 1 267.31
3108	Eye socket reconstruction		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	5,00T	R 1 267.31
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously		Procedural fees	300.00	R 10 945.96	240.00	R 8 756.76	5,00T	R 1 267.31
3110	Second stage hydroxyapetite implantation		Procedural fees	110.00	R 4 013.52	110.00	R 4 013.52	5,00T	R 1 267.31
16.9	**Cornea**								
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)		Procedural fees	*	RCF Missing	*	RCF Missing		
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		Procedural fees	12.20	R 445.14	12.20	R 445.14		
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		Procedural fees	200.00	R 7 297.30	160.00	R 5 837.84		
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only		Procedural fees	78.85	R 2 876.96				
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		Procedural fees	166.00	R 6 056.76	132.80	R 4 845.41		

3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty		Procedural fees	135.20	R 4 932.98	120.00	R 4 378.38	6,00T	R 1 520.78
3117	Removal of foreign body: On the basis of fee per consultation		Procedural fees	*	RCF Missing	*	RCF Missing	4,00T	R 1 013.85
3118	Curettage of cornea after removal of foreign body (after-care excluded)		Procedural fees	10.00	R 364.87	10.00	R 364.87		
3119	Tattooing		Procedural fees	26.00	R 948.65	26.00	R 948.65	4,00T	R 1 013.85
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	6,00T	R 1 520.78
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	+	Procedural fees	52.18	R 1 903.87	52.18	R 1 903.87		
3121	Corneal graft (Lamellar or full thickness)		Procedural fees	289.00	R 10 544.60	231.20	R 8 435.68	6,00T	R 1 520.78
3122	Epikeratophakia		Procedural fees	289.00	R 10 544.60	231.20	R 8 435.68		
3123	Insertion of intra-corneal or intrascleral prosthesis: Pathological cornea		Procedural fees	470.80	R 17 177.85	376.64	R 13 742.28	6,00T	R 1 520.78
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). For use of sterile tray, add item 0202		Procedural fees	9.00	R 328.38	9.00	R 328.38		
3125	Keratectomy		Procedural fees	127.00	R 4 633.79	120.00	R 4 378.38	6,00T	R 1 520.78
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	6,00T	R 1 520.78
3129	Additional to item 3128 for the use of own diamond knives	+	Procedural fees	40.00	R 1 459.46	40.00	R 1 459.46		
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used		Procedural fees	96.90	R 3 535.54	96.90	R 3 535.54	4,00T	R 1 013.85
3131	Cornea: Paracentesis - stand-alone procedure		Procedural fees	53.00	R 1 933.79	53.00	R 1 933.79	4,00T	R 1 013.85
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)		Procedural fees	150.00	R 5 472.98	120.00	R 4 378.38	6,00T	R 1 520.78
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure		Procedural fees	116.30	R 4 243.38	116.30	R 4 243.38	4,00T	R 1 013.85
3136	Conjunctival flap or graft (not for use with pterigium surgery)		Procedural fees	95.70	R 3 491.76	95.70	R 3 491.76	6,00T	R 1 520.78
3138	Removal corneal epithelium and chelating agent for band keratopathy		Procedural fees	69.50	R 2 535.81	69.50	R 2 535.81	4,00T	R 1 013.85
4980	Corneal transplant: Endothelial		Procedural fees	274.80	R 10 026.50	219.84	R 8 021.20	6,00T	R 1 520.78
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)		Procedural fees		R -				

4983	Lamellar corneal surgery keratome and equipment		Procedural fees		R -				
4985	Corneal cross linking		Procedural fees	150.00	R 5 472.98	150.00	R 5 472.98	6,00T	R 1 520.78
4986	Cross linking: Equipment hire		Procedural fees	54.00	R 1 970.27	54.00	R 1 970.27		
4988	Endothelial specular microscope for donor corneas		Procedural fees		R -				
4989	Endothelial specular microscope for clinical use		Procedural fees		R -				

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
16.10	**Ducts**								
3133	Probing and/or syringing, per duct		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
3135	Insert polythene tubes/stent: Unilateral. Additional		Procedural fees	51.80	R 1 890.00	51.80	R 1 890.00	4,00T	R 1 013.85
3137	Excision of lacrimal sac: Unilateral		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85
3139	Dacrocystorhinostomy (Single) with or without polythene tube		Procedural fees	210.00	R 7 662.17	168.00	R 6 129.74	5,00T	R 1 267.31
3141	Sealing Punctum surgical or by cautery: Per eye		Procedural fees	24.90	R 908.51	24.90	R 908.51	4,00T	R 1 013.85
3142	Sealing Punctum with plugs: Per eye		Procedural fees	20.00	R 729.73	20.00	R 729.73	4,00T	R 1 013.85
3143	Three-snip operation		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
3145	Repair of caniculus: Primary procedure		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85
3147	Repair of caniculus: Secondary procedure		Procedural fees	175.00	R 6 385.14	140.00	R 5 108.11	4,00T	R 1 013.85
16.11	**Iris**								
3149	Iridectomy or iridotomy by open operation as isolated procedure		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85
3151	Excision of iris tumour		Procedural fees	185.00	R 6 750.01	148.00	R 5 400.00	6,00T	R 1 520.78
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)		Procedural fees	105.00	R 3 831.08	105.00	R 3 831.08	4,00T	R 1 013.85
3155	Iridocyclectomy for tumour		Procedural fees	266.00	R 9 705.41	212.80	R 7 764.33	6,00T	R 1 520.78
3157	Division of anterior synechiae as isolated procedure		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85

3158	Repair iris as in dialysis: Anterior chamber reconstruction		Procedural fees	142.00	R 5 181.09	120.00	R 4 378.38	4,00T	R 1 013.85
16.12	**Lids**								
3161	Tarsorrhaphy		Procedural fees	47.00	R 1 714.87	47.00	R 1 714.87	4,00T	R 1 013.85
3163	Excision of superficial lid tumour		Procedural fees	47.00	R 1 714.87			4,00T	R 1 013.85
3165	Repair of skin laceration lid: Simple		Procedural fees	27.30	R 996.08	27.30	R 996.08	4,00T	R 1 013.85
3167	Diathermy to wart on lid margin		Procedural fees	12.00	R 437.84	12.00	R 437.84	4,00T	R 1 013.85
3169	Electrolysis of any number of eyelashes: Per eye		Procedural fees	15.00	R 547.30	15.00	R 547.30		
3171	Excision of Meibomian cyst. For use of sterile tray, add item 0202		Procedural fees	20.40	R 744.33	20.40	R 744.33	4,00T	R 1 013.85
3173	Epicanthal folds		Procedural fees	128.70	R 4 695.82	120.00	R 4 378.38	4,00T	R 1 013.85
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)		Procedural fees		R -				
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)		Procedural fees		R -				
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material		Procedural fees	187.00	R 6 822.98	149.60	R 5 458.38	4,00T	R 1 013.85
16.12.1	**Lids: Entropion or ectropion**								
3177	Entropion or ectropion by Cautery		Procedural fees	10.00	R 364.87	10.00	R 364.87	4,00T	R 1 013.85
3179	Entropion or ectropion by Suture		Procedural fees	49.40	R 1 802.43	49.40	R 1 802.43	4,00T	R 1 013.85
3181	Entropion or ectropion by Open operation		Procedural fees	111.50	R 4 068.25	111.50	R 4 068.25	4,00T	R 1 013.85
3183	Entropion or ectropion by Free skin, mucosal grafting or flap		Procedural fees	122.60	R 4 473.25	120.00	R 4 378.38	4,00T	R 1 013.85
16.12.2	**Lids: Reconstruction of eyelid**								
3185	Staged procedure for partial or total loss of eyelid: First stage		Procedural fees	259.00	R 9 450.01	207.20	R 7 560.01	4,00T	R 1 013.85
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage		Procedural fees	206.00	R 7 516.22	164.80	R 6 012.98	4,00T	R 1 013.85
3189	Full thickness eyelid laceration for tumour or injury: Direct repair		Procedural fees	136.50	R 4 980.41	120.00	R 4 378.38	4,00T	R 1 013.85
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)		Procedural fees	150.20	R 5 480.28	120.16	R 4 384.22	4,00T	R 1 013.85
3172	Blepharoplasty lower eyelid plus fat pad		Procedural fees	125.80	R 4 590.00	120.00	R 4 378.38	4,00T	R 1 013.85
16.12.3	**Lids: Ptosis**								

3193	Repair by superior rectus, levator or frontalis muscle operation		Procedural fees	190.00	R 6 932.44	152.00	R 5 545.95	4,00T	R 1 013.85
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral		Procedural fees	137.60	R 5 020.55	120.00	R 4 378.38	4,00T	R 1 013.85
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral		Procedural fees	166.00	R 6 056.76	132.80	R 4 845.41	4,00T	R 1 013.85
16.13	**Conjunctiva**								
3199	Repair of conjunctiva by grafting		Procedural fees	132.00	R 4 816.22	120.00	R 4 378.38	4,00T	R 1 013.85
3200	Repair of lacerated conjunctiva		Procedural fees	47.00	R 1 714.87	47.00	R 1 714.87	4,00T	R 1 013.85

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
16.14	**Eye: General**								
3196	Diamond knife: Use of own diamond knife during intraocular surgery		Procedural fees	12.00	R 437.84				R -
3198	Excimer laser: Hire fee (per eye)		Procedural fees	284.13	R 10 366.91				R -
3201	Laser apparatus (ophthalmic): Equipment hire for one or both eyes done in one sitting (Not to be used with IOL Master)		Procedural fees	109.00	R 3 977.03				R -
3190	Holmium laser apparatus (ophthalmic): Equipment hire for one or both eyes done in one session		Procedural fees	109.00	R 3 977.03				R -
3202	Phako emulsification apparatus: Equipment hire		Procedural fees	109.00	R 3 977.03				R -
3203	Vitrectomy apparatus: Equipment hire		Procedural fees	120.00	R 4 378.38				R -
17. Ear									
17.1	**External ear (Pinna)**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
3267	Major congenital deformity reconstruction of external ear: Unilateral		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31
3269	Major congenital deformity reconstruction of external ear: Bilateral		Procedural fees	242.00	R 8 829.74	193.60	R 7 063.79	5,00T	R 1 267.31
3270	Excision of superficial pre-auricular fistula		Procedural fees	55.00	R 2 006.76	55.00	R 2 006.76	4,00T	R 1 013.85
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear		Procedural fees	*	RCF Missing	*	RCF Missing		
3272	Excision of complicated pre-auricular fistula		Procedural fees	140.00	R 5 108.11	120.00	R 4 378.38	4,00T	R 1 013.85
5170	Drainage: Haematoma or abscess of external ear		Procedural fees	34.80	R 1 269.73	34.80	R 1 269.73	5,00T	R 1 267.31

5171	Drainage: Abscess of external auditory canal		Procedural fees	21.00	R 766.22	21.00	R 766.22	5,00T	R 1 267.31
5173	Biopsy: External ear		Procedural fees	12.40	R 452.43	12.40	R 452.43	5,00T	R 1 267.31
5175	Excision: External ear, partial, simple repair		Procedural fees	63.50	R 2 316.89	63.50	R 2 316.89	5,00T	R 1 267.31
5176	Excision: External ear, complete		Procedural fees	66.80	R 2 437.30	66.80	R 2 437.30	5,00T	R 1 267.31
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		Procedural fees	21.58	R 787.38	21.58	R 787.38		
3205	External ear canal: Removal of foreign body: Under general anaesthetic		Procedural fees	21.00	R 766.22	21.00	R 766.22	4,00T	R 1 013.85
3208	Biopsy: External auditory canal		Procedural fees	15.50	R 565.54	15.50	R 565.54	5,00T	R 1 267.31
3215	Meatus atresia: Repair of stenosis of cartilaginous portion		Procedural fees	164.00	R 5 983.79	131.20	R 4 787.03	4,00T	R 1 013.85
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) - not to be used combined with item 3206		Procedural fees	17.42	R 635.60	17.42	R 635.60		
3219	Meatus atresia: Removal of osteoma from meatus: Solitary		Procedural fees	77.00	R 2 809.46	77.00	R 2 809.46	4,00T	R 1 013.85
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) - not to be used combined with item 3206		Procedural fees	23.14	R 844.30	23.14	R 844.30		
3221	Meatus atresia: Removal of osteoma from meatus: Multiple		Procedural fees	215.00	R 7 844.60	172.00	R 6 275.68	4,00T	R 1 013.85
17.3	**Middle ear**								
3206	Microscopic examination of tympanic membrane including microsuction		Procedural fees	8.00	R 291.89	8.00	R 291.89		
3207	Myringotomy: Unilateral		Procedural fees	28.00	R 1 021.62	28.00	R 1 021.62	4,00T	R 1 013.85
3209	Myringotomy: Bilateral		Procedural fees	46.00	R 1 678.38	46.00	R 1 678.38	4,00T	R 1 013.85
3211	Unilateral myringotomy with insertion of ventilation tube		Procedural fees	38.00	R 1 386.49	38.00	R 1 386.49	4,00T	R 1 013.85
3212	Bilateral myringotomy with insertion of unilateral ventilation tube		Procedural fees	57.00	R 2 079.73	57.00	R 2 079.73	4,00T	R 1 013.85
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)		Procedural fees	65.00	R 2 371.62	65.00	R 2 371.62	4,00T	R 1 013.85
3214	Reconstruction of middle ear ossicles (ossiculoplasty)		Procedural fees	255.00	R 9 304.06	204.00	R 7 443.25	5,00T	R 1 267.31
3237	Exploratory tympanotomy		Procedural fees	158.90	R 5 797.71	127.12	R 4 638.17	5,00T	R 1 267.31
3243	Myringoplasty		Procedural fees	138.00	R 5 035.14	120.00	R 4 378.38	5,00T	R 1 267.31

3245	Functional reconstruction of tympanic membrane		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00T	R 1 267.31
3249	Stapedotomy and stapedectomy		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00T	R 1 267.31
3257	Cortical mastoidectomy		Procedural fees	188.50	R 6 877.71	150.80	R 5 502.17	5,00T	R 1 267.31
3259	Radical mastoidectomy (excluding minor procedures)		Procedural fees	277.40	R 10 121.36	221.92	R 8 097.09	5,00T	R 1 267.31
3261	Muscle grafting to mastoid cavity without tympanoplasty		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	5,00T	R 1 267.31
3263	Autogenous bone graft to mastoid cavity		Procedural fees	180.00	R 6 567.57	144.00	R 5 254.06	5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
3264	Tympanomastoidectomy		Procedural fees	375.00	R 13 682.45	300.00	R 10 945.96	5,00T	R 1 267.31
3265	Reconstruction of posterior canal wall, following radical mastoid		Procedural fees	320.00	R 11 675.69	256.00	R 9 340.55	5,00T	R 1 267.31
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)		Procedural fees	30.00	R 1 094.60	30.00	R 1 094.60	5,00T	R 1 267.31
5190	Debridement: Mastoidectomy cavity, complex (anaesthesia/more than routine cleaning)		Procedural fees	24.10	R 879.33	24.10	R 879.33	5,00T	R 1 267.31
5191	Tympanolysis: Transcanal		Procedural fees	119.40	R 4 356.49	119.40	R 4 356.49	5,00T	R 1 267.31
5193	Implantation/replacement: Electromagnetic temporal bone conduction hearing device		Procedural fees	199.60	R 7 282.71	159.68	R 5 826.17	5,00T	R 1 267.31
5194	Removal/repair: Electromagnetic temporal bone conduction hearing device		Procedural fees	199.60	R 7 282.71	159.68	R 5 826.17	5,00T	R 1 267.31
5196	Implantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy		Procedural fees	265.40	R 9 683.52	212.32	R 7 746.82	5,00T	R 1 267.31
5197	Implantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy		Procedural fees	336.20	R 12 266.77	268.96	R 9 813.41	5,00T	R 1 267.31
5199	Revision: Stapedectomy or stapedotomy		Procedural fees	314.90	R 11 489.61	251.92	R 9 191.68	5,00T	R 1 267.31
5201	Revision: Mastoidectomy resulting in total mastoidectomy		Procedural fees	271.50	R 9 906.09	217.20	R 7 924.87	5,00T	R 1 267.31
5202	Revision: Mastoidectomy resulting in modified radical mastoidectomy		Procedural fees	279.50	R 10 197.98	222.80	R 8 129.20	5,00T	R 1 267.31
5203	Revision: Mastoidectomy followed by tympanoplasty		Procedural fees	287.00	R 10 471.63	229.60	R 8 377.30	5,00T	R 1 267.31
5204	Revision: Mastoidectomy, with apicectomy		Procedural fees	346.80	R 12 653.53	277.44	R 10 122.82	5,00T	R 1 267.31
17.4	**Facial nerve**								

17.4.1	**Facial nerve: Facial nerve tests**								
3223	Percutaneous stimulation of the facial nerve		Procedural fees	9.00	R 328.38	9.00	R 328.38	4,00T	R 1 013.85
3224	Electroneurography (ENOG)		Procedural fees	75.00	R 2 736.49	75.00	R 2 736.49	4,00T	R 1 013.85
17.4.2	**Facial nerve: Facial nerve surgery**								
3227	Exploration of facial nerve: Exploration of tympanomastiod segment		Procedural fees	297.00	R 10 836.50	237.60	R 8 669.20	5,00T	R 1 267.31
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)		Procedural fees	436.00	R 15 908.12	348.80	R 12 726.50	5,00T	R 1 267.31
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve		Procedural fees	436.00	R 15 908.12	348.80	R 12 726.50	5,00T	R 1 267.31
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis		Procedural fees	124.00	R 4 524.33	120.00	R 4 378.38	6,00T	R 1 520.78
17.5	**Inner ear**								
17.5.1	**Inner ear: Audiometry**								
3273	Pure tone audiometry (air conduction)		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
3274	Pure tone audiometry (bone conduction with masking)		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
3275	Impedance audiometry (tympanometry)		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral		Procedural fees	50.00	R 1 824.33				R -
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral		Procedural fees	88.00	R 3 210.81				R -
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels		Procedural fees	60.00	R 2 189.19				R -
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels		Procedural fees	105.00	R 3 831.08				R -
2695	Audiology 40Hz response: Unilateral		Procedural fees	30.00	R 1 094.60				R -
2696	Audiology 40Hz response: Bilateral		Procedural fees	53.00	R 1 933.79				R -
2697	Mid- and long latency auditory evoked potentials: Unilateral		Procedural fees	30.00	R 1 094.60				R -
2698	Mid- and long latency auditory evoked potentials: Bilateral		Procedural fees	53.00	R 1 933.79				R -

2699	Electro-cochleography: Unilateral		Procedural fees	50.00	R 1 824.33				R -
2700	Electro-cochleography: Bilateral		Procedural fees	88.00	R 3 210.81				R -
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography		Procedural fees	140.00	R 5 108.11			4,00T	R 1 013.85
3248	Otoacoustic emission performed as a screening test		Procedural fees	33.24	R 1 212.81	33.24	R 1 212.81		R -
3250	Otoacoustic emission (high risk patients only)		Procedural fees	66.48	R 2 425.62	66.48	R 2 425.62		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
17.5.2	**Inner ear: Balance tests**								
3251	Minimal caloric test (excluding consultation fee)		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -
3254	Video nystagmoscopy (monocular)		Procedural fees	25.00	R 912.16	25.00	R 912.16		R -
3256	Video nystagmoscopy (binocular)		Procedural fees	50.00	R 1 824.33	50.00	R 1 824.33		R -
3258	Otolith repositioning manoeuvre		Procedural fees	14.00	R 510.81	14.00	R 510.81	4,00T	R 1 013.85
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems		Procedural fees	71.48	R 2 608.06	71.48	R 2 608.06		R -
5210	Nystagmus test: Spontaneous, including gaze and fixation nystagmus (report included)		Procedural fees	10.20	R 372.16	10.20	R 372.16		R -
5211	Nystagmus test: Positional, minimum of 4 positions (report included)		Procedural fees	9.10	R 332.03	9.10	R 332.03		R -
5212	Caloric vestibular test: Each irrigation (report included)		Procedural fees	3.20	R 116.76	3.20	R 116.76		R -
5213	Nystagmus test: Optokinetic bidirectional, foveal or peripheral stimulation (report included)		Procedural fees	7.20	R 262.70	7.20	R 262.70		R -
5214	Oscillating tracking test (report included)		Procedural fees	6.50	R 237.16	6.50	R 237.16		R -
5215	Rotational testing: Sinusoidal vertical axis		Procedural fees	8.00	R 291.89	8.00	R 291.89		R -
5216	Posturography: Dynamic, computerised		Procedural fees	25.10	R 915.81	25.10	R 915.81		R -
17.5.3	**Middle and Inner ear surgery**								
3233	Labyrinthectomy via the middle ear or mastoid		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00T	R 1 267.31
3240	Endolymphatic sac surgery		Procedural fees	277.00	R 10 106.77	221.60	R 8 085.41	5,00T	R 1 267.31

3241	Fenestration: Semicircular canal		Procedural fees	199.00	R 7 260.82	159.20	R 5 808.65	5,00T	R 1 267.31
3242	Fenestration: Revision		Procedural fees	197.60	R 7 209.74	158.08	R 5 767.79	5,00T	R 1 267.31
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)		Procedural fees	310.00	R 11 310.82	248.00	R 9 048.66	5,00T	R 1 267.31
3246	Cochlear implant surgery		Procedural fees	340.50	R 12 423.66	272.40	R 9 938.93	5,00T	R 1 267.31
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)		Procedural fees	565.80	R 20 644.07	452.64	R 16 515.26	5,00T	R 1 267.31
5221	Grafting of labyrinthine segment of facial nerve (repair and graft only) - the procedure is for repair and closure or grafts for skull base surgery and does not include approach or resection. Graft harvesting is not included		Procedural fees	463.20	R 16 900.56	370.56	R 13 520.44	5,00T	R 1 267.31
5222	Facial nerve surgery inside the internal auditory canal - this procedure is for resection and does not include approach or repair and closure or grafts		Procedural fees	375.50	R 13 700.69	300.40	R 10 960.55	5,00T	R 1 267.31
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours or similar middle fossa surgery - this procedure is for resection and does not include approach or repair and closure or grafts		Procedural fees	535.20	R 19 527.59	424.00	R 15 470.28	11,00T	R 2 788.09
5224	Removal of acoustic neuroma via the middle fossa approach		Procedural fees		R -				R -
17.6.2	**Microsurgery of the skull base: Translabyrinthe approach**								
5227	Cochleo-vestibular neurectomy		Procedural fees	530.00	R 19 337.86	424.00	R 15 470.28	11,00T	R 2 788.09
5228	Nerve section: Vestibular, transcranial approach (approach 1): Graft harvesting not included		Procedural fees	458.50	R 16 729.07	366.80	R 13 383.26	11,00T	R 2 788.09
3239	Acoustic neuroma removal translabyrinthine		Procedural fees		R -				R -
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required the grafting and harvesting of graft are included)		Procedural fees		R -				R -
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		Procedural fees		R -				R -
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		Procedural fees		R -				R -
17.6.5	**Microsurgery of the skull base: Intratemporal fossa approach type B**								
5238	Removal of tumour: Temporal bone		Procedural fees	643.40	R 23 475.43	514.72	R 18 780.34	11,00T	R 2 788.09
5239	Removal of tumour of the clivus		Procedural fees		R -				R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
17.6.6	**Microsurgery of the skull base: Intrafemoral approach type C**								
5242	Removal of nasopharyngeal angiofibroma or carcinoma		Procedural fees		R -				R -
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx		Procedural fees		R -				R -
17.6.7	**Microsurgery of the skull base: Subtotal petrosectomy**								
5246	Resection of temporal bone: External approach by elevating the auricle with superior flap		Procedural fees	804.40	R 29 349.76	643.52	R 23 479.81	5,00T	R 1 267.31
5247	Petrous apicectomy: Includes radical mastoidectomy through postaural or endaural incision		Procedural fees	505.50	R 18 443.94	404.40	R 14 755.15	5,00T	R 1 267.31
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		Procedural fees	520.00	R 18 972.99	416.00	R 15 178.39	11,00T	R 2 788.09
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland		Procedural fees	600.00	R 21 891.91	480.00	R 17 513.53	8,00T	R 2 027.70
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland		Procedural fees	660.00	R 24 081.10	528.00	R 19 264.88	8,00T	R 2 027.70
18.	**Physical Treatment**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
	Specialists in physicial medicine (PR 34) Physical treatment: General information For medical doctors, not qualified in physical medicine (34), refer to notes included in the descriptions of the items.								
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)	+	Consultation fees	0.75	R 57.44		R -		R -
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)		Consultation fees	13.50	R 1 033.92		R -		R -
3281	Ultrasonic therapy		Procedural fees	10.00	R 364.87				R -
3282	Shortwave diathermy		Procedural fees	10.00	R 364.87				R -
3284	Sensory nerve conduction studies (Other specialists/General practitioners use item 0735)		Procedural fees	31.00	R 1 131.08				R -
3285	Motor nerve conduction studies (Other specialists/General practitioners use item 0733)		Procedural fees	26.00	R 948.65				R -
3287	Spinal joint and ligament injection		Procedural fees	20.00	R 729.73	20.00	R 729.73		R -
3288	Epidural injection (Other specialists/General practitioners use item 2801)		Procedural fees	36.00	R 1 313.51				R -
3289	Multiple injections: First joint (Other specialists/General practitioners use to item 0663)		Procedural fees	7.50	R 273.65				R -

3290	Multiple injections: Each additional joint (Other specialists/General practitioners use item 0665)	+	Procedural fees	4.50	R 164.19				R -
3291	Tendon or ligament injection (Other specialists/General practitioners use item 0763)		Procedural fees	9.00	R 328.38				R -
3292	Aspiration of joint or inter-articular injection (Other specialists/General practitioners use item 0661)		Procedural fees	9.00	R 328.38				R -
3293	Aspiration or injection of bursa or ganglion (Other specialists/General practitioners use item 0851)		Procedural fees	9.00	R 328.38				R -
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389) (Other specialists/General practitioners use item 2800)		Procedural fees	20.00	R 729.73				R -
3295	Paravertebral root block: Unilateral (Other specialists/General practitioners use item 2800)		Procedural fees	20.00	R 729.73				R -
3296	Paravertebral root block: Bilateral (Other specialists/General practitioners use item 2800)		Procedural fees	30.00	R 1 094.60				R -
3297	Manipulation of spine performed by a specialist in Physical Medicine (Pr "034")		Procedural fees	14.00	R 510.81				R -
3298	Spinal traction		Procedural fees	6.00	R 218.92				R -
3299	Manipulation of large joints: Under general anaesthesia (Other specialists/General practitioners use to item 0669) - Anaesthetic: Knee/Shoulder		Procedural fees	14.00	R 510.81			3,00T	R 760.39
3299a	Manipulation of large joints: Under general anaesthesia (Other specialists/General practitioners use to item 0669) - Anaesthetic: Hip		Anaesthetic		R -			4,00T	R 1 013.85
3300	Manipulation of large joints: Without anaesthetic (Other specialists/General practitioners use item 0670)		Procedural fees	*	RCF Missing				R -
3301	Muscle fatigue studies (Other specialists/General practitioners use item 0740)		Procedural fees	20.00	R 729.73				R -
3302	Strength duration curve per session (Other specialists/General practitioners use item 0715)		Procedural fees	10.50	R 383.11				R -
3303	Electromyography (Other specialists/General practitioners use item 0713)		Procedural fees	75.00	R 2 736.49				R -
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)		Procedural fees	10.00	R 364.87	10.00	R 364.87		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
19. Radiology:									
	Applicable to non-radiologists and general practitioners only (refer to Radiology 5 digit code structure for specialist radiologists and nuclear medicine physicians)								
19.1	**Vascular Studies**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
	Please note: Modifier 0083 is not applicable to Section 19.8: Vascular studies and Section 19.14: Interventional radiological procedures								

	Rules applicable to Section 19.8: Vascular studies and section 19.14: Interventional radiological procedures: a. The Technical Component (TC) of items 3536-3550 includes the cost of the following:i. All runs ii. All film costs (modifier 0084 is not applicable) iii. All fluoroscopy (item 3601 does not apply) iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media, anaesthetic consumables and drugs) b. The Technical Component (TC) for items 3526-3550 may only be once per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will use their respective full units as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologist and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 apply.								
	Note: In the case of selective catheterisation of a branch of the aorta, the professional component for catheterisation of the aorta is included								
3545	Venography: Per limb		Radiology	27.50	R 753.50	16.50	R 452.10		
3551	Lymphangiogram per limb (global code) including lymphatic catheterisation (includes equipment)		Radiology	278.00	R 7 617.20	166.80	R 4 570.32		
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram		Radiology	81.00	R 2 219.40	48.60	R 1 331.64	4,00T	R 1 013.85
3558	Translumbar aortic puncture, with full study		Radiology	116.00	R 3 178.40	69.60	R 1 907.04	5,00T	R 1 267.31
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram		Radiology	95.00	R 2 603.00	57.00	R 1 561.80	4,00T	R 1 013.85
3560	Selective second order catheterisation, arterial or venous, with angiogram/venogram		Radiology	109.00	R 2 986.60	65.40	R 1 791.96	4,00T	R 1 013.85
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram		Radiology	122.00	R 3 342.80	73.20	R 2 005.68	4,00T	R 1 013.85
3564	Direct femoral, arterial, venous or jugular venous puncture. Not to be used with catheterisation procedures - stand alone procedure		Radiology	62.00	R 1 698.80	37.20	R 1 019.28		
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or arteriovenous malformation (AVM)		Radiology	143.00	R 3 918.20	85.80	R 2 350.92	5,00T	R 1 267.31
3569	Intravascular pressure studies, arterial or venous, once-off per case		Radiology	33.00	R 904.20	19.80	R 542.52		
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)		Radiology	218.00	R 5 973.20	130.80	R 3 583.92	5,00T	R 1 267.31
3572	Transcatheter selective blood sampling, arterial or venous		Radiology	54.00	R 1 479.60	32.40	R 887.76		
3574	Spinal angiogram (global code) including all selective catheterisations		Radiology	800.00	R 21 920.00	480.00	R 13 152.00	5,00T	R 1 267.31
	Vascular studies: Introduction of contrast medium		Radiology				R -		
3563	Direct intravenous for limb: ADD		Radiology	11.10	R 304.14	7.40	R 202.76		
3575	Cut-downs for venography: ADD		Radiology	16.55	R 453.47	11.00	R 301.40		

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
19.2	Tomography and cinematography: Computed Tomography	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
6403	CT limb without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6404	CT limb with contrast only		Anaesthetic		R -			5,00T	R 1 267.31
6405	CT limb pre- AND post contrast		Anaesthetic		R -			5,00T	R 1 267.31
6406	CT joint without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6407	CT joint with contrast only		Anaesthetic		R -			5,00T	R 1 267.31
6408	CT joint pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6409	CT brain without contrast (including posterior fossa)		Anaesthetic		R -			5,00T	R 1 267.31
6410	CT brain with contrast only (including posterior fossa)		Anaesthetic		R -			5,00T	R 1 267.31
6411	CT brain pre- AND post-contrast (including posterior fossa)		Anaesthetic		R -			5,00T	R 1 267.31
6412	CT orbits complete study, axial OR coronal, without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6413	CT orbits complete study, axial AND coronal, without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6414	CT orbits complete study, axial OR coronal pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6415	CT orbits complete study, axial AND coronal pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6416	CT paranasal sinuses limited study axial OR coronal		Anaesthetic		R -			5,00T	R 1 267.31
6417	CT paranasal sinuses limited study axial AND coronal		Anaesthetic		R -			5,00T	R 1 267.31
6418	CT paranasal sinuses complete study, axial or coronal, without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6419	CT paranasal sinuses complete study, axial AND coronal, without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6420	CT paranasal sinuses complete study, axial OR coronal, pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6421	CT paranasal sinuses complete study, axial AND coronal, pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31

6422	CT pituitary fossa, without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6423	CT pituitary fossa, pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6424	CT internal auditory meati, without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6425	CT internal auditory meati, pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6426	CT mastoids		Anaesthetic		R -			5,00T	R 267.31 1
6427	CT ear structures, limited study		Anaesthetic		R -			5,00T	R 267.31 1
6428	CT middle AND inner ear, complete study including reconstructions		Anaesthetic		R -			5,00T	R 267.31 1
6429	CT facial bones		Anaesthetic		R -			5,00T	R 267.31 1
6430	CT neck soft tissue, without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6431	CT neck soft tissue with contrast only		Anaesthetic		R -			5,00T	R 267.31 1
6432	CT neck pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6433	CT cervical spine without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6434	CT cervical spine pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6435	CT cervical spine post-myelogram		Anaesthetic		R -			5,00T	R 267.31 1
6436	CT dorsal spine without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6437	CT dorsal spine pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6438	CT dorsal spine post-myelogram		Anaesthetic		R -			5,00T	R 267.31 1
6439	CT lumbar spine without contrast		Anaesthetic		R -			5,00T	R 267.31 1
6440	CT lumbar spine pre- AND post-contrast		Anaesthetic		R -			5,00T	R 267.31 1
6441	CT lumbar spine post-myelogram		Anaesthetic		R -			5,00T	R 267.31 1
6442	CT pelvimetry (topogram only)		Anaesthetic		R -			5,00T	R 267.31 1
6443	CT chest without contrast		Anaesthetic		R -			5,00T	R 267.31 1

6444	CT chest with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6445	CT chest pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6446	CT chest high resolution lungs, limited study		Anaesthetic		R -			5,00T	R 1 267.31
6447	CT high resolution lungs, complete study		Anaesthetic		R -			5,00T	R 1 267.31
6448	CT abdomen without contrast		Anaesthetic		R -			5,00T	R 1 267.31

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
6449	CT abdomen with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6451	CT abdomen triphasic study		Anaesthetic		R -			5,00T	R 1 267.31
6452	CT pelvis without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6453	CT pelvis with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6454	CT pelvis pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6455	CT abdomen AND pelvis without contrast		Anaesthetic		R -			5,00T	R 1 267.31
6456	CT abdomen AND pelvis with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6457	CT abdomen AND pelvis pre- AND post-contrast		Anaesthetic		R -			5,00T	R 1 267.31
6458	CT chest, abdomen AND pelvis with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6459	CT base of skull to symphysis pubis with contrast		Anaesthetic		R -			5,00T	R 1 267.31
6460	CT for dental implants maxilla OR mandible		Anaesthetic		R -			5,00T	R 1 267.31
6461	CT for dental implants maxilla AND mandible		Anaesthetic		R -			5,00T	R 1 267.31
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)		Anaesthetic		R -			5,00T	R 1 267.31
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)		Anaesthetic		R -			5,00T	R 1 267.31
6464	CT limited study, any region. Region to be identified on the account		Anaesthetic		R -			5,00T	R 1 267.31

6465	CT guidance for aspiration, biopsy or drainage		Anaesthetic		R -			11,00T	R 2 788.09
6467	CT stereotactic localisation for biopsy		Anaesthetic		R -			11,00T	R 2 788.09
19,3	**Radiology: Miscellaneous**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**Other Specialists/ General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445 and 3447)		Radiology			7.70	R 210.98		R -
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD		Radiology			10.70	R 293.18		R -
3603	Sinography		Radiology			18.40	R 504.16		R -
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except item 3309): Per half hour: Plus units for examination performed (Only to be used by radiological technical staff)		Radiology			5.60	R 153.44		R -
3609	Foreign body localisation: Units for part examined plus two-thirds for every additional series and add fluoroscopy units if this is done		Radiology				R -		R -
3611	Foreign body localisation: Introduction of sterile needle markers: ADD		Radiology			11.00	R 301.40		R -
3613	Setting of sterile trays		Radiology			3.30	R 90.42		R -
5034	Fine needle aspiration or biopsy or core biopsy of mamma		Radiology			25.00	R 685.00		R -
5027	Downloading and perusal of digital radiological images		Radiology			17.65	R 483.61		R -
19,4	**Ultrasound Investigations**	**Add-on Codes**	**RCF Type**	**Specialist Units**	**Specialist Value**	**Other Specialists/ General Practitioners Units**	**General Practitioners Value**	**Anaesthesia administered Units**	**Anaesthesia administered Value**
5100	Pelvic organs ultrasound: Transvaginal or transrectal probe		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3619	Intravascular ultrasound imaging assesses the atherosclerotic process to guide the placement of an intracoronary stent. This item may be applied once per vessel (left anterior descending territory, circumflex territory and/or right coronary territory) in which a stent or multiple stents are deployed		Radiology Ultrasound	30.00	R 552.90	30.00	R 552.90		R -
3596	Intravascular ultrasound per case, arterial or venous, for intervention		Radiology Ultrasound	30.00	R 552.90	30.00	R 552.90		R -
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure		Radiology Ultrasound	88.00	R 1 621.84	88.00	R 1 621.84		R -
5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery [LAD (left anterior descending), circumflex or right coronary artery]. May be used a maximum of twice per angiographic procedure		Radiology Ultrasound	44.00	R 810.92	44.00	R 810.92		R -
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy		Radiology Ultrasound	128.00	R 2 359.04	120.00	R 2 211.60		R -
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with items 5110, 5112, 5113 or 5114)		Radiology Ultrasound	206.00	R 3 796.58	164.80	R 3 037.26		R -
5112	Peripheral arterial ultrasound vascular study: B mode, pulsed and colour Doppler; per limb; to include waveforms at a minimum of three levels, pressure studies at two levels and full interpretation of results		Radiology Ultrasound	117.00	R 2 156.31	117.00	R 2 156.31		R -

5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis		Radiology Ultrasound	117.00	R 2 156.31	117.00	R 2 156.31		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally		Radiology Ultrasound	178.00	R 3 280.54	142.40	R 2 624.43		R -
3634	Peripheral vascular study, B mode only		Radiology Ultrasound	39.00	R 718.77	39.00	R 718.77		R -
3620	Cardiac examination plus Colour Flow mapping		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3621	Cardiac examination (MMode)		Radiology Ultrasound	25.00	R 460.75	25.00	R 460.75		R -
3622	Cardiac examination: 2 Dimensional		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3623	Cardiac examination + effort: ADD		Radiology Ultrasound	10.00	R 184.30	10.00	R 184.30		R -
3624	Cardiac examinations + contrast: ADD		Radiology Ultrasound	10.00	R 184.30	10.00	R 184.30		R -
3625	Cardiac examinations + doppler		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3626	Cardiac examination + phonocardiography: ADD		Radiology Ultrasound	10.00	R 184.30	10.00	R 184.30		R -
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)		Radiology Ultrasound	60.00	R 1 105.80	60.00	R 1 105.80		R -
3628	Renal tract		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
5101	Pleural space ultrasound		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
5103	Ultrasound soft tissue, any region		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3631	Ophthalmic examination		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3632	Axial length measurement and calculation of intra-ocular lens power. Per eye. Not to be used with item 3034		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3633	Neonatal head scan		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
3635	Plus (+) doppler		Radiology Ultrasound	39.00	R 718.77	39.00	R 718.77		R -

3636	Trans-oesophageal echocardiography including passing the device		Radiology Ultrasound	100.00	R 1 843.00	100.00	R 1 843.00		R -
3637	Plus (+) colour doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)		Radiology Ultrasound	78.00	R 1 437.54	78.00	R 1 437.54		R -
5115	Intra-operative ultrasound study		Radiology Ultrasound	50.00	R 921.50	50.00	R 921.50		R -
5017	Endoscopic ultrasound: Colon		Radiology Ultrasound	79.90	R 1 472.56	79.90	R 1 472.56		R -
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy		Radiology Ultrasound	100.70	R 1 855.90	100.70	R 1 855.90		R -
5021	Proctosigmoidoscopy with endoscopic ultrasound examination		Radiology Ultrasound	41.90	R 772.22	41.90	R 772.22		R -
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy		Radiology Ultrasound	64.10	R 1 181.36	64.10	R 1 181.36		R -
5024	Endoscopic ultrasound: Oesophagus		Radiology Ultrasound	50.90	R 938.09	50.90	R 938.09		R -
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy		Radiology Ultrasound	70.20	R 1 293.79	70.20	R 1 293.79		R -
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate		Radiology Ultrasound	81.40	R 1 500.20	81.40	R 1 500.20		R -
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy		Radiology Ultrasound	113.80	R 2 097.33	113.80	R 2 097.33		R -

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
	Interventional radiological procedures	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
	Please note: Modifier 0083 is not applicable to Section 19.8: Vascular studies and Section 19.14: Interventional radiological procedures								
	Rules applicable to Section 19.8: Vascular studies and section 19.14: Interventional radiological procedures: a. The Technical Component (TC) of items 3536-3550 includes the cost of the following:i. All runs ii. All film costs (modifier 0084 is not applicable) iii. All fluoroscopy (item 3601 does not apply) iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media, anaesthetic consumables and drugs) b. The Technical Component (TC) for items 3526-3550 may only be once per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will use their respective full units as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologist and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 apply.								
5002	Percutaneous transluminal angioplasty: Aortic/IVC		Radiology	171.00	R 4 685.40	102.60	R 2 811.24	13,00T	R 3 295.02
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel or subclavian vessel		Radiology	171.00	R 4 685.40	102.60	R 2 811.24	13,00T	R 3 295.02

5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial		Radiology	171.00	R 685.40	4	102.60	R 811.24	2	13,00T	R 295.02	3
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral – stand alone procedure		Radiology	287.00	R 863.80	7	172.20	R 718.28	4	13,00T	R 295.02	3
5014	Atherectomy (per vessel)		Radiology	341.00	R 343.40	9	204.60	R 606.04	5			
5016	Aspiration thrombectomy (per vessel)		Radiology	219.00	R 000.60	6	131.40	R 600.36	3			
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite		Radiology	178.00	R 877.20	4	106.80	R 926.32	2	5,00T	R 267.31	1
5022	Embolisation non-intracranial, per vessel		Radiology	178.00	R 877.20	4	106.80	R 926.32	2	9,00T	R 281.17	2
5030	Percutaneous nephrostomy for further procedure or drainage		Radiology	123.00	R 370.20	3	73.80	R 022.12	2	6,00T	R 520.78	1
5031	Antegrade ureteric stent insertion		Radiology	116.00	R 178.40	3	69.60	R 907.04	1	6,00T	R 520.78	1
5033	Percutaneous cystostomy in radiology suite		Radiology	50.00	R 370.00	1	30.00	R 822.00				
5035	Urethral balloon dilatation in radiology suite		Radiology	38.00	R 041.20	1	22.80	R 624.72				
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality		Radiology	57.00	R 561.80	1	34.20	R 937.08				
5037	Urethral stenting in radiology suite		Radiology	171.00	R 685.40	4	102.60	R 811.24	2			
5038	Intracranial/spinal AVM embolisation (per session)		Radiology	559.00	R 316.60	15	335.40	R 189.96	9	13,00T	R 295.02	3
5039	Intracranial thrombolysis (on-table) per session		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3
5040	Intracranial aneurysm occlusion		Radiology	478.00	R 097.20	13	286.80	R 858.32	7	13,00T	R 295.02	3
5041	Balloon occlusion/Wada test		Radiology	178.00	R 877.20	4	106.80	R 926.32	2	9,00T	R 281.17	2
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation		Radiology	478.00	R 097.20	13	286.80	R 858.32	7	13,00T	R 295.02	3
5043	Intracranial angioplasty		Radiology	341.00	R 343.40	9	204.60	R 606.04	5	13,00T	R 295.02	3
5044	Transhepatic portogram		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	9,00T	R 281.17	2
5045	Hepatic arterial infusion catheter insertion		Radiology	260.00	R 124.00	7	156.00	R 274.40	4	6,00T	R 520.78	1

5046	Percutaneous biliary drainage (external)		Radiology	171.00	R 685.40	4	102.60	R 811.24	2	9,00T	R 281.17	2
5047	Combined internal/external biliary drainage		Radiology	171.00	R 685.40	4	102.60	R 811.24	2	9,00T	R 281.17	2
5048	Biliary stent insertion		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	9,00T	R 281.17	2
5049	Percutaneous gall bladder drainage		Radiology	116.00	R 178.40	3	69.60	R 907.04	1	9,00T	R 281.17	2
5050	Percutaneous or renal gall bladder stone removal		Radiology	287.00	R 863.80	7	172.20	R 718.28	4	5,00T	R 267.31	1
5058	Stent insertion: Aortic/IVC – including percutaneous transluminal angioplasty (PTA), including the use of a drug eluting balloon (DEB)		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3
5060	Stent insertion: Iliac/subclavian/AV fistula – including percutaneous transluminal angioplasty (PTA), including the use of a drug eluting balloon (DEB)		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial – including percutaneous transluminal angioplasty (PTA), including the use of a drug eluting balloon (DEB)		Radiology	232.00	R 356.80	6	139.20	R 814.08	3	13,00T	R 295.02	3

Code	Description	Add-on Codes	RCF Type	Specialist Units	Specialist Value	General Practitioners Units	General Practitioners Value	Anaesthesia administered Units	Anaesthesia administered Value
5064	Stent insertion: Sub-popliteal – including percutaneous transluminal angioplasty (PTA), including the use of a drug eluting balloon (DEB)		Radiology	287.00	R 863.80 7	172.20	R 718.28 4	13,00T	R 295.02 3
5066	Stent insertion: Renal/visceral/brachiocephalic – including percutaneous transluminal angioplasty (PTA), including the use of a drug eluting balloon (DEB)		Radiology	341.00	R 343.40 9	204.60	R 606.04 5	13,00T	R 295.02 3
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure, including the use of a drug eluting balloon (DEB)		Radiology	341.00	R 343.40 9	204.60	R 606.04 5	13,00T	R 295.02 3
5070	Stent insertion: Aorto-iliac stent graft - including percutaneous transluminal angioplasty (PTA)		Radiology	519.00	R 220.60 14	311.40	R 532.36 8	13,00T	R 295.02 3
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite		Radiology	137.00	R 753.80 3	82.20	R 252.28 2	5,00T	R 267.31 1
5074	IVC filter insertion jugular or femoral route		Radiology	260.00	R 124.00 7	156.00	R 274.40 4	9,00T	R 281.17 2
5076	Intravascular foreign body removal, arterial or venous, any route		Radiology	341.00	R 343.40 9	204.60	R 606.04 5	9,00T	R 281.17 2
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)		Radiology	117.00	R 205.80 3	70.20	R 923.48 1	5,00T	R 267.31 1
5080	Transjugular intrahepatic porto-systemic shunt		Radiology	559.00	R 316.60 15	335.40	R 189.96 9	13,00T	R 295.02 3
5082	Transjugular liver biopsy		Radiology	116.00	R 178.40 3	69.60	R 907.04 1	9,00T	R 281.17 2
5084	Endoluminal fallopian tube recanalisation		Radiology	287.00	R 863.80 7	172.20	R 718.28 4	6,00T	R 520.78 1
5086	Renal cyst aspiration/ablation		Radiology	38.00	R 041.20 1	22.80	R 624.72		

5088	Oesophageal stent insertion in radiology suite		Radiology	171.00	R 4 685.40	102.60	R 2 811.24	6,00T	R 1 520.78
5090	Tracheal stent insertion		Radiology	171.00	R 4 685.40	102.60	R 2 811.24	6,00T	R 1 520.78
5091	GIT balloon dilatation under fluoroscopy		Radiology	111.00	R 3 041.40	66.60	R 1 824.84	6,00T	R 1 520.78
5092	Other GIT stent insertion		Radiology	171.00	R 4 685.40	102.60	R 2 811.24	6,00T	R 1 520.78
5093	Percutaneous gastrostomy in radiology suite		Radiology	143.00	R 3 918.20	85.80	R 2 350.92		
5094	Cutting needle biopsy with image guidance		Radiology	38.00	R 1 041.20	22.80	R 624.72		
5095	Chest drain insertion in radiology suite		Radiology	54.00	R 1 479.60	32.40	R 887.76		
5096	Percutaneous cyst or tumour ablation (non-aspiration)		Radiology	91.00	R 2 493.40	54.60	R 1 496.04		
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level		Radiology	117.00	R 3 205.80		R -	13,00T	R 3 295.02

MENTAL HEALTH CARE FACILITIES (PR 055)

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 CCSA 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 CCSA 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.

Code	Description	Value
4	General ward fee: with overnight stay	R 1 994.47
5	General ward fee: without overnight stay	R 1 467.06
6	General ward fee: under 5 hours stay	R 759.54
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)	R 996.82
231	Monitors	R 291.95
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.	0

Road Accident Fund Tariff

OCCUPATIONAL AND ART THERAPY (PR 066 & PR 067)

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

006	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 hoursthe 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.
008	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.
009	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS
	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.
0010	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS
	Modifier 0010 must be quoted after the appropriate code numbers to show that this rule is applicable.
0011	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.
0013	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
0006	Add 50% of the total fee for the procedure. Modifier 0006 does not apply to art therapy.
0008	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.
0009	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.
00010	Materials used in treatment to be charged (exclusive of VAT) at net acquisition price plus -

Road Accident Fund Tariff

	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS
00011	Travelling costs according to AA rates.
21	Services rendered to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.

Code:	Description:	PR 066	PR 067
1	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**	**Value:**	**Value:**
108	Interview, guidance or consultation: 30 minute duration.	R 390.85	R 213.59
109	Interview, guidance or consultation. Each additional 15 mins. A maximum of four instances of this code may be charged per session.	R 195.34	R 106.72
	Time based items in this section exclude time spent on procedures charged in addition to the consultation		
110	Reports. To be used to motivate for therapy and/or give a progress report and/or a preauthorisation report, where such a report is specifically required	R 309.74	R 222.61
501	Treatment in nursing home or other health care facilities. Relevant fee plus (once per day)	R 132.90	
503	Domicillary treatments: Relevant fee plus	R 265.70	
2	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT.**		
201	Observation and screening.	R 137.99	R 100.55
203	Specific evaluation for a single aspect of dysfunction (Specify which aspect).	R 137.99	R 100.55
205	Specific evaluation of dysfunction involving one part of the body for a specific functional problem (Specify part and aspects evaluated)	R 413.83	R 301.50
207	Specific evaluation for dysfunction involving the whole body (Specify condition and which aspects evaluated).	R 827.66	R 603.15
209	Specific in depth evaluation of certain functions affecting the total person (Specify the aspects assessed).	R 1 379.50	R 1 004.89
211	Comprehensive in depth evaluation of the total person (Specify aspects assessed)	R 1 931.80	R 1 406.78
	Measurement for designing.		
213	A static orthosis.	R 137.99	
215	A dynamic orthosis.	R 137.99	
217	A pressure garment for one limb.	R 137.99	
219	A pressure garment for one hand.	R 137.99	
221	A pressure garment for the trunk.	R 137.99	
223	A pressure garment for the face (chin strap only).	R 137.99	
225	A pressure garment for the face (full face mask).	R 137.99	
	The whole body or part thereof will be the sum total of the parts		
227	Specific built-in musical aids		R 100.55
3	**PROCEDURES OF THERAPY.**		
301	Group treatment in a task-centered activity, per patient (Treatment time 60 minutes or more).	R 183.94	R 142.92

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)	R 276.15	R 100.55
305	Groups directed to achieve common aims, per patient) (Treatment time 60 minutes or more).	R 367.88	R 266.71
307	Simultaneous treatment with two to four patients, each with specific problems, utilising individual activities, per patient (Treatment time 60 minutes or more)	R 367.88	R 201.26
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)	R 551.83	R 301.50
	Individual and undivided attention during treatment sessions utilising specific activity and/or techniques in an integrated treatment session		
309	On level one (15 minutes).	R 183.94	R 161.89
311	On level two (30 minutes).	R 367.88	R 323.48
313	On level three (45 minutes).	R 551.83	R 485.05
315	On level four (60 minutes).	R 735.77	R 646.47

Code:	Description:	PR 066	PR 067
317	On level five (90 minutes).	R 919.88	R 808.21
319	On level six (120 minutes).	R 1 103.65	R 969.95
4	**PROCEDURES REQUIRED TO PROMOTE TREATMENT.**		
401	Recommendations with regards to assistive devices, environmental adaptations, alternative/compensatory methods, handling the patient	R 276.15	R 161.89
	Designing and constructing a custom-made adaptation, assistive device, splint or simple pressure garment for treatment in a taskcentered activity (specify the adaptation, assistive device, splint or simple pressure garment)		
403	On level one.	R 183.94	R 161.89
405	On level two.	R 367.88	R 323.48
407	On level three.	R 551.83	R 485.05
409	On level four.	R 735.77	R 646.47
411	On level five.	R 919.88	R 808.21
413	On level six.	R 1 103.65	R 969.95
415	Designing and constructing a static orthosis.	R 1 103.65	R 969.95
417	Designing and constructing a dynamic orthosis.	R 2 207.15	
	Designing and constructing pressure garment for:		
419	Limb.	R 1 103.65	
421	Face (chin strap only).	R 827.66	
423	Face (full face mask).	R 1 103.65	
425	Trunk.	R 1 655.80	
427	Hand.	R 1 655.80	
	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.	R 1 655.80	R 1 206.15
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		

Code:	Description:	PR 066	PR 067
	Annexure A		
	Numbers and names of splints to be used with modifier 0009		
701	Static finger extension/flexion splint		
702	Dynamic finger extension/flexion		
703	Buddy strap		
704	DIP/PIP flexion strap		
705	MP, PIP, DIP flexion strap		
706	Hand based static finger extension/flexion		
707	Hand based static thumb extension/flexion/opposition/ abduction		
708	Hand based dynamic finger flexion/extension		
709	Hand based dynamic thumb flexion/extension/opposition/abduction		
710	Static wrist extension/flexion		
711	Dynamic wrist extension/flexion		
712	Flexion glove		
713	Forearm based dynamic finger flexion/extension		
714	Forearm based dorsal protection		
715	Forearm based volar resting		
716	Static elbow extension/flexion		
717	Dynamic elbow flexion/extension splint		
718	Shoulder abduction splint		
719	Static rigid neck splint		
720	Static soft neck splint/brace		
721	Static knee extension		
722	Static foot dorsiflexion		
	Annexure B		

	Numbers and names of pressure garments to be used with modifier 0009		
801	Glove to wrist		
802	Glove to elbow		
803	Gauntlet (Glove with palm and thumb only)		
804	Sleeve: Upper/forearm		
805	Sleeve: full		
806	Vest + sleeves		
807	Sleeveless vest		
808	Upper leg		
809	Lower leg		
810	Full leg		
811	Pants (trunk and full legs)		
812	Briefs		
813	Anklet		
814	Knee length stocking		
815	Chin strap		
816	Full face mask		
817	Neck only		
818	Finger sock		

Code:	Description:	PR 066	PR 067
	Annexure C		
	List of materials used in treatment under modifier 0010		
901	Therapeutic putty		
902	Wood, leather, sisal		
903	Sponge		
904	Elastonet		
905	Silicon gel sheeting		
	Annexure D		
	Assistive devices made by the therapist her/himself to be used with modifier 0008		
1001	Hip abduction cushion		

1002	Sponge on a stick		
1003	Hand grips (for utensils)		
1004	Bath bench		
1005	Bath seat		
1006	Transfer board		
1007	Plate surround		
1008	Wheelchair strap		

Road Accident Fund Tariff

OPTOMETRY (PR 70)			
Code:	**Description:**		**Value:**
11001	Optometric Examination		R 655.29
11021	Optometric Re-Examination within six months of 11001/11081		R 436.27
11041	Consultation :15 min. without performing Optometric Examination		R 326.89
11081	Optometric Examination & Visual Fields		R 763.03
11141	Evaluation of Refractive Status		R 436.27
11161	Screening for Pathology		R 326.89
11171	Ocular Pathology Examination Follow up		R 310.97
11183	Keratometry		R 218.89
11202	Tonometry (Non-contact)		R 218.89
11212	Tonometry (Aplanation)		R 218.89
11221	Colour Vision Screening		R 218.89
11246	Colour Vision Evaluation		R 109.51
11265	Evaluation of Contrast Sensitivity		R 326.89
11283	Evaluation of Lacrimal System		R 218.89
11303	Cycloplegic Refraction		R 326.89
11323	Preferential Looking (Infants < Two Years)		R 326.89
11346	Corneal Topography		R 218.89
11356	Gonioscopy		R 218.89
11366	Dilated Fundus Examination / BIO		R 218.89
11402	Visual Field - Screening		R 218.89
11423	Visual Field- evaluation		R 326.89
11443	Threshold Visual Fields		R 545.78
11501	Dispensing Fee - Single Vision		R 109.51
11521	Dispensing Fee - Bifocals		R 218.89
11541	Dispensing Fee - Varifocals		R 326.89
11604	Photography of Anterior Segment		R 218.89
11624	Photography of Fundus		R 218.89
11702	Pachymetry		R 218.89

11707	After Hours or Away from Practice Visit		
11729	Appointment not kept		
11802	Optical Coherence Tomography (OCT)		R 545.78
11809	Screening School (per hour)		
11829	Screening Industrial (per hour)		
11902	Visual Evoked Potentials (VEP) - Unilatera		R 417.84
11904	Visual Evoked Potentials (VEP) - Bilateral		R 763.03
12012	C Lens Consultation Basic - per 30 minutes		R 655.29
12032	C Lens Consultation Complex - per 30 minutes		R 872.29
12052	C Lens Consultation Advanced - per 30 minutes		R 1 091.44
12062	C Lens Consultation - Therapeutic - per 30 minutes		R 1 091.44
12072	C Lens Dispensing and/or Assessment		R 326.89
12112	C Lens follow-up Examination/Basic Case - per 30 minutes		R 326.89
12132	C Lens follow-up Examination/Complex Case - per 30 minutes		R 545.78
12152	C Lens follow-up Examination/Advanced Case - per 30 minutes		R 655.29
12162	C Lens Follow-up Therapeutic - per 30 minutes		R 655.29

Road Accident Fund Tariff

12503	C Lens Related Problems Assessment - Monocular		R 218.89
12523	C Lens Related Problems Assessment- Binocular		R 326.89
12533	C Lens Instruction		R 326.89
13003	Binocular Instability Evaluation - Simple Case		R 655.29
13023	Binocular Instability Evaluation - Complex Case		
13105	Visually Related Learning Disorders Evaluation		
13125	Eye Movements Evaluation (E.G. Visigraph)		R 655.29
13403	Vision Training - Home Therapy Instruction		R 218.89
13423	Vision Training - Individual (per 15 minutes)		R 326.89
13445	Vision Training - Individual (per 30 minutes)		R 655.29
13463	Vision Training - Group per Patient (per 15 minutes)		R 82.86
13509	Reading Rate- screening		R 326.89
13529	Reading Ortho-Didactical skills evaluation		R 981.93
13549	Colorimetry Intuitive - evaluation		R 1 308.81
14008	Sports Vision Individual Screening		R 436.27

14218	Sports Vision Individual Evaluation		R 981.93
14238	Sports Vision Individual Training (per 15 minutes)		R 326.89
14268	Sports Vision Group Screening		R 82.86
14278	Sports Vision Group Evaluation		R 192.37
14288	Sports Vision Group Training (per 15 minutes)		R 82.86
15000	Removal of Foreign Body External Eye Conjunctiva		R 310.97
15002	Removal of Foreign Body Embedded Conjunctival/Scleral Nonperforating		R 414.42
15004	Removal of Foreign Body Corneal with Slit Lamp		R 518.12
15006	Conjunctiva Cyst– Incision and Drainage		R 518.12
15008	Incision of Conjunctiva; Drainage of Cyst		R 518.12
15010	Expression Conjunctival Follicles/Trachoma		R 518.12
15012	Lacrimal System - Repair		R 518.12
15014	Closure of Lacrimal Punctum by Plug		R 518.12
16013	Low Vision Assessment per 30 mins		R 655.29
16023	Low Vision Rehabilitation per 30 mins		R 655.29
16073	Low Vision Training per 30 mins		R 655.29
19001	Report at request of Medical Aid.		R 326.89
19021	Report at Patient's request (arising from Series 11001)		R 545.78
23801	OTC Eyedrops		
23907	Contact Lens Solutions		
23919	Contact Lens Accessories		
24022	Hard Contact Lens		
24024	Rigid Scleral Contact lens		
24202	Bifocal Hard Lens		
25412	Fenestration Hard Lens (per hole)		
25512	Truncation Hard Lens		
26012	Laboratory Service / Modification / Polish		
26115	Analysis of Hard Lens		

ORAL HYGIENISTS (PR 113)

GENERAL RULES

Reimbursement for the tariff codes for procedures performed within the scope of practice for oral hygienist will be subject to Fund rules and regulations.		
Funding for these tariff codes is subject to the Fund protocols and billing rules		
Code:	**Description:**	**Value:**
8154	Oral examination	R142.60
8164	Limited oral examination	R111.30
8106	Special report	R0.00
8107	Intraoral radiograph - periapical	R111.60
8108	Intraoral radiographs - complete series	R862.80
8109	Infection control/barrier techniques	R24.70
8110	Sterilized instrumentation	R63.60
8111	Dental testimony	R0.00
8112	Intraoral radiograph - bitewing	R111.60
8113	Intraoral radiograph - occlusal	R127.90
8115	Extraoral radiograph - panoramic	R445.50
8116	Extraoral radiograph - cephalometric	R0.00
8117	Diagnostic models	R88.70
8119	Diagnostic models mounted	R223.20
8120	Treatment plan completed	R0.00
8121	Oral and/or facial image (digital/conventional)	R114.90
8124	Pulp Tests	R0.00
8125	Pulp Tests - more than 3 teeth	R0.00
8129	Office/hospital visit – after regularly scheduled hours	R0.00
8131	Emergency dental treatment	R0.00
8139	Appointment not kept /30min	R0.00
8140	House/extended care facility/hospital call	R226.60
8145	Local anaesthetic - per visit	R107.50
8151	Oral hygiene instruction (not to be billed together with 8153)	R0.00
8153	Oral hygiene instruction - each additional visit (not to be billed together with 8151)	R0.00
8155	Polishing - complete dentition	R136.90
8159	Prophylaxis - complete dentition	R249.60
8160	Removal of gross calculus	R0.00
8163	Dental sealant	R101.50
8165	Sedative filling Placement of temporary filling	R0.00
8166	Application of desensitising resin, per tooth	R94.20
8167	Application of desensitising medicament, per visit	R109.80
8169	Occlusal guard	R0.00
8171	Mouth guard	R145.60
8222	Temporary re cementation of crown/bridge	R0.00
8223	Temporary re cementation of inlay/onlay	R0.00
8228	ART restorations	R292.30
8265	Tissues conditioning per arch (including soft self-cure reline)	R196.00

8273	Impression to repair or modify a denture or other intra-oral appliance	R0.00

Road Accident Fund Tariff

8278	Modification of surgical conformer.	R0.00
8304	Rubber dam per arch	R98.00
8327	Internal bleaching - each additional visit	R0.00
8590	Implant maintenance procedures - per implant	R0.00
8722	Cost of provisional splinting materials. See Rule 002 Appendix A.	R0.00
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	R337.40
8727	Provisional; splinting - intra coronal - per tooth	R0.00
8733	Periodontal packs	R0.00
8735	Suture Removal	R0.00

Road Accident Fund Tariff

ORTHOPTISTS (PR 074)

Code	DESCRIPTION	UNITS	VALUE
1	Orthoptic consultation (Ocular motility assessment, comprehensive examination)	10.00	R 296.43
3	Orthoptic treatment (Ocular motility imbalance)	8.70	R 257.89
5	Orthoptic consultation (Hess chart)	11.10	R 329.50
7	Orthoptic visual fields charting or field of binocular single vision	21.70	R 642.89

Road Accident Fund Tariff

ORTHOTICS / PROSTHETICS (PR 087)		
	ORTHOTICS	
Code	**DESCRIPTION**	**VALUE**
	CONSULTATIONS	
10001	Consultation (30 minutes)	R 359.61
10012	Prosthetic consultation casting and measuring (per 60min or part thereof)	R 1 943.97
10160	Consultation (60 minutes)	R 719.23
10071	Prosthetic Repairs (To be charged only once)	R 995.70
10059	Re-adjustment consultation for custom specialised wheelchairs (per 15 minutes or part thereof)	R 313.24
10020	Hospital visit	R 341.71
10030	Theatre attendance	R 1 394.59
10072	Footwear modification repairs per 30 minutes	R 132.70
10073	Surgical footwear repairs per 30 minutes	R 1 253.60
10074	Myo-electric arm repairs per 30 minutes	R 1 284.60
10075	Aesthetic silicone repairs per 30 minutes	R 1 189.67
10009	Additional fee for measuring/fitting hospitalised patient in bed	R 208.82
10021	Hospital visit - no travelling required	R 227.81
10025	House call	R 455.62
10035	After hours fee - per 30 minutes or part thereof	R 341.71
10160	Orthotic Repairs (To be charged once only)	R 995.70
	FOOTWEAR MODIFICATIONS	
10139	Surgical boots made to measure	R 13 212.01
10142	Surgical shoes made to measure	R 11 692.20
10151	C & E Heels	R 825.10
10154	Excavate heels	R 559.70
10157	Flared heels	R 559.70
10178	Raise heel 1 cm and sole to balance	R 705.06
10178	Raise heel 2 cm and sole to balance	R 766.62
10184	Raised heel insert - moulded to cast	R 2 375.70
10178	Raise heel up to 1 cm	R 493.30
10178	Raise heel up to 2 cm	R 493.30
10202	Raise shoe by adiustment	R 2 203.10
10205	Raise shoe - Cork - up to 2.5 cm	R 2 468.60

10208	Raise shoe- Cork- 2.5 to 5 cm	R 2 733.80
10211	Raise shoe - Cork - 5 to 10 cm	R 4 334.40
10214	Raise shoe - Pattern	R 2 443.19
10217	Rocker sole	R 803.86
10220	Stretch shoes	R 433.33
10223	Thomas's heels	R 803.86
10226	Torque heels, per pair	R 738.50
10229	Wedged heel	R 738.50
10232	Wedged heel and sole	R 1 003.90
10235	Wedged sole	R 738.50
10238	Toe cap steel	R 1 082.30
10241	Toe cap moulded plastic	R 947.60

	ANKLE ORTHOTICS	
10244	Ankle brace - custom moulded plastic	R 5 191.70
10247	Ankle foot orthosis - leg rotation control - resting splint	R 5 191.70
10250	Ankle foot orthosis - moulded - with lapped joint	R 7 802.10
10253	Ankle foot orthosis - moulded - with system joint	R 5 811.10
10256	Ankle foot orthosis - moulded - CROW / PTB Gaiter	R 13 775.50
10259	Ankle foot orthosis - spring loaded ankle with heel socket	R 4 862.50
10262	Below knee DOUBLE caliper	R 2 628.00
10265	Below knee DOUBLE caliper, socket and T-strap	R 4 862.50
10268	Below knee SINGLE caliper	R 2 628.00
10271	Below knee SINGLE caliper, socket and T-strap	R 4 740.70
10274	Clubfoot night splint - AFO custom moulded	R 3 820.10
10277	Clubfoot night splint - KAFO custom moulded	R 6 533.90
10280	Dropfoot splint - O'Gorman	R 2 628.00
10283	Dropfoot splint - plastic custom made	R 6 533.90
10286	Fracture brace BK leather	R 6 853.50
10289	Fracture brace BK plastic	R 8 524.90
10292	Heel socket round	R 993.80
10295	Heel socket square	R 993.80
	KNEE ORTHOTICS	
10307	Knee brace - custom moulded with polycentric joints	R 19 887.90
10313	Knee brace - custom moulded with overlapping joints	R 20 958.40
10322	Post-op ROM brace • custom made	R 14 741.60
10319	Knee brace - Rigid ACL custom brace	R 20 184.00

10322	Post-op ROM brace - custom made	R 14 741.60
10325	Post-op knee extention lock	R 6 533.90
	KNEE ANKLE FOOT ORTHOTICS	
10328	Bi-valved full length moulded leg brace	R 14 741.60
10331	Caliper full length with knee hinges and spurs	R 26 931.60
10334	Caliper full length with knee, ankle hinges and footplates	R 39 364.80
10337	Caliper - AK straight	R 13 070.40
10343	Caliper - KAFO weight bearing with knee joints, spurs etc	R 26 360.10
10346	Full leg brace - moulded to patient model - no hinges	R 19 155.10
10349	Full leg brace - moulded to patient model - hinged at knee (hinges not included)	R 27 149.10
10352	Full leg brace, including hip - moulded to patient model	R 31 996.80
10355	Genu valgum night splints	R 5 105.90
10358	Genu varum night splints	R 5 105.90
	CERVICAL ORTHOTICS	
10373	Cervical orthosis semi rigid,moulded to patient model	R 5 678.20
10376	Cervical orthosis plastizote, moulded to patient	R 2 761.60
10379	Cervical Thoraco Lumbar Sacral moulded to patient model - Milwaukee brace	R 24 874.40
10382	Cervical Thoraco Lumbar Sacral moulded to patient model - Milwaukee brace - double curve	R 28 871.50
	LUMBO SACRAL ORTHOTICS	
10385	Lumbo Sacral Orthosis moulded to patient model - Bennett's Brace	R 12 606.60
10388	Lumbo-sacral Orthosis moulded to patient model - Pantaloon brace	R 14 597.80
10391	Lumbo sacral Orthosis moulded to patient model -bivalve	R 16 588.90
	THORACO LUMBAR SACRAL ORTHOTICS	
10394	Thoraco Lumbar Sacral Orthosis moulded to patient model - Boston brace corrective including f	R 17 075.70
10397	Thoraco Lumbar Sacral Orthosis moulded to patient model	R 12 850.10
10400	Thoraco Lumbar Sacral Orthosis moulded to patient model - bivalve	R 16 832.20

10406	Taylors extension custom made	R 2 697.20
	ARM ORTHOTICS	
10409	Arm abduction splint - custom made	R 17 757.70
10412	Elbow orthosis- moulded to patient model	R 5 811.10
10415	Elbow orthosis- moulded to patient model with hinges	R 7 802.10
10418	Fracture brace - Humerus moulded to patient model	R 5 811.10
10421	Fracture brace - Radius, ulna moulded to patient model	R 5 191.70
10424	Hand orthosis - custom made dynamic	R 5 017.50

10427	Hand orthosis -resting/immobilizing, moulded to patient	R 5 017.50
10430	Hand orthosis - resting/immobilizing, moulded to patient model	R 5 017.50
10433	Wrist-hand orthosis - custom made dynamic	R 5 017.50
10436	Wrist-hand orthosis - moulded to patient	R 2 782.80
10439	Wrist-hand orthosis - moulded to patient model	R 5 017.50
10442	Wrist-hand orthosis - moulded silicone	R 7 008.50
10445	Wheelchair insert - custom moulded	R 40 969.00
	PROSTHETICS	
	FOOT PROSTHETICS	
10469	Prosthetic fitting - toe disarticulation (functional silicone)	R 9 629.00
10470	Prosthetic fitting - Ray amputation	R 14 159.80
10471	Prosthetic fitting - trans-metatarsal	R 14 159.80
10472	Prosthetic fitting - tarso-metatarsal	R 27 752.60
10473	Prosthetic fitting - partial foot - silicone	R 64 746.70
10487	Chopart prosthesis	R 39 093.20
10490	O'Conners extension	R 39 093.20
10493	Symes prosthesis	R 58 390.30
	BELOW KNEE PROSTHESIS	
10502	BK endoskeletal fitting	R 56 032.80
10496	BK exoskeletal fitting	R 60 580.60
	Refit of Below Knee prosthesis	
	NOTE: Refit includes new cosmetic cover	
10505	Refit BK endoskeletal	R 58 306.90
10505	Refit BK endoskeletal	R 58 306.90
	THROUGH KNEE PROSTHESIS	
10511	TK exoskeletal	R 92 467.90
10517	TK endoskeletal	R 83 372.50
	Refit of Through Knee prosthesis	
	NOTE: Refit includes new cosmetic cover	
10514	Refit TK exoskeletal	R 99 289.60

10520	Refit TK endoskeletal	R 85 646.60
	ABOVE KNEE PROSTHESIS	
10523	AK prosthesis - exoskeletal	R 96 455.50
10526	AK prosthesis endoskeletal	R 91 907.90
	Refit of Above Knee prosthesis	
	NOTE: Refit includes new cosmetic cover	
10529	Refit AK exoskeletal	R 107 466.84
10532	Refit AK endoskeletal	R 102 517.00
	HIP DISARTICULATION PROSTHESIS	
10535	HD prosthesls endoskeletal	R 132 837.50
10538	HD prosthesis endoskeletal - Refit	R 135 111.50

	HAND PROSTHESIS	
10644	Prosthetic fitting - finger - silicone aesthetic, each	R 44 219.40
10649	Prosthetic fitting - partial hand -silicone aesthetic, per finger	R 33 045.22
10652	Prosthetic fitting - hand - functional aesthetic silicone	R 126 971.45
	PARTIAL HAND PROSTHESIS	
10637	Partial hand passive	R 36 617.50
10640	Partial hand functional	R 45 537.50
10643	Partial opposition post	R 20 524.90
	PARTIAL HAND REPAIRS	
10644	Partial new silicone socket	R 44 219.40
10644	Prosthetic fitting - finger - silicone aesthetic, each	R 44 219.40
10645	Additional fee - silicone nail for aesthetic finger/hand/cover, each	R 1 652.00
10646	Additional fee - acrylic nail for aesthetic finger/hand/cover, each	R 3 269.20
	WRIST DISARTICULATION PROSTHESIS	
10655	Wrist disarticulation - passive	R 56 553.31
10655	Wrist disarticulation - functional	R 74 631.93
10664	Refit Wrist Disarticulation functional	R 72 138.00
10658	Refit Wrist Disarticulation	R 38 891.20
	BELOW ELBOW PROSTHESIS	
10667	Below elbow prosthesis -passive hand & cosmetic cover	R 56 553.31
10673	Below elbow prosthesis - functional hand & cosmetic	R 74 631.93

Road Accident Fund Tariff

10676	Refit BE functional	R 78 522.21
10670	Refit BE	R 47 986.80
	ELBOW DISARTICULATION PROSTHESIS	
10679	Elbow disarticulation prosthesis - passive and active hand and cosmetic cover	R 89 132.20
10685	Prosthetic fitting - wrist disarticulation - myoelectric	R 120 848.60
10688	Prosthetic fitting - refit wrist disarticulation - myoelectric	R 123 114.10
10682	Refit ED	R 91 397.80
	ABOVE ELBOW PROSTHESIS	
10691	Above elbow prosthesis - passive hand & cosmetic cover incl	R 75 539.70
10697	Above elbow prosthesis - functional hand & cosmetic cover incl	R 123 332.10
10700	Refit AE functional	R 125 901.40
10694	Refit AE	R 77 805.10
	SHOULDER DISARTICULATION PROSTHESIS	
10703	Shoulder disarticulation prosthesis manual elbow (Incl. passive hand & cosmetic Cover)	R 111 786.60
10709	Shoulder disarticulation prosthesis electric elbow (incl. passive hand & cosmetic cover)	R 179 856.10
10709	Shoulder disarticulation - with electric elbow functional hand & cosmetic cover Incl	R 179 856.10
10712	Refit shoulder Disarticulation functional	R 177 894.70
10706	Refit shoulder Disarticulation	R 114 052.30
	ACCESSORIES	
10724	Cable - AE	R 3 176.75
10727	Cable - BE	R 2 903.56
10730	Corset- BE	R 2 894.91
10733	Harness - AE	R 2 903.62
10736	Harness - BE	R 4 530.80
	FACIAL, NOSE AND EAR PROSTHETICS	
10461	Partial nose, prosaide	R 46 618.39
10462	Full nose, prosaide	R 46 618.39
10468	Implant attachment: ear or finger (excludes implant)	R 62 154.58
10467	½ face, prosaide (excludes artificial eye)	R 77 697.32
10466	¼ face, prosaide (excludes artificial eye)	R 62 157.85
10464	Prosaide affixation ear prosthesis	R 41 438.56
10460	Hair for facial prosthesis - colour match and insertion (per square cm or part thereof)	R 2 589.91
	BREAST PROSTHETICS	
10463	Prosthetic fitting - silicone breast	R 41 438.56
	ORTHOTIC FITTING FEES	

10003	Fit OTS soft orthosis (per item = 15min max).	R	216.83
10004	Fit & modify OTS soft orthosis (per item = 25 min max).	R	361.27
10005	Measure & fit custom-made soft orthosis (per item = 30 min max).	R	433.33
10006	Fit & adjust semi-rigid OTS orthosis (per item = max 30 min).	R	529.66
10007	Custom fit & adjust semi-rigid orthosis (per item = max 30 min)	R	794.61
10008	Custom fit rigid OTS orthosis (per item = max 50 min)	R	1 324.49
	ADMINISTRATIVE FEES		
10040	Administrative fee - Quotation / Motivation/Billing procedures	R	371.96
10045	Court appearance / legal proceedings - per day or part thereof	R	10 910.69
10050	Orthotic/Prosthetic - Telephonic medico-legal consultation per 30min or part thereof	R	681.92
10055	Orthotic/Prosthetic assessment/report/record - per hour	R	1 363.84
10058	Custom specialised wheelchairs seating	R	2 727.67
	LABORATORY FEES		
10060	Lab fee custom fabricate Orthotic per hour	R	1 859.78
10061	Lab fee custom fabricate Prosthetic per hour	R	2 116.01
10062	Lab fee footwear modification per 30 minutes	R	495.94
10063	Lab fee - custom fabrication Surgical footwear per hour	R	2 341.94
10064	Lab fee custom Myo-electric arm per hour	R	2 399.80
10065	Lab fee custom Aesthetic silicon O/P per hour	R	2 589.91
	ADDITIONS		
10551	Repair to prosthesis - Replace AK, TK & HD cosmetic cover	R	7 430.37
10552	Repair to prosthesis - Replace BK cosmetic cover	R	5 486.40
10568	Repair to prosthesis - re-laminate shin of prosthesis	R	8 516.76
10584	Addition to prosthetic fitting - fitting of hydraulic / pneumatic knee	R	1 943.97
10585	Addition to prosthetic fitting - fitting of micro-processor controlled hydraulic / pneumatic knee	R	3 410.70
10484	Addition to prosthetic fitting - partial foot - silicone aesthetic restoration	R	107 241.06
10485	Addition to prosthetic fitting - BK aesthetic silicone cover	R	107 241.06
10653	Additional fee - extend silicone aesthetic hand/cover to elbow	R	31 102.22
10646	Additional fee - acrylic nail for aesthetic finger/hand/cover, each	R	3 269.20
10486	Addition to prosthetic fitting - BK aesthetic silicone cover - extended over knee	R	31 102.22
10506	Addition to prosthetic fitting - transtibial supra-condular fitting	R	3 887.94
10533	Addition to prosthetic fitting - TF/KD suction socket	R	4 887.91
10534	Addition to prosthetic fitting - TF/KD TSB socket	R	4 887.91
10547	Addition to prosthetic fitting - Prosthetic skin - BK	R	6 380.80
10550	Addition to prosthetic fitting - Prosthetic skin - AK	R	6 831.88
10533	Addition to prosthetic fitting - TF/KD suction socket	R	6 223.50
10534	Addition to prosthetic fitting - TF/KD TSB socket	R	6 223.50
10553	Addition to prosthetic fitting - flexible inner socket	R	9 061.30
10554	Addition to prosthetic fitting - Ischium Containment Socket	R	7 775.88
10556	Addition to prosthetic fitting - test socket - diagnostic	R	3 887.94
10558	Addition to prosthetic fitting - test socket - diagnostic for silicone prosthesis	R	15 354.60
10565	Addition to prosthetic fitting - socket liner replaced (Trans Tibial - below the knee)	R	3 887.94
10566	Addition to prosthetic fitting - socket liner replaced (Knee Disarticulation / Ankle Disarticulation [S	R	7 775.88

Road Accident Fund Tariff

10567	Addition to prosthetic fitting - socket liner replaced (Trans Femeral - above the knee)	R 5 831.91

10508	Addition to prosthetic fitting - transtibial supra-condular fitting	R 4 530.80
10507	Addition to prosthetic fitting - transtibial Total Surface Bearing fitting	R 4 530.80
10547	Addition to prosthetic fitting - Prosthetic skin - BK	R 6 380.80
10571	Laminate thigh of prosthesis	R 10 460.73
10574	Socket lined with leather	R 2 338.84
10059	Re-adjustment consultation for custom specialised wheelchairs (per 15 minutes or part thereof)	R 313.24
10580	Re-alignment (dynamic)of AK/TK modular prosthesis	R 3 306.84
10583	Re-alignment (dynamic)of BK modular prosthesis	R 1 943.97
10646	Additional fee - silicone nail for aesthetic finger/hand/cover, each	R 1 652.00
10068	Prosthetic fitting and adjusting	R 2 265.50
10019	Gait analysis/dynamic alignment/training session - per 45 min.	R 973.30
10715	BE test socket - diagnostic	R 7 576.40
10715	ED test socket - diagnostic	R 7 576.40
10715	Symes test socket - diagnostic	R 7 576.40
10715	AE test socket - diagnostic	R 7 576.40
10715	TK test socket - diagnostic	R 7 576.40
10715	AK test socket - diagnostic	R 7 576.40
10586	Belt - prosthetic - fit hip-joint and pelvic band to prosthesis (excluding cost of hip joint)	R 2 588.90
10589	Belt - prosthetic - shoulder	R 2 588.90
10592	Belt - prosthetic - silesion	R 2 056.10
10598	Belt - prosthetic - waist	R 2 588.90
10601	Corset thigh and knee joints fitted to prosthesis (excluding joints)	R 9 552.60
10604	Corset thigh weightbearing and knee joints added to prosthesis (excluding joints)	R 11 826.70
10607	Belt - prosthetic back check strap	R 1 256.60
10610	Belt - prosthetic backlift	R 1 256.60
10613	Belt - prosthetic crutch strap	R 1 351.40
10616	Belt - prosthetic ptb strap	R 1 523.10
10619	Belt - prosthetic thigh corset	R 3 654.80
10622	Belt - prosthetic waistbelt leather	R 2 147.70
10625	Belt - prosthetic waistbelt webbing	R 1 616.70
10628	Silicone sleeve - custom made (sleeve only)	R 26 740.30
10631	Fit shuttle lock fitted to prosthesis (excl lock)	R 2 273.90
10637	Prosthetic fitting - partial hand - passive	R 36 617.50

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

PHARMACY (PR 060)

Practice Type	Procedure Code	Procedure Description	Max	Performed by	Time in Minutes	Value

Road Accident Fund
Tariff

60	1(a)	Evaluation of Script	0	Pharmacist	1		
	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	R	237.60
60	3	Preparation of a sterile product	0	Pharmacist	14	R	457.02
60	4	Preparation of an intravenous admixture or parenteral solution	0	Pharmacist	6	R	214.90
60	5	Preparation of TPN script	0	Pharmacist	13	R	453.74
60	7	Establish pharmaco-kinetic impact	0	Pharmacist registered as a specialist in pharmaco-kinetics	18	R	657.99
60	8	Information related to condition / script	0	Pharmacist	4	R	95.17
60	9	Application of Pharmaceutical care	0	Pharmacist	3	R	80.84
60	10	PCDT	0	Pharmacist	8	R	286.11
60	11	Review of patient's medication history and apply pharmaceutical care.	0	Pharmacist	4	R	143.88
60	12	Blood glucose	55.8	Pharmacist	4	R	108.05
60	13	Blood cholesterol and / or tri-glycerides	91	Pharmacist	7	R	176.41
60	14	Urine analysis	0	Pharmacist	7	R	161.27
60	15	Blood pressure monitoring	49.5	Pharmacist	4	R	95.78
60	18	Pregnancy screening	0	Pharmacist	7	R	171.72
60	19	Peak Flow measurement	0	Pharmacist	4	R	86.16
60	20	Reproductive health service	0	Pharmacist	5	R	151.66
60	21	Administering of an intra-muscular or sub-cutaneous injection	51.1	Pharmacist	4	R	104.80
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	R	79.82
60	28	Pharmacist Initiated Therapy (PIT)	0	Pharmacist	3	R	75.52

The following rules applies to the following tariffs:

PHYSIOTHERAPY (PR 072)

General rules

	REGULATIONS DEFINING THE SCOPE OF THE PROFESSION OF PHYSIOTHERAPY (R2301 - 3 December 1976)
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 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 and a pre-authorisation must be obtained from the RAF.

Road Accident Fund

Tariff

5	After a series of 15 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, Saturday 7:00 to 13:00.
	Modifier 0006 must be quoted after the appropriate code number(s) to indicate that this rule is applicable.
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.
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		
3	15% of the relevant rate to be deducted where equipment used is not owned by the practitioner		
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.		

Code:	**Description:**	**Units:**	**Value:**
1	**RADIATION THERAPY / MOIST HEAT / CRYOTHERAPY**		
72001	Infra-red, Radiant heat, Wax therapy, Hot packs	5.00	R 91.73
72005	Ultraviolet light	10.00	R 184.11
72006	Laser beam	15.00	R 275.83
72007	Cryotherapy	5.00	R 91.73

Road Accident Fund
Tariff

2	LOW FREQUENCY CURRENTS		
72072	Galvanism, Diodynamic current, Tens.	10.00	R 184.11
72105	Muscle and nerve stimulating currents.	12.00	R 220.50
72107	Interferential Therapy.	10.00	R 184.11
3	**HIGH FREQUENCY CURRENTS**		
72201	Shortwave diathermy.	5.00	R 91.73
72203	Ultrasound.	10.00	R 184.11
72205	Microwave.	5.00	R 91.73
4	**PHYSICAL MODALITIES**		
72300	Vibration	10.00	R 184.11
72301	Percussion	16.10	R 296.11
72302	Massage	10.00	R 184.11
72303	Myofascial release/soft tissue mobilisation, one or more body parts	20.09	R 369.21
72304	Acupuncture	15.00	R 275.83
72305	Re-education of movement/Exercises (excluding ante- and post-natal exercises)	10.00	R 184.11
72307	Pre- and post-operative exercises and/or breathing exercises	10.00	R 184.11
72308	Group exercises (excluding ante- and post-natal exercises - maximum of 10 in a group)	10.00	R 184.11
72309	Isokinetic treatment.	10.00	R 184.11
72310	Neural tissue mobilisation	20.00	R 367.56
72313	Ante and post natal exercises/counselling	10.00	R 184.11
72314	Lymph drainage	5.00	R 91.73
72315	Postural drainage.	10.00	R 184.11
72317	Traction.	10.00	R 184.11
72318	Upper respiratory nebulisation and/or lavage	10.00	R 184.11
72319	Nebulisation	10.00	R 184.11
72321	Intermittent positive pressure ventilation.	10.00	R 184.11
72323	Suction: Level 1 (including sputum specimen taken by suction)	5.00	R 91.73
72325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	20.09	R 369.21
72327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient).	5.00	R 91.73
72328	Dry needling	15.00	R 275.83
5	**MANIPULATION/MOBILISATION OF JOINTS OR IMMOBILISATION**		
72401	Spinal	15.00	R 275.83
72402	Pre meditated manipulation	10.00	R 184.11
72405	All other joints.	15.00	R 275.83
72407	Immobilisation (excluding materials). Rule 008 does not apply.	15.00	R 275.83

6	REHABILITATION		
72501	Rehabilitation where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	25.00	R 459.27
72502	Hydrotherapy where the pathology requires the undivided attention of the physiotherapist. Rule 008 does not apply. Duration: 30min.	25.00	R 459.27
72503	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.	55.00	R 1 010.94

Road Accident Fund
Tariff

72504	EMG Biofeedback treatment	15.00	R	275.83
72505	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	12.00	R	220.50
72506	Stress management	20.00	R	367.56
72507	Respiratory Re-education and Training. Duration: 30min.	15.00	R	275.83
72509	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.	15.00	R	275.83
7	**EVALUATION**			
72701	Evaluation/counselling at the first visit only (to be fully documented)	15.00	R	275.83
72702	Complex evaluation/counselling at the first visit only (to be fully documented).	30.00	R	551.16
72703	One complete re-assessment of a patient's condition during the course of treatment. To be used only once per episode of care.	15.00	R	275.83
72704	Lung function: Peak flow (once per treatment).	5.00	R	91.73
72705	Computerised/Electronic test for lung pathology	15.00	R	275.83
72706	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 by the Fund.	15.00	R	275.83
72707	Physical Performance test. Must be fully documented.	20.00	R	367.56
72708	Interview, guidance or consultation with the patient or his family. To be used only once per episode of care.	15.00	R	275.83
72720	Essential continuation of physiotherapy care, in an after-hours situation. (See general Rules on tariff codes 720 and 721)	20.00	R	367.56
72721	Emergency physiotherapy intervention (See general Rules on tariff codes 720 and 721)	30.00	R	551.16
72801	Electrical test for diagnostic purposes (including IT curve and Isokinetic tests) for a specific medical condition	35.00	R	642.72
72803	Effort test - multistage treadmill.	35.00	R	642.72
8	**VISITING CODES**			
72901	Treatment at a nursing home : Relevant fee plus (to be charged only once per day and not with every hospital visit	10.00	R	184.11
72903	Domicilliary treatments : Relevant fee plus.	20.00	R	367.56
9	**OTHER**			
72937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day.	10.00	R	184.11
72938	Bird or equivalent freestanding nebuliser excluding oxygen domicilliary per day.	10.00	R	184.11
72939	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.			
72940	Cost of appliances: 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 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.			
72941	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			

Road Accident Fund
Tariff

	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:
	a. Weekdays before 07:00 and after 17:00
	b. Saturdays before and after the normal working hours of the practice (Saturday 07:00 - 13:00)
	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.

Road Accident Fund Tariff

PODIATRY (PR 068)

General Rules

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	SEE GENERAL INFORMATION FOR DETAILS ON PHARMACY REGULATIONS
	Modifiers
2	For procedures 021 to 031 carried out in a day clinic or unattached operating theatre unit, the rate shall be reduced to twothirds.
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.

Code:	Description:	Units:	Value:
1	**CONSULTATIONS.**		
68301	Consultation (initial or follow up) 5-10 minutes	7.50	R 209.21
68302	Consultation (initial or follow up) 11-20 minutes	15.00	R 418.90
68303	Consultation (initial or follow up) 21-30 minutes	25.00	R 697.72
68304	Consultation (initial or follow up) 31-45 minutes	37.50	R 1 046.67
6	More than one patient seen at a residence (See note below).	8.50	R 214.35
	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.		
2	**INJECTIONS.**		
9	Administration of injection, per administration	1.30	R 33.07
3	**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	3.90	R 98.20
11	General podiatric care (30 minutes) including the following: 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	7.80	R 196.74
12	Extended care for chronic disease management or ulcer management (applicable to diabetes, arthritis and peripheral vascular diseases)	7.40	R 186.77
13	General podiatric care more than 30 minutes (a combination of items 010 and 011)	11.80	R 297.60

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.			
4	**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).	5.90	R	148.88
15	Subsequent lesion.	2.90	R	72.94
16	Cryotherapy first lesion (consultation and treatment).	7.80	R	196.74
17	Subsequent lesion.	3.90	R	98.21
18	Diathermy first lesion (consultation and treatment).	6.90	R	174.31
19	Subsequent lesion.	3.50	R	88.24
5	**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).	19.60	R	494.34
22	Two nails - one side.	25.50	R	642.89
24	Two nails - both sides.	36.40	R	918.23
23	One nail - two sides (including consultation).	25.50	R	642.89
25	Avulsion with matrix phenolisation (including consultation).	19.60	R	494.34
31	Avulsion without matrix phenolisation (including consultation).	12.80	R	322.69
6	**Other**			
40	Infection control, per patient	1.20	R	30.24
41	Remedial therapy.	4.90	R	123.63
42	Sterile pack.	5.90	R	148.88
44	Suturing (includes consultation).	7.80	R	196.74
46	Incision Biopsy.	5.90	R	148.88
47	Removal of foreign body.	8.90	R	224.65
48	Suturing / Wound closure material : Cost of material plus 10%			
146	Excision biopsy.	8.90	R	224.65
201	Sterile Surgical Blades (maximum of 2 per patient)	1.00	R	24.92
203	Wound dressing material (maximum of 2 per patient)	2.00	R	50.35
205	Plaster of Paris bandage roll (maximum of 2 per patient). At net acquisition price.			
207	Moulded Orthotic material fee	11.80	R	297.60
209	Simple insole material fee	5.90	R	148.88
211	Local anaesthetic medication per ampoule (maximum of 5 per patient)	2.00	R	50.35
213	Injection medication fee (other than local anaesthetic). At net acquisition price.		R	-
	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.		R	-
215	Padding and strapping : Digital, per foot	2.80	R	70.95
217	Padding and strapping: Metatarsal, per foot	3.50	R	88.24
219	Padding and strapping: Heel, per foot	3.50	R	88.24

Road Accident Fund Tariff

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.			
7	**Appliances and Orthotics**			
	(By arrangement).			
43	Biomechanical examination.	15.70	R	396.31
51	Neutral impression Plaster of Paris casting	8.50	R	214.35
52	Orthotic repair.	12.80	R	322.69
53	Temporary orthotic or corrective component.	12.80	R	322.69
54	Prescription covering and soft tissue supplements.	8.90	R	224.65
55	Silicone devices: Digital	5.40	R	136.25
56	Computerised gait analysis	19.60	R	494.34
57	Template measurement.	2.90	R	72.94
58	Immobilisation casting	10.60	R	267.69
59	Simple insole - one foot.	11.10	R	280.15
61	Simple insoles - both feet.	20.10	R	507.13
60	Silicone devices: metatarsal	10.70	R	269.52
64	Silicone devices: heel	15.90	R	401.28
	The rates for items 063 and 065 include the cost of instrinsic and extrinsic posting adjustments			
63	Prescription orthotic : one foot.	19.10	R	481.54
65	Prescription orthotics : both feet.	38.30	R	966.07
67	Preformed moulded insoles: Adult, both feet	22.10	R	557.64
69	Preformed moulded insoles: Adult, one foot	11.00	R	277.16
71	Preformed moulded insoles: Child, both feet	17.00	R	428.87
73	Preformed moulded insoles: Child, one foot	8.50	R	214.35

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.			
8	**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		
	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 (PR 57, 58 & 77)

GENERAL RULES

Code	Description	55700	55800	57700
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.			
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 number			
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 conducted			
G	All accounts submitted by private and unattached operating theatre units/day clinics shall comply with all of the requirements in terms of Fund regulations. Where possible, such accounts shall also reflect the practice code number			
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 request			
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 Annexure B shall be deemed to be included in ward fees, and no charge in respect thereof may be levied.			
1.1	**General Wards**			
001	Surgical cases: per day.	R 5 050.53	R 5 050.53	
002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	R 5 305.10	R 5 305.10	
003	Psychiatric general ward fee, per day	R 3 757.97	R 3 757.97	

004	Medical and neurological cases: per day.	R 5 050.53	R 5 050.53	
005	Paediatric cases (under 14 years of age)	R 6 235.00	R 6 235.00	
006	Sub-acute/Stepdown	R 2 715.62	R 2 715.62	
	Day admissions - all patients admitted as day patients and discharged before 23h00 on the same day			
007	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	R 3 231.59	R 3 231.59	R 1 902.41
019	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 complication.	R 1 495.42	R 1 495.42	R 1 495.42
	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			

Code	Description	55700	55800	57700
022	Out-patient wound care facility	R 1 151.98	R 1 151.98	R 1 151.98
	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 for service basis.			
	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).			
	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 these specific services.			
	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 uncomplicated pregnancy.			
	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 on a fee for service basis, until such time that the baby is delivered. If delivery itself is uncomplicated, then the first day (fixed) fee will be chargeable on the date of delivery, and second and subsequent days until the mother is discharged.			
	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.			
	Natural births			
9	First day (Day of confinement).	R 8 298.82	R 8 298.34	
10	Subsequent day(s).Per day	R 2 858.62	R 2 858.62	
17	Subsequent day(s) excluding nursery fee.	R 2 079.54	R 2 079.42	
	Caesarean			
12	First day (Day of confinement).	R 12 889.79	R 12 890.15	
13	Subsequent day(s). Per day	R 2 834.42	R 2 834.18	
	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.	R 805.69	R 805.08	
16	Delivery room.	R 3 459.86	R 3 460.22	
	This item is not applicable for deliveries by registered midwifes in private practice.			
18	Subsequent day(s) excluding nursery fee	R 2 043.25	R 2 043.74	

Code	Description	55700	55800	57700
	Epidural fee			
11	Use of epidural anaesthesia for MATERNITY CASES ONLY. (Note: This item includes all surgicals and nursing but no ethicals)	R 1 260.55	R 1 260.67	
	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 pharmaceuticals.			
	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.	R 5 184.95	R 5 184.71	
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.	R 8 043.57	R 8 043.32	
32	Additional Birthing Unit fee chargeable for every additional 12 hours of patient stay beyond the 24 hours contemplated in code 031	R 1 428.70	R 1 428.22	
1.2	**Private Wards**			
20	Private ward	R 2 217.45	R 2 216.97	
	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 applicable			
21	Private ward on member's request or for convenience of hospital will be funded at scale of benefits for general ward.	R 1 715.41	R 1 715.29	

Road Accident Fund Tariff

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	R 27 316.38	R 27 316.38	
	(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.	R 20 790.66	R 20 790.66	
202	Neonatal Intensive Care Unit: Per day.	R 13 681.61	R 13 681.61	
	(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.	R 13 317.02	R 13 317.02	
216	Neonatal High Care Ward `A' (Intensive nursing and monitoring)	R 4 913.97	R 4 913.97	
217	Neonatal High Care Ward `B' (Standard nursing and monitoring)	R 3 213.07	R 3 212.47	
218	Neonatal ward fee (Pre-discharge - This fee may not be charged for routine post-natal nursery care).	R 2 117.05	R 2 117.41	
	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, e.g., 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	R 2 181.16	R 2 181.28	
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.	R 500.83	R 500.95	R 500.95
	Note: The procedure room fee (071) cannot be charged in addition to 302			

Code	Description	55700	55800	57700
2	THEATRE FEES			
61	Excimer Laser Theatre fee, per minute	R 31.45	R 30.97	R 30.97
	The items listed as non-recoverable in Annexure 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 available			
	Time in minor theatre			
71	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	R 24.19	R 23.83	R 20.32
	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			
2.1	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, whether carried out individually or in combination with each other, this surcharge shall be deemed to cover the equipment in the criteria.			
	Note: Specialised intensive care units and specialised theatres are to be individually inspected and approved by BHF			
0002	Modifier 0002: Orthopaedic, Neurosurgical and Vascular:	R 6 763.96	R 6 763.96	

	· 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)			
0003	Modifier 0003: Cardiac surgery	R 15 497.59	R 15 497.59	
	· 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			
	Specialised Theatre Modifiers			
	Time in Theatre			
081	Charge per minute (which includes 0.16c per minute for those items in the surgical basket).	R 265.56	R 265.56	R 265.56
	The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows			
	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.	R 682.29	R 682.17	R 682.17
53	Angiograms.	R 682.29	R 682.17	
55	Electroconvulsive therapy (ECT)	R 682.29	R 682.17	R 682.17
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 equipped to perform the relevant surgery.	R 2 447.31	R 2 447.06	
	NB: For EPS studies, the Bard Apparatus (item 529) must be charged additionally.			

Code	Description	55700	55800	57700
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 equipped to perform the relevant surgery.	R 4 610.32	R 4 610.68	
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 equipped to perform the relevant surgery.	R 11 977.64	R 11 977.40	
	NB: EPS for cardiac ablations - items 529 must be charged additionally.			
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 equipped to perform the relevant surgery.	R 8 858.93	R 8 858.45	
75	Catheterisation laboratory film price (once per procedure)	R 263.72	R 263.97	
3.3	**Stereotactic radiosurgery**			

399	Linear Accelerator radiosurgery - Global Fee	R 175 184.97	R 175 185.45	
	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 involved in the treatment rendered under this item.			
430	Global fee for stereotactic radiosurgery	R 119 896.19	R 119 895.95	
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	R 889.16	R 889.40	R 889.40
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)	R 592.77	R 592.29	R 592.29
222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	R 5 928.94	R 5 928.58	R 5 928.58
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)	R 3 948.59	R 3 948.96	R 3 948.96
224	Stone basket (reusable) for the removal of kidney-, bladder- or gallstones: Per case	R 2 390.45	R 2 390.93	R 2 390.93
225	Stereotactic equipment for use in neuro-surgical procedures, when used in conjunction with x-rays, MRI scans or CAT scans: Per case	R 2 285.20	R 2 284.72	
226	Continuous Passive Exerciser: Per day.	R 181.46	R 181.10	R 181.10
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	R 504.46	R 504.58	R 504.58
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	R 249.21	R 249.45	R 249.45
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 to administration of analgesics: Per day	R 191.14	R 191.26	R 191.26
	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	R 531.05	R 531.05	
233	Croupettes (excluding oxygen): Per day or part thereof	R 42.34	R 42.58	
235	Oxygen tents (excluding oxygen): Per day or part thereof	R 68.96	R 69.20	
237	CUSA (plus CUSA pack as per section 5).	R 3 225.17	R 3 225.29	
238	Lasers - Argon or Holium (ophthalmic).	R 999.25	R 999.00	R 999.00
239	Lasers - CO2 (surgical).	R 1 290.79	R 1 290.79	R 1 290.79
241	Lasers - Candella (Rates by arrangement)			
242	Occutomes.	R 424.62	R 424.86	R 424.86
243	Lasers - YAG (ophthalmic).	R 1 126.27	R 1 126.63	R 1 126.63
244	Lasers - YAG (surgical).	R 1 403.30	R 1 402.94	R 1 402.94
245	First Extra Corporeal Shock Wave Lithotripsy (ESWL) treatment for one or more stones in same kidney which are eliminated in one treatment.	R 12 979.31	R 12 979.07	R 12 979.07
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)	R 8 644.81	R 8 644.32	R 8 644.32
	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.			

Code	Description	55700	55800	57700
249	C Arm (not chargeable when Modifiers 0002, 0003 or item 251 applies).	R 419.78	R 419.54	R 419.54
250	Ultrasonic imaging equipment.	R 701.65	R 701.04	R 701.04

	(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)	R 946.02	R 945.78	R 945.78
	Note: May not be used in conjunction with items 220 to 223, 245 to 246 and 339 to 341.	R -	R -	R -
252	Gastroscope (fibre optic/flexible only).	R 552.85	R 552.61	R 552.61
253	Colonoscope (fibre optic/flexible only)	R 618.18	R 617.94	R 617.94
254	Duodenoscope (fibre optic/flexible only).	R 585.51	R 585.64	R 585.64
255	Sigmoidoscope (fibre optic).	R 474.22	R 474.58	R 474.58
256	Bronchoscope (flexible/fibre optic, adults).	R 390.75	R 390.14	R 390.14
257	Laryngoscope (fibre optic/flexible excluding intubation)	R 227.43	R 227.79	R 227.79
258	Sinoscope (rigid only)	R 260.09	R 259.85	R 259.85
259	Oesophagoscope (rigid only)	R 129.44	R 129.56	R 129.56
261	Hysteroscope	R 163.31	R 163.07	R 163.07
262	Colposcope (Not chargeable when item 239 applies)	R 227.43	R 227.79	R 227.79
263	Cysto Urethroscope	R 195.98	R 195.49	R 195.49
264	Arthroscope (including basic reusable instruments and equipment)	R 532.29	R 532.65	R 532.65
	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			
	- 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	R 1 161.35	R 1 161.35	
295	Ultrasonic Cutting and Coagulating Devices (See section 5.3.3)	R 319.37	R 319.73	R 319.73
335	Excimer laser: Hire fee per eye	R 3 523.97	R 3 524.34	R 3 524.34
337	Microkeratome used with an excimer laser, per operation.	R 647.21	R 647.21	R 647.21
339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	R 394.38	R 393.77	R 393.77
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)	R 262.51	R 262.63	R 262.63
343	Sigmoidoscope (rigid, adults)	R 97.99	R 97.63	R 97.63
345	Sigmoidoscope (rigid, paediatrics)	R 78.63	R 78.75	R 78.75
347	Bronchoscope (flexible/fibre optic, paediatrics)	R 390.75	R 390.14	R 390.14
	Note: For codes 252-256 and 343-347, reusable biopsy and polyp forceps are included in the fee.			
348	Bronchoscope (rigid, adults)	R 156.06	R 156.30	R 156.30
349	Bronchoscope (rigid, paediatrics)	R 227.43	R 227.79	R 227.79
360	Category 1 - Laparoscopy and thoracoscopy, per case. See Annexure A	R 1 276.28	R 1 276.03	R 1 276.03
364	Category 2 - Interventional Laparoscopic and Thorascopic procedures, per case. See Annexure A	R 1 515.81	R 1 515.81	R 1 515.81
507	Argon Beamer (See section 5.3.2)	R 129.44	R 129.32	R 129.32
	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)	R 781.49	R 781.25	R 781.25

CONTINUES ON PAGE 258 OF BOOK 3

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511	Colour Doppler (external)	R 2 338.43	R 2 338.67	R 2 338.67
513	Transoesphageal Colour Doppler. (May be charged together with Modifier 0003)	R 2 822.33	R 2 821.72	R 2 821.72
515	Cardiorhythm Ablater. (May be charged in addition to the catheterisation Laboratory).	R 1 537.58	R 1 537.10	R 1 537.10
517	Phaco emulsifier	R 827.46	R 827.70	R 827.70
519	Uretho Reno Fibroscope, per case	R 698.02	R 697.42	R 697.42
521	OAS Frameless Stereotaxy	R 8 225.03	R 8 224.66	
523	OPD Tacography (Includes paper)	R 133.07	R 133.19	
525	RFG3C Lesion Generator (Rhizotomy)	R 2 662.64	R 2 662.76	
527	Swift Lase Kit (Tonsillectomy)	R 518.98	R 518.86	

Code	Description	55700	55800	57700
529	Bard Apparatus	R 1 992.44	R 1 991.96	
	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.			
531	Densitometer	R 1 227.89	R 1 227.89	
533	Civus (Cardiac Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	R 3 335.26	R 3 335.26	
535	Ivus (Intra-vascular Ultrasound) (This may be charged in addition to the catheterisation laboratory).	R 7 326.19	R 7 325.95	
537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery.	R 31.45	R 30.85	
	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)			
540	Stereotactic guided digital imaged breast biopsy procedure	R 13 448.69	R 13 448.32	
541	Stereotactic guided digital imaged cover needle biopsy	R 7 911.70	R 7 911.34	
542	Stereotactic guided digital imaged vacuum assisted core needle biopsy.	R 7 911.70	R 7 911.34	
543	Stereotactic guided digital imaged fine needle aspiration	R 5 540.61	R 5 540.01	
544	Mammotome Stereotactic Driver - vacuum assisted core needle biopsy. (UNDER REVIEW)			
545	Mammotome Hand Held ultrasound vacuum assisted vacuum core needle biopsy. (UNDER REVIEW)			
550	Equipment fee for dynamic (non-frame based - Stealth Station) 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	R 8 598.84	R 8 598.84	
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)			
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			
576	Infrared Coagulator: per use			
578	Prostatic hyperthermia and thermotherapy: per case	R 12 192.98	R 12 192.49	
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			
614	Urodynamic studies			
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			
282	Theatre			

Code	Description	55700	55800	57700
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	**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/disposable products.			
5.2.1	Drills, burrs, cutters, blades			
280	Neuro/Craniotomy			
432	Arthroscopy			
433	Orthopaedic			
437	Mastoidectomy and major ear surgery			
439	Maxillo- Facial drills and burrs (not applicable to oral surgery, eg wisdom teeth)			
5.2.2	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			
5.2.3	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			
5.2.4	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			

5.2.5	Diathermy pencils, laryngeal masks and fluoroshield gloves			
431	Diathermy pencils			
435	Laryngeal masks			
441	Fluoroshield gloves (1 pair per procedure)			
5.3	**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	Gauteng area	R 4.84	R 5.24	R 5.20
701	Cape Town	R 7.26	R 7.17	R 7.14
702	Port Elizabeth	R 6.05	R 6.39	R 6.41
703	East London	R 7.26	R 7.09	R 7.14

Code	Description	55700	55800	57700
704	Durban	R 6.05	R 6.58	R 6.53
705	Other areas	R 6.05	R 5.86	R 5.81
	Oxygen, ward use			
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex			
284	Gauteng area	R 7.26	R 7.69	R 7.74
710	Cape Town	R 13.31	R 12.70	R 12.70
711	Port Elizabeth	R 12.10	R 12.22	R 12.22
712	East London	R 12.10	R 11.78	R 11.73
713	Durban	R 9.68	R 9.99	R 10.04
714	Other areas	R 9.68	R 9.52	R 9.56
	Oxygen, recovery room or emergency room			
	Flat rate for oxygen per case			
720	Gauteng area	R 15.73	R 15.24	R 15.24
721	Cape Town	R 25.40	R 25.28	R 25.28
722	Port Elizabeth	R 24.19	R 24.32	R 24.32
723	East London	R 24.19	R 23.59	R 23.59
724	Durban	R 20.57	R 19.96	R 19.96
725	Other areas	R 19.36	R 19.11	R 19.11
	Oxygen in Theatre			
	Fee for oxygen per minute in the operating theatre when no other gas administered			
730	Gauteng area		R 0.47	R 0.48
731	Cape Town	R 1.21	R 0.85	R 0.85
732	Port Elizabeth	R 1.21	R 0.80	R 0.85
733	East London	R 1.21	R 0.80	R 0.85
734	Durban	R 1.21	R 0.63	R 0.60
735	Other areas	R 1.21	R 0.63	R 0.60
	Carbon Dioxide			
291	Per minute	R 1.21	R 0.96	R 0.97

	Laser Mix			
292	Per minute	R 18.15	R 18.27	R 18.27
	Entonox			
293	Per 30 minutes	R 174.20	R 174.57	R 174.57
5.5	**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	R 1.71	R 1.71	R 1.71
752	Ethrane (Enflurane): per minute	R 9.12	R 9.12	R 9.12
753	Forane (Isoflurane): per minute	R 8.58	R 8.58	R 8.58
754	Isofor (Isoflurane): per minute	R 7.77	R 7.77	R 7.77
755	Ultane (Sevoflurane): per minute	R 15.74	R 15.74	R 15.74
756	Suprane (Desflurane), per minute	R 13.39	R 13.39	R 13.39
757	Aerrane (Isoflurane): per minute	R 6.98	R 6.98	R 6.98
758	Alyrane (Enflurane): per minute	R 7.03	R 7.03	R 7.03
759	Fluothane (Halothane), per minute	R 1.68	R 1.68	R 1.68
5.6	**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 nececary part			
	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.			
5.7	**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.		-	

Code	Description	55700	55800	57700
5.8	**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	R 921.82	R 922.31	
5.9	**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)			
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			

Road Accident Fund Tariff

	APPENDIX A			
	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			
	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 appointed representatives of the individual contractor, medical aid, 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 reused 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			
	Disposable Means the manufacturer states one time use only.			

Code	Description	55700	55800	57700
	APPENDIX B:			
	Medically Prescribed Meals:			
	ORAL SUP + 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			
	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 tube feeds subject to Case Management			

Private Nursing (PR 088)

GENERAL RULES

Code:	Description:	Units:	Value:
01	CONSULTATION, COUNSELING, PLANNING AND/OR ASSESSMENT: Consultation, counseling and / or assessment (codes 001 and 002 below) encompasses consultation, history taking, patient examination and assessment, observation, treatment planning, after care treatment planning, discharge planning and/or counseling. If a consultation and one or more procedures are performed in the visit, both a consultation code and the relevant procedure code(s) may be charged but the time spent on the procedure shall not be included in the consultation period for purposes of determining the consultation fee. A consultation may not be charged where the sole purpose of the visit was to perform a procedure.		
02	EMERGENCY VISITS Bona-fide, justifiable emergency nursing services rendered to a patient, at any time, may attract an additional fee as specified in item 014. These specifically relate to home visits for procedures which become necessary outside those which have been pre-arranged, such as but not exclusively, blocked urinary catheters, IV therapy which tissues or wound(s) which are draining excessively and require additional dressing. These should be accompanied by a written motivation. NOTE THAT THIS FEE IS ONLY APPLICABLE TO REGISTERED NURSES IN PRIVATE PRACTICE, AND NOT TO NURSING AGENCIES.		
021	SUNDAYS AND PUBLIC HOLIDAYS When codes 036, 037 or 038 are charged for services rendered on a Sunday, the fee in respect of these codes shall be inflated by 50%. Modifier 0007 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. When codes 036, 037 or 038 are charged for services rendered on a public holiday, the fee in respect of these codes shall be inflated by 100%. Modifier 0001 must be quoted after the appropriate code number(s) to indicate that this rule is applicable. NOTE THAT THIS FEE IS ONLY APPLICABLE TO NURSING AGENCIES AND NOT TO REGISTERED NURSES IN PRIVATE PRACTICE.		
03	PROCEDURES If a composite fee or general hourly rate is charged, no additional fee for procedures may be charged. The fee in respect of more than one procedure performed at the same time shall be the fee in respect of the major procedure plus 50% of the fee of each subsidiary or additional procedure. Modifier 0002 to be quoted.		
04	FEES The rate that may be charged in respect of rendering a service not listed in this benefit schedule shall be based on the rate in respect of a comparable service. Modifier 0003 to be quoted with the description of service rendered and the applicable item number used.		
05	COST OF MEDICINES AND MATERIALS SEE GENERAL INFORMATION FOR DETAILS.		
051	MEDICINES Scheduled medicines may not be supplied by an institution. Intramascular/Intravenous injection and OPAT may only be administered by a registered nurse.		

06	EQUIPMENT (HIRE AND SALES) 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. To be billed in terms of item 302. Payment of this item is at the discretion of medical scheme concerned, and should be considered in instances where cost savings can be achieved. For equipment that is sold to a member, the net acquisition cost of the equipment may be charged (item 303). This should be on a separate invoice attached to the account as the cost of these items are refunded to the member and not paid to the supplier.		
08	TRAVEL FEE Please note that generally the Fund do not accept the responsibility for transport expenses, as they are deemed to be included in the fee.		
	MODIFIERS		
002	Only 50% of the fee in respect of subsidiary/additional procedures may be charged.		
0003	The fee that may be charged in respect of the rendering of a service not listed in this recommended benefit schedule, shall be based on the fee in respect of a fee for a comparable service. Motivation must be attached.		
1.	**ITEMS**		
	CONSULTATIONS (THE PATHOLOGY/DIAGNOSIS MUST BE STATED)		
88005	Individual consultation, counseling, planning and/or assessment. 5 - 15 minutes.	10.00	R 116.22
88006	Individual consultation, counseling, planning and/or assessment. 16 - 30 minutes.	22.50	R 261.40
88001	Individual consultation, counseling, planning and/or assessment. 31 - 45 minutes.	37.50	R 435.54
88002	Individual consultation, counseling, planning and/or assessment. 46+ minutes.	52.50	R 609.56
88014	For emergency consultation/visit, all hours - See General Rule 2.	7.70	R 143.98
2.	**SPECIMENS.**		
88020	This must form part of a consultation when a consultation is charged. Where a consultation was not performed and the nurse visited or attended to the patient with the sole purpose of obtaining a specimen, and dispatching to a laboratory or using own machine to test – please state specimen type and, where applicable, machine and test performed.	4.60	R 86.29
3.	**OBSERVATIONS. (TEMPERATURE, PULSE RESPIRATION AND B.P.)**		
88025	Where a consultation was not performed and the nurse attended to the patient with the sole purpose of doing an observation.	4.60	R 86.29
4.	**ADMINISTRATION OF MEDICATION.**		
88030	Where a consultation was not performed and the nurse attended to or visited the patient with the sole purpose of administering intramuscular or intravenous medication. The route of administration of medication to be stated, as well as the name of the medication. Oral, rectal, vaginal medication excluded as well as the application of topical medicine.	4.60	R 86.29

88035	All inclusive global fee for the setting up of an IV line and administration of intravenous therapy by a registered nurse.	24.30	R 454.57
88036	When a SRN returns to add medication to an existing IV infusion	12.20	R 228.24

5.	**CARE OF WOUNDS (THE PATHOLOGY MUST BE STATED).**		
88040	Treatment of simple wounds/burns requiring dressing only.	8.80	R 164.45
88041	Treatment of extensive wounds/burns requiring extensive nursing management eg irrigation, etc.	12.40	R 231.83
88042	Treatment of moderate wounds/Burns eg drains or fistulas and inserting of sutures	11.00	R 205.74
88045	Laser treatment for wound healing where prescribed by medical practitioner	7.67	R 143.50
6.	**RESPIRATORY SYSTEM.**		
88050	Nebulization/Inhalation.	3.80	R 70.97
88051	Tracheostomy care.	7.90	R 147.57
88052	Peak flow measurement.	3.10	R 58.05
	For ICU trained nurses registered with SANC as such and nurses working in the occupational health setting but not for a company. (Item 053)		
88053	Flow volume test: inspiration/expiration using ELF/similar machine.	13.10	R 245.00
7.	**CARDIO-VASCULAR SYSTEM.**		
	Only for ICU trained nurses registered as such with SANC. A medical practitioner must be available in the event of a resuscitation being required. (Items 062 and 063).		
88060	Cardiopulmonary resuscitation.	23.00	R 430.03
88061	Performing ECG only.	4.60	R 86.29
88062	Effort test - bicycle.	16.90	R 316.09
8.	**CARDIO-VASCULAR SYSTEM.**		
88070	Application or removal splints and prosthesis.	3.90	R 73.13
88071	Application or removal of traction	7.70	R 143.98
88072	Application of skin traction	7.70	R 143.98
9.	**GASTRO INTESTINAL SYSTEM.**		
88080	Nasogastric tube insertion, feeding and removal.	9.20	R 172.11
88082	Enema administration	4.80	R 89.88
88083	Aspiration of stomach/gastric lavage.	6.90	R 128.90
88084	Faecal impaction/manual removal.	8.70	R 162.53
10.	**URINARY SYSTEM.**		
88090	Any urinary tract procedure including catheterisation, bladder stimulation and emptying.	9.50	R 177.61

88091	Condom catheter application, penile dressing, catheter care including bag change or catheter removal.	5.80	R 108.68
88093	Incontinence management (30 minutes) This fee includes intermittent catheterisation, external sheath drainage, taking of history, providing literature and	9.50	R 177.61
	teaching.		
11.	**GENERAL CARE**		
88100	This includes all aspects of elementary nursing care performed at a patient's home which may include : Bath/ bedbath, getting patient out of bed, making of bed, hairwash, mouth hygiene, nail care, shave, put patient back to bed, pressure area care, per visit. (irrespective of time spent)	16.10	R 300.77

12.	**STOMALTHERAPY NURSING.**		
	Applicable to stomal therapy trained registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.		
	Please Note: Items 200, 201, 202, 204, 205, 079 and 081 may not be used in conjunction with items 230, 234, 238 and 250		
88079	Stomal irrigation - 60 minutes. May not be used in conjunction with the global fees.	4.80	R 89.88
	Colonic lavage - may be performed by all nurse practitioners but only when prescribed by a medical practitioner, and the written prescription is attached.		
88081	Colonic lavage	4.80	R 89.88
88200	Simple stoma - a well constructed, sited stoma which is easy to pouch. Very little or no peristomal skin excoriation.	8.80	R 164.45
88201	Complex stoma - a poorly constructed, non-sited stoma requiring convexity or build up. Difficult to pouch. Severe peristomal skin excoriation.	12.40	R 231.83
88202	Moderate stoma - a fairly well constructed, sited stoma which may require straight forward convexity or build up. Mild to moderate peristomal skin excoriation.	11.00	R 205.74
88205	Stoma products charged in accordance with rule 05.		
88230	"Global fee - Simple Stoma - Permanent: Includes the following: • 1 X Pre-op consultation: includes history, stomal siting, ounselling • 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle • 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) • 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)"	124.90	R 2 334.96
88234	"Global fee - Moderate Stoma - Permanent (Includes the following): • 1 X Pre-op consultation: includes history, stomal siting,counselling • 3 X Post-op consultations - includes checking stomaand pouch, teach, advise on management, diet, lifestyle • 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) • 6 Month clinic visit and assessment: including materials(gloves, linen saver, gauze, etc)"	137.20	R 2 564.88

88238	"Global fee: Complex stoma - Permanent (Includes the following): • 1 X Pre-op consultation: includes history, stomal siting, counselling • 3 X Post-op consultations - includes checking stoma and pouch, teach, advise on management, diet, lifestyle • 2 X Clinic visits plus procedure (remove sutures, check stoma, skin integrity, show/teach other pouches, advise on diet and lifestyle: enema/irrigation/intermittent catheterisation) and materials (gloves, linen saver, gauze etc) • 6 Month clinic visit and assessment: including materials (gloves, linen saver, gauze, etc)"	159.90	R 2 988.93
88250	Clinic visits after 6 months per half hour plus one procedure - eg irrigation, enema, etc. - plus material	10.00	R 187.07
13.	**EQUIPMENT**		
	Applicable only to registered nurses who are working as private practitioners and not for a company other than a registered nursing agency.		
302	Equipment hire per day, charged according to rule 06.		
303	Equipment sold to a member should be net acquisition cost. This should be on a separate invoice attached to the account as the cost of these items are refunded to the member, and not paid to the supplier."		

14.	**PSYCHIATRIC NURSING THERAPY**		
	Psychiatric Nursing Therapy may only be performed by a nurse with a psychiatric nursing qualification registered as such with the SANC		
88500	Individual interview/assessment. Adult, child, school, employer - per hour.	21.60	R 403.82
88501	Individual therapy. (irrespective of time)	30.70	R 573.78
88502	Family/marital/group per patient - specify number.	6.20	R 116.10
88503	Play therapy/Home stimulation programme.	16.90	R 316.09
88504	Co-therapist.	16.90	R 316.09
15.	**MEDICINES AND MATERIALS**		
88301	Consumables used, and charged according to rule 05	-	

PRIVATE SUB ACUTE FACILITIES (PR 049)

GENERAL RULES			
Code	**Description**	**Units**	**Value**
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.		
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.		
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.		
	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	10.000	R 2 640.18
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 nontraumatic), Spinal cord dysfunction.		
101	General ward/facility fee: under 5 hours stay	2.227	R 588.39
105	General care (Daily ward rate, excluding therapy)	10.286	R 2 715.62
	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 behavioural		
003	Ward fee: with overnight stay (specific motivation from the doctor-in-charge) (ward/supporting facilities and equipment)	10.430	R 2 753.51
005	General ward fee: under 5 hours stay	2.260	R 598.03
007	General ward fee: without overnight stay	5.392	R 1 423.53

Code	Description	Units	Value
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 the Medicine and Related Substances Act, 1965 (Act 101 of 1965)		
	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	-	
2.2	**Gases**		
	Oxygen, ward use		
	Fee for oxygen, per quarter hour of part thereof.To charged using the appropriate NAPPI code.		
284	Gauteng area	1.000	R 7.26
710	Cape Town	1.000	R 13.31
711	Port Elizabeth	1.000	R 12.10
712	East London	1.000	R 12.10
713	Durban	1.000	R 9.68
714	Other areas	1.000	R 9.68
850	PPE Gen Modifier		R 146.95

PSYCHOLOGY (PR 086)

GENERAL RULES			
Code:	**Description:**	**Units:**	**Value:**
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.		
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.		
1	**CONSULTATIVE AND THERAPEUTIC SERVICES**		
86200	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	5.00	R 157.51
86201	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	15.00	R 471.74
86202	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	25.00	R 786.29
86203	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	35.00	R 1 100.83
86204	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	45.00	R 1 415.38
86205	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	55.00	R 1 730.43
86206	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	65.00	R 1 941.69
86207	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	75.00	R 2 240.06
86208	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	85.00	R 2 538.90
86209	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 91-100min.	95.00	R 2 837.74

86210	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 101-110min.	105.00	R 3 136.75
86211	Psychology assessment, consultation, counselling and/or therapy (individual or family). Duration: 111-120min.	115.00	R 3 434.80
	This code would be used in addition to code 211.		
86290	Extended assessment, consultation, counselling and/or therapy (individual or family) - per full 15 minutes in excess of 120 minutes	7.50	R 235.96

Code:	Description:	Units:	Value:
2	**GROUP SERVICES**		
86300	Psychology group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	1.00	R 31.24
86301	Psychology group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	3.00	R 94.05
86302	Psychology group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	5.00	R 157.36
86303	Psychology group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	7.00	R 220.33
86304	Psychology group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	9.00	R 282.98
86305	Psychology group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	11.00	R 345.78
86306	Psychology group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	13.00	R 408.76
86307	Psychology group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	15.00	R 471.74
86308	Psychology group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	17.00	R 534.72
86309	Psychology group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	19.00	R 597.69
86310	Psychology group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	21.00	R 660.67
86311	Psychology group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	23.00	R 723.49

PSYCHOMETRY (PR 85)

GENERAL RULES

Code:	Description:	Units:	Value:
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		
200	Psychometric testing. Duration: 1-10min.	0.50	R 78.59
201	Psychometric testing. Duration: 11-20min.	1.50	R 235.96
202	Psychometric testing. Duration: 21-30min.	2.50	R 393.15
203	Psychometric testing. Duration: 31-40min.	3.50	R 550.34
204	Psychometric testing. Duration: 41-50min.	4.50	R 707.53
205	Psychometric testing. Duration: 51-60min.	5.50	R 864.55
206	Psychometric testing. Duration: 61-70min.	6.50	R 1 022.41
207	Psychometric testing. Duration: 71-80min.	7.50	R 1 179.44
208	Psychometric testing. Duration: 81-90min.	8.50	R 1 336.79
209	Psychometric testing. Duration: 91-100min.	9.50	R 1 494.15
210	Psychometric testing. Duration: 101-110min.	10.50	R 1 651.34
211	Psychometric testing. Duration: 111-120min.	11.50	R 1 808.86
290	Psychometric testing - per full 15 minutes in excess of 120 minutes.	0.75	R 118.14

RADIOGRAPHY (PR 039)

GENERAL RULES

	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.		
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	12.30	R 82.42
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)	16.20	R 108.68
5	Smith-Petersen or equivalent control, in theatre	134.60	R 902.11
7	Stress studies, e.g. joint	16.20	R 108.68
9	Length studies per right and left pair of long bones	16.20	R 108.68
11	Skeletal survey under 5 years	48.50	R 325.18
13	Skeletal survey over 5 years	52.30	R 350.61
15	Arthrography per joint	39.50	R 264.71
1.2	**SPINAL COLUMN**		
17	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	24.60	R 165.00
21	Stress studies	10.00	R 67.13
25	Scoliosis studies	39.30	R 263.53
27	Pelvis (sacro-iliac or hip joints only to be added where an extra set of views is required)	17.00	R 114.16
1.2.1	**MYELOGRAPHY**		
29	Lumbar	43.10	R 288.96
31	Thoracic	40.10	R 268.85
33	Cervical	59.40	R 398.29
35	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	-	
37	Discography	31.50	R 211.02
1.3	**SKULL**		
39	Skull studies	32.30	R 216.51
41	Paranasal sinuses	17.00	R 114.16
43	Facial bones and/or orbits	34.90	R 233.80
45	Mandible	26.00	R 174.31

47	Nasal bone	16.20	R	108.68
49	Mastoid: Bilateral	50.00	R	335.15

1.4	**TEETH**			
51	One quadrant	7.70	R	51.51
53	Two quadrants	8.50	R	56.99
55	Full mouth	10.80	R	72.45
57	Rotation tomography of the teeth and jaws	14.60	R	97.88
59	Temporo-mandibular joints: Per side	19.20	R	128.61
61	Tomography: Per side	30.50	R	204.38
63	Localisation of foreign body in the eye	30.70	R	205.88
65	Ventriculography	37.40	R	250.74
67	Post-nasal studies: Lateral neck	10.00	R	67.13
69	Maxillo-facial cephalometry	26.90	R	180.29
71	Dacryocystography	24.20	R	162.34
2	**ALIMENTARY TRACT**			
73	Sialography (plus 80% for each additional gland)	24.60	R	165.00
75	Pharynx and oesophagus	22.80	R	152.71
77	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through	31.50	R	211.02
79	Small bowel meal (control film of abdomen included, except when part of item 081)	27.70	R	185.61
81	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	47.20	R	316.38
83	Barium enema (control film of abdomen included)	50.90	R	341.14
85	Biliary tract: ERCP (choledogram and/or pancreatography screening included)	47.00	R	315.05
87	Gastric/oesophageal/duodenal intubation control	20.80	R	139.58
89	Hypotonic duodenography (077 included)	57.30	R	384.17
3	**BILIARY TRACT**			
91	Oral cholecystography	47.80	R	320.53
93	Intravenous	58.60	R	392.81
95	Operative: First series	58.10	R	389.49
97	Subsequent series	24.00	R	160.68
99	Post-operative: T-tube	20.10	R	134.76
101	Trans-hepatic, percutaneous	34.60	R	231.80
103	Tomography of biliary tract: Add	21.50	R	144.07
4	**CHEST**			
105	Larynx (tomography included)	42.40	R	284.14
107	Chest (item 167 included)	19.20	R	128.61
109	Chest and cardiac studies (item 167 included)	23.10	R	154.87
111	Ribs	19.20	R	128.61
113	Sternum or sterno-clavicular joints	24.60	R	165.00
4.1	**BRONCHOGRAPHY**			
115	Unilateral	33.50	R	224.49
117	Bilateral	56.50	R	378.85
119	Pleurography	15.70	R	105.18
121	Laryngography	15.70	R	105.18
123	Thoracic inlet	15.70	R	105.18
5	**ABDOMEN**			

125	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram, etc.)	17.00	R	114.16
127	Acute abdomen or equivalent studies	30.70	R	205.88
6	**URINARY TRACT**			
129	Control film included and bladder views before and after micturition	270.3	R	449.14
133	Waterload test: Add	81.1	R	134.76
135	Cystography only or urethrography only (retrograde)	151.7	R	252.07

6.1	**CYSTO-URETHROGRAPHY**			
137	Retrograde	33.10	R	222.00
139	Retrograde-prograde pyelography	42.40	R	284.14
141	Aspiration renal cyst	17.00	R	114.16
143	Tomography of renal tract: Add	19.20	R	128.61
7	**GYNAECOLOGY AND OBSTETRICS**			
145	Pregnancy	19.20	R	128.61
147	Pelvimetry	35.50	R	238.12
149	Hysterosalpingography	32.00	R	214.35
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	262.70	R	1 760.67
157	Head, repeat examination at the same visit, after contrast, full series	90.20	R	604.67
159	Chest	303.70	R	2 035.68
161	Abdomen (including base of chest and/or pelvis)	353.00	R	2 366.01
163	Multiple examinations: For an additional part, the lesser fee shall be reduced to	82.10	R	550.34
165	Limbs and other limited examinations	82.10	R	550.34
	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)	21.40	R	143.40
169	Where a C-arm portable x-ray unit is used in hospital or theatre: Per half hour: Add	29.60	R	198.41
171	Sinography	44.30	R	296.94
173	Bone densitometry	80.90	R	542.19
175	Mammography: Unilateral or bilateral	58.10	R	389.49
177	Repeat mammography, unilateral or bilateral for localisation of tumour	58.10	R	389.49
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	17.60	R	117.97
181	Setting of sterile trays	3.00	R	20.11
	Films 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			
300	rands. X- Ray films			

Road Accident Fund Tariff

	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.	43.00	R 288.30
192	Post-processing in catheterisation laboratory for purposes of cardiac catheterisation and/or invasive intravascular procedures	43.00	R 288.30
193	Coronary angiogram per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
194	Right heart investigation of valve and venous system of the right heart	43.00	R 288.30
195	PTCA per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
196	Left heart investigation of valve of the left heart and ventrical	43.10	R 288.96
197	Stent procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
199	Vascular Study per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
201	Temporary pacemaker procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
203	Permanent pacemaker procedure in catheterisation laboratory per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
205	Intra-aortic balloon pump procedure per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
207	Electro-physiological studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
209	Bleomycine and other studies per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
211	Intra vascular ultrasound per 30 minutes of part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
213	Rotablator/Laser procedures per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
215	Embolisation per 30 minutes or part thereof provided that such part comprises 50% or more of the time	43.00	R 288.30
	RULES		
Z	No fee to be subject to more than one reduction		
11	**PORTABLE UNIT EXAMINATIONS**		
185	Where portable x-ray unit is used in the hospital or theatre: Add	19.40	R 130.11
187	Theatre investigations with fixed installation : Add	8.30	R 55.66

RADIOLOGY (PR 038 & 025)

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 codes with a 3rd digit of 9. Practitioners reistered as both radiologists and nuclear physicians may use all codes.

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

Coding 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:

"Head / Skull and Brain / General x-ray" = 101xx

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%.

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

Code	Description	Add	Nuclear Medicine	Radiology

Road Accident Fund Tariff

			Units	Value	Units	Value
1.	**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	R 998.49
00115	X-ray skeletal survey over five years				10.400	R 1 658.82
00120	X-ray sinogram any region				10.890	R 1 737.08
00130	X-ray with mobile unit in other facility	+			1.900	R 303.08
	To be added to applicable procedure codes eg 30100.					
00135	X-ray control view in theatre any region				5.260	R 838.96
00140	X-ray fluoroscopy any region	+			2.260	R 360.41
	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	R 845.45
	Add to the procedure eg. 80600, 80605, 80610.					
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour				2.420	R 386.00
	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	R 366.73
00160	X-ray fixed theatre installation (equipment fee only)				2.260	R 360.41
	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	R 293.44
	Add to the relevant ultrasound examination codes eg 10200.					
00220	Ultrasound intra-operative study				7.320	R 1 167.47
	Covers all regions studied. Single code per operative procedure.					
00230	Ultrasound guidance	+			12.100	R 1 930.33
	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	R 1 793.08
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure code to be added if performed by a radiologist. 80620 or 80630.					

00250	Ultrasound limited Doppler study any region				6.500	R 1 036.87
	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	R 3 408.69
00591	Radiology prosthetic device					
	To be used once per planning session for any region					
00320	CT guidance (separate procedure)				16.920	R 2 699.01
	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	R 1 349.42
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.					

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
00340	CT guidance and monitoring for tissue ablation				21.150	R 3 373.64
	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	R 11 229.54
00420	MR Spectroscopy any region	+			28.900	R 4 609.90
	May be added to the regional study, once only.					
00430	MR guidance for needle replacement	+			42.560	R 6 788.81
	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	R 1 914.21
00450	MR planning study for radiotherapy or surgical procedure				38.000	R 6 061.51
00455	MR planning study for radiotherapy or surgical procedure, with contrast				47.000	R 7 497.16
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	R 6 541.56
	A machine code may be added once per complete procedure / patient visit.					
00520	Analogue monoplane table with DSA attachment	+			47.500	R 7 576.76

	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	R 7 576.76
	A machine code may be added once per complete procedure / patient visit.					
00540	Digital monoplane screening table	+			79.920	R 12 748.12
	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	R 14 839.30
	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	R 19 939.04
	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	R 5 484.41		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT		48.330	R 7 590.21		
00906	Nuclear Medicine study - Venous thrombosis regional		21.540	R 3 382.77		
00909	Nuclear Medicine study - Tumour whole body		34.150	R 5 363.28		
00912	Nuclear Medicine study - Tumour whole body multiple studies		47.560	R 7 469.25		
00915	Nuclear Medicine study - Tumour whole body and SPECT		47.560	R 7 469.25		
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT		60.980	R 9 577.04		
00921	Nuclear Medicine study – Infection whole body		31.450	R 4 939.40		
00924	Nuclear Medicine study – infection whole body with SPECT		44.860	R 7 045.20		
00927	Nuclear Medicine study – infection whole body multiple studies		44.860	R 7 045.20		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies		58.270	R 9 151.49		
00933	Nuclear Medicine study - Bone marrow imaging limited area		24.100	R 3 785.05		
00936	Nuclear Medicine study - Bone marrow imaging whole body		37.510	R 5 891.03		
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies		37.510	R 5 891.03		
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies		50.920	R 7 997.15		
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic		24.100	R 3 785.05		
00960	Nuclear Medicine therapy – Hyperthyroidism		11.990	R 1 882.98		
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases		6.470	R 1 016.26		

00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy		6.470	R 1 016.26		
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy		6.470	R 1 016.26		
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate		6.470	R 1 016.26		
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy		6.470	R 1 016.26		
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 Fund				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 Fund					
2.	**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 to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. • Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. • Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. • Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.					
01010	Emergency call out fee, first case				3.000	R 478.55
01020	Emergency call out fee, subsequent cases same trip				2.000	R 318.87
01030	Radiologist assistance in theatre, per half hour				6.000	R 956.94
01040	Radiographer attendance in theatre, per half hour				1.600	R 255.23
01050	Written report on study done elsewhere, short				1.500	R 239.28
01055	Written report on study done elsewhere, extensive				4.200	R 669.80
01060	Written report for medico legal purposes, per hour				9.720	R 1 550.32
01070	Consultation for pre-assessment of interventional procedure				4.860	R 775.32
01100	X-ray procedure after hours, per procedure				2.000	R 318.87
01200	Ultrasound procedure after hours, per procedure				4.000	R 638.08
01300	CT procedure after hours, per procedure				10.000	R 1 595.01
01400	MR procedure after hours, per procedure				14.000	R 2 233.24
01500	Angiography procedure after hours, per procedure				20.000	R 3 190.35

01600	Interventional procedure after hours, per procedure				26.000	R 4 147.29
01970	Consultation for nuclear medicine study		2.200	R 345.46		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
3.	**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	R 318.87
4	**Head**					
4.1	**Skull and Brain**					
	Codes 10100 (skull) and 10110 (tomography) may be combined.					
10100	X-ray of the skull				3.860	R 615.64
10110	X-ray tomography of the skull				4.300	R 685.92
10120	X-ray shuntogram for VP shunt				15.360	R 2 450.09
10200	Ultrasound of the brain – Neonatal				7.380	R 1 177.28
10210	Ultrasound of the brain including doppler				13.220	R 2 108.79
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler				15.040	R 2 399.08
10300	CT Brain uncontrasted				22.650	R 3 613.07
10310	CT Brain with contrast only				33.280	R 5 308.62
10320	CT Brain pre and post contrast				40.480	R 6 457.14
10325	CT brain pre and post contrast for perfusion studies				49.100	R 7 831.98
	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	R 12 375.09
10335	CT of the brain pre and post contrast with angiography				97.910	R 15 617.78
10340	CT brain for cranio-stenosis including 3D				34.160	R 5 449.02
10350	CT Brain stereotactic localisation				19.360	R 3 088.17
10360	CT base of skull coronal high resolution study for CSF leak				34.900	R 5 567.01
10400	MR of the brain, limited study				43.560	R 6 948.32
10410	MR of the brain uncontrasted				63.800	R 10 176.89
10420	MR of the brain with contrast				75.940	R 12 113.54
10430	MR of the brain pre and post contrast				104.040	R 16 595.65
10440	MR of the brain pre and post contrast, for perfusion studies				107.440	R 17 138.01

10450	MR of the brain plus angiography				92.200	R 14 706.87
10460	MR of the brain pre and post contrast plus angiography				121.230	R 19 337.53
10470	MR angiography of the brain uncontrasted				58.500	R 9 331.46
10480	MR angiography of the brain contrasted				74.020	R 11 806.96
10485	MR of the brain, with diffusion studies				79.000	R 12 601.40
10490	MR of the brain, pre and post contrast, with diffusion studies,				110.640	R 17 648.30
10492	MR study of the brain plus angiography plus diffusion, uncontrasted				95.000	R 15 153.52
10495	MR of the brain pre and post contrast plus angiography and diffusion				125.440	R 20 009.17
10500	Arteriography of intracranial vessels: 1 - 2 vessels				48.600	R 7 752.23
10510	Arteriography of intracranial vessels: 3 - 4 vessels				82.330	R 13 132.46
10520	Arteriography of extra-cranial (non-cervical) vessels				48.440	R 7 726.64
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels				118.090	R 18 836.72
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography				97.570	R 15 563.61
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography				37.290	R 5 948.18
10560	Venography of dural sinuses				52.230	R 8 331.31
10900	Nuclear Medicine study – Bone regional, static		21.500	R 3 376.45		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
10905	Nuclear Medicine study – Bone regional, static, with flow		27.530	R 4 323.76		
10910	Nuclear Medicine study – Bone regional, static with SPECT		34.920	R 5 484.41		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT		40.940	R 6 429.56		
10920	Nuclear Medicine study – Brain, planar, complete, static		16.920	R 2 657.14		
10925	Nuclear Medicine study – Brain complete static with vascular flow		22.950	R 3 604.27		
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT		30.330	R 4 763.59		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT		36.360	R 5 710.57		
10940	Nuclear Medicine study - CSF flow imaging cisternography		21.600	R 3 392.24		
10945	Nuclear Medicine study – Ventriculography		13.410	R 2 106.13		
10950	Nuclear Medicine study - Shunt evaluation static, planar		13.410	R 2 106.13		
10955	Nuclear Medicine study - CFS leakage detection and localisation		13.410	R 2 106.13		
10960	Nuclear medicine study - CSF SPECT		13.410	R 2 106.13		
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	
4.2	**Facial bones and nasal bones**					
	Codes 11100 (facial bones) and 11110 (tomography) may be combined					
11100	X-ray of the facial bones				3.930	R 626.93
11110	X-ray tomography of the facial bones				4.300	R 685.92
11120	X-ray of the nasal bones				2.390	R 381.35
11300	CT of the facial bones				20.960	R 3 343.39
11310	CT of the facial bones with 3D reconstructions				30.400	R 4 849.17
11320	CT of the facial bones/soft tissue, pre and post contrast				41.260	R 6 581.43
11400	MR of the facial soft tissue				62.400	R 9 953.40
11410	MR of the facial soft tissue pre and post contrast				100.600	R 16 046.98
11420	MR of the facial soft tissue plus angiography, with contrast				110.300	R 17 594.14
11430	MR angiography of the facial soft tissue				74.020	R 11 806.96
4.3	**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	R 567.78
12110	X-ray of the orbits, three or more views, including foramina				5.300	R 845.45
12120	X-ray of the orbits for foreign body				3.560	R 567.78
12130	X-ray tomography of the orbits				4.300	R 685.92
12140	X-ray dacrocystography				11.200	R 1 786.60
12200	Ultrasound of the orbit/eye				5.130	R 818.36
12210	Ultrasound of the orbit/eye including doppler				10.970	R 1 749.71
12300	CT of the orbits single plane				15.700	R 2 504.43
12310	CT of the orbits, more than one plane				20.590	R 3 284.24
12320	CT of the orbits pre and post contrast single plane				36.030	R 5 747.12
12330	CT of the orbits pre and post contrast multiple planes				39.700	R 6 332.52
12400	MR of the orbits				62.460	R 9 963.21
12410	MR of the orbitae, pre and post contrast				100.640	R 16 053.30
12900	Nuclear Medicine study – Dacrocystography		20.770	R 3 261.80		

Code	Description	Add	Nuclear Medicine	Radiology

			Units	Value	Units	Value
4.4	**Paranasal sinuses**					
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).					
13100	X-ray of the paranasal sinuses, single view				2.740	R 437.02
13110	X-ray of the paranasal sinuses, two or more views				3.660	R 583.90
13120	X-ray tomography of the paranasal sinuses				4.300	R 685.92
13130	X-ray of the naso-pharyngeal soft tissue				2.740	R 437.02
13300	CT of the paranasal sinuses single plane, limited study				7.200	R 1 148.53
13310	CT of the paranasal sinuses, two planes, limited study				12.400	R 1 978.02
13320	CT of the paranasal sinuses, any plane, complete study				15.420	R 2 459.73
13330	CT of the paranasal sinuses, more than one plane, complete study				20.770	R 3 312.98
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast				34.740	R 5 541.58
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast				41.010	R 6 541.56
13400	MR of the paranasal sinuses				60.270	R 9 613.59
13410	MR of the paranasal sinuses, pre and post contrast				96.590	R 15 407.25
4.5	**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 (tomography) may be combined with 14130 or 14140 or 14150 (teeth). Code 14160 (tomography) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14330 and 14340 (Dental implants) may be combined if mandible and maxilla are examined at the same visit.					
14100	X-ray of the mandible				3.660	R 583.90
14110	X-ray orthopantomogram of the jaws and teeth				4.060	R 647.54
14120	X-ray maxillofacial cephalometry				2.770	R 441.83
14130	X-ray of the teeth single quadrant				2.000	R 318.87
14140	X-ray of the teeth more than one quadrant				2.530	R 403.78
14150	X-ray of the teeth full mouth				3.620	R 577.42
14160	X-ray tomography of the teeth per side				3.230	R 515.28
14300	CT of the mandible				22.280	R 3 553.92
14310	CT of the mandible, pre and post contrast				41.260	R 6 581.43
14320	CT mandible with 3D reconstructions				30.400	R 4 849.17
14330	CT for dental implants in the mandible				27.450	R 4 378.59
14340	CT for dental implants in the maxilla				27.450	R 4 378.59
14400	MR of the mandible/maxilla				63.800	R 10 176.89
14410	MR of the mandible/maxilla, pre and post contrast				98.640	R 15 734.43

4.6	**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	R 567.78
15110	X-ray tempero-mandibular joint, right				3.560	R 567.78
15120	X-ray tomography tempero-mandibular joint, left				4.300	R 685.92
15130	X-ray tomography tempero-mandibular joint, right				4.300	R 685.92
15140	X-ray arthrography of the tempero-mandibular joint, left				15.410	R 2 458.06
15150	X-ray arthrography of the tempero-mandibular joint, right				15.410	R 2 458.06
15200	Ultrasound tempero-mandibular joints, one or both sides				6.560	R 1 046.33
15300	CT of the tempero-mandibular joints				25.380	R 4 048.43
15310	CT of the tempero-mandibular joints plus 3D reconstructions				34.500	R 5 503.20
15320	CT arthrogram of the tempero-mandibular joints				35.960	R 5 736.00

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
15400	MR of the tempero-mandibular joints				63.800	R 10 176.89
15410	MR of the tempero-mandibular joints, pre and post contrast				100.840	R 16 085.20
15420	MR arthrogram of the tempero-mandibular joints				74.710	R 11 917.13
4.7	**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	R 572.77
16110	X-ray of the mastoids, bilateral				7.180	R 1 145.21
16120	X-ray tomography of the petro-temporal bone, unilateral				4.300	R 685.92
16130	X-ray tomography of the petro-temporal bone, bilateral				8.600	R 1 371.69
16140	X-ray internal auditory canal, bilateral				5.230	R 834.31
16150	X-ray tomography of the internal auditory canal, bilateral				4.300	R 685.92
16300	CT of the mastoids				12.600	R 2 009.92
16310	CT of the internal auditory canal				21.470	R 3 424.64
16320	CT of the internal auditory canal, pre and post contrast				34.200	R 5 455.34
16330	CT of the ear structures, limited study				13.400	R 2 137.54
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes				43.350	R 6 914.76

16400	MR of the internal auditory canals, limited study				43.560	R 6 948.32
16410	MR of the internal auditory canals, pre and post contrast, limited study				68.930	R 10 995.25
16420	MR of the internal auditory canals, pre and post contrast, complete study				102.640	R 16 372.16
16430	MR of the ear structures				64.400	R 10 272.61
16440	MR of the ear structures, pre and post contrast				102.640	R 16 372.16
4.8	**Sella turcica**					
	Code 17100 (sella) and 17110 (tomography) may be combined.					
17100	X-ray of the sella turcica				3.080	R 491.34
17110	X-ray tomography of the sella turcica				4.300	R 685.92
17300	CT of the sella turcica/hypophysis				17.450	R 2 783.42
17310	CT of the sella turcica/hypophysis, pre and post contrast				42.260	R 6 740.95
17400	MR of the hypophysis				43.560	R 6 948.32
17410	MR of the hypophysis, pre and post contrast				74.030	R 11 808.63
4.9	**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	R 452.97
18110	X-ray of the salivary ducts, open mouth for calculus				1.900	R 303.08
18120	X-ray sialography, per gland				14.080	R 2 246.04
18200	Ultrasound of the salivary glands/floor of the mouth				6.560	R 1 046.33
18300	CT of the salivary glands, uncontrasted				12.600	R 2 009.92
18310	CT of the salivary glands/floor of the mouth, pre and post contrast				42.100	R 6 715.54
18320	CT sialography				26.280	R 4 191.99
18400	MR of the salivary glands/floor of the mouth				63.200	R 10 081.19
18410	MR of the salivary glands/floor of the mouth, pre and post contrast				100.840	R 16 085.20
18900	Nuclear Medicine study - Salivary gland imaging		20.770	R 3 261.80		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
4.10	**Soft Tissue**					
19900	Nuclear Medicine study - Tumour localisation planar, static		20.740	R 3 257.48		
19905	Nuclear Medicine study - Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		
19910	Nuclear Medicine study - Tumour localisation planar, static and SPECT		34.150	R 5 363.28		

19915	Nuclear Medicine study - Tumour localisation planar, static, multiple studies and SPECT		47.560	R 7 469.25		
19920	Nuclear medicine study - Infection localisation planar, static		18.040	R 2 833.26		
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies		31.450	R 4 939.40		
19930	Nuclear medicine study - Infection localisation planar, static and SPECT		31.450	R 4 939.40		
19935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT		44.860	R 7 045.20		
5.	**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	R 437.02
20110	X-ray of the larynx including tomography				9.390	R 1 497.81
20120	X-ray laryngography				8.280	R 1 320.67
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording				8.300	R 1 323.83
20200	Ultrasound of the thyroid				6.560	R 1 046.33
20210	Ultrasound of soft tissue of the neck				6.560	R 1 046.33
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler				15.000	R 2 392.76
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler				21.840	R 3 483.80
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler				10.800	R 1 722.63
20300	CT of the soft tissues of the neck				18.250	R 2 911.03
20310	CT of the soft tissues of the neck, with contrast				38.150	R 6 085.43
20320	CT of the soft tissues of the neck, pre and post contrast				43.810	R 6 988.38
20330	CT angiography of the extracranial vessels in the neck				79.360	R 12 658.89
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain				107.500	R 17 147.49
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	R 19 847.99
20400	MR of the soft tissue of the neck				63.600	R 10 144.83
20410	MR of the soft tissue of the neck, pre and post contrast				102.040	R 16 276.62
20420	MR of the soft tissue of the neck and uncontrasted angiography				92.600	R 14 770.84
20430	MR angiography of the extracranial vessels in the neck, without contrast				59.600	R 9 507.09
20440	MR angiography of the extracranial vessels in the neck, with contrast				74.020	R 11 806.96
20450	MR angiography of the extra and intracranial vessels with contrast				116.050	R 18 511.36
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast				135.170	R 21 561.14
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast				156.050	R 24 891.91

20500	Arteriography of cervical vessels: carotid 1 - 2 vessels				44.430	R 7 087.24
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels				50.730	R 8 092.04

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
20520	Arteriography of cervical vessels: carotid and vertebral				77.630	R 12 382.73
20530	Arteriography of aortic arch and cervical vessels				91.970	R 14 670.31
20540	Arteriography of aortic arch, cervical and intracranial vessels				108.870	R 17 365.99
20550	Venography of jugular and vertebral veins				48.950	R 7 808.06
5.1	**Thyroid (Nuclear Medicine)**					
21900	Nuclear Medicine study - Thyroid, single uptake		9.680	R 1 520.24		
21910	Nuclear medicine study - Thyroid, multiple uptake		14.690	R 2 307.19		
21920	Nuclear medicine study - Thyroid imaging with uptake		17.720	R 2 782.92		
21930	Nuclear medicine study - Thyroid imaging		12.720	R 1 997.63		
21940	Nuclear medicine study - Thyroid imaging with vascular flow		18.740	R 2 943.10		
21950	Nuclear medicine study - Thyroid suppression/stimulation		12.720	R 1 997.63		
21960	PET scan of the thyroid - by arrangement with Fund				-	-
5.2	**Parathyroid (Nuclear Medicine)**					
22900	Nuclear Medicine study - Parathyroid, planar, static		16.520	R 2 594.49		
22910	Nuclear medicine study - Parathyroid, planar, static, multiple		28.910	R 4 540.61		
22920	Nuclear medicine study - Parathyroid, planar, static with subtraction technique		21.880	R 3 436.27		
22930	Nuclear medicine study - Parathyroid SPECT		13.410	R 2 106.13		
22940	PET scan of the parathyroid - by arrangement with Fund					
5.3	**Soft Tissue**					
29900	Nuclear Medicine study - Tumour localisation planar, static		20.740	R 3 257.48		
29905	Nuclear medicine study - Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		
29910	Nuclear medicine study - Tumour localisation planar, static and SPECT		34.150	R 5 363.28		
29915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT		47.560	R 7 469.25		
29920	Nuclear medicine study - Tumour localisation planar, static		18.040	R 2 833.26		
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies		31.450	R 4 939.40		
29930	Nuclear medicine study - Infection localisation planar, static and SPECT		31.450	R 4 939.40		
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT		44.860	R 7 045.20		

29940	Nuclear medicine study - Regional lymph node mapping, static, planar		24.100	R 3 785.05		
29945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple		36.490	R 5 730.68		
29950	Nuclear medicine study – Lymph node localisation with gamma probe		12.390	R 1 946.12		
29960	PET scan of the soft tissue of the neck - by arrangement with Fund					
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	
6.	**Thorax**					
6.1	**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	R 485.04
30110	X-ray of the chest two views, PA and lateral				3.840	R 612.49

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
30120	X-ray of the chest complete with additional views				4.240	R 676.46
30130	X-ray of the chest complete including fluoroscopy				4.480	R 714.50
30140	X-ray tomography of the chest				4.300	R 685.92
30150	X-ray of the ribs				4.790	R 764.19
30155	X-ray of the chest and ribs				6.420	R 1 023.90
30160	X-ray of the thoracic inlet				2.560	R 408.27
30170	X-ray of the sterno-clavicular joints				4.210	R 671.64
30175	X-ray tomography of the sterno-clavicular joint				4.300	R 685.92
30180	X-ray of the sternum				4.210	R 671.64
30185	X-ray tomography of the sternum				4.300	R 685.92
30200	Ultrasound of the chest wall, any region				6.560	R 1 046.33
30210	Ultrasound of the pleural space				6.560	R 1 046.33
30220	Ultrasound of the mediastinal structures				6.560	R 1 046.33
30300	CT of the chest, limited study				9.500	R 1 515.25
30310	CT of the chest uncontrasted				26.600	R 4 243.01
30320	CT of the chest contrasted				42.430	R 6 767.86
30330	CT of the chest, pre and post contrast				45.700	R 7 289.62
30340	CT of the chest, limited high resolution study				11.200	R 1 786.60

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30350	CT of the chest, complete high resolution study				24.010	R 3 829.92
30355	CT of the chest, complete high resolution study with additonal prone and expiratory studies				33.300	R 5 311.77
30360	CT of the chest for pulmonary embolism				57.120	R 9 111.45
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs				80.280	R 12 805.61
30400	MR of the chest				63.600	R 10 144.83
30410	MR of the chest with uncontrasted angiography				92.600	R 14 770.84
30420	MR of the chest, pre and post contrast				102.040	R 16 276.62
30900	Nuclear Medicine study - Lung perfusion		21.540	R 3 382.77		
30910	Nuclear Medicine study - Lung ventilation, aerosol		21.500	R 3 376.45		
30920	Nuclear Medicine study - Lung perfusion and ventilation		42.030	R 6 600.87		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas		14.170	R 2 225.44		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas		34.690	R 5 448.02		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic		26.510	R 4 163.41		
30960	Nuclear medine study - alveolar permeabillity		26.510	R 4 163.41		
	Stand alone code. Not to be combined with 30910.					
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation		6.020	R 945.47		
	Stand alone code. Not to be combined with 30920.					
30980	PET scan of the chest - by arrangement with Fund					
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	
6.2	**Oesophagus**					
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).					
31100	X-ray barium swallow				6.600	R 1 052.65
31105	Xray 3 phase dynamic contrasted swallow				12.600	R 2 009.92
31110	X-ray barium swallow, double contrast				7.920	R 1 263.18
31120	X-ray barium swallow with cinematography				10.070	R 1 606.31

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
6.3	**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	R 669.80
32210	Ultrasound intravascular (IVUS) first vessel				8.440	R 1 346.26
32220	Ultrasound intravascular (IVUS) subsequent vessels				5.300	R 845.45
32300	CT angiography of the aorta and branches				79.080	R 12 614.36
32305	CT angiography of the thoracic and abdominal aorta and branches				105.500	R 16 828.62
32310	CT angiography of the pulmonary vasculature				79.080	R 12 614.36
32400	MR angiography of the aorta and branches				78.500	R 12 521.81
32410	MR angiography of the pulmonary vasculature				105.270	R 16 791.72
32500	Arteriography of thoracic aorta				28.260	R 4 507.70
32510	Arteriography of bronchial intercostal vessels alone				50.150	R 7 999.48
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels				67.430	R 10 755.98
32530	Arteriography of pulmonary vessels				63.270	R 10 092.32
32540	Arteriography of heart chambers, coronary arteries				44.270	R 7 061.65
32550	Venography of thoracic vena cava				28.380	R 4 526.81
32560	Venography of vena cava, azygos system				56.310	R 8 982.18
32570	Venography patency of A-port or other central line				19.640	R 3 132.86
6.4	**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	R 1 962.07
	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					R -
33200	Ultrasound study of the heart, including Doppler				8.200	R 1 307.88
33210	Ultrasound study of the heart trans-oesophageal				10.520	R 1 678.26
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel				5.200	R 829.50
33300	CT anatomical/functional study of the heart				34.610	R 5 520.80
33310	CT angiography of heart vessels				81.280	R 12 965.29
33400	MR of the heart, anatomical study				62.200	R 9 921.66
33410	MR of the heart, anatomical and functional study				69.000	R 11 006.23
33420	MR of the heart, pre and post contrast				103.040	R 16 436.14
33430	MR angiography of the heart vessels				70.710	R 11 279.07
33440	MR of the heart, anatomical, functional and coronary angiography				106.840	R 17 042.31
33900	Nuclear Medicine study - Cardiac shunt detection		21.500	R 3 376.45		

33905	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion single study		26.510	R 4 163.41		
33910	Nuclear Medicine study - Cardiac blood pool imaging, ejection fraction plus wall motion multiple studies		34.920	R 5 484.41		
33915	Nuclear Medicine study - Cardiac blood pool imaging, gated SPECT		13.410	R 2 106.13		
33920	Nuclear medicine study - Cardiac blood pool imaging, first pass technique		26.510	R 4 163.41		
33925	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi) planar, non gated		16.520	R 2 594.49		
33930	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi) planar, non gated		16.520	R 2 594.49		
33935	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (non gated)		16.520	R 2 594.49		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
33940	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT non gated		16.520	R 2 594.49		
33945	Nuclear medicine study - Myocardial perfusion, single, rest (thallium/mibi), SPECT (gated)		28.910	R 4 540.61		
33950	Nuclear medicine study - Myocardial perfusion, single, stress (thallium/mibi), SPECT (gated)		28.910	R 4 540.61		
33955	Nuclear medicine study - Plus wall movement and ejection fraction, SPECT		6.020	R 945.47		
33960	Nuclear medicine study - Cardiac hot spot imaging (infarction) planar		21.500	R 3 376.45		
33965	Nuclear medicine study - Cardiac hot spot imaging (infarction) SPECT		13.410	R 2 106.13		
33970	Nuclear Medicine study - Multi stage treadmill ECG test		6.660	R 1 046.00		
33980	PET scan of the heart - by arrangement with Fund				-	-
33981	PET/CT scan of the heart - by arrangement with Fund					-
6.5	**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	R 1 665.13
34101	X-Ray mammography unilateral, including ultrasound				8.352	R 1 332.31
	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					R -
34105	X-ray mammography galactography				9.400	R 1 499.30
	Once off fee per visit. May be added to 34100					
34110	X-ray mammography study for localisation				7.240	R 1 154.84
34120	X-ray stereotactic mammography – localisation				10.400	R 1 658.82
34130	X-ray stereotactic mammography – biopsy				11.600	R 1 850.40
34140	X-ray of biopsy specimen of the mamma				2.740	R 437.02
34150	X-ray Mammotome hand held biopsy apparatus				9.800	R 1 563.11

34200	Ultrasound study of the breast				7.900	R 1 260.02
34205	Ultrasound guided aspiration FNA/localisation of the breast				12.100	R 1 930.33
34300	Computer assisted diagnosis for mammography				1.400	R 223.33
34400	MR study of the breast				62.600	R 9 985.47
34410	MR study of the breast pre and post contrast				100.840	R 16 085.20
34900	PET scan of the breast/mamma - by arrangement with scheme				-	-
6.6	**Soft Tissue**					
39900	Nuclear medicine study - Tumour localisation planar, static		20.740	R 3 257.48		
39905	Nuclear medicine study - Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		
39910	Nuclear medicine study - Tumour localisation planar, static and SPECT		34.150	R 5 363.28		
39915	Nuclear medicine study - Tumour localisation planar, static, multiple studies and SPECT		47.560	R 7 469.25		
39920	Nuclear medicine study - Infection localisation planar, static		18.040	R 2 833.26		
	Nuclear medicine study - Infection localisation planar, static, multiple studies		31.450	R 4 939.40		
39930	Nuclear medicine study - Infection localisation planar, static and SPECT		31.450	R 4 939.40		
39935	Nuclear medicine study - Infection localisation planar, static, multiple studies, SPECT		44.860	R 7 045.20		
39940	Nuclear medicine study - Regional lymph node mapping, static, planar		24.100	R 3 785.05		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
39945	Nuclear medicine study - Regional lymph node mapping, static, planar, multiple		36.490	R 5 730.68		
39950	Nuclear medicine study – Lymph node localisation with gamma probe		12.390	R 1 946.12		
7.	**Abdomen and Pelvis**					
7.1	**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	R 529.56
40105	X-ray of the abdomen supine and erect, or decubitus				5.360	R 854.91
40110	X-ray of the abdomen multiple views including chest				8.100	R 1 292.09
40120	X-ray tomography of the abdomen				4.300	R 685.92
40140	X-ray barium meal single contrast				8.870	R 1 414.89
40143	X-ray barium meal double contrast				11.990	R 1 912.55
40147	X-ray barium meal double contrast with follow through				15.800	R 2 520.22

40150	X-ray small bowel enteroclysis (meal)				25.450	R 4 059.56
	Code 40150 excludes duodenal intubation and 40175 (Duodenal intubation) may be added.					
40153	X-ray small bowel meal follow through single contrast				19.550	R 3 118.41
40157	X-ray small bowel meal with pneumocolon				25.630	R 4 088.31
40160	X-ray large bowel enema single contrast				12.970	R 2 068.92
40165	X-ray large bowel enema double contrast				19.630	R 3 131.20
40170	X-ray guided gastro oesophageal intubation				1.600	R 255.23
40175	X-ray guided duodenal intubation				2.800	R 446.65
40180	X-ray defaecogram				12.970	R 2 068.92
40190	X-ray guided reduction of intussusception				16.270	R 2 595.16
40200	Ultrasound study of the abdominal wall				5.540	R 883.66
40210	Ultrasound study of the whole abdomen including the pelvis				8.240	R 1 314.19
40300	CT study of the abdomen				26.410	R 4 212.76
40310	CT study of the abdomen with contrast				44.820	R 7 149.38
40313	CT study of the abdomen pre and post contrast				52.990	R 8 452.45
40320	CT of the pelvis				26.130	R 4 168.24
40323	CT of the pelvis with contrast				47.480	R 7 573.60
40327	CT of the pelvis pre and post contrast				53.870	R 8 592.85
40330	CT of the abdomen and pelvis				38.500	R 6 141.09
40333	CT of the abdomen and pelvis with contrast				62.170	R 9 916.69
40337	CT of the abdomen and pelvis pre and post contrast				67.430	R 10 755.98
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast				74.110	R 11 821.43
40345	CT of the chest, abdomen and pelvis without contrast				70.120	R 11 184.85
40350	CT of the chest, abdomen and pelvis with contrast				88.350	R 14 093.06
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast				93.050	R 14 842.46
40360	CT of the base of skull to symphysis pubis with contrast				102.730	R 16 386.63
40365	CT colonoscopy				34.780	R 5 547.90
	Stand alone study, may not be added to any code between 40300 and 40360					
40400	MR of the abdomen				64.580	R 10 301.18
40410	MR of the abdomen pre and post contrast				100.840	R 16 085.20
40420	MR of the pelvis, soft tissue				64.580	R 10 301.18
40430	MR of the pelvis, soft tissue, pre and post contrast				102.040	R 16 276.62

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Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying		21.500	R 3 376.45		
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies		34.920	R 5 484.41		
40910	Nuclear Medicine study - Gastro intestinal protein loss		21.500	R 3 376.45		
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies		34.920	R 5 484.41		
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic		21.500	R 3 376.45		
40925	Nuclear medicine study – Acute GIT bleed multiple studies		34.920	R 5 484.41		
40930	Nuclear medicine study - Meckel's localisation		20.770	R 3 261.80		
40935	Nuclear medicine study - Gastric mucosa imaging		20.770	R 3 261.80		
40940	Nuclear medicine study - colonic transit multiple studies		44.860	R 7 045.20		
	Stand alone code					
40950	PET scan of the abdomen and pelvis - by arrangement with Fund					
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	
7.2	**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	R 3 014.72
41105	X-ray ERCP reporting on images done in theatre				2.400	R 382.84
41110	X-ray cholangiography intra-operative				8.450	R 1 347.76
41120	X-ray T-tube cholangiography post operative				14.050	R 2 241.06
41130	X-ray transhepatic percutaneous cholangiography				32.340	R 5 158.57
41200	Ultrasound study of the upper abdomen				7.000	R 1 116.46
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis				9.800	R 1 563.11
	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	R 8 757.36
41400	MR study of the liver/pancreas				64.780	R 10 333.09
41410	MR study of the liver/pancreas pre and post contrast				100.840	R 16 085.20
41420	MRCP				49.200	R 7 847.93
41430	MR study of the abdomen with MRCP				92.980	R 14 831.32
41440	MR study of the abdomen pre and post contrast with MRCP				133.600	R 21 310.73

41900	Nuclear Medicine study - Liver and spleen, planar views only		21.500	R 3 376.45		
41905	Nuclear Medicine study - Liver and spleen, with flow study		27.530	R 4 323.76		
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT		34.920	R 5 484.41		
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT		40.940	R 6 429.56		
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic		21.500	R 3 376.45		
41925	Nuclear Medicine study – hepatobiliary tract including flow		26.510	R 4 163.41		
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies		34.920	R 5 484.41		
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies		39.920	R 6 269.37		
41940	Nuclear medicine study - Gall bladder ejection fraction		6.020	R 945.47		
41945	Nuclear medicine study – Biliary gastric reflux study		20.770	R 3 261.80		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
7.3	**Renal tract**					
42100	X-ray tomography of the renal tract				4.300	R 685.92
	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	R 3 965.35
42115	X-ray excretory urogram including tomography with micturating study				32.860	R 5 241.65
42120	X-ray cystography				15.050	R 2 400.58
42130	X-ray urethrography				15.370	R 2 451.58
42140	X-ray micturating cysto-urethrography				19.300	R 3 078.53
42150	X-ray retrograde/prograde pyelography				12.530	R 1 998.63
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre				2.410	R 384.51
42160	X-ray prograde pyelogram – percutaneous				32.670	R 5 211.25
42200	Ultrasound study of the renal tract including bladder				7.420	R 1 183.59
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney				3.800	R 606.17
	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	R 1 690.72
42300	CT of the renal tract for a stone				25.150	R 4 011.87
42400	MR of the renal tract for obstruction				47.000	R 7 497.16
42410	MR of the kidneys without contrast				64.580	R 10 301.18

42420	MR of the kidneys pre and post contrast				102.240	R 16 308.53
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)		21.940	R 3 445.91		
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow		27.960	R 4 391.22		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT		35.350	R 5 551.71		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT		41.370	R 6 497.53		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow		26.510	R 4 163.41		
42930	Nuclear Medicine study – Renovascular study, baseline		26.510	R 4 163.41		
42940	Nuclear Medicine study – Renovascular study, with intervention		26.510	R 4 163.41		
42950	Nuclear medicine study - indirect voiding cystogram		6.020	R 945.47		
7.4	**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	R 638.08
43110	X-ray pelvimetry multiple views				5.800	R 925.04
43120	X-ray hystero-salpingography				10.030	R 1 599.83
43130	X-ray hystero-salpingography with introduction of contrast				13.530	R 2 158.31
43200	Ultrasound study of the pelvis transabdominal				5.700	R 909.08
43205	Ultrasound study of the female pelvis transvaginal				7.210	R 1 150.02
43210	Ultrasound study of the prostate transrectal				7.380	R 1 177.28
43215	Ultrasound transrectal prostate volume for brachytherapy				10.400	R 1 658.82
43220	Ultrasound study of the testes				7.380	R 1 177.28

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
43225	Ultrasound study for male impotence including doppler and injection of vaso contrictor				15.000	R 2 392.76
	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	R 2 153.49
43240	Ultrasound guided amniocenthesis				5.840	R 931.52
43250	Ultrasound study of the pregnant uterus, first trimester				4.200	R 669.80
43260	Ultrasound study of the pregnant uterus, second trimester				6.360	R 1 014.44
43270	Ultrasound study of the pregnant uterus, third trimester, first visit				6.360	R 1 014.44
43273	Ultrasound study of the pregnant uterus, third trimester, follow-up visit				4.200	R 669.80
43277	Ultrasound study of the pregnant uterus, multiple gestation, second or third trimester, first visit				8.170	R 1 303.40

43280	Ultrasound doppler of the umbilical cord for resistive index				3.800	R 606.17
	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	R 1 049.49
43400	MR study of pelvic reproductive organs - limited study				47.600	R 7 592.71
43405	MR study for pelvimetry				20.000	R 3 190.35
43410	MR study of pelvic reproductive organs - complete – uncontrasted				64.580	R 10 301.18
43420	MR study of pelvic reproductive organs - complete – pre and post contrast				102.240	R 16 308.53
43950	Nuclear medicine study - Radio pharmaceutical voiding cystogram		21.500	R 3 376.45		
43960	Nuclear medicine study - Testicular imaging		26.510	R 4 163.41		
43961	PET scan of the testis - by arrangement with Fund				-	-
43970	Nuclear medicine study - hystero-salpingography		26.510	R 4 163.41		
7.5	**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	R 2 922.16
44205	Ultrasound study of the IVC and pelvic veins including Doppler				14.000	R 2 233.24
	This is a stand alone code and may not be added to 44200.					
44300	CT angiography of abdominal aorta and branches				76.720	R 12 237.66
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen				94.320	R 15 045.01
44310	CT angiography of the pelvis				78.640	R 12 544.08
44320	CT angiography of the abdominal aorta and pelvis				89.540	R 14 282.65
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis				119.150	R 19 005.71
44330	CT portogram				74.400	R 11 867.62
44400	MR angiography of abdominal aorta and branches				76.640	R 12 224.87
44500	Arteriography of abdominal aorta alone				28.120	R 4 485.27
44503	Arteriography of aorta plus coeliac, mesenteric branches				75.630	R 12 063.86
44505	Arteriography of aorta plus renal, adrenal branches				63.010	R 10 050.78
44507	Arteriography of aorta plus non-visceral branches				60.790	R 9 696.68
44510	Arteriography of coeliac, mesenteric vessels alone				64.350	R 10 264.46
44515	Arteriography of renal, adrenal vessels alone				49.490	R 7 894.30
44517	Arteriography of non-visceral abdominal vessels alone				54.910	R 8 758.68
44520	Arteriography of internal and external iliac vessels alone				56.720	R 9 047.48
44525	Venography of internal and external iliac veins alone				62.110	R 9 907.21

44530	Corpora cavernosography				25.060	R 3 997.42
44535	Vasography, vesciculography				29.190	R 4 656.09

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
44540	Venography of inferior vena cava				26.120	R 4 166.40
44543	Venography of hepatic veins alone				53.770	R 8 577.06
44545	Venography of inferior vena cava and hepatic veins				68.910	R 10 992.09
44550	Venography of lumbar azygos system alone				43.890	R 7 000.83
44555	Venography of inferior vena cava and lumbar azygos veins				65.460	R 10 441.60
44560	Venography of renal, adrenal veins alone				43.990	R 7 016.78
44565	Venography of inferior vena cava and renal/adrenal veins				68.390	R 10 909.02
44570	Venography of spermatic, ovarian veins alone				40.390	R 6 442.68
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins				73.990	R 11 802.32
44580	Venography indirect splenoportogram				48.670	R 7 763.36
44583	Venography direct splenoportogram				31.590	R 5 038.93
44587	Venography transhepatic portogram				66.750	R 10 647.47
7.6	**Soft Tissue**					
49900	Nuclear Medicine study – Tumour localisation planar, static		20.740	R 3 257.48		
49905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		
49910	Nuclear Medicine study – Tumour localisation planar, static and SPECT		34.150	R 5 363.28		
49915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT		47.560	R 7 469.25		
49920	Nuclear medicine study – Infection localisation planar, static		18.040	R 2 833.26		
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies		31.450	R 4 939.40		
49940	Nuclear medicine study – Infection localisation planar, static and SPECT		31.450	R 4 939.40		
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT		44.860	R 7 045.20		
49960	Nuclear medicine study – Regional lymph node mapping dynamic		5.010	R 786.96		
49965	Nuclear medicine study – Regional lymph node mapping, static, planar		24.100	R 3 785.05		
49970	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple		37.510	R 5 891.03		
49975	Nuclear medicine study – Regional lymph node mapping SPECT		13.410	R 2 106.13		
49980	Nuclear medicine study – Lymph node localisation with gamma probe		13.410	R 2 106.13		
8	**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					
8.1	**General**					
50100	X-ray of the spine scoliosis view AP only				7.000	R 1 116.46
50105	X-ray of the spine scoliosis view AP and lateral				12.000	R 1 914.21
50110	X-ray of the spine scoliosis view AP and lateral including stress views				18.540	R 2 957.39
50120	X-ray bone densitometry				11.520	R 1 837.77
50130	X-ray guided lumbar puncture				4.800	R 765.52
50140	X-ray guided cisternal puncture cisternogram				22.980	R 3 665.59
50300	CT quantitive bone mineral density				11.830	R 1 886.96
50500	Arteriogram of the spinal column and cord, all vessels				127.230	R 20 294.64
50510	Venography of the spinal, paraspinal veins				58.450	R 9 323.31

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
8.2	**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 of the cervical spine, stress views only				4.140	R 660.33
51110	X-ray of the cervical spine, one or two views				3.010	R 480.21
51120	X-ray of the cervical spine, more than two views				4.280	R 682.76
51130	X-ray of the cervical spine, more than two views including stress views				7.580	R 1 209.02
51140	X-ray Tomography cervical spine				4.300	R 685.92
51160	X-ray myelography of the cervical spine				27.460	R 4 380.09
51170	X-ray discography cervical spine per level				25.170	R 4 015.02
51300	CT of the cervical spine limited study				9.500	R 1 515.25
51310	CT of the cervical spine – regional study				13.910	R 2 218.79
51320	CT of the cervical spine – complete study				37.130	R 5 922.76
51330	CT of the cervical spine pre and post contrast				58.850	R 9 387.29
51340	CT myelography of the cervical spine				47.190	R 7 527.41
51350	CT myelography of the cervical spine following myelogram				21.690	R 3 460.03
51400	MR of the cervical spine, limited study				44.400	R 7 082.25
51410	MR of the cervical spine and cranio-cervical junction				64.820	R 10 339.57

51420	MR of the cervical spine and cranio-cervical junction pre and post contrast				102.140	R 16 292.58
51900	Nuclear Medicine study – Bone regional cervical		21.500	R 3 376.45		
51910	Nuclear Medicine study – Bone tomography regional cervical		13.410	R 2 106.13		
51920	Nuclear Medicine study – with flow		6.020	R 945.47		
8.3	**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	R 512.12
52110	X-ray of the thoracic spine, more than two views				4.000	R 638.08
52120	X-ray tomography thoracic spine				4.300	R 685.92
52140	X-ray of the thoracic spine, more that two views including stress views				6.640	R 1 059.13
52150	X-ray myelography of the thoracic spine				18.620	R 2 970.02
52300	CT of the thoracic spine limited study				9.500	R 1 515.25
52305	CT of the thoracic spine – regional study				13.910	R 2 218.79
52310	CT of the thoracic spine complete study				35.780	R 5 707.41
52320	CT of the thoracic spine pre and post contrast				58.850	R 9 387.29
52330	CT myelography of the thoracic spine				48.090	R 7 670.81
52340	CT myelography of the thoracic spine following myelogram				20.370	R 3 249.17
52400	MR of the thoracic spine, limited study				46.600	R 7 433.20
52410	MR of the thoracic spine				64.340	R 10 262.97
52420	MR of the thoracic spine pre and post contrast				101.420	R 16 177.75
52900	Nuclear Medicine study – Bone regional dorsal		21.500	R 3 376.45		
52910	Nuclear Medicine study – Bone tomography regional dorsal		13.410	R 2 106.13		
52920	Nuclear Medicine study – with flow		6.020	R 945.47		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
8.4	**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	R 660.33
53110	X-ray of the lumbar spine, one or two views				3.560	R 567.78
53120	X-ray of the lumbar spine, more than two views				4.460	R 711.35

53130	X-ray of the lumbar spine, more than two views including stress views				7.520	R 1 199.54
53140	X-ray tomography lumbar spine				4.300	R 685.92
53160	X-ray myelography of the lumbar spine				23.940	R 3 818.62
53170	X-ray discography lumbar spine per level				25.170	R 4 015.02
53300	CT of the lumbar spine limited study				9.500	R 1 515.25
53310	CT of the lumbar spine – regional study				13.910	R 2 218.79
53320	Ct of the lumbar spine complete study				37.640	R 6 004.18
53330	CT of the lumbar spine pre and post contrast				58.850	R 9 387.29
53340	CT myelography of the lumbar spine				49.110	R 7 833.65
53350	CT myelography of the lumbar spine following myelogram				23.460	R 3 742.18
53400	MR of the lumbar spine, limited study				46.200	R 7 369.39
53410	MR of the lumbar spine				64.320	R 10 259.82
53420	MR of the lumbar spine pre and post contrast				103.290	R 16 475.85
53900	Nuclear medicine study – Bone regional lumbar		21.500	R 3 376.45		
53910	Nuclear medicine study – Bone tomography regional lumbar		13.410	R 2 106.13		
53920	Nuclear medicine study – with flow		6.020	R 945.47		
8.5	**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	R 570.94
54110	X-ray of the sacro-iliac joints				4.100	R 654.03
54120	X-ray tomography – sacrum and/or coccyx				4.300	R 685.92
54300	CT of the sacrum – limited study				7.600	R 1 212.16
54310	CT of the sacrum – complete study – uncontrasted				25.610	R 4 085.15
54320	CT of the sacrum with contrast				46.930	R 7 486.03
54330	CT of the sacrum pre and post contrast				52.970	R 8 449.29
54400	MR of the sacrum				65.000	R 10 368.32
54410	MR of the sacrum pre and post contrast				101.040	R 16 117.11

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
8.6	**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	R 583.90
55110	X-ray tomography – pelvis				4.300	R 685.92
55300	CT of the bony pelvis limited				9.500	R 1 515.25
55310	CT of the bony pelvis complete uncontrasted				25.610	R 4 085.15
55320	CT of the bony pelvis complete 3D recon				37.470	R 5 976.93
55330	CT of the bony pelvis with contrast				46.930	R 7 486.03
55340	CT of the bony pelvis – pre and post contrast				52.970	R 8 449.29
55400	MR of the bony pelvis				65.000	R 10 368.32
55410	MR of the bony pelvis pre and post contrast				102.240	R 16 308.53
55900	Nuclear medicine study – Bone regional pelvis		21.500	R 3 376.45		
55910	Nuclear medicine study – Bone tomography regional pelvis		13.410	R 2 106.13		
55920	Nuclear medicine study – with flow		6.020	R 945.47		
8.7	**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	R 507.13
56110	X-ray of the right hip				3.180	R 507.13
56120	X-ray pelvis and hips				6.020	R 960.26
56130	X-ray tomography – hip				4.300	R 685.92
56140	X-ray of the hip/s – stress study				4.380	R 698.72
56150	X-ray arthrography of the hip joint including introduction contrast				15.750	R 2 512.40
56160	X-ray guidance and introduction of contrast into hip joint only				7.410	R 1 181.92
56200	Ultrasound of the hip joints				6.500	R 1 036.87
56300	CT of hip – limited				9.500	R 1 515.25
56310	CT of hip – complete				27.370	R 4 365.96
56320	CT of hip – complete with 3D recon				39.780	R 6 345.47
56330	CT of hip with contrast				43.260	R 6 900.46
56340	CT of hip pre and post contrast				47.880	R 7 637.41
56400	MR of the hip joint/s, limited study				44.900	R 7 162.01
56410	MR of the hip joint/s				64.100	R 10 224.75
56420	MR of the hip joint/s, pre and post contrast				101.640	R 16 212.81

56900	Nuclear medicine study – Bone regional pelvis		21.500	R 3 376.45		
56910	Nuclear medicine study – Bone limited static plus flow		27.530	R 4 323.76		
56920	Nuclear medicine study – Bone tomography regional		13.410	R 2 106.13		
9.	**Upper limbs**					
9.1	**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	R 720.82
60110	X-ray upper limbs - any region – tomography				4.300	R 685.92
60200	Ultrasound upper limb – soft tissue - any region				7.380	R 1 177.28
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler				13.640	R 2 175.75

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler				13.640	R 2 175.75
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis				12.540	R 2 000.28
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler				17.260	R 2 753.17
60300	CT of the upper limbs limited study				9.500	R 1 515.25
60310	CT angiography of the upper limb				78.280	R 12 486.58
60400	MR of the upper limbs limited study, any region				44.800	R 7 146.22
60410	MR angiography of the upper limb				74.660	R 11 909.00
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral				45.670	R 7 284.97
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral				82.670	R 13 186.62
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral				56.750	R 9 052.30
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral				88.110	R 14 054.67
60540	Venography, antegrade of upper limb veins, unilateral				26.120	R 4 166.40
60550	Venography, antegrade of upper limb veins, bilateral				49.430	R 7 884.83
60560	Venography, retrograde of upper limb veins, unilateral				31.010	R 4 946.38
60570	Venography, retrograde of upper limb veins, bilateral				54.810	R 8 742.90
60580	Venography, shuntogram, dialysis access shunt				23.790	R 3 794.85
60900	Nuclear medicine study – Venogram upper limb		37.120	R 5 829.70		
9.2	**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	R 485.04
61105	X-ray of the right clavicle				3.040	R 485.04
61110	X-ray of the left scapula				3.040	R 485.04
61115	X-ray of the right scapula				3.040	R 485.04
61120	X-ray of the left acromio-clavicular joint				3.140	R 500.82
61125	X-ray of the right acromio-clavicular joint				3.140	R 500.82
61128	X-ray of acromio-clavicular joints plus stress studies bilateral				7.680	R 1 224.96
61130	X-ray of the left shoulder				3.480	R 554.99
61135	X-ray of the right shoulder				3.480	R 554.99
61140	X-ray of the left shoulder plus subacromial impingement views				5.920	R 944.31
61145	X-ray of the right shoulder plus subacromial impingement views				5.920	R 944.31
61150	X-ray of the left subacromial impingement views only				3.240	R 516.77
61155	X-ray of the right subacromial impingement views only				3.240	R 516.77
61160	X-ray arthrography shoulder joint including introduction of contrast				15.830	R 2 525.03
61170	X-ray guidance and introduction of contrast into shoulder joint only				7.410	R 1 181.92
61200	Ultrasound of the left shoulder joint				6.500	R 1 036.87
61210	Ultrasound of the right shoulder joint				6.500	R 1 036.87
61300	CT of the left shoulder joint – uncontrasted				24.360	R 3 885.75
61305	CT of the right shoulder joint – uncontrasted				24.360	R 3 885.75
61310	CT of the left shoulder – complete with 3D recon				37.660	R 6 007.33
61315	CT of the right shoulder – complete with 3D recon				37.660	R 6 007.33
61320	CT of the left shoulder joint - pre and post contrast				48.630	R 7 757.04
61325	CT of the right shoulder joint - pre and post contrast				48.630	R 7 757.04
61400	MR of the left shoulder				64.640	R 10 310.82
61405	MR of the right shoulder				64.640	R 10 310.82

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
61410	MR of the left shoulder pre and post contrast				101.040	R 16 117.11
61415	MR of the right shoulder pre and post contrast				101.040	R 16 117.11
9.3	**Humerus**					

62100	X-ray of the left humerus				2.940	R 468.91
62105	X-ray of the right humerus				2.940	R 468.91
62300	CT of the left upper arm				24.360	R 3 885.75
62305	CT of the right upper arm				24.360	R 3 885.75
62310	CT of the left upper arm contrasted				39.970	R 6 375.73
62315	CT of the right upper arm contrasted				39.970	R 6 375.73
62320	CT of the left upper arm pre and post contrast				48.580	R 7 749.07
62325	CT of the right upper arm pre and post contrast				48.580	R 7 749.07
62400	MR of the left upper arm				64.200	R 10 240.54
62405	MR of the right upper arm				64.200	R 10 240.54
62410	MR of the left upper arm pre and post contrast				102.040	R 16 276.62
62415	MR of the right upper arm pre and post contrast				102.040	R 16 276.62
62900	Nuclear medicine study – Bone limited/regional static		21.500	R 3 376.45		
62905	Nuclear medicine study – Bone limited static plus flow		27.530	R 4 323.76		
62910	Nuclear medicine study – Bone tomography regional		13.410	R 2 106.13		
9.4	**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	R 500.82
63105	X-ray of the right elbow				3.140	R 500.82
63110	X-ray of the left elbow with stress				4.340	R 692.24
63115	X-ray of the right elbow with stress				4.340	R 692.24
63120	X-ray arthrography elbow joint including introduction of contrast				15.890	R 2 534.67
63130	X-ray guidance and introduction of contrast into elbow joint only				7.410	R 1 181.92
63200	Ultrasound of the left elbow joint				6.500	R 1 036.87
63205	Ultrasound of the right elbow joint				6.500	R 1 036.87
63300	CT of the left elbow				24.360	R 3 885.75
63305	CT of the right elbow				24.360	R 3 885.75
63310	CT of the left elbow – complete with 3D recon				37.660	R 6 007.33
63315	CT of the right elbow – complete with 3D recon				37.660	R 6 007.33
63320	CT of the left elbow contrasted				39.970	R 6 375.73
63325	CT of the right elbow contrasted				39.970	R 6 375.73
63330	CT of the left elbow pre and post contrast				48.630	R 7 757.04

63335	CT of the right elbow pre and post contrast				48.630	R 7 757.04
63400	MR of the left elbow				64.640	R 10 310.82
63405	MR of the right elbow				64.640	R 10 310.82
63410	MR of the left elbow pre and post contrast				101.040	R 16 117.11
63415	MR of the right elbow pre and post contrast				101.040	R 16 117.11
63905	Nuclear medicine study – Bone limited/regional static		21.500	R 3 376.45		
63910	Nuclear medicine study – Bone limited static plus flow		27.530	R 4 323.76		
63915	Nuclear medicine study – Bone tomography regional		13.410	R 2 106.13		
9.5	**Forearm**					
64100	X-ray of the left forearm				2.940	R 468.91
64105	X-ray of the right forearm				2.940	R 468.91
64110	X-ray peripheral bone densitometry				1.960	R 312.55

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
64300	CT of the left forearm				24.360	R 3 885.75
64305	CT of the right forearm				24.360	R 3 885.75
64310	CT of the left forearm contrasted				39.970	R 6 375.73
64315	CT of the right forearm contrasted				39.970	R 6 375.73
64320	CT of the left forearm pre and post contrast				48.580	R 7 749.07
64325	CT of the right forearm pre and post contrast				48.580	R 7 749.07
64400	MR of the left forearm				64.200	R 10 240.54
64405	MR of the right forearm				64.200	R 10 240.54
64410	MR of the left forearm pre and post contrast				98.040	R 15 638.38
64415	MR of the right forearm pre and post contrast				98.040	R 15 638.38
64900	Nuclear medicine study – Bone limited/regional static		21.500	R 3 376.45		
64905	Nuclear medicine study – Bone limited static plus flow		27.530	R 4 323.76		
64910	Nuclear medicine study – Bone tomography regional		13.410	R 2 106.13		
9.6	**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	R 491.34
65105	X-ray of the right hand				3.080	R 491.34

65110	X-ray of the left hand – bone age				3.080	R 491.34
65120	X-ray of a finger				2.670	R 425.88
65130	X-ray of the left wrist				3.180	R 507.13
65135	X-ray of the right wrist				3.180	R 507.13
65140	X-ray of the left scaphoid				3.300	R 526.41
65145	X-ray of the right scaphoid				3.300	R 526.41
65150	X-ray of the left wrist, scaphoid and stress views				7.560	R 1 205.86
65155	X-ray of the right wrist, scaphoid and stress views				7.560	R 1 205.86
65160	X-ray arthrography wrist joint including introduction of contrast				15.930	R 2 540.98
65170	X-ray guidance and introduction of contrast into wrist joint only				7.410	R 1 181.92
65200	Ultrasound of the left wrist				6.500	R 1 036.87
65210	Ultrasound of the right wrist				6.500	R 1 036.87
65300	CT of the left wrist and hand				24.360	R 3 885.75
65305	CT of the right wrist and hand				24.360	R 3 885.75
65310	CT of the left wrist and hand - complete with 3D recon				37.660	R 6 007.33
65315	CT of the right wrist and hand - complete with 3D recon				37.660	R 6 007.33
65320	CT of the left wrist and hand contrasted				39.970	R 6 375.73
65325	CT of the right wrist and hand contrasted				39.970	R 6 375.73
65330	CT of the left wrist and hand pre and post contrast				48.630	R 7 757.04
65335	CT of the right wrist and hand pre and post contrast				48.630	R 7 757.04
65400	MR of the left wrist and hand				64.640	R 10 310.82
65405	MR of the right wrist and hand				64.640	R 10 310.82
65410	MR of the left wrist and hand pre and post contrast				101.040	R 16 117.11
65415	MR of the right wrist and hand pre and post contrast				101.040	R 16 117.11
65900	Nuclear Medicine study – bone limited/regional static		21.500	R 3 376.45		
65905	Nuclear Medicine study – bone limited static plus flow		27.530	R 4 323.76		
65910	Nuclear Medicine study – bone tomography regional		13.410	R 2 106.13		

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
9.7	**Soft Tissue**					
69900	Nuclear medicine study – Tumour localisation planar, static		20.740	R 3 257.48		
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		

69910	Nuclear medicine study – Tumour localisation planar, static and SPECT		34.150	R 5 363.28		
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT		47.560	R 7 469.25		
69920	Nuclear medicine study – Infection localisation planar, static		18.040	R 2 833.26		
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies		31.450	R 4 939.40		
69930	Nuclear medicine study – Infection localisation planar, static and SPECT		31.450	R 4 939.40		
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT		44.860	R 7 045.20		
69940	Nuclear medicine study – Regional lymph node mapping dynamic		6.020	R 945.47		
69945	Nuclear medicine study – Regional lymph node mapping, static, planar		24.100	R 3 785.05		
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple		37.510	R 5 891.03		
69955	Nuclear medicine study – Regional lymph node mapping SPECT		13.410	R 2 106.13		
69960	Nuclear medicine study – Lymph node localisation with gamma probe		13.410	R 2 106.13		
10.	**Lower Limbs**					
10.1	**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	R 720.82
70110	X-ray lower limbs - any region-tomography				4.300	R 685.92
70120	X-ray of the lower limbs full length study				6.460	R 1 030.56
70200	Ultrasound lower limb – soft tissue - any region				7.380	R 1 177.28
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler				13.640	R 2 175.75
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler				13.640	R 2 175.75
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis				13.640	R 2 175.75
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	R 3 136.01
70300	CT of the lower limbs limited study				9.500	R 1 515.25
70310	CT angiography of the lower limb				79.430	R 12 670.02
70320	CT angiography abdominal aorta and outflow lower limbs				98.340	R 15 686.24
70400	MR of the lower limbs limited study				46.400	R 7 401.46
70410	MR angiography of the lower limb				76.660	R 12 228.03
70420	MR angiography of the abdominal aorta and lower limbs				118.860	R 18 959.52
70500	Angiography of pelvic and lower limb arteries unilateral				40.590	R 6 474.59

70505	Angiography of pelvic and lower limb arteries bilateral				75.920	R 12 109.89
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral				61.230	R 9 766.81
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral				85.660	R 13 663.69

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
70520	Angiography translumbar aorta with full peripheral study				45.680	R 7 286.46
70530	Venography, antegrade of lower limb veins, unilateral				25.460	R 4 061.23
70535	Venography, antegrade of lower limb veins, bilateral				49.430	R 7 884.83
70540	Venography, retrograde of lower limb veins, unilateral				31.170	R 4 972.13
70545	Venography, retrograde of lower limb veins, bilateral				56.790	R 9 058.61
70560	Lymphangiography, lower limb, unilateral				51.040	R 8 141.39
70565	Lymphangiography, lower limb, bilateral				83.970	R 13 394.18
70900	Nuclear medicine study – Venogram lower limb		37.120	R 5 829.70		
10.2	**Femur**					
71100	X-ray of the left femur				2.940	R 468.91
71105	X-ray of the right femur				2.940	R 468.91
71300	CT of the left femur				24.520	R 3 911.17
71305	CT of the right femur				24.520	R 3 911.17
71310	CT of the left upper leg contrasted				41.830	R 6 672.32
71315	CT of the right upper leg contrasted				41.830	R 6 672.32
71320	CT of the left upper leg pre and post contrast				49.710	R 7 929.36
71325	CT of the right upper leg pre and post contrast				49.710	R 7 929.36
71400	MR of the left upper leg				64.800	R 10 336.41
71405	MR of the right upper leg				64.800	R 10 336.41
71410	MR of the left upper leg pre and post contrast				102.040	R 16 276.62
71415	MR of the right upper leg pre and post contrast				102.040	R 16 276.62
71900	Nuclear Medicine study – bone limited/regional static		21.500	R 3 376.45		
71905	Nuclear Medicine study – Bone limited static plus flow		27.530	R 4 323.76		
71910	Nuclear Medicine study – Bone tomography regional		13.410	R 2 106.13		
10.3	**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	R 441.83

72105	X-ray of the right knee one or two views				2.770	R 441.83
72110	X-ray of the left knee, more than two views				3.320	R 529.56
72115	X-ray of the right knee, more than two views				3.320	R 529.56
72120	X-ray of the left knee including patella				4.620	R 736.94
72125	X-ray of the right knee including patella				4.620	R 736.94
72130	X-ray of the left knee with stress views				5.820	R 928.36
72135	X-ray of the right knee with stress views				5.820	R 928.36
72140	X-ray of left patella				2.770	R 441.83
72145	X-ray of right patella				2.770	R 441.83
72150	X-ray both knees standing – single view				2.800	R 446.65
72160	X-ray arthrography knee joint including introduction of contrast				15.810	R 2 521.87
72170	X-ray guidance and introduction of contrast into knee joint only				7.410	R 1 181.92
72200	Ultrasound of the left knee joint				6.500	R 1 036.87
72205	Ultrasound of the right knee joint				6.500	R 1 036.87
72300	CT of the left knee				24.520	R 3 911.17
72305	CT of the right knee				24.520	R 3 911.17
72310	CT of the left knee complete study with 3D reconstructions				35.930	R 5 731.34
72315	CT of the right knee complete study with 3D reconstructions				35.930	R 5 731.34
72320	CT of the left knee contrasted				41.830	R 6 672.32
72325	CT of the right knee contrasted				41.830	R 6 672.32
72330	CT of the left knee pre and post contrast				49.760	R 7 937.17
72335	CT of the right knee pre and post contrast				49.760	R 7 937.17

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
72400	MR of the left knee				64.100	R 10 224.75
72405	MR of the right knee				64.100	R 10 224.75
72410	MR of the left knee pre and post contrast				100.840	R 16 085.20
72415	MR of the right knee pre and post contrast				100.840	R 16 085.20
72900	Nuclear Medicine study – Bone limited/regional static		21.500	R 3 376.45		
72905	Nuclear Medicine study – Bone limited static plus flow		27.530	R 4 323.76		
72910	Nuclear Medicine study – Bone tomography regional		13.410	R 2 106.13		
10.4	**Lower Leg**					

73100	X-ray of the left lower leg				2.940	R 468.91
73105	X-ray of the right lower leg				2.940	R 468.91
73300	CT of the left lower leg				24.520	R 3 911.17
73305	CT of the right lower leg				24.520	R 3 911.17
73310	CT of the left lower leg contrasted				41.830	R 6 672.32
73315	CT of the right lower leg contrasted				41.830	R 6 672.32
73320	CT of the left lower leg pre and post contrast				49.710	R 7 929.36
73325	CT of the right lower leg pre and post contrast				49.710	R 7 929.36
73400	MR of the left lower leg				64.200	R 10 240.54
73405	MR of the right lower leg				64.200	R 10 240.54
73410	MR of the left lower leg pre and post contrast				102.040	R 16 276.62
73415	MR of the right lower leg pre and post contrast				102.040	R 16 276.62
73900	Nuclear Medicine study – bone limited/regional static		21.500	R 3 376.45		
73905	Nuclear Medicine study – bone limited static plus flow		27.530	R 4 323.76		
73910	Nuclear Medicine study – bone tomography regional		13.410	R 2 106.13		
10.5	**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	R 529.56
74105	X-ray of the right ankle				3.320	R 529.56
74110	X-ray of the left ankle with stress views				4.520	R 720.82
74115	X-ray of the right ankle with stress views				4.520	R 720.82
74120	X-ray of the left foot				2.800	R 446.65
74125	X-ray of the right foot				2.800	R 446.65
74130	X-ray of the left calcaneus				2.740	R 437.02
74135	X-ray of the right calcaneus				2.740	R 437.02
74140	X-ray of both feet – standing – single view				2.800	R 446.65
74145	X-ray of a toe				2.670	R 425.88
74150	X-ray of the sesamoid bones one or both sides				2.800	R 446.65
74160	X-ray arthrography ankle joint including introduction of contrast				15.910	R 2 537.83
74170	X-ray guidance and introduction of contrast into ankle joint				7.410	R 1 181.92
74210	Ultrasound of the left ankle				6.500	R 1 036.87

74215	Ultrasound of the right ankle				6.500	R 1 036.87
74220	Ultrasound of the left foot				6.500	R 1 036.87
74225	Ultrasound of the right foot				6.500	R 1 036.87
74290	Ultrasound bone densitometry				2.040	R 325.51
74300	CT of the left ankle/foot				24.520	R 3 911.17
74305	CT of the right ankle/foot				24.520	R 3 911.17
74310	CT of the left ankle/foot – complete with 3D recon				37.810	R 6 031.10
74315	CT of the right ankle/foot – complete with 3D recon				37.810	R 6 031.10

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
74320	CT of the left ankle/foot contrasted				41.830	R 6 672.32
74325	CT of the right ankle/foot contrasted				41.830	R 6 672.32
74330	CT of the left ankle/foot pre and post contrast				49.710	R 7 929.36
74335	CT of the right ankle/foot pre and post contrast				49.710	R 7 929.36
74400	MR of the left ankle				64.100	R 10 224.75
74405	MR of the right ankle				64.100	R 10 224.75
74410	MR of the left ankle pre and post contrast				100.640	R 16 053.30
74415	MR of the right ankle pre and post contrast				100.640	R 16 053.30
74420	MR of the left foot				64.200	R 10 240.54
74425	MR of the right foot				64.200	R 10 240.54
74430	MR of the left foot pre and post contrast				102.040	R 16 276.62
74435	MR of the right foot pre and post contrast				102.040	R 16 276.62
74900	Nuclear Medicine study – Bone limited/regional static		21.500	R 3 101.93	R 3 376.45	
74905	Nuclear Medicine study – Bone limited static plus flow		27.530	R 3 972.22	R 4 323.76	
74910	Nuclear Medicine study – Bone tomography regional		13.410	R 1 934.89	R 2 106.13	
10.6	**Soft Tissue**					
79900	Nuclear Medicine study – Tumour localisation planar, static		20.740	R 3 257.48		
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies		35.170	R 5 523.63		
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT		34.150	R 5 363.28		
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT		47.560	R 7 469.25		
79920	Nuclear Medicine study – Infection localisation planar, static		18.430	R 2 894.59		
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies		31.840	R 5 000.55		

79930	Nuclear Medicine study – Infection localisation planar, static and SPECT		31.840	R 5 000.55		
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT		45.250	R 7 106.51		
79940	Nuclear Medicine study – Regional lymph node mapping dynamic		6.020	R 945.47		
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar		24.100	R 3 785.05		
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies		37.510	R 5 891.03		
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT		13.410	R 2 106.13		
79960	Nuclear Medicine study – Lymph node localisation with gamma probe		13.410	R 2 106.13		
11.	**Intervention**					
11.1	**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	R 1 494.65
80605	Fine needle aspiration biopsy, any region				4.220	R 672.96
80610	Cutting needle, trochar biopsy, any region				6.360	R 1 014.44
80620	Tumour/cyst ablation chemical				25.370	R 4 046.76
80630	Tumour ablation radio frequency, per lesion				21.210	R 3 383.10

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
80640	Insertion of CVP line in radiology suite				8.990	R 1 434.00
80645	Peripheral central venous line insertion				12.120	R 1 933.49
80650	Infiltration of a peripheral joint, any region				6.400	R 1 020.74
	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.					
11.2	**Neuro intervention**					
81600	Intracranial aneurysm occlusion, direct				214.520	R 34 218.38
81605	Intracranial arteriovenous shunt occlusion				254.820	R 40 646.77
81610	Dural sinus arteriovenous shunt occlusion				264.330	R 42 163.52
81615	Extracranial arteriovenous shunt occlusion				157.280	R 25 087.98
81620	Extracranial arterial embolisation (head and neck)				163.120	R 26 019.49
81625	Caroticocavernous fistula occlusion				192.290	R 30 672.43

81630	Intracranial angioplasty for stenosis, vasospasm				126.920	R 20 245.29
81632	Intracranial stent placement (including PTA)				133.720	R 21 329.84
81635	Temporary balloon occlusion test				83.420	R 13 306.43
	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	R 28 421.73
81645	Intracranial aneurysm occlusion with balloon remodelling				216.350	R 34 510.33
81650	Intracranial aneurysm occlusion with stent assistance				230.450	R 36 759.36
81655	Intracranial thrombolysis, catheter directed				58.940	R 9 401.57
	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	R 1 221.80
81665	Neurolysis, head and neck, per level				20.140	R 3 212.62
81670	Nerve block, head and neck, radio frequency, per level				19.040	R 3 037.15
81680	Nerve block, coeliac plexus or other regions, per level				9.280	R 1 480.35
11.3	**Thorax**					
82600	Chest drain insertion				8.820	R 1 406.74
82605	Trachial, bronchial stent insertion				30.360	R 4 842.85
11.4	**Gastrointestinal**					
83600	Oesophageal stent insertion				31.220	R 4 979.77
83605	GIT balloon dilation				24.360	R 3 885.75
83610	GIT stent insertion (non-oesophageal)				32.020	R 5 107.56
83615	Percutaneous gastrostomy, jejunostomy				25.360	R 4 045.27
11.5	**Hepatobiliary**					
84600	Percutaneous biliary drainage, external				33.980	R 5 420.27
84605	Percutaneous external/internal biliary drainage				37.210	R 5 935.39
84610	Permanent biliary stent insertion				51.220	R 8 170.14
84615	Drainage tube replacement				20.220	R 3 225.25
84620	Percutaneous bile duct stone or foreign object removal				49.980	R 7 972.40
84625	Percutaneous gall bladder drainage				29.580	R 4 718.24
84630	Percutaneous gallstone removal, including drainage				69.250	R 11 046.27
84635	Transjugular liver biopsy				24.930	R 3 976.64
84640	Transjugular intrahepatic Portosystemic shunt				119.470	R 19 056.71

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
84645	Transhepatic Portogram including venous sampling, pressure studies				81.890	R 13 062.34
84650	Transhepatic Portogram with embolisation of varices				100.810	R 16 080.38
84655	Percutaneous hepatic tumour ablation				15.680	R 2 501.27
84660	Percutaneous hepatic abscess, cyst drainage				13.200	R 2 105.63
84665	Hepatic chemoembolisation				59.440	R 9 481.34
84670	Hepatic arterial infusion catheter placement				60.300	R 9 618.58
11.6	**Urogenital**					
85600	Percutaneous nephrostomy, external drainage				29.970	R 4 780.54
85605	Percutaneous double J stent insertion including access				40.820	R 6 511.32
85610	Percutaneous renal stone, foreign body removal including access				66.790	R 10 653.79
85615	Percutaneous nephrostomy tract establishment				29.270	R 4 669.05
85620	Change of nephrostomy tube				15.900	R 2 536.34
85625	Percutaneous cystostomy				16.520	R 2 635.20
85630	Urethral balloon dilatation				14.240	R 2 271.47
85635	Urethral stent insertion				31.220	R 4 979.77
85640	Renal cyst ablation				11.920	R 1 901.42
85645	Renal abscess, cyst drainage				15.160	R 2 418.19
85655	Fallopian tube recanalisation				45.060	R 7 187.60
11.7	**Spinal**					
86600	Spinal vascular malformation embolisation				275.160	R 43 891.30
86605	Verteboplasty per level				22.300	R 3 557.08
86610	Facet joint block per level, uni- or bilateral				9.540	R 1 521.57
	Code 86610 may only be billed once per level, and not per left and right side per level					
86615	Spinal nerve block per level, uni- or bilateral				8.160	R 1 301.56
86620	Epidural block				9.420	R 1 502.46
86625	Chemonucleolysis, including discogram				18.320	R 2 922.16
86630	Spinal nerve ablation per level				11.600	R 1 850.40
11.8	**Vascular**					
	Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedue, 87650 (thrombolysis). If a balloon angioplasty and / or stent placement is perfomed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multple balloon dilations or stent placements at one defined site will only attact one procedue code.					

87600	Percutaneous transluminal angioplasty: aorta, IVC				56.560	R 9 022.05
87601	Percutaneous transluminal angioplasty: iliac				55.760	R 8 894.44
87602	Percutaneous transluminal angioplasty: femoropopliteal				60.160	R 9 596.15
87603	Percutaneous transluminal angioplasty: subpopliteal				73.340	R 11 698.46
87604	Percutaneous transluminal angioplasty: brachiocephalic				67.120	R 10 706.29
87605	Percutaneous transluminal angioplasty: subclavian, axillary				60.160	R 9 596.15
87606	Percutaneous transluminal angioplasty: extracranial carotid				71.620	R 11 424.12
87607	Percutaneous transluminal angioplasty: extracanial vertebral				73.300	R 11 692.15
87608	Percutaneous transluminal angioplasty: renal				87.690	R 13 987.37
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric				87.690	R 13 987.37
87620	Aorta stent-graft placement				120.750	R 19 261.10
87621	Stent insertion (including PTA): aorta, IVC				73.870	R 11 783.04
87622	Stent insertion (including PTA): iliac				76.370	R 12 181.84
87623	Stent insertion (including PTA): femoropopliteal				77.970	R 12 437.07
87624	Stent insertion (including PTA): subpopliteal				84.550	R 13 486.56
87625	Stent insertion (including PTA): brachiocephalic				98.470	R 15 707.17

Code	Description	Add	Nuclear Medicine		Radiology	
			Units	Value	Units	Value
87626	Stent insertion (including PTA): subclavian, axillary				86.690	R 13 827.86
87627	Stent insertion (including PTA): extracranial carotid				106.990	R 17 066.07
87628	Stent insertion (including PTA): extracanial vertebral				100.550	R 16 038.83
87629	Stent insertion (including PTA): renal				98.590	R 15 726.28
87630	Stent insertion (including PTA): coeliac, mesenteric				98.590	R 15 726.28
87631	Stent-graft placement: iliac				76.370	R 12 181.84
87632	Stent-graft placement: femoropopliteal				77.970	R 12 437.07
87633	Stent-graft placement: brachiocephalic				98.470	R 15 707.17
87634	Stent-graft placement: subclavian, axillary				82.770	R 13 202.75
87635	Stent-graft placement: extracranial carotid				120.430	R 19 210.09
87636	Stent-graft placement: extracranial vertebral				114.730	R 18 300.66
87637	Stent-graft placement: renal				98.590	R 15 726.28
87638	Stent-graft placement: coeliac, mesenteric				98.590	R 15 726.28
87650	Thrombolysis in angiography suite, per 24 hours				45.820	R 7 308.90

Road Accident Fund Tariff

	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional 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	Aspiration, rheolytic thrombectomy				77.670	R 12 389.37
87652	Atherectomy, per vessel				91.890	R 14 657.68
87653	Percutaneous tunnelled / subcutaneous aterial or venous central or other line insertion				28.150	R 4 490.26
87654	Thrombolysis follow-up				23.570	R 3 759.80
87655	Percutaneous sclerotherapy, vascular malformation				21.100	R 3 365.66
87660	Embolisation, mesenteric				100.430	R 16 019.74
87661	Embolisation, renal				99.360	R 15 848.92
87662	Embolisation, bronchial, intercostal				108.340	R 17 281.59
87663	Embolisation, pulmonary arteriovenous shunt				103.220	R 16 464.72
87664	Embolisation, abdominal, other vessels				101.440	R 16 180.91
87665	Embolisation, thoracic, other vessels				97.600	R 15 568.09
87666	Embolisation, upper limb				90.920	R 14 502.65
87667	Embolisation, lower limb				92.140	R 14 697.39
87668	Embolisation, pelvis, non-uterine				117.120	R 18 681.85
87669	Embolisation, uterus				113.880	R 18 165.08
87670	Embolisation, spermatic, ovaria veins				85.820	R 13 689.27
87680	Inferior vena cava filter placement				61.840	R 9 864.34
87681	Intravascular foreign body removal				85.030	R 13 563.16
87682	Revision of access port (tunnelled or implantable)				14.120	R 2 252.36
87683	Removal of access port (tunnelled or implantable)				11.120	R 1 773.63
87690	Superior petrosal venous sampling				73.010	R 11 645.96
87691	Pancreatic stimulation test				89.790	R 14 322.53
87692	Transportal venous sampling				76.950	R 12 274.38
87693	Adrenal venous sampling				55.010	R 8 774.64
87694	Parathyroid venous sampling				86.660	R 13 823.37
87695	Renal venous sampling				55.010	R 8 774.64

Road Accident Fund Tariff

REGISTERED COUNSELLORS (PR 081)

GENERAL RULES

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.		

Code	Description	Units	Value
81300	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 1-10min.	0.50	R 78.59
81301	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 11-20min.	1.50	R 235.96
81302	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 21-30min.	2.50	R 393.15
81303	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 31-40min.	3.50	R 550.34
81304	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 41-50min.	4.50	R 707.53
81305	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 51-60min.	5.50	R 864.55
81306	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 61-70min.	6.50	R 1 022.41
81307	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 71-80min.	7.50	R 1 179.44
81308	Assessment, consultation, counselling and/or therapy (individual or family). Duration: 81-90min.	8.50	R 1 336.79
81400	Group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	0.10	R 15.65
81401	Group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	0.30	R 47.19
81402	Group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	0.50	R 78.59
81403	Group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	0.70	R 110.00
81404	Group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	0.90	R 141.40
81405	Group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	1.10	R 172.98
81406	Group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	1.30	R 204.54
81407	Group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	1.50	R 235.96
81408	Group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	1.70	R 267.69
81409	Group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	1.90	R 298.76
81410	Group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2.10	R 330.34
81411	Group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2.30	R 361.74
81490	Extended group consultation, counselling and/or therapy - per patient per full 15 minutes in excess of 120 minutes	0.15	R 7.15

Road Accident Fund Tariff

REHABILITATION FACILITIES (PR 059)

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.	
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 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. 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 CCSA 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 CCSA 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.	

Code	Description	Value
	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 replacement)	
	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)	R 962.42
101	Out patients, 6 hours per day (maximum 18 days)	R 2 030.36
105	General care (Daily ward rate, excluding therapy)	R 4 050.11

107	High care (maximum 36 days) (Per day)	R	8 444.00
109	Rehabilitation ICU (maximum 7 days) (Per day)	R	11 080.00

Road Accident Fund Tariff

SOCIAL WORKERS (PR 089)

GENERAL RULES			
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.		

Code	Description	Units	Value
89200	Social worker consultation, counselling and/or therapy. Duration: 1-10min.	0.50	R 83.09
89201	Social worker consultation, counselling and/or therapy. Duration: 11-20min.	1.50	R 249.57
89202	Social worker consultation, counselling and/or therapy. Duration: 21-30min.	2.50	R 416.58
89203	Social worker consultation, counselling and/or therapy. Duration: 31-40min.	3.50	R 583.07
89204	Social worker consultation, counselling and/or therapy. Duration: 41-50min.	4.50	R 711.92
89205	Social worker consultation, counselling and/or therapy. Duration: 51-60min.	5.50	R 869.70
89206	Social worker consultation, counselling and/or therapy. Duration: 61-70min.	6.50	R 1 028.28
89207	Social worker consultation, counselling and/or therapy. Duration: 71-80min.	7.50	R 1 186.22
89208	Social worker consultation, counselling and/or therapy. Duration: 81-90min.	8.50	R 1 344.64
89209	Social worker consultation, counselling and/or therapy. Duration: 91-100min.	9.50	R 1 502.89
89210	Social worker consultation, counselling and/or therapy. Duration: 101-110min.	10.50	R 1 661.00
89211	Social worker consultation, counselling and/or therapy. Duration: 111-120min.	11.50	R 1 818.93
	Group consultation, counselling or therapy		
	Group consultation, counselling and/or therapy items are chargeable to a maximum of 12 patients.		

89300	Social worker group consultation, counselling and/or therapy, per patient. Duration: 1-10min.	0.10	R	16.79
89301	Social worker group consultation, counselling and/or therapy, per patient. Duration: 11-20min.	0.30	R	49.85
89302	Social worker group consultation, counselling and/or therapy, per patient. Duration: 21-30min.	0.50	R	83.09
89303	Social worker group consultation, counselling and/or therapy, per patient. Duration: 31-40min.	0.70	R	116.65
89304	Social worker group consultation, counselling and/or therapy, per patient. Duration: 41-50min.	0.90	R	142.32

Road Accident Fund Tariff

89305	Social worker group consultation, counselling and/or therapy, per patient. Duration: 51-60min.	1.10	R 174.36
89306	Social worker group consultation, counselling and/or therapy, per patient. Duration: 61-70min.	1.30	R 205.76
89307	Social worker group consultation, counselling and/or therapy, per patient. Duration: 71-80min.	1.50	R 236.99
89308	Social worker group consultation, counselling and/or therapy, per patient. Duration: 81-90min.	1.70	R 268.71
89309	Social worker group consultation, counselling and/or therapy, per patient. Duration: 91-100min.	1.90	R 300.73
89310	Social worker group consultation, counselling and/or therapy, per patient. Duration: 101-110min.	2.10	R 332.29
89311	Social worker group consultation, counselling and/or therapy, per patient. Duration: 111-120min.	2.30	R 363.69

SPEECH THERAPY AND AUDIOLOGY (PR 082 & 083)

Speech Therapy: 082 Audiology: 083

General Rules

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	COST OF MEDICINES AND MATERIALS SEE GENERAL INFORMATION FOR DETAILS.
	Use item 300 for this purpose.

Code	Description	Value			
1	**Assessment, Consultation & Treatment**				
	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				
1.1	**Consultations**	**Practice Type: Speech Therapy: 082**		**Practice Type: Audiology: 083**	
1.1.1	**Audiology Consultations**	**Units**	**Value**	**Units**	**Value**
1010	Audiology consultation. Duration 1 - 15 mins			10.00	R 190.93
1011	Audiology consultation. Duration 16 - 30 mins			22.50	R 429.03
1012	Audiology consultation. Duration 31 - 45 mins			37.50	R 715.50
1013	Audiology consultation. Duration 46 - 60 mins			52.50	R 1 001.97
1015	Prolonged audiology consultation, each additional full 15 mins, to a maximum of 60 mins			15.00	R 286.30
1.1.2	**Speech Therapy Consultations**				
1020	Speech therapy consultation. Duration 1 - 15 mins	10.00	R 190.93		
1021	Speech therapy consultation. Duration 16 - 30 mins	22.50	R 429.03		
1022	Speech therapy consultation. Duration 31 - 45 mins	37.50	R 715.50		
1023	Speech therapy consultation. Duration 46 - 60 mins	52.50	R 1 001.97		
1.2	**Assessment & Treatment**				
1.2.1	**Speech Therapy Assessment & Treatment**				
1050	Speech therapy assessment and treatment. Duration 1 - 15 mins	10.00	R 190.93		
1051	Speech therapy assessment and treatment. Duration 16 - 30 mins	22.50	R 429.03		
1052	Speech therapy assessment and treatment. Duration 31 - 45 mins	37.50	R 715.50		
1053	Speech therapy assessment and treatment. Duration 46 - 60 mins	52.50	R 1 001.97		
2	**Speech, Voice and Language Disorder**				
0007	Group therapy: per patient at rooms (Maximum of 3 patients per therapy)	15.00	R 286.30		
	Note: Professional Group Consultations - no fee to be charged.				

0009	Preparation of a home programme	15.00	R 286.30		
	Note: This category is to prepare the home programme prior to consultation with patient or care giver				
0020	Report writing	30.00	R 572.43	30.00	R 572.43
3	**Audiology**				
A.	**Peripheral Hearing Evaluation**				
1100	Pure Tone Audiogram (Air conduction) (3273)			15.00	R 327.34
1105	Pure Tone Audiogram (Bone conduction) (3274)			12.00	R 261.88
1110	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels. (3277)			15.00	R 327.34
1115	Speech audiogram screening			5.00	R 109.50
1120	Visual reinforcement audiometry and/or combined play audiometry employed in a sound field environment to assess peripheral hearing			40.00	R 892.64
1121	Conditioning play audiometry			40.00	R 892.64
1122	Select picture audiometry			40.00	R 892.64
1125	Tinnitus Evaluation			15.00	R 327.34

B.	**Middle Ear Function Evaluation**				
1200	Tympanometry			8.00	R 165.16
1205	Immittance Measurements - Impedance / Stapedial reflex (3276): Limited reflex spectrum (eg : 1-2 frequencies)			4.00	R 82.75
1210	Immittance Measurements - Impedance / Stapedial reflex (3276): Extended reflex spectrum (250-8000Hz e.g. 4-8 frequencies)			12.00	R 247.92
1215	Immittance Measurements - Impedance / High Frequency Tympanometry (for peadiatric population)			8.00	R 165.16
1220	Eustachian Tube Function Test - multiple tympanograms - bilateral			12.00	R 247.92
1225	Rinné & Weber tests			4.00	R 87.24
C.	**Diagnostic Audiological Tests for Differential Diagnosis between Cochlear; Retro-cochlear; Central; Functional and/or Vestibular Pathology**				
1300	Tone Decay (for retro cochlear pathology)			8.00	R 174.80
1305	Reflex decay (for retro cochlear pathology)			8.00	R 165.16
1310	Short Increment Sensitivity Index (SISI)			5.00	R 109.50
1315	Air conduction MCL (Most comfortable levels) & UCL (Uncomfortable levels)			8.00	R 174.80
1320	Speech thresholds MCL (Most comfortable levels) & UCL (Uncomfortable levels)			4.00	R 87.24
1325	Test for functional hearing loss			10.00	R 218.34
1331	Stenger test - pure tone			5.00	R 109.50
1332	Stenger test - speech			5.00	R 109.50
1335	Fistula test - (for peri-lymph fluid leakage)			15.00	R 327.34
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.			13.00	R 290.12
E.	**Electro-Physiological Examinations/ Auditory Evoked Potentials (AEP)**				
1500	Diagnostic Neurological short latency ABR (Auditory Brainstem Response) Bilateral; single decibel (2692)			60.00	R 1 338.62
1505	AABR - Bilateral (Automated Auditory Brainstem Response). Cannot be charged with 1510			30.00	R 618.96
1510	Screening ABR - Bilateral (Auditory Brainstem Response) . Cannot be charged with 1505			20.00	R 412.75
1515	Diagnostic Audiological Click ABR (Auditory Brainstem Evoked Response) – Bilateral Air conduction threshold determination using click stimuli			60.00	R 1 338.62
1520	Diagnostic Audiological Click ABR-(Auditory Brainstem Response) – Bilateral Bone conduction threshold determination using click stimuli			80.00	R 1 784.61
	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			30.00	R 669.48
1532	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies			60.00	R 1 338.62
1533	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies			90.00	R 2 008.10
1534	Diagnostic Audiological Tone Burst ABR (Auditory Brainstem Response) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies			120.00	R 2 677.41
	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			25.00	R 557.98
1542	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 2 frequencies			50.00	R 1 115.97
1543	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses (2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 3 frequencies			75.00	R 1 673.28
1544	Diagnostic Audiological Middle latency & Late Cortical Auditory Evoked responses(2698) – Bilateral Frequency specific threshold determination using tone-burst stimuli at : 4 frequencies			100.00	R 2 231.25
	Combinations of items 1551 to 1554 cannot be billed together.				
1551	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 1 frequency			30.00	R 669.48
1552	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 2 frequencies			40.00	R 892.64
1553	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 3 frequencies			60.00	R 1 338.62
1554	ASSER (Auditory Steady State Evoked Response) – Bilateral threshold determination : 4 frequencies			80.00	R 1 784.61
1560	P300 Cognitive AEP (Auditory Evoked Potential) or MMN (Mismatch Negativity)			35.00	R 780.97
1565	Electrocochleography: unilateral (2699). Cannot be charged with item 1570.			45.00	R 1 003.80
1570	Electrocochleography: bilateral (2700). Cannot be charged with item 1565.			90.00	R 2 008.10
1575	Cochlear nerve function test - intra-operative monitoring - per 30min			30.00	R 669.48
1580	OAE (Oto-acoustic emissions) - limited frequencies (transient or distortion product) for hearing screening of neonatal and pediatric population.			15.00	R 297.60

1581	OAE (Oto-acoustic emissions) - comprehensive diagnostic evaluation			30.00	R 618.96
F.	**Balance/Vestibular Examinations and Treatment**				
1600	Spontaneous and positional nystagmus using electro-nystagmography (ENG) (3253). Cannot use with item 1605.			55.00	R 1 227.29
1605	Spontaneous and positional nystagmus using Video-nystagmography (VNG). Cannot use with item 1600.			55.00	R 1 291.60
1610	Eye Visualization – spontaneous and positional nystagmus – monocular			35.00	R 695.23
1615	Eye Visualization – spontaneous and positional nystagmus – binocular			35.00	R 722.49
1620	Oculo-motor/central tests using electro-nystagmography (ENG). Cannot be used with item 1625.			25.00	R 587.22
1625	Oculo-motor/central tests using video-nystagmography (VNG). Cannot be used with item 1620.			25.00	R 587.22
1630	DVA (Dynamic Visual Acuity) test using Video-nystagmography (VNG)			10.00	R 235.12
1635	Caloric test using ENG electro-nystagmography (3255). Cannot be used with item 1640.			50.00	R 1 174.12
1640	Caloric test using VNG electro-nystagmography (3255). Cannot be used with item 1635.			50.00	R 1 174.12
1645	Posturography			25.00	R 587.22
1650	Rotational Chair test			15.00	R 309.73
1655	Otolith repositioning/canalith maneuvre			25.00	R 476.89
1660	Vestibular rehabilitation (neuromuscular) re-education of movement, balance, coordination, kinesthetic sense, posture, and proprioception			25.00	R 476.89
G.	**Cochlear Implant Tests**				
1700	Cochlear Implants: Pre-implant round window promontory testing.			45.00	R 928.69
1710	Cochlear Implants : Electrode mapping : per 15min (max 120min)			15.00	R 352.10
1720	Cochlear Implants : Implant test : Four test modes : intra- or post-operatively			5.00	R 109.50
1725	Cochlear Implants : Neural Response Telemetry : intra-operatively (during cochlear implant surgery)			20.00	R 469.74
1730	Cochlear Implants : Neural Response Telemetry : post-operatively (after cochlear implant surgery)			55.00	R 1 201.03
1735	Cochlear Implants : Electrical Stapedius Reflex Thresholds : intra-operatively only			13.00	R 305.24
1740	Cochlear Implants : Comprehensive speech perception testing, pre- and post-cochlear implant, per 15min (max 45min)			15.00	R 334.33
H.	**Hearing Amplification / Hearing Aids**				
1800	Hearing aid evaluation - per ear			15.00	R 297.60
1805	Free Field Hearing Aid Evaluation : Pure tone and speech (with and without lipreading)			13.00	R 290.12
1810	Insertion gain measurement, per ear			10.00	R 206.87
1815	Re-programming of hearing aid, per ear			10.00	R 198.73
1820	Technical adjustment of hearing aid/device, per ear.			6.00	R 119.64
1825	Repairs to hearing aids			-	R0.00

1830	Global charge for supply and fitting of hearing aid and follow-up (By arrangement).			-	R0.00
I.	**Occupational Health / Industrial Hearing Assessment**				
1900	Pure Tone Audiogram (Air conduction). (3237)			15.00	R 286.30
1905	Pure Tone Audiogram (Bone conduction) (3274)			12.00	R 228.81
1910	Full Speech Audiogram including speech reception threshold and discrimination at two or more levels (3277)			15.00	R 286.30
1915	Speech audiogram screening			5.00	R 95.38
1920	Immittance Measurements (Impedance) (Tympanometry)			4.00	R 76.43
1925	Immittance Measurements (Impedance) (Stapedial reflex) (3276)			12.00	R 228.81
4	**Material**				
300	Medication			-	R0.00
301	Material			-	R0.00

UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS (PR 076)

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	All accounts submitted by unattached operating theatre units/day clinics shall comply with all of the requirements in terms of the Fund regulations. 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 CCSA 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 CCSA 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.		

Code	Description	Units	Value
9	UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE NUMBER COMMENCING WITH '76'		
5	Local anaesthetic theatre, Per minute	11.40	R 13.79
10	General anaesthetic theatre, Per minute	35.70	R 43.19
15	Dental anaesthetic theatre (Applicable to units registered for dental procedures only), Per minute	24.10	R 29.15
61	Excimer laser theatre fee, per minute	25.70	R 31.09
	Ward fees (including recovery room)		

19	Out-patients facility fee for ambulatory admission - chargeable for patients NOT requiring general anaesthetic- No ward fees applicable. 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.	419.90	R 507.97
25	Day rate.	481.50	R 582.49
	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 101 of 1965).	-	
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.	414.10	R 500.95
	Non-chargeable items (1)		
40	Theatre items: Refer to Appendix B.	-	
	Non chargeable items (2)		
60	Wards: Refer to Appendix B.	-	
	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	417.10	R 504.58
228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	206.30	R 249.57
335	Excimer laser: Hire fee per eye	2 913.20	R 3 524.22
337	Microkeratome used with an excimer laser, per operation	535.00	R 647.21
	GASES		
	Oxygen and Nitrous Oxide		
	For both gases together, per minute		
283	Gauteng area	4.34	R 5.25
701	Cape Town	5.95	R 7.20
702	Port Elizabeth	5.31	R 6.42
703	East London	5.85	R 7.08
704	Durban	5.44	R 6.58
705	Other areas	4.84	R 5.86
	Oxygen, ward use		
	Fee for oxygen, per quarter hour or part thereof, outside the operating theatre complex		
284	Gauteng area	6.35	R 7.68
710	Cape Town	10.60	R 12.82
711	Port Elizabeth	10.10	R 12.22
712	East London	9.74	R 11.78
713	Durban	8.25	R 9.98
714	Other areas	7.87	R 9.52
	Oxygen, recovery room and emergency units		
	Flat rate for oxygen per case		

720	Gauteng area	12.60	R 15.24
721	Cape Town	20.90	R 25.28
722	Port Elizabeth	20.00	R 24.19
723	East London	19.50	R 23.59
724	Durban	16.50	R 19.96
725	Other areas	15.80	R 19.11
	Oxygen in Theatre		
	Fee for oxygen per minute in the operating theatre when no other gas administered.		
730	Gauteng area	0.38	R 0.46
731	Cape Town	0.70	R 0.85
732	Port Elizabeth	0.66	R 0.80
733	East London	0.66	R 0.80
734	Durban	0.54	R 0.65
735	Other areas	0.50	R 0.60
	Carbon Dioxide		
291	Per minute	0.78	R 0.94
	Laser		
292	Per minute	15.10	R 18.27
	Entonox		
293	Per 30 minutes	144.30	R 174.57
	Inhalation anaesthetics		
285	Halothane (Halothane): per minute	0.34	R 0.41
752	Ethrane (Enflurane): per minute	1.44	R 1.74
753	Forane (Isoflurane): per minute	1.60	R 1.94
754	Isofor (Isoflurane); per minute	1.60	R 1.94
755	Ultane (Sevoflurane): per minute	4.59	R 5.55
756	Suprane (Desflurane); per minute	3.93	R 4.75
757	Aerrane (Isoflurane): per minute	1.60	R 1.94
758	Alyrane (enflurane): per minute	1.44	R 1.74
759	Fluothane (Halothane): per minute	0.34	R 0.41

	ANNEXURES		
	APPENDIX A		
	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:		
	¢ 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.		
	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		
	APPENDIX B:		
	Medically Prescribed Meals:		
	ORAL SUP+B134:B144PLEB134:B163MENTS 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		
	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		

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