CONTRACTED ANAESTHESIOLOGY FOR ALL OPTIONS

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS
WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. **ALL GEMS TARIFFS ARE VAT INCLUSIVE.**				
	RULES GOVERNING THE STRUCTURE				
A.	Consultations: Definitions: (a) New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. (b) Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or 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. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: (1) An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity"; (2) In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; (3) Is 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				

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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 after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). (b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. (c) When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. (d) Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions				
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days				
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.				
K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists				
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged				
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion				
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention				
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme				

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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 16km 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 8km 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. Medical scheme 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: category 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.				

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V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods				
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used				
Z.	No fee is subject to more than one reduction				
AA.	Procedures to exclude cost of isotope				
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes				
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp				
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account 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 medical scheme by the patient or the doctor, as the case may be. (d) In case of a referral to a radiologist, no motivation should be required from the radiologist				
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.				
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years				

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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				
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 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 practitioner who owns/rents the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors’ own procedure rooms. d) Please note that modifier 0004 may not be used in conjunction with modifiers 0074 and 0075.				
0005	Multiple therapeutic procedures/operations under the same anaesthetic: a) Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail (refer to modifier 0060 for poly-trauma). c) Diagnostic endoscopic procedures: (i) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. (ii) Refer to modifier 0013 for related endoscopic examinations done at operations. (iii)Ref to rule FF for governing the urinary system section with regards to cystoscopies only. d)More than one small procedure: 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)Add on items: P(“+”) 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). The units of plus (“+”) procedures must not be added to the units of the definitive item and must appear on a separate line on the account.				
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				

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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.				
0008	Specialist surgeon assistant: The units of the procedure(s) for a specialist surgeon acting as assistant surgeon in procedures of a specialised nature, is 40% of the units for the procedure(s) performed by the specialist surgeon.				
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units				
0076	“Assistant paediatric cardiologist: the units for a paediatric cardiologist acting as an assistant, is 40% of the units of the procedure(s) performed. Modifier 0076 to be used by paediatric surgeons for any procedures performed on neonates with a birth weight of less than 1000g - in any setting. Modifier 0076 may not be used together with modifier 0008 or modifier 0009 for the same paediatric cardiologist assistant“				
0010	Local anaesthesic: (a) A fee for a local anaesthetic administered by the operator may only be charged for (1) an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. (b) The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. (c) Not applicable to radiological procedures (such as angiography and myelography. (d) No fee may be levied for topical application of local anaesthetic. (e) Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon’s account for procedures that were performed under general anaesthetic.				
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)				
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged				
0014	Operations previously performed by other surgeons: a) Use modifier 0014(a) for information only as an indicator that the operation was previously performed by another surgeon. b) Where an operation is performed which has been previously 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 an additional units to be negotiated under general Rule J: In exceptional cases where the units is disproportionately low in relation to actual service rendered, except where already specified in the structure.				
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions				

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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 modifier 0019(a) when appropriate				
0017	Injections or flu vaccinations administered by the medical doctor: When desensitisation, intravenous, intramuscular or subcutaneous injections or flu vaccinations 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 injection for the same condition should be charged according to item 0131 (not chargeable together with a consultation item)				
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists				
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists				
0060	Musculo-Skeletal poly trauma: Significant injury to more than one musculo-skeletal system. Examples: two long bone fractures, or a long bone fracture or 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 musculo-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, eg. femur where a proximal and distal fracture is present which necessitates two different surgical approaches and fixation methods. • Multiple small bone fractures of the hand or feet, eg. crush injuries plus any other musculo-skeletal injuries”				
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant’s fee where applicable. After one month, a full fee as for the initial treatment, is applicable				
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis				
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)				
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement				

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0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)				
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units				
0052	Except where otherwise specified, fracture (traumatic or surgical, i.e. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixtion/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 practitioners for HAND or FOOT fracture/osteotomy: Add				
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				
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units				
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/ operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot				
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers)				
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. Each surgeon may charge an assistant fee for the procedures performed by the other surgeon, at general practitioner rate (refer to modifier 0009)				
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure				
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts				
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere				
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee				
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff)				
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083				

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0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope				
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins				
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%				
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.				
0075	Endoscopic procedures performed in own procedure room: (a) The value of modifier 0075 = 21,00 clinical procedure units, where endoscopic procedures are performed in rooms. (b) This fee is chargeable by medical practitioners who own or rent the facility. (c) Modifier 0075 may not be used in conjunction 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.				
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)				
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure				
0079	When a first or follow-up consultation/visit proceeds into or is immediately followed by a medical psychotherapeutic procedure, both the consultation/visit and the psychotherapy codes (items 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)				
0080	Multiple examinations: Full Fee				
0081	Repeat examinations: No reduction				
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.				
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used				
0084	Charging for films and thermal paper by non-radiologist: in the case of radiological services rendered by non-radiologists where films, thermal paper or magnetic media are used, these media is charged for according to the film price of 2007, as compiled by the Radiological Society of South Africa (this list is available on request at radsoc@iafrica.com)				
0085	Left Side' modifier to be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined				
0086	Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations				

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Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0090	Doctor's remuneration for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)				
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)				
0092	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)				
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, is available from the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0198 and item 0201 should not be used for these materials				
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope				
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				
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Real-time): Fee for part examined plus 30% of the units				
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units				
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%				
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability				
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability				
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"				
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)				
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)				
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure				

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6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value				
I.	**CONSULTATIVE SERVICES (REFER TO PSYCHIATRISTS CONSULTATIVE SERVICE GUIDE)**				
I.a	**General Practitioner visits**				
I.b	**Specialists tiered consultation structure**				
I.b.1	**New and established patients: Consultations/visits by psychiatrists (22) only**				
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)				
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)				
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)				
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0166-0169)				
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				
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				
0168	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 36 and 45 minutes				
0169	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 46 and 60 minutes				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
I.c	**General practitioner and specialist services (Refer to the Medical Practitioner Consultative service guide)**				
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/ visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure				
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure				
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/ visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure				
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)				
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)				
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure)				
0178	Hospital follow-up visit to patient in ward or nursing facility with a duration of 31-60 minutes: ADD only to item 0109, as appropriate. Psychiatrists ("22") refer to items 0166-0169 for hospital follow-up visits				
0179	Prolonged face-to-face attendance to a patient in ward or nursing facility: ADD only to 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).				
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)				
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				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0129	Prolonged face-to-face attendance to a patient: ADD to either item 0192, item 0175, item 0164 or item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes				
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof				
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof				
0147	For an emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof				
0148	For elective after-hours services on request of the patient or family (non emergency) (refer to general rule B(a)): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0193, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0148. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the practitioners' normal hours period.				
0149	After-hours bona fide emergency consultation/visit (21:00-06:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0193, items 0173-0175, items 0161-0164, items 0166-0169, items 0151-0153 or item 0113) and reflect this as a separate item 0149				
0126	For an UNSCHEDULED consultation/visit at the doctor's home or rooms: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof				
I.e	**Pre-anaesthetic assessment**				
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes				
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes				
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes				
I.f	**Prenatal visits and new born attendance**				
0107	New born attendance: Exclusive attendance to baby at Caesarean section, normal delivery or visit in the ward (once per patient) (items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to item 0107)				
	Item 0107 can be used once only for given confinement				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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)				
I.g	**Consultative services: Miscellaneous**				
0130	Telephone consultation (all hours)				
0131	Subsequent injections or flu vaccinations 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)				
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)				
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				
0137	Patient and/or family education and/or guidance for a specific condition for 20 minutes, supported by the appropriate ICD-10 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 wording of the description)				
0138	Patient and/or family education and/or guidance for a specific condition for 40 minutes, supported by the appropriate ICD-10 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 wording of the description)				
0139	Patient and/or family education and/or guidance for a specific condition for 41 minutes and longer, supported by the appropriate ICD-10 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 wording of the description)				
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				
II.	**MEDICINE, MATERIAL, SUPPLIES AND USE OF OWN EQUIPMENT**				
II.a	**Medicine codes**				
II.a.1	**Dispensing of medicine by licensed dispensing medical practitioners**				
0197	Licensed dispensing medical practitioners: Dispensing cost : As per legislated tariff. Add to each Nappi code to provide for the dispensing cost.				
II.a.2	**Once-off administration of medicine used during a consultation**				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0198	"Once-off administration of medicines: This item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS legislated tariff for dispensing fees.(Where applicable, VAT should be added to the dispensing fee only and not to the SEP, since the SEP is VAT inclusive).[According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation]. The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment."				
II.a.3	**Cost of chemotherapy drugs**				
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.				
0195	Active treatment of cancer by licensed dispensing medical doctors: To be used for dispensed items where the practice is a licensed dispensing doctors practice. This code will be used for medicine, material and/or unregistered/unscheduled products that are dispensed, eg., hormonal and/or oral products used in the active treatment of cancer. The use of this item will assist in the correct benefit allocation for this treatment, subject to scheme rules and managed care requirements. The appropriate NAPPI code(s), where applicable, must be provided				
II.b	**Material codes**				
II.b.1	**Prosthesis and/or internal fixation**				
II.b.2	**Material used during a consultation**				
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above). The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to item 0198 for once off administration of medicine.				
II.c	**Setting of sterile tray**				
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate				
0194	Procurement cost for human donor material. No mark up is allowed				
II.d	**Own equipment used in treatment**				
5930	Surgical laser apparatus: Hire fee for own equipment				
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)				

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II.e.2	**Calculation of own equipment costs**				
5934	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%) (1) Cost of equipment + maintenance cost over the lifespan of the equipment based on manufacturer's information (2) Divide by utilisation of the equipment over the manufacturers lifespan information (events in this period) (3) + % Return on Investment = Cost per event. Specify equipment used and reflect modifier in a separate line from procedure performed but directly underneath the code for the procedure. Equipment already in use, must be calculated on the original figures.				
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				
	GENERAL MODIFIERS GOVERNING THIS SECTION				
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment)				
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged				
0014	Operations previously performed by other surgeons: a) Use modifier 0014(a) for information only as an indicator that the operation was previously performed by another surgeon. b) Where an operation is performed which has been previously 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 an additional units to be negotiated under general Rule J: In exceptional cases where the units is disproportionately low in relation to actual service rendered, except where already specified in the structure.				
	MODIFIERS GOVERNING SECTION 1				
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions				
0017	Injections or flu vaccinations administered by the medical doctor: When desensitisation, intravenous, intramuscular or subcutaneous injections or flu vaccinations 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 injection for the same condition should be charged according to item 0131 (not chargeable together with a consultation item)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1	**GENERAL**				
1.1	**Injections, Infusions and Inhalation Sedation Treatment**				
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof				
0204	Inhalation sedation: Per additional quarter-hour or part thereof				
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) (patients under three years): Cut-down and/or insertion of cannula - chargeable once per 24 hours				
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours				
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours				
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)				
0209	Umbilical artery cannulation at birth				
0210	Collection of blood/pap smear specimen(s) by medical practitioner for pathology examination, per venesection/sample (not to be used by pathologists)				
0211	Exchange transfusion: First and subsequent (including after-care)				
	"Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS: Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to item 0205)"				
1.2	**Chemotherapy treatment (not in chemotherapy facilities)**				
0213	Treatment with cytostatic agents: Administering of Chemotherapy: Intramuscular or subcutaneous: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment				
0214	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous bolus technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment				
0215	Intravenous treatment with cytostatic agents: Administering of Chemotherapy: Intravenous infusion technique: Per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment				
1.3	**Oncology related services in non-oncology facilities**				
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included				
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote after loading brachytherapy. The cost of materials is not included				

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5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included				
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)				
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS				
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.				
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 modifiers (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 also be added.				
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one (1) hour the number of units shall, after one (1) hour, be 3,00 anaesthetic units per 15 minute period or part thereof.				
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.				
0025	Calculation of anaesthetic time: Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.				
0026	One lung ventilation: Utilisation of one lung ventilation: Add 3.00 anaesthetic units		3,000	R359,80	
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units				
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute. No additional fee to be charged.				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic				
0030	Indicator for use of low flow anaesthetic technique 1-2 litre/minute: Fresh gas flow of 1 to 2 litre/minute. No additional fee to be charged.				
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time				
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added				
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.				
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added				
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).				
0036	Anaesthetic administered by general practitioners: (a) Anaesthesia administered lasting one hour or less: The units (basic units plus time plus the appropriate modifiers) used to calculate the units for an anaesthesia administered by a general practitioner lasting one hour or less, shall be the same as that for a specialist anaesthesiologist. No anaesthesia performed should be less than 7.00 anaesthetic units (see modifier 0035). (b) Anaesthesia lasting more than one hour, the units used to calculate the units for an anaesthesia administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time plus the appropriate modifiers) applicable to the specialist anaesthesiologist. The calculated anaesthetic units shall not be less than 11.00 anaesthetic units.				
0037	Body hypothermia: Utilisation of total body hypothermia: Add 3,00 anaesthetic units	30	3,000	R359,80	
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage				
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof				
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units				
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units	30	3,000	R359,80	
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units	30	3,000	R359,80	

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0043	Anaesthesia for patients under one year of age or over 70 years of age: For all cases where the patient is under one year of age or over 70 years of age – 3,00 anaesthetic units to be added	30	3,000	R359,80	
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	30	3,000	R359,80	
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.				
	"Modifiers 5441 to 5448				
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in Modifiers 5442 to 5448	30	1,000	R119,70	
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	30	2,000	R240,10	
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	30	3,000	R359,80	
5444	Shaft of femur: Add four (4,00) anaesthetic units	30	4,000	R480,30	
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units	30	5,000	R600,10	
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	30	8,000	R959,80	
5433	Physical status modifier: A patient with sever systemic disease, ASA 3: Add 1.00 anaesthetic unit		1,000	R119,90	
5434	Physical status modifier: A patient with sever systemic disease that is a constant threat to life, ASA 4: Add 2.00 anaesthetic units		2,000	R239,90	
5435	Physical status modifier: A moribund patient who is not expected to survive without an operation, ASA 5: Add 3.00 anaesthetic units		3,000	R359,80	
	POST-OPERATIVE ALLEVIATION OF PAIN				
0045	"Post-operative alleviation of pain: 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)" (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 charged 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 charged, provided that it was not the primary anaesthetic technique. (c) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain in the ward or nursing facility, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (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 drug)"				

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2	**INTEGUMENTARY SYSTEM**				
2.1	**Allergy**				
0217	Allergy: Patch tests: First patch				
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs				
0219	Allergy: Patch tests: Each additional patch				
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens				
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen				
2.2	**Skin (general)**				
0222	Intralesional injection into areas of pathology e.g. Keloid: Single				
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple				
0225	Epilation: Per session				
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session	30	4,000	R480,30	T
0228	PUVA Treatment: Maximum of 21 treatments				
0229	PUVA: Follow-up or maintenance therapy once a week				
0230	UVR-Treatment				
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				
0232	Biopsy of superficial soft tissue: Back or flank		5,000	R600,10	T
0233	Biopsy without suturing: First lesion	30	3,000	R359,80	T
0234	Biopsy without suturing: Subsequent lesions (each)	30	3,000	R359,80	T
0235	Biopsy without suturing: Maximum for multiple additional lesions	30	3,000	R359,80	T
0236	Biopsy of superficial soft tissue: Shoulder area		3,000	R359,80	T
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	30	3,000	R359,80	T
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		3,000	R359,80	T

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0239	Biopsy of superficial soft tissue: Forearm and/or wrist		3,000	R359,80	T
0240	Biopsy of superficial soft tissue: Leg or ankle area		3,000	R359,80	T
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	30	3,000	R359,80	T
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	30	3,000	R359,80	T
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	30	3,000	R359,80	T
0244	Repair of nail bed	30	3,000	R359,80	T
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	30	3,000	R359,80	T
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	30	3,000	R359,80	T
0247	Biopsy of superficial soft tissue: Pelvis and hip area		3,000	R359,80	T
0248	Biopsy of superficial soft tissue: Thigh or knee area		3,000	R359,80	T
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	30	3,000	R359,80	T
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	30	3,000	R359,80	T
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	30	3,000	R359,80	T
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	30	3,000	R359,80	T
0259	Removal of foreign body superficial to deep fascia (except hands)	30	3,000	R359,80	T
0261	Removal of foreign body deep to deep fascia (except hands)	30	3,000	R359,80	T
0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax; less than 3 cm		5,000	R600,10	T
0263	Excision tumour of subcutaneous soft tissue: Shoulder area; less than 3 cm		3,000	R359,80	T
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area; less than 3 cm		3,000	R359,80	T
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area; less than 3 cm		3,000	R359,80	T
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger; less than 1,5 cm		3,000	R359,80	T
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area; less than 3 cm		3,000	R359,80	T
0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area; less than 3 cm		3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area; less than 3 cm		3,000	R359,80	T
0270	Excision tumour of subcutaneous soft tissue: Foot or toe; less than 1,5 cm		3,000	R359,80	T
0271	Kurtin planing for acne scarring: Whole face	30	4,000	R480,30	T
0273	Kurtin planing for acne scarring: Extensive	30	4,000	R480,30	T
0274	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): First stage, up to 5 tissue blocks		5,000	R600,10	T
0275	Kurtin planing for acne scarring: Limited	30	4,000	R480,30	T
0276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional stage after the first stage, up to 5 tissue blocks		5,000	R600,10	T
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	30	4,000	R480,30	T
0278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional block after the first 5 tissue blocks, any stage		5,000	R600,10	T
0279	Surgical treatment for axillary hyperhidrosis	30	4,000	R480,30	T
0280	Laser treatment for small skin lesions: First lesion	30	3,000	R359,80	T
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	30	3,000	R359,80	T
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	30	3,000	R359,80	T
0283	Laser treatment for large skin lesions: Limited area	30	4,000	R480,30	T
0284	Laser treatment for large skin lesions: Extensive area	30	4,000	R480,30	T
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	30	4,000	R480,30	T
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp				
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device				
0258	Incision/removal of foreign body: Subcutaneous tissue, simple		3,000	R359,80	T
0260	Incision/removal of foreign body: Subcutaneous tissue, complicated		3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2.3	**Major plastic repair**				
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	30	4,000	R480,30	T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	30	4,000	R480,30	T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	30	4,000	R480,30	T
0292	Distant flaps: First stage	30	4,000	R480,30	T
0293	Contour grafts (excluding cost of material)	30	4,000	R480,30	T
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	30	6,000	R720,00	T
0295	Local skin flaps (large, complicated)	30	4,000	R480,30	T
0296	Other procedures of major technical nature	30	4,000	R480,30	T
0297	Subsequent major procedures for repair of same lesion	30	4,000	R480,30	T
0298	Lower abdominal dermo-lipectomy	30	5,000	R600,10	T
0299	Major abdominal lipectomy with repositioning of umbilicus	30	5,000	R600,10	T
0288	Harvesting of graft: Fascia lata graft, complex or sheet		4,000	R480,30	T
2.4	**Lacerations, scars, tumours, cysts and other skin lesions**				
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care)	30	3,000	R359,80	T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	30	3,000	R359,80	T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	30	4,000	R480,30	T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	30	4,000	R480,30	T
0304	Major debridement of wound, sloughectomy or secondary suture	30	3,000	R359,80	T
0305	Needle biopsy - soft tissue	30	3,000	R359,80	T
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	30	3,000	R359,80	T
0308	Each additional small procedure done at the same time	30	3,000	R359,80	T
0310	Radical excision of nailbed	30	3,000	R359,80	T
0311	Excision of large benign tumour (more than 5 cm)	30	3,000	R359,80	T

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0313	Extensive resection for malignant soft tissue tumour including muscle	30	4,000	R480,30	T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	30	4,000	R480,30	T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	30	3,000	R359,80	T
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		3,000	R359,80	T
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof		3,000	R359,80	T
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		5,000	R600,10	T
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof		5,000	R600,10	T
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		6,000	R720,00	TM
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof		6,000	R720,00	TM
4880	Biopsy soft tissue: Neck or thorax		5,000	R600,10	T
4881	Biopsy of soft tissue: Deep: Back or flank		5,000	R600,10	T
4882	Biopsy of soft tissue: Deep: Shoulder area		5,000	R600,10	T
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular): Upper arm or elbow area		3,000	R359,80	T
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular): Forearm and/or wrist		3,000	R359,80	T
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular): Thigh or knee area		4,000	R480,30	T
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular): Leg or ankle area		3,000	R359,80	T
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular): Pelvis and hip area		4,000	R480,30	T
0306	Excision subcutaneous mass <2cm: Head and neck, eg., lipoma, cyst		3,000	R359,80	T
0309	Excision subcutaneous mass >2cm: Head and neck, eg., lipoma, cyst		4,000	R480,30	T
0312	Excision subcutaneous mass>2cm involving muscle/subgaleal: Head and neck, eg., lipoma, cyst		4,000	R480,30	T
0318	Excision subcutaneous mass <2cm involving muscle/subgaleal: Head and neck, eg., lipoma, cyst		4,000	R480,30	T
4840	Excision malignant lesion, including margins: Trunk/arms/legs <=0.5 cm		3,000	R359,80	T
4841	Excision malignant lesion, including margins: Trunk/arms/legs 0.6-1.0 cm		3,000	R359,80	T
4842	Excision malignant lesion, including margins: Trunk/arms/legs 1.1-2.0 cm		6,000	R719,60	T

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4843	Excision malignant lesion, including margins: Trunk/arms/legs 2.1-3.0 cm		6,000	R1 079,40	T
4844	Excision malignant lesion, including margins: Trunk/arms/legs 3.1-4.0 cm		6,000	R1 439,20	T
4845	Excision malignant lesion, including margins: Trunk/arms/legs >4.0 cm		6,000	R1 799,10	T
4848	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane <=0.5 cm		3,000	R359,80	T
4849	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 0.6-1.0 cm		3,000	R359,80	T
4850	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 1.1-2.0 cm		6,000	R719,60	T
4851	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 2.1-3.0 cm		6,000	R1 079,40	T
4852	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 3.1-4.0 cm		6,000	R1 439,20	T
4853	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane > 4.0 cm		6,000	R1 799,10	T
4856	Split thickness autograft of the trunk, arms and/or legs <=100 cm (1% of body area for infants and children)		4,000	R480,30	T
4857	Split thickness autograft of the trunk, arms and/or legs; each additional 100 cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)		3,000	R359,80	T
4858	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 cm (1% of body area for infants and children)		4,000	R480,30	T
4859	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)		4,000	R480,30	T
4862	Full thickness graft of the trunk, free graft including direct closure of donor site: <=20cm		4,000	R480,30	T
4863	Full thickness graft of the trunk, free graft including direct closure of donor site, each additional 20cm (modifier 0005 not applicable)		3,000	R359,80	T
4864	Full thickness graft of the scalp, arms and/or legs, free graft including direct closure of donor site: <=20cm		4,000	R480,30	T
4865	Full thickness graft of the scalp, arms and/or legs, free graft including direct closure of donor site; each additional 20cm (modifier 0005 not applicable)		3,000	R359,80	T
4866	Full thickness graft of the face, neck, axilla, genitalia, hands and/or feet, free graft including direct closure of donor site: <=20cm		4,000	R480,30	T
4867	Full thickness graft of the face, neck, axilla, genitalia, hands and/or feet, free graft including direct closure of donor site; each additional 20cm (modifier 0005 not applicable)		3,000	R359,80	T
4868	Full thickness graft of the nose, ears, eyelids and/or lips, free graft including direct closure of donor site: <=20cm		4,000	R480,30	T
4869	Full thickness graft of the nose, ears, eyelids and/or lips, free graft including direct closure of donor site; each additional 20cm (modifier 0005 not applicable)		3,000	R359,80	T
4940	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) <= 0.5 cm		3,000	R359,80	T

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4941	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 0.6-1.0 cm		3,000	R359,80	T
4942	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 1.1-2.0 cm		3,000	R359,80	T
4943	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 2.1-3.0 cm		3,000	R359,80	T
4944	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 3.1-4.0 cm		3,000	R359,80	T
4945	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) > 4.0 cm		3,000	R359,80	T
4950	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia		3,000	R359,80	T
4951	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 0.6-1.0 cm		3,000	R359,80	T
4952	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 1.1-2.0 cm		3,000	R359,80	T
4953	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 2.1-3.0 cm		3,000	R359,80	T
4954	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 3.1-4.0 cm		3,000	R359,80	T
4955	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia > 4.0 cm		3,000	R359,80	T
4960	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane		3,000	R359,80	T
4961	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 0.6-1.0 cm		3,000	R359,80	T
4962	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 1.1-2.0 cm		3,000	R359,80	T
4963	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 2.1-3.0 cm		3,000	R359,80	T
4964	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 3.1-4.0 cm		3,000	R359,80	T
4965	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane > 4.0 cm		3,000	R359,80	T
4970	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia		3,000	R359,80	T
4971	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 0.6-1.0 cm		3,000	R359,80	T
4972	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 1.1-2.0 cm		3,000	R359,80	T
4973	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 2.1-3.0 cm		3,000	R359,80	T
4974	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 3.1-4.0 cm		3,000	R359,80	T
4975	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia > 4.0 cm		3,000	R359,80	T
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100 cm (1% of body area for infants and children)				Refer Rule C

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4873	Acellular dermal allograft of the trunk, arms and/or legs; each additional 100 cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)				Refer Rule C
4874	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 cm (1% of body area for infants and children)				Refer Rule C
4875	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 cm or part thereof (1% of body area for infants and children) (modifier 0005 not applicable)				Refer Rule C
2.5	**Breasts**				
0316	Fine needle aspiration for soft tissue (all areas)				
0317	Aspiration of cyst or tumour	30	3,000	R359,80	T
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	30	3,000	R359,80	T
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	30	3,000	R359,80	T
0323	Subareolar cone excision of ducts of wedge excision of breast	30	3,000	R359,80	T
0324	Wedge excision of breast and axillary dissection	30	5,000	R600,10	T
0325	Total mastectomy	30	5,000	R600,10	T
0327	Total mastectomy with axillary gland biopsy	30	5,000	R600,10	T
0329	Total mastectomy with axillary gland dissection	30	5,000	R600,10	T
0330	Nipple and areola reconstruction	30	4,000	R480,30	T
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	30	4,000	R480,30	T
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	30	4,000	R480,30	T
0334	Removal of breast implant by means of capsulectomy: Per breast	30	4,000	R480,30	T
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	30	4,000	R480,30	T
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	30	5,000	R600,10	T
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	30	5,000	R600,10	T
0341	Gynaecomastia: Unilateral	30	3,000	R359,80	T
0343	Gynaecomastia: Bilateral	30	3,000	R359,80	T
0338	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle (suture of donor site included)		5,000	R600,30	T

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0340	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, with microvascular anastomosis (supercharging) (suture of donor site included)		5,000	R600,30	T
0342	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), double pedicle (suture of donor site included)		5,000	R600,30	T
0336	Breast reconstruction: Lattisimus dorsi flap, without prosthetic implant				Refer Rule C
0344	Breast reconstruction: Revision				Refer Rule C
2.6	**Burns**				
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	30	5,000	R600,10	T
0353	Tangential excision and grafting: Small	30	5,000	R600,10	T
0354	Tangential excision and grafting: Large	30	5,000	R600,10	T
0345	Minor burns				Refer Rule C
0347	Moderate burns				Refer Rule C
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	30	4,000	R480,30	T
0357	Small skin graft in acute hand injury	30	3,000	R359,80	T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	30	3,000	R359,80	T
0361	Z-plasty	30	3,000	R359,80	T
0363	Local flap and skin graft	30	3,000	R359,80	T
0365	Cross finger flap (all stages)	30	3,000	R359,80	T
0367	Palmar flap (all stages)	30	3,000	R359,80	T
0369	Distant flap: First stage	30	3,000	R359,80	T
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	30	3,000	R359,80	T
0373	Transfer neurovascular island flap	30	3,000	R359,80	T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	30	3,000	R359,80	T
0375	Dupuytren’s contracture: Fasciotomy	30	3,000	R359,80	T
0376	Dupuytren’s contracture: Fasciectomy	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2.8	**Acupuncture**				
	Please note: General Rule M not applicable to section 2.8 of this price list				
0377	Standard acupuncture				
0378	Laser acupuncture using more than 6 points				
0379	Electro-acupuncture				
0380	Scalp acupuncture				
0381	Micro-acupuncture (ear, hand)				
	RULES GOVERNING THE SECTION ACUPUNCTURE				
CC.	Acupuncture: (a) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. (b) Not more than two separate techniques may be charged for at each session. (c) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. (d) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp				
3	**MUSCULO-SKELETAL SYSTEM**				
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS				
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis				
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care)				
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement				
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)				
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0052	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 practitioners for HAND or FOOT fracture/osteotomy: Add				
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				
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units				
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/ operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot				
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers)				
3.1	**Bones**				
3.1.1	**Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)**				
0383	Fracture (reduction under general anaesthetic): Scapula	30	3,000	R359,80	TM
0384	Fracture: Scapula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0386	Fracture: Clavicle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0387	Fracture (reduction under general anaesthetic): Clavicle	30	3,000	R359,80	TM
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	30	3,000	R359,80	TM
0389	Fracture (reduction under general anaesthetic): Humerus	30	3,000	R359,80	TM
0390	Fracture: Humerus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	30	3,000	R359,80	TM
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	30	3,000	R359,80	TM
0401	Fracture: Carpal bone: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0402	Fracture (reduction under general anaesthetic): Carpal bone	30	3,000	R359,80	TM
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	30	3,000	R359,80	TM
0404	Fracture: Bennett fracture/dislocation: Open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)		3,000	R359,80	TM

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	30	3,000	R359,80	TM
0406	Fracture: Metacarpal bone: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	30	3,000	R359,80	TM
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		3,000	R359,80	TM
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	30	3,000	R359,80	TM
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	30	3,000	R359,80	T
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		3,000	R359,80	T
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	30	3,000	R359,80	TM
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	30	3,000	R359,80	T
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	30	3,000	R359,80	TM
0420	Fracture: Acetabulum: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	30	3,000	R359,80	TM
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0425	Fracture (reduction under general anaesthetic): Patella	30	3,000	R359,80	TM
0426	Fracture: Patella: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	30	3,000	R359,80	TM
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		3,000	R359,80	TM
0433	Fracture (reduction under general anaesthetic): Fibula shaft	30	3,000	R359,80	TM
0434	Fracture: Fibula shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	30	3,000	R359,80	TM
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	30	3,000	R359,80	TM
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	30	3,000	R359,80	TM
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	30	3,000	R359,80	TM

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0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	30	3,000	R359,80	TM
0441	Fracture (reduction under general anaesthetic): Metatarsal	30	3,000	R359,80	TM
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal Simple	30	3,000	R359,80	T
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	T
0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound	30	3,000	R359,80	TM
0446	Fracture: Tarsal bones (excluding talus and calcaneus): Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0447	Fracture (reduction under general anaesthetic): Other: Simple	30	3,000	R359,80	T
0448	Fracture: Calcaneus (reduction under general anaesthetic)		3,000	R359,80	TM
0449	Fracture (reduction under general anaesthetic): Other: Compound	30	3,000	R359,80	TM
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed	30	3,000	R359,80	T
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	30	3,000	R359,80	TM
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical	30	3,000	R359,80	TM
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical	30	3,000	R359,80	TM
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical	30	3,000	R359,80	TM
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest	30	3,000	R359,80	TM
3.1.1.1	**Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047): Operations for fractures**				
0465	Fractures involving large joints (includes the item for the relative bone) (this item may not be used as a modifier)	30	3,000	R359,80	TM
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3,000	R359,80	TM
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
0475	Bone grafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	30	3,000	R359,80	TM
0479	Bone grafting or internal fixation for malunion or non-union: Other bones	30	3,000	R359,80	TM
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		10,000	R1 199,90	TM
0481	Radical resection of bone tumour: Fibula		4,000	R480,30	TM

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0482	Radical resection of bone tumour: Femur or knee		5,000	R600,10	TM
0483	Radical resection of malignant bone tumour: Scapula		6,000	R720,00	TM
0484	Radical resection of bone tumour: Clavicle		6,000	R720,00	TM
0485	Radical resection of bone tumour: Metatarsal		4,000	R480,30	TM
3.1.2	**Bony operations**				
3.1.2.1	**Bony operations: Bone grafting**				
0497	Resection of bone or tumour with or without grafting (benign)	30	3,000	R359,80	TM
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits	30	3,000	R359,80	TM
0499	Grafts to cysts: Large bones	30	3,000	R359,80	TM
0501	Grafts to cysts: Small bones	30	3,000	R359,80	TM
0503	Grafts to cysts: Cartilage graft	30	3,000	R359,80	TM
0505	Grafts to cysts: Inter-metacarpal bone graft	30	3,000	R359,80	TM
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	30	3,000	R359,80	TM
0506	Harvesting of graft: Cartilage graft, costochondral		6,000	R719,60	T
3.1.2.2	**Bony operations: Acute or chronic osteomyelitis**				
0509	Acute or chronic osteomyelitis: Conservative treatment				
0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care				
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage: Including six weeks after-care	30	3,000	R359,80	TM
3.1.2.3	**Bony operations: Osteotomy**				
0514	Osteotomy: Sternum: Repair of pectus excavatum	30	3,000	R359,80	TM
0515	Osteotomy: Sternum: Repair of pectus carinatum	30	3,000	R359,80	TM
0516	Osteotomy: Pelvic	30	3,000	R359,80	TM
0521	Osteotomy: Femoral: Proximal	30	3,000	R359,80	TM
0527	Osteotomy: Knee region	30	3,000	R359,80	TM

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0528	Osteotomy: Os Calcis (Dwyer operation)	30	3,000	R359,80	TM
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation	30	3,000	R359,80	TM
0531	Rotational osteotomy of tibia and fibula - stand alone procedure	30	3,000	R359,80	TM
0532	Osteotomy: Rotation osteotomy of the Radius, Ulna or Humerus	30	3,000	R359,80	TM
0533	Osteotomy: Single metatarsal	30	3,000	R359,80	TM
0534	Osteotomy: Multiple metatarsal osteotomies	30	3,000	R359,80	TM
3.1.2.4	**Bony operations: Exostosis**				
0535	Exostosis: Excision: Readily accessible sites	30	3,000	R359,80	TM
0537	Exostosis: Excision: Less accessible sites	30	3,000	R359,80	TM
3.1.2.5	**Bony operations: Biopsy**				
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)	30	4,000	R480,30	T
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)	30	4,000	R480,30	T
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site				
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site				
3.2	**Joints**				
3.2.1	**Joints: Dislocations**				
0547	Joint: Dislocation: Clavicle either end	30	3,000	R359,80	TM
0549	Joint: Dislocation: Shoulder	30	3,000	R359,80	TM
0551	Joint: Dislocation: Elbow	30	3,000	R359,80	TM
0552	Joint: Dislocation: Wrist	30	3,000	R359,80	TM
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation	30	3,000	R359,80	TM
0555	Joint: Dislocation: Lunate	30	3,000	R359,80	TM
0556	Joint: Dislocation: Carpo-metacarpo dislocation	30	3,000	R359,80	TM
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)	30	3,000	R359,80	TM

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0559	Joint: Dislocation: Hip	30	3,000	R359,80	TM
0561	Joint: Dislocation: Knee	30	3,000	R359,80	TM
0563	Joint: Dislocation: Patella	30	3,000	R359,80	TM
0565	Joint: Dislocation: Ankle	30	3,000	R359,80	TM
0567	Joint: Dislocation: Sub-Talar dislocation	30	3,000	R359,80	TM
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	30	3,000	R359,80	TM
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	30	3,000	R359,80	TM
3.2.2	**Joints: Operations for dislocations**				
0578	Operations for dislocations: Recurrent dislocation of shoulder	30	3,000	R359,80	TM
0579	Operations for dislocations: Recurrent dislocation of all other joints	30	3,000	R359,80	TM
3.2.3	**Joints: Capsular operations**				
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	30	3,000	R359,80	TM
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	30	3,000	R359,80	TM
0585	Capsulectomy digital joint	30	3,000	R359,80	TM
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	30	3,000	R359,80	TM
0587	Release of digital joint contracture	30	3,000	R359,80	TM
3.2.4	Joints: Synovectomy				
0589	Synovectomy: Digital joint	30	3,000	R359,80	TM
0592	Synovectomy: Large joint	30	3,000	R359,80	TM
0593	Tendon synovectomy	30	3,000	R359,80	TM
3.2.5	**Joints: Arthrodesis**				
0597	Arthrodesis: Shoulder	30	3,000	R359,80	TM
0598	Arthrodesis: Elbow	30	3,000	R359,80	TM
0599	Arthrodesis: Wrist	30	3,000	R359,80	TM

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0600	Arthrodesis: Digital joint	30	3,000	R359,80	TM
0601	Arthrodesis: Hip	30	3,000	R359,80	TM
0602	Arthrodesis: Knee	30	3,000	R359,80	TM
0603	Arthrodesis: Ankle	30	3,000	R359,80	TM
0604	Arthrodesis: Sub-talar	30	3,000	R359,80	TM
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	30	3,000	R359,80	TM
0607	Arthrodesis: Mid-tarsal wedge resection	30	3,000	R359,80	TM
3.2.6	**Joints: Arthroplasty**				
0614	Arthroplasty: Debridement large joints	30	3,000	R359,80	TM
0615	Arthroplasty: Excision medial or lateral end of clavicle	30	3,000	R359,80	TM
0617	Shoulder: Acromioplasty	30	3,000	R359,80	TM
0619	Shoulder: Partial replacement	30	5,000	R600,10	TM
0620	Shoulder: Total replacement	30	5,000	R600,10	TM
0621	Elbow: Excision head of radius	30	3,000	R359,80	TM
0622	Elbow: Excision	30	3,000	R359,80	TM
0623	Elbow: Partial replacement	30	3,000	R359,80	TM
0624	Elbow: Total replacement	30	3,000	R359,80	TM
0625	Wrist: Excision distal end of ulna	30	3,000	R359,80	TM
0626	Wrist: Excision single bone	30	3,000	R359,80	TM
0627	Wrist: Excision proximal row	30	3,000	R359,80	TM
0631	Wrist: Total replacement	30	3,000	R359,80	TM
0635	Digital Joint: Total replacement	30	3,000	R359,80	TM
0637	Hip: Total replacement	30	3,000	R359,80	TM
0641	Hip: Prosthetic replacement of femoral head	30	3,000	R359,80	TM

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0643	Hip: Girdlestone	30	3,000	R359,80	TM
0645	Knee: Partial replacement	30	3,000	R359,80	TM
0646	Knee: Total replacement	30	3,000	R359,80	TM
0649	Ankle: Total replacement	30	3,000	R359,80	TM
0650	Ankle: Astragalectomy	30	3,000	R359,80	TM
3.2.7	**Joints: Miscellaneous (joints)**				
0661	Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint	30	3,000	R359,80	T
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	30	3,000	R359,80	T
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	30	3,000	R359,80	T
0669	Manipulation knee or shoulder joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
0669A	Manipulation hip joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	30	4,000	R480,30	T
	Only the consultation fee should be charged when manipulation of a large joint is performed without general anaesthetic				
0673	Meniscectomy or operation for other internal derangement of knee	30	3,000	R359,80	TM
0658	Aspiration and/or injection: Small joint, bursa (eg., fingers, toes) (excluding after care, modifier 0005 not applicable)		3,000	R359,80	T
0659	Aspiration and/or injection: Intermediate joint, bursa (eg., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (excluding after care, modifier 0005 not applicable)		3,000	R359,80	T
0660	Aspiration and/or injection: Major joint, bursa (eg., shoulder, hip, knee joint, subacromial bursa) (excluding after care, modifier 0005 not applicable)		3,000	R359,80	T
0668	Manipulation of knee joint under general anaesthesia (includes application of traction or other fixation devices) (excluding after-care) (modifier 0005 is not applicable)		3,000	R359,80	T
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Knee/ Shoulder		3,000	R359,80	T
0670a	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Hip		3,000	R359,80	T
3.2.8	**Joints: Joint ligament reconstruction or suture**				
0675	Joint ligament reconstruction or suture: Ankle: Collateral	30	3,000	R359,80	TM

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0677	Joint ligament reconstruction or suture: Knee: Collateral	30	3,000	R359,80	TM
0678	Joint ligament reconstruction or suture: Knee: Cruciate	30	3,000	R359,80	TM
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	30	3,000	R359,80	TM
0680	Joint ligament reconstruction or suture: Digital joint ligament	30	3,000	R359,80	TM
0676	Joint ligament reconstruction or suture: Ankle (eg., Watson-Jones type)		3,000	R359,80	TM
3.3	**Amputations**				
3.3.1	**Amputations: Specific Amputations**				
0681	Amputation Humerus: Includes primary closure		4,000	R480,30	TM
0682	Amputation: Fore-quarter amputation	30	9,000	R1 079,70	TM
0683	Amputation: Through shoulder	30	5,000	R600,10	TM
0684	Amputation: Forearm		3,000	R359,80	TM
0685	Amputation: Upper arm or fore-arm	30	3,000	R359,80	TM
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		4,000	R480,30	TM
0687	Partial amputation of the hand: One ray	30	3,000	R359,80	TM
0688	Amputation: Foot, midtarsal (Chopart type)		3,000	R359,80	TM
0691	Amputation: Whole or part of finger	30	3,000	R359,80	TM
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		3,000	R359,80	T
0693	Hindquarter amputation	30	6,000	R720,00	TM
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		3,000	R359,80	T
0695	Amputation: Through hip joint region	30	6,000	R720,00	TM
0696	Re-amputation: Thigh, through femur, any level		3,000	R359,80	T
0697	Amputation: Through thigh	30	6,000	R720,00	TM
0698	Re-amputation: Leg, through tibia and fibula		3,000	R359,80	T
0699	Amputation: Below knee, through knee or Syme	30	5,000	R600,10	TM

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0700	Scar revision/secondary closure: Amputated shoulder		3,000	R359,80	TM
0701	Amputation: Trans-metatarsal or trans-tarsal	30	3,000	R359,80	TM
0702	Scar revision/secondary closure: Amputated humerus		3,000	R359,80	TM
0703	Amputation: Foot: One ray	30	3,000	R359,80	TM
0704	Scar revision/secondary closure: Amputated forearm		3,000	R359,80	T
0705	Amputation: Toe	30	3,000	R359,80	TM
0708	Re-amputation: Humerus		6,000	R720,00	TM
0710	Re-amputation: Through forearm		3,000	R359,80	TM
3.3.2	**Amputations: Post-amputation reconstruction**				
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	30	3,000	R359,80	TM
0707	Post-amputation reconstruction: Krukenberg reconstruction	30	3,000	R359,80	TM
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	30	3,000	R359,80	TM
0712	Post-amputation reconstruction: Toe to thumb transfer	30	3,000	R359,80	TM
3.4	**Muscles, tendons and fasciae**				
3.4.1	**Muscles, tendons and fasciae: Investigations**				
0713	Electromyography	30	3,000	R359,80	T
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)	30	3,000	R359,80	T
0715	Strength duration curve per session	30	3,000	R359,80	T
0717	Electrical examination of single nerve or muscle	30	3,000	R359,80	T
0718	Oxidative study for mitochondrial function				
0721	Voltage integration during isometric contraction	30	3,000	R359,80	T
0723	Tonometry with edrophonium	30	3,000	R359,80	T
0725	Isometric tension studies with edrophonium	30	3,000	R359,80	T
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	30	3,000	R359,80	T
0729	Tendon reflex time	30	3,000	R359,80	T
0730	Limb brain somatosensory studies (per limb)				
0731	Vision and audio-sensory studies				
0733	Motor nerve conduction studies (single nerve)				
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	30	3,000	R359,80	T
0737	Biopsy for motor nerve terminals and end plates	30	3,000	R359,80	T
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	30	8,000	R959,80	T
0740	Muscle fatigue studies	30	3,000	R359,80	T
0741	Muscle biopsy	30	8,000	R959,80	T
0742	Global fee for all muscle studies, including histochemical studies			R0,00	
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase			R0,00	
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase			R0,00	
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase			R0,00	
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase			R0,00	
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase			R0,00	
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase			R0,00	
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase			R0,00	
4715	Biochemical estimations on muscle biopsy specimens: Enolase			R0,00	
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase			R0,00	
4719	Biochemical estimations on muscle biopsy specimens: Aldolase			R0,00	
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase			R0,00	
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase			R0,00	
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase			R0,00	
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study			R0,00	
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)			R0,00	
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)			R0,00	
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies			R0,00	
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)			R0,00	
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation			R0,00	
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia			R0,00	
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy			R0,00	
3.4.2	**Muscles, tendons and fasciae: Decompression Operations**				
0743	Major compartmental decompression	30	3,000	R359,80	T
0744	Decompression operation: Fasciotomy only	30	3,000	R359,80	T
5550	Decompression Faciotomy: Buttock compartments:(unilateral)		5,000	R600,10	TM
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		3,000	R359,80	TM
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		4,000	R480,30	TM
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe		3,000	R359,80	TM
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		3,000	R359,80	TM
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		3,000	R359,80	TM
5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		3,000	R359,80	TM

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5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		3,000	R359,80	TM
5563	Decompression Faciotomy: Fingers and/or hand		3,000	R359,80	TM
3.4.3	**Muscles, tendons and fasciae: Muscle and tendon repair**				
0745	Muscle and tendon repair: Biceps humeri	30	3,000	R359,80	T
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	30	3,000	R359,80	TM
0747	Muscle and tendon repair: Rotator cuff	30	4,000	R480,30	T
0748	Muscle and tendon repair: Debridement rotator cuff	30	4,000	R480,30	T
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	30	4,000	R480,30	T
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	30	3,000	R359,80	T
0757	Muscle and tendon repair: Achilles tendon repair	30	4,000	R480,30	T
0759	Muscle and tendon repair: Other single tendon	30	3,000	R359,80	T
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (modifier 0005 applicable)		3,000	R359,80	T
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (modifier 0005 applicable		3,000	R359,80	T
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (modifier 0005 applicable		3,000	R359,80	T
0763	Muscle and tendon repair: Tendon or ligament injection	30	3,000	R359,80	T
0764	Hand: Flexor tendon repair: Secondary, zone 1		3,000	R359,80	T
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)		3,000	R359,80	T
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)		3,000	R359,80	T
0767	Hand: Flexor tendon suture: Primary (per tendon)	30	3,000	R359,80	T
0768	Repair: Intrinsic muscles of hand (each) (modifier 0005 applicable)		3,000	R359,80	T
0769	Hand: Flexor tendon suture: Secondary (per tendon)	30	3,000	R359,80	T
0771	Extensor tendon suture: Primary (per tendon)	30	3,000	R359,80	T
0773	Extensor tendon suture: Secondary (per tendon)	30	3,000	R359,80	T
0774	Repair of Boutonniere deformity or Mallet finger with graft	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3.4.4	**Muscles, tendons and fasciae: Tendon graft**				
0775	Free tendon graft	30	3,000	R359,80	T
0776	Reconstruction of pulley for flexor tendon	30	3,000	R359,80	T
0777	Tendon graft: Finger: Flexor	30	3,000	R359,80	T
0779	Tendon graft: Finger: Extensor	30	3,000	R359,80	T
0780	Two stage flexor tendon graft using silastic rod	30	3,000	R359,80	T
3.4.5	**Muscles, tendons and fasciae: Tendolysis**				
0781	Tendon freeing operation, except where specified elsewhere	30	3,000	R359,80	T
0782	Carpal tunnel syndrome	30	3,000	R359,80	T
0783	Tenolysis: De Quervain	30	3,000	R359,80	T
0784	Trigger finger	30	3,000	R359,80	T
0785	Flexor tendon freeing operation following free tendon graft or suture	30	3,000	R359,80	T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	30	3,000	R359,80	T
0788	Intrinsic tendon release per finger	30	3,000	R359,80	T
0789	Central tendon tenotomy for Boutonniere deformity	30	3,000	R359,80	T
3.4.6	**Muscles, tendons and fasciae: Tenodesis**				
0790	Tenodesis: Digital joint	30	3,000	R359,80	T
3.4.7	**Muscles, tendons and fasciae: Muscle tendon and facia transfer**				
0791	Single tendon transfer	30	3,000	R359,80	T
0792	Multiple tendon transfer	30	3,000	R359,80	T
0793	Hamstring to quadriceps transfer	30	3,000	R359,80	T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	30	5,000	R600,10	T
0795	Tendon transfer at elbow	30	3,000	R359,80	T
0802	Radial club hand repair - stand alone procedure	30	3,000	R359,80	T

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0803	Hand tendons: Single tendon transfer (first)	30	3,000	R359,80	T
0809	Hand tendons: Substitution for intrinsic paralysis of hand	30	3,000	R359,80	T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	30	3,000	R359,80	T
3.4.8	**Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening**				
0812	Percutaneous Tenotomy: All sites	30	3,000	R359,80	T
0813	Torticollis	30	5,000	R600,10	T
0815	Scalenotomy	30	5,000	R600,10	T
0817	Scalenotomy with excision of first rib	30	3,000	R359,80	TM
0821	Tennis elbow	30	3,000	R359,80	T
0822	Open release elbow (Mitals) - stand alone procedure	30	3,000	R359,80	TM
0823	Excision or slide for Volkmann's Contracture	30	3,000	R359,80	T
0825	Hip: Open muscle release	30	7,000	R839,80	T
0829	Knee: Quadriceps plasty	30	3,000	R359,80	T
0831	Knee: Open tenotomy	30	3,000	R359,80	T
0835	Calf	30	4,000	R480,30	T
0837	Open elongation tendon Achilles	30	4,000	R480,30	T
0838	Percutaneous "Hoke" elongation tendo Achilles	30	4,000	R480,30	T
0845	Foot: Plantar fasciotomy	30	3,000	R359,80	T
0846	Foot: Postero-medial release for club-foot	30	3,000	R359,80	T
3.5	**Bursae and ganglia**				
0847	Excision: Semimembranosus	30	4,000	R480,30	T
0849	Excision: Prepatellar	30	3,000	R359,80	T
0851	Excision: Olecranon	30	3,000	R359,80	T
0853	Excision: Small bursa or ganglion	30	3,000	R359,80	T

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0855	Excision: Compound palmar ganglion or synovectomy	30	3,000	R359,80	T
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
3.6	**Musculo-skeletal system: Miscellaneous**				
3.6.1	**Musculo-skeletal system: Miscellaneous: Leg equalisation and congenital hips and feet**				
0859	Leg equalisation and congenital hips and feet: Leg shortening	30	3,000	R359,80	TM
0861	Leg equalisation and congenital hips and feet: Leg lengthening	30	3,000	R359,80	TM
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	30	3,000	R359,80	TM
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip	30	3,000	R359,80	TM
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips	30	3,000	R359,80	TM
0868	Open reduction of congenital dislocation of the hip	30	3,000	R359,80	TM
0869	Subsequent plasters				
0873	Congenital club foot: Manipulation and plaster: One foot	30	3,000	R359,80	T
0874	Ponseti technique assistant (medical practitioner)				
3.6.2	**Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis**				
0883	Removal of internal fixatives or prosthesis: Readily accessible	30	3,000	R359,80	T
0884	Removal of internal fixatives: Less accessible	30	3,000	R359,80	T
0885	Removal of prosthesis for infection soon after operation	30	6,000	R720,00	TM
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the item for total joint replacement of the specific joint	30	6,000	R720,00	TM
3.6.2.1	**Musculo-skeletal system: Miscellaneous: Removal of foreign bodies**				
0644	Removal of foreign body: Shoulder, subcutaneous		3,000	R359,80	T
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous		3,000	R359,80	T
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular		3,000	R359,80	T
0651	Exploration with removal of deep foreign body: Forearm or wrist		3,000	R359,80	T
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue		3,000	R359,80	T

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0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular		3,000	R359,80	T
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular		3,000	R359,80	T
0655	Removal of foreign body: Foto, subcutaneous		3,000	R359,80	T
0656	Removal of foreign body: Foto, deep		3,000	R359,80	T
0657	Removal of foreign body: Foto, complicated		3,000	R359,80	T
3.7	**Plasters (exclusive of after-care)**				
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
0888	Application of short limb cast (forearm, lower leg) (excluding after-care) (first cast included in procedure)		3,000	R359,80	T
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	30	4,000	R480,30	T
0891	Turnbuckle cast for scoliosis (excluding after-care)	30	5,000	R600,10	T
0892	Application of cast: Revision (walker, window, bivalve) (excluding after-care)		5,000	R600,10	T
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	30	5,000	R600,10	T
0894	Application of cast: Clubfoot (excluding after-care) (first cast included in procedure		5,000	R600,10	T
3.8	**Musculo-skeletal system: Special areas**				
3.8.1	**Special areas: Foot and Ankle**				
0895	Club foot: Revision club foot release - stand alone procedure	30	3,000	R359,80	TM
0896	Club foot: Posterior release only - stand alone procedure	30	3,000	R359,80	TM
0900	Excision tarsal coalition - stand alone procedure	30	3,000	R359,80	TM
0901	Tenotomy: Single tendon	30	3,000	R359,80	TM
0903	Hammer toe: One toe	30	3,000	R359,80	TM
0905	Filleting of toe or Ruiz-Mora procedure	30	3,000	R359,80	TM
0906	Arthrodesis Hallux	30	3,000	R359,80	TM
0907	Silver bunionectomy or similar for Hallux Valgus	30	3,000	R359,80	TM
	Not to be charged with item 0911				

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0909	Excision arthroplasty	30	3,000	R359,80	TM
0910	Cheilectomy or metatarsophangeal implant Hallux	30	3,000	R359,80	TM
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	30	3,000	R359,80	TM
	Not to be charged with item 0907				
5730	Hallux Valgus double osteotomy etc.	30	3,000	R359,80	TM
5731	Distal soft tissue procedure for Hallux Valgus	30	3,000	R359,80	TM
5732	Aitkin procedure or similar	30	3,000	R359,80	T
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)	30	3,000	R359,80	TM
5735	Repair angular deformity toe (lesser toes)	30	3,000	R359,80	TM
5736	Sesamoidectomy	30	3,000	R359,80	TM
5737	Repair major foot tendons e.g. Tib Post	30	3,000	R359,80	TM
5738	Repair of dislocating peroneal tendons	30	3,000	R359,80	T
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot	30	3,000	R359,80	TM
5740	Steindler strip - plantar fascia	30	3,000	R359,80	T
5741	Kelikian syndactilly (one web space)	30	3,000	R359,80	T
5742	Tendon transfer foot	30	3,000	R359,80	T
5743	Capsulotomy metatarsophalangeal joints: Foot	30	3,000	R359,80	T
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	30	3,000	R359,80	TM
0913	Replantation of thumb	30	3,000	R359,80	TM
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	30	3,000	R359,80	TM
0915	Replantation operation through the palm	30	3,000	R359,80	TM
3.8.4	**Special areas: Hands: (Note: Skin: See Integumentary System)**				

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Practice Type: **Anaesthesiology**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0919	Tumours: Epidermoid cysts	30	3,000	R359,80	TM
0920	Tumours: Ganglion or fibroma	30	3,000	R359,80	TM
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)	30	3,000	R359,80	TM
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	30	3,000	R359,80	TM
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	30	3,000	R359,80	TM
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum	30	3,000	R359,80	TM
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		3,000	R359,80	TM
	Item 0924: The number of units chargeable under this item ranges from 37.00 to 110.00 for Specialists and General Practitioners.				
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	30	3,000	R359,80	TM
3.8.5	**Special areas: Spine**				
	Please note the following with regard to section 3.8.5: Spine **a. Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together:** **1. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis.** **2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition.** **b. 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)	30	3,000	R359,80	TM
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	30	3,000	R359,80	TM
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)	30	5,000	R600,10	TM
0930	Posterior osteotomy of spine: One vertebral segment	30	3,000	R359,80	TM
0931	Posterior spinal fusion: One level	30	3,000	R359,80	TM
0932	Posterior osteotomy of spine: Each additional vertebral segment	30	3,000	R359,80	TM
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	30	3,000	R359,80	TM
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	30	3,000	R359,80	TM
0938	Anterior fusion base of skull to C2	30	4,000	R480,30	TM

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	30	3,000	R359,80	TM
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	30	3,000	R359,80	TM
0941	Anterior interbody fusion: One level	30	3,000	R359,80	TM
0942	Anterior interbody fusion: Each additional level	30	3,000	R359,80	TM
0944	Posterior fusion: Occiput to C2	30	4,000	R480,30	TM
0946	Posterior spinal fusion: Each additional level	30	3,000	R359,80	TM
0948	Posterior interbody lumbar fusion: One level	30	3,000	R359,80	TM
0950	Posterior interbody lumbar fusion: Each additional interspace	30	3,000	R359,80	TM
0959	Excision of coccyx	30	3,000	R359,80	TM
0961	Costo-transversectomy	30	3,000	R359,80	TM
0963	Antero-lateral decompression of spinal cord or anterior debridement	30	3,000	R359,80	T
	MODIFIER				
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. Each surgeon may charge an assistant fee for the procedures performed by the other surgeon, at general practitioner rate (refer to modifier 0009)				
3.8.6	**Special areas: Spinal deformities**				
	Please note : Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).				
0952	Posterior fusion for spinal deformity: Up to 6 levels	30	3,000	R359,80	TM
0954	Posterior fusion for spinal deformity: 7 to 12 levels	30	3,000	R359,80	TM
0955	Posterior fusion for spinal deformity: 13 or more levels	30	3,000	R359,80	TM
0956	Anterior fusion for spinal deformity: 2 or 3 levels	30	3,000	R359,80	TM
0957	Anterior fusion for spinal deformity: 4 to 7 levels	30	3,000	R359,80	TM
0958	Anterior fusion for spinal deformity: 8 or more levels	30	3,000	R359,80	TM
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere				

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3.8.7	**Special areas: All spinal problems**				
0943	Laminectomy with decompression of nerve roots and disc removal: One level	30	3,000	R359,80	TM
0960	Posterior non-segmental instrumentation	30	5,000	R600,10	TM
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	30	5,000	R600,10	TM
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	30	5,000	R600,10	TM
0966	Posterior segmental instrumentation:13 or more vertebrae	30	5,000	R600,10	TM
0968	Anterior instrumentation: 2 to 3 vertebrae	30	5,000	R600,10	TM
0969	Skull or skull-femoral traction including two weeks after-care				
0970	Anterior instrumentation: 4 to 7 vertebrae	30	5,000	R600,10	TM
0971	Halo-splint and POP jacket including two weeks after-care				
0972	Anterior instrumentation: 8 or more vertebrae	30	5,000	R600,10	TM
0974	Additional pelvic fixation of instrumentation other than sacrum	30	5,000	R600,10	TM
5750	Reinsertion of instrumentation	30	6,000	R720,00	TM
5751	Removal of posterior non-segmental instrumentation	30	6,000	R720,00	TM
5752	Removal of posterior segmental instrumentation	30	6,000	R720,00	TM
5753	Removal of anterior instrumentation	30	6,000	R720,00	TM
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	30	3,000	R359,80	TM
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	30	3,000	R359,80	TM
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	30	3,000	R359,80	TM
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	30	3,000	R359,80	TM
5759	Laminectomy for decompression diskectomy, etc. revision operation	30	4,000	R480,30	TM
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	30	3,000	R359,80	TM
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	30	3,000	R359,80	TM
5763	Anterior disc removal and spinal decompression cervical: One level	30	3,000	R359,80	TM

CONTRACTED ANAESTHESIOLOGY FOR ALL OPTIONS

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5764	Anterior disc removal and spinal decompression cervical: Each additional level	30	3,000	R359,80	TM
5765	Vertebral corpectomy for spinal decompression: One level	30	3,000	R359,80	TM
5766	Vertebral corpectomy for spinal decompression: Each additional level	30	3,000	R359,80	TM
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)				
3.9	**Facial bone procedures**				
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9				
0987	Repair of orbital floor (blowout fracture)	30	4,000	R480,30	TM
0988	Genioplasty	30	4,000	R480,30	TM
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	30	4,000	R480,30	TM
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	30	4,000	R480,30	TM
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	30	4,000	R480,30	TM
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	30	4,000	R480,30	TM
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	30	4,000	R480,30	TM
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	30	4,000	R480,30	TM
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	30	4,000	R480,30	TM
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement				
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation	30	3,000	R359,80	TM
0998	Excision mandible bone, e.g. osteomyelitis,abscess		5,000	R599,80	TM
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	30	3,000	R359,80	TM
1000	Excision facial bone e.g., osteomyelitis, abscess		5,000	R599,80	TM
1001	Temporo-mandibular joint: Reconstruction for dysfunction	30	4,000	R480,30	TM
1002	Harvesting: Bone for contouring of benign bony growths (e.g., fibrous dysplasia)		5,000	R599,80	TM
1003	Manipulation: Immobilisation and follow-up of fractured nose	30	3,000	R359,80	TM
1005	Nasal fracture without manipulation				

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Practice Type: **Anaesthesiology**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1007	Mandibulectomy	30	5,000	R600,10	TM
1008	Excision: Torus Mandibularis		5,000	R599,80	TM
1009	Maxillectomy	30	4,000	R480,30	TM
1010	Excision: Torus Palatinus		5,000	R599,80	TM
1011	Bone graft to mandible	30	4,000	R480,30	TM
1012	Adjustment of occlusion by ramisection	30	4,000	R480,30	TM
1013	Fracture of arch of zygoma without displacement				
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	30	3,000	R359,80	TM
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	30	3,000	R359,80	TM
1006	Fracture: Nose and septum, open reduction		3,000	R359,80	TM
4	**RESPIRATORY SYSTEM**				
4.1	**Nose and sinuses**				
1018	Flexible nasopharyngolaryngoscope examination				
1019	ENT endoscopy in rooms with rigid endoscope				
1020	Repair of perforated septum: Any method	30	4,000	R480,30	T
1022	Functional reconstruction of nasal septum	30	4,000	R480,30	T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	30	4,000	R480,30	T
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	30	4,000	R480,30	T
1027	Dacrocystorhinostomy	30	5,000	R600,10	T
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	30	4,000	R480,30	T
1030	Endoscopic turbinectomy: Laser or microdebrider	30	5,000	R600,10	T
1031	Removal of single nasal polyp at rooms (at initial consultation only)				
1033	Removal of multiple polyps in hospital under general anaesthetic	30	4,000	R480,30	T
1034	Autogenous nasal bone transplant: Bone removal included	30	4,000	R480,30	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1035	Functional endoscopic sinus surgery: Unilateral	30	4,000	R480,30	T
1036	Functional endoscopic sinus surgery: Bilateral	30	4,000	R480,30	T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic				
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	30	4,000	R480,30	T
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	30	6,000	R720,00	T
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	30	6,000	R720,00	T
1045	Ligation anterior ethmoidal artery	30	6,000	R720,00	T
1047	Caldwell-Luc operation: Unilateral	30	4,000	R480,30	T
1048	Endonasal frontal sinus drainage, with or without removal of tissue (modifier 0069 applies)		5,000	R599,80	T
1049	Ligation internal maxillary artery	30	6,000	R720,00	T
1050	Vidian neurectomy (transantral or transnasal)	30	4,000	R480,30	T
1051	Removal nasopharyngeal fibroma	30	6,000	R720,00	T
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	30	4,000	R480,30	T
1053	Frontal sinus drainage, trephine operation	30	4,000	R480,30	T
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)				
1055	External frontal ethmoidectomy	30	4,000	R480,30	T
1056	Anterior cranial fossa, craniofacial approach, extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration		3,000	R359,80	T
1057	External ethmoidectomy and/or sphenoidectomy	30	4,000	R480,30	T
1058	Sublabial transseptal sphenoidotomy	30	4,000	R480,30	T
1059	Frontal osteomyelitis	30	4,000	R480,30	T
1060	Obliteration of frontal sinus	30	4,000	R480,30	T
1061	Lateral rhinotomy	30	4,000	R480,30	T
1062	Excision nasolabial cyst	30	4,000	R480,30	T
1063	Removal of foreign bodies from nose: At rooms				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1065	Removal of foreign body from nose: Under general anaesthetic	30	4,000	R480,30	T
1067	Proof puncture at rooms: Unilateral	30	4,000	R480,30	T
1069	Proof puncture, uni- or bilateral under general anaesthetic	30	4,000	R480,30	T
1071	Proetz treatment (consultation fee only to be charged for first treatment)				
1077	Septum abscess: At rooms, including after-care				
1079	Septum abscess: Under general anaesthetic	30	4,000	R480,30	T
1081	Oro-antral fistula (without Caldwell-Luc)	30	4,000	R480,30	T
1083	Choanal atresia: Intranasal approach	30	5,000	R600,10	T
1084	Choanal atresia: Transpalatal approach	30	7,000	R839,80	T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	30	5,000	R600,10	T
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	30	5,000	R600,10	T
1089	Forehead rhinoplasty (all stages): Total	30	5,000	R600,10	T
1091	Forehead rhinoplasty (all stages): Partial	30	5,000	R600,10	T
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	30	5,000	R600,10	T
1095	Full nasal reconstruction for secondary cleft lip deformity	30	5,000	R600,10	T
1097	Partial nasal reconstruction for cleft lip deformity	30	5,000	R600,10	T
1099	Columella reconstruction or lengthening	30	5,000	R600,10	T
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision		3,000	R359,80	T
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision		3,000	R359,80	T
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision		3,000	R359,80	T
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision		3,000	R359,80	T
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision		3,000	R359,80	T
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision		3,000	R359,80	T
1023	Harvesting of graft: Cartilage graft of nasal septum		4,000	R480,30	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1038	Hypophysectomy or excision of pituitary tumour: Transnasal/transseptal approach (total procedure)		11,000	R1 319,70	T
1040	Repair of CSF leak: Ethmoid region. transnasal endoscopic approach (modifier 0069 not applicable)		5,000	R599,90	T
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach (modifier 0069 not applicable)		11,000	R1 319,70	T
1044	Transnasal endoscopic decompression: Transnasal endoscopic optic nerve (modifier 0069 not applicable)		11,000	R1 319,70	T
4890	Endoscopy: Sinus/nasal, with maxillary antrostomy		4,000	R480,30	T
4891	Endoscopy: Sinus/nasal, with maxillary antrostomy and removal of tissue		4,000	R480,30	T
4892	Endoscopy: Sinus/nasal, with partial, anterior ethmoidectomy		4,000	R480,30	T
4893	Endoscopy: Sinus/nasal, with medial or inferior orbital wall decompression		5,000	R600,30	T
1026	Biopsy: Intranasal				Refer Rule C
1028	Lysis: Intranasal synechia				Refer Rule C
	MODIFIERS GOVERNING NASAL OPERATIONS				
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083				
4.2	**Throat**				
1101	Tonsillectomy (dissection of the tonsils)	30	4,000	R552,30	T
1102	Laser tonsillectomy	30	6,000	R720,00	T
1105	Removal of adenoids	30	4,000	R480,30	T
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)	30	5,000	R600,10	T
1107	Opening of quinsy: At rooms	30	6,000	R720,00	T
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	30	5,000	R600,10	T
1109	Opening of quinsy: Under general anaesthetic	30	6,000	R720,00	T
1110	Ludwig's Angina: Drainage	30	9,000	R1 079,70	T
1111	Post tonsillectomy or adenoidectomy haemorrhage	30	6,000	R720,00	T
1112	Pharyngeal pouch operation	30	5,000	R600,10	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1113	Retropharyngeal abscess: Internal approach	30	6,000	R720,00	T
1115	Retropharyngeal abscess: External approach	30	6,000	R720,00	T
1116	Functional reconstruction of palate and uvula	30	5,000	R600,10	T
1096	Removal of foreign body: Pharynx		5,000	R600,00	T
1100	Control of oropharyngeal haemorrhage with secondary sugical intervention, primary or secondary (e.g. post-tonsillectomy)		6,000	R720,00	T
1103	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, without closure		4,000	R480,30	T
1104	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, with local flap closure		4,000	R480,30	T
1098	Resection: Lateral pharyngeal wall or pyriform sinus, closure by advancement of lateral and posterio pharyngeal walls				Refer Rule C
1114	Pharyngectomy: Partial				Refer Rule C
4.3	**Larynx**				
1117	Laryngeal intubation				
1118	Laryngeal stroboscopy with video capture	30	6,000	R720,00	T
1119	Laryngectomy without block dissection of the neck	30	7,000	R839,80	T
1122	Laryngeal function studies		3,000	R359,80	T
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)				
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	30	6,000	R720,00	T
1126	Post laryngectomy for voice restoration	30	9,000	R1 079,70	T
1127	Tracheotomy	30	9,000	R1 079,70	T
1128	Endolaryngeal operations	30	8,000	R959,80	T
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	30	8,000	R959,80	T
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	30	6,000	R720,00	T
1131	Direct laryngoscopy plus foreign body removal	30	6,000	R720,00	T
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal		3,000	R359,80	T
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy		3,000	R359,80	T

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4918	Laryngoplasty: Open reduction of fracture		3,000	R359,80	T
4919	Laryngoplasty: Cricoid split		3,000	R359,80	T
4922	Tracheostoma: Revision, without flap rotation, simple		3,000	R359,80	T
4923	Tracheostoma: Revision, with flap rotation, complex		3,000	R359,80	T
4926	Tracheostomy: Fenestration with skin flaps		3,000	R359,80	T
4927	Tracheostomy: Revision of scar		3,000	R359,80	T
4928	Tracheostomy/fistula: Closure, without plastic repair		3,000	R359,80	T
4929	Tracheostomy/fistula: Closure, with plastic repair		3,000	R359,80	T
4932	Tracheobronchoscopy: Through established tracheostomy incision		3,000	R359,80	T
4933	Tracheoplasty: Cervical		3,000	R359,80	T
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage		3,000	R359,80	T
1120	Intubation, endtoracheal, emergency procedure				
1121	Stroboscopy - equipment fee				
4904	Laryngectomy: Total, with radical neck dissection		7,000	R840,00	T
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection		7,000	R839,80	T
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection		7,000	R840,00	T
4907	Laryngectomy: Hemilaryngectomy, horisontal		7,000	R839,80	T
4908	Laryngectomy: Hemilaryngectomy, laterovertical		7,000	R839,80	T
4909	Laryngectomy: Hemilaryngectomy, anterovertical		7,000	R839,80	T
4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical		7,000	R839,80	T
1124	Arytenoidectomy/arytenoidopexy: External approach				Refer Rule C
4913	Pharyngolaryngectomy: With radical neck dissection, without reconstruction				Refer Rule C
4914	Pharyngolaryngectomy: With radical neck dissection, with reconstruction				Refer Rule C
	MODIFIERS				

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0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (For other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhere in the Tariff)				
4.4	**Bronchial procedures**				
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy				
1132	Bronchoscopy: Diagnostic bronchoscopy	30	6,000	R720,00	T
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	30	8,000	R959,80	T
1134	Bronchoscopy: Bronchoscopy with laser	30	8,000	R959,80	T
1136	Nebulisation (in rooms)	20	12,000	R229,40	ç
1137	Bronchial lavage	30	8,000	R959,80	T
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	30	12,000	R1 440,10	T
4.5	**Pleura**				
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)	30	3,000	R359,80	T
1141	Insertion of intercostal catheter (under water drainage)	30	6,000	R720,00	T
1142	Intra-pleural block	20	36,000	R688,20	ç
1143	Paracentesis chest: Diagnostic	30	3,000	R359,80	T
1145	Paracentesis chest: Therapeutic	30	3,000	R359,80	T
1147	Pneumothorax: Induction (diagnostic)				
1149	Pleurectomy	30	11,000	R1 319,70	T
1151	Decortication of lung	30	11,000	R1 319,70	T
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	30	3,000	R359,80	T
4.6	**Pulmonary procedures**				
4.6.1	Pulmonary procedures: Surgical				
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)	30	5,000	R600,10	T
1157	Pneumonectomy	30	11,000	R1 319,70	T
1159	Pulmonary lobectomy	30	11,000	R1 319,70	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1161	Segmental lobectomy	30	11,000	R1 319,70	T
1163	Excision tracheal stenosis: Cervical	30	8,000	R959,80	T
1164	Excision tracheal stenosis: Intra thoracic	30	12,000	R1 440,10	T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	30	12,000	R1 440,10	T
1168	Thoracoplasty: Complete	30	11,000	R1 319,70	T
1169	Thoracoplasty: Limited (osteoplastic)	30	11,000	R1 319,70	T
1171	Drainage empyema (including six weeks after treatment)	30	11,000	R1 319,70	T
1173	Drainage of lung abscess (including six weeks after treatment)	30	11,000	R1 319,70	T
1175	Thoracotomy (limited): For lung or pleural biopsy	30	11,000	R1 319,70	T
1177	Major: Diagnostic, as for inoperable carcinoma	30	11,000	R1 319,70	T
1179	Thoracoscopy	30	11,000	R1 319,70	T
1181	Lung transplant: Unilateral	30	15,000	R1 799,80	T
1182	Harvesting donor lung: Unilateral	30	5,000	R600,10	T
1183	Excision or plication of emphysematous cyst: Unilateral	30	11,000	R1 319,70	T
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	30	11,000	R1 319,70	T
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	30	11,000	R1 319,70	T
4.6.2	**Pulmonary function tests**				
	When these procedures are performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.				
1186	Flow volume test: Inspiration/expiration	20	30,000	R573,40	ç
1187	Exhaled nitric oxide determination				
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation - thereafter item 1186 applies)	20	50,000	R956,10	ç
1189	Forced expirogram only	20	10,000	R190,90	ç
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry				
1191	N2 single breath distribution	20	10,000	R190,90	ç

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1192	Peak expiratory flow only	20	5,000	R95,50	ç
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method				
1195	Thoracic gas volume				
1196	Determination of resistance to airflow, oscillary or plethysmographic methods				
1197	Compliance and resistance, using oesophageal balloon	20	24,000	R459,00	ç
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				
1199	Pulmonary stress testing: For determination of VO2 max				
1200	Carbon monoxide diffusing capacity, any method				
1201	Maximum inspiratory/expiratory pressure	20	5,000	R95,50	ç
4.7	**Intensive care**				
	RULES GOVERNING THIS SECTION				
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: category 1: Cases requiring intensive monitoring				
4.7.1	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Neonatal procedures**				
1202	Insertion of central venous catheter via peripheral vein in neonates	20	40,000	R764,70	ç

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4.7.2	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Tariff items for intensive care**				
1204	Intensive care: Category 1 (High Care) : Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.): Per day “(i) Only one practitioner may charge category 1: Intensive monitoring of patient in high care unit. (ii) Item 1204 may not be charged by the surgeon who performed a surgical procedure. Intensive monitoring is regarded as normal postoperative care, which is included in the global fee attached to that surgical procedure. (iii) Practitioners involved in treating a patient in a high care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered. “	20	30,000	R573,40	ç
1205	Intensive care: Category 2 (ICU): 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	20	100,000	R1 911,90	ç
1206	Intensive care: Category 2 (ICU): 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 day	20	50,000	R956,10	ç
1207	Intensive care: Category 2(ICU): 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 day	20	30,000	R573,40	ç
	Please Note: **i. The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109** **ii. Only one practitioner may charge category 2: Intensive monitoring of patient in intensive care unit.** **iii. Should a patient during the post-operative care period require active system support, the person who is responsible for the active systems support, may use items 1205-1207 (as appropriate).** **iv. It would be acceptable for the surgeon who performed a surgical procedure of which the after-care is included, to charge fees according to the appropriate hospital follow-up visit (item 0109)** **v. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.”**				
1208	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	20	137,000	R2 619,20	ç
1209	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	20	58,000	R1 108,70	ç

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1210	Intensive care: Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	20	50,000	R956,10	ç
	"Please note: i. Items 1208-1210 are used if more than one practitioner is involved in active system support on a category 2 patient in the intensive care unit. ii. Items 1208-1210 are used for category 3 patients with multiple organ failure. iii. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered."				
4.7.3	**Intensive care: (in intensive care or high care unit): Respiratory, cardiac, general: Procedures**				
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or 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 practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.				
1212	Ventilation: First day	20	75,000	R1 434,00	ç
1213	Ventilation: Subsequent days, per day	20	50,000	R956,10	ç
1214	Ventilation: After two weeks, per day	20	25,000	R478,00	ç
1215	Insertion of arterial pressure cannula	20	25,000	R478,00	ç
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	20	50,000	R956,10	ç
1217	Insertion of central venous line via peripheral vein	20	10,000	R190,90	ç
1218	Insertion of central venous line via subclavian or jugular veins	20	25,000	R478,00	ç
1219	Hyperalimentation (daily tariff)	20	15,000	R286,80	ç
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)	20	30,000	R573,40	ç
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)	20	30,000	R573,40	ç
4.8	**Hyperbaric Oxygen Therapy**				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	"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 pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT				
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT				
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Routine HBO table (2-2,5 ATA x 90-120 min): PROFESSIONAL COMPONENT				
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT				
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Emergency HBO table (2,5-3 ATA x 90-120 min): PROFESSIONAL COMPONENT				
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT				
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT5 (2,8 ATA x 135 min): PROFESSIONAL COMPONENT				
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT				
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6 (2,8 ATA x 285 min): PROFESSIONAL COMPONENT				
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT				
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min): PROFESSIONAL COMPONENT				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT				
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT				
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT				
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				
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.				
5	**MEDIASTINAL PROCEDURES**				
1222	Mediastinal tumours	30	11,000	R1 319,70	T
1223	Mediastinoscopy	30	5,000	R600,10	T
1224	Mediastinotomy	30	11,000	R1 319,70	T
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	30	11,000	R1 319,70	T
1226	Removal of single rib with a lesion	30	11,000	R1 319,70	T
6	**CARDIOVASCULAR SYSTEM**				
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP				
6.1	**Cardiovascular system: General**				
1227	Prolonged neonatal resuscitation	20	20,000	R382,30	ç
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG				
1228	General Practitioner's fee for the taking of an ECG only: Without effort: ½ (item 1232)				
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: ½ (item 1233)				
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added				
1230	Physician's fee for interpreting an ECG: Without effort				
1231	Physician's fee for interpreting an ECG: With and without effort				
	A specialist physician is entitled to the fees specified in item 1230 and 1231 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 for interpretation				

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1232	Electrocardiogram: Without effort				
1233	Electrocardiogram: With and without effort				
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus				
1235	Multi-stage treadmill test				
1236	Electrocardiogram without effort: Under 4 years old				
1237	24 Hour ambulatory blood pressure: Hire fee				
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee				
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation				
1240	Signal averaged electrocardiogram				
1241	X-ray Screening: Chest				
1242	X-ray screening: Prosthetic valves				
1243	Two week event triggered ambulatory ECG monitoring: Hire fee				
1244	Two week event triggered ambulatory ECG monitoring: Interpretation				
1245	Angiography cerebral: First two series	30	4,000	R480,30	T
1246	Angiography peripheral: Per limb	30	4,000	R480,30	T
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	30	6,000	R720,00	T
1248	Paracentesis of pericardium	30	9,000	R1 079,70	T
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing				
	MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER				
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%				
6.2	**Invasive Cardiology**				
6.2.1	**Invasive cardiology: Cardiac catheterisation**				
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	30	9,000	R1 079,70	T
1250	Endomyocardial biopsy	30	9,000	R1 079,70	T

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1251	Transeptal puncture	30	9,000	R1 079,70	T
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	30	9,000	R1 079,70	T
1253	Right heart catheterisation (with or without biopsy)	30	9,000	R1 079,70	T
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	30	9,000	R1 079,70	T
1255	Tilt test				
6.2.2	**Invasive cardiology: Electrophysiological study**				
1256	Ventricular stimulation study	30	9,000	R1 079,70	T
1257	Full electrophysiological study	30	9,000	R1 079,70	T
6.2.3	**Invasive cardiology: Pacemakers**				
1258	Pacemaker: Permanent - single chamber	30	9,000	R1 079,70	T
1259	Pacemaker: Permanent - dual chamber	30	9,000	R1 079,70	T
1260	AV nodal ablation	30	9,000	R1 079,70	T
1261	Accessory pathway ablation	30	9,000	R1 079,70	T
1262	Electrophysiological mapping				
1263	Insertion transvenous implantable defibrillator	30	15,000	R1 799,80	T
1264	Test for implantable transvenous defibrillator	30	15,000	R1 799,80	T
1265	Renewal of pacemaker unit only, team fee	30	9,000	R1 079,70	T
1266	Resiting pacemaker generator				
1267	Repositioning of catheter electrode	30	9,000	R1 079,70	T
1268	Threshold testing: Own equipment				
1269	Threshold testing: Hospital equipment				
1270	Programming of atrio-ventricular sequential pacemaker				
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	30	9,000	R1 079,70	T
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts				

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1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer	30	9,000	R1 079,70	T
1272	Coronary sinus lead implantation (add to either item 1258: Pacemaker: Permanent - single chamber or item 1259: Pacemaker: Permanent - dual chamber)				Refer Rule C
6.2.4	**Invasive cardiology: Percutaneous translumical angioplasty**				
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	30	13,000	R1 559,70	T
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	30	13,000	R1 559,70	T
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	30	13,000	R1 559,70	T
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	30	13,000	R1 559,70	T
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	30	13,000	R1 559,70	T
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	30	13,000	R1 559,70	T
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty	30	15,000	R1 799,80	T
1283	Use of balloon procedure as in item 1282: Second cardiologist	30	15,000	R1 799,80	T
1284	Atherectomy: Single lesion: First cardiologist				
1285	Atherectomy: Single lesion: Second cardiologist				
1286	Insertion of intravascular stent: First cardiologist				
1287	Insertion of intravascular stent: Second cardiologist				
	The insertion of a stent(s) (item 1286 & 1267) may only be charged once per vessel regardless of the number of stents inserted in this vessel.				
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 arteriosus	30	15,000	R1 799,80	T
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)	30	15,000	R1 799,80	T
1292	Multi-slice computed tomography coronary angiography: Own equipment				
5961	Balloon angioplasty pulmonary mitral valve or tricuspid valve		10,000	R1 199,90	T
5962	Balloon angioplasty aortic valve (congenital aortic stenosis)		10,000	R1 199,90	T
5963	Balloon angioplasty, pulmonary artery branches: First vessel		10,000	R1 199,90	T

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5964	Balloon angioplasty, pulmonary artery branches: Subsequent vessels (per vessel)		10,000	R1 199,90	T
5965	Balloon angioplasty aorta for congenital lesion/coarctation		10,000	R1 199,90	T
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl MAPCA) or venous system (IVC, SVC, systemic vein): First vessel		5,000	R600,10	T
5967	Balloon angioplasty, collateral vessel (incl. MAPCA): Subsequent vessels (per vessel)		5,000	R600,10	T
5968	Balloon angioplasty venous system (IVC, SVC, systemic vein)		5,000	R600,10	T
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		5,000	R600,10	T
5970	Cutting balloon angioplasty, cardiovascular structure: Subsequent vessels (per vessel)		5,000	R600,10	T
1293	Multi-slice computed tomography coronary angiography: Interpretation and report				
6.2.5	**Invasive cardiology: Paediatric cardiac catheterisation**				
1288	Cardiac catheterisation for congenital heart disease: All ages above 1 year old	30	12,000	R1 440,10	T
1289	Paediatric cardiac catheterisation: Infants below the age of one year	30	12,000	R1 440,10	T
6.3	**Cardiac surgery**				
1294	Patent ductus arteriosus	30	13,000	R1 559,70	T
1295	Pericardiectomy for constrictive pericarditis	30	15,000	R1 799,80	T
1296	Fractional flow reserve (FFR): First vessel (add-on code)				
1297	Coarctation of aorta	30	15,000	R1 799,80	T
1298	Fractional flow reserve (FFR): Each additional vessel (add-on code)				
1299	Systemo-pulmonary anastomosis	30	15,000	R1 799,80	T
1300	Renal denervation (RDN), per artery (modifier 0005 applicable)				
1301	Mitral valvotomy: Closed heart technique	30	15,000	R1 799,80	T
1302	Heart transplant	30	15,000	R1 799,80	T
1303	Harvesting donor heart	30	5,000	R600,10	T
1305	Operative implantation of cardiac pacemaker by thoracotomy	30	15,000	R1 799,80	T
1307	Re-exploration after cardiac surgery	30	15,000	R1 799,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1308	Heart and lung transplant	30	15,000	R1 799,80	T
1309	Harvesting donor heart and lungs	30	5,000	R600,10	T
1311	Pericardial drainage	30	13,000	R1 559,70	T
6.3.1	**Cardiac surgery: Open heart surgery**				
1312	Evaluation of coronary angiogram by cardiothoracic surgeon				
1320	Repeat open heart surgery (additional fee above procedure fee)	30	15,000	R1 799,80	T
1321	Stand-by fee for coronary angioplasty	20	30,000	R573,40	ç
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour				
6.3.1.1	**Cardiac surgery: Open heart surgery: Congenital conditions**				
1323	Atrial septal defect: Osteum secundum	30	15,000	R1 799,80	T
1325	Atrial septal defect: Sinus venosus or osteum primum	30	15,000	R1 799,80	T
1327	Atrial septal defect: Ventricular septal defect	30	15,000	R1 799,80	T
1329	Atrial septal defect: Fallot's tetralogy	30	15,000	R1 799,80	T
1330	Atrial septal defect: Pulmonary stenosis	30	15,000	R1 799,80	T
1331	Transposition of large vessels (venous repair)	30	15,000	R1 799,80	T
1332	Transposition of great arteries (arterial repair)	30	15,000	R1 799,80	T
1333	Ebstein's Anomaly	30	15,000	R1 799,80	T
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	30	20,000	R2 399,50	T
1335	Total anomalous venous drainage	30	15,000	R1 799,80	T
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	30	20,000	R2 399,50	T
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	30	15,000	R1 799,80	T
1338	Fontan type repair	30	15,000	R1 799,80	T
6.3.1.2	**Cardiac surgery: Open heart surgery: Acquired conditions**				
1339	Mitral valve replacement	30	15,000	R1 799,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1340	Mitral valvuloplasty	30	15,000	R1 799,80	T
1341	Aortic valve replacement	30	15,000	R1 799,80	T
1342	Tricuspid annulo plasty	30	15,000	R1 799,80	T
1343	Double valve replacement	30	15,000	R1 799,80	T
1344	Acute dissecting aneurysm repair	30	15,000	R1 799,80	T
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	30	15,000	R1 799,80	T
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)				
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)				
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	30	15,000	R1 799,80	T
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery	30	15,000	R1 799,80	T
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery	30	15,000	R1 799,80	T
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	30	15,000	R1 799,80	T
1352	Cardiac aneurysm	30	15,000	R1 799,80	T
1353	Ascending/descending thoracic aortic aneurysm repair	30	15,000	R1 799,80	T
1354	Arrhythmia surgery	30	15,000	R1 799,80	T
1355	Cardiac tumour	30	15,000	R1 799,80	T
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	30	15,000	R1 799,80	T
1358	Harvesting of radial artery				
6.4	**Peripheral vascular system**				
	MODIFIER GOVERNING THIS SECTION				
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins				
6.4.1	**Peripheral vascular system: Investigations**				
1357	Skin temperature test: Response to reflex heating				
1359	Skin temperature test: Response to reflex cooling				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1360	Closure: Left atrial appendage (LAA)		15,000	R1 799,80	T
1361	Cold sensitivity test				
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		15,000	R1 799,80	T
1363	Oscillometry test				
1365	Sweating test				
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site				
1367	Doppler blood tests				
5369	Doppler arterial pressures				
5371	Doppler arterial pressures with exercise				
5373	Doppler segmental pressures and wave forms				
5375	Venous doppler examination (both limbs)				
5377	Venous plethysmography				
5379	Supra-orbital doppler test				
5381	Carotid non-invasive complex tests				
6.4.2	**Peripheral vascular system: Arterio-venous abnormalities**				
1369	Fistula or aneurysm (as for grafting of various arteries)				
6.4.3	**Arteries**				
6.4.3.1	**Peripheral vascular system: Arteries: Aorta-iliac and major branches**				
1372	Abdominal aorta and iliac artery: Unruptured	30	15,000	R1 799,80	T
1373	Abdominal aorta and iliac artery: Ruptured	30	15,000	R1 799,80	T
1375	Grafting and/or thrombo-endarterectomy for thrombosis	30	15,000	R1 799,80	T
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	30	15,000	R1 799,80	T
6.4.3.2	**Peripheral vascular system: Arteries: Iliac artery**				
1379	Prosthetic grafting and/or thrombo-endarterectomy	30	13,000	R1 559,70	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6.4.3.3	**Peripheral vascular system: Arteries: Peripheral**				
1385	Prosthetic grafting	30	5,000	R600,10	T
1387	Grafting vein: Vein grafting proximal to knee joint	30	5,000	R600,10	T
1388	Grafting vein: Distal to knee joint	30	5,000	R600,10	T
1389	Grafting vein: Endarterectomy when not part of another specified procedure	30	5,000	R600,10	T
1390	Grafting vein: Carotid endarterectomy	30	15,000	R1 799,80	T
1393	Embolectomy: Peripheral embolectomy transfemoral	30	5,000	R600,10	T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	30	5,000	R600,10	T
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	30	15,000	R1 799,80	T
1397	Profundoplasty	30	5,000	R600,10	T
1399	Distal tibial (ankle region)	30	5,000	R600,10	T
1401	Femoro-femoral	30	5,000	R600,10	T
1402	Carotid-subclavian	30	8,000	R959,80	T
1403	Axillo-femoral: (Bifemoral + 50%)	30	8,000	R959,80	T
6.4.4	**Peripheral vascular system: Veins**				
1407	Ligation of saphenous vein	30	3,000	R359,80	T
1408	Placement of Hickman catheter or similar	30	4,000	R480,30	T
1410	Litigation of inferior vena cava: Abdominal	30	8,000	R959,80	T
1412	Umbrella operation on inferior vena cava: Abdominal	30	8,000	R959,80	T
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral	30	3,000	R359,80	T
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral	30	3,000	R359,80	T
1417	Extensive sub-fascial ligation of perforating veins	30	3,000	R359,80	T
1419	Lesser varicose vein procedures	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9) injections per leg (excluding cost of material)				
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	30	11,000	R1 319,70	T
1427	Thrombectomy: Illio-femoral	30	6,000	R720,00	T
1422	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: First vein		3,000	R359,80	T
1424	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: Subsequent veins (modifier 0005 is not applicable)		3,000	R359,80	T
6.4.5	**Peripheral vascular system: Portal hypertension**				
1429	Porto-caval shunt	30	11,000	R1 319,70	T
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				
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group				
	"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**				
1435	Splenectomy (in all cases)	30	9,000	R1 079,70	T
1436	Splenorrhaphy	30	9,000	R1 079,70	T
1437	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic donor lymphocyte infusions - PROFESSIONAL COMPONENT				
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic - PROFESSIONAL COMPONENT				
7.2	**Lymph nodes and lymphatic channels**				
1439	Excision of lymph node for biopsy: Neck or axilla	30	4,000	R480,30	T
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous - PROFESSIONAL COMPONENT				
1441	Excision of lymph node for biopsy: Groin	30	3,000	R359,80	T
1442	Lymphadenectomy: Modified radical neck dissection, cervical		3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1443	Simple excision of lymph nodes for tuberculosis	30	3,000	R359,80	T
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic - PROFESSIONAL COMPONENT				
1445	Radical excision of lymph nodes of neck: Total: Unilateral	30	5,000	R600,10	T
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous - PROFESSIONAL COMPONENT				
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral	30	5,000	R600,10	T
1448	Bone marrow harvesting for transplant - PROFESSIONAL COMPONENT				
1449	Radical excision of lymph nodes of axilla	30	4,000	R480,30	T
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	30	5,000	R600,10	T
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	30	4,000	R480,30	T
1453	Radical excision of lymph nodes of groin: Inguinal	30	4,000	R480,30	T
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	30	5,000	R600,10	T
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	30	6,000	R720,00	T
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	30	5,000	R600,10	T
1457	Bone marrow biopsy: By trephine	30	3,000	R359,80	T
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula				
1459	Staging laparotomy for lymphoma (including splenectomy	30	7,000	R839,80	T
1460	Sentinel lymph node(s): Intra-operative indentification; INCLUDES injection of non-radioactive dye, when performed				
8	**DIGESTIVE SYSTEM**				
	MODIFIERS GOVERNING THIS SECTION				
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.				
0075	Endoscopic procedures performed in own procedure room: (a) The value of modifier 0075 = 21,00 clinical procedure units, where endoscopic procedures are performed in rooms. (b) This fee is chargeable by medical practitioners who own or rent the facility. (c) Modifier 0075 may not be used in conjunction 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.				

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8.1	**Oral cavity**				
1461	All dental procedures	30	4,000	R480,30	T
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	30	4,000	R480,30	T
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	30	4,000	R480,30	T
1467	Drainage of intra-oral abscess	30	4,000	R480,30	T
1469	Local excision of mucosal lesion of oral cavity	30	4,000	R480,30	T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	30	7,000	R839,80	T
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	30	7,000	R839,80	T
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	30	6,000	R720,00	T
1477	Cleft palate: Secondary repair	30	6,000	R720,00	T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	30	6,000	R720,00	T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	30	6,000	R720,00	T
1480	Repair of oronasal fistula (large) e.g. distant flap	30	6,000	R720,00	T
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	30	5,000	R600,10	T
1482	Repair of oronasal fistula (large): Second stage	30	5,000	R600,10	T
1483	Alveolar periosteal or other flaps for arch closure	30	4,000	R480,30	T
1486	Closure of anterior nasal floor	30	5,000	R600,10	T
1462	Removal of embedded foreign body: Vestibule of mouth, simple		3,000	R359,80	T
1464	Removal of embedded foreign body: Vestibule of mouth, complicated		3,000	R359,80	T
1466	Removal of embedded foreign body: Denotalveolar structures, soft tissues		3,000	R359,80	T
8.2	**Lips**				
1484	Cleft lip repair: Lip adhesion (cleft lip)	30	5,000	R600,10	T
1485	Local excision of benign lesion of lip	30	4,000	R480,30	T
1487	Resection for lip malignancy	30	4,000	R480,30	T

CONTRACTED ANAESTHESIOLOGY FOR ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	30	5,000	R600,10	T
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages	30	5,000	R600,10	T
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage	30	5,000	R600,10	T
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage	30	5,000	R600,10	T
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	30	5,000	R600,10	T
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	30	5,000	R600,10	T
1495	Abbé or Estlander type flap (all stages included)	30	5,000	R600,10	T
1497	Vermilionectomy	30	4,000	R480,30	T
1499	Lip reconstruction following an injury: Direct repair	30	4,000	R480,30	T
1501	Lip reconstruction following an injury or tumour removal: Flap repair	30	4,000	R480,30	T
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	30	4,000	R480,30	T
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)	30	4,000	R480,30	T
8.3	**Tongue**				
1505	Partial glossectomy	30	6,000	R720,00	T
1507	Local excision of lesion of tongue	30	4,000	R480,30	T
8.4	**Palate, uvula and salivary glands**				
1509	Wide excision of lesion of palate	30	5,000	R600,10	T
1511	Radical resection of palate (including skin graft)	30	7,000	R839,80	T
1513	Excision of ranula	30	5,000	R600,10	T
1515	Excision of sublingual salivary gland	30	4,000	R480,30	T
1517	Excision of submandibular salivary gland	30	4,000	R480,30	T
1519	Excision of submandibular salivary gland with suprahyoid dissection	30	5,000	R600,10	T
1521	Excision of submandibular salivary gland: With radical neck dissection	30	6,000	R720,00	T
1523	Local resection of parotid tumour	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1525	Partial parotidectomy	30	5,000	R600,10	T
1526	Total parotidectomy with preservation of facial nerve	30	5,000	R600,10	T
1527	Total parotidectomy	30	5,000	R600,10	T
1529	Parotidectomy: Extracapsular	30	5,000	R600,10	T
1531	Drainage of parotid abscess	30	4,000	R480,30	T
1533	Closure of salivary fistula	30	4,000	R480,30	T
1535	Dilatation of salivary duct	30	4,000	R480,30	T
1537	Operative removal of salivary calculus	30	4,000	R480,30	T
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated		3,000	R359,80	T
1539	Salivary duct: Meatotomy	30	4,000	R480,30	T
1541	Branchial cyst and/or fistula: Excision	30	5,000	R600,10	T
1543	Excision of cystic hygroma	30	5,000	R600,10	T
1544	Ludwig's Angina: Drainage	30	9,000	R1 079,70	T
8.5	**Oesophagus**				
1545	Oesophagoscopy with rigid instrument: First and subsequent	30	4,000	R480,30	T
1549	Oesophagoscopy with dilatation of stricture	30	4,000	R480,30	T
1550	Oesophagoscopy with removal of foreign body	30	4,000	R480,30	T
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	30	4,000	R480,30	T
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	30	4,000	R480,30	T
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	30	4,000	R480,30	T
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	30	15,000	R1 799,80	T
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic		7,000	R839,80	T
1557	Oesophageal dilatation	30	4,000	R480,30	T
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		7,000	R839,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1559	Oesophagectomy: Two stage	30	11,000	R1 319,70	T
1560	Oesophagectomy: Three stage	30	11,000	R1 319,70	T
1561	Thoraco-abdominal oesophagogastrectomy	30	11,000	R1 319,70	T
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	30	11,000	R1 319,70	T
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		7,000	R839,80	T
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	30	11,000	R1 319,70	T
1566	Private fee: Gastroplasty	30	8,000	R959,80	T
1567	Bochdalek hernia repair in newborn	30	14,000	R1 679,70	T
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	30	11,000	R1 319,70	T
1569	Heller's operation	30	14,000	R1 679,70	T
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure)		7,000	R839,80	T
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		15,000	R1 799,80	T
1575	Insertion of indwelling oesophageal tube by laparotomy	30	6,000	R720,00	T
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): ADD to major procedure (modifier 0005 does not apply)		7,000	R839,80	T
1578	Oesophageal motility (4 channel + pneumograph)	30	4,000	R480,30	T
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	30	11,000	R1 319,70	T
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	30	4,000	R480,30	T
1581	Removal of benign oesophageal tumours	30	11,000	R1 319,70	T
1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	30	4,000	R480,30	T
1583	Excision of intrathoracic oesophageal diverticulum	30	11,000	R1 319,70	T
1584	24 Hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe: 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)				
1585	24 Hour oesophageal pH studies: Interpretation				
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		7,000	R839,80	T
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		7,000	R839,80	T

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5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		15,000	R1 799,80	T
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		15,000	R1 799,80	T
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		15,000	R1 799,80	T
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		15,000	R1 799,80	T
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		7,000	R839,80	T
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		7,000	R839,80	T
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)				Refer Rule C
8.6	**Stomach**				
1587	Upper gastro-intestinal endoscopy: Hospital equipment	30	4,000	R480,30	T
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587)	30	4,000	R480,30	T
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (item 1587) or colonoscopy (item 1653)	30	6,000	R720,00	T
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (Item 1587)	30	4,000	R480,30	T
1593	Augmented histamine test: Gastric intubation with x-ray screening				
1597	Gastrostomy or Gastrotomy	30	6,000	R720,00	T
1598	Gastrotomy with suture repair of bleeding ulcer	30	6,000	R720,00	T
1599	Pyloromyotomy (Rammstedt)	30	6,000	R720,00	T
1601	Local excision of ulcer or benign neoplasm	30	6,000	R720,00	T
1603	Vagotomy: Abdominal	30	6,000	R720,00	T
1604	Vagotomy: Thoracic	30	11,000	R1 319,70	T
1605	Truncal or selective with drainage procedures	30	6,000	R720,00	T
1607	Vagotomy and antrectomy	30	6,000	R720,00	T
1609	Highly selective vagotomy	30	6,000	R720,00	T

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1611	Pyloroplasty	30	6,000	R720,00	T
1613	Gastroenterostomy	30	6,000	R720,00	T
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	30	7,000	R839,80	T
1617	Partial gastrectomy	30	7,000	R839,80	T
1619	Total gastrectomy	30	7,000	R839,80	T
1621	Revision of gastrectomy or gastro-enterostomy	30	7,000	R839,80	T
1625	Gastro-esophageal operation for portal hypertension (Tanner)	30	11,000	R1 319,70	T
8.7	**Duodenum**				
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	30	6,000	R720,00	T
1627	Duodenal intubation (under X-ray screening)				
1629	Duodenal intubation with biliary drainage after gall bladder stimulation				
1631	Duodenal intubation: Under 3 years of age				
8.8	**Intestines**				
1632	H2 breath test (intestines)				
1633	Complete test using lactose or lactulose				
1634	Enterotomy or Enterostomy	30	6,000	R720,00	T
1635	Intestinal obstruction of the newborn	30	7,000	R839,80	T
1636	Oral food challenge test				
1637	Operation for relief of intestinal obstruction	30	7,000	R839,80	T
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering		3,000	R359,80	T
1639	Resection of small bowel with enterostomy or anastomosis	30	6,000	R720,00	T
1640	Resection of small bowel for congenital atresia, proximal segment, with tapering		3,000	R359,80	T
1641	Entero-enterostomy or entero-colostomy for bypass	30	6,000	R720,00	T

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1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (item 0201 applicable for video capsule - disposable single patient use) (Please note: All patients should have had a normal gastroscopy and colonoscopy)				
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report				
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	30	6,000	R720,00	T
1647	Closure of intestinal fistula	30	6,000	R720,00	T
1649	Excision of Meckel's diverticulum	30	6,000	R720,00	T
1651	Excision of lesion of mesentery	30	4,000	R480,30	T
1652	Laparotomy for mesenteric thrombosis	30	8,000	R959,80	T
1653	Total colonoscopy: With hospital equipment (including biopsy)	30	4,000	R480,30	T
1654	Plus removal of polyps: ADD to colonoscopy (Item 1653)	30	4,000	R480,30	T
1656	Left-sided colonoscopy	30	4,000	R480,30	T
1657	Right or left hemicolectomy or segmental colectomy	30	6,000	R720,00	T
1658	Reconstruction of colon after Hartman's procedure	30	6,000	R720,00	T
1659	Surgeon present assisting with air enema for reduction of intussuception (Paediatric surgeons add modifier 0016)				
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (Paediatric surgeons add modifier 0016)		4,000	R480,30	T
1661	Colotomy: Including removal of tumour or foreign body	30	6,000	R720,00	T
1663	Total colectomy	30	6,000	R720,00	T
1665	Colostomy or ileostomy isolated procedure	30	6,000	R720,00	T
1666	Continent ileostomy pouch (all types)	30	6,000	R720,00	T
1667	Colostomy: Closure	30	5,000	R600,10	T
1668	Revision of ileostomy pouch	30	6,000	R720,00	T
1669	Total proctocolectomy and ileostomy	30	7,000	R839,80	T
1670	Proctocolectomy, ileostomy and ileostomy pouch	30	7,000	R839,80	T
1671	Colomyotomy (Reilly operation)	30	6,000	R720,00	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
8.9	**Appendix**				
1673	Drainage of appendix abscess	30	5,000	R600,10	T
1675	Appendicectomy	30	4,000	R480,30	T
8.10	**Rectum and anus**				
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	30	3,000	R359,80	T
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	30	3,000	R359,80	T
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	30	3,000	R359,80	T
1679	Sigmoidoscopy with removal of polyps, first and subsequent	30	3,000	R359,80	T
1681	Proctoscopy with removal of polyps: First time	30	3,000	R359,80	T
1683	Proctoscopy with removal of polyps: Subsequent times	30	3,000	R359,80	T
1685	Endoscopic fulguration of tumour	30	4,000	R480,30	T
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	30	6,000	R720,00	T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	30	8,000	R959,80	T
1689	Perineal resection of rectum	30	5,000	R600,10	T
	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	30	7,000	R839,80	T
1692	Abdomino-perineal resection of rectum: Perineal surgeon				
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	30	4,000	R480,30	T
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	30	7,000	R839,80	T
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz	30	6,000	R720,00	T
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge	30	6,000	R720,00	T
1701	Repair of prolapsed rectum: Abdominal: Perineal	30	4,000	R480,30	T
1703	Repair of prolapsed rectum: Abdominal: Thierisch suture	30	4,000	R480,30	T
1705	Incision and drainage of peri-anal abscess	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1707	Drainage of submucous abscess	30	3,000	R359,80	T
1709	Drainage of ischio-rectal abscess	30	3,000	R359,80	T
1711	Excision of pelvi-rectal fistula	30	5,000	R600,10	T
1713	Excision of fistula-in-ano	30	3,000	R359,80	T
1715	Operation for fissure-in-ano	30	3,000	R359,80	T
1716	Rectal Tumour: Destruction (any method):Transanal Approach		5,000	R600,10	T
1717	Rectal tumour: Excision, transanal approach, EXCLUDING muscularis propria (partial thickness)		5,000	R600,10	T
1718	Rectal Tumour: Excision, Transanal Approach,INCLUDING muscularis propria(full thickness)		5,000	R600,10	T
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	30	3,000	R359,80	T
1721	Sclerosing injection for haemorrhoids: Per injection				
1723	Haemorrhoidectomy	30	3,000	R359,80	T
1725	Drainage of external thrombosed pile	30	3,000	R359,80	T
1727	Multiple procedures (haemorrhoids, fissure, etc.)	30	3,000	R359,80	T
1728	Biopsy of ano-rectal wall, for congenital megacolon	30	5,000	R600,10	T
1729	Excision of anal skin tags	30	3,000	R359,80	T
1731	Operation for low imperforate anus	30	6,000	R720,00	T
1733	Anoplasty: Y-V-plasty	30	3,000	R359,80	T
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)		3,000	R359,80	T
1735	Anal sphincteroplasty for incontinence	30	3,000	R359,80	T
1737	Dilation of ano-rectal stricture	30	3,000	R359,80	T
1739	Closure of recto-vesical fistula	30	5,000	R600,10	T
1741	Closure of recto-urethral fistula	30	5,000	R600,10	T
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor				
8.11	**Liver**				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1743	Needle biopsy of liver	30	3,000	R359,80	T
1745	Biopsy of liver by laparotomy	30	4,000	R480,30	T
1747	Drainage of liver abscess or cyst	30	7,000	R839,80	T
1748	Body composition measured by bio-electrical impedance				
1749	Hemi-hepatectomy: Right	30	9,000	R1 079,70	T
1751	Hemi-hepatectomy: Left	30	9,000	R1 079,70	T
1752	Extended right or left hepatectomy	30	9,000	R1 079,70	T
1753	Partial or segmental hepatectomy	30	9,000	R1 079,70	T
1754	Hepatico-jejunostomy	30	9,000	R1 079,70	T
1755	Liver transplant	30	15,000	R1 799,80	T
1756	Harvesting donor hepatectomy	30	5,000	R600,10	T
1757	Suture of liver wound or injury	30	9,000	R1 079,70	T
1744	Extensive debridement, haemostasis and packing of liver wound or injury				Refer Rule C
1746	Re-exploration of liver wound for removal of packing				Refer Rule C
1758	Complex suture of liver wound or injury, including hepatic artery ligation				Refer Rule C
8.12	**Biliary tract**				
1759	Cholecystostomy	30	6,000	R720,00	T
1761	Cholecystectomy	30	6,000	R720,00	T
1762	Cholecystectomy and operative cholangiogram	30	6,000	R720,00	T
1763	With exploration of common bile duct	30	6,000	R720,00	T
1765	Exploration of common bile duct: Secondary operation	30	6,000	R720,00	T
1767	Reconstruction of common bile duct	30	6,000	R720,00	T
1768	Resection bile duct tumour with reconstruction	30	6,000	R720,00	T
1769	Cholecysto-enterostomy or gastrostomy	30	6,000	R720,00	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	30	6,000	R720,00	T
1773	Transduodenal sphincteroplasty	30	6,000	R720,00	T
1774	Balloon dilatation of common bile duct strictures	30	6,000	R720,00	T
1775	Excision choledochal cyst with reconstruction	30	6,000	R720,00	T
1777	Porto-enterostomy for biliary atresia	30	11,000	R1 319,70	T
1766	Resection bile duct tumour: Intrahepatic				Refer Rule C
8.13	**Pancreas**				
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	30	4,000	R480,30	T
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	30	4,000	R480,30	T
1780	Gastric and duodenal intubation				
1781	Procedure (excluding laboratory tests)				
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	30	4,000	R480,30	T
1783	Drainage of pancreatic abscess	30	6,000	R720,00	T
1784	Debridement pancreatic necrosis	30	6,000	R720,00	T
1785	Internal drainage of pancreatic cyst	30	6,000	R720,00	T
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	30	6,000	R720,00	T
1786	Internal drainage of pancreatic cyst with Roux-Y	30	6,000	R720,00	T
1787	Operative pancreatogram: ADD				
1788	Biopsy of pancreas	30	6,000	R720,00	T
1789	Pancreatico-duodenectomy	30	8,000	R959,80	T
1791	Local, partial or subtotal pancreatectomy	30	8,000	R959,80	T
1793	Distal pancreatectomy with internal drainage	30	8,000	R959,80	T
1790	Endoscopic cannulation of papilla with direct visualisation of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)		4,000	R480,30	T
1792	Near-total pancreatectomy (with preservation of duodenum)		8,000	R959,80	T

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1794	Total pancreatectomy		8,000	R959,80	T
8.14	**Peritoneal cavity**				
1797	Pneumo-peritoneum: First	30	4,000	R480,30	T
1799	Pneumo-peritoneum: Repeat	30	4,000	R480,30	T
1800	Peritoneal lavage				
1801	Diagnostic paracentesis: Abdomen				
1803	Therapeutic paracentesis: Abdomen				
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	30	5,000	R600,10	T
1808	Omentectomy (separate procedures)		6,000	R720,00	T
1809	Laparotomy	30	4,000	R480,30	T
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	30	7,000	R839,80	T
1811	Suture of burst abdomen	30	7,000	R839,80	T
1812	Laparotomy for control of surgical haemorrhage	30	9,000	R1 079,70	T
1813	Drainage of sub-phrenic abscess	30	7,000	R839,80	T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	30	5,000	R600,10	T
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	30	4,000	R480,30	T
9	**HERNIAE**				
1819	Inguinal or femoral hernia: Adult	30	4,000	R480,30	T
1821	Inguinal or femoral hernia: Child under 14 years	30	4,000	R480,30	T
1823	Inguinal hernia: Infant under one year	30	4,000	R480,30	T
1825	Recurrent inguinal or femoral hernia	30	4,000	R480,30	T
1827	Strangulated hernia or femoral hernia	30	7,000	R839,80	T
1829	Epigastric hernia	30	4,000	R480,30	T
1831	Umbilical hernia: Adult	30	4,000	R480,30	T

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1833	Umbilical hernia: Child under 14 years	30	4,000	R480,30	T
1835	Incisional hernia	30	4,000	R480,30	T
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)	30	4,000	R480,30	T
1837	Repair of omphalocele in new-born (one or more procedures)	30	7,000	R839,80	T
10	**URINARY SYSTEM**				
	RULES GOVERNING THE SECTION URINARY SYSTEM				
FF.	(a) When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. (b) When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. (c) No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.				
10.1	**Kidney**				
1839	Renal biopsy: Per kidney: Open	30	5,000	R600,10	T
1841	Renal biopsy: Needle	30	3,000	R359,80	T
1843	Peritoneal dialysis: First day				
1845	Peritoneal dialysis: Every subsequent day				
1847	Haemodialysis: Per hour or part thereof				
1849	Haemodialysis: Maximum: Eight hours				
1851	Haemodialysis: Thereafter per week				
1852	Continuous haemodiafiltration per day in intensive or high care unit				
1853	Nephrectomy: Primary nephrectomy	30	5,000	R600,10	T
1855	Nephrectomy: Secondary nephrectomy	30	5,000	R600,10	T
1857	Radical with regional lymph adenectomy for tumour	30	6,000	R720,00	T
1859	Nephrectomy: Partial	30	5,000	R600,10	T
1861	Symphysiotomy for horse-shoe kidney	30	6,000	R720,00	T
1863	Nephro-ureterectomy	30	5,000	R600,10	T

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1865	Nephrotomy with drainage nephrostomy	30	6,000	R720,00	T
1868	Nephrolithotomy, for congenital kidney abnormality, complicated		3,000	R359,80	T
1869	Nephrolithotomy	30	5,000	R600,10	T
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	30	5,000	R600,10	T
1871	Staghorn stone: Surgical	30	6,000	R720,00	T
1873	Suture renal laceration (renorraphy)	30	6,000	R720,00	T
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	30	3,000	R359,80	T
1877	Operation for renal cyst: Marsupialisation or excision	30	5,000	R600,10	T
1878	Ablation of 1 or more renal tumour(s): Cryotherapy, percutaneous, unilateral		3,000	R359,80	T
1879	Closure renal fistula	30	5,000	R600,10	T
1881	Pyeloplasty	30	5,000	R600,10	T
1882	Pyeloplasty, complicated; with or without plastic procedure on ureter; nephropexy; nephrostomy; pyelostomy; ureteral splinting. (Secondary procedure for congenital kidney abnormality or solitary kidney)		3,000	R359,80	T
1883	Pyelostomy	30	5,000	R600,10	T
1885	Pyelolithotomy	30	5,000	R600,10	T
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	30	5,000	R600,10	T
1889	Nephrectomy for Allograft: Living or dead	30	5,000	R600,10	T
1891	Perinephric abscess or renal abscess: Drainage	30	7,000	R839,80	T
1893	Aberrant renal vessels: Repositioning with pyeloplasty	30	5,000	R600,10	T
1894	Auto transplantation of kidney	30	10,000	R1 199,90	T
1895	Allo transplantation of kidney	30	10,000	R1 199,90	T
1860	Laparoscopic nephrectomy, partial (item 1807 may not be added to this item)		10,000	R1 200,20	T
1862	Laparoscopic nephrectomy, includes partial ureterectomy (item 1807 may not be added to this item)		10,000	R1 200,20	T
1880	Laparoscopic ablation of renal mass or lesion(s) (item 1807 may not be added to this item)		10,000	R1 200,20	T
1890	Laparoscopic living donor nephrectomy (item 1807 may not be added to this item)		10,000	R1 200,20	T

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Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1892	Laparoscopic drainage of lymphocele to peritoneal cavity (item 1807 may not be added to this item)		10,000	R1 200,20	T
10.2	**Ureter**				
1897	Ureterorraphy: Suture of ureter	30	5,000	R600,10	T
1898	Ureterorraphy: Lumbar approach	30	5,000	R600,10	T
1899	Ureteroplasty	30	5,000	R600,10	T
1901	Ureterolysis	30	5,000	R600,10	T
1902	Ureterolysis: Lumbar approach	30	5,000	R600,10	T
1903	Ureterectomy only	30	5,000	R600,10	T
1905	Ureterolithotomy	30	5,000	R600,10	T
1907	Cutaneous ureterostomy: Unilateral	30	5,000	R600,10	T
1909	Cutaneous ureterostomy: Bilateral	30	5,000	R600,10	T
1911	Uretero-enterostomy: Unilateral	30	5,000	R600,10	T
1913	Uretero-enterostomy: Bilateral	30	5,000	R600,10	T
1915	Uretero-ureterostomy	30	5,000	R600,10	T
1917	Transuretero-ureterostomy	30	5,000	R600,10	T
1919	Closure of ureteric fistula	30	5,000	R600,10	T
1921	Immediate deligation of ureter	30	5,000	R600,10	T
1923	Ureterolysis for retrocaval ureter with anastomosis	30	5,000	R600,10	T
1924	Ureterocalicostomy		3,000	R359,80	T
1925	Uretero-pyelostomy	30	5,000	R600,10	T
1927	Uretero-neo-cystostomy: Unilateral	30	5,000	R600,10	T
1929	Uretero-neo-cystostomy: Bilateral	30	5,000	R600,10	T
1931	Uretero-neo-cystostomy: With Boariplasty	30	5,000	R600,10	T
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1935	Uretero-ileal conduit	30	5,000	R600,10	T
1937	Replacement of ureter by bowel segment: Unilateral	30	5,000	R600,10	T
1939	Replacement of ureter by bowel segment: Bilateral	30	5,000	R600,10	T
1941	Ureterostomy-in-situ: Unilateral	30	5,000	R600,10	T
1943	Ureterostomy-in-situ: Bilateral	30	5,000	R600,10	T
1904	Ureterectomy with bladder cuff (stand alone procedure)		7,000	R840,20	T
1932	Laparoscopic uretero-neocystostomy, excludes cystoscopy and ureteral stent insertion (item 1807 may not be added to this item)		10,000	R1 200,20	T
1936	Contrast injection for ileal conduit visualisation				Refer Rule C
10.3	**Bladder**				
1952	J J Stent catheter	30	3,000	R359,80	T
1953	With hydrodilatation of the bladder for interstitial cystitis	30	3,000	R359,80	T
1954	Uretroscopy	30	3,000	R359,80	T
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	30	3,000	R359,80	T
1957	With dilatation of the ureter or ureters	30	3,000	R359,80	T
1959	With manipulation of ureteral calculus	30	3,000	R359,80	T
1961	With removal of foreign body or calculus from urethra or bladder	30	3,000	R359,80	T
1963	With fulguration or treatment of minor lesions, with or without biopsy	30	3,000	R359,80	T
1964	And control of haemorrhage and blood clot evacuation	30	3,000	R359,80	T
1965	And catheterisation of the ejaculatory duct	30	3,000	R359,80	T
1967	With ureteric meatotomy: Unilateral or bilateral	30	3,000	R359,80	T
1969	And cold biopsy	30	3,000	R359,80	T
1971	With cryosurgery for bladder or prostatic disease	30	3,000	R359,80	T
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	30	3,000	R359,80	T
1975	Ultraviolet cystoscopy for bladder tumour	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1976	Optic urethrotomy	30	3,000	R359,80	T
1977	Transurethral resection of ejaculatory duct	30	3,000	R359,80	T
1979	Internal urethrotomy: Female	30	3,000	R359,80	T
1981	Internal urethrotomy: Male	30	3,000	R359,80	T
1983	Transurethral resection of bladder tumour	30	5,000	R600,10	T
1984	Transurethral resection of bladder tumours: Large multiple tumours	30	5,000	R600,10	T
1985	Transurethral resection of bladder neck: Female or child	30	5,000	R600,10	T
1986	Transurethral resection of bladder neck: Male	30	5,000	R600,10	T
1987	Litholapaxy	30	5,000	R600,10	T
1989	Cystometrogram	30	3,000	R359,80	T
1991	Flometric bladder, studies with videocystograph	30	3,000	R359,80	T
1992	Without videocystograph	30	3,000	R359,80	T
1993	Voiding cysto-urethrogram	30	3,000	R359,80	T
1994	Rigiscan examination				
1995	Percutaneous aspiration of bladder	30	3,000	R359,80	T
1996	Bladder catheterisation: Male (not at operation)	30	3,000	R359,80	T
1997	Bladder catheterisation: Female (not at operation)				
1999	Percutaneous cystostomy	30	3,000	R359,80	T
1945	Instillation of radio-opaque material for cystography or urethrocystography	30	3,000	R359,80	T
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	30	3,000	R359,80	T
1949	Cystoscopy: Hospital equipment	30	3,000	R359,80	T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	30	3,000	R359,80	T
2001	Total cystectomy: After previous urinary diversion	30	8,000	R959,80	T
2003	Total cystectomy: With conduit construction and ureteric anastomosis	30	8,000	R959,80	T

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Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	30	8,000	R959,80	T
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	30	8,000	R959,80	T
2007	Partial cystectomy	30	6,000	R720,00	T
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	30	8,000	R959,80	T
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	30	8,000	R959,80	T
2010	Reversion of temporary conduit	30	8,000	R959,80	T
2011	Partial cystectomy with uretero-neo-cystostomy	30	6,000	R720,00	T
2012	Reversion of conduit with major urinary tract reconstruction	30	8,000	R959,80	T
2013	Diverticulectomy (independent procedure): Multiple or single	30	5,000	R600,10	T
2014	Closure of cystostomy (stand alone procedure)		3,000	R359,80	T
2015	Suprapubic cystostomy	30	5,000	R600,10	T
2016	Abdomino-neo-urethrostomy	30	5,000	R600,10	T
2017	Open loop fulguration or excision of bladder tumour	30	5,000	R600,10	T
2019	Operation for vesico-vaginal or urethra-vaginal fistula	30	5,000	R600,10	T
2020	Repair of vesico vaginal fistula: Abdominal approach	30	5,000	R600,10	T
2021	Vesico-plication (Hamilton Stewart)	30	5,000	R600,10	T
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	30	5,000	R600,10	T
2025	Vesico-urethropexy with rectus sling	30	5,000	R600,10	T
2027	Open operation for ureterocele: Unilateral	30	5,000	R600,10	T
2029	Open operation for ureterocele: Bilateral	30	5,000	R600,10	T
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	30	8,000	R959,80	T
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	30	8,000	R959,80	T
2035	Cutaneous vesicostomy	30	5,000	R600,10	T
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2039	Operation for ruptured bladder	30	6,000	R720,00	T
2042	Enterocystoplasty plus bowel anastomosis	30	5,000	R600,10	T
2043	Cysto-lithotomy	30	5,000	R600,10	T
2045	Excision of patent-urachus or urachal cyst	30	5,000	R600,10	T
2047	Drainage of perivesical or prevesical abscess	30	5,000	R600,10	T
2049	Evacuation of clots from bladder: Other than post-operative	30	3,000	R359,80	T
2050	Evacuation of clots from bladder: Post-operative	30	4,000	R480,30	T
2051	Simple bladder lavage: Including catheterisation	30	3,000	R359,80	T
2053	Bladder neck plasty: Male	30	5,000	R600,10	T
2057	Bladder neck plasty: Female	30	5,000	R600,10	T
2004	Complete pelvic exenteration for malignancy; includes combinations of removal of bladder, urethral transplantation, with or without hysterectomy, abdominoperineal resection of rectum or colon, colostomy		8,000	R959,80	T
2034	Appendico-vesicostomy, cutaneous		5,000	R600,10	T
2036	Revision of urinary-cutaneous anastomasis, includes repair of fascial defect and hernia				Refer Rule C
10.4	**Urethra**				
2059	Open biopsy of urethra: Male	30	3,000	R359,80	T
2061	Open biopsy of urethra: Female	30	3,000	R359,80	T
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	30	3,000	R359,80	T
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	30	3,000	R359,80	T
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	30	3,000	R359,80	T
2069	Dilatation of female urethra	30	3,000	R359,80	T
2071	Urethrorraphy: Suture of urethral wound or injury	30	4,000	R480,30	T
2073	External urethrotomy: Pendulous urethra (anterior)	30	3,000	R359,80	T
2075	Urethraplasty: Pendulous urethra: First stage	30	4,000	R480,30	T
2077	Urethraplasty: Pendulous urethra: Second stage	30	4,000	R480,30	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2079	Reconstruction of female urethra	30	4,000	R480,30	T
2081	Reconstruction or repair of male anterior urethra (one stage)	30	4,000	R480,30	T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	30	6,000	R720,00	T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	30	6,000	R720,00	T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	30	6,000	R720,00	T
2087	Urethral diverticulectomy: Male or female	30	4,000	R480,30	T
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units				
2089	Marsupialisation of urethral diverticula: Male or female	30	4,000	R480,30	T
2091	Total urethrectomy: Female	30	5,000	R600,10	T
2093	Total urethrectomy: Male	30	5,000	R600,10	T
2095	Drainage of simple localised perineal urinary extravasation	30	5,000	R600,10	T
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	30	5,000	R600,10	T
2099	Fulguration for urethral caruncle or polyp	30	3,000	R359,80	T
2101	Excision of urethral caruncle	30	3,000	R359,80	T
2103	Simple urethral meatotomy	30	3,000	R359,80	T
2105	Incision of deep peri-urethral abscess: Female	30	3,000	R359,80	T
2107	Incision of deep peri-urethral abscess: Male	30	3,000	R359,80	T
2108	Sling operation for male urinary incontinence (fascia or synthetic)		3,000	R359,80	T
2109	Badenoch pull-through for intractable stricture or incontinence	30	5,000	R600,10	T
2110	Removal/revision: Sling for male urinary incontinence (fascia or synthetic)		3,000	R359,80	T
2111	External sphincterotomy	30	5,000	R600,10	T
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff		3,000	R359,80	T
2113	Drainage of Skene gland abscess or cyst	30	3,000	R359,80	T
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff		3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	30	5,000	R600,10	T
2116	Urethral meatoplasty	30	3,000	R359,80	T
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	30	3,000	R359,80	T
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff		3,000	R359,80	T
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff		3,000	R359,80	T
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridment of infected tissue		3,000	R359,80	T
2121	Closure of urethrovaginal fistula: Including diversionary procedures	30	5,000	R600,10	T
2070	Transvaginal urethrolysis, includes cystoscopy		4,000	R480,30	T
2104	Debridement of external genitalia and perineum (Fourniers gangrene)		3,000	R359,80	T
2106	Debridement of external genitalia, perineum and abdominal wall (Fourniers gangrene)		3,000	R359,80	T
11	**MALE GENITAL SYSTEM**				
11.1	**Penis**				
2123	Biopsy of penis (independent procedure)	30	3,000	R359,80	T
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)	30	3,000	R359,80	T
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	30	3,000	R359,80	T
2129	Electrodesiccation: Limited number	30	3,000	R359,80	T
2131	Electrodesiccation: Multiple extensive	30	3,000	R359,80	T
2132	Ligation of abnormal venous drainage	30	3,000	R359,80	T
2133	Circumcision: Clamp procedure	30	3,000	R359,80	T
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	30	3,000	R359,80	T
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	30	3,000	R359,80	T
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	30	3,000	R359,80	T
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	30	3,000	R359,80	T
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	30	3,000	R359,80	T

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2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	30	3,000	R359,80	T
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	30	3,000	R359,80	T
2153	Reconstructive operation for epispadias with incontinence	30	3,000	R359,80	T
2154	Induction of artificial erection	30	3,000	R359,80	T
2155	Hypospadias: Urethral reconstruction	30	3,000	R359,80	T
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	30	3,000	R359,80	T
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	30	3,000	R359,80	T
2161	Total amputation of penis: Without gland dissection	30	4,000	R480,30	T
2163	Total amputation of penis: With gland-dissection	30	6,000	R720,00	T
2165	Partial amputation of penis: With gland-dissection	30	6,000	R720,00	T
2167	Partial amputation of penis: Without gland-dissection	30	4,000	R480,30	T
2169	Injection procedure for Peyronie's disease	30	3,000	R359,80	T
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	30	3,000	R359,80	T
2173	Priapism operation: Shunt procedure: Any type	30	4,000	R480,30	T
2174	Priapism operation: Stab shunt	30	4,000	R480,30	T
2172	Removal foreign body: Deep penile tissue (eg., plastic implant)		3,000	R359,80	T
2168	Excision: Penile plaque (Peyronie disease), <= 5cm in length				Refer Rule C
2170	Excision: Penile plaque (Peyronie disease), >5cm in length				Refer Rule C
11.2	**Testis and epididymis**				
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure				
2175	Testis biopsy: Needle (independent procedure)	30	3,000	R359,80	T
2177	Testis biopsy: Incisional: Independent procedure: Unilateral	30	3,000	R359,80	T
2179	Testis biopsy: Incisional: Independent procedure: Bilateral	30	3,000	R359,80	T
2181	Epididymis biopsy: Needle	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2183	Puncture aspiration hydrocele with or without injection of medication	30	3,000	R359,80	T
2185	Operation for maldescended testicle: Including herniotomy	30	4,000	R480,30	T
2187	Operation for torsion appendix testis	30	4,000	R480,30	T
2189	Operation for torsion testis with fixation of contralateral testis	30	4,000	R480,30	T
2191	Orchidectomy (total or subcapsular): Unilateral	30	3,000	R359,80	T
2193	Orchidectomy (total or subcapsular): Bilateral	30	3,000	R359,80	T
2195	Radical operation for malignant testis: Excluding gland dissection	30	6,000	R720,00	T
2197	Operation for hydrocele or spermatocele	30	4,000	R480,30	T
2199	Varicocelectomy	30	4,000	R480,30	T
2201	Abdominal ligation of spermatic vein for varicocele	30	4,000	R480,30	T
2203	Epididymectomy: Unilateral	30	3,000	R359,80	T
2205	Epididymectomy: Bilateral	30	3,000	R359,80	T
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	30	3,000	R359,80	T
2209	Vasotomy: Unilateral or bilateral	30	3,000	R359,80	T
2210	Vasogram, seminal vesiculogram: Unilateral	30	3,000	R359,80	T
2211	Vasogram, seminal vesiculogram: Bilateral	30	3,000	R359,80	T
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	30	4,000	R480,30	T
2213	Suture or repair of testicular injury	30	4,000	R480,30	T
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	30	4,000	R480,30	T
2217	Excision of local lesion of testis or epididymis	30	4,000	R480,30	T
2219	Vaso-vasostomy: Unilateral	30	3,000	R359,80	T
2221	Vaso-vasostomy: Bilateral	30	3,000	R359,80	T
2223	Epididymo-vasostomy: Unilateral	30	3,000	R359,80	T
2225	Epididymo-vasostomy: Bilateral	30	3,000	R359,80	T

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2227	Incision and drainage of scrotal wall abscess	30	3,000	R359,80	T
2229	Excision of Mullerian duct cyst	30	4,000	R480,30	T
2231	Excision of lesion of spermatic cord	30	3,000	R359,80	T
2233	Seminal Vesiculectomy	30	5,000	R600,10	T
2194	Laparoscopic orchiectomy (item 1807 may not be added to this item)		8,000	R959,90	T
2196	Laparoscopic orchiopexy: Intra-abdominal testis (item 1807 may not be added to this item)		8,000	R959,90	T
2198	Diagnostic laparoscopy (excluding aftercare) (male)		5,000	R600,10	T
2228	Removal of foreign body: Scrtoum		3,000	R359,80	T
2232	Excision: Retroperitoneal primary or secondary tumours		8,000	R959,80	T
11.3	**Prostate**				
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	30	3,000	R359,80	T
2237	Biopsy prostate: Incisional, any approach	30	4,000	R480,30	T
2239	Transurethral drainage of prostatic abscess	30	4,000	R480,30	T
2241	Perineal drainage of prostatic abscess	30	4,000	R480,30	T
2243	Trans-urethral cryo-surgical removal of prostate	30	6,000	R720,00	T
2245	Trans-urethral resection of prostate	30	6,000	R720,00	T
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	30	6,000	R720,00	T
2249	Trans-urethral resection of post-operative bladder neck contracture	30	5,000	R600,10	T
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing		8,000	R959,80	T
2251	Prostatectomy: Perineal: Sub-total	30	6,000	R720,00	T
2253	Prostatectomy: Perineal: Radical	30	8,000	R959,80	T
2254	Pelvic lymph adenectomy	30	8,000	R959,80	T
2255	Supra-pelvic, transversical	30	6,000	R720,00	T
2257	Retropubic: Sub-total	30	6,000	R720,00	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2259	Retropubic: Radical	30	8,000	R959,80	T
2260	Prostate brachytherapy	30	8,000	R959,80	T
2236	Interstitial device(s): Single or multiple placement (via needle, any approach), of for radiation therapy guidance (eg., fiducial markers, dosimeter), prostate		3,000	R359,80	T
2265	Cryosurgical ablation of the prostate, includes ultrasound guidance		6,000	R720,00	T
2266	Transrectal high-intensity focused ultrasound (HIFU)		5,000	R600,10	T
12	**FEMALE GENITAL SYSTEM**				
12.1	**Vulva and introitus**				
2271	Removal of tag or polyp	30	3,000	R359,80	T
2272	Removal of small superficial benign lesions	30	3,000	R359,80	T
2273	Biopsy with suture in theatre (excluding after-care)	30	3,000	R359,80	T
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	30	3,000	R359,80	T
2275	Reduction labial hypertrophy	30	4,000	R480,30	T
2277	Removal of extensive benign vulva tumour	30	4,000	R480,30	T
2279	Secondary perineal repair: Repair second degree tear	30	6,000	R720,00	T
2280	Secondary perineal repair: Repair third degree tear	30	6,000	R720,00	T
2281	Excision of inclusion cyst	30	4,000	R480,30	T
2283	Hymenectomy	30	4,000	R480,30	T
2285	Drainage haematocolpos	30	4,000	R480,30	T
2287	Clitoris repair for injury: Including skin graft, if required	30	4,000	R480,30	T
2288	Clitoral reduction	30	4,000	R480,30	T
2289	Denervation or alcohol infiltration vulva (Woodruff)	30	4,000	R480,30	T
2291	Vulva: Undercutting skin (ball)	30	4,000	R480,30	T
2293	Vulva and introitus: Drainage of abscess	30	3,000	R359,80	T
2295	Bartholin gland: Bartholin abscess marsupialisation	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2297	Bartholin gland: Bartholin gland excision	30	3,000	R359,80	T
2299	Bartholin gland: Bartholin radical excision for malignant lesion	30	6,000	R720,00	T
2301	Operation for enlarging introitus: Fenton plasty	30	4,000	R480,30	T
2303	Operation for enlarging introitus: Bilateral Z-plastic	30	4,000	R480,30	T
2305	Vulvectomy: Partial	30	4,000	R480,30	T
2307	Vulvectomy	30	6,000	R720,00	T
2309	Radical vulvectomy with bilateral lymphdenectomy	30	6,000	R720,00	T
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	30	6,000	R720,00	T
2270	Biopsy of vulva or perineum, each separate additional lesion (List separately in addition to item 2273 only)				
2308	Vulvectomy, radical, partial; without lymphadenectomy		4,000	R480,30	T
2310	Vulvectomy, radical complete, with unilateral inguinofemoral lymphadenectomy		6,000	R720,00	T
2278	Perineoplasty, non-obstetrical (stand alone procedure)				Refer Rule C
12.2	**Vaginal procedures and operations**				
2312	Artificial insemination				
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure	30	3,000	R359,80	T
2314	Intra uterine insemination				
2315	Simms Hühner test plus wet smear				
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	30	3,000	R359,80	T
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited	30	3,000	R359,80	T
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	30	3,000	R359,80	T
2319	Excision of cysts or tumours	30	3,000	R359,80	T
2321	Drainage of vaginal abscess	30	3,000	R359,80	T
2322	Pudendal nerve block				
2323	Reconstruction of vagina after atresia	30	5,000	R600,10	T

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2324	Revision of prosthetic vaginal graft:Vaginal approach (removal included)		5,000	R599,80	T
2325	Construction of artificial vagina: Labial fusion	30	4,000	R480,30	T
2326	Revision of prosthetic vaginal graft: Abdominal approach (removal included)		3,000	R359,80	T
2327	Construction of artificial vagina: Macindoe type	30	5,000	R600,10	T
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each	30	6,000	R720,00	T
2330	Fitting/insertion of pessary or other intravaginal support device		3,000	R359,80	T
2331	Vaginal septum removal	30	4,000	R480,30	T
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	30	6,000	R720,00	T
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	30	6,000	R720,00	T
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	30	6,000	R720,00	T
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	30	6,000	R720,00	T
2339	Colpotomy: Diagnostic (excluding after-care)	30	4,000	R480,30	T
2341	Colpotomy: Therapeutic, with or without sterilisation	30	4,000	R480,30	T
2343	Vaginal hysterectomy: Without repair	30	6,000	R720,00	T
2345	Vaginal hysterectomy: With repair	30	6,000	R720,00	T
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	30	6,000	R720,00	T
2355	Posterior colporrhaphy, Repair of rectocele with or without perineorrhaphy		5,000	R599,80	T
2359	Colporrhaphy: Anteroposterior, with enterocele repair		3,000	R359,80	T
2361	Vaginal hysterectomy and repair for total prolapse	30	6,000	R720,00	T
2363	Fothergill or Manchester repair operation	30	5,000	R600,10	T
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	30	5,000	R600,10	T
2366	Posterior repair alone	30	5,000	R600,10	T
2367	Other operations for prolapse: Anterior repair - with or without posterior repair	30	5,000	R600,10	T
2368	Uterovesical fistula	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2369	Repair of Vesico- or urethro-vaginal fistula	30	5,000	R600,10	T
2370	Repair of VVF - Obstetric or radiation	30	5,000	R600,10	T
2371	Closure of uretero-vaginal fistula	30	5,000	R600,10	T
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	30	5,000	R600,10	T
2373	Closure of recto-vaginal fistula	30	5,000	R600,10	T
2374	Closure of recto-vaginal fistula: Obstetric or radiation	30	5,000	R600,10	T
2375	Colpocleisis	30	4,000	R480,30	T
2379	Schauta operation	30	8,000	R959,80	T
2381	Vaginectomy	30	8,000	R959,80	T
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee	30	8,000	R959,80	T
2385	Vaginal laceration or trauma: Repair	30	4,000	R480,30	T
2386	Repair: Paravaginal defect repair (including repair of cystocele, if performed), abdominal approach		3,000	R359,80	T
2387	Repair: Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach		3,000	R359,80	T
2320	Revision of prosthetic vaginal graft or mesh: Laparoscopic revision (including removal)		10,000	R1 199,90	T
2328	Laparoscopic repair of paravaginal defect repair (including repair of cystocele, if performed) (item 1807 may not be added to this item)		8,000	R959,90	T
2337	Colpopexy: Vaginal, extra-peritoneal approach (sacrospinous, iliococcygeus)		5,000	R600,00	T
2338	Colpopexy: Vaginal, intra-peritoneal approach (uretrosacral, levator myorrhaphy)		6,000	R720,00	T
2340	Laparoscopic colpopexy (item 1807 may not be added to this item)		11,000	R1 320,10	T
2344	Vaginal hysterectomy with unilateral/bilateral salpingectomy and/or oophorectomy, without repair		6,000	R720,00	T
2346	Laparoscopic assisted vaginal hysterectomy (LAVH): Uterus <= 200g (item 1807 may not be added to this item)		11,000	R1 320,10	T
2354	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele		6,000	R719,60	T
2358	Colporrhaphy: Anteroposterior, without enterocele repair		3,000	R359,80	T
2360	Insertion of mesh/other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (modifier 0005 not applicable)		6,000	R720,00	T
2362	Repair: Enterocele, vaginal approach (stand alone procedure)		5,000	R600,10	T

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2364	Repair: Enterocele, abdominal approach (stand alone procedure)		5,000	R600,10	T
2380	Vaginectomy, simple, partial: Removal of vaginal wall		8,000	R959,80	T
2382	Radical vaginectomy, complete removal of vaginal wall, with removal of para- vaginal tissue		8,000	R959,80	T
12.3	**Cervix**				
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)				
2391	Cervix: Canal reconstruction	30	3,000	R359,80	T
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room				
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	30	3,000	R359,80	T
2396	Laser or harmonic scalpel treatment of the cervix	30	3,000	R359,80	T
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	30	3,000	R359,80	T
2399	Punch biopsy (excluding after-care)	30	3,000	R359,80	T
2400	Biopsy during pregnancy (excluding after-care)	30	3,000	R359,80	T
2403	Wedge biopsy: Cervix (excluding after-care)	30	3,000	R359,80	T
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	30	3,000	R359,80	T
2405	Cone biopsy: Cervix (excluding after-care)	30	3,000	R359,80	T
2407	Amputation: Cervix	30	3,000	R359,80	T
2409	Cervix encirclage: McDonald stitch	30	3,000	R359,80	T
2411	Cervix encirclage: Shirodkar suture	30	3,000	R359,80	T
2413	Cervix encirclage: Lash	30	3,000	R359,80	T
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic				
2416	Cervix: Removal items 2409 and 2411: With anaesthetic in theatre	30	3,000	R359,80	T
2417	Repair of tears: Emmet repair of tears	30	3,000	R359,80	T
2418	Repair of tears: Sturmdorff repair of tears	30	3,000	R359,80	T
2421	Extirpation of cervical stump: Vaginal	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2423	Extirpation of cervical stump: Abdominal	30	5,000	R600,10	T
2425	Removal of cervical polyps (excluding after-care)	30	3,000	R359,80	T
2427	Removal of cervical myomata	30	3,000	R359,80	T
2429	Colposcopy (excluding after-care)	30	3,000	R359,80	T
2408	Radical trachelectomy, with bilateral total pelvic lymphadenectomy with or without para-aortic lymphadenectomy, vaginal or abdominal approach		3,000	R359,80	T
2410	Cervical cerclage, any route, non-obstetrical (Add 1807 if done by laparoscopy)		3,000	R359,80	T
2422	Removal of cervical stump, vaginal approach; with enterocele/apical repair		5,000	R600,10	T
2424	Removal of cervical stump, abdominal approach; with enterocele/apical repair		5,000	R600,10	T
12.4	**Uterus**				
2432	Hysteroscopic bilateral tubal occlusion with permanent implants (includes hysteroscopy)		3,000	R359,80	T
2433	Embryo transfer	30	4,000	R480,30	T
2434	Endometrial biopsy (excluding after-care)	30	3,000	R359,80	T
2435	Hysterosalpingogram (excluding after-care)	30	3,000	R359,80	T
2436	Hysteroscopy (excluding after-care)	30	3,000	R359,80	T
2437	Hysteroscopy and D&C (excluding after-care)	30	3,000	R359,80	T
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	30	3,000	R359,80	T
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	30	3,000	R359,80	T
2440	Hysteroscopy and polypectomy (excluding after-care)	30	3,000	R359,80	T
2441	Hysteroscopy and myomectomy (excluding after-care)	30	3,000	R359,80	T
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	30	3,000	R359,80	T
2443	Dilatation and curettage (D&C) (excluding after-care)	30	3,000	R359,80	T
2444	Fractional dilatation and curettage (D&C) (excluding after-care)	30	3,000	R359,80	T
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	30	4,000	R480,30	T
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	30	4,000	R480,30	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2448	Termination of pregnancy before 12 weeks	30	4,000	R480,30	T
2449	Evacuation: Missed abortion: Before 12 weeks gestation	30	4,000	R480,30	T
2451	Evacuation: Missed abortion: After 12 weeks gestation	30	4,000	R480,30	T
2452	Termination of pregnancy after 12 weeks - administration of intra/extra amniotic prostaglandin	30	4,000	R480,30	T
2453	Evacuation hydatidiform mole	30	5,000	R600,10	T
2455	Evacuation uterus post-partum	30	6,000	R720,00	T
2461	Ventrosuspension	30	4,000	R480,30	T
2463	Uteroplasty: Strassman	30	6,000	R720,00	T
2465	Uteroplasty: Tompkins	30	6,000	R720,00	T
2467	Myomectomy	30	6,000	R720,00	T
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	30	6,000	R720,00	T
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy - uncomplicated	30	6,000	R828,10	T
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	30	6,000	R828,10	T
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	30	8,000	R959,80	T
2477	Abdominal hysterotomy with or without sterilisation	30	6,000	R720,00	T
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	30	6,000	R720,00	T
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	30	6,000	R720,00	T
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)				
2468	Myomectomy by laparoscopy: Excision of 1 to 4 intramural myomas with total weight of <=200g and/or removal of surface myomas (item 1807 may not be added to this item)		11,000	R1 320,10	T
2470	Laparoscopy: Subtotal abdominal hysterectomy, with or without removal of tube(s), with or without removal of ovary(s)		11,000	R1 320,10	T
2472	Laparoscopy, total abdominal hysterectomy, with or without unilateral or bilateral salpingectomy, and/or oophorectomy		11,000	R1 320,10	T
2474	Total abdominal hysterectomy and bilateral salpingo-oophorectomy and total omentectomy for malignancy		8,000	R959,80	T
2476	Laparoscopy, radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymphnode sampling, with or without salpingectomy, with or without oophorectomy		13,000	R1 559,90	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
12.5	**Fallopian tubes**				
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee				
2481	Insufflation Fallopian tubes (excluding after-care)	30	3,000	R359,80	T
2483	Salpingolysis	30	4,000	R480,30	T
2485	Salpingostomy	30	4,000	R480,30	T
2487	Tuboplasty tubal anastomosis or re-implantation	30	4,000	R480,30	T
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	30	6,000	R720,00	T
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	30	6,000	R720,00	T
2491	Ectopic pregnancy - after 12 weeks	30	6,000	R720,00	T
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	30	5,000	R600,10	T
	Note: Use item 1807 for open procedures performed with a laparoscope instead of item 2493. Item 1807 may only be added once, and may not be charged together with item 2493 for more than one procedure performed laparoscopically				
2493	Diagnostic laparoscopy (excluding after-care)	30	5,000	R600,10	T
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	30	5,000	R600,10	T
2497	Laparoscopy: Plus sterilisation	30	5,000	R600,10	T
2499	Laparoscopy: Plus biopsy (excluding after-care)	30	5,000	R600,10	T
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	30	5,000	R600,10	T
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	30	5,000	R600,10	T
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	30	5,000	R600,10	T
2503	Laparoscopy: Plus ovarian drilling	30	5,000	R600,10	T
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	30	5,000	R600,10	T
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	30	5,000	R600,10	T
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)				
2486	Salpingostomy/salpingoneostomy by laparoscopy (item 1807 may not be added to this item)		9,000	R1 080,40	T
2488	Laparoscopy, tuboplasty, tubal anastomosis or re-implantation - stand alone procedure		9,000	R1 080,40	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2510	Treatment of ectopic pregnancy by laparoscopy, without salpingectomy and/or oophorectomy (item 1807 may not be added to this item)		6,000	R720,00	T
2511	Treatment of ectopic pregnancy by laparoscopy, with salpingectomy and/or oophorectomy (item 1807 may not be added to this item)		6,000	R720,00	T
12.6	**Ovaries**				
2525	Wedge resection of ovaries, unilateral or bilateral	30	4,000	R480,30	T
2527	Removal of ovarian tumour or cyst	30	4,000	R480,30	T
2529	Oophorectomy: Uni- or bilateral	30	4,000	R480,30	T
2531	Ovarian carcinoma debulking and omentectomy	30	6,000	R720,00	T
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	30	6,000	R720,00	T
2530	Resection (initial) of suspected ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and total omentectomy		6,000	R720,00	T
2533	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy, and radical dissection for cytoreduction, with pelvic lymphadenectomy and limited para-aortic lymphadenectomy		6,000	R720,00	T
2534	Resection (tumour cytoreduction) primary of recurrent ovarian, tubal, primary peritoneal, uterine malignancy (intra-abdominal/retroperitoneal tumours) with omentectomy, with or without pelvic or para-aortic lymphadenectomy		6,000	R720,00	T
2526	Transposition of the ovaries				Refer Rule C
12.7	**Miscellaneous procedures**				
2535	Exenteration: Anterior Exenteration	30	8,000	R959,80	T
2537	Exenteration: Posterior Exenteration	30	8,000	R959,80	T
2539	Exenteration: Total	30	8,000	R959,80	T
2541	Presacral neurectomy	30	5,000	R600,10	T
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)		3,000	R359,80	T
2543	Moschowitz operation	30	5,000	R600,10	T
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be used together with this item)	30	5,000	R600,10	T
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	30	5,000	R600,10	T
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach	30	6,000	R720,00	T
2547	Operations for stress incontinence: Burch colposuspension	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2548	Operation for stress incontinence: Use of tape	30	5,000	R600,10	T
2550	Operations for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach	30	5,000	R600,10	T
2551	Laparotomy	30	4,000	R480,30	T
2552	Removal benign retroperitoneal tumour	30	6,000	R720,00	T
2553	Radical removal of malignant retroperitoneal tumour	30	8,000	R959,80	T
2554	Drainage of pelvic abscess per abdomen	30	6,000	R720,00	T
2556	Drainage of pelvic abscess per vagina (refer to item 2341)	30	5,000	R600,10	T
2558	Drainage intra-abdominal abscess: Delayed closure	30	6,000	R720,00	T
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	30	6,000	R720,00	T
2561	Surgery for severe endometriosis (AFS stage 4 - retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	30	6,000	R720,00	T
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	30	6,000	R720,00	T
2565	Implantation hormone pellets (excluding after-care)				
2570	Ligation of internal iliac vessels (when not part of another procedure)	30	8,000	R959,80	T
2566	Insertion of contraceptive hormone delivery implant (excluding aftercare)				
13	**OBSTETRIC PROCEDURES**				
	RULES GOVERNING THIS SECTION				
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.				
13.1	**Pre-natal care and procedures**				
2603	External cephalic version (excluding after-care)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2605	Amniocentesis (excluding after-care)				
2607	Amnioscopy (excluding after-care)				
2609	Intra-uterine transfusion of foetus or cordocentesis				
2610	Tococardiography - pre-natal and intrapartum (including stress and non-stress test: Own machine) (excluding after-care)				
2611	Chorion villus sampling (excluding after-care)				
2599	Pregnancy reduction(s): Multifoetal (MPR)		4,000	R480,30	T
2600	Foeticide (includes ultrasound guidance)		4,000	R480,30	T
2604	Amniocentesis: Therapeutic, amnitoic fluid reduction (includes ultrasound guidance)		4,000	R480,10	T
2606	Cordocentesis (intrauterine): Any method		4,000	R480,10	T
2608	Foetal umbilical cord occlusion (TTTS) (includes ultrasound guidance)		6,000	R720,00	T
2612	Foetal fluid drainage (eg., vesicocentesis, thoracocentesis, paracentesis) (includes ultrasound guidance)		6,000	R720,00	T
2613	Foetal shunt placement (includes ultrasound guidance)		4,000	R480,00	T
13.2	**Confinements**				
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding Caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (6 weeks visit)	30	6,000	R720,00	T
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).	30	6,000	R720,00	T
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)				

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	Global obstetric care includes: • All modes of delivery (including Caesarean) • All inductions of labour (medical or surgical) • Intrapartum paracervical and pudential blocks • Intrapartum amnioscopy • Foetal blood sampling • Application of scalp leads • Symphysiotomy • Repair cervical tears • Correction of uterine inversion • Drainage of vulval haematoma • Repair third degree tear • Repair second degree tear				
	• Repair episiotomy • Resuscitation of newborn by obstetrician • Tracheal intubation • Missed confinement" Global obstetric care excludes: • Prenatal consultations • Prenatal procedures (Items 2603 - 2611) • Emergency hysterectomy for obstetrical reasons • Abdominal operation for repair of ruptured gravid uterus • Intensive care for obstetrical emergencies • Tubal ligation performed as a post-partum procedure • Post-partum complications occurring after discharge from the hospital				
13.3	**Operative procedures (excluding antenatal care)**				
2653	Caesarean-hysterectomy	30	9,000	R1 079,70	T
2657	Post-partum hysterectomy	30	8,000	R959,80	T
2669	Abdominal operation for ruptured gravid uterus: Repair	30	9,000	R1 079,70	T
14	**NERVOUS SYSTEM**				
14.1	**Diagnostic procedures**				
2680	Haemodynamic and autonomic nervous system testing with task Force system-PROFFESIONEL COMPONENTS				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2681	Visual evoked potentials (VEP): Unilateral				
2682	Visual evoked potentials (VEP): Bilateral				
2683	Electro-retinography (Ganzfeld method): Unilateral				
2684	Electro-retinography (Ganzfeld method): Bilateral				
2685	Electro-oculography: Unilateral				
2686	Electro-oculography: Bilateral				
2687	VEP stable condition (photic drive): Unilateral				
2689	VEP stable condition (photic drive): Bilateral				
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP				
	Note: See items 2691 to 2702 under section 17.5.1: Audiometry				
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex				
2704	Neurostimulation, percutaneous: Sacral nerve				
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment				
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming				
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation				
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus				
2709	Full spinogram including bilateral median and posterior-tibial studies				
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)				
2711	Electro-encephalography: Taking of record				
2712	Electro-encephalography: Interpretation				
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications				
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.				
2714	Cisternal puncture and/or intrathecal injections				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2715	8 Hour ambulatory EEG monitoring (Holter): Hire				
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation				
2717	Electromyography: First				
2718	Electromyography: Subsequent				
2719	Overnight polysomnogram and sleep staging: Hire				
2720	Overnight polysomnogram and sleep staging: Interpretation				
2721	Daytime polysomnogram: Hire				
2722	Daytime polysomnogram: Interpretation				
2723	Multiple sleep latency test: Interpretation				
2724	Overnight continuous positive airways pressure (CPAP) titration				
2725	Angiography carotis: Unilateral	30	4,000	R480,30	T
2726	Angiography carotis: Bilateral	30	4,000	R480,30	T
2727	Vertebral artery: Direct needling	30	4,000	R480,30	T
2728	Unattended overnight home-based polysomnogram: Interpretation				
2729	Vertebral catheterisation	30	4,000	R480,30	T
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with item 0714)				
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	30	4,000	R480,30	T
2732	Overnight home-based polysomnogram: Interpretation				
2733	Cortical Stimulation				
2734	Sodium Amytal Testing (WADA test)	30	13,000	R1 559,70	T
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician				
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen				
2739	Ventricular needling without burring: Tapping only	30	4,000	R480,30	T
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	30	4,000	R480,30	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2743	Subdural tapping: First sitting	30	4,000	R480,30	T
2745	Subdural tapping: Subsequent	30	4,000	R480,30	T
2746	Biopsy: Temporal artery				
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record				
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation				
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised sixteen or more channel EEG, which may include video recording (e.g. for pre-operative localisation): Each full 24 hour period				
6011	Interpretation of item 6010: Electro-encephalogram monitoring: To be charged once only for each full 24 hour period of monitoring				
6015	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation				
6016	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation (no EEG) (Technical component)				
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				
6020	Electroencephalogram (EEG): Monitoring; 41-60 minutes				
6021	Electroencephalogram (EEG): Monitoring; 61> minutes				
6023	Electroencephalogram (EEG): All night recording (includes interpretation)				
6024	Functional cortical and subcortical mapping: Stimulation and/or recording of electrodes on brain surface or depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance				
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 60 minutes of attendance (ADD to item 6024 when appropriate)				
6030	Electro-encephalogram (EEG): Monitoring (41-60 minutes): Equipment cost for taking of record (Technical component) (refer to item 6020 for interpretation and				
6031	Electro-encephalogram (EEG): Monitoring (>60 minutes): Equipment cost for taking of record (Technical component) (refer to item 6021 for interpretation and report)				
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)				
2679	Cisternal or lateral cervical (C1-C2) puncture: Injection of medication/toher substance, diagnosis/treatment				Refer Rule C
2680	Haemodynamic and autonomic nervous system testing with 'Task Force' system - PROFESSIONEL COMPONENT				Refer Rule C

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2688	Shunt tubing or reservoir puncture: For aspiration or injection procedure				Refer Rule C
6026	Electronic analysis: Implanted neurostimulator pulse generator system (eg., 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				Refer Rule C
6027	Electronic analysis: Implanted neurostimulator pulse generator system (eg., 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				Refer Rule C
6028	Electronic analysis: Implanted neurostimulator pulse generator system (eg., 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 hour. ADD to primary procedure				Refer Rule C
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)				Refer Rule C
6000	Clinical interpretation and report of item 5999: Actigraphy: Patient monitored for a minimum of 72 hours (Professional component)				Refer Rule C
14.2	**Introduction of burr holes for**				
2747	Ventriculography	30	8,000	R959,80	T
2749	Catheterisation for ventriculography and/or drainage	30	8,000	R959,80	T
2751	Biopsy of brain tumour	30	8,000	R959,80	T
2753	Subdural haematoma or hygroma	30	8,000	R959,80	T
2755	Subdural empyema	30	8,000	R959,80	T
2757	Brain abscess	30	8,000	R959,80	T
2748	Twist drill hole: Subdural or ventricular puncture		8,000	R959,80	T
2750	Twist drill hole(s): Includes subdural, intracerebral, or ventricular puncture for implanting ventricular catheter, pressure recording device or toher intracerebral monitoring device		8,000	R959,80	T
2754	Burr hole(s) or trephine: Includes subsequent tapping (aspiration) of intracranial abscess or cyst		9,000	R1 079,70	T
2758	Insertion: Subcutaneous reservoir, pump/continuous infusion system. Includes connection to ventricular catheter		9,000	R1 079,70	T
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery		8,000	R959,80	T
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral		8,000	R959,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2752	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for evacuation and/or drainage of subdural haematoma				Refer Rule C
2756	Subdural implantation of strip electrodes through one or more burr or trephine hole(s) for long term seizure monitoring				Refer Rule C
14.3	**Nerve procedures**				
2759	Nerve biopsy: Peripheral	30	4,000	R480,30	T
2763	Nerve biopsy: Cranial nerves: Extra-cranial	30	4,000	R480,30	T
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)	30	4,000	R480,30	T
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)				
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)				
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)				
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)				
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)				
2766	Insertion of deep brain stimulator for movement disorders and pain - first side				Refer Rule C
14.3.1	**Nerve procedures: Nerve repair or suture**				
2767	Suture brachial plexus (see also items 2837 and 2839)	30	6,000	R720,00	T
2769	Suture: Large nerve: Primary	30	5,000	R600,10	T
2771	Suture: Large nerve: Secondary	30	5,000	R600,10	T
2773	Digital nerve: Primary	30	3,000	R359,80	T
2775	Digital nerve: Secondary	30	3,000	R359,80	T
2777	Nerve graft: Simple	30	4,000	R480,30	T
2779	Fascicular: First fasciculus	30	4,000	R480,30	T
2781	Fascicular: Each additional fasciculus	30	4,000	R480,30	T
2782	Nerve pedicle transfer: First stage (not to be used together with item 2783)		4,000	R480,10	T
2783	Fascicular: Nerve flap: To include all stages	30	4,000	R480,30	T
2784	Nerve pedicle transfer: Second stage (not to be used together with item 2783)		4,000	R480,10	T

CONTRACTED ANAESTHESIOLOGY FOR ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	30	6,000	R720,00	T
2787	Fascicular: Grafting of facial nerve	30	5,000	R600,10	T
14.3.2	**Nerve procedures: Neurectomy**				
2789	Trigeminal ganglion: Injection of alcohol	30	4,000	R480,30	T
2791	Trigeminal ganglion: Injection of cortisone	30	3,000	R359,80	T
2793	Trigeminal ganglion: Coagulation through high frequency	30	3,000	R359,80	T
2799	Procedures for pain relief: Intrathecal injections for pain	30	4,000	R480,30	T
2800	Procedures for pain relief: Plexus nerve block	20	36,000	R688,20	ç
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) (refer to modifier 0021 for epidural anaesthetic)				
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.				
2802	Procedures for pain relief: Peripheral nerve block	20	25,000	R478,00	ç
2803	Alcohol injection in peripheral nerves for pain: Unilateral	30	3,000	R359,80	T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique)	20	10,000	R190,90	ç
2805	Alcohol injection in peripheral nerves for pain: Bilateral	30	3,000	R359,80	T
2809	Peripheral nerve section for pain	30	3,000	R359,80	T
2811	Pudendal neurectomy: Bilateral	30	3,000	R359,80	T
2813	Obturator or Stoffels	30	3,000	R359,80	T
2815	Interdigital	30	3,000	R359,80	T
2825	Excision: Neuroma: Peripheral	30	3,000	R359,80	T
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)		5,000	R599,70	T
2796	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, each additional level each additional level (unilateral or bilateral)		5,000	R95,60	T
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)		3,000	R359,80	T
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)		5,000	R95,60	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
14.3.3	**Nerve procedures: Other nerve procedures**				
2827	Transposition of ulnar nerve	30	3,000	R359,80	T
2829	Neurolysis: Minor	30	3,000	R359,80	T
2831	Neurolysis: Major	30	3,000	R359,80	T
2833	Neurolysis: Digital	30	3,000	R359,80	T
2834	Neuroplasty: Sciatic nerve		3,000	R359,80	T
2835	Scalenotomy	30	6,000	R720,00	T
2837	Neuroplasty:Brachial Plexus	30	5,000	R599,80	T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	30	6,000	R720,00	T
2841	Carpal Tunnel	30	3,000	R359,80	T
2843	Lumbar sympathectomy: Unilateral	30	4,000	R480,30	T
2845	Lumbar sympathectomy: Bilateral	30	6,000	R720,00	T
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)	30	11,000	R1 319,70	T
2847	Cervical sympathectomy: Unilateral	30	4,000	R480,30	T
2848	Cervical sympathectomy: Bilateral	30	6,000	R720,00	T
2849	Sympathetic block: Other levels: Unilateral	30	3,000	R359,80	T
2851	Sympathetic block: Other levels: Bilateral	30	3,000	R359,80	T
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion	30	4,000	R480,30	T
2854	Insertion of vagus nerve stimulator				Refer Rule C
14.4	**Skull procedures**				
2855	Removal of skull tumour: With or without plastic repair: Small	30	5,000	R600,10	T
2857	Removal of skull tumour: With or without plastic repair: Major	30	8,000	R959,80	T
2859	Repair of depressed fracture of skull: Without brain laceration: Major	30	8,000	R959,80	T
2860	Repair of depressed fracture of skull: Without brain laceration: Small	30	8,000	R959,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2861	Repair of depressed fracture of skull: With brain lacerations: Small	30	8,000	R959,80	T
2862	Repair of depressed fracture of skull: With brain lacerations: Major	30	8,000	R959,80	T
2863	Cranioplasty	30	8,000	R959,80	T
2864	Encephalocele (excluding frontal)	30	8,000	R959,80	T
2865	Craniostenosis: Few suturae	30	9,000	R1 079,70	T
2867	Craniostenosis: Multiple suturae	30	9,000	R1 079,70	T
6035	Craniotomy: Craniosynostosis, frontal or parietal bone flap (total procedure)		11,000	R1 319,70	T
6036	Craniotomy: Craniosynostosis, bifrontal bone flap (ttoal procedure)		11,000	R1 319,70	T
6037	Craniectomy: Extensive for multiple cranial suture craniosynostosis (eg., cloverleaf skull); not requiring bone grafts (ttoal procedure)		11,000	R1 319,70	T
6038	Craniectomy: Extensive for multiple cranial suture craniosynostosis (eg., cloverleaf skull); reconoturing with multiple ostetoomies and bone autografts (eg., barrel-stave procedure) (includes obtaining grafts) (ttoal procedure)		11,000	R1 319,70	T
6040	Craniomegalic skull: Reduction (eg., treated hydrocephalus) not requiring bone grafts or cranioplasty (ttoal procedure)		11,000	R1 319,70	T
6042	Craniomegalic skull: Reduction (eg., treated hydrocephalus), requiring Craniotomy and reconstruction with or without bone graft (includes obtaining grafts) (ttoal procedure)		11,000	R1 319,70	T
6043	Cranioplasty: Skull defect; >5 cm diameter		9,000	R1 079,70	T
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		9,000	R1 079,70	T
6045	Replacement of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/open fracture/late effect of fracture/infection or inflammatory reaction due to device, implant or graft (total procedure)		9,000	R1 079,70	T
6046	Cranioplasty: Skull defect, with reparative brain surgery: With/without prosthesis		11,000	R1 319,70	T
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =		9,000	R1 079,70	T
6048	Cranioplasty: Includes autograft and obtaining bone grafts; >5 cm diameter (ttoal procedure)		9,000	R1 079,70	T
6039	Excision of benign tumour of cranial bone (eg., fibrous dysplasia), intra- and extracranial, with decompression of optic nerve				Refer Rule C
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure				Refer Rule C
14.5	**Shunt procedures**				
2869	Ventriculo-cisternostomy	30	8,000	R959,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2871	Ventriculo-caval shunt	30	11,000	R1 319,70	T
2873	Ventriculo-peritoneal shunt	30	8,000	R959,80	T
2875	Theco-peritoneal C.S.F. shunt	30	8,000	R959,80	T
6063	Ventriculocisternostomy of the third ventricle: Steretoactic, neuroendoscopic method (under CT guidance for steretoactic positioning) (items 6055 and 6148 may not be added)		10,000	R1 199,80	T
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		8,000	R959,80	T
6068	Cerebrospinal fluid (CSF) shunt system: Complete removal, with replacement by similar or toher shunt at same operation		10,000	R1 199,80	T
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure				Refer Rule C
6056	Neuroendoscopy: Intracranial, with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (includes placement, replacement, or removal of ventricular catheter)				Refer Rule C
6057	Neuroendoscopy: Intracranial with fenestration or excision of colloid cyst (includes placement of external ventricular catheter for drainage)				Refer Rule C
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body				Refer Rule C
6059	Neuroendoscopy: Intracranial, with excision of brain tumour (includes placement of external ventricular catheter for drainage)				Refer Rule C
6060	Neuroendoscopy: Intracranial, includes excision of pituitary tumour, transnasal or trans-sphenoidal approach				Refer Rule C
6061	Creation of subarachnoid/subdural-peritoneal shunt: Pleural or peritoneal space or toher terminus, through burr hole and directing and tunneling the distal end of the shunt subcutaneously towards the draining site (non-neuroendoscopic procedure) (ttoal procedure)				Refer Rule C
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (ttoal procedure)				Refer Rule C
6064	Replacement/irrigation: Previously placed intraoperative ventricular catheter				Refer Rule C
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit				Refer Rule C
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)				Refer Rule C
14.6	**Aneurysm repair**				
2876	Repair of aneurysms or arteriovenous anomalies (Intracranial)	30	15,000	R1 799,80	T
2877	Extracranial to intracranial vascular	30	15,000	R1 799,80	T
2878	Posterior fossa arteriovenous anomalies	30	15,000	R1 799,80	T
6075	Intracranial arteriovenous malformation (IAM): Surgery, supratenotrial, complex		15,000	R1 799,80	T

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6076	Intracranial arteriovenous malformation (IAM): Surgical, infratenotrial, complex		15,000	R1 799,80	T
6077	Intracranial arteriovenous malformation (IAM): Surgery, dural, simple		15,000	R1 799,80	T
6078	Intracranial arteriovenous malformation (IAM): Surgery, dural, complex		15,000	R1 799,80	T
6079	Intracranial aneurysm: Complex, intracranial approach, cartoid circulation		15,000	R1 799,80	T
6080	Intracranial aneurysm: Surgical, complex, intracranial approach, vertebrobasilar circulation		15,000	R1 799,80	T
6081	Intracranial aneurysm: Surgical, simple, open posterior cranial fossa approach approach, vertebrobasilar circulation		15,000	R1 799,80	T
6082	Intracranial aneurysm: Surgical, cervical approach by application of occluding clamp to cervical cartoid artery (Selverstone-Crutchfield type)		15,000	R1 799,80	T
6083	Aneurysm: Surgical, for vascular malformation or cartoid-cavernous fistula with intracranial and cervical occlusion of cartoid artery		15,000	R1 799,80	T
14.7	**Craniectomy or Craniotomy**				
2879	Glosso pharyngeal nerve	30	6,000	R720,00	T
2881	Eighth nerve: Intracranial	30	8,000	R959,80	T
2883	Eighth nerve: Extracranial	30	4,000	R480,30	T
2884	Sub-temporal section of the trigeminal nerve	30	9,000	R1 079,70	T
2885	Trigeminal tractotomy	30	9,000	R1 079,70	T
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	30	9,000	R1 079,70	T
2887	Vestibular nerve	30	9,000	R1 079,70	T
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	30	11,000	R1 319,70	T
2891	Posterior fossa tumour removal: Glioma, secondary deposits	30	11,000	R1 319,70	T
2893	Posterior fossa tumour removal: Abscess	30	11,000	R1 319,70	T
2895	Excision of tumour of glomus jugulare: Intracranial	30	11,000	R1 319,70	T
2897	Excision of tumour of glomus jugulare: Extracranial	30	9,000	R1 079,70	T
2898	Excision of tumour of glomus jugulare: Hemispherectomy	30	15,000	R1 799,80	T

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2888	Micro vascular decompression 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 branch is sectioned, bone flap is replaced and fastened (total procedure)		11,000	R1 319,80	T
6085	Craniectomy/craniotomy: With exploration of the infratenotrial area (below the tenotrium of the cerebellum), posterior fossa (ttoal procedure)		13,000	R1 559,70	T
6087	Craniectomy/craniotomy: With drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)		13,000	R1 559,70	T
2892	Micro vascular decompression of cranial nerve (suboccipital)				Refer Rule C
6086	Craniectomy/craniotomy: With evacuation of infratenotrial. intracerebellar haematoma (ttoal procedure)				Refer Rule C
6088	Cranial decompression caused by excess fluid (eg.. blood and pathological tissue). using posterior fossa approach by drilling/sawing through the occipital bone (ttoal procedure)				Refer Rule C
6090	Craniectomy at base of skull (suboccipital): With freeing and section of one or more cranial nerves (ttoal procedure)				Refer Rule C
6091	Craniectomy at base of skull (suboccipital): With mesencephalic tracttoomy or peduncultoomy (resecting a nerve tract as it passes through the mesencephalon or the cerebellar or cerebral peduncle) (ttoal procedure)				Refer Rule C
6092	Craniectomy: With excision of meningioma (neoplasm of meninges) from infratenotrial structures or posterior fossa (ttoal procedure)				Refer Rule C
6093	Craniectomy: With excision of midline brain tumour at base of skull; using posterior auricular or transmastoid approach (ttoal procedure)				Refer Rule C
6094	Craniectomy: With excision or fenestration (creating opening for draining) of cyst in the infratenotrium or posterior fossa (ttoal procedure)				Refer Rule C
6095	Craniectomy (bone flap Craniotomy): With excision of cerebellopontine angle tumour (acoustic neuroma/tumour/vestibular neurofibromatosis (NF1 or NF2)/angle tumour); using transtemporal (mastoid) approach (ttoal procedure)				Refer Rule C
6096	Craniectomy (bone flap Craniotomy): With excision of cerebellopontine angle tumour (acoustic tumour/neuroma; vestibular neurofibromatosis (NF1 or NF2); angle tumour); using combined transtemporal (mastoid) and middle or posterior fossa approach				Refer Rule C
14.7.1	**Posterior fossa surgery: Supratentorial procedures**				
2899	Craniectomy for extra-dural haematoma or empyema	30	11,000	R1 319,70	T
14.8	**Craniotomy for**				
2900	Craniotomy for Extra-dural orbital decompression or excision of orbital tumour	30	11,000	R1 319,70	T
2901	Craniotomy for Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	30	11,000	R1 319,70	T
2903	Craniotomy for Abscess, Glioma	30	11,000	R1 319,70	T
2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	30	11,000	R1 319,70	T

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2905	Craniotomy for Focal epilepsy: Excision of cortical scar	30	11,000	R1 319,70	T
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	30	11,000	R1 319,70	T
2907	Craniotomy for Temporal lobectomy	30	11,000	R1 319,70	T
2908	Craniotomy for Torkildsen anastomosis	30	11,000	R1 319,70	T
2910	Craniotomy for removal of arteriovenous malformation	30	11,000	R1 319,70	T
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)		11,000	R1 319,70	T
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess		11,000	R1 319,70	T
6131	Craniotomy with elevation of bone flap: Lobectomy. temporal lobe. without electrocorticography during surgery(includes removal of electrode array)		11,000	R1 319,70	T
2902	Craniotomy for subdural implantation of strip- and grid electrodes for seizure monitoring and brain mapping				Refer Rule C
6115	Craniectomy/Craniotomy: Supratenotrial exploration				Refer Rule C
6116	Incision and subcutaneous placement of cranial bone graft (eg.. split- or full thickness); shaving graft or bone dust; with donor site already exposed for the main procedure.				Refer Rule C
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				Refer Rule C
6119	Decompressive craniectomy/Craniotomy: With or without duraplasty. for treating intracranial hypertensionwithout evacuation of associated intraparenchymal haematoma. with lobectomy				Refer Rule C
6120	Decompression of (roof of) orbit only: Transcranial approach (ttoal procedure)				Refer Rule C
6121	Exploration of orbit: Transcranial approach with biopsy (ttoal procedure)				Refer Rule C
6123	Cranial decompression: Subtemporal (pseudtoumour cerebri. slit ventricle syndrome)				Refer Rule C
6126	Craniectomy/trephination (bone flap Craniotomy): Supratenotrial excision/fenestration of cyst				Refer Rule C
6127	Implantation. chemotherapy agent: Intracavity. brain intracavitary. ADD to main procedure				Refer Rule C
6128	Implantation. subdural: Strip electrodes through 1 or more burr/trephine hole(s). Long-term seizure monitoring				Refer Rule C
6129	Craniotomy with elevation of bone flap: Subdural implantation of an electrode array. Long-term seizure monitoring				Refer Rule C
6130	Craniotomy with elevation of bone flap: Excision of cerebral epileptogenic focus. Including electrocorticography during surgery (includes removal of electrode array)				Refer Rule C
6132	Craniotomy with elevation of bone flap: Lobectomy. temporal lobe with electrocorticography during surgery				Refer Rule C

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6133	Craniotomy with elevation of bone flap: Lobectomy. toher than temporal lobe. partial or ttoal. with electrocorticography during surgery				Refer Rule C
6134	Craniotomy with elevation of bone flap: Lobectomy. toher than temporal lobe. partial or ttoal. without electrocorticography during surgery				Refer Rule C
6135	Craniotomy with elevation of bone flap: Transection of corpus callosum				Refer Rule C
6136	Craniotomy with elevation of bone flap: Partial or subttoal (functional) hemispherectomy				Refer Rule C
6137	Craniotomy with elevation of bone flap: Excision or coagulation of choroid plexus				Refer Rule C
6138	Craniotomy with elevation of bone flap: Excision of craniopharyngioma				Refer Rule C
6139	Craniotomy with elevation of bone flap: Selective amygdalohippocampectomy				Refer Rule C
6140	Craniotomy with elevation of bone flap: Multiple subpial transections. with electrocorticography during surgery				Refer Rule C
6141	Craniectomy/Craniotomy: Excision of foreign body from brain				Refer Rule C
6142	Craniectomy/Craniotomy: Treatment of penetrating wound of brain				Refer Rule C
14.8.1	**Stereotaxis; Stereotactic Radiosurgery (Cranial); Neurostimulators (Intracranial)**				
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	30	4,000	R480,30	T
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	30	4,000	R480,30	T
2915	Transnasal hypophysectomy	30	11,000	R1 319,70	T
2916	Transfrontal hypophysectomy	30	11,000	R1 319,70	T
2917	Transnasal hypophyseal implants	30	11,000	R1 319,70	T
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)				
6145	Biopsy. stereotactic: Aspiration/excision for intracranial lesion. Includes burr hole(s)		11,000	R1 319,70	T
6155	Stereotactic radiosurgery (particle beam. gamma ray. or linear accelerator): 1 cranial lesion. complex				
6143	Creation of lesion: Globus pallidus or thalamus. steretoactic. includes burr hole(s) and localising and recording techniques. single or multiple stages				Refer Rule C
6144	Creation of lesion: Subcortical structure(s). toher than globus pallidus or thalamus. steretoactic. includes burr hole(s) and localising and recording techniques. single or multiple stages				Refer Rule C
6146	Implantation. steretoactic: Depth electrodes inot the cerebrum for long-term seizure monitoring				Refer Rule C
6147	Localisation. steretoactic: Insertion of catheter(s) or probe(s) for placement of radiation source. Includes burr hole(s)				Refer Rule C
6148	Steretoactic computer-assisted (navigational) procedure: Cranial. intradural. ADD to main procedure				Refer Rule C

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6149	Stereotactic computer-assisted (navigational) procedure: Cranial. extradural. ADD to main procedure				Refer Rule C
6150	Stereotactic computer-assisted (navigational) procedure: Spinal. ADD to main procedure				Refer Rule C
6151	Creation of lesion: Gasserian ganglion. steretoactic. percutaneous. by neurolytic agent (eg.. alcohol. thermal. electrical. radiofrequency)				Refer Rule C
6152	Creation of lesion: Trigeminal medullary tract. stereotactic method. percutaneous. by neurolytic agent (eg.. alcohol. thermal. electrical. radiofrequency)				Refer Rule C
6153	Stereotactic radiosurgery (particle beam. gamma ray. or linear accelerator): 1 cranial lesion. simple				Refer Rule C
6154	Stereotactic radiosurgery (particle beam. gamma ray. or linear accelerator): Each additional cranial lesion. simple. ADD to main procedure				Refer Rule C
6156	Stereotactic radiosurgery (particle beam. gamma ray. or linear accelerator): Each additional cranial lesion. complex. ADD to main procedure				Refer Rule C
6157	Stereotactic radiosurgery: Application of stereotactic headframe. ADD to main procedure				Refer Rule C
6158	Implantation of neurostimulator electrodes: Cortical. twist drill or burr hole(s)				Refer Rule C
6159	Craniectomy/craniotomy: Implantation of neurostimulator electrodes. cerebral. cortical				Refer Rule C
6160	Craniotomy/craniectomy/twist drill/burr hole: Thalamus. globus pallidus. subthalamic nucleus. periventricular. periaqueductal gray). Steretoactic implantation of neurostimulator electrode array in subcortical site. without use of intra-operative microelec				Refer Rule C
6161	Cranitoomy/craniectomy/twist drill/burr hole: Thalamus. globus pallidus. subthalamic nucleus. periventricular. periaqueductal gray). Steretoactic implantation of neurostimulator electrode array in subcortical site. without use of intraoperative microelect				Refer Rule C
6162	Cranitoomy/craniectomy/twist drill/burr hole: Thalamus. globus pallidus. subthalamic nucleus. periventricular. periaqueductal gray). Steretoactic implantation of neurostimulator electrode array in subcortical site. with use of intraoperative microelectrod				Refer Rule C
6163	Cranitoomy/craniectomy/twist drill/burr hole: Thalamus. globus pallidus. subthalamic nucleus. periventricular. periaqueductal gray). Steretoactic implantation of neurostimulator electrode array in subcortical site. with use of intraoperative microelectrod				Refer Rule C
6164	Craniectomy: Implantation of neurostimulator electrodes. cerebellar. cortical				Refer Rule C
6166	Revision/removal: Neurostimulator electrodes. intracranial				Refer Rule C
6167	Insertion/replacement: Cranial neurostimulator pulse generator or receiver with direct or inductive coupling and connection. 1 electrode array				Refer Rule C
6168	Insertion/replacement: Cranial neurostimulator pulse generator or receiver with direct or inductive coupling and connection. => 2 electrode arrays				Refer Rule C
6169	Revision/removal: Neurostimulator pulse generator/receiverof. cranial				Refer Rule C
14.8.2	**Surgery of Skull Base**				
14.8.2.1	**Approach Procedures**				
14.8.2.1.1	**Anterior Cranial Fossa**				

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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.		11,000	R1 319,70	T
6195	Destruction of cartoid aneurysm/arteriovenous malformation (AVM) or cartoid-cavernous fistula by dissection within cavernous sinus		15,000	R1 799,80	T
6170	Transoral approach: Skull base. brain stem or upper spinal cord for biopsy. decompression/excision of lesion and tracheostomy				Refer Rule C
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				Refer Rule C
6172	Insertion/replacement: Cranial neurostimulator pulse generator/receiver with direct or inductive coupling. >2 electrode arrays				Refer Rule C
6173	Revision/removal: Cranial neurostimulator pulse generator/receiver				Refer Rule C
6175	Anterior cranial fossa: Orbitocranial approach. with exposure of the to treat an extradural lesion/defect at the skull base requiring supraorbital ridge ostetoomy (included in the approach procedure) and elevation of the frontal and/or temporal lobes. wit				Refer Rule C
6176	Anterior cranial fossa: Orbitocranial approach. extradural. including supraorbital ridge ostetoomy and elevation of frontal and/or temporal lobe(s). with orbital exenteration				Refer Rule C
6177	Treatment of lesion/defect at the skull base: Bicoronal (scalp incision). transzygomatic (removal of the zygoma) and/or LeFort1 ostetoomy (intraoral approach to fracture the maxilla). with/without internal fixation /without bone graft.				Refer Rule C
14.8.2.1.2	**Middle Cranial Fossa**				
6178	Middle cranial fossa: Pre-auricular approach. Infratemporal . (parapharyngeal space. infratemporal and midline skull base. nasopharynx). with/without disarticulation of the mandible. includes partoidectomy. cranitoomy. decompression and/or mobilisation of				Refer Rule C
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				Refer Rule C
6180	Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and cartoid artery. clivus. basilar artery or petrous apex) including ostetoomy of zygoma. cranitoomy. extra- or intradural elevation of temporal lobe				Refer Rule C
14.8.2.1.3	**Posterior Cranial Fossa**				
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				Refer Rule C
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 cartoid artery				Refer Rule C
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				Refer Rule C

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6184	Posterior cranial fossa: Transpetrosal approach to clivus/foramen magnum. includes ligation of superior petrosal sinus and/or sigmoid sinus				Refer Rule C
14.8.2.2	**Definitive Procedures**				
	Definitive Procedures: The definitive procedure(s) describes the repair. biopsy. resection. or excision of various lesions of the skull base and. when appropriate. primary closure of the dura. mucous membranes. and skin.				
14.8.2.2.1	**Base of Anterior Cranial Fossa**				
6185	Resection/excision neoplastic/vascular/infectious lesion: Base of anterior cranial fossa. extradural				Refer Rule C
6186	Resection/excision of neoplastic. vascular or infectious lesion of base of anterior cranial fossa (includes dural repair. with/without graft). intradural				Refer Rule C
14.8.2.2.2	**Base of Middle Cranial Fossa**				
6187	Resection/excision of neoplastic/vascular/ infectious lesion: Infratemporal fossa. parapharyngeal space. petrous apex. extradural				Refer Rule C
6188	Resection/excision of neoplastic/vascular/infectious lesion: Infratemporal fossa. parapharyngeal space. petrous apex. includes dural repair. with/without graft. intradural				Refer Rule C
6189	Resection/excision of neoplastic. vascular or infectious lesion: Parasellar area. cavernous sinus. clivus or midline skull base. extradural				Refer Rule C
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				Refer Rule C
6192	Transection/ligation: Cartoid artery in cavernous sinus. with repair by anastomosis/graft. ADD to main procedure				Refer Rule C
6193	Transection or ligation. cartoid artery in petrous canal; without repair. ADD to main procedure				Refer Rule C
6194	Transection or ligation. cartoid artery in petrous canal; with repair by anastomosis or graft. ADD to main procedure				Refer Rule C
14.8.2.2.3	**Base of Posterior Cranial Fossa**				
14.8.2.2.4	**Repair and/or Reconstruction of Surgical Defects of Skull Base**				
6196	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary repair. anterior. middle or posterior cranial fossa following surgery of the skull base. by free tissue graft (eg.. pericranium. fascia. tensor fascia lata. adipose tissue. homologous or synthet				Refer Rule C
6197	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary ranterior. middle or posterior cranial fossa following surgery of the skull base; by local or regionalised vascularised pedicle flap or myocutaneous flap (including galea. temporalis. frontalis				Refer Rule C
14.9	**Spinal operations**				
	See section 3.8.7 for laminectomy procedures				
2923	Chordotomy: Unilateral	30	3,000	R359,80	TM

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2925	Chordotomy: Open	30	3,000	R359,80	TM
2927	Rhizotomy: Extradural, but intraspinal	30	3,000	R359,80	TM
2928	Rhizotomy: Intradural	30	3,000	R359,80	TM
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach	30	8,000	R959,80	T
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach	30	8,000	R959,80	T
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach	30	3,000	R359,80	TM
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach	30	8,000	R959,80	T
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach	30	7,000	R839,80	T
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy	30	3,000	R359,80	T
2937	Repair of meningocele, involving nerve tissue	30	9,000	R1 079,70	T
2938	Simple	30	9,000	R1 079,70	T
2939	Excision of arterial vascular malformations and cysts of the spinal cord	30	9,000	R1 079,70	T
2940	Lumbar osteophyte removal	30	3,000	R359,80	TM
2941	Cervical or thoracic osteophyte removal	30	3,000	R359,80	TM
14.10	**Arterial ligations**				
2951	Carotis: Trauma	30	8,000	R959,80	T
2953	Carotis: For aneurysm (AV anomaly)	30	8,000	R959,80	T
2955	Removal of carotid body tumour (without vascular reconstruction)	30	8,000	R959,80	T
14.11	**Medical psychotherapy**				
2957	Individual psychotherapy (specify type): Including play therapy for children: Per short session (20 minutes)				
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session				
2963	Pairs, marriage or sex therapy: Per 20-minute session				
2968	Group therapy: Adults (specify number): Tariff per person per 80-minute session; Children (specify number): Tariff per person per 80-minute session				
2974	Individual psychotherapy (specify type): Including play therapy for children: Per intermediate session (40 minutes)				

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2975	Individual psychotherapy (specify type): Including play therapy for children: Per extended session (60 minutes or longer)				
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session				
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session				
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY				
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				
0079	When a first or follow-up consultation/visit proceeds into or is immediately followed by a medical psychotherapeutic procedure, both the consultation/visit and the psychotherapy codes (items 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)				
99	"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: • Stat test requesting may only be done by the referring practitioner and not by the pathologist. • Specimens must be collected on a stat basis where applicable. • Test must be performed on a stat basis. • Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained. • This modifier will only apply during normal working hours and will never be used in combination with item 4547: After-hours service. "				
14.12	**Physical treatment methods**				
2970	Electro-convulsive treatment (ECT): Each time (See rule Va)	30	3,000	R359,80	T
14.13	Psychiatric examination methods				
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per 60 min session				
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)				
15	**ENDOCRINE SYSTEM**				
15.1	**Thyroid**				
2983	Lobectomy: Partial	30	5,000	R600,10	T
2985	Lobectomy: Total	30	5,000	R600,10	T

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2987	Thyroidectomy: Subtotal	30	5,000	R600,10	T
2989	Thyroidectomy: Total	30	5,000	R600,10	T
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		6,000	R720,00	T
2991	Thyroglossal cyst or fistula excision	30	5,000	R600,10	T
15.2	**Parathyroid**				
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		12,000	R1 440,10	T
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	30	5,000	R600,10	T
2994	Parathyroid: Autotransplantation of parathyriod: ADD to major procedure (modifier 0005 does not apply)		6,000	R720,00	T
15.3	**Adrenals**				
2995	Adrenalectomy: Unilateral	30	9,000	R1 079,70	T
2997	Bilateral exploration of adrenal glands: Including removal	30	11,000	R1 319,70	T
15.4	**Hypophysis**				
2999	Transethmoidal hypophysectomy	30	11,000	R1 319,70	T
3000	Transnasal hypophysectomy (see also item 2915)	30	11,000	R1 319,70	T
15.5	**Endocrine system: General**				
3001	Implantation of pellets (excluding cost of material) (excluding after-care)				
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 prinotut of recording				Refer Rule C
2998	Ambulatory continuous glucose monitoring: Interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours (includes interpretation and report)				Refer Rule C
16	**EYE**				
16.1	**Eye: Procedures performed in rooms**				
	"(a) Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions. (b) Material used is excluded. (c) The fee for photography is not related to the number of photographs taken"				

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16.1.1	**Eye investigations**				
3002	Gonioscopy				
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)				
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)				
3006	Keratometry				
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				
3012	Pre-surgical retinal examination before retinal surgery				
3013	Ocular motility assessment: Comprehensive examination				
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)				
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations				
3038	Sensorimtoor examination: With multiple measurements of ocular deviation; one or btoh eyes (eg.. restrictive or paretic muscle with diplopia) with interpretation and report. for children 7 years and younger				Refer Rule C
16.1.2	**Special eye investigations**				
3005	Endothelial cell count				
3007	Potential acuity measurement				
3008	Contrast sensitivity test				
3010	Orthoptics consultation				
3011	Orthoptic subsequent sessions				
3015	Charting of visual field with manual perimeter				
3016	Retinal threshold test without storage facilities				
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs				
3018	Retinal threshold trend evaluation (additional to item 3017)				
3019	Ocular muscle function with Hess screen or perimeter				
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3022	Digital fluorescein video angiography	30	9,000	R1 079,70	T
3023	Digital indocyanine video angiography	30	9,000	R1 079,70	T
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039				
3025	Electronic tonography				
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum				
3027	Fundus photography				
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye				
3029	Anterior segment microphotography				
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)				
3032	Eyelid and orbit photography				
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians				
3034	Determination of lens implant power per eye				
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged				
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)				
3040	Femtosecond Laser: Hire Fee. For one or btoh eyes done in one session				Refer Rule C
16.2	**Retina**				
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	30	6,000	R720,00	T
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	30	6,000	R720,00	T
3041	Pan retinal photocoagulation (per eye): Done in one sitting	30	6,000	R720,00	T
3044	Removal of encircling band and/or buckling material	30	6,000	R720,00	T
16.3	**Cataract**				
3045	Cataract: Intra-capsular	30	7,000	R839,80	T

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3047	Cataract: Extra-capsular (including capsulotomy)	30	7,000	R839,80	T
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	30	7,000	R839,80	T
3050	Repositioning of intra ocular lens	30	7,000	R839,80	T
3051	Needling or capsulotomy	30	4,000	R480,30	T
3052	Laser capsulotomy	30	4,000	R480,30	T
3057	Removal of lenticulus	30	7,000	R839,80	T
3058	Exchange of intra ocular lens	30	7,000	R839,80	T
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	30	7,000	R839,80	T
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)				
16.4	**Glaucoma**				
3061	Drainage operation	30	6,000	R720,00	T
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	30	6,000	R720,00	T
3063	Cyclocryotherapy or cyclodiathermy	30	6,000	R720,00	T
3064	Laser trabeculoplasty	30	6,000	R720,00	T
3065	Removal of blood from anterior chamber	30	4,000	R480,30	T
3067	Goniotomy	30	7,000	R839,80	T
16.5	**Intra-ocular foreign body**				
3071	Intra-ocular foreign body: Anterior to Iris	30	4,000	R480,30	T
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	30	6,000	R720,00	T
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)				
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	30	5,000	R600,10	T
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	30	5,000	R600,10	T
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	30	5,000	R600,10	T
16.7	**Globe**				
3079	Transcleral biopsy	30	4,000	R480,30	T
3080	Examination of eyes under general anaesthetic where no surgery is done	30	4,000	R480,30	T
3081	Treatment of minor perforating injury	30	6,000	R720,00	T
3083	Treatment of major perforating injury	30	6,000	R720,00	T
3085	Enucleation or Evisceration	30	5,000	R600,10	T
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	30	5,000	R600,10	T
3088	Hydroxyapetite insertion (additional to item 3087)	30	5,000	R600,10	T
3089	Subconjunctival injection if not done at time of operation	30	5,000	R600,10	T
3090	Intra vitreal injection drug	30	4,000	R480,30	T
3091	Retrobulbar injection (if not done at time of operation)	30	4,000	R480,30	T
3092	External laser treatment for superficial lesions				
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	30	6,000	R720,00	T
3094	Implantation of intra vitreal drug delivery system	30	4,000	R480,30	T
3095	Biopsy of vitreous body or anterior chamber contents	30	6,000	R720,00	T
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	30	7,000	R839,80	T
3097	Anterior vitrectomy	30	6,000	R720,00	T
3098	Removal of silicon from globe	30	6,000	R720,00	T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	30	6,000	R720,00	T
3100	Lensectomy done at time of posterior vitrectomy	30	7,000	R839,80	T
16.8	**Orbit**				
3101	Drainage of orbital abscess	30	5,000	R600,10	T
3103	Orbit: Removal of tumour	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3104	Removal orbital prosthesis	30	5,000	R600,10	T
3105	Orbit: Exenteration	30	5,000	R600,10	T
3107	Orbitotomy requiring bone flap	30	5,000	R600,10	T
3108	Eye socket reconstruction	30	5,000	R600,10	T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	30	5,000	R600,10	T
3110	Second stage hydroxyapetite implantation	30	5,000	R600,10	T
16.9	**Cornea**				
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)				
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens as for corneal erosion, ulcer, abrasion or corneal wound.				
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				
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only				
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				
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	30	6,000	R720,00	T
3117	Removal of foreign body: On the basis of fee per consultation	30	4,000	R480,30	T
3118	Curettage of cornea after removal of foreign body (after-care excluded)				
3119	Tattooing	30	4,000	R480,30	T
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)	30	6,000	R720,00	T
3121	Corneal graft (Lamellar or full thickness)	30	6,000	R720,00	T
3122	Epikeratophakia				
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	30	6,000	R720,00	T
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see item 0202)				
3125	Keratectomy	30	6,000	R720,00	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser				
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	30	4,000	R480,30	T
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	30	6,000	R720,00	T
3129	Additional to item 3128 for the use of own diamond knives				
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	30	4,000	R480,30	T
3131	Cornea: Paracentesis	30	4,000	R480,30	T
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	30	6,000	R720,00	T
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure	30	4,000	R480,30	T
3136	Conjunctival flap or graft (not for use with pterigium surgery)	30	6,000	R720,00	T
3138	Removal corneal epithelium and chelating agent for band keratopathy	30	4,000	R480,30	T
4980	Corneal transplant: Endothelial		3,000	R359,80	T
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)				
4985	Corneal cross linking		3,000	R359,80	T
4986	Cross linking equipment hire				
16.10	**Ducts**				
3133	Probing and/or syringing, per duct	30	4,000	R480,30	T
3135	Insert polythene tubes	30	4,000	R480,30	T
3137	Excision of lacrimal sac: Unilateral	30	4,000	R480,30	T
3139	Dacrocystorhinostomy (Single) with or without polythene tube	30	5,000	R600,10	T
3141	Sealing Punctum surgical or by cautery: Per eye	30	4,000	R480,30	T
3142	Sealing Punctum with plugs: Per eye	30	4,000	R480,30	T
3143	Three-snip operation	30	4,000	R480,30	T
3145	Repair of caniculus: Primary procedure	30	4,000	R480,30	T
3147	Repair of caniculus: Secondary procedure	30	4,000	R480,30	T

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16.11	**Iris**				
3149	Iridectomy or iridotomy by open operation as isolated procedure	30	4,000	R480,30	T
3151	Excision of iris tumour	30	6,000	R720,00	T
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	30	4,000	R480,30	T
3155	Iridocyclectomy for tumour	30	6,000	R720,00	T
3157	Division of anterior synechiae as isolated procedure	30	4,000	R480,30	T
3158	Repair iris as in dialysis: Anterior chamber reconstruction	30	4,000	R480,30	T
16.12	**Lids**				
3161	Tarsorrhaphy	30	4,000	R480,30	T
3163	Excision of superficial lid tumour	30	4,000	R480,30	T
3165	Repair of skin laceration lid: Simple	30	4,000	R480,30	T
3167	Diathermy to wart on lid margin	30	4,000	R480,30	T
3169	Electrolysis of any number of eyelashes: Per eye				
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see item 0202)	30	4,000	R480,30	T
3173	Epicanthal folds	30	4,000	R480,30	T
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)				
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)				
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	30	4,000	R480,30	T
3168	Removal of foreign body: Embedded, per eyelid (modifier 0005 is applicable)		3,000	R359,80	T
16.12.1	Lids: Entropion or ectropion by				
3177	Entropion or ectropion by Cautery	30	4,000	R480,30	T
3179	Entropion or ectropion by Suture	30	4,000	R480,30	T
3181	Entropion or ectropion by Open operation	30	4,000	R480,30	T
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	30	4,000	R480,30	T

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16.12.2	Lids: Reconstruction of eyelid				
3185	Staged procedure for partial or total loss of eyelid: First stage	30	4,000	R480,30	T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	30	4,000	R480,30	T
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	30	4,000	R480,30	T
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	30	4,000	R480,30	T
3172	Blepharoplasty lower eyelid plus fat pad	30	4,000	R480,30	T
16.12.3	Lids: Ptosis				
3193	Repair by superior rectus, levator or frontalis muscle operation	30	4,000	R480,30	T
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	30	4,000	R480,30	T
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	30	4,000	R480,30	T
16.13	**Conjunctiva**				
3199	Repair of conjunctiva by grafting	30	4,000	R480,30	T
3200	Repair of lacerated conjunctiva	30	4,000	R480,30	T
16.14	**Eye: General**				
	“OWN EQUIPMENT USED IN TREATMENT: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.”				
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting				
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of the indicated amount per minute may be charged				
3196	Diamond knife: Use of own diamond knife during intraocular surgery				
3198	Excimer laser: Hire fee (per eye)				
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting (Not to be used with IOL Master)				
3202	Phako emulsification apparatus: Hire fee				
3203	Vitrectomy apparatus: Hire fee				
3208	Biopsy: External auditory canal		3,000	R359,80	T

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17	**EAR**				
	Fitting / orientation / checking of a hearing aid: report this service using the appropriate consultation code				
	Repair / modification of hearing aid: report this service using item 0201 and supply invoice				
17.1	**External ear (Pinna)**				
	Fitting / orientation / checking of a hearing aid: report this service using the appropriate consultation code				
	Repair / modification of hearing aid: report this service using 0201 and supply invoice				
3267	Major congenital deformity reconstruction of external ear: Unilateral	30	5,000	R600,10	T
3269	Major congenital deformity reconstruction of external ear: Bilateral	30	5,000	R600,10	T
3270	Excision of superficial pre-auricular fistula	30	4,000	R480,30	T
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear				
3272	Excision of complicated pre-auricular fistula	30	4,000	R480,30	T
5170	Drainage: Haematoma or abscess of external ear		3,000	R359,80	T
5173	Biopsy: External ear		3,000	R359,80	T
5175	Excision: External ear, partial, simple repair		3,000	R359,80	T
5176	Excision: External ear, complete		3,000	R359,80	T
5171	Drainage: Abscess of external auditory canal		3,000	R359,80	T
17.2	**External ear canal**				
3204	External ear canal: Removal of foreign body: At rooms				
3205	External ear canal: Removal of foreign body: Under general anaesthetic	30	4,000	R480,30	T
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	30	4,000	R480,30	T
3217	Meatus atresia: Congenital	30	4,000	R480,30	T
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) - not to be used combined with item 3206				
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	30	4,000	R480,30	T
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) - not to be used combined with item 3206		3,000	R359,80	T

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3221	Meatus atresia: Removal of osteoma from meatus: Multiple	30	4,000	R480,30	T
3216	Excision: Radical, external auditory canal lesion, without neck dissection				Refer Rule C
3222	Excision: Radical, external auditory canal lesion, with neck dissection				Refer Rule C
17.3	**Middle ear**				
3206	Microscopic examination of tympanic membrane including microsuction				
3207	Myringotomy: Unilateral	30	4,000	R480,30	T
3209	Myringotomy: Bilateral	30	4,000	R480,30	T
3211	Unilateral myringotomy with insertion of ventilation tube	30	4,000	R480,30	T
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	30	4,000	R480,30	T
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	30	4,000	R480,30	T
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	30	5,000	R600,10	T
3237	Exploratory tympanotomy	30	5,000	R600,10	T
3242	Fenestration: Revision		3,000	R359,80	T
3243	Myringoplasty	30	5,000	R600,10	T
3245	Functional reconstruction of tympanic membrane	30	5,000	R600,10	T
3249	Stapedotomy and stapedectomy	30	5,000	R600,10	T
3257	Cortical mastoidectomy	30	5,000	R600,10	T
3259	Radical mastoidectomy (excluding minor procedures)	30	5,000	R600,10	T
3261	Muscle grafting to mastoid cavity without tympanoplasty	30	5,000	R600,10	T
3263	Autogenous bone graft to mastoid cavity	30	5,000	R600,10	T
3264	Tympanomastoidectomy	30	5,000	R600,10	T
3265	Reconstruction of posterior canal wall, following radical mastoid	30	5,000	R600,10	T
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	30	5,000	R600,10	T
5190	Debridement: Mastoidectomy cavity, complex (anaesthesia/more than routine cleaning)		5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5193	Implantation/replacement: Electromagnetic temporal bone conduction hearing device		3,000	R359,80	T
5201	Revision: Mastoidectomy resulting in ttoal mastoidectomy		5,000	R600,10	T
5202	Revision: Mastoidectomy resulting in modified radical mastoidectomy		5,000	R600,10	T
5203	Revision: Mastoidectomy followed by tympanoplasty		5,000	R600,10	T
5204	Revision: Mastoidectomy, with apicectomy		5,000	R600,10	T
5191	Tympanolysis: Transcanal				Refer Rule C
5194	Removal/repair: Electromagnetic temporal bone conduction hearing device				Refer Rule C
17.4	**Facial nerve**				
17.4.1	**Facial nerve: Facial nerve tests**				
3223	Percutaneous stimulation of the facial nerve	30	4,000	R480,30	T
3224	Electroneurography (ENOG)	30	4,000	R480,30	T
17.4.2	**Facial nerve: Facial nerve surgery**				
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	30	5,000	R600,10	T
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)	30	5,000	R600,10	T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	30	5,000	R600,10	T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	30	6,000	R720,00	T
17.5	**Inner ear**				
17.5.1	**Inner ear: Audiometry**				
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral				
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral				
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels				
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels				
2695	Audiology 40Hz response: Unilateral				
2696	Audiology 40Hz response: Bilateral				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2697	Mid- and long latency auditory evoked potentials: Unilateral				
2698	Mid- and long latency auditory evoked potentials: Bilateral				
2699	Electro-cochleography: Unilateral				
2700	Electro-cochleography: Bilateral				
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	30	4,000	R480,30	T
3248	Otoacoustic emission performed as a screening test				
3250	Otoacoustic emission (high risk patients only)				
3273	Pure tone audiometry (air conduction)				
3274	Pure tone audiometry (bone conduction with masking)				
3275	Impedance audiometry (tympanometry)				
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.				
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score				
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)				
17.5.2	**Inner ear: Balance tests**				
3251	Minimal caloric test (excluding consultation fee)				
3252	Bithermal Halpike caloric test (excluding consultation fee)				
3253	Electro-nystagmography for spontaneous and positional nystagmus				
3254	Video nystagmoscopy (monocular)				
3255	Caloric test done with electronystamography				
3256	Video nystagmoscopy (binocular)				
3258	Otolith repositioning manoeuvre	30	4,000	R480,30	T
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems				
5210	Nystagmus test: Spontaneous, including gaze and fixation nystagmus (report included)				
5211	Nystagmus test: Positional, minimum of 4 positions (report included)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5212	Caloric vestibular test: Each irrigation (report included)				
5213	Nystagmus test: Optokinetic bidirectional, foveal or peripheral stimulation (report included)				
5216	Posturography: Dynamic, computerised				
5214	Oscillating tracking test (report included)				Refer Rule C
5215	Rotational testing: Sinusoidal vertical axis				Refer Rule C
17.5.3	Middle and Inner Ear Surgery				
3233	Labyrinthectomy via the middle ear or mastoid	30	5,000	R600,10	T
3240	Endolymphatic sac surgery	30	4,000	R480,30	T
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	30	5,000	R600,10	T
3246	Cochlear implant surgery	30	5,000	R600,10	T
5196	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy		3,000	R359,80	T
5197	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy		3,000	R359,80	T
5199	Revision: Stapedectomy or stapedotomy		3,000	R359,80	T
3241	Fenestration: Semicircular canal				Refer Rule C
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: Exploration of the labyrinthine segment	30	5,000	R600,10	T
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	30	11,000	R1 319,70	T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	30	11,000	R1 319,70	T
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	30	11,000	R1 319,70	T
17.6.2	**Microsurgery of the skull base: Translabyrinthe approach**				
3239	Acoustic neuroma removal translabyrinthine	30	5,000	R600,10	T
5227	Cochleo-vestibular neurectomy	30	11,000	R1 319,70	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5228	Nerve section: Vestibular, transcranial approach (approach 1): Graft harvesting not included		11,000	R1 319,70	T
17.6.3	**Microsurgery of the skull base: Transotic approach to the cerebellopontime angle**				
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	30	11,000	R1 319,70	T
17.6.5	**Microsurgery of the skull base: Intratemporal fossa approach type B**				
5238	Removal of tumour of the petrous apex	30	11,000	R1 319,70	T
17.6.6	**Microsurgery of the skull base: Intrafemoral approach type C**				
5242	Removal of nasopharyngeal angiofibroma or carcinoma	30	8,000	R959,80	T
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	30	11,000	R1 319,70	T
17.6.7	**Microsurgery of the skull base: Subtotal petrosectomy**				
5246	Subtotal petrosectomy for removal of temporal bone tumour	30	11,000	R1 319,70	T
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	30	11,000	R1 319,70	T
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	30	11,000	R1 319,70	T
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	30	8,000	R959,80	T
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	30	8,000	R959,80	T
18	**PHYSICAL TREATMENT**				
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)				
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)				
3281	Ultrasonic therapy				
3282	Shortwave diathermy				
3284	Sensory nerve conduction studies				
3285	Motor nerve conduction studies				
3287	Spinal joint and ligament injection				

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3288	Epidural injection				
3289	Multiple injections: First joint				
3290	Multiple injections: Each additional joint				
3291	Tendon or ligament injection				
3292	Aspiration of joint or inter-articular injection				
3293	Aspiration or injection of bursa or ganglion				
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389)				
3295	Paravertebral root block: Unilateral				
3296	Paravertebral root block: Bilateral				
3297	Manipulation of spine performed by a specialist in Physical Medicine				
3298	Spinal traction				
3299	Manipulation of large joints: Under general anaesthesia	30	3,000	R359,80	T
3299a	Manipulation of large joints: Under general anaesthesia	30	4,000	R480,30	T
3300	Manipulation of large joints: Without anaesthetic				
3301	Muscle fatigue studies				
3302	Strength duration curve per session				
3303	Electromyography				
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 initial treatment: A fee for the treatment only, is applicable: See general rules L and M)				
	SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT				
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)				
5431	Physical status modifier: Normal health patient, ASA 1: Add 0.00 anaesthetic units				
5432	Physical status modifier: A patient with mild systemic disease, ASA 2: Add 0,00 anaesthetic units				
5436	Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes ASA 6: Add 0,00 anaesthetic units				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
19	**RADIOLOGY**				
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values				
	RULES GOVERNING THE SECTION RADIOLOGY				
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used				
Z.	No fee is subject to more than one reduction				
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””).				
	MODIFIERS GOVERNING THE SECTION				
0080	Multiple examinations: Full Fee				
0081	Repeat examinations: No reduction				
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.				
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used				
0084	Charging for films and thermal paper by non-radiologist: in the case of radiological services rendered by non-radiologists where films, thermal paper or magnetic media are used, these media is charged for according to the film price of 2007, as compiled by the Radiological Society of South Africa (this list is available on request at radsoc@iafrica.com)				
19.1	**Skeleton**				
19.1.1	**Skeleton: Limbs**				
3305	Finger, toe				
3309	Smith-Petersen or equivalent control, in theatre				
3311	Stress studies, e.g, joint				
3313	Full length study, both legs				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3315	Skeletal survey under 5 years				
3317	Skeletal survey over 5 years				
3319	Arthrography per joint				
3320	Introduction of contrast medium or air: ADD				
6500	Hand				
6501	Wrist (specify region)				
6503	Scaphoid				
6504	Radius and ulna				
6505	Elbow				
6506	Humerus				
6507	Shoulder				
6508	Acromio-Clavicula joint				
6509	Clavicle				
6510	Scapula				
6511	Foot				
6512	Ankle				
6513	Calcaneus				
6514	Tibia and fibula				
6515	Knee				
6516	Patella				
6517	Femur				
6518	Hip				
6519	Sesamoid Bone				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
19.1.2	**Skeleton: Spinal column**				
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic				
3325	Stress studies				
3329	Scoliosis studies				
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)				
3333	Myelography: Lumbar	30	4,000	R480,30	T
3334	Myelography: Thoracic	30	4,000	R480,30	T
3335	Myelography: Cervical	30	4,000	R480,30	T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	30	4,000	R480,30	T
3344	Introduction of contrast medium				
3345	Discography	30	4,000	R480,30	T
3347	Introduction of contrast medium per disc level: ADD				
19.1.3	**Skeleton: Skull**				
3349	Skull studies				
3351	Paranasal sinuses				
3353	Facial bones and/or orbits				
3355	Mandible				
3357	Nasal bone				
3359	Mastoid: Bilateral				
3361	Teeth: One quadrant				
3363	Teeth: Two quadrants				
3365	Teeth: Full mouth				
3366	Teeth: Rotation tomography of the teeth and jaws				
3367	Teeth: Tempero-mandibular joints: Per side				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3369	Teeth: Tomography: Per side				
3371	Localisation of foreign body in the eye				
3381	Ventriculography	30	4,000	R480,30	T
3385	Post-nasal studies: Lateral neck				
3387	Maxillo-facial cephalometry				
3389	Dacrocystography	30	4,000	R480,30	T
3391	For introduction of contrast medium: ADD				
19.2	**Alimentary tract**				
3393	Bowel washout: ADD				
3395	Sialography (plus 80% for each additional gland)	30	4,000	R480,30	T
3397	Introduction of contrast medium (plus 80% for each additional gland: ADD)				
3399	Pharynx and oesophagus				
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through				
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)				
3409	Barium enema (control film of abdomen included)				
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included	30	4,000	R480,30	T
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included	30	4,000	R480,30	T
	Note: For items 3415 and 3416: Endoscopy (see item 1778)				
3417	Gastric/oesophageal/duodenal intubation control				
3419	Gastric/oesophageal intubation insertion of tube: ADD				
3421	Duodenal intubation: Insertion of tube: ADD				
19.3	**Biliary tract**				
3425	Oral cholecystography				
3427	Cholangiography: Intravenous				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3431	Operative cholangiography: First series: ADD item 3607 only when the Radiologist attends personally in theatre				
3433	Post operative: T-tube				
3435	Introduction of contrast medium: ADD				
3437	Trans hepatic, percutaneous				
3439	Introduction of contrast medium: ADD				
3441	Tomography of biliary tract: ADD				
19.4	**Chest**				
3443	Larynx (Tomography included)				
3445	Chest (item 3601 included)				
3447	Chest and cardiac studies (item 3601)				
3449	Ribs				
3451	Sternum or sterno-clavicular joints				
3453	Bronchography: Unilateral	30	8,000	R959,80	T
3455	Bronchography: Bilateral	30	8,000	R959,80	T
3461	Pleurography	30	3,000	R359,80	T
3465	Laryngography				
3467	For introduction of contrast medium: ADD				
3468	Thoracic inlet				
19.5	**Abdomen**				
3477	Control films of the Abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)				
3479	Acute abdomen or equivalent studies				
19.6	**Urinary tract**				
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)				
3493	Waterload test: ADD				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3497	Cystography only or urethrography only (retrograde)				
3499	Cysto-urethrography: Retrograde				
3503	Cysto-urethrography: Introduction of contrast medium				
3505	Retrograde-prograde pyelography	30	3,000	R359,80	T
3511	Aspiration renal cyst				
19.7	**Gynaecology and obstetrics**				
3515	Pregnancy				
3517	Pelvimetry				
3519	Hystero-salpingography	30	3,000	R359,80	T
3521	Introduction of contrast medium: ADD				
19.8	**Vascular studies**				
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): c. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). 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). d. The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. e. 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 fee at their respective full rates as per modifiers and the applicable items. f. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note : Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)				
	MODIFIER GOVERNING VASCULAR STUDIES				
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations				
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)				

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6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)				
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure				
6305	When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value				
19.8.1	**Vascular studies: Film Series**				
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.				
3545	Venography: Per limb				
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)				
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	30	4,000	R480,30	T
3558	Translumbar aortic puncture, with full study	30	5,000	R600,10	T
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram	30	4,000	R480,30	T
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram	30	4,000	R480,30	T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	30	4,000	R480,30	T
3564	Direct femoral arterial or venous or jugular venous puncture				
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	30	5,000	R600,10	T
3569	Intravascular pressure studies, arterial or venous, once off per case				
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	30	5,000	R600,10	T
3572	Transcatheter selective blood sampling, arterial or venous				
3574	Spinal angiogram (global fee) including all selective catheterisations	30	5,000	R600,10	T
19.8.2	**Vascular studies: Introduction of contrast medium**				
3563	Direct intravenous for limb				
3575	Cut-downs for venography: ADD				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
19.9	**Tomography and cinematography**				
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values				
19.9.1	**Tomography and cinematography: Computed Tomography**				
3592	Where a fully digital C-arm portable x-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour				
6403	CT limb uncontrasted	30	5,000	R600,10	T
6404	CT limb with contrast only	30	5,000	R600,10	T
6405	CT limb pre- AND post contrast	30	5,000	R600,10	T
6406	CT joint uncontrasted	30	5,000	R600,10	T
6407	CT joint with contrast only	30	5,000	R600,10	T
6408	CT joint pre AND post contrast	30	5,000	R600,10	T
6409	CT brain uncontrasted (including posterior fossa)	30	5,000	R600,10	T
6410	CT brain with contrast only (including posterior fossa)	30	5,000	R600,10	T
6411	CT brain pre AND post contrast (including posterior fossa)	30	5,000	R600,10	T
6412	CT orbits complete study, axial OR coronal, uncontrasted	30	5,000	R600,10	T
6413	CT orbits complete study, axial AND coronal, uncontrasted	30	5,000	R600,10	T
6414	CT orbits complete study, axial OR coronal pre AND post contrast	30	5,000	R600,10	T
6415	CT orbits complete study, axial AND coronal pre AND post contrast	30	5,000	R600,10	T
6416	CT paranasal sinuses limited study axial OR coronal	30	5,000	R600,10	T
6417	CT paranasal sinuses limited study axial AND coronal	30	5,000	R600,10	T
6418	CT paranasal sinuses complete study, axial or coronal, uncontrasted	30	5,000	R600,10	T
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	30	5,000	R600,10	T
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	30	5,000	R600,10	T
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	30	5,000	R600,10	T
6422	CT pituitary fossa, uncontrasted	30	5,000	R600,10	T

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6423	CT pituitary fossa, pre AND post contrast	30	5,000	R600,10	T
6424	CT internal auditory meati, uncontrasted	30	5,000	R600,10	T
6425	CT internal audiory meati, pre AND post contrast	30	5,000	R600,10	T
6426	CT mastoids	30	5,000	R600,10	T
6427	CT ear structures, limited study	30	5,000	R600,10	T
6428	CT middle AND inner ear, complete study including reconstructions	30	5,000	R600,10	T
6429	CT facial bones	30	5,000	R600,10	T
6430	CT neck soft tissue, uncontrasted	30	5,000	R600,10	T
6431	CT neck soft tissue with contrast only	30	5,000	R600,10	T
6432	CT neck pre AND post contrast	30	5,000	R600,10	T
6433	CT cervical spine uncontrasted	30	5,000	R600,10	T
6434	CT cervical spine pre AND post contrast	30	5,000	R600,10	T
6435	CT cervical spine post myelogram	30	5,000	R600,10	T
6436	CT dorsal spine uncontrasted	30	5,000	R600,10	T
6437	CT dorsal spine pre AND post contrast	30	5,000	R600,10	T
6438	CT dorsal spine post myelogram	30	5,000	R600,10	T
6439	CT lumbar spine uncontrasted	30	5,000	R600,10	T
6440	CT lumbar spine pre AND post contrast	30	5,000	R600,10	T
6441	CT lumbar spine post myelogram	30	5,000	R600,10	T
6442	CT pelvimetry (topogram only)	30	5,000	R600,10	T
6443	CT chest uncontrasted	30	5,000	R600,10	T
6444	CT chest with contrast	30	5,000	R600,10	T
6445	CT chest pre AND post contrast	30	5,000	R600,10	T
6446	CT chest high resolution lungs, limited study	30	5,000	R600,10	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6447	CT high resolution lungs, complete study	30	5,000	R600,10	T
6448	CT abdomen uncontrasted	30	5,000	R600,10	T
6449	CT abdomen with contrast	30	5,000	R600,10	T
6450	CT abdomen pre AND post contrast	30	5,000	R600,10	T
6451	CT abdomen triphasic study	30	5,000	R600,10	T
6452	CT pelvis uncontrasted	30	5,000	R600,10	T
6453	CT pelvis with contrast	30	5,000	R600,10	T
6454	CT pelvis pre AND post contrast	30	5,000	R600,10	T
6455	CT abdomen AND pelvis uncontrasted	30	5,000	R600,10	T
6456	CT abdomen AND pelvis with contrast	30	5,000	R600,10	T
6457	CT abdomen AND pelvis pre AND post contrast	30	5,000	R600,10	T
6458	CT chest, abdomen AND pelvis with contrast	30	5,000	R600,10	T
6459	CT base of skull to symphysis pubis with contrast	30	5,000	R600,10	T
6460	CT for dental implants maxilla OR mandible		5,000	R600,10	T
6461	CT for dental implants maxilla AND mandible		5,000	R600,10	T
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)	30	5,000	R600,10	T
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	30	5,000	R600,10	T
6464	CT limited study, any region. Region to be identified on the account	30	5,000	R600,10	T
6465	CT guidance for aspiration, biopsy or drainage	30	11,000	R1 319,70	T
6467	CT stereotactic localisation for biopsy	30	11,000	R1 319,70	T
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast	30	5,000	R600,10	T
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast	30	5,000	R600,10	T
19.10	**Radiology: Miscellaneous**				
3594	Mammogram of surgically removed breast biopsy specimen				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3600	Peripheral bone densitometry utilizing ionizing radiation				
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445 and 3447)				
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD				
3603	Sinography				
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)				
3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This item may not be used together with an item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, item 3629 is used				
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour				
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 fee or examination performed (Only to be used by radiological technical staff)				
3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position	30	3,000	R359,80	T
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done				
3611	Foreign body localisation: Introduction of sterile needle markers: ADD				
3613	Setting of sterile trays				
5029	Mammotome - stereotaxis: Hand held				
5034	Fine needle aspiration or biopsy or core biopsy of mamma	30	6,000	R720,00	T
5027	Downloading and perusal of digital radiological images			R0,00	
19.10.2	**Radiology: Miscellaneous: Mammography**				
19.11	**Ultrasound investigations**				
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values				
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.				
3596	Intravascular ultrasound per case, arterial or venous, for intervention				
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	30	5,000	R600,10	T
3612	Ultrasonic bone densitometry				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3614	Transvaginal aspiration of ova				
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment				
3616	Contrast media: General Rule Y applies				
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment				
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)				
3619	Intravascular ultrasound imaging assesses the atheroschlerotic 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	30	9,000	R1 079,70	T
3620	Cardiac examination plus Doppler colour mapping				
3621	Cardiac examination (MMode)				
3622	Cardiac examination: 2 Dimensional				
3623	Cardiac examination + effort				
3624	Cardiac examinations + contrast				
3625	Cardiac examinations + doppler				
3626	Cardiac examination + phonocardiography				
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)				
3628	Renal tract				
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.				
3631	Ophthalmic examination				
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034				
3633	Neonatal head scan				
3634	Peripheral vascular study, B mode only				
3635	+ Doppler				
3636	Trans-oesophageal echocardiography including passing the device				
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5026	Ultrasound guided amniocentesis	30	6,000	R720,00	T
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe				
5101	Pleural space ultrasound				
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint				
5103	Ultrasound soft tissue, any region		7,590	R911,10	T
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy				
5107	Ultrasound after 24 weeks - motivation required				
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)				
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy				
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)				
5112	Peripheral arterial ultrasound vascular study: B mode, pulsed and colour Doppler; per limb; to include waveforms at minimum of three levels, pressure studies at two levels and full interpretation of results				
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis				
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				
5115	Intra-operative ultrasound study	30	3,000	R359,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure				
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 desending), Circumflex or Right coronary artery]). May be used a maximum of twice per angiographic procedure				
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS				
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Real-time): Fee for part examined plus 30% of the units				
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units				
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%				
	GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY				
EE.	Ultrasound examinations: The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: (a) The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. (b) In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). (c) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account 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 medical scheme 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				
19.12	**Portable unit examinations**				
3639	Where portable X-ray unit is used in the hospital or theatre: ADD				
3640	Theatre investigations with fixed installation				
19.13	**Diagnostic procedures requiring the use of radio-isotopes**				
AA.	Procedures to exclude cost of isotope				
3641	Tracer test				
3642	Repeat of further tracer tests for same investigation: Half of above fee				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee				
3644	Tracer test of complete body or brain tumour location				
3645	Other organ scanning with use of relevant radio isotopes				
3646	Thyroid scanning				
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera				
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera				
19.14	**Interventional radiological procedures**				
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). 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). b. The machine fee (items 3536 to 3550) may only be billed for as a once off fee 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 fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note : Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)				
	Note: In regard to multiple examinations see modifier 0080				
5002	Percutaneous transluminal angioplasty: Aortic/IVC	30	13,000	R1 559,70	T
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel	30	13,000	R1 559,70	T
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial	30	13,000	R1 559,70	T
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial	30	13,000	R1 559,70	T
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic	30	13,000	R1 559,70	T
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral - stand alone procedure	30	13,000	R1 559,70	T

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5014	Atherectomy (per vessel)				
5016	Aspiration thrombectomy (per vessel)				
5017	Endoscopic ultrasound: Colon				
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite	30	5,000	R600,10	T
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy				
5021	Proctosigmoidoscopy with endoscopic ultrasound examination				
5022	Embolisation non-intracranial, per vessel	30	9,000	R1 079,70	T
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy				
5024	Endoscopic ultrasound: Oesophagus				
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy				
5030	Percutaneous nephrostomy for further procedure or drainage	30	6,000	R720,00	T
5031	Antegrade ureteric stent insertion	30	6,000	R720,00	T
5033	Percutaneous cystostomy in radiology suite				
5035	Urethral balloon dilatation in radiology suite				
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality				
5037	Urethral stenting in radiology suite				
5038	Intracranial/spinal AVM embolisation (per session)	30	13,000	R1 559,70	T
5039	Intracranial thrombolysis (on-table) per session	30	13,000	R1 559,70	T
5040	Intracranial aneurysm occlusion	30	13,000	R1 559,70	T
5041	Balloon occlusion/Wada test	30	9,000	R1 079,70	T
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation	30	13,000	R1 559,70	T
5043	Intracranial angioplasty	30	13,000	R1 559,70	T
5044	Transhepatic portogram	30	9,000	R1 079,70	T
5045	Hepatic arterial infusion catheter insertion	30	6,000	R720,00	T

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5046	Percutaneous biliary drainage (external)	30	9,000	R1 079,70	T
5047	Combined internal/external biliary drainage	30	9,000	R1 079,70	T
5048	Biliary stent insertion	30	9,000	R1 079,70	T
5049	Percutaneous gall bladder drainage	30	9,000	R1 079,70	T
5050	Percutaneous or renal gall bladder stone removal	30	5,000	R600,10	T
5058	Stent insertion: Aortic/IVC - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5060	Stent insertion: Iliac/subclavian/AV fistula - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5064	Stent insertion: Sub-popliteal - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5066	Stent insertion: Renal/visceral/brachiocephalic - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure	30	13,000	R1 559,70	T
5070	Stent insertion: Aorto-iliac stent graft - including percutaneous transluminal angioplasty (PTA)	30	13,000	R1 559,70	T
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite	30	5,000	R600,10	T
5074	IVC filter insertion jugular or femoral route	30	9,000	R1 079,70	T
5076	Intravascular foreign body removal, arterial or venous, any route	30	9,000	R1 079,70	T
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)	30	5,000	R600,10	T
5080	Transjugular intrahepatic porto-systemic shunt	30	13,000	R1 559,70	T
5082	Transjugular liver biopsy	30	9,000	R1 079,70	T
5084	Endoluminal fallopian tube recanalisation	30	6,000	R720,00	T
5086	Renal cyst aspiration/ablation				
5088	Oesophageal stent insertion in radiology suite	30	6,000	R720,00	T
5090	Tracheal stent insertion	30	6,000	R720,00	T
5091	GIT balloon dilatation under fluoroscopy	30	6,000	R720,00	T
5092	Other GIT stent insertion	30	6,000	R720,00	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5093	Percutaneous gastrostomy in radiology suite				
5094	Cutting needle biopsy with image guidance				
5095	Chest drain insertion in radiology suite				
5096	Percutaneous cyst or tumour ablation (non aspiration)				
5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation - PROFESSIONAL COMPONENT				
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal - PROFESSIONAL COMPONENT				
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		6,000	R720,00	T
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)		6,000	R720,00	T
5974	Stent placement,branch pulmonary artery: First vessel		6,000	R720,00	T
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)		6,000	R720,00	T
5976	Stent placement coarctation of the aorta		6,000	R720,00	T
5980	Stent patent ductus arteriosus and interatrial communication		6,000	R720,00	T
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		6,000	R720,00	T
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		10,000	R1 199,90	T
5986	VSD closure, percutaneous, device placement		10,000	R1 199,90	T
5987	PFO closure with device		10,000	R1 199,90	T
5989	PDA closure-coil or ductal device		6,000	R720,00	T
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		6,000	R720,00	T
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		6,000	R720,00	T
5992	Closure interatrial communication (Fontan fenestration etc)		10,000	R1 199,90	T
5995	Rapid right ventricular pacing for percutaneous procedure		10,000	R1 199,90	T
5996	Removal of embolised device/materials		6,000	R720,00	T
5998	Biopsy: Endomyocardial		7,000	R839,80	T

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6000	Actigraphy: Patient monitored for a minimum of 72 hours (includes equipment fee and interpretation)				
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level	30	13,000	R1 559,70	T
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate				
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy				
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES				
0090	Doctor's remuneration for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only)				
19.15	**Magnetic Resonance Imaging (MRI)**				
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability				
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability				
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series"				
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.				
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.				
6200	Magnetic Resonance Imaging: Per anatomical region: Brain	30	5,000	R600,10	T
6201	Magnetic Resonance Imaging: Per anatomical region: Orbitae	30	5,000	R600,10	T
6202	Magnetic Resonance Imaging: Per anatomical region: Paranasal sinuses	30	5,000	R600,10	T
6203	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Face/skull	30	5,000	R600,10	T
6204	Magnetic Resonance Imaging: Per anatomical region: Skull basis/cranio-cervical joint	30	5,000	R600,10	T
6205	Magnetic Resonance Imaging: Per anatomical region: Middle and internal ears	30	5,000	R600,10	T
6206	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Neck	30	5,000	R600,10	T
6207	Magnetic Resonance Imaging: Per anatomical region: Thyroid/para-thyroid	30	5,000	R600,10	T

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6208	Magnetic Resonance Imaging: Per anatomical region: Hypophysis (see modifiers 6104 and 6105 for limited examinations)	30	5,000	R600,10	T
6209	Magnetic Resonance Imaging: Per anatomical region: Bone tumour (see modifier 6103)	30	5,000	R600,10	T
6210	Magnetic Resonance Imaging: Per anatomical region: Cervical vertebrae	30	5,000	R600,10	T
6211	Magnetic Resonance Imaging: Per anatomical region: Thoracic vertebrae	30	5,000	R600,10	T
6212	Magnetic Resonance Imaging: Per anatomical region: Lumbar vertebrae	30	5,000	R600,10	T
6213	Magnetic Resonance Imaging: Per anatomical region: Sacrum	30	5,000	R600,10	T
6214	Magnetic Resonance Imaging: Per anatomical region: Pelvis	30	5,000	R600,10	T
6215	Magnetic Resonance Imaging: Per anatomical region: Pelvic organs	30	5,000	R600,10	T
6216	Magnetic Resonance Imaging: Per anatomical region: Abdomen	30	5,000	R600,10	T
6217	Magnetic Resonance Imaging: Per anatomical region: Thorax wall	30	5,000	R600,10	T
6218	Magnetic Resonance Imaging: Per anatomical region: Mediastinum	30	5,000	R600,10	T
6219	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Back	30	5,000	R600,10	T
6220	Magnetic Resonance Imaging: Per anatomical region: Left shoulder	30	5,000	R600,10	T
6221	Magnetic Resonance Imaging: Per anatomical region: Right shoulder	30	5,000	R600,10	T
6222	Magnetic Resonance Imaging: Per anatomical region: Both hips	30	5,000	R600,10	T
6223	Magnetic Resonance Imaging: Per anatomical region: Left hip	30	5,000	R600,10	T
6224	Magnetic Resonance Imaging: Per anatomical region: Right hip	30	5,000	R600,10	T
6225	Magnetic Resonance Imaging: Per anatomical region: Left upper-arm	30	5,000	R600,10	T
6226	Magnetic Resonance Imaging: Per anatomical region: Right upper-arm	30	5,000	R600,10	T
6227	Magnetic Resonance Imaging: Per anatomical region: Left elbow	30	5,000	R600,10	T
6228	Magnetic Resonance Imaging: Per anatomical region: Right elbow	30	5,000	R600,10	T
6229	Magnetic Resonance Imaging: Per anatomical region: Left fore-arm	30	5,000	R600,10	T
6230	Magnetic Resonance Imaging: Per anatomical region: Right fore-arm	30	5,000	R600,10	T
6231	Magnetic Resonance Imaging: Per anatomical region: Left wrist and hand	30	5,000	R600,10	T

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6232	Magnetic Resonance Imaging: Per anatomical region: Right wrist and hand	30	5,000	R600,10	T
6233	Magnetic Resonance Imaging: Per anatomical region: Left upper-leg	30	5,000	R600,10	T
6234	Magnetic Resonance Imaging: Per anatomical region: Right upper-leg	30	5,000	R600,10	T
6235	Magnetic Resonance Imaging: Per anatomical region: Left knee	30	5,000	R600,10	T
6236	Magnetic Resonance Imaging: Per anatomical region: Right knee	30	5,000	R600,10	T
6237	Magnetic Resonance Imaging: Per anatomical region: Left lower-leg	30	5,000	R600,10	T
6238	Magnetic Resonance Imaging: Per anatomical region: Right lower-leg	30	5,000	R600,10	T
6239	Magnetic Resonance Imaging: Per anatomical region: Left ankle	30	5,000	R600,10	T
6240	Magnetic Resonance Imaging: Per anatomical region: Right ankle	30	5,000	R600,10	T
6241	Magnetic Resonance Imaging: Per anatomical region: Left foot	30	5,000	R600,10	T
6242	Magnetic Resonance Imaging: Per anatomical region: Right foot	30	5,000	R600,10	T
6250	Magnetic Resonance angiography (See modifiers 6106 to 6108): Brain	30	5,000	R600,10	T
6251	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Neck	30	5,000	R600,10	T
6252	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Chest	30	5,000	R600,10	T
6253	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Abdomen	30	5,000	R600,10	T
6254	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Legs	30	5,000	R600,10	T
6255	Magnetic Resonance angiography (See modifiers 6106 to 6108): Heart	30	5,000	R600,10	T
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations	30	5,000	R600,10	T
20	**RADIATION ONCOLOGY**				
	“GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST				
	(a) Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services. (b) The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.”				
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values				
20.1	**Kilovolt therapy**				
20.2	**Radium therapy**				
20.3	**Isotope therapy**				
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope				
20.4	**Megavolt therapy**				
20.5	**Beta-ray therapy with strontium-90-applicator**				
20.6	**Planning of therapy**				
20.7	**Technical aids**				
5141	Radiation materials (see modifier 0095)				
20.8	**Oncological surgical procedures**				
20.9	**Special procedures**				
20.10	**Chemotherapy**				
	Where patients are not treated in chemotherapy facilities, items 0213, 0214 and 0215 are used instead of items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.				
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities				
5790	Non Infusional Chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day - for exclusive use by doctors with appropriate oncology training (consultations to be charged separately) - (not applicable to oral hormonal therapy)				
5791	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured or scripted for oral chemotherapy, intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5792	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee				
	Non-infusional chemotherapy: Consultations are charged separately.				
	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.				
5793	Infusional Chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day - for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities(consultations to be charged separately)				
5794	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured, stored, admixed and administered, and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee				
5795	Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) - only one of the parties are to charge this fee				
	Item 5795 is chargeable in addition to item 5793 by the Oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to item 5793 if own or rented facility is used).				
20.11	**Radiation Therapy Planning**				
20.11.1	**Manual Radiotherapy Planning Procedures**				
5801	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT				
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest -TECHNICAL COMPONENT				
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT				
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT				
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT				
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
20.11.2	**Conventional Radiotherapy Planning Procedures**				
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT				
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT				
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT				
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT				
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT				
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT				
20.11.3	**Three Dimensional Radiotherapy Planning Procedures**				
5820	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				
5620	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
5821	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				
5621	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
5822	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				
5622	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
20.11.4	**Intensity Modulated Radiotherapy Planning Procedures**				
5823	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				
5623	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
5825	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5625	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
5826	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)				
5626	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)				
20.11.5	**Kilovolt Radiation Treatment**				
5834	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT				
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT				
20.11.6	**Short Course Radiation Treatment**				
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT				
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT				
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT				
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT				
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT				
20.11.7	**Weekly Radiation Treatment Sessions**				
20.11.7.1	**Weekly Radiation Treatment Sessions - Conventional Techniques**				
5839	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - PROFESSIONAL COMPONENT				
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT				
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT				
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT				
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT				
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
20.11.7.2	**Weekly Radiation Treatment Sessions - Advanced Techniques**				
5849	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - PROFESSIONAL COMPONENT				
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT				
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT				
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT				
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT				
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT				
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT				
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT				
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT				
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT				
20.11.8	**Stereotactic Radiation**				
5860	Stereotactic Radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee - PROFESSIONAL COMPONENT				
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT				
5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT				
5661	Stereotactic Radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee - TECHNICAL COMPONENT				
20.12	**Brachytherapy**				
20.12.1	**Isotope/Applicator Therapy**				
5870	Isotope/Applicator Therapy: Isotopes - Low Complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5872	Isotope/Applicator Therapy: Isotopes - Intermediate Complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included				
5873	Isotope/Applicator Therapy: Isotopes - High Complexity, surface application of seed arrays requiring dosimetric assessment and/or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included				
20.12.2	**Brachytherapy Implants**				
5882	Brachytherapy Implants: Implants - Low Complexity, placement of a single guide tube for the administration of brachytherapy requiring <8 dwell points. The cost of materials are not included				
5883	Brachytherapy Implants: Implants - Intermediate Complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included				
5885	Brachytherapy Implants: Implants - High Complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included				
20.12.3	**Brachytherapy Treatment**				
5890	Brachytherapy Treatment: Global fee for manual afterloading - includes storage, handling, calibration, planning (manual or computerized), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included				
5892	Brachytherapy Treatment: Global fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - PROFESSIONAL COMPONENT				
5893	Global Fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - TECHNICAL COMPONENT				
20.12.4	**Brachytherapy Imaging**				
5895	Brachytherapy Imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than items 5883 or 5885				
21	**CLINICAL PATHOLOGY**				
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				
	"Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values.				
	Note: For fees for Histology and Cytology refer to items 4561-4593 under Section 22: Anatomical Pathology."				
21.1	**Haematology**				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3705	Alkali resistant haemoglobin				
3709	Antiglobulin test (Coombs' or trypsinzied red cells)				
3710	Antibody titration				
3712	Antibody identification				
3713	Bleeding time (does not include the cost of the simplate device)				
3714	Blood volume, dye method				
3715	Buffy layer examination				
3716	Mean Cell Volume				
3717	Bone marrow cytological examination only				
3719	Bone marrow: Aspiration				
3720	Bone marrow trephine biopsy				
3721	Bone marrow aspiration and trephine biopsy (excluding histology)				
3722	Capillary fragility: Hess				
3723	Circulating anticoagulants				
3724	Coagulation factor inhibitor assay				
3726	Activated protein C resistance				
3727	Coagulation time				
3728	Anti-factor Xa Activity				
3729	Cold agglutinins				
3730	Protein S: Functional				
3731	Compatibility for blood transfusion				
3732	Cryoglobulin				
3734	Protein C (chromogenic)				
3735	Anti-thrombin III (chromogenic)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3736	Plasminogen (chromogenic)				
3737	Lupus Russel Viper method				
3738	Lupus Kaolin Exner method				
3739	Erythrocyte count				
3740	Factors V and VII: Qualitative				
3741	Coagulation factor assay: Functional				
3743	Erythrocyte sedimentation rate				
3744	Fibrin stabilizing factor (urea test)				
3746	Fibrin monomers				
3748	Plasminogen activator inhibitor (PAI-I)				
3750	Tissue plasminogen Activator (tPA)				
3753	Osmotic fragility (before and after incubation)				
3754	ABO Reverse Group				
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)				
3756	Full cross match				
3757	Coagulation factors: Quantitative				
3758	Factor VIII related antigen				
3759	Coagulation factor correction study				
3761	Factor XIII related antigen				
3762	Haemoglobin estimation				
3763	Contact activated product assay				
3764	Grouping: A B and O antigens				
3765	Grouping: Rh antigen				
3766	PIVKA				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3767	Euglobulin Lysis time				
3768	Haemoglobin A2 (column chromatography)				
3769	Haemoglobin electrophoresis				
3770	Haemoglobin-S (solubility test)				
3772	Haptoglobin: Quantitative				
3773	Ham's acidified serum test				
3775	Heinz bodies				
3776	Haemosiderin in urinary sediment				
3783	Leucocyte differential count				
3785	Leucocytes: Total count				
3786	QBC malaria concentration and fluorescent staining				
3787	LE-cells				
3789	Neutrophil alkaline phosphatase				
3791	Packed cell volume: Haematocrit				
3792	Plasmodium falciparum: Monoclonal immunological identification				
3793	Plasma haemoglobin				
3794	Platelet sensitivities				
3795	Platelet aggregation per aggregant				
3797	Platelet count				
3799	Platelet adhesiveness				
3801	Prothrombin consumption				
3803	Prothrombin determination (two stages)				
3805	Prothrombin index				
3806	Therapeutic drug level: Dosage				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3809	Reticulocyte count				
3810	Schumm's test				
3811	Sickling test				
3814	Sucrose lysis test for PNH				
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)				
3820	Thrombo - Elastogram				
3825	Fibrinogen titre				
3829	Glucose 6-phosphate-dehydrogenase: Qualitative				
3830	Glucose 6-phosphate-dehydrogenase: Quantitative				
3832	Red cell pyruvate kinase: Quantitative				
3834	Red cell Rhesus phenotype				
3835	Haemoglobin F in blood smear				
3837	Partial thromboplastin time				
3841	Thrombin time (screen)				
3843	Thrombin time (serial)				
3847	Haemoglobin H				
3851	Fibrin degeneration products (diffusion plate)				
3853	Fibrin degeneration products (latex slide)				
3854	XDP (Dimer test or equivalent latex slide test)				
3855	Haemagglutination inhibition				
3856	D-Dimer (quantitative)				
3857	Ristocetin Cofactor				
3858	Heparin removal				
3718	Quantitative reverse transcriptase polymerase chain reaction (QR-PCR) for monitoring minimal residual disease (MRD) in leukaemia patients			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3751	Osmtoic fragility (screen)			R0,00	
3752	Osmotic fragility test: Quantitative			R0,00	
3771	Factor III-availability test			R0,00	
3781	Heparin tolerance			R0,00	
3796	Platelet antibodies: Agglutination			R0,00	
3807	Recalcification time			R0,00	
3828	Soluble urokrinase Plasminogen Activator Receptor (suPAR) ELISA			R0,00	
4415	Ptoassium			R0,00	
3711	Arneth count			R0,00	
21.2	**Microscopic and miscellaneous tests**				
3863	Autogenous vaccine				
3864	Entomological examination				
3865	Parasites in blood smear				
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)				
3868	Fungus identification				
3869	Faeces (including parasites)				
3873	Transmission electron microscopy				
3874	Scanning electron microscopy				
3875	Inclusion bodies				
3878	Crystal identification polarized light microscopy				
3879	Campylobacter in stool: Fastidious culture				
3880	Antigen detection with polyclonal antibodies				
3881	Mycobacteria				
3882	Antigen detection with monoclonal antibodies				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3883	Concentration techniques for parasites				
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana				
3885	Cytochemical stain				
3872	Automated urine microscopy			R0,00	
21.3	**Bacteriology**				
3887	Antibiotic susceptibility test: Per organism				
3888	Adhesive tape preparation				
3889	Clostridium difficile toxin: Monoclonal immunological				
3890	Antibiotic assay of tissues and fluids				
3891	Blood culture: Aerobic				
3892	Blood culture: Anaerobic				
3893	Bacteriological culture: Miscellaneous				
3894	Radiometric blood culture				
3895	Bacteriological culture: Fastidious organisms				
3896	In vivo culture: Bacteria				
3897	In vivo culture: Virus				
3899	Bacterial exotoxin production (in vivo assay)				
3901	Fungal culture				
3902	Clostridium difficile (cytotoxicity neutralisation)				
3903	Antibiotic level: Biological fluids				
3904	Rotavirus latex slide test				
3905	Identification of virus or rickettsia				
3906	Identification: Chlamydia				
3908	Anaerobe culture: Comprehensive				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3909	Anaerobe culture: Limited procedure				
3911	Beta-lactamase assay				
3914	Sterility control test: Biological method				
3915	Mycobacterium culture				
3916	Radiometric tuberculosis culture				
3918	Mycoplasma culture: Comprehensive				
3919	Identification of mycobacterium				
3920	Mycobacterium: Antibiotic sensitivity				
3921	Antibiotic synergistic study				
3922	Viable cell count				
3923	Biochemical identification of bacterium: Abridged				
3924	Biochemical identification of bacterium: Extended				
3925	Serological identification of bacterium: Abridged				
3926	Serological identification of bacterium: Extended				
3927	Grouping for streptococci				
3928	Antimicrobic substances				
3929	Radiometric mycobacterium identification				
3930	Radiometric mycobacterium antibiotic sensitivity				
3931	Helicobacter: Monoclonal immunological				
4650	Antibiotic MIC per organism per antibiotic				
4651	Non-radiometric automated blood cultures				
4652	Rapid automated bacterial identification per organism				
4653	Rapid automated antibiotic susceptibility per organism				
4654	Rapid automated MIC per organism per antibiotic				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4655	Mycobacteria: MIC determination - E Test				
4656	Mycobacteria: Identification HPLC				
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain				
3898	Bacterial extooxin production (in vitro assay)			R0,00	
3900	Cytomegalovirus (CMV) pp65 antigen detection assay			R0,00	
3917	Mycoplasma culture: Limited			R0,00	
21.4	**Serology**				
3958	Anti Gad/Ia2 Ab				
3959	Rose Waaler agglutination test				
3960	Gonococcal, listeria or echinococcus agglutination				
3961	Slide agglutination test				
3963	Serum complement level: Each component				
3965	Anti Ia2 Antibodies				
3966	Anti Gad Antibodies				
3967	Auto-antibody: Sensitized erythrocytes				
3968	Herpes virus typing: Monoclonal immunological				
3969	Western blot technique				
3932	Antibodies to human immunodeficiency virus (HIV): ELISA				
3933	IgE: Total: EMIT or ELISA				
3934	Auto antibodies by labelled antibodies				
3935	Sperm antibodies				
3936	Virus neutralisation test: First antibody				
3937	Virus neutralisation test: Each additional antibody				
3938	Precipitation test per antigen				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3939	Agglutination test per antigen				
3940	Haemagglutination test: Per antigen				
3941	Modified Coombs' test for brucellosis				
3942	Hepatitis Rapid Viral Ab				
3943	Antibody titer to bacterial exotoxin				
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag				
3945	Complement fixation test				
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag				
3947	C-reactive protein				
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag				
3949	Qualitative Kahn, VDRL or other flocculation				
3950	Neutrophil phagocytosis				
3951	Quantitative Kahn, VDRL or other flocculation				
3952	Neutrophil chemotaxis				
3953	Tube agglutination test				
3955	Paul Bunnell: Presumptive				
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)				
3971	Immuno-diffusion test: Per antigen				
3972	Respiratory syncytial virus (ELISA technique)				
3973	Immuno electrophoresis: Per immune serum				
3974	Polymerase chain reaction				
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)				
3978	Lymphocyte transformation				
3980	Bilharzia Ag Serum/Urine				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3982	Histone Ab				
4600	Anti-CCP				
4601	Panel typing: Antibody detection: Class I				
4602	Panel typing: Antibody detection: Class II				
4603	HLA test for specific locus/antigen - serology				
4604	HLA typing: Class I - serology				
4605	HLA typing: Class II - serology				
4606	HLA typing: Class I & II - serology				
4607	Cross matching T-cells (per tray)				
4608	Cross matching B-cells				
4609	Cross matching T- & B-cells				
4610	Helicobacter: Pylori antigen test				
4611	Erythropoietin				
4612	HTLV I/II				
4613	Anti-Gm1 Antibody Assay				
4614	HIV Ab - Rapid Test				
3957	Paul Bunnell: Absorption			R0,00	
3962	Rebuck skin window			R0,00	
3977	Counter immuno-electrophoresis			R0,00	
3984	Quantiferon TB assay			R0,00	
3986	Anti R7-V			R0,00	
21.5	**Skin tests**				
	For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section				
21.6	**Biochemical tests: Blood**				

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Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3991	Abnormal pigments: Qualitative				
3993	Abnormal pigments: Quantitative				
3995	Acid phosphate				
3998	Amino acids Quantitative (Post derivatisation HPLC)				
3999	Albumin				
4000	Alcohol				
4001	Alkaline phosphatase				
4002	Alkaline phosphatase-iso-enzymes				
4003	Ammonia: Enzymatic				
4004	Ammonia: Monitor				
4005	Alpha-1-antitrypsin: Total				
4006	Amylase				
4007	Arsenic in blood, hair or nails				
4008	Bilirubin - Reflectance				
4009	Bilirubin: Total				
4010	Bilirubin: Conjugated				
4011	Breath Hydrogen Test				
4012	CSF Nicotinic Acid				
4013	CSF Glutamine				
4014	Cadmium: Atomic absorption				
4016	Calcium: Ionized				
4017	Calcium: Spectrophotometric				
4018	Calcium: Atomic absorption				
4019	Carotene				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4020	Carnitine (Total or free) in biological fluid: Each				
4021	Carnitine (Total or free) in muscle: Each				
4022	Acyl Carnitine				
4023	Chloride				
4025	Chol/HDL/LDL/Trig				
4026	LDL cholesterol (chemical determination)				
4027	Cholesterol total				
4028	HDL cholesterol				
4029	Cholinesterase: Serum or erythrocyte: Each				
4030	Cholinesterase phenotype (Dibucaine or fluoride each)				
4031	Total CO2				
4032	Creatinine				
4033	CSF-Immunoglobulin G				
4034	C1-Esterase Inhibitor				
4035	CSF-Albumin				
4036	CSF-IgG Index				
4038	Glutamic acid				
4040	Homocysteine (random)				
4041	Homocysteine (after Methionine load)				
4042	D-Xylose absorption test: Two hours				
4045	Fibrinogen: Quantitative				
4049	Glucose tolerance test (2 specimens)				
4050	Glucose strip-test with photometric reading				
4051	Galactose				

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Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4052	Glucose tolerance test (3 specimens)				
4053	Glucose tolerance test (4 specimens)				
4057	Glucose: Quantitative				
4061	Glucose tolerance test (5 specimens)				
4062	Galactose-1-phosphate uridyl transferase				
4063	Fructosamine				
4064	HbA1C				
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda				
4067	Lithium: Flame ionisation				
4068	Lithium: Atomic absorption				
4071	Iron				
4073	Iron-binding capacity				
4076	Blood gases: Astrup/pO2 and ancillary tests - can only be charged to a maximum of 6 times per patient per day				
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb				
4079	Ketones in plasma: Qualitative				
4081	Drug level-biological fluid: Quantitative				
4082	Tacrolimus assay				
4083	Lysosomal enzyme assay				
4084	Thymidine kinase				
4085	Lipase				
4086	Lactate				
4091	Lipoprotein electrophoresis				
4092	Orosmucoid				
4093	Osmolality: Serum or urine				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4094	Magnesium: Spectrophotometric				
4095	Magnesium: Atomic absorption				
4096	Mercury: Atomic absorption				
4098	Copper: Atomic absorption				
4105	Protein electrophoresis				
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class				
4109	Phosphate				
4113	Potassium				
4114	Sodium				
4117	Protein: Total				
4121	pH, pCO2 or pO2: Each				
4123	Pyruvic acid				
4125	Salicylates				
4127	Caeruloplasmin				
4128	Phenylalanine: Quantitative				
4130	Aspartate aminotransferase (AST)				
4131	Alanine aminotransferase (ALT)				
4132	Creatine kinase (CK)				
4133	Lactate dehidrogenase (LD)				
4134	Gamma glutamyl transferase (GGT)				
4135	Aldolase				
4136	Angiotensin converting enzyme (ACE)				
4137	Lactate dehydrogenase isoenzyme				
4138	CK-MB: Immunoinhibition/precipitation				

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Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4139	Adenosine deaminase				
4143	Serum/plasma enzymes				
4144	Transferrin				
4146	Lead: Atomic absorption				
4147	Triglyceride				
4148	Tay - Sachs Study				
4149	Red cell magnesium				
4151	Urea				
4152	CK-MB: Mass determination: Quantitative (Automated)				
4153	CK-MB: Mass determination: Quantitative (Not automated)				
4154	Myoglobin quantitative: Monoclonal immunological				
4155	Uric acid				
4156	Vitamin D3				
4157	Vitamin A-saturation test				
4158	Vitamin E (tocopherol)				
4159	Vitamin A				
4161	Troponin isoforms: Each				
4163	Apoprotein AI: Turbidometric method				
4165	Apoprotein AII: Turbidometric method				
4167	Apoprotein B: Turbidometric method				
4170	Lipoprotein (a)(Lp(a)) assay				
4171	Sodium + potassium + chloride + CO2 + urea				
4172	ELISA/EMIT technique				
4173	Sirolimus Assay				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4181	Quantitative protein estimation: Mancini method				
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method				
4183	Quantitative protein estimation: Labelled antibody				
4184	C-reactive protein (Ultra sensitive)				
4185	Lactose				
4186	Vitamin B6				
4187	Zinc: Atomic absorption				
3996	Serum Amyloid A			R0,00	
3997	Acid phosphatase fractionation			R0,00	
4047	Hollander test			R0,00	
4080	Everolimus assay			R0,00	
4111	Phospholipids			R0,00	
4126	Secretin-pancreozymin response			R0,00	
4129	Glutamate dehydrogenase (GDH)			R0,00	
4142	Red cell enzymes: Each			R0,00	
4160	Vitamin C (ascorbic acid)			R0,00	
21.7	**Biochemical tests: Urine**				
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)				
4189	Abnormal pigments				
4193	Alkapton test: Homogentisic acid				
4194	Amino acids: Quantitative (Post derivatisation HPLC)				
4195	Amino laevulinic acid				
4197	Amylase				
4198	Arsenic				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4199	Ascorbic acid				
4201	Bence-Jones protein				
4204	Calcium: Atomic absorption				
4205	Calcium: Spectrophotometric				
4209	Lead: Atomic absorption				
4210	Urine collagen telopeptides				
4211	Bile pigments: Qualitative				
4213	Protein: Quantitative				
4216	Mucopolysaccharides: Qualitative				
4217	Oxalate				
4218	Glucose: Quantitative				
4219	Steroids: Chromatography (each)				
4221	Creatinine				
4223	Creatinine clearance				
4227	Electrophoresis: Qualitative				
4228	Fetal Lung Maturity				
4230	Urine/Fluid - Specific Gravity				
4231	Metabolites HPLC (High Pressure Liquid Chromatography)				
4232	Metabolites (Gaschromatography/Mass spectrophotometry)				
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)				
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)				
4237	5-Hydroxy-indole-acetic acid: Screen test				
4238	5HIAA (Hplc)				
4247	Ketones: Excluding dip-stick method				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4248	Reducing substances				
4251	Metanephrines: Column chromatography				
4252	Metanephrine (Hplc)				
4253	Aromatic amines (gas chromatography/mass spectrophotometry)				
4254	Nitrosonaphtol test for tyrosine				
4255	Orotic Acid - Urine				
4256	Very long Chain Fatty Acids				
4261	Micro Albumin: Quantitative				
4262	Micro Albumin: Qualitative				
4263	pH: Excluding dip-stick method				
4265	Thin layer chromatography: One way				
4266	Thin layer chromatography: Two way				
4268	Organic acids: Quantitative: GCMS				
4269	Phenylpyruvic acid: Ferric chloride				
4270	Chromium Total Urine				
4271	Phosphate excretion index				
4272	Porphobilinogen qualitative screen: Urine				
4273	Porphobilinogen/ALA: Quantitative each				
4283	Magnesium: Spectrophotometric				
4284	Magnesium: Atomic absorption				
4285	Identification of carbohydrate				
4287	Identification of drug: Qualitative				
4288	Identification of drug: Quantitative				
4293	Urea clearance				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4297	Copper: Spectrophotometric				
4298	Copper: Atomic absorption				
4301	Chloride				
4309	Urobilinogen: Quantitative				
4313	Phosphates				
4315	Potassium				
4316	Sodium				
4319	Urea				
4321	Uric acid				
4323	Total protein and protein electrophoresis				
4325	VMA: Quantitative				
4326	Catecholamines (HPLC)				
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda				
4328	Immunoglobulin D				
4335	Cystine: Quantitative				
4336	Dinitrophenol hydrazine test: Ketoacids				
4203	Phenol			R0,00	
4206	Calcium: Absorption and excretion studies			R0,00	
4229	Uric acid clearance			R0,00	
4235	Inborn errors of metabolism (IEM) screening test by Tandem Mass Spectrometry for the detection of aminoacidopathies and cacylcamtine metabolic defects			R0,00	
4239	5-Hydroxy-indole-acetic acid: Quantitative			R0,00	
4267	Ttoal organic matter screen: Infrared			R0,00	
4300	Indican or indole: Qualitative			R0,00	
4307	Ammonium chloride loading test			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4322	Fluoride			R0,00	
4337	Hydroxyproline: Quantitative			R0,00	
4220	Klinolab Newborn Screen			R0,00	
21.8	**Biochemical tests: Faeces**				
4339	Chloride				
4343	Fat: Qualitative				
4345	Fat: Quantitative				
4347	Ph				
4351	Occult blood: Chemical test				
4352	Occult blood: Monoclonal antibodies				
4357	Potassium				
4358	Sodium				
4359	Secretory IgA				
4362	Elastase quantitative ELISA				
4363	Stercobilinogen: Quantitative				
4350	M2 Pyruvate Kinase quantitative ELISA			R0,00	
4361	Stercobilin			R0,00	
4364	Chymotrypsin determination: Enzymatic			R0,00	
21.9	**Biochemical tests: Miscellaneous**				
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each				
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each				
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each				
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each				
4370	Drug level in biological fluid: Monoclonal immunological				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4371	Amylase in exudate				
4372	Fluoride in biological fluids and water				
4374	Trace metals in biological fluid: Atomic absorption				
4375	Calcium in fluid: Spectrophotometric				
4376	Calcium in fluid: Atomic absorption				
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)				
4378	Urea breath test				
4380	Lecithin in amniotic fluid: L/S ratio				
4381	Lamellar body count in amniotic fluid				
4390	Foam test: Amniotic fluid				
4391	Renal calculus: Chemistry				
4392	Renal calculus: Crystallography				
4395	Sweat: Sodium				
4396	Sweat: Potassium				
4397	Sweat: Chloride				
4399	Sweat collection by iontophoresis (excluding collection material)				
4400	Tryptophane loading test				
4373	Breast milk analysis			R0,00	
4382	Bilirubin in amnitoic fluid: Spectrophtoometric essay			R0,00	
4386	Oestrogen/Progesterone receptors: Fluorescent method			R0,00	
4387	Oestrogen/Progesterone receptors: Cytosol radio-istoope technique			R0,00	
4388	Gastric contents: Maximal stimulation test			R0,00	
4389	Gastric fluid: Ttoal acid per specimen			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4393	Saliva: Ptoassium			R0,00	
4394	Saliva: Sodium			R0,00	
21.10	**Cerebrospinal fluid**				
4401	Cell count				
4407	Cell count, protein, glucose and chloride				
4409	Chloride				
4416	Sodium				
4417	Protein: Qualitative				
4419	Protein: Quantitative				
4421	Glucose				
4423	Urea				
4425	Protein electrophoresis				
21.11	**RNA/DNA based tests and andrology**				
21.11.1	**RNA/DNA based tests and andrology: RNA/DNA based tests**				
4424	HLA test for specific allele DNA-PCR				
4426	HLA typing low resolution Class I DNA-PCR per locus				
4427	HLA typing low resolution Class II DNA-PCR per locus				
4428	HLA typing high resolution Class I or II DNA-PCR per locus				
4429	Quantitative PCR (DNA/RNA)				
4430	Recombinant DNA technique				
4431	Ribosomal RNA targeting for bacteriological identification				
4432	Ribosomal RNA amplification for bacteriological identification				
4433	Bacteriological DNA identification (LCR)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4434	Bacteriological DNA identification (PCR)				
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.				
21.11.2	**RNA/DNA based tests and andrology: Andrology**				
4435	Mixed antiglobulin reaction: Semen				
4436	Friberg test: Semen				
4437	Kremer test: Semen				
4440	Semen analysis: Cell count				
4441	Semen analysis: Cytology				
4442	Semen analysis: Viability + motility - 6 hours				
4443	Semen analysis: Supravital stain				
4445	Seminal fluid: Alpha glucosidase				
4446	Seminal fluid fructose				
4447	Seminal fluid: Acid phosphatase				
21.12	**Immunology**				
4448	HCG: Latex agglutination: Qualitative (side room)				
4449	HCG: Latex agglutination: Semi-quantitative (side room)				
4450	HCG: Monoclonal immunological: Qualitative				
4451	HCG: Monoclonal immunological: Quantitative				
4452	Bone Specific Alk Phosphatase				
4455	Anti IgE receptor antibody test (10 samples and dilution)				
4456	Eosinophil cationic protein				
4457	Mast cell tryptase				
4458	Micro-albuminuria: Radio-isotope method				
4459	Acetyl choline receptor antibody				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4460	CA-199 tumour marker				
4461	Nuclear Matrix Protein 22				
4462	CA-125 tumour marker				
4463	C6 complement functional essay				
4466	Beta-2-microglobulin				
4467	Chromograqnin A				
4468	CA-549				
4469	Tumour markers: Monoclonal immunological (each)				
4470	CA-195 tumour marker				
4471	Carcino-embryonic antigen				
4473	TSH Receptor Ab				
4474	Cast Per Allergen				
4475	CA-724				
4477	Neuron specific enolase				
4478	Osteocalcin				
4479	Vitamin B12-absorption: Shilling test				
4480	Serotonin				
4482	Free thyroxine (FT4)				
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)				
4485	Insulin				
4486	C-Peptide				
4487	Calcitonin				
4488	B-Type Natriuretic Peptide				
4490	Releasing hormone response				

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Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4491	Vitamin B12				
4492	Vitamin D3: Calcitroil (RIA)				
4493	Drug concentration: Quantitative				
4494	Free hormone assay				
4495	Growth hormone				
4496	Hormone concentration: Quantitative				
4497	Carbohydrate deficient transferrin				
4499	Cortisol				
4500	DHEA sulphate				
4501	Testosterone				
4502	Free testosterone				
4503	Oestradiol				
4505	Oestriol				
4506	Multiple antigen specific IgE screening test for Atopy				
4507	Thyrotropin (TSH)				
4508	Combined antigen specific IgE				
4509	Free tri-iodothyronine (FT3)				
4511	Renin activity				
4512	Parathormone				
4513	IgE: Total				
4514	Antigen specific IgE				
4515	Aldosterone				
4516	Follitropin (FSH)				
4517	Lutropin (LH)				

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4518	Soluble transferrin receptor				
4519	Prostate specific antigen				
4520	17 Hydroxy progesterone				
4521	Progesterone				
4522	Alpha-feto protein				
4523	ACTH				
4524	Free PSA				
4526	Sex hormone binding globulin				
4527	Gastrin				
4528	Ferritin				
4529	Anti-DNA antibodies				
4530	Antiplatelet antibodies				
4531	Hepatitis: Per antigen or antibody				
4532	Transcobalamine				
4533	Folic acid				
4534	Prostatic acid phosphatase				
4536	Erythrocyte folate				
4537	Prolactin				
4538	Procalcitonin: Semi-quantitative				
4539	Procalcitonin: Quantitative				
4540	HCG: Quantitative as used for Down's screen				
4546	First trimester Downs screen				
4552	Second Trimester Down's screen				
4553	Thyroglubulin				

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4554	SCC marker				
4464	House dust mite antigen ELIZA			R0,00	
4472	MCA antigen tumour marker			R0,00	
4476	Neopterin			R0,00	
4504	Anti-mullerian hormone			R0,00	
21.13	**Clinical pathology: Miscellaneous**				
4544	Attendance in theatre				
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays - Refer to General Rule B.				
4551	Unlisted pathology service: Fees for items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee 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 fee 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 charged separately				
4549	Minimum fee: After-hours			R0,00	
22	**ANATOMICAL PATHOLOGY**				
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values				
22.1	**Exfoliative cytology**				
4561	Sputum, all body fluids and tumour aspirates: First unit				
4563	Sputum, all body fluids and tumour aspirates: Each additional unit				
4564	Performance of fine-needle aspiration for cytology				
4565	Examination of fine needle aspiration in theatre				
4566	Vaginal or cervical smears, each				
4559	Cytology preparation using approved liquid bases cytology method: First unit			R0,00	
4560	Cytology preparation using approved liquid bases cytology method: Each additional unit			R0,00	

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Practice Type: **Anaesthesiology**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
22.2	**Histology**				
4567	Histology per sample				
4571	Histology per additional block, each				
4575	Histology and frozen section in laboratory				
4577	Histology and frozen section in theatre				
4578	Second and subsequent frozen sections, each				
4579	Attendance in theatre - no frozen section performed				
4582	Serial step sections (including item 4567)				
4584	Serial step sections per additional block, each				
4587	Histology consultation				
4589	Special stains				
4591	Immunofluorescence studies				
4592	Immunoperoxidase studies				
4593	Electron microscopy				
4595	Foetal autopsy excluding histology				
4590	Special procedures (special procedures are confined to polarization, decalcification and submission of blocks for radiological examination to identify microcalcifications)				Refer Rule C
23	**HUMAN GENETICS**				
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values				
23.1	**Cytogenitc**				
4750	Cell culture: Lymphocytes, cord blood				
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures				
4752	Cell culture: Chorionic villi				

CONTRACTED ANAESTHESIOLOGY FOR ALL OPTIONS

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique				
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique				
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques				
4760	FISH procedure, including cell culture				
4761	FISH analysis per probe system				
23.2	DNA-testing				
4763	Blood: DNA extraction				
4764	Blood: Genotype per person: Southern blotting				
4765	Blood: Genotype per person: PCR				
4766	HIV Drug Resistance Testing				
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction				
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting				
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR				
IV.	Travelling Expenses				
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 16km 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 8km 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. Medical scheme benefits will not be applicable in such instances.				
5003	The indicated amount for each kilometre in excess of 16km travelled in own car e.g. where a practitioner has to travel 19km in total to visit a patient, the fees shall be calculated as follows: 19-16=3 X Indicated amount		1,000	R19,00	
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof				
5007	Normal hours: General practitioner: 18,00 clinical procedure units per hour or part thereof				
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them				

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS FOR ALL OPTIONS WITH EFFECT FROM 1 JANUARY 2020

Practice Type: **Anaesthesiology**
Code: **010**

TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5009	After hours: Specialist: 27.00 clinical procedure units per hour or part thereof			R0,00	
5011	After hours: General Practitioner: 27.00 clinical procedure units per hour or part thereof			R0,00	
V.	LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED				
	"Modifier 0004 is not applicable to the following sections: • All anaesthetic services • Section 19: Radiology • Section 20: Radiation Oncology • Section 21: Clinical Pathology (except for items 3719, 3720 and 3721 where modifier 0004 may be applied) • Section 22: Anatomical Pathology • Section 23: Human Genetic Please note : This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures."				