CONTRACTED PHYSICIANS ALL OPTIONS

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

Practice Type: **Physicians only**
Code: **17; 18; 19; 20; 21 and 31**

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				

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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				
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. 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: Catogory 1: Cases requiring intensive monitoring				

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U.	Obstetric procedures: (a) When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. (i) If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. (ii) If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. (b) When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. (c) When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.				
V.	(a) Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods				
Y.	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				

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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				
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/produre 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 conjuction with modifiers 0074 and 0075.				

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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				
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.				
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	Assitant paediatric cardiologist: the units for a paediatric cardiologist acting as an assistant, is 40% of the units of the procedure(s) performed.				

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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				
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)	10	7,500	R231,90	

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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: Signficant 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 signifcant 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 neccesitates 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 defination, a significant ijury 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 signifcant 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)	20	27,000	R397,20	
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	20	77,000	R1 132,50	

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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)	20	115,500	R1 698,50	
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	20	77,000	R1 132,50	
0052	Except where otherwise specified, fracture (traumatic or surgical, ie. 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		81,100	R1 192,20	
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	20	32,000	R470,60	
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	20	77,000	R1 132,50	
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 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				

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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				
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope	20	45,000	R860,50	
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.	20	21,000	R308,80	
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 psychotherpay items after a first or follow-up consultation the clinician must ensure that the time stipulated for the psychotherapy items are adhered to (ie. 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				

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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				
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 Realtime): Fee for part examined plus 30% of the units				
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	60	6,000	R109,40	
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				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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				
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)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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				
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			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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 inot the next 15-minute period following on the first 60 minutes (please state duration of visit on account in minutes).			R0,00	
0109	Hospital follow-up visit to patient in ward or nursing facility - Refer to general rule G(a) for post-operative care) (may only be charged once per day) (not to be used with items 0111, 0145, 0146, 0147 or ICU items 1204-1214)				
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				
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.			R0,00	
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			R0,00	
0126	For an UNSCHEDULED consultation/visit at the doctor's home or rooms: ADD only to the consultation/visit items 0190-0192, items 01610164 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged and not combinations thereof			R0,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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				
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)			R0,00	
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)			R0,00	
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)			R0,00	

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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)			R0,00	
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent				
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	Licenced 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				
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				

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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	20	10,000	R146,80	
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	20	109,000	R1 603,10	
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned)				
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.			R0,00	
III.	**PROCEDURES**				
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use item 6999				
	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				

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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)	10	7,500	R231,90	
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	20	6,000	R114,90	
0204	Inhalation sedation: Per additional quarter-hour or part thereof	20	3,000	R57,30	
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	20	12,000	R229,40	
0206	Intravenous treatment: Intravenous infusions (push-in) (patients over three years): Insertion of cannula - chargeable once per 24 hours	20	6,000	R114,90	
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years): Cut-down and insertion of cannula - chargeable once per 24 hours	20	8,000	R152,90	
0208	Venesection: Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	20	6,000	R114,90	
0209	Umbilical artery cannulation at birth	20	18,000	R344,00	
0210	Collection of blood/pap smear specimen(s) by medical practitioner for pathology examination, per venesection/sample (not to be used by pathologists)	20	3,250	R62,10	
0211	Exchange transfusion: First and subsequent (including after-care)	20	80,000	R1 529,60	

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	"Note: HOW TO CHARGE FOR INTRAVENOUS INFUSIONS:				
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	20	5,000	R73,60	
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	20	9,000	R132,40	
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	20	14,000	R205,80	
1.3	Oncology related services in non-oncology facilties				
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included	20	394,860	R5 806,70	z
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included	20	262,410	R3 858,90	z
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included	20	77,810	R1 144,50	z
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)	20	42,650	R627,20	z
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS				
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/ theatre account.				
0021	Determination of anaesthetic fees: (a) Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column [refer to modifier 0027 for more than one procedure under the same anaesthetic]) plus the time units (calculated according to the formula in Modifier 0023) and the appropriate modifers (see modifiers 0026 and 0037-0044). (b) In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by Modifiers 5441 to 5448. c) The appropriate physical status modifier (refer to modifiers 5431-5436) should also be added.				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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				
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.				
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				

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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				
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage				
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour: Add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof				
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units				
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3,00 anaesthetic units				
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3,00 anaesthetic units				
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				
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				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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				
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units				
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units				
5444	Shaft of femur: Add four (4,00) anaesthetic units				
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units				
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units				
5433	Physical status modifier: A patient with sever systemic disease, ASA 3: Add 1.00 anaesthetic unit				
5434	Physical status modifier: A patient with sever systemic disease that is a constant threat to life, ASA 4: Add 2.00 anaesthetic units				
5435	Physical status modifier: A moribund patient who is not expected to survivie without an operation, ASA 5: Add 3.00 anaesthetic units				
	POST-OPERATIVE ALLEVIATION OF PAIN				
0045	"Post-operative alleviation of pain:				
2	**INTEGUMENTARY SYSTEM**				
2.1	Allergy				
0217	Allergy: Patch tests: First patch	20	4,000	R76,70	
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	20	2,800	R53,70	
0219	Allergy: Patch tests: Each additional patch	20	2,000	R38,20	
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	20	1,900	R36,40	
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen	20	2,800	R53,70	
2.2	Skin (general)				
0222	Intralesional injection into areas of pathology e.g. Keloid: Single	20	4,000	R59,10	
0223	Intralesional injection into areas of pathology e.g. Keloids: Multiple	20	8,000	R117,50	

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0225	Epilation: Per session	20	8,000	R117,50	
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	20	8,000	R117,50	
0228	PUVA Treatment: Maximum of 21 treatments	20	20,000	R294,20	
0229	PUVA: Follow-up or maintenance therapy once a week	20	20,000	R294,20	
0230	UVR-Treatment	20	20,000	R294,20	
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	20	5,500	R80,90	
0232	Biopsy of superficial soft tissue: Back or flank		47,400	R906,00	
0233	Biopsy without suturing: First lesion	20	6,000	R114,90	
0234	Biopsy without suturing: Subsequent lesions (each)	20	3,000	R57,30	
0235	Biopsy without suturing: Maximum for multiple additional lesions	20	18,000	R344,00	
0236	Biopsy of superficial soft tissue: Shoulder area		49,100	R938,40	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	20	12,000	R176,50	
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		49,100	R938,40	
0239	Biopsy of superficial soft tissue: Forearm and/or wrist		48,500	R926,90	
0240	Biopsy of superficial soft tissue: Leg or ankle area		48,300	R923,10	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	20	6,000	R88,30	
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	20	3,000	R44,00	
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	20	42,000	R617,70	
0244	Repair of nail bed	20	30,000	R441,20	
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	20	14,000	R205,80	
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	20	7,000	R103,10	
0247	Biopsy of superficial soft tissue: Pelvis and hip area		58,300	R857,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0248	Biopsy of superficial soft tissue: Thigh or knee area		52,300	R768,90	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	20	30,000	R441,20	
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	20	15,000	R220,60	
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	20	20,000	R294,20	
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	20	87,000	R1 279,30	
0259	Removal of foreign body superficial to deep fascia (except hands)	20	20,000	R294,20	
0261	Removal of foreign body deep to deep fascia (except hands)	20	31,000	R455,90	
0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax; less than 3 cm		90,100	R1 324,60	
0263	Excision tumour of subcutaneous soft tissue: Shoulder area; less than 3 cm		84,200	R1 238,00	
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area; less than 3 cm		94,500	R1 389,30	
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area; less than 3 cm		94,700	R1 392,20	
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger; less than 1,5 cm		99,300	R1 459,70	
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area; less than 3 cm		111,600	R1 640,80	
0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area; less than 3 cm		92,100	R1 353,90	
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area; less than 3 cm		92,600	R1 361,20	
0270	Excision tumour of subcutaneous soft tissue: Foot or toe; less than 1,5 cm		78,300	R1 151,10	
0271	Kurtin planing for acne scarring: Whole face	20	206,000	R3 029,30	
0273	Kurtin planing for acne scarring: Extensive	20	70,000	R1 029,50	
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		113,900	R1 674,60	
0275	Kurtin planing for acne scarring: Limited	20	30,000	R441,20	
0276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional stage after the first stage, up to 5 tissue blocks		60,500	R889,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	20	103,000	R1 514,60	
0278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional block after the first 5 tissue blocks, any stage		15,900	R233,80	
0279	Surgical treatment for axillary hyperhidrosis	20	64,000	R941,40	
0280	Laser treatment for small skin lesions: First lesion	20	14,000	R205,80	
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	20	7,000	R103,10	
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	20	56,000	R823,70	
0283	Laser treatment for large skin lesions: Limited area	20	30,000	R441,20	
0284	Laser treatment for large skin lesions: Extensive area	20	70,000	R1 029,50	
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	20	206,000	R3 029,30	
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	20	56,630	R832,70	
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	20	43,440	R638,90	
0258	Incision/removal of foreign body: Subcutaneous tissue, simple		31,000	R456,20	
0260	Incision/removal of foreign body: Subcutaneous tissue, complicated		31,000	R455,90	
2.3	Major plastic repair				
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	20	234,000	R3 441,10	
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	20	410,000	R6 029,40	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	20	800,000	R11 765,00	
0292	Distant flaps: First stage	20	206,000	R3 029,30	
0293	Contour grafts (excluding cost of material)	20	206,000	R3 029,30	
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	20	1200,000	R17 647,00	
0295	Local skin flaps (large, complicated)	20	206,000	R3 029,30	
0296	Other procedures of major technical nature	20	206,000	R3 029,30	
0297	Subsequent major procedures for repair of same lesion	20	104,000	R1 529,40	

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0298	Lower abdominal dermo-lipectomy	20	170,000	R2 500,10	
0299	Major abdominal lipectomy with repositioning of umbilicus	20	275,000	R4 044,30	
0288	Harvesting of graft: Fascia lata graft, complex or sheet		127,400	R1 873,50	
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)	20	14,000	R205,80	
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	20	7,000	R103,10	
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	20	64,000	R941,40	
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	20	128,000	R1 882,30	
0304	Major debridement of wound, sloughectomy or secondary suture	20	50,000	R735,50	
0305	Needle biopsy - soft tissue	20	25,000	R367,60	
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	20	27,000	R397,20	
0308	Each additional small procedure done at the same time	20	14,000	R205,80	
0310	Radical excision of nailbed	20	38,000	R558,90	
0311	Excision of large benign tumour (more than 5 cm)	20	55,000	R808,70	
0313	Extensive resection for malignant soft tissue tumour including muscle	20	283,900	R4 175,30	
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	20	104,000	R1 529,40	
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	20	55,000	R808,70	
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		13,900	R204,60	
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof		5,300	R77,90	
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		36,000	R529,10	
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof		11,200	R164,60	
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		62,500	R918,80	
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof		19,500	R286,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4880	Biopsy soft tissue: Neck or thorax		46,400	R682,00	
4881	Biopsy of soft tissue: Deep: Back or flank		100,400	R1 476,00	
4882	Biopsy of soft tissue: Deep: Shoulder area		117,600	R1 728,70	
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular): Upper arm or elbow area		117,600	R1 728,70	
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular): Forearm and/or wrist		106,600	R1 567,10	
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular): Thigh or knee area		112,900	R1 659,80	
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular): Leg or ankle area		119,500	R1 756,80	
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular): Pelvis and hip area		197,700	R2 906,50	
0306	Excision subcutaneous mass <2cm: Head and neck, eg., lipoma, cyst		55,000	R808,70	
0309	Excision subcutaneous mass >2cm: Head and neck, eg., lipoma, cyst		104,000	R1 529,40	
0312	Excision subcutaneous mass>2cm involving muscle/subgaleal: Head and neck, eg., lipoma, cyst		104,000	R1 529,40	
0318	Excision subcutaneous mass <2cm involving muscle/subgaleal: Head and neck, eg., lipoma, cyst		101,900	R1 498,50	
4840	Excision malignant lesion, including margins: Trunk/arms/legs <=0.5 cm		30,000	R441,20	
4841	Excision malignant lesion, including margins: Trunk/arms/legs 0.6-1.0 cm		30,000	R441,20	
4842	Excision malignant lesion, including margins: Trunk/arms/legs 1.1-2.0 cm		45,000	R661,80	
4843	Excision malignant lesion, including margins: Trunk/arms/legs 2.1-3.0 cm		60,000	R882,40	
4844	Excision malignant lesion, including margins: Trunk/arms/legs 3.1-4.0 cm		75,000	R1 103,00	
4845	Excision malignant lesion, including margins: Trunk/arms/legs >4.0 cm		90,000	R1 323,60	
4848	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane <=0.5 cm		30,000	R441,20	
4849	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 0.6-1.0 cm		30,000	R441,20	
4850	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 1.1-2.0 cm		45,000	R661,80	
4851	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 2.1-3.0 cm		60,000	R882,40	
4852	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 3.1-4.0 cm		75,000	R1 103,00	
4853	Excision malignant lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane > 4.0 cm		90,000	R1 323,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4856	Split thickness autograft of the trunk, arms and/or legs <=100 cm (1% of body area for infants and children)		104,000	R1 529,40	
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)		31,500	R463,20	
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)		104,000	R1 529,40	
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)		51,600	R758,80	
4862	Full thickness graft of the trunk, free graft including direct closure of donor site: <=20cm		104,000	R1 529,40	
4863	Full thickness graft of the trunk, free graft including direct closure of donor site, each additional 20cm (modifier 0005 not applicable)		25,600	R376,40	
4864	Full thickness graft of the scalp, arms and/or legs, free graft including direct closure of donor site: <=20cm		104,000	R1 529,40	
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)		23,000	R338,20	
4866	Full thickness graft of the face, neck, axilla, genitalia, hands and/or feet, free graft including direct closure of donor site: <=20cm		104,000	R1 529,40	
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)		36,200	R532,30	
4868	Full thickness graft of the nose, ears, eyelids and/or lips, free graft including direct closure of donor site: <=20cm		104,000	R1 529,40	
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)		43,100	R633,70	
4940	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) <= 0.5 cm		14,000	R205,80	
4941	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 0.6-1.0 cm		27,000	R397,20	
4942	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 1.1-2.0 cm		14,000	R205,80	
4943	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 2.1-3.0 cm		7,000	R103,10	
4944	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) 3.1-4.0 cm		14,000	R205,80	
4945	Excision, benign lesion, including margins: Trunk/arms/legs (except skin tags) > 4.0 cm		14,000	R205,80	
4950	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia		14,000	R205,80	
4951	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 0.6-1.0 cm		14,000	R205,80	

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4952	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 1.1-2.0 cm		14,000	R205,80	
4953	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 2.1-3.0 cm		14,000	R205,80	
4954	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia 3.1-4.0 cm		14,000	R205,80	
4955	Excision benign lesion, including margins: Scalp/neck/hands/feet/genitalia > 4.0 cm		14,000	R205,80	
4960	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane		14,000	R205,80	
4961	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 0.6-1.0 cm		14,000	R205,80	
4962	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 1.1-2.0 cm		14,000	R205,80	
4963	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 2.1-3.0 cm		14,000	R205,80	
4964	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane 3.1-4.0 cm		14,000	R205,80	
4965	Excision benign lesion, including margins: Face/ears/eyelids/nose/lips/mucous membrane > 4.0 cm		14,000	R205,80	
4970	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia		14,000	R205,80	
4971	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 0.6-1.0 cm		30,000	R441,20	
4972	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 1.1-2.0 cm		14,000	R205,80	
4973	Excision, malignant lesio, including margins: Scalp/neck/hands/feet/genitalia 2.1-3.0 cm		14,000	R205,80	
4974	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia 3.1-4.0 cm		30,000	R441,20	
4975	Excision, malignant lesion, including margins: Scalp/neck/hands/feet/genitalia > 4.0 cm		14,000	R205,80	
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100 cm (1% of body area for infants and children)				Refer Rule C
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)	20	15,000	R220,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0317	Aspiration of cyst or tumour	20	9,000	R132,40	
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	20	42,000	R617,70	
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	20	94,200	R1 385,30	
0323	Subareolar cone excision of ducts of wedge excision of breast	20	90,000	R1 323,60	
0324	Wedge excision of breast and axillary dissection	20	225,000	R3 308,80	
0325	Total mastectomy	20	155,000	R2 279,60	
0327	Total mastectomy with axillary gland biopsy	20	185,000	R2 720,70	
0329	Total mastectomy with axillary gland dissection	20	275,000	R4 044,30	
0330	Nipple and areola reconstruction	20	95,000	R1 397,00	
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	20	234,000	R3 441,10	
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	20	410,000	R6 029,40	
0334	Removal of breast implant by means of capsulectomy: Per breast	20	234,000	R3 441,10	
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	20	150,000	R2 205,90	
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	20	234,000	R3 441,10	
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	20	410,000	R6 029,40	
0341	Gynaecomastia: Unilateral	20	92,000	R1 353,00	
0343	Gynaecomastia: Bilateral	20	161,000	R2 367,50	
0338	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle (suture of donor site included)		467,300	R6 872,00	
0340	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), single pedicle, with microvascular anastomosis (supercharging) (suture of donor site included)		555,500	R8 169,10	
0342	Breast reconstruction: Transverse rectus abdominis myocutaneous flap (TRAM), double pedicle (suture of donor site included)		526,500	R7 742,60	
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)	20	276,000	R4 058,80	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0353	Tangential excision and grafting: Small	20	100,000	R1 470,60	
0354	Tangential excision and grafting: Large	20	200,000	R2 941,10	
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	20	147,400	R2 167,70	
0357	Small skin graft in acute hand injury	20	45,000	R661,90	
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	20	192,000	R2 823,60	
0361	Z-plasty	20	220,100	R3 236,80	
0363	Local flap and skin graft	20	150,000	R2 205,90	
0365	Cross finger flap (all stages)	20	192,000	R2 823,60	
0367	Palmar flap (all stages)	20	192,000	R2 823,60	
0369	Distant flap: First stage	20	158,000	R2 323,70	
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	20	77,000	R1 132,50	
0373	Transfer neurovascular island flap	20	230,500	R3 389,70	
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	20	242,400	R3 564,50	
0375	Dupuytren's contracture: Fasciotomy	20	51,000	R749,90	
0376	Dupuytren's contracture: Fasciectomy	20	218,000	R3 205,90	
2.8	Acupuncture				
	Please note: General Rule M not applicable to section 2.8 of this price list				
0377	Standard acupuncture	20	10,000	R190,90	
0378	Laser acupuncture using more than 6 points	20	14,000	R267,50	
0379	Electro-acupuncture	20	14,000	R267,50	
0380	Scalp acupuncture	20	10,000	R190,90	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0381	Micro-acupuncture (ear, hand)	20	10,000	R190,90	
	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)	20	27,000	R397,20	
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	20	77,000	R1 132,50	
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)	20	115,500	R1 698,50	
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	20	77,000	R1 132,50	
0052	Except where otherwise specified, fracture (traumatic or surgical, ie. 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		81,100	R1 192,20	
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	20	32,000	R470,60	
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	20	77,000	R1 132,50	

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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	20	3,000	R1 651,00	
0384	Fracture: Scapula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		284,200	R4 178,10	
0386	Fracture: Clavicle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		209,400	R3 078,30	
0387	Fracture (reduction under general anaesthetic): Clavicle	20	77,000	R1 132,50	
0388	Percutaneous pinning of supracondylar fracture: Elbow - stand alone procedure	20	175,700	R2 583,70	
0389	Fracture (reduction under general anaesthetic): Humerus	20	111,600	R1 641,30	
0390	Fracture: Humerus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		255,300	R3 753,10	
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	20	77,000	R1 132,50	
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	20	210,000	R3 088,30	
0401	Fracture: Carpal bone: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		208,700	R3 068,00	
0402	Fracture (reduction under general anaesthetic): Carpal bone	20	64,000	R941,40	
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	20	51,000	R749,90	
0404	Fracture: Bennett fracture/dislocation: Open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)		179,800	R2 643,30	
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal: Simple	20	118,300	R1 739,60	
0406	Fracture: Metacarpal bone: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		163,600	R2 405,10	
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	20	3,000	R1 132,10	
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		141,100	R2 074,20	
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Compound	20	52,000	R764,80	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0413	Fracture (reduction under general anaesthetic): Proximal or middle: Simple	20	48,000	R705,80	
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		169,900	R2 497,70	
0415	Fracture (reduction under general anaesthetic): Proximal or middle: Compound	20	102,000	R1 500,10	
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed	20	3,000	R2 017,00	
0419	Fracture (reduction under general anaesthetic): Pelvis: Operative reduction and fixation	20	320,000	R4 706,00	
0420	Fracture: Acetabulum: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		560,000	R8 232,60	
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	20	237,000	R3 485,20	
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		392,300	R5 767,10	
0425	Fracture (reduction under general anaesthetic): Patella	20	51,000	R749,90	
0426	Fracture: Patella: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		219,500	R3 226,90	
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	20	128,000	R1 882,30	
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable		293,200	R4 310,20	
0433	Fracture (reduction under general anaesthetic): Fibula shaft	20	3,000	R1 652,40	
0434	Fracture: Fibula shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207,000	R3 043,20	
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	20	58,000	R852,90	
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207,100	R3 044,60	
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	20	128,000	R1 882,30	
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	20	198,700	R2 922,00	
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	20	64,000	R941,40	
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	20	403,500	R5 934,00	
0441	Fracture (reduction under general anaesthetic): Metatarsal	20	41,800	R614,50	
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		154,700	R2 274,30	
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal Simple	20	-		
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		144,500	R2 124,20	

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0445	Fracture (reduction under general anaesthetic): Toe phalanx: Compound	20	32,000	R470,60	
0446	Fracture: Tarsal bones (excluding talus and calcaneus): Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		178,200	R2 619,80	
0447	Fracture (reduction under general anaesthetic): Other: Simple	20	26,000	R382,30	
0448	Fracture: Calcaneus (reduction under general anaesthetic)		103,300	R1 518,70	
0449	Fracture (reduction under general anaesthetic): Other: Compound	20	52,000	R764,80	
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Closed	20	-		
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	20	230,000	R3 382,40	
0455	Fracture (reduction under general anaesthetic): Spine: With or without paralysis: Cervical	20	-		
0461	Fracture (reduction under general anaesthetic): Compression fracture: Cervical	20	-		
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Cervical	20	-		
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes: Rest	20	-		
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)	20	288,000	R4 235,30	
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		210,900	R3 100,60	
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	20	43,000	R632,50	
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	20	282,000	R4 147,20	
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	20	154,000	R2 264,70	
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		415,000	R6 100,90	
0481	Radical resection of bone tumour: Fibula		240,100	R3 529,80	
0482	Radical resection of bone tumour: Femur or knee		371,800	R5 465,80	
0483	Radical resection of malignant bone tumour: Scapula		237,700	R3 494,40	
0484	Radical resection of bone tumour: Clavicle		413,800	R6 083,40	
0485	Radical resection of bone tumour: Metatarsal		185,000	R2 719,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3.1.2	Bony operations				
3.1.2.1	Bony operations: Bone grafting				
0497	Resection of bone or tumour with or without grafting (benign)	20	282,000	R4 147,20	
0498	Resection of bone or tumour with or without grafting (malignant) - does not include digits	20	340,000	R5 000,10	
0499	Grafts to cysts: Large bones	20	192,000	R2 823,60	
0501	Grafts to cysts: Small bones	20	128,000	R1 882,30	
0503	Grafts to cysts: Cartilage graft	20	206,000	R3 029,30	
0505	Grafts to cysts: Inter-metacarpal bone graft	20	147,000	R2 161,70	
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	20	50,000	R735,50	
0506	Harvesting of graft: Cartilage graft, costochondral		91,100	R1 340,20	
3.1.2.2	Bony operations: Acute or chronic osteomyelitis				
0509	Acute or chronic osteomyelitis: Conservative treatment	20	-		
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	20	128,000	R1 882,30	
3.1.2.3	Bony operations: Osteotomy				
0514	Osteotomy: Sternum: Repair of pectus excavatum	20	330,000	R4 852,90	
0515	Osteotomy: Sternum: Repair of pectus carinatum	20	330,000	R4 852,90	
0516	Osteotomy: Pelvic	20	320,000	R4 706,00	
0521	Osteotomy: Femoral: Proximal	20	320,000	R4 706,00	
0527	Osteotomy: Knee region	20	320,000	R4 706,00	
0528	Osteotomy: Os Calcis (Dwyer operation)	20	115,000	R1 691,20	
0530	Osteotomy: Metacarpal and phalanx: Corrective for malunion or rotation	20	120,000	R1 764,40	
0531	Rotational osteotomy of tibia and fibula - stand alone procedure	20	278,900	R4 101,20	
0532	Osteotomy: Rotation osteotomy of the Radius, Ulna or Humerus	20	160,000	R2 353,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
0533	Osteotomy: Single metatarsal	20	60,000	R882,40	
0534	Osteotomy: Multiple metatarsal osteotomies	20	150,000	R2 205,90	
3.1.2.4	Bony operations: Exostosis				
0535	Exostosis: Excision: Readily accessible sites	20	60,000	R882,40	
0537	Exostosis: Excision: Less accessible sites	20	96,000	R1 411,80	
3.1.2.5	Bony operations: Biopsy				
0539	Needle Biopsy: Spine (no after-care) (modifier 0005 not applicable)	20	50,000	R735,50	
0541	Needle Biopsy: Other sites (no after-care) (modifier 0005 not applicable)	20	32,000	R470,60	
0543	Biopsy: Open (modifier 0005 not applicable): Readily accessible site	20	64,000	R941,40	
0545	Biopsy: Open (modifier 0005 not applicable): Less accessible site	20	96,000	R1 411,80	
3.2	Joints				
3.2.1	Joints: Dislocations				
0547	Joint: Dislocation: Clavicle either end	20	38,000	R558,90	
0549	Joint: Dislocation: Shoulder	20	51,000	R749,90	
0551	Joint: Dislocation: Elbow	20	51,000	R749,90	
0552	Joint: Dislocation: Wrist	20	77,000	R1 132,50	
0553	Joint: Dislocation: Perilunar trans-scaphoid fracture dislocation	20	130,000	R1 911,90	
0555	Joint: Dislocation: Lunate	20	77,000	R1 132,50	
0556	Joint: Dislocation: Carpo-metacarpo dislocation	20	51,000	R749,90	
0557	Joint: Dislocation: Metacarpo-phalangeal or interphalangeal (hand)	20	26,000	R382,30	
0559	Joint: Dislocation: Hip	20	109,000	R1 603,10	
0561	Joint: Dislocation: Knee	20	96,000	R1 411,80	
0563	Joint: Dislocation: Patella	20	32,000	R470,60	
0565	Joint: Dislocation: Ankle	20	90,000	R1 323,60	

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0567	Joint: Dislocation: Sub-Talar dislocation	20	90,000	R1 323,60	
0569	Joint: Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	20	77,000	R1 132,50	
0571	Joint: Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	20	14,000	R205,80	
3.2.2	Joints: Operations for dislocations				
0578	Operations for dislocations: Recurrent dislocation of shoulder	20	200,000	R2 941,10	
0579	Operations for dislocations: Recurrent dislocation of all other joints	20	161,000	R2 367,50	
3.2.3	Joints: Capsular operations				
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	20	51,000	R749,90	
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	20	96,000	R1 411,80	
0585	Capsulectomy digital joint	20	64,000	R941,40	
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	20	90,000	R1 323,60	
0587	Release of digital joint contracture	20	128,000	R1 882,30	
3.2.4	Joints: Synovectomy				
0589	Synovectomy: Digital joint	20	77,000	R1 132,50	
0592	Synovectomy: Large joint	20	160,000	R2 353,00	
0593	Tendon synovectomy	20	203,700	R2 995,70	
3.2.5	Joints: Arthrodesis				
0597	Arthrodesis: Shoulder	20	224,000	R3 294,10	
0598	Arthrodesis: Elbow	20	180,000	R2 646,90	
0599	Arthrodesis: Wrist	20	180,000	R2 646,90	
0600	Arthrodesis: Digital joint	20	128,000	R1 882,30	
0601	Arthrodesis: Hip	20	320,000	R4 706,00	
0602	Arthrodesis: Knee	20	180,000	R2 646,90	
0603	Arthrodesis: Ankle	20	180,000	R2 646,90	

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0604	Arthrodesis: Sub-talar	20	130,000	R1 911,90	
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	20	180,000	R2 646,90	
0607	Arthrodesis: Mid-tarsal wedge resection	20	180,000	R2 646,90	
3.2.6	Joints: Arthroplasty				
0614	Arthroplasty: Debridement large joints	20	160,000	R2 353,00	
0615	Arthroplasty: Excision medial or lateral end of clavicle	20	116,000	R1 706,00	
0617	Shoulder: Acromioplasty	20	192,000	R2 823,60	
0619	Shoulder: Partial replacement	20	277,000	R4 073,60	
0620	Shoulder: Total replacement	20	416,000	R6 117,80	
0621	Elbow: Excision head of radius	20	96,000	R1 411,80	
0622	Elbow: Excision	20	192,000	R2 823,60	
0623	Elbow: Partial replacement	20	188,000	R2 764,90	
0624	Elbow: Total replacement	20	282,000	R4 147,20	
0625	Wrist: Excision distal end of ulna	20	96,000	R1 411,80	
0626	Wrist: Excision single bone	20	110,000	R1 617,70	
0627	Wrist: Excision proximal row	20	166,000	R2 441,20	
0631	Wrist: Total replacement	20	249,000	R3 661,80	
0635	Digital Joint: Total replacement	20	192,000	R2 823,60	
0637	Hip: Total replacement	20	416,000	R6 117,80	
0641	Hip: Prosthetic replacement of femoral head	20	288,000	R4 235,30	
0643	Hip: Girdlestone	20	320,000	R4 706,00	
0645	Knee: Partial replacement	20	277,000	R4 073,60	
0646	Knee: Total replacement	20	416,000	R6 117,80	
0649	Ankle: Total replacement	20	290,400	R4 270,70	

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0650	Ankle: Astragalectomy	20	154,000	R2 264,70	
3.2.7	Joints: Miscellaneous (joints)				
0661	Aspiration of joint or intra-articular injection (not including after-care) (modifier 0005 not applicable)	20	9,000	R172,40	
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): First joint	20	7,500	R143,40	
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) (modifier 0005 not applicable): Additional (each)	20	4,000	R76,70	
0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	20	60,000	R882,40	
0669	Manipulation knee or shoulder joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	20	14,000	R205,80	
0669A	Manipulation hip joint under general anaesthetic (not including after-care) (modifier 0005 not applicable)	20	14,000	R205,80	
	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	20	109,000	R1 603,10	
0658	Aspiration and/or injection: Small joint, bursa (eg., fingers, toes) (excluding after care, modifier 0005 not applicable)		9,000	R132,40	
0659	Aspiration and/or injection: Intermediate joint, bursa (eg., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (excluding after care, modifier 0005 not applicable)		9,000	R132,40	
0660	Aspiration and/or injection: Major joint, bursa (eg., shoulder, hip, knee joint, subacromial bursa) (excluding after care, modifier 0005 not applicable)		9,000	R132,40	
0668	Manipulation of knee joint under general anaesthesia (includes application of traction or other fixation devices) (excluding after-care) (modifier 0005 is not applicable)		14,000	R205,80	
0670	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Knee/Shoulder				
0670a	Only the consultation fee should be charged when manipulation of a large joint is performed with or without local anaesthetic - Anaesthetic: Hip				
3.2.8	Joints: Joint ligament reconstruction or suture				
0675	Joint ligament reconstruction or suture: Ankle: Collateral	20	160,000	R2 353,00	
0677	Joint ligament reconstruction or suture: Knee: Collateral	20	160,000	R2 353,00	
0678	Joint ligament reconstruction or suture: Knee: Cruciate	20	160,000	R2 353,00	
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	20	280,000	R4 118,00	

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0680	Joint ligament reconstruction or suture: Digital joint ligament	20	165,000	R2 426,50	
0676	Joint ligament reconstruction or suture: Ankle (eg., Watson-Jones type)		191,500	R2 816,20	
3.3	Amputations				
3.3.1	Amputations: Specific Amputations				
0681	Amputation Humerus: Includes primary closure		211,600	R3 110,80	
0682	Amputation: Fore-quarter amputation	20	294,000	R4 323,80	
0683	Amputation: Through shoulder	20	148,000	R2 176,40	
0684	Amputation: Forearm		213,500	R3 138,70	
0685	Amputation: Upper arm or fore-arm	20	116,000	R1 706,00	
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		204,100	R3 000,40	
0687	Partial amputation of the hand: One ray	20	102,000	R1 500,10	
0688	Amputation: Foot, midtarsal (Chopart type)		165,700	R2 436,00	
0691	Amputation: Whole or part of finger	20	116,800	R1 717,70	
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		150,700	R2 215,50	
0693	Hindquarter amputation	20	420,000	R6 176,40	
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		173,900	R2 556,60	
0695	Amputation: Through hip joint region	20	192,000	R2 823,60	
0696	Re-amputation: Thigh, through femur, any level		217,300	R3 194,50	
0697	Amputation: Through thigh	20	205,000	R3 014,80	
0698	Re-amputation: Leg, through tibia and fibula		198,200	R2 913,80	
0699	Amputation: Below knee, through knee or Syme	20	194,000	R2 853,20	
0700	Scar revision/secondary closure: Amputated shoulder		128,100	R1 883,20	
0701	Amputation: Trans-metatarsal or trans-tarsal	20	142,000	R2 088,40	
0702	Scar revision/secondary closure: Amputated humerus		163,100	R2 397,70	

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0703	Amputation: Foot: One ray	20	97,000	R1 426,70	
0704	Scar revision/secondary closure: Amputated forearm		184,100	R2 706,40	
0705	Amputation: Toe	20	66,000	R970,40	
0708	Re-amputation: Humerus		223,100	R3 279,70	
0710	Re-amputation: Through forearm		206,000	R3 028,40	
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	20	75,000	R1 103,00	
0707	Post-amputation reconstruction: Krukenberg reconstruction	20	206,000	R3 029,30	
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	20	282,000	R4 147,20	
0712	Post-amputation reconstruction: Toe to thumb transfer	20	800,000	R11 765,00	
3.4	Muscles, tendons and fasciae				
3.4.1	Muscles, tendons and fasciae: Investigations				
0713	Electromyography	20	75,000	R1 434,00	
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with item 2730)	20	57,000	R1 089,70	
0715	Strength duration curve per session	20	10,500	R200,70	
0717	Electrical examination of single nerve or muscle	20	9,000	R172,40	
0718	Oxidative study for mitochondrial function	20	64,000	R1 223,70	
0721	Voltage integration during isometric contraction	20	12,000	R229,40	
0723	Tonometry with edrophonium	20	8,000	R152,90	
0725	Isometric tension studies with edrophonium	20	10,000	R190,90	
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	20	8,000	R152,90	
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	20	14,000	R267,50	
0729	Tendon reflex time	20	7,000	R134,00	
0730	Limb brain somatosensory studies (per limb)	20	49,000	R936,90	

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0731	Vision and audio-sensory studies	20	49,000	R936,90	
0733	Motor nerve conduction studies (single nerve)	20	26,000	R497,20	
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	20	31,000	R592,50	
0737	Biopsy for motor nerve terminals and end plates	20	20,000	R382,30	
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	20	34,000	R649,90	
0740	Muscle fatigue studies	20	20,000	R382,30	
0741	Muscle biopsy	20	20,000	R382,30	
0742	Global fee for all muscle studies, including histochemical studies	20	262,000	R5 008,70	
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	20	20,250	R387,00	
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	20	33,300	R636,60	
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	20	5,700	R109,00	
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	20	1,600	R30,50	
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	20	9,900	R189,30	
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	20	13,700	R262,00	
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	20	25,900	R495,20	
4715	Biochemical estimations on muscle biopsy specimens: Enolase	20	32,700	R625,00	
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	20	37,700	R720,90	
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	20	15,750	R301,40	
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	20	11,060	R211,70	
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	20	34,700	R663,40	
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	20	40,300	R770,50	
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase	20	28,800	R550,50	
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	20	43,000	R822,30	
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	20	14,000	R267,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	20	20,000	R382,30	
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	20	71,000	R1 357,20	
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	20	69,000	R1 318,90	
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation	20	82,000	R1 567,90	
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	20	143,000	R2 733,80	
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	20	75,000	R1 434,00	
3.4.2	Muscles, tendons and fasciae: Decompression Operations				
0743	Major compartmental decompression	20	132,000	R1 941,10	
0744	Decompression operation: Fasciotomy only	20	60,000	R882,40	
5550	Decompression Faciotomy: Buttock compartments:(unilateral)		243,000	R3 572,40	
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		151,900	R2 233,20	
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		253,100	R3 720,80	
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve		123,700	R1 818,40	
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/ or nerv		162,100	R2 383,30	
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		130,800	R1 923,00	
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		171,500	R2 521,30	
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		137,300	R2 018,50	
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe		86,600	R1 273,20	
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		226,300	R3 327,00	
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		354,500	R5 211,50	

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5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		166,800	R2 452,10	
5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		321,100	R4 720,50	
5563	Decompression Faciotomy: Fingers and/or hand		165,600	R2 434,40	
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair				
0745	Muscle and tendon repair: Biceps humeri	20	109,000	R1 603,10	
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	20	96,000	R1 411,80	
0747	Muscle and tendon repair: Rotator cuff	20	134,000	R1 970,60	
0748	Muscle and tendon repair: Debridement rotator cuff	20	139,700	R2 054,60	
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	20	271,900	R3 998,80	
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	20	128,000	R1 882,30	
0757	Muscle and tendon repair: Achilles tendon repair	20	197,600	R2 906,00	
0759	Muscle and tendon repair: Other single tendon	20	77,000	R1 132,50	
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (modifier 0005 applicable)		220,300	R3 238,70	
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (modifier 0005 applicable		249,600	R3 669,20	
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (modifier 0005 applicable		191,300	R2 812,40	
0763	Muscle and tendon repair: Tendon or ligament injection	20	9,000	R132,40	
0764	Hand: Flexor tendon repair: Secondary, zone 1		243,900	R3 585,70	
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)		249,600	R3 669,20	
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)		190,600	R2 802,00	
0767	Hand: Flexor tendon suture: Primary (per tendon)	20	128,000	R1 882,30	
0768	Repair: Intrinsic muscles of hand (each) (modifier 0005 applicable)		125,300	R1 841,90	
0769	Hand: Flexor tendon suture: Secondary (per tendon)	20	160,000	R2 353,00	
0771	Extensor tendon suture: Primary (per tendon)	20	129,700	R1 907,40	

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0773	Extensor tendon suture: Secondary (per tendon)	20	80,000	R1 176,50	
0774	Repair of Boutonniere deformity or Mallet finger with graft	20	183,700	R2 701,40	
3.4.4	Muscles, tendons and fasciae: Tendon graft				
0775	Free tendon graft	20	160,000	R2 353,00	
0776	Reconstruction of pulley for flexor tendon	20	50,000	R735,50	
0777	Tendon graft: Finger: Flexor	20	192,000	R2 823,60	
0779	Tendon graft: Finger: Extensor	20	122,000	R1 794,20	
0780	Two stage flexor tendon graft using silastic rod	20	240,000	R3 529,40	
3.4.5	Muscles, tendons and fasciae: Tendolysis				
0781	Tendon freeing operation, except where specified elsewhere	20	64,000	R941,40	
0782	Carpal tunnel syndrome	20	98,700	R1 451,70	
0783	Tenolysis: De Quervain	20	38,000	R558,90	
0784	Trigger finger	20	38,000	R558,90	
0785	Flexor tendon freeing operation following free tendon graft or suture	20	186,800	R2 747,30	
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	20	180,900	R2 660,20	
0788	Intrinsic tendon release per finger	20	64,000	R941,40	
0789	Central tendon tenotomy for Boutonniere deformity	20	64,000	R941,40	
3.4.6	Muscles, tendons and fasciae: Tenodesis				
0790	Tenodesis: Digital joint	20	90,000	R1 323,60	
3.4.7	Muscles, tendons and fasciae: Muscle tendon and facia transfer				
0791	Single tendon transfer	20	96,000	R1 411,80	
0792	Multiple tendon transfer	20	128,000	R1 882,30	
0793	Hamstring to quadriceps transfer	20	141,000	R2 073,50	
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	20	320,000	R4 706,00	

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0795	Tendon transfer at elbow	20	116,000	R1 706,00	
0802	Radial club hand repair - stand alone procedure	20	360,300	R5 298,50	
0803	Hand tendons: Single tendon transfer (first)	20	96,000	R1 411,80	
0809	Hand tendons: Substitution for intrinsic paralysis of hand	20	224,000	R3 294,10	
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	20	220,600	R3 244,40	
3.4.8	Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening				
0812	Percutaneous Tenotomy: All sites	20	38,000	R558,90	
0813	Torticollis	20	96,000	R1 411,80	
0815	Scalenotomy	20	132,000	R1 941,10	
0817	Scalenotomy with excision of first rib	20	190,000	R2 794,30	
0821	Tennis elbow	20	96,000	R1 411,80	
0822	Open release elbow (Mitals) - stand alone procedure	20	278,200	R4 091,20	
0823	Excision or slide for Volkmann's Contracture	20	192,000	R2 823,60	
0825	Hip: Open muscle release	20	116,000	R1 706,00	
0829	Knee: Quadriceps plasty	20	160,000	R2 353,00	
0831	Knee: Open tenotomy	20	141,000	R2 073,50	
0835	Calf	20	96,000	R1 411,80	
0837	Open elongation tendon Achilles	20	96,000	R1 411,80	
0838	Percutaneous "Hoke" elongation tendo Achilles	20	79,300	R1 166,10	
0845	Foot: Plantar fasciotomy	20	70,000	R1 029,50	
0846	Foot: Postero-medial release for club-foot	20	192,000	R2 823,60	
3.5	Bursae and ganglia				
0847	Excision: Semimembranosus	20	90,000	R1 323,60	
0849	Excision: Prepatellar	20	45,000	R661,90	

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0851	Excision: Olecranon	20	81,800	R1 202,70	
0853	Excision: Small bursa or ganglion	20	80,900	R1 189,60	
0855	Excision: Compound palmar ganglion or synovectomy	20	128,000	R1 882,30	
0857	Bursae and ganglia: Aspiration or injection (no after-care) (modifier 0005 not applicable)	20	9,000	R132,40	
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	20	282,000	R4 147,20	
0861	Leg equalisation and congenital hips and feet: Leg lengthening	20	416,000	R6 117,80	
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	20	116,000	R1 706,00	
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: One hip	20	109,000	R1 603,10	
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast: Both hips	20	160,000	R2 353,00	
0868	Open reduction of congenital dislocation of the hip	20	186,000	R2 735,30	
0869	Subsequent plasters	20	32,000	R470,60	
0873	Congenital club foot: Manipulation and plaster: One foot	20	26,000	R382,30	
0874	Ponseti technique assistant (medical practitioner)	20	13,000	R190,90	
3.6.2	Musculo-skeletal system: Miscellaneous: Removal of internal fixatives of prosthesis				
0883	Removal of internal fixatives or prosthesis: Readily accessible	20	36,600	R538,20	
0884	Removal of internal fixatives: Less accessible	20	75,500	R1 110,40	
0885	Removal of prosthesis for infection soon after operation	20	128,000	R1 882,30	
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	20	64,000	R941,40	
3.6.2.1	Musculo-skeletal system: Miscellaneous: Removal of foreign bodies				
0644	Removal of foreign body: Shoulder, subcutaneous		20,000	R294,20	
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous		20,000	R294,20	
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular		31,000	R455,90	

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0651	Exploration with removal of deep foreign body: Forearm or wrist		31,000	R455,90	
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue		20,000	R294,20	
0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular		31,000	R455,90	
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular		31,000	R455,90	
0655	Removal of foreign body: Foto, subcutaneous		20,000	R294,20	
0656	Removal of foreign body: Foto, deep		31,000	R455,90	
0657	Removal of foreign body: Foto, complicated		31,000	R455,90	
3.7	Plasters (exclusive of after-care)				
0887	Limb cast (excluding after-care) (modifier 0005 not applicable)	20	13,000	R190,90	
0888	Application of short limb cast (forearm, lower leg) (excluding after-care) (first cast included in procedure)		18,400	R270,50	
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	20	32,000	R470,60	
0891	Turnbuckle cast for scoliosis (excluding after-care)	20	51,000	R749,90	
0892	Application of cast: Revision (walker, window, bivalve) (excluding after-care)		18,900	R277,90	
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	20	19,000	R279,60	
0894	Application of cast: Clubfoot (excluding after-care) (first cast included in procedure		34,000	R499,80	
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	20	302,700	R4 451,60	
0896	Club foot: Posterior release only - stand alone procedure	20	159,300	R2 342,60	
0900	Excision tarsal coalition - stand alone procedure	20	141,500	R2 080,80	
0901	Tenotomy: Single tendon	20	63,300	R931,00	
0903	Hammer toe: One toe	20	99,500	R1 463,50	
0905	Filleting of toe or Ruiz-Mora procedure	20	99,500	R1 463,50	
0906	Arthrodesis Hallux	20	148,000	R2 176,40	

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0907	Silver bunionectomy or similar for Hallux Valgus	20	126,200	R1 855,80	
	Not to be charged with item 0911				
0909	Excision arthroplasty	20	145,200	R2 135,20	
0910	Cheilectomy or metatarsophangeal implant Hallux	20	183,000	R2 691,30	
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	20	189,200	R2 782,30	
	Not to be charged with item 0907				
5730	Hallux Valgus double osteotomy etc.	20	182,600	R2 685,40	
5731	Distal soft tissue procedure for Hallux Valgus	20	173,600	R2 552,90	
5732	Aitkin procedure or similar	20	166,800	R2 453,20	
5734	Removal bony prominence foot e.g. bunionette (ò Bunionette not applicable to COID)	20	91,000	R1 338,00	
5735	Repair angular deformity toe (lesser toes)	20	97,200	R1 429,60	
5736	Sesamoidectomy	20	97,800	R1 438,20	
5737	Repair major foot tendons e.g. Tib Post	20	147,300	R2 166,20	
5738	Repair of dislocating peroneal tendons	20	173,200	R2 547,10	
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar: One foot	20	202,300	R2 974,90	
5740	Steindler strip - plantar fascia	20	97,200	R1 429,60	
5741	Kelikian syndactilly (one web space)	20	97,200	R1 429,60	
5742	Tendon transfer foot	20	172,000	R2 529,60	
5743	Capsulotomy metatarsophalangeal joints: Foot	20	86,800	R1 276,40	
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	20	730,000	R10 735,10	
0913	Replantation of thumb	20	670,000	R9 853,10	
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	20	580,000	R8 529,50	

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0915	Replantation operation through the palm	20	1270,000	R18 676,70	
3.8.4	Special areas: Hands: (Note: Skin: See Integumentary System)				
0919	Tumours: Epidermoid cysts	20	35,000	R514,70	
0920	Tumours: Ganglion or fibroma	20	77,500	R1 139,80	
0921	Tumours: Nodular synovitis (Giant cell tumour of tendon sheath)	20	86,000	R1 264,50	
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	20	19,000	R279,60	
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	20	32,000	R470,60	
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) - Minimum	20	37,000	R544,20	
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		110,000	R1 617,80	
	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	20	16,000	R235,20	
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)	20	207,000	R3 044,40	
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	20	42,000	R617,70	
0929	Manipulation of spine under general anaesthetic: (no after-care) (modifier 0005 not applicable)	20	14,000	R205,80	
0930	Posterior osteotomy of spine: One vertebral segment	20	339,000	R4 985,40	
0931	Posterior spinal fusion: One level	20	385,000	R5 661,90	
0932	Posterior osteotomy of spine: Each additional vertebral segment	20	103,000	R1 514,60	
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	20	315,000	R4 632,30	

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0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	20	103,000	R1 514,60	
0938	Anterior fusion base of skull to C2	20	449,000	R6 603,20	
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	20	160,000	R2 353,00	
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	20	160,000	R2 353,00	
0941	Anterior interbody fusion: One level	20	360,000	R5 294,30	
0942	Anterior interbody fusion: Each additional level	20	102,000	R1 500,10	
0944	Posterior fusion: Occiput to C2	20	390,000	R5 735,10	
0946	Posterior spinal fusion: Each additional level	20	111,000	R1 632,40	
0948	Posterior interbody lumbar fusion: One level	20	364,000	R5 352,70	
0950	Posterior interbody lumbar fusion: Each additional interspace	20	95,000	R1 397,00	
0959	Excision of coccyx	20	96,000	R1 411,80	
0961	Costo-transversectomy	20	198,000	R2 911,70	
0963	Antero-lateral decompression of spinal cord or anterior debridement	20	326,000	R4 794,40	
	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 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	20	359,000	R5 279,50	
0954	Posterior fusion for spinal deformity: 7 to 12 levels	20	547,000	R8 044,20	
0955	Posterior fusion for spinal deformity: 13 or more levels	20	593,000	R8 720,50	
0956	Anterior fusion for spinal deformity: 2 or 3 levels	20	410,000	R6 029,40	
0957	Anterior fusion for spinal deformity: 4 to 7 levels	20	444,000	R6 529,50	

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0958	Anterior fusion for spinal deformity: 8 or more levels	20	539,000	R7 926,60	
	MODIFIER				
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				
3.8.7	Special areas: All spinal problems				
0943	Laminectomy with decompression of nerve roots and disc removal: One level	20	240,000	R3 529,40	
0960	Posterior non-segmental instrumentation	20	167,000	R2 456,00	
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	20	176,000	R2 588,10	
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	20	201,000	R2 955,90	
0966	Posterior segmental instrumentation:13 or more vertebrae	20	245,000	R3 603,20	
0968	Anterior instrumentation: 2 to 3 vertebrae	20	159,000	R2 338,30	
0969	Skull or skull-femoral traction including two weeks after-care	20	64,000	R941,40	
0970	Anterior instrumentation: 4 to 7 vertebrae	20	185,000	R2 720,70	
0971	Halo-splint and POP jacket including two weeks after-care	20	116,000	R1 706,00	
0972	Anterior instrumentation: 8 or more vertebrae	20	206,000	R3 029,30	
0974	Additional pelvic fixation of instrumentation other than sacrum	20	108,000	R1 588,10	
5750	Reinsertion of instrumentation	20	276,000	R4 058,80	
5751	Removal of posterior non-segmental instrumentation	20	173,000	R2 544,20	
5752	Removal of posterior segmental instrumentation	20	175,000	R2 573,70	
5753	Removal of anterior instrumentation	20	204,000	R3 000,10	
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	20	295,000	R4 338,30	
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	20	304,000	R4 470,60	
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	20	321,000	R4 720,80	
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	20	63,000	R926,50	

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5759	Laminectomy for decompression diskectomy, etc. revision operation	20	352,000	R5 176,50	
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	20	301,000	R4 426,60	
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	20	68,000	R1 000,00	
5763	Anterior disc removal and spinal decompression cervical: One level	20	344,000	R5 058,60	
5764	Anterior disc removal and spinal decompression cervical: Each additional level	20	81,000	R1 191,30	
5765	Vertebral corpectomy for spinal decompression: One level	20	466,000	R6 853,00	
5766	Vertebral corpectomy for spinal decompression: Each additional level	20	88,000	R1 294,00	
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	20	71,000	R1 044,00	
3.9	Facial bone procedures				
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9				
0987	Repair of orbital floor (blowout fracture)	20	184,600	R2 714,60	
0988	Genioplasty	20	263,000	R3 867,70	
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	20	202,200	R2 973,60	
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	20	302,000	R4 441,20	
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	20	433,000	R6 367,90	
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	20	970,000	R14 264,70	
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	20	302,000	R4 441,20	
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	20	1103,000	R16 220,70	
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	20	1654,000	R24 323,70	
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement	20	-		
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation	20	302,000	R4 441,20	
0998	Excision mandible bone, e.g. osteomyelitis,abscess		219,300	R3 225,40	
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	20	184,000	R2 705,90	
1000	Excision facial bone e.g., osteomyelitis, abscess		144,300	R2 122,20	

CONTRACTED PHYSICIANS ALL OPTIONS

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1001	Temporo-mandibular joint: Reconstruction for dysfunction	20	206,000	R3 029,30	
1002	Harvesting: Bone for contouring of benign bony growths (e.g., fibrous dysplasia)		189,200	R2 782,70	
1003	Manipulation: Immobilisation and follow-up of fractured nose	20	35,000	R514,70	
1005	Nasal fracture without manipulation	20	-		
1007	Mandibulectomy	20	320,000	R4 706,00	
1008	Excision: Torus Mandibularis		84,100	R1 237,00	
1009	Maxillectomy	20	382,500	R7 312,50	
1010	Excision: Torus Palatinus		83,300	R1 225,20	
1011	Bone graft to mandible	20	206,000	R3 029,30	
1012	Adjustment of occlusion by ramisection	20	227,000	R3 338,30	
1013	Fracture of arch of zygoma without displacement	20	-		
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	20	131,000	R1 926,50	
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	20	262,000	R3 852,90	
1006	Fracture: Nose and septum, open reduction		177,400	R2 608,80	
4	**RESPIRATORY SYSTEM**				
4.1	Nose and sinuses				
1018	Flexible nasopharyngolaryngoscope examination	20	51,940	R764,00	
1019	ENT endoscopy in rooms with rigid endoscope	20	12,000	R176,50	
1020	Repair of perforated septum: Any method	20	141,900	R2 086,80	
1022	Functional reconstruction of nasal septum	20	121,200	R1 782,60	
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	20	30,000	R441,20	
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	20	64,600	R949,90	
1027	Dacrocystorhinostomy	20	210,000	R3 088,30	

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1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	20	62,600	R920,60	
1030	Endoscopic turbinectomy: Laser or microdebrider	20	90,000	R1 323,60	
1031	Removal of single nasal polyp at rooms (at initial consultation only)	20	25,400	R373,50	
1033	Removal of multiple polyps in hospital under general anaesthetic	20	81,800	R1 202,70	
1034	Autogenous nasal bone transplant: Bone removal included	20	100,000	R1 470,60	
1035	Functional endoscopic sinus surgery: Unilateral	20	140,000	R2 058,70	
1036	Functional endoscopic sinus surgery: Bilateral	20	245,000	R3 603,20	
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	20	8,000	R117,50	
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	20	35,000	R514,70	
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	20	40,000	R588,10	
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	20	60,000	R882,40	
1045	Ligation anterior ethmoidal artery	20	135,400	R1 991,00	
1047	Caldwell-Luc operation: Unilateral	20	137,300	R2 019,00	
1048	Endonasal frontal sinus drainage, with or without removal of tissue (modifier 0069 applies)		152,200	R2 238,40	
1049	Ligation internal maxillary artery	20	196,000	R2 882,30	
1050	Vidian neurectomy (transantral or transnasal)	20	113,000	R1 661,80	
1051	Removal nasopharyngeal fibroma	20	285,000	R4 191,30	
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	20	50,000	R735,50	
1053	Frontal sinus drainage, trephine operation	20	93,100	R1 369,20	
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	20	37,300	R548,60	
1055	External frontal ethmoidectomy	20	190,700	R2 804,60	
1056	Anterior cranial fossa, craniofacial approach, extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	20	433,300	R6 371,80	
1057	External ethmoidectomy and/or sphenoidectomy	20	199,400	R2 932,50	
1058	Sublabial transseptal sphenoidotomy	20	137,000	R2 014,80	

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1059	Frontal osteomyelitis	20	194,000	R2 853,20	
1060	Obliteration of frontal sinus	20	291,100	R4 281,00	
1061	Lateral rhinotomy	20	164,000	R2 411,70	
1062	Excision nasolabial cyst	20	186,100	R2 736,50	
1063	Removal of foreign bodies from nose: At rooms	20	10,000	R146,80	
1065	Removal of foreign body from nose: Under general anaesthetic	20	38,600	R567,50	
1067	Proof puncture at rooms: Unilateral	20	10,000	R146,80	
1069	Proof puncture, uni- or bilateral under general anaesthetic	20	35,000	R514,70	
1071	Proetz treatment (consultation fee only to be charged for first treatment)	20	4,000	R59,10	
1077	Septum abscess: At rooms, including after-care	20	8,000	R117,50	
1079	Septum abscess: Under general anaesthetic	20	35,000	R514,70	
1081	Oro-antral fistula (without Caldwell-Luc)	20	111,800	R1 644,00	
1083	Choanal atresia: Intranasal approach	20	113,000	R1 661,80	
1084	Choanal atresia: Transpalatal approach	20	194,000	R2 853,20	
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	20	350,000	R5 147,10	
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	20	210,000	R3 088,30	
1089	Forehead rhinoplasty (all stages): Total	20	552,000	R8 117,80	
1091	Forehead rhinoplasty (all stages): Partial	20	414,000	R6 088,30	
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	20	138,000	R2 029,60	
1095	Full nasal reconstruction for secondary cleft lip deformity	20	357,900	R5 263,30	
1097	Partial nasal reconstruction for cleft lip deformity	20	199,700	R2 936,70	
1099	Columella reconstruction or lengthening	20	138,000	R2 029,60	
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision	20	220,100	R3 236,50	
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision	20	232,900	R3 424,70	

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4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision	20	181,600	R2 670,50	
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision	20	120,000	R1 764,70	
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision	20	196,600	R2 890,50	
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision	20	195,400	R2 874,30	
1023	Harvesting of graft: Cartilage graft of nasal septum		100,000	R1 470,60	
1038	Hypophysectomy or excision of pituitary tumour: Transnasal/transseptal approach (total procedure)		300,000	R4 411,90	
1040	Repair of CSF leak: Ethmoid region. transnasal endoscopic approach (modifier 0069 not applicable)		343,500	R5 051,60	
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach (modifier 0069 not applicable)		300,000	R4 411,90	
1044	Transnasal endoscopic decompression: Transnasal endoscopic optic nerve (modifier 0069 not applicable)		300,000	R4 411,90	
4890	Endoscopy: Sinus/nasal, with maxillary antrostomy		64,600	R949,90	
4891	Endoscopy: Sinus/nasal, with maxillary antrostomy and removal of tissue		103,000	R1 514,60	
4892	Endoscopy: Sinus/nasal, with partial, anterior ethmoidectomy		91,200	R1 341,10	
4893	Endoscopy: Sinus/nasal, with medial or inferior orbital wall decompression		280,600	R4 126,70	
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)	20	75,000	R1 103,00	
1102	Laser tonsillectomy	20	75,000	R1 103,00	
1105	Removal of adenoids	20	40,000	R588,10	
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ item 5930 for hire of laser)	20	168,300	R2 475,20	
1107	Opening of quinsy: At rooms	20	12,000	R176,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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	20	85,000	R1 249,90	
1109	Opening of quinsy: Under general anaesthetic	20	35,000	R514,70	
1110	Ludwig's Angina: Drainage	20	42,000	R617,70	
1111	Post tonsillectomy or adenoidectomy haemorrhage	20	46,000	R676,60	
1112	Pharyngeal pouch operation	20	231,800	R3 408,90	
1113	Retropharyngeal abscess: Internal approach	20	35,000	R514,70	
1115	Retropharyngeal abscess: External approach	20	85,000	R1 249,90	
1116	Functional reconstruction of palate and uvula	20	168,300	R2 475,20	
1096	Removal of foreign body: Pharynx		40,500	R774,30	
1100	Control of oropharyngeal haemorrhage with secondary sugical intervention, primary or secondary (eg., post-tonsillectomy)		46,000	R676,60	
1103	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, without closure		75,000	R1 103,00	
1104	Resection: Radical, tonsil, tonsillar pillars and/or retromolar trigone, with local flap closure		75,000	R1 103,00	
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	20	10,000	R190,90	
1118	Laryngeal stroboscopy with video capture	20	39,000	R745,60	
1119	Laryngectomy without block dissection of the neck	20	430,000	R8 220,50	
1122	Laryngeal function studies	20	11,600	R221,90	
1123	Botulinus toxin injection for adductor disphonia (+ item 0198 + item 0201 + item 0202)	20	35,000	R669,10	
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	20	81,100	R1 192,40	
1126	Post laryngectomy for voice restoration	20	139,500	R2 666,90	
1127	Tracheotomy	20	90,000	R1 720,60	
1128	Endolaryngeal operations	20	75,000	R1 103,00	

CONTRACTED PHYSICIANS ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	20	294,400	R4 329,30	
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	20	41,400	R791,40	
1131	Direct laryngoscopy plus foreign body removal	20	64,600	R1 235,00	
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal	20	220,500	R3 242,50	
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy	20	342,100	R5 030,70	
4918	Laryngoplasty: Open reduction of fracture	20	293,800	R4 320,00	
4919	Laryngoplasty: Cricoid split	20	184,200	R3 522,30	
4922	Tracheostoma: Revision, without flap rotation, simple	20	102,400	R1 957,70	
4923	Tracheostoma: Revision, with flap rotation, complex	20	133,800	R1 968,30	
4926	Tracheostomy: Fenestration with skin flaps	20	144,300	R2 759,10	
4927	Tracheostomy: Revision of scar	20	105,500	R2 017,00	
4928	Tracheostomy/fistula: Closure, without plastic repair	20	104,000	R1 529,50	
4929	Tracheostomy/fistula: Closure, with plastic repair	20	120,000	R1 764,70	
4932	Tracheobronchoscopy: Through established tracheostomy incision	20	37,700	R720,90	
4933	Tracheoplasty: Cervical	20	208,100	R3 060,00	
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage	20	263,200	R3 870,60	
1120	Intubation, endtoracheal, emergency procedure		10,000	R190,80	
1121	Stroboscopy - equipment fee		13,800	R203,00	
4904	Laryngectomy: Total, with radical neck dissection		508,700	R8 776,00	
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection		434,800	R8 312,20	
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection		563,200	R9 716,30	
4907	Laryngectomy: Hemilaryngectomy, horisontal		429,700	R8 214,80	
4908	Laryngectomy: Hemilaryngectomy, laterovertical		391,000	R7 474,90	
4909	Laryngectomy: Hemilaryngectomy, anterovertical		405,100	R7 744,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical		414,200	R7 918,30	
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				
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)				
4.4	Bronchial procedures				
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy				
1132	Bronchoscopy: Diagnostic bronchoscopy	20	65,000	R1 242,50	
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	20	80,000	R1 529,60	
1134	Bronchoscopy: Bronchoscopy with laser	20	75,000	R1 434,00	
1136	Nebulisation (in rooms)	20	12,000	R229,40	
1137	Bronchial lavage				
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	20	350,000	R6 691,30	
4.5	Pleura				
1139	Pleural needle biopsy (no after-care) (modifier 0005 not applicable)	20	50,000	R956,10	
1141	Insertion of intercostal catheter (under water drainage)	20	50,000	R956,10	
1142	Intra-pleural block	20	36,000	R688,20	
1143	Paracentesis chest: Diagnostic	20	8,000	R152,90	
1145	Paracentesis chest: Therapeutic	20	13,000	R248,20	
1147	Pneumothorax: Induction (diagnostic)	20	25,000	R478,00	
1149	Pleurectomy	20	250,000	R4 779,50	
1151	Decortication of lung	20	350,000	R5 147,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	20	55,000	R1 051,40	
4.6	Pulmonary procedures				
4.6.1	Pulmonary procedures: Surgical				
1155	Needle biopsy lung: (no after-care) (modifier 0005 not applicable)	20	32,000	R470,60	
1157	Pneumonectomy	20	350,000	R5 147,10	
1159	Pulmonary lobectomy	20	389,500	R5 727,90	
1161	Segmental lobectomy	20	365,000	R5 367,70	
1163	Excision tracheal stenosis: Cervical	20	375,000	R5 514,80	
1164	Excision tracheal stenosis: Intra thoracic	20	350,000	R5 147,10	
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	20	215,000	R3 161,80	
1168	Thoracoplasty: Complete	20	250,000	R3 676,50	
1169	Thoracoplasty: Limited (osteoplastic)	20	200,000	R2 941,10	
1171	Drainage empyema (including six weeks after treatment)	20	170,000	R2 500,10	
1173	Drainage of lung abscess (including six weeks after treatment)	20	170,000	R2 500,10	
1175	Thoracotomy (limited): For lung or pleural biopsy	20	115,000	R1 691,20	
1177	Major: Diagnostic, as for inoperable carcinoma	20	215,000	R3 161,80	
1179	Thoracoscopy	20	89,000	R1 701,50	
1181	Lung transplant: Unilateral	20	600,000	R8 823,60	
1182	Harvesting donor lung: Unilateral	20	120,000	R1 764,40	
1183	Excision or plication of emphysematous cyst: Unilateral	20	250,000	R3 676,50	
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	20	438,000	R6 441,10	
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	20	100,000	R1 470,60	
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.				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1186	Flow volume test: Inspiration/expiration	20	30,000	R573,40	
1187	Exhaled nitric oxide determination	20	4,900	R93,80	
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	
1189	Forced expirogram only	20	10,000	R190,90	
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	20	45,310	R866,10	
1191	N2 single breath distribution	20	10,000	R190,90	
1192	Peak expiratory flow only	20	5,000	R95,50	
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	20	37,760	R721,90	
1195	Thoracic gas volume	20	37,930	R725,30	
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	20	45,310	R866,10	
1197	Compliance and resistance, using oesophageal balloon	20	24,000	R459,00	
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	20	55,890	R1 068,50	
1199	Pulmonary stress testing: For determination of VO2 max	20	96,500	R1 844,80	
1200	Carbon monoxide diffusing capacity, any method	20	38,060	R727,70	
1201	Maximum inspiratory/expiratory pressure	20	5,000	R95,50	
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)				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
R.	Multiple organ failure: Units for items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation)				
S.	Ventilation: Units for items 1212, 1213 and 1214 (ventilation) include the following: (a) Measurement of minute volume, vital capacity, time- and vital capacity studies. (b) Testing and connecting the machine. (c) Putting patient on machine: setting machine, synchronising patient with machine. (d) Instruction to nursing staff. (e) All subsequent visits for 24 hours.				
T.	Ventilation (items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to item 1204: Catogory 1: Cases requiring intensive monitoring				
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	
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	20	30,000	R573,40	
	(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.				
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	
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	
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	

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	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	
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	
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	
	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	

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1213	Ventilation: Subsequent days, per day	20	50,000	R956,10	
1214	Ventilation: After two weeks, per day	20	25,000	R478,00	
1215	Insertion of arterial pressure cannula	20	25,000	R478,00	
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	20	50,000	R956,10	
1217	Insertion of central venous line via peripheral vein	20	10,000	R190,90	
1218	Insertion of central venous line via subclavian or jugular veins	20	25,000	R478,00	
1219	Hyperalimentation (daily tariff)	20	15,000	R286,80	
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	
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	
4.8	Hyperbaric Oxygen Therapy				
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic). b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias. f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis. i. Bone and soft tissue radiation necrosis. j. Compromised skin grafts and flaps. k. Acute thermal burns. l. Acute bloodloss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia). m. Cerebral abscesses				
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 min): PROFESSIONAL COMPONENT	20	30,000	R573,40	
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT	20	101,130	R1 933,30	

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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	20	60,000	R1 147,20	
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT	20	131,260	R2 509,30	
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	20	80,000	R1 529,60	
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT	20	131,260	R2 509,30	
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	20	90,000	R1 720,60	
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT	20	214,180	R4 094,50	
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	20	190,000	R3 632,40	
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	20	386,420	R7 387,60	
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	20	327,000	R6 251,60	
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	20	680,850	R13 016,30	
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	20	678,280	R12 967,20	
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	20	671,850	R12 844,30	
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	20	285,000	R4 191,30	
1223	Mediastinoscopy	20	95,000	R1 397,00	
1224	Mediastinotomy	20	115,000	R1 691,20	
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	20	350,000	R5 147,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1226	Removal of single rib with a lesion	20	282,000	R4 147,20	
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	
	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	20	6,000	R114,90	
1231	Physician's fee for interpreting an ECG: With and without effort	20	10,000	R190,90	
	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				
1232	Electrocardiogram: Without effort	20	9,000	R172,40	
1233	Electrocardiogram: With and without effort	20	13,000	R248,20	
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	20	40,000	R764,70	
1235	Multi-stage treadmill test	20	60,000	R1 147,20	
1236	Electrocardiogram without effort: Under 4 years old	20	18,000	R344,00	
1237	24 Hour ambulatory blood pressure: Hire fee	20	30,000	R441,20	
1238	24 Hour ambulatory ECG monitoring (holter): Hire fee	20	55,000	R808,70	
1239	24 Hour ambulatory ECG monitoring (holter): Interpretation	20	27,000	R516,30	
1240	Signal averaged electrocardiogram	20	80,000	R1 529,60	
1241	X-ray Screening: Chest	20	4,000	R76,70	
1242	X-ray screening: Prosthetic valves	20	10,000	R190,90	

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1243	Two week event triggered ambulatory ECG monitoring: Hire fee	20	55,000	R808,70	
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	20	25,000	R478,00	
1245	Angiography cerebral: First two series	20	34,300	R655,70	
1246	Angiography peripheral: Per limb	20	25,000	R478,00	
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	20	65,000	R1 242,50	
1248	Paracentesis of pericardium	20	50,000	R956,10	
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	20	51,000	R974,80	
	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)	20	140,000	R2 676,40	
1250	Endomyocardial biopsy	20	70,000	R1 338,40	
1251	Transeptal puncture	20	70,000	R1 338,40	
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	20	140,000	R2 676,40	
1253	Right heart catheterisation (with or without biopsy)	20	70,000	R1 338,40	
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	20	40,000	R764,70	
1255	Tilt test	20	31,300	R598,50	
6.2.2	Invasive cardiology: Electrophysiological study				
1256	Ventricular stimulation study	20	160,000	R3 058,90	
1257	Full electrophysiological study	20	300,000	R5 735,40	
6.2.3	Invasive cardiology: Pacemakers				
1258	Pacemaker: Permanent - single chamber	20	155,000	R2 963,50	

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1259	Pacemaker: Permanent - dual chamber	20	230,000	R4 397,00	
1260	AV nodal ablation	20	300,000	R5 735,40	
1261	Accessory pathway ablation	20	600,000	R11 470,80	
1262	Electrophysiological mapping	20	500,000	R9 558,80	
1263	Insertion transvenous implantable defibrillator	20	212,000	R4 053,20	
1264	Test for implantable transvenous defibrillator	20	120,000	R2 294,00	
1265	Renewal of pacemaker unit only, team fee	20	125,000	R2 389,90	
1266	Resiting pacemaker generator	20	80,000	R1 529,60	
1267	Repositioning of catheter electrode	20	50,000	R956,10	
1268	Threshold testing: Own equipment	20	15,000	R286,80	
1269	Threshold testing: Hospital equipment	20	11,000	R210,20	
1270	Programming of atrio-ventricular sequential pacemaker	20	50,000	R956,10	
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	20	120,000	R2 294,00	
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts	20	260,000	R4 970,90	
1275	Termination of arrhythmia - programmed stipulation and lead insertion of temporary pacer	20	200,000	R3 823,50	
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	20	260,000	R4 970,90	
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	20	140,000	R2 676,40	
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	20	60,000	R1 147,20	
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	20	40,000	R764,70	
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	20	60,000	R1 147,20	
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	20	40,000	R764,70	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy; Pulmonary valve valvuloplasty; Aortic valve valvuloplasty; Coarctation dilation; Mitral valve valvuloplasty	20	260,000	R4 970,90	
1283	Use of balloon procedure as in item 1282: Second cardiologist	20	140,000	R2 676,40	
1284	Atherectomy: Single lesion: First cardiologist	20	300,000	R5 735,40	
1285	Atherectomy: Single lesion: Second cardiologist	20	180,000	R3 441,20	
1286	Insertion of intravascular stent: First cardiologist	20	100,000	R1 911,90	
1287	Insertion of intravascular stent: Second cardiologist	20	50,000	R956,10	
	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	20	300,000	R5 735,40	
1291	Use of balloon procedure as in item 1290: Second paediatric cardiologist (33)	20	160,000	R3 058,90	
1292	Multi-slice computed tomography coronary angiography: Own equipment	20	655,260	R12 527,00	
5961	Balloon angioplasty pulmonary mitral valve or tricuspid valve		437,700	R8 365,10	
5962	Balloon angioplasty aortic valve (congenital aortic stenosis)		424,100	R8 105,20	
5963	Balloon angioplasty, pulmonary artery branches: First vessel		202,000	R3 860,40	
5964	Balloon angioplasty, pulmonary artery branches: Subsequent vessels (per vessel)		101,600	R1 941,90	
5965	Balloon angioplasty aorta for congenital lesion/coarctation		629,700	R12 034,40	
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl MAPCA) or venous system (IVC, SVC, systemic vein): First vessel		451,400	R8 626,70	
5967	Balloon angioplasty, collateral vessel (incl. MAPCA): Subsequent vessels (per vessel)		112,850	R2 156,80	
5968	Balloon angioplasty venous system (IVC, SVC, systemic vein)		451,400	R8 626,70	
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		451,400	R8 626,70	
5970	Cutting balloon angioplasty, cardiovascular structure: Subsequent vessels (per vessel)		112,850	R2 156,80	
1293	Multi-slice computed tomography coronary angiography: Interpretation and report		30,000	R483,70	
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1288	Cardiac catheterisation for congenital heart disease: All ages above 1 year old	20	210,000	R4 014,90	
1289	Paediatric cardiac catheterisation: Infants below the age of one year	20	263,000	R5 027,90	
6.3	Cardiac surgery				
1294	Patent ductus arteriosus	20	320,000	R4 706,00	
1295	Pericardiectomy for constrictive pericarditis	20	400,000	R5 882,40	
1296	Fractional flow reserve (FFR): First vessel (add-on code)		28,000	R535,10	
1297	Coarctation of aorta	20	425,000	R6 250,00	
1298	Fractional flow reserve (FFR): Each additional vessel (add-on code)		22,400	R428,10	
1299	Systemo-pulmonary anastomosis	20	425,000	R6 250,00	
1300	Renal denervation (RDN), per artery (modifier 0005 applicable)		223,000	R4 261,80	
1301	Mitral valvotomy: Closed heart technique	20	350,000	R5 147,10	
1302	Heart transplant	20	875,000	R12 867,80	
1303	Harvesting donor heart	20	75,000	R1 103,00	
1305	Operative implantation of cardiac pacemaker by thoracotomy	20	220,000	R3 235,30	
1307	Re-exploration after cardiac surgery	20	215,000	R3 161,80	
1308	Heart and lung transplant	20	1000,000	R14 706,00	
1309	Harvesting donor heart and lungs	20	120,000	R1 764,40	
1311	Pericardial drainage	20	140,000	R2 676,40	
6.3.1	Cardiac surgery: Open heart surgery				
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	20	25,000	R367,60	
1320	Repeat open heart surgery (additional fee above procedure fee)	20	250,000	R3 676,50	
1321	Stand-by fee for coronary angioplasty	20	30,000	R573,40	
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour	20	20,000	R382,30	
6.3.1.1	Cardiac surgery: Open heart surgery: Congenital conditions				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1323	Atrial septal defect: Osteum secundum	20	500,000	R7 353,00	
1325	Atrial septal defect: Sinus venosus or osteum primum	20	563,000	R8 279,40	
1327	Atrial septal defect: Ventricular septal defect	20	603,800	R8 879,50	
1329	Atrial septal defect: Fallot's tetralogy	20	563,000	R8 279,40	
1330	Atrial septal defect: Pulmonary stenosis	20	500,000	R7 353,00	
1331	Transposition of large vessels (venous repair)	20	563,000	R8 279,40	
1332	Transposition of great arteries (arterial repair)	20	750,000	R11 029,40	
1333	Ebstein's Anomaly	20	563,000	R8 279,40	
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	20	548,800	R8 070,60	
1335	Total anomalous venous drainage	20	563,000	R8 279,40	
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	20	658,900	R9 689,80	
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	20	500,000	R7 353,00	
1338	Fontan type repair	20	750,000	R11 029,40	
6.3.1.2	Cardiac surgery: Open heart surgery: Acquired conditions				
1339	Mitral valve replacement	20	657,000	R9 661,80	
1340	Mitral valvuloplasty	20	688,000	R10 117,80	
1341	Aortic valve replacement	20	623,800	R9 173,60	
1342	Tricuspid annulo plasty	20	188,000	R2 764,90	
1343	Double valve replacement	20	968,900	R14 248,50	
1344	Acute dissecting aneurysm repair	20	750,000	R11 029,40	
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	20	1000,000	R14 706,00	
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Unilateral (modifier 0005 not applicable)	20	100,000	R1 470,60	
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins: Bilateral (modifier 0005 not applicable)	20	175,000	R2 573,70	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	20	750,000	R11 029,40	
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant: Any artery	20	781,000	R11 485,40	
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant: Any artery	20	813,000	R11 956,00	
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	20	875,000	R12 867,80	
1352	Cardiac aneurysm	20	563,000	R8 279,40	
1353	Ascending/descending thoracic aortic aneurysm repair	20	625,000	R9 191,20	
1354	Arrhythmia surgery	20	688,000	R10 117,80	
1355	Cardiac tumour	20	625,000	R9 191,20	
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	20	188,000	R2 764,90	
1358	Harvesting of radial artery	20	175,000	R2 573,70	
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	20	15,000	R286,80	
1359	Skin temperature test: Response to reflex cooling	20	15,000	R286,80	
1360	Closure: Left atrial appendage (LAA)		828,000	R15 824,20	
1361	Cold sensitivity test	20	17,000	R325,00	
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		397,500	R7 596,80	
1363	Oscillometry test	20	5,000	R95,50	
1365	Sweating test	20	17,000	R325,00	
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	20	26,300	R502,90	
1367	Doppler blood tests	20	6,000	R114,90	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5369	Doppler arterial pressures	20	6,000	R114,90	
5371	Doppler arterial pressures with exercise	20	10,000	R190,90	
5373	Doppler segmental pressures and wave forms	20	12,000	R229,40	
5375	Venous doppler examination (both limbs)	20	9,000	R172,40	
5377	Venous plethysmography	20	16,000	R305,90	
5379	Supra-orbital doppler test	20	5,000	R95,50	
5381	Carotid non-invasive complex tests	20	39,000	R745,60	
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	20	540,000	R7 941,20	
1373	Abdominal aorta and iliac artery: Ruptured	20	600,000	R8 823,60	
1375	Grafting and/or thrombo-endarterectomy for thrombosis	20	444,000	R6 529,50	
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	20	594,000	R8 735,30	
6.4.3.2	Peripheral vascular system: Arteries: Iliac artery				
1379	Prosthetic grafting and/or thrombo-endarterectomy	20	300,000	R4 411,90	
6.4.3.3	Peripheral vascular system: Arteries: Peripheral				
1385	Prosthetic grafting	20	255,000	R3 750,00	
1387	Grafting vein: Vein grafting proximal to knee joint	20	300,000	R4 411,90	
1388	Grafting vein: Distal to knee joint	20	444,000	R6 529,50	
1389	Grafting vein: Endarterectomy when not part of another specified procedure	20	264,000	R3 882,50	
1390	Grafting vein: Carotid endarterectomy	20	321,000	R4 720,80	
1393	Embolectomy: Peripheral embolectomy transfemoral	20	168,000	R3 212,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	20	125,000	R2 389,90	
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	20	264,000	R3 882,50	
1397	Profundoplasty	20	210,000	R3 088,30	
1399	Distal tibial (ankle region)	20	456,000	R6 705,90	
1401	Femoro-femoral	20	254,000	R3 735,20	
1402	Carotid-subclavian	20	288,000	R4 235,30	
1403	Axillo-femoral: (Bifemoral + 50%)	20	288,000	R4 235,30	
6.4.4	Peripheral vascular system: Veins				
1407	Ligation of saphenous vein	20	50,000	R735,50	
1408	Placement of Hickman catheter or similar	20	91,000	R1 338,00	
1410	Litigation of inferior vena cava: Abdominal	20	180,000	R2 646,90	
1412	Umbrella operation on inferior vena cava: Abdominal	20	100,000	R1 470,60	
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral	20	141,000	R2 073,50	
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral	20	247,000	R3 632,30	
1417	Extensive sub-fascial ligation of perforating veins	20	125,000	R1 838,30	
1419	Lesser varicose vein procedures	20	31,000	R455,90	
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine (9) injections per leg (excluding cost of material)	20	9,000	R132,40	
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	20	240,000	R3 529,40	
1427	Thrombectomy: Illio-femoral	20	175,000	R3 345,70	
1422	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: First vein		96,200	R1 414,70	

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1424	Endovenous ablation of incompetent vein by radiofrequency or laser, inclusive of all imaging guidance and monitoring: Subsequent veins (modifier 0005 is not applicable)		47,000	R691,20	
6.4.5	Peripheral vascular system: Portal hypertension				
1429	Porto-caval shunt	20	500,000	R9 558,80	
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	20	12,000	R229,40	
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group	20	6,000	R114,90	
	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)	20	221,300	R3 254,40	
1436	Splenorrhaphy	20	231,800	R3 408,90	
1437	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic donor lymphocyte infusions - PROFESSIONAL COMPONENT		28,100	R413,10	
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic - PROFESSIONAL COMPONENT		36,900	R542,60	
7.2	Lymph nodes and lymphatic channels				
1439	Excision of lymph node for biopsy: Neck or axilla	20	65,000	R955,80	
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous - PROFESSIONAL COMPONENT		36,800	R540,90	
1441	Excision of lymph node for biopsy: Groin	20	65,000	R955,80	
1442	Lymphadenectomy: Modified radical neck dissection, cervical	20	293,100	R4 310,80	
1443	Simple excision of lymph nodes for tuberculosis	20	91,000	R1 338,00	
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic - PROFESSIONAL COMPONENT		23,500	R345,40	
1445	Radical excision of lymph nodes of neck: Total: Unilateral	20	315,000	R4 632,30	

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1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous - PROFESSIONAL COMPONENT		23,800	R349,70	
1447	Radical excision of lymph nodes of neck: Total: Suprahyoid unilateral	20	235,000	R3 455,50	
1448	Bone marrow harvesting for transplant - PROFESSIONAL COMPONENT		101,000	R1 484,70	
1449	Radical excision of lymph nodes of axilla	20	160,000	R2 353,00	
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	20	58,000	R852,90	
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	20	175,000	R2 573,70	
1453	Radical excision of lymph nodes of groin: Inguinal	20	150,000	R2 205,90	
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	20	39,000	R573,50	
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	20	275,000	R4 044,30	
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	20	42,000	R617,70	
1457	Bone marrow biopsy: By trephine	20	13,000	R248,20	
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	20	8,000	R152,90	
1459	Staging laparotomy for lymphoma (including splenectomy	20	245,000	R3 603,20	
1460	Sentinel lymph node(s): Intra-operative indentification; INCLUDES injection of non-radioactive dye, when performed		40,400	R594,00	
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.	20	21,000	R308,80	
8.1	Oral cavity				
1461	All dental procedures			R0,00	

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1463	Surgical biopsy of tongue or palate: Under general anaesthetic	20	35,000	R514,70	
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	20	15,000	R220,60	
1467	Drainage of intra-oral abscess	20	31,000	R455,90	
1469	Local excision of mucosal lesion of oral cavity	20	23,000	R338,40	
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	20	549,000	R8 073,70	
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	20	-		
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	20	215,000	R3 161,80	
1477	Cleft palate: Secondary repair	20	174,200	R2 562,10	
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	20	240,000	R3 529,40	
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	20	227,000	R3 338,30	
1480	Repair of oronasal fistula (large) e.g. distant flap	20	227,000	R3 338,30	
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	20	138,000	R2 029,60	
1482	Repair of oronasal fistula (large): Second stage	20	138,000	R2 029,60	
1483	Alveolar periosteal or other flaps for arch closure	20	138,000	R2 029,60	
1486	Closure of anterior nasal floor	20	138,000	R2 029,60	
1462	Removal of embedded foreign body: Vestibule of mouth, simple		20,000	R294,20	
1464	Removal of embedded foreign body: Vestibule of mouth, complicated		31,000	R455,90	
1466	Removal of embedded foreign body: Denotalveolar structures, soft tissues		20,000	R294,20	
8.2	Lips				
1484	Cleft lip repair: Lip adhesion (cleft lip)	20	95,000	R1 397,00	
1485	Local excision of benign lesion of lip	20	27,000	R397,20	
1487	Resection for lip malignancy	20	91,000	R1 338,00	
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	20	227,000	R3 338,30	
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction): One of two stages	20	251,600	R3 700,10	

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1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction): One stage	20	329,900	R4 851,30	
1492	Cleft lip repair: Bilateral cleft lip repair: Second stage	20	227,000	R3 338,30	
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	20	251,600	R3 700,10	
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	20	91,000	R1 338,00	
1495	Abbé or Estlander type flap (all stages included)	20	273,100	R4 016,10	
1497	Vermilionectomy	20	94,900	R1 395,50	
1499	Lip reconstruction following an injury: Direct repair	20	105,600	R1 553,20	
1501	Lip reconstruction following an injury or tumour removal: Flap repair	20	206,000	R3 029,30	
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	20	206,000	R3 029,30	
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see item 0297)	20	104,000	R1 529,40	
8.3	Tongue				
1505	Partial glossectomy	20	225,000	R3 308,80	
1507	Local excision of lesion of tongue	20	27,000	R397,20	
8.4	Palate, uvula and salivary glands				
1509	Wide excision of lesion of palate	20	100,000	R1 470,60	
1511	Radical resection of palate (including skin graft)	20	250,000	R3 676,50	
1513	Excision of ranula	20	85,600	R1 259,10	
1515	Excision of sublingual salivary gland	20	120,000	R1 764,40	
1517	Excision of submandibular salivary gland	20	146,000	R2 147,00	
1519	Excision of submandibular salivary gland with suprahyoid dissection	20	150,000	R2 205,90	
1521	Excision of submandibular salivary gland: With radical neck dissection	20	352,000	R5 176,50	
1523	Local resection of parotid tumour	20	169,600	R2 493,90	
1525	Partial parotidectomy	20	310,000	R4 558,80	
1526	Total parotidectomy with preservation of facial nerve	20	358,500	R5 272,30	

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1527	Total parotidectomy	20	358,500	R5 272,30	
1529	Parotidectomy: Extracapsular	20	300,000	R4 411,90	
1531	Drainage of parotid abscess	20	25,000	R367,60	
1533	Closure of salivary fistula	20	91,000	R1 338,00	
1535	Dilatation of salivary duct	20	10,000	R146,80	
1537	Operative removal of salivary calculus	20	55,000	R808,70	
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated	20	58,500	R860,30	
1539	Salivary duct: Meatotomy	20	20,000	R294,20	
1541	Branchial cyst and/or fistula: Excision	20	140,000	R2 058,70	
1543	Excision of cystic hygroma	20	140,000	R2 058,70	
1544	Ludwig's Angina: Drainage	20	42,000	R617,70	
8.5	Oesophagus				
1545	Oesophagoscopy with rigid instrument: First and subsequent	20	47,000	R898,40	
1549	Oesophagoscopy with dilatation of stricture	20	70,000	R1 338,40	
1550	Oesophagoscopy with removal of foreign body	20	70,000	R1 338,40	
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	20	80,000	R1 529,60	
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	80,000	R1 529,60	
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	65,000	R1 242,50	
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	20	400,000	R5 882,40	
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic		314,700	R4 626,40	
1557	Oesophageal dilatation	20	40,000	R764,70	
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		389,800	R5 730,30	
1559	Oesophagectomy: Two stage	20	500,000	R7 353,00	
1560	Oesophagectomy: Three stage	20	550,000	R8 088,40	

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1561	Thoraco-abdominal oesophagogastrectomy	20	500,000	R7 353,00	
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	20	300,000	R4 411,90	
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		357,100	R5 249,60	
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	20	350,000	R5 147,10	
1566	Private fee: Gastroplasty	20	325,000	R4 779,30	
1567	Bochdalek hernia repair in newborn	20	250,000	R3 676,50	
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	20	375,000	R5 514,80	
1569	Heller's operation	20	250,000	R3 676,50	
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure)		377,700	R5 552,70	
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		313,100	R4 602,80	
1575	Insertion of indwelling oesophageal tube by laparotomy	20	142,000	R2 088,40	
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): ADD to major procedure (modifier 0005 does not apply)		48,300	R710,20	
1578	Oesophageal motility (4 channel + pneumograph)	20	100,000	R1 911,90	
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	20	400,000	R7 647,00	
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	20	110,000	R2 103,10	
1581	Removal of benign oesophageal tumours	20	285,000	R4 191,30	
1582	Oesophageal motility (4 or 6 channel + pneumograph - ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	20	150,000	R2 867,70	
1583	Excision of intrathoracic oesophageal diverticulum	20	250,000	R4 779,50	
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)	20	55,000	R1 051,40	
1585	24 Hour oesophageal pH studies: Interpretation	20	27,000	R516,30	
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		348,200	R5 118,80	
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		378,100	R5 558,30	

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5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		382,200	R5 618,70	
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		411,800	R6 053,80	
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		451,200	R6 633,10	
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		492,500	R7 240,30	
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		463,600	R6 815,30	
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		520,900	R7 657,70	
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	20	48,750	R932,20	
1588	Plus polypectomy: ADD to gastro-intestinal endoscopy (Item 1587)	20	25,000	R478,00	
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)	20	34,000	R649,90	
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (Item 1587)	20	25,000	R478,00	
1593	Augmented histamine test: Gastric intubation with x-ray screening	20	5,000	R95,50	
1597	Gastrostomy or Gastrotomy	20	147,500	R2 819,90	
1598	Gastrotomy with suture repair of bleeding ulcer	20	251,200	R4 802,40	
1599	Pyloromyotomy (Rammstedt)	20	116,000	R2 217,70	
1601	Local excision of ulcer or benign neoplasm	20	195,600	R2 876,70	
1603	Vagotomy: Abdominal	20	150,000	R2 205,90	
1604	Vagotomy: Thoracic	20	150,000	R2 205,90	

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1605	Truncal or selective with drainage procedures	20	250,000	R3 676,50	
1607	Vagotomy and antrectomy	20	320,000	R4 706,00	
1609	Highly selective vagotomy	20	250,000	R3 676,50	
1611	Pyloroplasty	20	180,200	R2 650,00	
1613	Gastroenterostomy	20	203,600	R2 994,30	
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	20	200,000	R2 941,10	
1617	Partial gastrectomy	20	328,300	R4 828,00	
1619	Total gastrectomy	20	384,430	R5 653,50	
1621	Revision of gastrectomy or gastro-enterostomy	20	375,000	R5 514,80	
1625	Gastro-esophageal operation for portal hypertension (Tanner)	20	375,000	R5 514,80	
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)	20	120,000	R2 294,00	
1627	Duodenal intubation (under X-ray screening)	20	8,000	R152,90	
1629	Duodenal intubation with biliary drainage after gall bladder stimulation	20	21,000	R401,50	
1631	Duodenal intubation: Under 3 years of age	20	15,000	R286,80	
8.8	Intestines				
1632	H2 breath test (intestines)	20	9,000	R172,40	
1633	Complete test using lactose or lactulose	20	27,000	R516,30	
1634	Enterotomy or Enterostomy	20	202,600	R2 979,50	
1635	Intestinal obstruction of the newborn	20	240,000	R3 529,40	
1636	Oral food challenge test		14,100	R269,50	
1637	Operation for relief of intestinal obstruction	20	240,000	R3 529,40	
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering	20	195,900	R2 881,40	
1639	Resection of small bowel with enterostomy or anastomosis	20	244,900	R3 601,40	

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1640	Resection of small bowel for congenital atresia, proximal segment, with tapering	20	431,100	R6 340,00	
1641	Entero-enterostomy or entero-colostomy for bypass	20	213,100	R3 133,80	
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)	20	150,000	R2 205,90	
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	20	90,000	R1 720,60	
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	20	185,200	R2 723,50	
1647	Closure of intestinal fistula	20	258,000	R3 794,10	
1649	Excision of Meckel's diverticulum	20	179,800	R2 644,00	
1651	Excision of lesion of mesentery	20	171,600	R2 523,60	
1652	Laparotomy for mesenteric thrombosis	20	300,000	R4 411,90	
1653	Total colonoscopy: With hospital equipment (including biopsy)	20	90,000	R1 720,60	
1654	Plus removal of polyps: ADD to colonoscopy (Item 1653)	20	30,000	R573,40	
1656	Left-sided colonoscopy	20	60,000	R1 147,20	
1657	Right or left hemicolectomy or segmental colectomy	20	325,000	R4 779,30	
1658	Reconstruction of colon after Hartman's procedure	20	359,400	R5 285,40	
1659	Surgeon present assisting with air enema for reduction of intussuception (Paediatric surgeons add modifier 0016)		60,600	R891,00	
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (Paediatric surgeons add modifier 0016)		20,500	R301,50	
1661	Colotomy: Including removal of tumour or foreign body	20	205,700	R3 025,20	
1663	Total colectomy	20	390,000	R5 735,10	
1665	Colostomy or ileostomy isolated procedure	20	233,800	R3 438,00	
1666	Continent ileostomy pouch (all types)	20	300,000	R4 411,90	
1667	Colostomy: Closure	20	179,100	R2 633,70	
1668	Revision of ileostomy pouch	20	375,000	R5 514,80	

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1669	Total proctocolectomy and ileostomy	20	480,000	R7 058,70	
1670	Proctocolectomy, ileostomy and ileostomy pouch	20	540,000	R7 941,20	
1671	Colomyotomy (Reilly operation)	20	185,000	R2 720,70	
8.9	Appendix				
1673	Drainage of appendix abscess	20	150,000	R2 205,90	
1675	Appendicectomy	20	160,000	R2 353,00	
8.10	Rectum and anus				
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	20	48,750	R932,20	
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	20	13,000	R248,20	
1678	Plus polypectomy: ADD to sigmoidoscopy (Item 1676)	20	25,000	R478,00	
1679	Sigmoidoscopy with removal of polyps, first and subsequent	20	30,000	R573,40	
1681	Proctoscopy with removal of polyps: First time	20	21,000	R401,50	
1683	Proctoscopy with removal of polyps: Subsequent times	20	15,000	R286,80	
1685	Endoscopic fulguration of tumour	20	50,000	R956,10	
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	20	381,300	R5 607,40	
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	20	445,000	R6 544,30	
1689	Perineal resection of rectum	20	141,000	R2 073,50	
	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	20	409,300	R6 019,40	
1692	Abdomino-perineal resection of rectum: Perineal surgeon	20	158,500	R2 331,00	
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	20	200,000	R2 941,10	
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	20	400,000	R5 882,40	
1697	Repair of prolapsed rectum: Abdominal: Roscoe Graham Moskovitz	20	300,000	R4 411,90	
1699	Repair of prolapsed rectum: Abdominal: Ivalon sponge	20	200,000	R2 941,10	

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1701	Repair of prolapsed rectum: Abdominal: Perineal	20	150,000	R2 205,90	
1703	Repair of prolapsed rectum: Abdominal: Thierisch suture	20	35,000	R514,70	
1705	Incision and drainage of peri-anal abscess	20	40,000	R588,10	
1707	Drainage of submucous abscess	20	40,000	R588,10	
1709	Drainage of ischio-rectal abscess	20	87,000	R1 279,30	
1711	Excision of pelvi-rectal fistula	20	200,000	R2 941,10	
1713	Excision of fistula-in-ano	20	105,000	R1 544,10	
1715	Operation for fissure-in-ano	20	66,800	R982,20	
1716	Rectal Tumour: Destruction (any method):Transanal Approach		167,900	R2 468,30	
1717	Rectal tumour: Excision, transanal approach, EXCLUDING muscularis propria (partial thickness)		96,400	R1 417,30	
1718	Rectal Tumour: Excision, Transanal Approach,INCLUDING muscularis propria(full thickness)		143,600	R2 110,90	
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	20	10,000	R146,80	
1721	Sclerosing injection for haemorrhoids: Per injection	20	5,000	R73,60	
1723	Haemorrhoidectomy	20	120,000	R1 764,40	
1725	Drainage of external thrombosed pile	20	12,500	R183,70	
1727	Multiple procedures (haemorrhoids, fissure, etc.)	20	90,000	R1 323,60	
1728	Biopsy of ano-rectal wall, for congenital megacolon	20	60,600	R891,40	
1729	Excision of anal skin tags	20	25,000	R367,60	
1731	Operation for low imperforate anus	20	105,000	R1 544,10	
1733	Anoplasty: Y-V-plasty	20	41,000	R602,90	
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)	20	90,000	R1 323,60	
1735	Anal sphincteroplasty for incontinence	20	120,000	R1 764,40	
1737	Dilation of ano-rectal stricture	20	12,500	R183,70	
1739	Closure of recto-vesical fistula	20	241,000	R3 544,20	

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1741	Closure of recto-urethral fistula	20	241,000	R3 544,20	
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	20	27,000	R516,30	
8.11	Liver				
1743	Needle biopsy of liver	20	30,300	R579,30	
1745	Biopsy of liver by laparotomy	20	125,000	R1 838,30	
1747	Drainage of liver abscess or cyst	20	179,100	R2 633,70	
1748	Body composition measured by bio-electrical impedance	20	3,000	R57,30	
1749	Hemi-hepatectomy: Right	20	564,000	R8 294,10	
1751	Hemi-hepatectomy: Left	20	521,100	R7 663,10	
1752	Extended right or left hepatectomy	20	570,900	R8 395,70	
1753	Partial or segmental hepatectomy	20	378,000	R5 559,00	
1754	Hepatico-jejunostomy	20	369,200	R5 429,30	
1755	Liver transplant	20	1400,800	R20 600,30	
1756	Harvesting donor hepatectomy	20	616,200	R9 061,90	
1757	Suture of liver wound or injury	20	214,200	R3 150,30	
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	20	171,600	R2 523,60	
1761	Cholecystectomy	20	225,000	R3 308,80	
1762	Cholecystectomy and operative cholangiogram	20	255,000	R3 750,00	
1763	With exploration of common bile duct	20	264,500	R3 889,90	
1765	Exploration of common bile duct: Secondary operation	20	327,700	R4 819,30	

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1767	Reconstruction of common bile duct	20	371,700	R5 466,20	
1768	Resection bile duct tumour with reconstruction	20	327,700	R4 819,30	
1769	Cholecysto-enterostomy or gastrostomy	20	236,300	R3 475,00	
1772	Endoscopic placement of a nasobiliary drainage tube: ADD to ERCP (item 1778)	20	25,600	R376,60	
1773	Transduodenal sphincteroplasty	20	225,000	R3 308,80	
1774	Balloon dilatation of common bile duct strictures	20	125,000	R1 838,30	
1775	Excision choledochal cyst with reconstruction	20	327,700	R4 819,30	
1777	Porto-enterostomy for biliary atresia	20	400,000	R5 882,40	
1766	Resection bile duct tumour: Intrahepatic				Refer rule C
8.13	Pancreas				
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	20	105,900	R2 024,80	
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (item 1778)	20	15,820	R302,40	
1780	Gastric and duodenal intubation	20	8,000	R152,90	
1781	Procedure (excluding laboratory tests)	20	21,000	R401,50	
1782	Endoscopic Sphincterotomy: ADD to ERCP (item 1778)	20	30,000	R573,40	
1783	Drainage of pancreatic abscess	20	239,300	R3 519,00	
1784	Debridement pancreatic necrosis	20	348,400	R5 123,30	
1785	Internal drainage of pancreatic cyst	20	250,600	R3 685,20	
1770	Endoscopic placement of biliduodenal endoprosthesis: ADD to ERCP (item 1778)	20	30,000	R573,40	
1786	Internal drainage of pancreatic cyst with Roux-Y	20	306,800	R4 511,90	
1787	Operative pancreatogram: ADD	20	10,000	R146,80	
1788	Biopsy of pancreas	20	177,700	R2 613,40	
1789	Pancreatico-duodenectomy	20	704,800	R10 364,60	
1791	Local, partial or subtotal pancreatectomy	20	351,300	R5 166,20	

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1793	Distal pancreatectomy with internal drainage	20	377,400	R5 550,00	
1790	Endoscopic cannulation of papilla with direct visualisation of pancreatic/common bile duct(s) (List separately in addition to code(s) for primary procedure)		35,800	R684,50	
1792	Near-total pancreatectomy (with preservation of duodenum)		415,900	R6 116,20	
1794	Total pancreatectomy		421,500	R6 198,60	
8.14	Peritoneal cavity				
1797	Pneumo-peritoneum: First	20	13,000	R190,90	
1799	Pneumo-peritoneum: Repeat	20	6,000	R88,30	
1800	Peritoneal lavage	20	20,000	R294,20	
1801	Diagnostic paracentesis: Abdomen	20	8,000	R117,50	
1803	Therapeutic paracentesis: Abdomen	20	13,000	R190,90	
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	20	45,000	R661,90	
1808	Omentectomy (separate procedures)		189,200	R2 781,40	
1809	Laparotomy	20	196,000	R2 882,30	
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	20	350,000	R5 147,10	
1811	Suture of burst abdomen	20	188,300	R2 769,30	
1812	Laparotomy for control of surgical haemorrhage	20	105,000	R1 544,10	
1813	Drainage of sub-phrenic abscess	20	180,000	R2 646,90	
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	20	248,400	R3 652,90	
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	20	75,000	R1 103,00	
9	**HERNIAE**				
1819	Inguinal or femoral hernia: Adult	20	125,000	R1 838,30	
1821	Inguinal or femoral hernia: Child under 14 years	20	90,000	R1 323,60	
1823	Inguinal hernia: Infant under one year	20	100,000	R1 470,60	
1825	Recurrent inguinal or femoral hernia	20	155,000	R2 279,60	

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1827	Strangulated hernia or femoral hernia	20	238,000	R3 500,10	
1829	Epigastric hernia	20	93,300	R1 372,20	
1831	Umbilical hernia: Adult	20	140,000	R2 058,70	
1833	Umbilical hernia: Child under 14 years	20	60,000	R882,40	
1835	Incisional hernia	20	166,800	R2 453,20	
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)	20	77,000	R1 132,50	
1837	Repair of omphalocele in new-born (one or more procedures)	20	275,000	R4 044,30	
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	20	71,000	R1 357,20	
1841	Renal biopsy: Needle	20	30,000	R573,40	
1843	Peritoneal dialysis: First day	20	33,000	R631,00	
1845	Peritoneal dialysis: Every subsequent day	20	33,000	R631,00	
1847	Haemodialysis: Per hour or part thereof	20	21,000	R401,50	
1849	Haemodialysis: Maximum: Eight hours	20	168,000	R3 212,00	
1851	Haemodialysis: Thereafter per week	20	55,000	R1 051,40	
1852	Continuous haemodiafiltration per day in intensive or high care unit	20	33,000	R631,00	
1853	Nephrectomy: Primary nephrectomy	20	225,000	R3 308,80	
1855	Nephrectomy: Secondary nephrectomy	20	267,000	R3 926,70	
1857	Radical with regional lymph adenectomy for tumour	20	280,000	R4 118,00	

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1859	Nephrectomy: Partial	20	267,000	R3 926,70	
1861	Symphysiotomy for horse-shoe kidney	20	287,000	R4 220,40	
1863	Nephro-ureterectomy	20	305,000	R4 485,10	
1865	Nephrotomy with drainage nephrostomy	20	189,000	R3 613,30	
1868	Nephrolithotomy, for congenital kidney abnormality, complicated	20	268,400	R3 947,00	
1869	Nephrolithotomy	20	227,000	R3 338,30	
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	20	284,000	R4 176,30	
1871	Staghorn stone: Surgical	20	341,000	R5 014,80	
1873	Suture renal laceration (renorraphy)	20	193,000	R2 838,30	
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	20	34,000	R649,90	
1877	Operation for renal cyst: Marsupialisation or excision	20	189,000	R2 779,50	
1878	Ablation of 1 or more renal tumour(s): Cryotherapy, percutaneous, unilateral	20	106,000	R2 026,50	
1879	Closure renal fistula	20	189,000	R3 613,30	
1881	Pyeloplasty	20	252,000	R3 705,70	
1882	Pyeloplasty, complicated; with or without plastic procedure on ureter; nephropexy; nephrostomy; pyelostomy; ureteral splinting. (Secondary procedure for congenital kidney abnormality or solitary kidney)	20	327,700	R4 819,10	
1883	Pyelostomy	20	189,000	R2 779,50	
1885	Pyelolithotomy	20	189,000	R2 779,50	
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	20	223,000	R3 279,50	
1889	Nephrectomy for Allograft: Living or dead	20	255,000	R3 750,00	
1891	Perinephric abscess or renal abscess: Drainage	20	200,000	R2 941,10	
1893	Aberrant renal vessels: Repositioning with pyeloplasty	20	210,000	R3 088,30	
1894	Auto transplantation of kidney	20	420,000	R6 176,40	
1895	Allo transplantation of kidney	20	420,000	R6 176,40	
1860	Laparoscopic nephrectomy, partial (item 1807 may not be added to this item)		312,000	R4 588,70	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
1862	Laparoscopic nephrectomy, includes partial ureterectomy (item 1807 may not be added to this item)		270,000	R3 970,80	
1880	Laparoscopic ablation of renal mass or lesion(s) (item 1807 may not be added to this item)		234,000	R3 441,40	
1890	Laparoscopic living donor nephrectomy (item 1807 may not be added to this item)		300,000	R4 412,00	
1892	Laparoscopic drainage of lymphocele to peritoneal cavity (item 1807 may not be added to this item)		293,400	R4 314,80	
10.2	Ureter				
1897	Ureterorraphy: Suture of ureter	20	147,000	R2 161,70	
1898	Ureterorraphy: Lumbar approach	20	189,000	R2 779,50	
1899	Ureteroplasty	20	181,000	R2 661,70	
1901	Ureterolysis	20	118,000	R1 735,20	
1902	Ureterolysis: Lumbar approach	20	189,000	R2 779,50	
1903	Ureterectomy only	20	137,000	R2 014,80	
1905	Ureterolithotomy	20	265,800	R3 908,70	
1907	Cutaneous ureterostomy: Unilateral	20	108,000	R1 588,10	
1909	Cutaneous ureterostomy: Bilateral	20	189,000	R2 779,50	
1911	Uretero-enterostomy: Unilateral	20	137,000	R2 014,80	
1913	Uretero-enterostomy: Bilateral	20	240,000	R3 529,40	
1915	Uretero-ureterostomy	20	137,000	R2 014,80	
1917	Transuretero-ureterostomy	20	155,000	R2 279,60	
1919	Closure of ureteric fistula	20	147,000	R2 161,70	
1921	Immediate deligation of ureter	20	147,000	R2 161,70	
1923	Ureterolysis for retrocaval ureter with anastomosis	20	168,000	R2 470,80	
1924	Ureterocalicostomy	20	20,000	R3 895,40	
1925	Uretero-pyelostomy	20	252,000	R3 705,70	
1927	Uretero-neo-cystostomy: Unilateral	20	316,100	R4 648,60	

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1929	Uretero-neo-cystostomy: Bilateral	20	474,150	R6 973,00	
1931	Uretero-neo-cystostomy: With Boariplasty	20	351,800	R5 173,40	
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	20	252,000	R3 705,70	
1935	Uretero-ileal conduit	20	388,000	R5 706,00	
1937	Replacement of ureter by bowel segment: Unilateral	20	277,000	R4 073,60	
1939	Replacement of ureter by bowel segment: Bilateral	20	485,000	R7 132,50	
1941	Ureterostomy-in-situ: Unilateral	20	100,000	R1 470,60	
1943	Ureterostomy-in-situ: Bilateral	20	175,000	R2 573,70	
1904	Ureterectomy with bladder cuff (stand alone procedure)		294,800	R4 335,50	
1932	Laparoscopic uretero-neocystostomy, excludes cystoscopy and ureteral stent insertion (item 1807 may not be added to this item)		361,100	R5 310,50	
1936	Contrast injection for ileal conduit visualisation				Refer Rule C
10.3	Bladder				
1952	J J Stent catheter	20	44,000	R647,30	
1953	With hydrodilatation of the bladder for interstitial cystitis	20	5,000	R73,60	
1954	Uretroscopy	20	35,000	R514,70	
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	20	35,000	R514,70	
1957	With dilatation of the ureter or ureters	20	25,000	R367,60	
1959	With manipulation of ureteral calculus	20	20,000	R294,20	
1961	With removal of foreign body or calculus from urethra or bladder	20	20,000	R294,20	
1963	With fulguration or treatment of minor lesions, with or without biopsy	20	15,000	R220,60	
1964	And control of haemorrhage and blood clot evacuation	20	15,000	R220,60	
1965	And catheterisation of the ejaculatory duct	20	10,000	R146,80	
1967	With ureteric meatotomy: Unilateral or bilateral	20	15,000	R220,60	
1969	And cold biopsy	20	15,000	R220,60	

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1971	With cryosurgery for bladder or prostatic disease	20	55,000	R808,70	
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	20	35,000	R514,70	
1975	Ultraviolet cystoscopy for bladder tumour	20	60,000	R882,40	
1976	Optic urethrotomy	20	80,000	R1 176,50	
1977	Transurethral resection of ejaculatory duct	20	60,700	R892,40	
1979	Internal urethrotomy: Female	20	50,000	R735,50	
1981	Internal urethrotomy: Male	20	76,200	R1 120,70	
1983	Transurethral resection of bladder tumour	20	100,000	R1 470,60	
1984	Transurethral resection of bladder tumours: Large multiple tumours	20	115,000	R1 691,20	
1985	Transurethral resection of bladder neck: Female or child	20	105,000	R1 544,10	
1986	Transurethral resection of bladder neck: Male	20	125,000	R1 838,30	
1987	Litholapaxy	20	80,000	R1 176,50	
1989	Cystometrogram	20	25,000	R367,60	
1991	Flometric bladder, studies with videocystograph	20	40,000	R588,10	
1992	Without videocystograph	20	25,000	R367,60	
1993	Voiding cysto-urethrogram	20	21,000	R308,80	
1994	Rigiscan examination	20	66,000	R970,40	
1995	Percutaneous aspiration of bladder	20	10,000	R146,80	
1996	Bladder catheterisation: Male (not at operation)	20	6,000	R88,30	
1997	Bladder catheterisation: Female (not at operation)	20	3,000	R44,00	
1999	Percutaneous cystostomy	20	24,000	R353,30	
1945	Instillation of radio-opaque material for cystography or urethrocystography	20	5,000	R73,60	
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	20	10,000	R146,80	
1949	Cystoscopy: Hospital equipment	20	44,000	R647,30	

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1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	20	10,000	R146,80	
2001	Total cystectomy: After previous urinary diversion	20	294,000	R4 323,80	
2003	Total cystectomy: With conduit construction and ureteric anastomosis	20	554,700	R8 157,40	
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	20	650,000	R9 558,90	
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	20	700,000	R10 294,20	
2007	Partial cystectomy	20	147,000	R2 161,70	
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	20	600,000	R8 823,60	
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	20	462,000	R6 794,20	
2010	Reversion of temporary conduit	20	360,000	R5 294,30	
2011	Partial cystectomy with uretero-neo-cystostomy	20	202,000	R2 970,50	
2012	Reversion of conduit with major urinary tract reconstruction	20	600,000	R8 823,60	
2013	Diverticulectomy (independent procedure): Multiple or single	20	137,000	R2 014,80	
2014	Closure of cystostomy (stand alone procedure)	20	120,000	R1 764,70	
2015	Suprapubic cystostomy	20	67,000	R985,30	
2016	Abdomino-neo-urethrostomy	20	252,000	R3 705,70	
2017	Open loop fulguration or excision of bladder tumour	20	101,000	R1 485,30	
2019	Operation for vesico-vaginal or urethra-vaginal fistula	20	155,000	R2 279,60	
2020	Repair of vesico vaginal fistula: Abdominal approach	20	255,000	R3 750,00	
2021	Vesico-plication (Hamilton Stewart)	20	118,000	R1 735,20	
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	20	195,000	R2 867,60	
2025	Vesico-urethropexy with rectus sling	20	229,400	R3 373,60	
2027	Open operation for ureterocele: Unilateral	20	118,000	R1 735,20	
2029	Open operation for ureterocele: Bilateral	20	207,000	R3 044,40	
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	20	264,000	R3 882,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	20	53,000	R779,50	
2035	Cutaneous vesicostomy	20	118,000	R1 735,20	
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	20	126,000	R1 853,10	
2039	Operation for ruptured bladder	20	137,000	R2 014,80	
2042	Enterocystoplasty plus bowel anastomosis	20	419,900	R6 175,20	
2043	Cysto-lithotomy	20	132,000	R1 941,10	
2045	Excision of patent-urachus or urachal cyst	20	112,000	R1 647,10	
2047	Drainage of perivesical or prevesical abscess	20	105,000	R1 544,10	
2049	Evacuation of clots from bladder: Other than post-operative	20	132,100	R2 525,40	
2050	Evacuation of clots from bladder: Post-operative				
2051	Simple bladder lavage: Including catheterisation	20	12,000	R229,40	
2053	Bladder neck plasty: Male	20	137,000	R2 014,80	
2057	Bladder neck plasty: Female	20	137,000	R2 014,80	
2004	Complete pelvic exenteration for malignancy; includes combinations of removal of bladder, urethral transplantation, with or without hysterectomy, abdominoperineal resection of rectum or colon, colostomy		662,300	R9 739,70	
2034	Appendico-vesicostomy, cutaneous		264,300	R3 886,60	
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	20	45,000	R661,90	
2061	Open biopsy of urethra: Female	20	45,000	R661,90	
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	20	20,000	R294,20	
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	20	10,000	R146,80	
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	20	20,000	R294,20	
2069	Dilatation of female urethra	20	5,000	R73,60	
2071	Urethrorraphy: Suture of urethral wound or injury	20	139,000	R2 044,10	

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2073	External urethrotomy: Pendulous urethra (anterior)	20	67,000	R985,30	
2075	Urethraplasty: Pendulous urethra: First stage	20	71,000	R1 044,00	
2077	Urethraplasty: Pendulous urethra: Second stage	20	145,000	R2 132,50	
2079	Reconstruction of female urethra	20	147,000	R2 161,70	
2081	Reconstruction or repair of male anterior urethra (one stage)	20	261,600	R3 847,00	
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	20	168,000	R2 470,80	
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	20	168,000	R2 470,80	
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	20	294,000	R4 323,80	
2087	Urethral diverticulectomy: Male or female	20	147,000	R2 161,70	
2088	Peri-urethral teflon injection: Male or female - fee as for cystoscopy (item 1949) plus 42,00 clinical procedure units	20	86,000	R1 264,50	
2089	Marsupialisation of urethral diverticula: Male or female	20	115,100	R1 692,80	
2091	Total urethrectomy: Female	20	147,000	R2 161,70	
2093	Total urethrectomy: Male	20	189,000	R2 779,50	
2095	Drainage of simple localised perineal urinary extravasation	20	128,800	R1 894,10	
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	20	137,000	R2 014,80	
2099	Fulguration for urethral caruncle or polyp	20	53,600	R788,40	
2101	Excision of urethral caruncle	20	53,600	R788,40	
2103	Simple urethral meatotomy	20	26,300	R386,80	
2105	Incision of deep peri-urethral abscess: Female	20	123,100	R1 810,40	
2107	Incision of deep peri-urethral abscess: Male	20	123,100	R1 810,40	
2108	Sling operation for male urinary incontinence (fascia or synthetic)	20	169,000	R2 484,90	
2109	Badenoch pull-through for intractable stricture or incontinence	20	181,000	R2 661,70	
2110	Removal/revision: Sling for male urinary incontinence (fascia or synthetic)	20	120,000	R1 764,70	
2111	External sphincterotomy	20	108,000	R1 588,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff	20	217,600	R3 200,00	
2113	Drainage of Skene gland abscess or cyst	20	42,300	R622,20	
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff	20	142,500	R2 095,50	
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	20	168,000	R2 470,80	
2116	Urethral meatoplasty	20	101,500	R1 492,50	
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	20	150,300	R2 210,10	
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff	20	154,400	R2 270,70	
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff	20	123,500	R1 816,40	
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridment of infected tissue	20	278,200	R4 090,70	
2121	Closure of urethrovaginal fistula: Including diversionary procedures	20	189,000	R2 779,50	
2070	Transvaginal urethrolysis, includes cystoscopy		193,000	R2 838,00	
2104	Debridement of external genitalia and perineum (Fourniers gangrene)		13,900	R204,60	
2106	Debridement of external genitalia, perineum and abdominal wall (Fourniers gangrene)		13,900	R204,60	
11	**MALE GENITAL SYSTEM**				
11.1	Penis				
2123	Biopsy of penis (independent procedure)	20	52,100	R766,10	
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see item 2317)	20	16,600	R244,20	
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	20	41,600	R611,80	
2129	Electrodesiccation: Limited number	20	20,800	R306,10	
2131	Electrodesiccation: Multiple extensive	20	41,600	R611,80	
2132	Ligation of abnormal venous drainage	20	106,100	R1 560,20	
2133	Circumcision: Clamp procedure	20	42,300	R622,20	
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	20	60,000	R882,40	
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	20	36,800	R541,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	20	101,000	R1 485,30	
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	20	188,600	R2 773,40	
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	20	224,600	R3 302,90	
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	20	168,000	R2 470,80	
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	20	168,000	R2 470,80	
2153	Reconstructive operation for epispadias with incontinence	20	168,000	R2 470,80	
2154	Induction of artificial erection	20	16,000	R235,20	
2155	Hypospadias: Urethral reconstruction	20	187,000	R2 750,20	
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	20	84,000	R1 235,10	
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	20	300,000	R4 411,90	
2161	Total amputation of penis: Without gland dissection	20	210,000	R3 088,30	
2163	Total amputation of penis: With gland-dissection	20	336,000	R4 941,20	
2165	Partial amputation of penis: With gland-dissection	20	210,000	R3 088,30	
2167	Partial amputation of penis: Without gland-dissection	20	84,000	R1 235,10	
2169	Injection procedure for Peyronie's disease	20	14,000	R205,80	
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	20	42,000	R617,70	
2173	Priapism operation: Shunt procedure: Any type	20	252,000	R3 705,70	
2174	Priapism operation: Stab shunt	20	114,400	R1 682,60	
2172	Removal foreign body: Deep penile tissue (eg., plastic implant)		31,000	R455,90	
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)	20	18,500	R272,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2177	Testis biopsy: Incisional: Independent procedure: Unilateral	20	58,900	R866,20	
2179	Testis biopsy: Incisional: Independent procedure: Bilateral	20	58,900	R866,20	
2181	Epididymis biopsy: Needle	20	86,100	R1 266,20	
2183	Puncture aspiration hydrocele with or without injection of medication	20	10,000	R146,80	
2185	Operation for maldescended testicle: Including herniotomy	20	135,000	R1 985,30	
2187	Operation for torsion appendix testis	20	119,200	R1 753,00	
2189	Operation for torsion testis with fixation of contralateral testis	20	119,200	R1 753,00	
2191	Orchidectomy (total or subcapsular): Unilateral	20	98,000	R1 441,30	
2193	Orchidectomy (total or subcapsular): Bilateral	20	147,000	R2 161,70	
2195	Radical operation for malignant testis: Excluding gland dissection	20	155,300	R2 283,70	
2197	Operation for hydrocele or spermatocele	20	99,800	R1 467,40	
2199	Varicocelectomy	20	106,100	R1 560,20	
2201	Abdominal ligation of spermatic vein for varicocele	20	112,800	R1 658,90	
2203	Epididymectomy: Unilateral	20	114,400	R1 682,60	
2205	Epididymectomy: Bilateral	20	158,200	R2 326,60	
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	20	55,900	R822,00	
2209	Vasotomy: Unilateral or bilateral	20	70,400	R1 035,40	
2210	Vasogram, seminal vesiculogram: Unilateral	20	58,100	R854,50	
2211	Vasogram, seminal vesiculogram: Bilateral	20	58,100	R854,50	
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	20	91,200	R1 340,90	
2213	Suture or repair of testicular injury	20	110,300	R1 622,00	
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	20	90,000	R1 323,60	
2217	Excision of local lesion of testis or epididymis	20	90,800	R1 335,30	
2219	Vaso-vasostomy: Unilateral	20	67,000	R985,30	

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2221	Vaso-vasostomy: Bilateral	20	117,000	R1 720,60	
2223	Epididymo-vasostomy: Unilateral	20	67,000	R985,30	
2225	Epididymo-vasostomy: Bilateral	20	117,000	R1 720,60	
2227	Incision and drainage of scrotal wall abscess	20	42,700	R627,80	
2229	Excision of Mullerian duct cyst	20	189,000	R2 779,50	
2231	Excision of lesion of spermatic cord	20	84,000	R1 235,10	
2233	Seminal Vesiculectomy	20	220,000	R3 235,30	
2194	Laparoscopic orchiectomy (item 1807 may not be added to this item)		192,000	R2 823,60	
2196	Laparoscopic orchiopexy: Intra-abdominal testis (item 1807 may not be added to this item)		192,000	R2 823,60	
2198	Diagnostic laparoscopy (excluding aftercare) (male)		94,400	R1 388,20	
2228	Removal of foreign body: Scrtoum		20,000	R294,20	
2232	Excision: Retroperitoneal primary or secondary tumours		387,000	R5 691,10	
11.3	Prostate				
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	20	23,300	R342,80	
2237	Biopsy prostate: Incisional, any approach	20	105,000	R1 544,10	
2239	Transurethral drainage of prostatic abscess	20	117,400	R1 726,60	
2241	Perineal drainage of prostatic abscess	20	77,000	R1 132,50	
2243	Trans-urethral cryo-surgical removal of prostate	20	126,000	R1 853,10	
2245	Trans-urethral resection of prostate	20	252,000	R3 705,70	
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	20	126,000	R1 853,10	
2249	Trans-urethral resection of post-operative bladder neck contracture	20	126,000	R1 853,10	
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing		501,800	R7 377,00	
2251	Prostatectomy: Perineal: Sub-total	20	252,000	R3 705,70	
2253	Prostatectomy: Perineal: Radical	20	336,000	R4 941,20	

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2254	Pelvic lymph adenectomy	20	175,000	R2 573,70	
2255	Supra-pelvic, transversical	20	252,000	R3 705,70	
2257	Retropubic: Sub-total	20	252,000	R3 705,70	
2259	Retropubic: Radical	20	336,000	R4 941,20	
2260	Prostate brachytherapy	20	230,000	R3 382,40	
2236	Interstitial device(s): Single or multiple placement (via needle, any approach), of for radiation therapy guidance (eg., fiducial markers, dosimeter), prostate		29,100	R427,90	
2265	Cryosurgical ablation of the prostate, includes ultrasound guidance		126,000	R1 853,10	
2266	Transrectal high-intensity focused ultrasound (HIFU)		110,000	R1 541,90	
12	**FEMALE GENITAL SYSTEM**				
12.1	Vulva and introitus				
2271	Removal of tag or polyp	20	6,000	R88,30	
2272	Removal of small superficial benign lesions	20	23,000	R338,40	
2273	Biopsy with suture in theatre (excluding after-care)	20	27,000	R397,20	
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	20	71,000	R1 044,00	
2275	Reduction labial hypertrophy	20	67,000	R985,30	
2277	Removal of extensive benign vulva tumour	20	67,000	R985,30	
2279	Secondary perineal repair: Repair second degree tear	20	45,000	R661,90	
2280	Secondary perineal repair: Repair third degree tear	20	96,000	R1 411,80	
2281	Excision of inclusion cyst	20	43,000	R632,50	
2283	Hymenectomy	20	43,000	R632,50	
2285	Drainage haematocolpos	20	54,000	R793,90	
2287	Clitoris repair for injury: Including skin graft, if required	20	67,000	R985,30	
2288	Clitoral reduction	20	160,000	R2 353,00	
2289	Denervation or alcohol infiltration vulva (Woodruff)	20	54,000	R793,90	

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2291	Vulva: Undercutting skin (ball)	20	58,000	R852,90	
2293	Vulva and introitus: Drainage of abscess	20	27,000	R397,20	
2295	Bartholin gland: Bartholin abscess marsupialisation	20	36,000	R529,30	
2297	Bartholin gland: Bartholin gland excision	20	45,000	R661,90	
2299	Bartholin gland: Bartholin radical excision for malignant lesion	20	357,000	R5 249,90	
2301	Operation for enlarging introitus: Fenton plasty	20	50,000	R735,50	
2303	Operation for enlarging introitus: Bilateral Z-plastic	20	88,000	R1 294,00	
2305	Vulvectomy: Partial	20	161,000	R2 367,50	
2307	Vulvectomy	20	225,000	R3 308,80	
2309	Radical vulvectomy with bilateral lymphdenectomy	20	357,000	R5 249,90	
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	20	402,000	R5 911,60	
2270	Biopsy of vulva or perineum, each separate additional lesion (List separately in addition to item 2273 only)		8,600	R126,50	
2308	Vulvectomy, radical, partial; without lymphadenectomy		161,000	R2 367,50	
2310	Vulvectomy, radical complete, with unilateral inguinofemoral lymphadenectomy		225,000	R3 308,80	
2278	Perineoplasty, non-obstetrical (stand alone procedure)				Refer Rule C
12.2	Vaginal procedures and operations				
2312	Artificial insemination	20	13,000	R190,90	
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) - Stand alone procedure	20	25,500	R375,00	
2314	Intra uterine insemination	20	18,000	R264,70	
2315	Simms Hühner test plus wet smear	20	5,000	R73,60	
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	20	14,000	R205,80	
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat - Limited	20	7,000	R103,10	
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	20	56,000	R823,70	
2319	Excision of cysts or tumours	20	54,000	R793,90	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2321	Drainage of vaginal abscess	20	54,000	R793,90	
2322	Pudendal nerve block	20	15,000	R220,60	
2323	Reconstruction of vagina after atresia	20	107,000	R1 573,60	
2324	Revision of prosthetic vaginal graft:Vaginal approach (removal included)	20	120,000	R1 909,10	
2325	Construction of artificial vagina: Labial fusion	20	179,000	R2 632,30	
2326	Revision of prosthetic vaginal graft: Abdominal approach (removal included)	20	199,100	R2 928,30	
2327	Construction of artificial vagina: Macindoe type	20	196,000	R2 882,30	
2329	Construction of vagina: Bowel pull-through operation: Two surgeons: Each	20	241,000	R3 544,20	
2330	Fitting/insertion of pessary or other intravaginal support device	20	11,998	R176,50	
2331	Vaginal septum removal	20	107,000	R1 573,60	
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	20	243,300	R3 578,10	
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	20	243,300	R3 578,10	
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	20	166,900	R2 454,20	
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	20	166,900	R2 454,20	
2339	Colpotomy: Diagnostic (excluding after-care)	20	20,000	R294,20	
2341	Colpotomy: Therapeutic, with or without sterilisation	20	103,000	R1 514,60	
2343	Vaginal hysterectomy: Without repair	20	210,500	R3 095,80	
2345	Vaginal hysterectomy: With repair	20	231,700	R3 407,40	
2355	Posterior colporrhaphy, Repair of rectocele with or without perineorrhaphy		110,300	R1 622,30	
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	20	320,000	R4 706,00	
2359	Colporrhaphy: Anteroposterior, with enterocele repair	20	163,900	R2 410,60	
2361	Vaginal hysterectomy and repair for total prolapse	20	320,000	R4 706,00	
2363	Fothergill or Manchester repair operation	20	196,000	R2 882,30	
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	20	232,000	R3 411,60	

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2366	Posterior repair alone	20	107,000	R1 573,60	
2367	Other operations for prolapse: Anterior repair - with or without posterior repair	20	161,000	R2 367,50	
2368	Uterovesical fistula	20	210,000	R3 088,30	
2369	Repair of Vesico- or urethro-vaginal fistula	20	179,000	R2 632,30	
2370	Repair of VVF - Obstetric or radiation	20	232,000	R3 411,60	
2371	Closure of uretero-vaginal fistula	20	250,000	R3 676,50	
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	20	250,000	R3 676,50	
2373	Closure of recto-vaginal fistula	20	134,000	R1 970,60	
2374	Closure of recto-vaginal fistula: Obstetric or radiation	20	151,000	R2 220,50	
2375	Colpocleisis	20	129,000	R1 897,20	
2379	Schauta operation	20	357,000	R5 249,90	
2381	Vaginectomy	20	268,000	R3 941,40	
2383	Synchronous combined hysterocolpectomy: One or two surgeons - total fee	20	429,000	R6 308,90	
2385	Vaginal laceration or trauma: Repair	20	50,000	R735,50	
2386	Repair: Paravaginal defect repair (including repair of cystocele, if performed), abdominal approach	20	172,800	R2 541,30	
2387	Repair: Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach	20	140,100	R2 060,00	
2320	Revision of prosthetic vaginal graft or mesh: Laparoscopic revision (including removal)		174,800	R2 571,00	
2328	Laparoscopic repair of paravaginal defect repair (including repair of cystocele, if performed) (item 1807 may not be added to this item)		217,800	R3 203,20	
2337	Colpopexy: Vaginal, extra-peritoneal approach (sacrospinous, iliococcygeus)		142,400	R2 094,20	
2338	Colpopexy: Vaginal, intra-peritoneal approach (uretrosacral, levator myorrhaphy)		195,900	R2 881,00	
2340	Laparoscopic colpopexy (item 1807 may not be added to this item)		288,300	R4 240,00	
2344	Vaginal hysterectomy with unilateral/bilateral salpingectomy and/or oophorectomy, without repair		261,800	R3 850,10	
2346	Laparoscopic assisted vaginal hysterectomy (LAVH): Uterus <= 200g (item 1807 may not be added to this item)		255,500	R3 757,70	
2354	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele		191,100	R2 810,70	

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2358	Colporrhaphy: Anteroposterior, without enterocele repair		163,900	R2 410,60	
2360	Insertion of mesh/other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (modifier 0005 not applicable)		73,100	R1 074,90	
2362	Repair: Enterocele, vaginal approach (stand alone procedure)		137,700	R2 024,90	
2364	Repair: Enterocele, abdominal approach (stand alone procedure)		228,300	R3 357,20	
2380	Vaginectomy, simple, partial: Removal of vaginal wall		141,300	R2 078,10	
2382	Radical vaginectomy, complete removal of vaginal wall, with removal of para- vaginal tissue		268,000	R3 941,40	
12.3	Cervix				
2389	Paracervical (pelvis) nerve block (for neck refer to item 3294)	20	20,000	R294,20	
2391	Cervix: Canal reconstruction	20	147,000	R2 161,70	
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room	20	14,000	R205,80	
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	20	22,000	R323,50	
2396	Laser or harmonic scalpel treatment of the cervix	20	80,000	R1 176,50	
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	20	31,000	R455,90	
2399	Punch biopsy (excluding after-care)	20	9,000	R132,40	
2400	Biopsy during pregnancy (excluding after-care)	20	13,000	R190,90	
2403	Wedge biopsy: Cervix (excluding after-care)	20	18,000	R264,70	
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	20	24,000	R353,30	
2405	Cone biopsy: Cervix (excluding after-care)	20	54,000	R793,90	
2407	Amputation: Cervix	20	67,000	R985,30	
2409	Cervix encirclage: McDonald stitch	20	35,000	R514,70	
2411	Cervix encirclage: Shirodkar suture	20	60,000	R882,40	
2413	Cervix encirclage: Lash	20	49,000	R720,70	
2415	Cervix encirclage: Removal items 2409 and 2411: Without anaesthetic	20	5,000	R73,60	
2416	Cervix: Removal items 2409 and 2411: With anaesthetic in theatre	20	30,000	R441,20	

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2417	Repair of tears: Emmet repair of tears	20	45,000	R661,90	
2418	Repair of tears: Sturmdorff repair of tears	20	54,000	R793,90	
2421	Extirpation of cervical stump: Vaginal	20	134,000	R1 970,60	
2423	Extirpation of cervical stump: Abdominal	20	134,000	R1 970,60	
2425	Removal of cervical polyps (excluding after-care)	20	13,000	R190,90	
2427	Removal of cervical myomata	20	54,000	R793,90	
2429	Colposcopy (excluding after-care)	20	27,000	R397,20	
2408	Radical trachelectomy, with bilateral total pelvic lymphadenectomy with or without para-aortic lymphadenectomy, vaginal or abdominal approach		67,000	R985,30	
2410	Cervical cerclage, any route, non-obstetrical (Add 1807 if done by laparoscopy)		35,000	R514,70	
2422	Removal of cervical stump, vaginal approach; with enterocele/apical repair		160,600	R2 361,80	
2424	Removal of cervical stump, abdominal approach; with enterocele/apical repair		134,000	R1 970,60	
12.4	Uterus				
2432	Hysteroscopic bilateral tubal occlusion with permanent implants (includes hysteroscopy)	20	120,000	R1 764,70	
2433	Embryo transfer	20	45,000	R661,90	
2434	Endometrial biopsy (excluding after-care)	20	18,000	R264,70	
2435	Hysterosalpingogram (excluding after-care)	20	22,000	R323,50	
2436	Hysteroscopy (excluding after-care)	20	40,000	R588,10	
2437	Hysteroscopy and D&C (excluding after-care)	20	58,000	R852,90	
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	20	80,000	R1 176,50	
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	20	63,000	R926,50	
2440	Hysteroscopy and polypectomy (excluding after-care)	20	75,000	R1 103,00	
2441	Hysteroscopy and myomectomy (excluding after-care)	20	130,000	R1 911,90	
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	20	18,000	R264,70	
2443	Dilatation and curettage (D&C) (excluding after-care)	20	35,000	R514,70	

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2444	Fractional dilatation and curettage (D&C) (excluding after-care)	20	45,000	R661,90	
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	20	50,000	R735,50	
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	20	71,000	R1 044,00	
2448	Termination of pregnancy before 12 weeks	20	50,000	R735,50	
2449	Evacuation: Missed abortion: Before 12 weeks gestation	20	50,000	R735,50	
2451	Evacuation: Missed abortion: After 12 weeks gestation	20	80,000	R1 176,50	
2452	Termination of pregnancy after 12 weeks - administration of intra/extra amniotic prostaglandin	20	54,000	R793,90	
2453	Evacuation hydatidiform mole	20	80,000	R1 176,50	
2455	Evacuation uterus post-partum	20	54,000	R793,90	
2461	Ventrosuspension	20	80,000	R1 176,50	
2463	Uteroplasty: Strassman	20	143,000	R2 102,90	
2465	Uteroplasty: Tompkins	20	143,000	R2 102,90	
2467	Myomectomy	20	143,000	R2 102,90	
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	20	254,100	R3 736,90	
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy - uncomplicated	20	252,200	R3 709,00	
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	20	355,000	R5 220,70	
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	20	472,800	R6 953,10	
2477	Abdominal hysterotomy with or without sterilisation	20	188,000	R2 764,90	
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	20	200,000	R2 941,10	
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	20	225,000	R3 308,80	
2480	Laparoscopy by second gynaecologist during endometrial ablation (item 2479)	20	120,000	R1 764,40	
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)		188,000	R2 764,90	
2470	Laparoscopy: Subtotal abdominal hysterectomy, with or without removal of tube(s), with or without removal of ovary(s)		299,100	R4 398,80	
2472	Laparoscopy, total abdominal hysterectomy, with or without unilateral or bilateral salpingectomy, and/or oophorectomy		297,200	R4 370,90	

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2474	Total abdominal hysterectomy and bilateral salpingo-oophorectomy and total omentectomy for malignancy		398,300	R5 857,40	
2476	Laparoscopy, radical abdominal hysterectomy with bilateral total pelvic lymphadenectomy and para-aortic lymphnode sampling, with or without salpingectomy, with or without oophorectomy		517,800	R7 615,00	
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)	20	16,000	R235,20	
2483	Salpingolysis	20	125,000	R1 838,30	
2485	Salpingostomy	20	161,000	R2 367,50	
2487	Tuboplasty tubal anastomosis or re-implantation	20	196,000	R2 882,30	
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	20	125,000	R1 838,30	
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	20	161,000	R2 367,50	
2491	Ectopic pregnancy - after 12 weeks	20	225,000	R3 308,80	
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	20	94,000	R1 382,40	
	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)	20	94,400	R1 388,20	
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	20	18,000	R264,70	
2497	Laparoscopy: Plus sterilisation	20	40,000	R588,10	
2499	Laparoscopy: Plus biopsy (excluding after-care)	20	18,000	R264,70	
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	20	51,000	R749,90	
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	20	18,000	R264,70	
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	20	52,000	R764,80	
2503	Laparoscopy: Plus ovarian drilling	20	40,000	R588,10	
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	20	107,000	R1 573,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	20	52,000	R764,80	
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	20	58,000	R852,90	
2486	Salpingostomy/salpingoneostomy by laparoscopy (item 1807 may not be added to this item)		206,000	R3 029,40	
2488	Laparoscopy, tuboplasty, tubal anastomosis or re-implantation - stand alone procedure		241,000	R3 544,20	
2510	Treatment of ectopic pregnancy by laparoscopy, without salpingectomy and/or oophorectomy (item 1807 may not be added to this item)		161,000	R2 367,50	
2511	Treatment of ectopic pregnancy by laparoscopy, with salpingectomy and/or oophorectomy (item 1807 may not be added to this item)		125,000	R1 838,30	
12.6	Ovaries				
2525	Wedge resection of ovaries, unilateral or bilateral	20	105,000	R1 544,10	
2527	Removal of ovarian tumour or cyst	20	187,000	R2 750,20	
2529	Oophorectomy: Uni- or bilateral	20	134,500	R1 978,00	
2531	Ovarian carcinoma debulking and omentectomy	20	357,000	R5 249,90	
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	20	469,000	R6 897,20	
2530	Resection (initial) of suspected ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and total omentectomy		325,100	R4 780,90	
2533	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy, and radical dissection for cytoreduction, with pelvic lymphadenectomy and limited para-aortic lymphadenectomy		469,000	R6 897,20	
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		505,200	R7 429,50	
2526	Transposition of the ovaries				Refer Rule C
12.7	Miscellaneous procedures				
2535	Exenteration: Anterior Exenteration	20	402,000	R5 911,60	
2537	Exenteration: Posterior Exenteration	20	402,000	R5 911,60	
2539	Exenteration: Total	20	625,000	R9 191,20	
2541	Presacral neurectomy	20	98,000	R1 441,30	
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)	20	151,400	R2 225,80	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2543	Moschowitz operation	20	120,000	R1 764,40	
2544	Laparoscopic vaginal suspension for stress incontinence (item 1807 may not be used together with this item)	20	193,100	R2 839,90	
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	20	195,000	R2 867,60	
2546	Operations for stress incontinence: Urethro-vesicopexy: Abdominal approach	20	149,000	R2 191,10	
2547	Operations for stress incontinence: Burch colposuspension	20	161,000	R2 367,50	
2548	Operation for stress incontinence: Use of tape	20	229,400	R3 373,60	
2550	Operations for stress incontinence: Urethro-vesicopexy: Combined abdominal and vaginal approach	20	196,000	R2 882,30	
2551	Laparotomy	20	196,000	R2 882,30	
2552	Removal benign retroperitoneal tumour	20	223,000	R3 279,50	
2553	Radical removal of malignant retroperitoneal tumour	20	350,000	R5 147,10	
2554	Drainage of pelvic abscess per abdomen	20	180,000	R2 646,90	
2556	Drainage of pelvic abscess per vagina (refer to item 2341)	20	75,000	R1 103,00	
2558	Drainage intra-abdominal abscess: Delayed closure	20	268,000	R3 941,40	
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	20	150,000	R2 205,90	
2561	Surgery for severe endometriosis (AFS stage 4 - retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	20	210,000	R3 088,30	
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	20	51,000	R749,90	
2565	Implantation hormone pellets (excluding after-care)	20	3,000	R44,00	
2570	Ligation of internal iliac vessels (when not part of another procedure)	20	225,000	R3 308,80	
2566	Insertion of contraceptive hormone delivery implant (excluding aftercare)		3,000	R44,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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)	20	22,000	R323,50	
2605	Amniocentesis (excluding after-care)	20	36,000	R529,30	
2607	Amnioscopy (excluding after-care)	20	18,000	R264,70	
2609	Intra-uterine transfusion of foetus or cordocentesis	20	134,000	R1 970,60	
2610	Tococardiography - pre-natal and intrapartum (including stress and non-stress test: Own machine) (excluding after-care)	20	16,000	R235,20	
2611	Chorion villus sampling (excluding after-care)	20	54,000	R793,90	
2599	Pregnancy reduction(s): Multifoetal (MPR)		63,600	R935,60	
2600	Foeticide (includes ultrasound guidance)		63,600	R935,60	
2604	Amniocentesis: Therapeutic, amnitoic fluid reduction (includes ultrasound guidance)		54,200	R896,20	
2606	Cordocentesis (intrauterine): Any method		61,200	R1 011,90	
2608	Foetal umbilical cord occlusion (TTTS) (includes ultrasound guidance)		75,000	R1 076,10	
2612	Foetal fluid drainage (eg., vesicocentesis, thoracocentesis, paracentesis) (includes ultrasound guidance)		75,000	R1 076,10	
2613	Foetal shunt placement (includes ultrasound guidance)		156,800	R2 373,50	
13.2	Confinements				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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)	20	282,000	R4 826,70	
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).	20	267,000	R4 826,70	
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	20	190,000	R2 794,30	
	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 • Manual removal of placenta • 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	20	335,000	R4 926,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2657	Post-partum hysterectomy	20	300,000	R4 411,90	
2669	Abdominal operation for ruptured gravid uterus: Repair	20	250,000	R3 676,50	
14	NERVOUS SYSTEM				
14.1	Diagnostic procedures				
2680	Haemodynamic and autonomic nervous system testing with task Force system-PROFFESIONEL COMPONENTS		29,00	R554,20	
2681	Visual evoked potentials (VEP): Unilateral	20	50,000	R956,10	
2682	Visual evoked potentials (VEP): Bilateral	20	88,000	R1 682,40	
2683	Electro-retinography (Ganzfeld method): Unilateral	20	60,000	R1 147,20	
2684	Electro-retinography (Ganzfeld method): Bilateral	20	105,000	R2 007,40	
2685	Electro-oculography: Unilateral	20	30,000	R573,40	
2686	Electro-oculography: Bilateral	20	53,000	R1 013,30	
2687	VEP stable condition (photic drive): Unilateral	20	50,000	R956,10	
2689	VEP stable condition (photic drive): Bilateral	20	88,000	R1 682,40	
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	20	150,000	R2 867,70	
	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	20	48,000	R917,60	
2704	Neurostimulation, percutaneous: Sacral nerve		120,800	R2 308,80	
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	20	6,000	R114,90	
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming		8,800	R168,20	
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation	20	220,000	R4 205,90	
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	20	80,000	R1 529,60	
2709	Full spinogram including bilateral median and posterior-tibial studies	20	140,000	R2 676,40	
2710	Morphia saturation testing in rooms (consultation x2 plus item 0206: Intravenous infusion) (excluding injection material)				
2711	Electro-encephalography: Taking of record	20	36,100	R690,30	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2712	Electro-encephalography: Interpretation	20	24,000	R459,00	
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	20	18,400	R351,70	
	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	20	15,000	R286,80	
2715	8 Hour ambulatory EEG monitoring (Holter): Hire	20	136,000	R2 000,10	
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation	20	30,000	R573,40	
2717	Electromyography: First	20	75,000	R1 434,00	
2718	Electromyography: Subsequent	20	75,000	R1 434,00	
2719	Overnight polysomnogram and sleep staging: Hire	20	125,000	R1 838,30	
2720	Overnight polysomnogram and sleep staging: Interpretation	20	23,000	R439,60	
2721	Daytime polysomnogram: Hire	20	125,000	R1 838,30	
2722	Daytime polysomnogram: Interpretation	20	17,000	R325,00	
2723	Multiple sleep latency test: Interpretation	20	125,000	R2 389,90	
2724	Overnight continuous positive airways pressure (CPAP) titration	20	155,000	R2 963,50	
2725	Angiography carotis: Unilateral	20	25,000	R478,00	
2726	Angiography carotis: Bilateral	20	44,000	R841,50	
2727	Vertebral artery: Direct needling	20	50,000	R956,10	
2728	Unattended overnight home-based polysomnogram: Interpretation		24,500	R468,30	
2729	Vertebral catheterisation	20	50,000	R956,10	
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with item 0714)	20	60,000	R1 147,20	
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	20	14,500	R277,10	
2732	Overnight home-based polysomnogram: Interpretation		24,500	R468,30	
2733	Cortical Stimulation	20	58,900	R1 126,00	

CONTRACTED PHYSICIANS ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2734	Sodium Amytal Testing (WADA test)	20	88,700	R1 695,50	
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	20	31,500	R601,90	
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	20	7,000	R134,00	
2739	Ventricular needling without burring: Tapping only	20	16,000	R305,90	
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	20	43,000	R822,30	
2743	Subdural tapping: First sitting	20	15,000	R286,80	
2745	Subdural tapping: Subsequent	20	10,000	R190,90	
2746	Biopsy: Temporal artery		91,000	R1 337,80	
6003	Sleep electro-encephalography: Adults and children over infant age: Taking of record	20	36,100	R690,30	
6004	Sleep electro-encephalography: Adults and children over infant age: Interpretation	20	24,500	R468,70	
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	20	294,600	R5 632,10	
6011	Interpretation of item 6010: Electro-encephalogram monitoring: To be charged once only for each full 24 hour period of monitoring	20	128,600	R2 458,50	
6015	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation		22,400	R428,50	
6016	Sleep study: Includes simultaneous recording of ventilation, respiratory effort, ECG/heart rate and oxygen saturation (no EEG) (Technical component)		35,600	R680,80	
6018	Combined Video and EEG monitoring (16-24 hours): scalp, subdural or depth. To include 1. Equipment cost; 2. Technologist's set up cost and electrodes; 3. Technologist's technical report; Neurologist's review of EEG and clinical interpretation: Each full 24 hour period		423,200	R8 090,60	
6020	Electroencephalogram (EEG): Monitoring; 41-60 minutes		24,000	R459,30	
6021	Electroencephalogram (EEG): Monitoring; 61> minutes		24,000	R459,30	
6023	Electroencephalogram (EEG): All night recording (includes interpretation)		24,000	R459,30	
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		84,500	R1 615,40	
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)		73,200	R1 399,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6030	Electro-encephalogram (EEG): Monitoring (41-60 minutes): Equipment cost for taking of record (Technical component) (refer to item 6020 for interpretation and		36,100	R690,20	
6031	Electro-encephalogram (EEG): Monitoring (>60 minutes): Equipment cost for taking of record (Technical component) (refer to item 6021 for interpretation and report)		36,100	R690,20	
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)		36,100	R690,20	
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
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 (ie., 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	20	150,000	R2 205,90	
2749	Catheterisation for ventriculography and/or drainage	20	150,000	R2 205,90	
2751	Biopsy of brain tumour	20	150,000	R2 205,90	
2753	Subdural haematoma or hygroma	20	150,000	R2 205,90	
2755	Subdural empyema	20	150,000	R2 205,90	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2757	Brain abscess	20	150,000	R2 205,90	
2748	Twist drill hole: Subdural or ventricular puncture		139,400	R2 050,10	
2750	Twist drill hole(s): Includes subdural, intracerebral, or ventricular puncture for implanting ventricular catheter, pressure recording device or toher intracerebral monitoring device		92,900	R1 366,20	
2754	Burr hole(s) or trephine: Includes subsequent tapping (aspiration) of intracranial abscess or cyst		296,400	R4 358,90	
2758	Insertion: Subcutaneous reservoir, pump/continuous infusion system. Includes connection to ventricular catheter		152,100	R2 236,80	
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery		150,000	R2 205,90	
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral		150,000	R2 205,90	
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	20	37,000	R707,20	
2763	Nerve biopsy: Cranial nerves: Extra-cranial	20	20,000	R382,30	
2765	Nerve biopsy: Nerve conduction studies (see items 0733 and 3285)	20	26,000	R497,20	
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + item 0201 + item 0202)	20	25,000	R478,00	
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ item 0198 + item 0201 + item 0202)	20	30,000	R573,40	
6007	Botulinus toxin injections: For adductor disphonia (+ item 0198 + 0201 + item 0202)	20	35,000	R669,10	
6008	Botulinus toxin injections: In extra-ocular muscles (+ item 0198 + item 0201 + item 0202)	20	35,000	R669,10	
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ item 0198 + item 0201 + item 0202)	20	50,000	R956,10	
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)	20	300,000	R4 411,90	
2769	Suture: Large nerve: Primary	20	134,000	R1 970,60	
2771	Suture: Large nerve: Secondary	20	202,000	R2 970,50	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2773	Digital nerve: Primary	20	65,000	R955,80	
2775	Digital nerve: Secondary	20	96,000	R1 411,80	
2777	Nerve graft: Simple	20	202,000	R2 970,50	
2779	Fascicular: First fasciculus	20	202,000	R2 970,50	
2781	Fascicular: Each additional fasciculus	20	50,000	R735,50	
2782	Nerve pedicle transfer: First stage (not to be used together with item 2783)		309,100	R4 546,10	
2783	Fascicular: Nerve flap: To include all stages	20	224,000	R3 294,10	
2784	Nerve pedicle transfer: Second stage (not to be used together with item 2783)		338,300	R4 975,60	
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	20	124,000	R1 823,40	
2787	Fascicular: Grafting of facial nerve	20	215,000	R3 161,80	
14.3.2	Nerve procedures: Neurectomy				
2789	Trigeminal ganglion: Injection of alcohol	20	150,000	R2 867,70	
2791	Trigeminal ganglion: Injection of cortisone	20	65,000	R1 242,50	
2793	Trigeminal ganglion: Coagulation through high frequency	20	170,000	R3 250,20	
2799	Procedures for pain relief: Intrathecal injections for pain	20	36,000	R688,20	
2800	Procedures for pain relief: Plexus nerve block	20	36,000	R688,20	
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)	20	36,000	R688,20	
	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	
2803	Alcohol injection in peripheral nerves for pain: Unilateral	20	20,000	R382,30	
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique)	20	10,000	R190,90	
2805	Alcohol injection in peripheral nerves for pain: Bilateral	20	35,000	R669,10	
2809	Peripheral nerve section for pain	20	45,000	R860,50	

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Practice Type: **Physicians only**
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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2811	Pudendal neurectomy: Bilateral	20	116,000	R1 706,00	
2813	Obturator or Stoffels	20	96,000	R1 411,80	
2815	Interdigital	20	82,300	R1 210,30	
2825	Excision: Neuroma: Peripheral	20	109,500	R1 610,20	
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)		45,400	R868,20	
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)		16,300	R311,60	
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)		44,000	R841,30	
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)		15,600	R298,20	
14.3.3	Nerve procedures: Other nerve procedures				
2827	Transposition of ulnar nerve	20	100,000	R1 470,60	
2829	Neurolysis: Minor	20	51,000	R749,90	
2831	Neurolysis: Major	20	132,000	R1 941,10	
2833	Neurolysis: Digital	20	96,000	R1 411,80	
2834	Neuroplasty: Sciatic nerve		168,800	R2 482,80	
2835	Scalenotomy	20	132,000	R1 941,10	
2837	Neuroplasty:Brachial Plexus	20	223,000	R3 279,50	
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	20	895,200	R13 164,60	
2841	Carpal Tunnel	20	64,000	R941,40	
2843	Lumbar sympathectomy: Unilateral	20	153,000	R2 250,20	
2845	Lumbar sympathectomy: Bilateral	20	268,000	R3 941,40	
2846	Cervical sympathectomy: Trans-thoracic approach (use item 2847 or item 2848 as appropriate)				
2847	Cervical sympathectomy: Unilateral	20	153,000	R2 250,20	

CONTRACTED PHYSICIANS ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2848	Cervical sympathectomy: Bilateral	20	268,000	R3 941,40	
2849	Sympathetic block: Other levels: Unilateral	20	20,000	R382,30	
2851	Sympathetic block: Other levels: Bilateral	20	35,000	R669,10	
2853	Sympathetic block: Other levels: Diagnostic/Therapeutic nerve block (unassociated with surgery) - either intercostal, or brachial, or peripheral, or stellate ganglion	20	20,000	R382,30	
2854	Insertion of vagus nerve stimulator				Refer Rule C
14.4	Skull procedures				
2855	Removal of skull tumour: With or without plastic repair: Small	20	170,000	R2 500,10	
2857	Removal of skull tumour: With or without plastic repair: Major	20	200,000	R2 941,10	
2859	Repair of depressed fracture of skull: Without brain laceration: Major	20	200,000	R2 941,10	
2860	Repair of depressed fracture of skull: Without brain laceration: Small	20	170,000	R2 500,10	
2861	Repair of depressed fracture of skull: With brain lacerations: Small	20	200,000	R2 941,10	
2862	Repair of depressed fracture of skull: With brain lacerations: Major	20	375,000	R5 514,80	
2863	Cranioplasty	20	280,000	R4 118,00	
2864	Encephalocele (excluding frontal)	20	200,000	R2 941,10	
2865	Craniostenosis: Few suturae	20	213,000	R3 132,30	
2867	Craniostenosis: Multiple suturae	20	280,000	R4 118,00	
6035	Craniotomy: Craniosynostosis, frontal or parietal bone flap (total procedure)		506,000	R7 441,80	
6036	Craniotomy: Craniosynostosis, bifrontal bone flap (ttoal procedure)		499,900	R7 352,00	
6037	Craniectomy: Extensive for multiple cranial suture craniosynostosis (eg., cloverleaf skull); not requiring bone grafts (ttoal procedure)		475,500	R6 993,20	
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)		537,400	R7 903,60	
6040	Craniomegalic skull: Reduction (eg., treated hydrocephalus) not requiring bone grafts or cranioplasty (ttoal procedure)		371,300	R5 460,80	
6042	Craniomegalic skull: Reduction (eg., treated hydrocephalus), requiring Craniotomy and reconstruction with or without bone graft (includes obtaining grafts) (ttoal procedure)		465,400	R6 844,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6043	Cranioplasty: Skull defect; >5 cm diameter		340,800	R5 012,20	
6044	Removal of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/infection or inflammatory reaction due to device, implant and/or graft		264,900	R3 895,90	
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)		311,400	R4 579,50	
6046	Cranioplasty: Skull defect, with reparative brain surgery: With/without prosthesis		421,700	R6 202,00	
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =		371,400	R5 462,20	
6048	Cranioplasty: Includes autograft and obtaining bone grafts; >5 cm diameter (ttoal procedure)		432,700	R6 363,70	
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	20	280,000	R4 118,00	
2871	Ventriculo-caval shunt	20	280,000	R4 118,00	
2873	Ventriculo-peritoneal shunt	20	280,000	R4 118,00	
2875	Theco-peritoneal C.S.F. shunt	20	280,000	R4 118,00	
6063	Ventriculocisternostomy of the third ventricle: Steretoactic, neuroendoscopic method (under CT guidance for steretoactic positioning) (items 6055 and 6148 may not be added)		358,800	R5 276,90	
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		252,300	R3 710,60	
6068	Cerebrospinal fluid (CSF) shunt system: Complete removal, with replacement by similar or toher shunt at same operation		335,500	R4 934,30	
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

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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)	20	700,000	R10 294,20	
2877	Extracranial to intracranial vascular	20	700,000	R10 294,20	
2878	Posterior fossa arteriovenous anomalies	20	700,000	R10 294,20	
6075	Intracranial arteriovenous malformation (IAM): Surgery, supratenotrial, complex		1236,500	R18 184,00	
6076	Intracranial arteriovenous malformation (IAM): Surgical, infratenotrial, complex		1330,300	R19 563,50	
6077	Intracranial arteriovenous malformation (IAM): Surgery, dural, simple		648,500	R9 536,90	
6078	Intracranial arteriovenous malformation (IAM): Surgery, dural, complex		1082,600	R15 920,70	
6079	Intracranial aneurysm: Complex, intracranial approach, cartoid circulation		1249,100	R18 369,40	
6080	Intracranial aneurysm: Surgical, complex, intracranial approach, vertebrobasilar circulation		1369,900	R20 145,80	
6081	Intracranial aneurysm: Surgical, simple, open posterior cranial fossa approach approach, vertebrobasilar circulation		1190,800	R17 511,90	
6082	Intracranial aneurysm: Surgical, cervical approach by application of occluding clamp to cervical cartoid artery (Selverstone-Crutchfield type)		404,200	R5 944,20	
6083	Aneurysm: Surgical, for vascular malformation or cartoid-cavernous fistula with intracranial and cervical occlusion of cartoid artery		770,800	R11 335,40	
14.7	Craniectomy or Craniotomy				
2879	Glosso pharyngeal nerve	20	480,000	R7 058,70	
2881	Eighth nerve: Intracranial	20	480,000	R7 058,70	

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2883	Eighth nerve: Extracranial	20	480,000	R7 058,70	
2884	Sub-temporal section of the trigeminal nerve	20	375,000	R5 514,80	
2885	Trigeminal tractotomy	20	480,000	R7 058,70	
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	20	450,000	R6 617,60	
2887	Vestibular nerve	20	480,000	R7 058,70	
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	20	700,000	R10 294,20	
2891	Posterior fossa tumour removal: Glioma, secondary deposits	20	450,000	R6 617,60	
2893	Posterior fossa tumour removal: Abscess	20	450,000	R6 617,60	
2895	Excision of tumour of glomus jugulare: Intracranial	20	420,000	R6 176,40	
2897	Excision of tumour of glomus jugulare: Extracranial	20	420,000	R6 176,40	
2898	Excision of tumour of glomus jugulare: Hemispherectomy	20	500,000	R7 353,00	
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)		570,200	R8 385,20	
6085	Craniectomy/craniotomy: With exploration of the infratenotrial area (below the tenotrium of the cerebellum), posterior fossa (ttoal procedure)		596,400	R8 770,60	
6087	Craniectomy/craniotomy: With drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)		631,800	R9 291,40	
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

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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	20	375,000	R5 514,80	
14.8	Craniotomy for				
2900	Craniotomy for Extra-dural orbital decompression or excision of orbital tumour	20	700,000	R10 294,20	
2901	Craniotomy for Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	20	700,000	R10 294,20	
2903	Craniotomy for Abscess, Glioma	20	450,000	R6 617,60	
2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	20	450,000	R6 617,60	
2905	Craniotomy for Focal epilepsy: Excision of cortical scar	20	450,000	R6 617,60	
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	20	375,000	R5 514,80	
2907	Craniotomy for Temporal lobectomy	20	450,000	R6 617,60	
2908	Craniotomy for Torkildsen anastomosis	20	375,000	R5 514,80	
2910	Craniotomy for removal of arteriovenous malformation	20	700,000	R10 294,20	
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)		564,700	R8 304,60	
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess		566,200	R8 326,60	
6131	Craniotomy with elevation of bone flap: Lobectomy. temporal lobe. without electrocorticography during surgery(includes removal of electrode array)		763,700	R11 230,80	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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
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

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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	20	280,000	R4 118,00	
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	20	196,000	R2 882,30	
2915	Transnasal hypophysectomy	20	300,000	R4 411,90	
2916	Transfrontal hypophysectomy	20	480,000	R7 058,70	
2917	Transnasal hypophyseal implants	20	172,000	R2 529,60	
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)	20			
6145	Biopsy. stereotactic: Aspiration/excision for intracranial lesion. Includes burr hole(s)		417,800	R6 144,30	
6155	Stereotactic radiosurgery (particle beam. gamma ray. or linear accelerator): 1 cranial lesion. complex		407,300	R5 990,20	
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
6149	Steretoactic computer-assisted (navigational) procedure: Cranial. extradural. ADD to main procedure				Refer Rule C
6150	Steretoactic 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	Steretoactic radiosurgery (particle beam. gamma ray. or linear accelerator): 1 cranial lesion. simple				Refer Rule C

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6154	Steretoactic radiosurgery (particle beam. gamma ray. or linear accelerator): Each additional cranial lesion. simple. ADD to main procedure				Refer Rule C
6156	Steretoactic radiosurgery (particle beam. gamma ray. or linear accelerator): Each additional cranial lesion. complex. ADD to main procedure				Refer Rule C
6157	Steretoactic radiosurgery: Application of steretoactic 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				
6174	Anterior cranial fossa: Craniofacial approach. to treat an extradural lesion/defect at the skull base which requires unilateral or bifrontal Craniotomy (included in the approach procedure) with elevation or resection of frontal lobe.		866,300	R12 739,80	
6195	Destruction of cartoid aneurysm/arteriovenous malformation (AVM) or cartoid-cavernous fistula by dissection within cavernous sinus		977,500	R14 375,10	

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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
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				

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	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	20	178,000	R2 617,70	
2925	Chordotomy: Open	20	350,000	R5 147,10	

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2927	Rhizotomy: Extradural, but intraspinal	20	320,000	R4 706,00	
2928	Rhizotomy: Intradural	20	350,000	R5 147,10	
2929	Removal of spinal cord tumour: Intramedullar: Posterior approach	20	700,000	R10 294,20	
2930	Removal of spinal cord tumour: Intramedullar: Anterio-lateral approach	20	700,000	R10 294,20	
2931	Removal of spinal cord tumour: Extramedullary, but intradural: Posterior approach	20	350,000	R5 147,10	
2932	Removal of spinal cord tumour: Extramedullary, but intradural: Anterio-lateral approach	20	350,000	R5 147,10	
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural: Posterior approach	20	320,000	R4 706,00	
2935	Removal of spinal cord tumour: Extramedullary, but intradural: Transcutaneous chordotomy	20	225,000	R3 308,80	
2937	Repair of meningocele, involving nerve tissue	20	250,000	R3 676,50	
2938	Simple	20	150,000	R2 205,90	
2939	Excision of arterial vascular malformations and cysts of the spinal cord	20	700,000	R10 294,20	
2940	Lumbar osteophyte removal	20	187,000	R2 750,20	
2941	Cervical or thoracic osteophyte removal	20	285,000	R4 191,30	
14.10	Arterial ligations				
2951	Carotis: Trauma	20	120,000	R1 764,40	
2953	Carotis: For aneurysm (AV anomaly)	20	150,000	R2 205,90	
2955	Removal of carotid body tumour (without vascular reconstruction)	20	335,600	R4 935,30	
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)				
2975	Individual psychotherapy (specify type): Including play therapy for children: Per extended session (60 minutes or longer)				

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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 psychotherpay items after a first or follow-up consultation the clinician must ensure that the time stipulated for the psychotherapy items are adhered to (ie. item 2957 - minimum 10 minutes, item 2974 - minimum 30 minutes, and item 2975 - minimum 50 minutes)				
0099	Stat basis tests: For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos: • 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)				
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	20	198,100	R2 913,40	
2985	Lobectomy: Total	20	200,000	R2 941,10	
2987	Thyroidectomy: Subtotal	20	266,000	R3 911,80	

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2989	Thyroidectomy: Total	20	279,000	R4 102,90	
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		335,300	R4 929,20	
2991	Thyroglossal cyst or fistula excision	20	126,200	R1 855,80	
15.2	Parathyroid				
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		370,700	R5 449,70	
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	20	275,000	R4 044,30	
2994	Parathyroid: Autotransplantation of parathyriod: ADD to major procedure (modifier 0005 does not apply)		70,500	R1 036,30	
15.3	Adrenals				
2995	Adrenalectomy: Unilateral	20	225,000	R3 308,80	
2997	Bilateral exploration of adrenal glands: Including removal	20	394,000	R5 794,10	
15.4	Hypophysis				
2999	Transethmoidal hypophysectomy	20	300,000	R4 411,90	
3000	Transnasal hypophysectomy (see also item 2915)	20	300,000	R4 411,90	
15.5	Endocrine system: General				
3001	Implantation of pellets (excluding cost of material) (excluding after-care)	20	3,000	R44,00	
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				

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	(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				
16.1.1	Eye investigations				
3002	Gonioscopy	20	7,000	R103,10	
3003	Fundus contact lens or 90 D lens examination (not to be charged with item 3004 or item 3012)	20	7,000	R103,10	
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with item 3003 and/or item 3012)	20	7,000	R103,10	
3006	Keratometry	20	7,000	R103,10	
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	20	11,680	R171,50	
3012	Pre-surgical retinal examination before retinal surgery	20	32,000	R470,60	
3013	Ocular motility assessment: Comprehensive examination	20	12,000	R176,50	
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	20	7,000	R103,10	
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	20	9,000	R132,40	
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	20	7,000	R103,10	
3007	Potential acuity measurement	20	7,000	R103,10	
3008	Contrast sensitivity test	20	7,000	R103,10	
3010	Orthoptics consultation	20	10,000	R146,80	
3011	Orthoptic subsequent sessions	20	5,000	R73,60	
3015	Charting of visual field with manual perimeter	20	28,000	R411,70	
3016	Retinal threshold test without storage facilities	20	30,000	R441,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	20	74,000	R1 088,10	
3018	Retinal threshold trend evaluation (additional to item 3017)	20	16,000	R235,20	
3019	Ocular muscle function with Hess screen or perimeter	20	16,000	R235,20	
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	20	46,000	R676,60	
3022	Digital fluorescein video angiography	20	68,000	R1 000,00	
3023	Digital indocyanine video angiography	20	110,000	R1 617,70	
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to items 3022, 3023, 3031, 3039	20	12,000	R176,50	
3025	Electronic tonography	20	19,000	R279,60	
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	20	19,300	R284,00	
3027	Fundus photography	20	21,000	R308,80	
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	20	40,000	R588,10	
3029	Anterior segment microphotography	20	21,000	R308,80	
3031	Fluorescein Angiography: One or both eyes (not to be used with item 3022)	20	45,000	R661,90	
3032	Eyelid and orbit photography	20	9,000	R132,40	
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinicians	20	16,000	R235,20	
3034	Determination of lens implant power per eye	20	15,000	R220,60	
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	20	22,000	R323,50	
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)	20	36,000	R529,30	
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	20	306,900	R4 513,50	
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	20	105,000	R1 544,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3041	Pan retinal photocoagulation (per eye): Done in one sitting	20	150,000	R2 205,90	
3044	Removal of encircling band and/or buckling material	20	105,000	R1 544,10	
16.3	Cataract				
3045	Cataract: Intra-capsular	20	210,000	R3 088,30	
3047	Cataract: Extra-capsular (including capsulotomy)	20	210,000	R3 088,30	
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	20	57,000	R838,30	
3050	Repositioning of intra ocular lens	20	171,100	R2 516,00	
3051	Needling or capsulotomy	20	130,000	R1 911,90	
3052	Laser capsulotomy	20	105,000	R1 544,10	
3057	Removal of lenticulus	20	210,000	R3 088,30	
3058	Exchange of intra ocular lens	20	236,000	R3 470,80	
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded)	20	210,000	R3 088,30	
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)	20	4,000	R59,10	
16.4	Glaucoma				
3061	Drainage operation	20	247,600	R3 641,20	
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to item 3061)	20	60,000	R882,40	
3063	Cyclocryotherapy or cyclodiathermy	20	105,000	R1 544,10	
3064	Laser trabeculoplasty	20	105,000	R1 544,10	
3065	Removal of blood from anterior chamber	20	105,000	R1 544,10	
3067	Goniotomy	20	210,000	R3 088,30	
16.5	Intra-ocular foreign body				
3071	Intra-ocular foreign body: Anterior to Iris	20	127,000	R1 867,80	
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	20	210,000	R3 088,30	
16.6	Strabismus				

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3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to item 0202)	20	20,000	R294,20	
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	20	175,600	R2 582,30	
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	20	200,000	R2 941,10	
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	20	120,000	R1 764,40	
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	20	150,000	R2 205,90	
16.7	Globe				
3079	Transcleral biopsy	20	132,000	R1 941,10	
3080	Examination of eyes under general anaesthetic where no surgery is done	20	80,000	R1 176,50	
3081	Treatment of minor perforating injury	20	161,600	R2 376,50	
3083	Treatment of major perforating injury	20	267,500	R3 933,80	
3085	Enucleation or Evisceration	20	105,000	R1 544,10	
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	20	160,000	R2 353,00	
3088	Hydroxyapetite insertion (additional to item 3087)	20	40,000	R588,10	
3089	Subconjunctival injection if not done at time of operation	20	10,000	R146,80	
3090	Intra vitreal injection drug	20	47,600	R700,10	
3091	Retrobulbar injection (if not done at time of operation)	20	16,000	R235,20	
3092	External laser treatment for superficial lesions	20	53,000	R779,50	
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	20	209,000	R3 073,50	
3094	Implantation of intra vitreal drug delivery system	20	247,600	R3 641,20	
3095	Biopsy of vitreous body or anterior chamber contents	20	105,000	R1 544,10	
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	20	130,000	R1 911,90	
3097	Anterior vitrectomy	20	280,000	R4 118,00	
3098	Removal of silicon from globe	20	280,000	R4 118,00	

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3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	20	419,000	R6 161,70	
3100	Lensectomy done at time of posterior vitrectomy	20	30,000	R441,20	
16.8	Orbit				
3101	Drainage of orbital abscess	20	105,000	R1 544,10	
3103	Orbit: Removal of tumour	20	240,000	R3 529,40	
3104	Removal orbital prosthesis	20	212,700	R3 128,00	
3105	Orbit: Exenteration	20	275,000	R4 044,30	
3107	Orbitotomy requiring bone flap	20	393,000	R5 779,40	
3108	Eye socket reconstruction	20	206,000	R3 029,30	
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	20	300,000	R4 411,90	
3110	Second stage hydroxyapetite implantation	20	110,000	R1 617,70	
16.9	Cornea				
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	20	-		
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.	20	12,200	R179,40	
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	20	200,000	R2 941,10	
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery - EQUIPMENT component only	20	78,850	R1 159,80	
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	20	166,000	R2 441,20	
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	20	135,200	R1 988,20	
3117	Removal of foreign body: On the basis of fee per consultation	20	-		
3118	Curettage of cornea after removal of foreign body (after-care excluded)	20	10,000	R146,80	
3119	Tattooing	20	26,000	R382,30	

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3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) (For machine hire fee for LTK: Use item 3201)	20	150,000	R2 205,90	
3121	Corneal graft (Lamellar or full thickness)	20	289,000	R4 250,00	
3122	Epikeratophakia	20	289,000	R4 250,00	
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	20	254,000	R3 735,20	
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see item 0202)	20	9,000	R132,40	
3125	Keratectomy	20	127,000	R1 867,80	
3126	Additional to item 3120 for the use of own microkeratome used with a excimer laser	20	52,180	R767,30	
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	20	10,000	R146,80	
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	20	150,000	R2 205,90	
3129	Additional to item 3128 for the use of own diamond knives	20	40,000	R588,10	
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	20	96,900	R1 425,00	
3131	Cornea: Paracentesis	20	53,000	R779,50	
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	20	150,000	R2 205,90	
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used - stand alone procedure	20	116,300	R1 710,20	
3136	Conjunctival flap or graft (not for use with pterigium surgery)	20	95,700	R1 407,40	
3138	Removal corneal epithelium and chelating agent for band keratopathy	20	69,500	R1 021,90	
4980	Corneal transplant: Endothelial	20	219,800	R3 233,00	
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)	20	-		
4985	Corneal cross linking	20	150,000	R2 205,80	
4986	Cross linking equipment hire	20	54,000	R794,20	
16.10	Ducts				
3133	Probing and/or syringing, per duct	20	10,000	R146,80	
3135	Insert polythene tubes	20	51,800	R761,80	
3137	Excision of lacrimal sac: Unilateral	20	132,000	R1 941,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3139	Dacrocystorhinostomy (Single) with or without polythene tube	20	210,000	R3 088,30	
3141	Sealing Punctum surgical or by cautery: Per eye	20	24,900	R366,20	
3142	Sealing Punctum with plugs: Per eye	20	20,000	R294,20	
3143	Three-snip operation	20	10,000	R146,80	
3145	Repair of caniculus: Primary procedure	20	132,000	R1 941,10	
3147	Repair of caniculus: Secondary procedure	20	175,000	R2 573,70	
16.11	Iris				
3149	Iridectomy or iridotomy by open operation as isolated procedure	20	132,000	R1 941,10	
3151	Excision of iris tumour	20	185,000	R2 720,70	
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	20	105,000	R1 544,10	
3155	Iridocyclectomy for tumour	20	266,000	R3 911,80	
3157	Division of anterior synechiae as isolated procedure	20	132,000	R1 941,10	
3158	Repair iris as in dialysis: Anterior chamber reconstruction	20	142,400	R2 094,20	
16.12	Lids				
3161	Tarsorrhaphy	20	47,000	R691,10	
3163	Excision of superficial lid tumour	20	47,000	R691,10	
3165	Repair of skin laceration lid: Simple	20	27,300	R401,40	
3167	Diathermy to wart on lid margin	20	12,000	R176,50	
3169	Electrolysis of any number of eyelashes: Per eye	20	15,000	R220,60	
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see item 0202)	20	20,400	R300,00	
3173	Epicanthal folds	20	128,700	R1 892,60	
3174	Botulinus toxin injection for blepharospasm (+ item 0198 + item 0201 + item 0202)	20	25,000	R367,60	
3175	Botulinus toxin injection in extra-ocular muscles (+ item 0198 + item 0201+ item 0202)	20	35,000	R514,70	
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	20	187,000	R2 750,20	

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3168	Removal of foreign body: Embedded, per eyelid (modifier 0005 is applicable)		20,000	R294,20	
16.12.1	Lids: Entropion or ectropion by				
3177	Entropion or ectropion by Cautery	20	10,000	R146,80	
3179	Entropion or ectropion by Suture	20	49,400	R726,40	
3181	Entropion or ectropion by Open operation	20	111,500	R1 639,60	
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	20	122,600	R1 802,90	
16.12.2	Lids: Reconstruction of eyelid				
3185	Staged procedure for partial or total loss of eyelid: First stage	20	259,000	R3 808,70	
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	20	206,000	R3 029,30	
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	20	136,500	R2 007,50	
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	20	150,200	R2 208,90	
3172	Blepharoplasty lower eyelid plus fat pad	20	125,800	R1 850,10	
16.12.3	Lids: Ptosis				
3193	Repair by superior rectus, levator or frontalis muscle operation	20	190,000	R2 794,30	
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	20	137,600	R2 023,80	
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	20	166,000	R2 441,20	
16.13	Conjunctiva				
3199	Repair of conjunctiva by grafting	20	132,000	R1 941,10	
3200	Repair of lacerated conjunctiva	20	47,000	R691,10	
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	20	109,000	R1 603,10	
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	20	2,250	R33,10	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3196	Diamond knife: Use of own diamond knife during intraocular surgery	20	12,000	R176,50	
3198	Excimer laser: Hire fee (per eye)	20	284,130	R4 178,30	
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting (Not to be used with IOL Master)	20	109,000	R1 603,10	
3202	Phako emulsification apparatus: Hire fee	20	109,000	R1 603,10	
3203	Vitrectomy apparatus: Hire fee	20	120,000	R1 764,40	
3208	Biopsy: External auditory canal	20	15,497	R228,00	
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	20	138,000	R2 029,60	
3269	Major congenital deformity reconstruction of external ear: Bilateral	20	242,000	R3 558,90	
3270	Excision of superficial pre-auricular fistula	20	55,000	R808,70	
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear	20	-		
3272	Excision of complicated pre-auricular fistula	20	140,000	R2 058,70	
5170	Drainage: Haematoma or abscess of external ear	20	34,800	R511,90	
5173	Biopsy: External ear	20	12,400	R182,40	
5175	Excision: External ear, partial, simple repair	20	63,500	R933,70	
5176	Excision: External ear, complete	20	66,800	R982,20	
5171	Drainage: Abscess of external auditory canal		21,000	R308,80	
17.2	External ear canal				
3204	External ear canal: Removal of foreign body: At rooms	20	-		

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3205	External ear canal: Removal of foreign body: Under general anaesthetic	20	21,000	R308,80	
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	20	164,000	R2 411,70	
3217	Meatus atresia: Congenital	20	277,000	R4 073,60	
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) - not to be used combined with item 3206	20	17,420	R256,10	
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	20	77,000	R1 132,50	
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) - not to be used combined with item 3206	20	23,100	R340,40	
3221	Meatus atresia: Removal of osteoma from meatus: Multiple	20	215,000	R3 161,80	
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	20	8,000	R117,50	
3207	Myringotomy: Unilateral	20	28,000	R411,70	
3209	Myringotomy: Bilateral	20	46,000	R676,60	
3211	Unilateral myringotomy with insertion of ventilation tube	20	38,000	R558,90	
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	20	57,000	R838,30	
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	20	65,000	R955,80	
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	20	255,000	R3 750,00	
3237	Exploratory tympanotomy	20	158,900	R2 336,70	
3242	Fenestration: Revision	20	20,000	R2 324,60	
3243	Myringoplasty	20	138,000	R2 029,60	
3245	Functional reconstruction of tympanic membrane	20	277,000	R4 073,60	
3249	Stapedotomy and stapedectomy	20	277,000	R4 073,60	
3257	Cortical mastoidectomy	20	188,500	R2 772,20	
3259	Radical mastoidectomy (excluding minor procedures)	20	277,400	R4 079,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3261	Muscle grafting to mastoid cavity without tympanoplasty	20	180,000	R2 646,90	
3263	Autogenous bone graft to mastoid cavity	20	180,000	R2 646,90	
3264	Tympanomastoidectomy	20	375,000	R5 514,80	
3265	Reconstruction of posterior canal wall, following radical mastoid	20	320,000	R4 706,00	
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	20	30,000	R573,40	
5190	Debridement: Mastoidectomy cavity, complex (anaesthesia/more than routine cleaning)		24,100	R354,40	
5193	Implantation/replacement: Electromagnetic temporal bone conduction hearing device		199,600	R2 935,80	
5201	Revision: Mastoidectomy resulting in ttoal mastoidectomy		271,500	R3 992,70	
5202	Revision: Mastoidectomy resulting in modified radical mastoidectomy		278,500	R4 095,60	
5203	Revision: Mastoidectomy followed by tympanoplasty		287,000	R4 220,60	
5204	Revision: Mastoidectomy, with apicectomy		346,800	R5 100,00	
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	20	9,000	R172,40	
3224	Electroneurography (ENOG)	20	75,000	R1 434,00	
17.4.2	Facial nerve: Facial nerve surgery				
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	20	297,000	R4 367,80	
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including item 3227)	20	436,000	R6 411,80	
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	20	436,000	R6 411,80	
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	20	124,000	R1 823,40	
17.5	Inner ear				
17.5.1	Inner ear: Audiometry				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	20	50,000	R956,10	
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	20	88,000	R1 682,40	
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels	20	60,000	R1 147,20	
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels	20	105,000	R2 007,40	
2695	Audiology 40Hz response: Unilateral	20	30,000	R573,40	
2696	Audiology 40Hz response: Bilateral	20	53,000	R1 013,30	
2697	Mid- and long latency auditory evoked potentials: Unilateral	20	30,000	R573,40	
2698	Mid- and long latency auditory evoked potentials: Bilateral	20	53,000	R1 013,30	
2699	Electro-cochleography: Unilateral	20	50,000	R956,10	
2700	Electro-cochleography: Bilateral	20	88,000	R1 682,40	
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	20	140,000	R2 676,40	
3248	Otoacoustic emission performed as a screening test	20	33,240	R635,70	
3250	Otoacoustic emission (high risk patients only)	20	66,480	R1 271,00	
3273	Pure tone audiometry (air conduction)	20	6,500	R124,50	
3274	Pure tone audiometry (bone conduction with masking)	20	6,500	R124,50	
3275	Impedance audiometry (tympanometry)	20	6,500	R124,50	
3276	Impedance audiometry (stapedial reflex) - no charge for volume, compliance etc.	20	6,500	R124,50	
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	20	10,000	R190,90	
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	20	6,500	R124,50	
17.5.2	Inner ear: Balance tests				
3251	Minimal caloric test (excluding consultation fee)	20	10,000	R190,90	
3252	Bithermal Halpike caloric test (excluding consultation fee)	20	20,000	R382,30	
3253	Electro-nystagmography for spontaneous and positional nystagmus	20	25,000	R478,00	
3254	Video nystagmoscopy (monocular)	20	25,000	R478,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3255	Caloric test done with electronystamography	20	70,000	R1 338,40	
3256	Video nystagmoscopy (binocular)	20	50,000	R956,10	
3258	Otolith repositioning manoeuvre	20	14,000	R267,50	
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	20	71,480	R1 366,40	
5210	Nystagmus test: Spontaneous, including gaze and fixation nystagmus (report included)		10,200	R195,00	
5211	Nystagmus test: Positional, minimum of 4 positions (report included)		9,100	R174,00	
5212	Caloric vestibular test: Each irrigation (report included)		3,200	R61,10	
5213	Nystagmus test: Optokinetic bidirectional, foveal or peripheral stimulation (report included)		7,200	R137,60	
5216	Posturography: Dynamic, computerised		25,100	R479,70	
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	20	277,000	R4 073,60	
3240	Endolymphatic sac surgery	20	277,000	R4 073,60	
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	20	310,000	R4 558,80	
3246	Cochlear implant surgery	20	340,500	R5 007,30	
5196	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy	20	212,300	R3 122,60	
5197	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy	20	269,000	R3 955,30	
5199	Revision: Stapedectomy or stapedotomy	20	251,900	R3 704,90	
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)				

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3229	Facial nerve: Exploration of the labyrinthine segment	20	420,000	R6 176,40	
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	20	510,000	R7 499,90	
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	20	620,000	R9 117,50	
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	20	530,000	R7 794,10	
17.6.2	Microsurgery of the skull base: Translabyrinthe approach				
3239	Acoustic neuroma removal translabyrinthine	20	660,000	R9 705,90	
5227	Cochleo-vestibular neurectomy	20	530,000	R7 794,10	
5228	Nerve section: Vestibular, transcranial approach (approach 1): Graft harvesting not included		458,500	R6 742,60	
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	20	710,000	R10 441,20	
17.6.5	Microsurgery of the skull base: Intratemporal fossa approach type B				
5238	Removal of tumour of the petrous apex	20	620,000	R9 117,50	
17.6.6	Microsurgery of the skull base: Intrafemoral approach type C				
5242	Removal of nasopharyngeal angiofibroma or carcinoma	20	520,000	R7 647,10	
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	20	520,000	R7 647,10	
17.6.7	Microsurgery of the skull base: Subtotal petrosectomy				
5246	Subtotal petrosectomy for removal of temporal bone tumour	20	600,000	R8 823,60	
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	20	480,000	R7 058,70	
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	20	520,000	R7 647,10	
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	20	600,000	R8 823,60	
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	20	660,000	R9 705,90	

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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)	20	0,750	R11,10	
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	20	13,500	R198,50	
3281	Ultrasonic therapy	20	10,000	R146,80	
3282	Shortwave diathermy	20	10,000	R146,80	
3284	Sensory nerve conduction studies	20	31,000	R455,90	
3285	Motor nerve conduction studies	20	26,000	R382,30	
3287	Spinal joint and ligament injection	20	20,000	R294,20	
3288	Epidural injection	20	36,000	R529,30	
3289	Multiple injections: First joint	20	7,500	R110,40	
3290	Multiple injections: Each additional joint	20	4,500	R66,10	
3291	Tendon or ligament injection	20	9,000	R132,40	
3292	Aspiration of joint or inter-articular injection	20	9,000	R132,40	
3293	Aspiration or injection of bursa or ganglion	20	9,000	R132,40	
3294	Paracervical (neck) nerve block (for pelvis refer to item 2389)	20	20,000	R294,20	
3295	Paravertebral root block: Unilateral	20	20,000	R294,20	
3296	Paravertebral root block: Bilateral	20	30,000	R441,20	
3297	Manipulation of spine performed by a specialist in Physical Medicine	20	14,000	R205,80	
3298	Spinal traction	20	6,000	R88,30	
3299	Manipulation of large joints: Under general anaesthesia	20	14,000	R205,80	
3299a	Manipulation of large joints: Under general anaesthesia	20	14,000	R205,80	
3300	Manipulation of large joints: Without anaesthetic	20	-		
3301	Muscle fatigue studies	20	20,000	R294,20	
3302	Strength duration curve per session	20	10,500	R154,30	

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3303	Electromyography	20	75,000	R1 103,00	
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (For subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment: A fee for the treatment only, is applicable: See general rules L and M)	20	10,000	R146,80	
	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				
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				

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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		6,300	R170,60	
3309	Smith-Petersen or equivalent control, in theatre		38,700	R1 048,20	
3311	Stress studies, e.g, joint		7,700	R208,80	
3313	Full length study, both legs		15,500	R419,70	
3315	Skeletal survey under 5 years				
3317	Skeletal survey over 5 years		28,000	R758,30	
3319	Arthrography per joint		15,400	R417,10	
3320	Introduction of contrast medium or air: ADD		13,800	R373,80	
6500	Hand		7,700	R208,80	
6501	Wrist (specify region)		7,700	R208,80	
6503	Scaphoid		7,700	R208,80	
6504	Radius and ulna		7,700	R208,80	
6505	Elbow		7,700	R208,80	
6506	Humerus		7,700	R208,80	
6507	Shoulder		7,700	R208,80	
6508	Acromio-Clavicula joint		7,700	R208,80	

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6509	Clavicle		7,700	R208,80	
6510	Scapula		7,700	R208,80	
6511	Foot		7,700	R208,80	
6512	Ankle		7,700	R208,80	
6513	Calcaneus		7,700	R208,80	
6514	Tibia and fibula				
6515	Knee		7,700	R208,80	
6516	Patella		7,700	R208,80	
6517	Femur		7,700	R208,80	
6518	Hip		7,700	R208,80	
6519	Sesamoid Bone		7,700	R208,80	
19.1.2	Skeleton: Spinal column				
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic		11,000	R297,80	
3325	Stress studies		11,000	R297,80	
3329	Scoliosis studies		21,000	R569,00	
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)		11,000	R297,80	
3333	Myelography: Lumbar		28,900	R782,70	
3334	Myelography: Thoracic		22,200	R601,40	
3335	Myelography: Cervical		35,500	R961,30	
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)				
3344	Introduction of contrast medium		18,700	R506,70	
3345	Discography		34,600	R937,10	
3347	Introduction of contrast medium per disc level: ADD		28,200	R764,00	
19.1.3	Skeleton: Skull				

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3349	Skull studies		15,700	R425,20	
3351	Paranasal sinuses		11,000	R297,80	
3353	Facial bones and/or orbits		12,600	R341,20	
3355	Mandible		9,400	R254,50	
3357	Nasal bone		7,800	R211,20	
3359	Mastoid: Bilateral				
3361	Teeth: One quadrant		3,700	R100,60	
3363	Teeth: Two quadrants		6,300	R170,60	
3365	Teeth: Full mouth		11,000	R297,80	
3366	Teeth: Rotation tomography of the teeth and jaws		13,300	R360,00	
3367	Teeth: Tempero-mandibular joints: Per side		11,000	R297,80	
3369	Teeth: Tomography: Per side		11,000	R297,80	
3371	Localisation of foreign body in the eye		15,700	R425,20	
3381	Ventriculography		27,300	R739,80	
3385	Post-nasal studies: Lateral neck		6,300	R170,60	
3387	Maxillo-facial cephalometry		8,800	R238,70	
3389	Dacrocystography		11,000	R297,80	
3391	For introduction of contrast medium: ADD		11,000	R297,80	
19.2	Alimentary tract				
3393	Bowel washout: ADD		4,800	R129,80	
3395	Sialography (plus 80% for each additional gland)		12,700	R344,30	
3397	Introduction of contrast medium (plus 80% for each additional gland: ADD)		11,000	R297,80	
3399	Pharynx and oesophagus		12,700	R344,30	
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through		20,000	R541,80	

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3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)		28,900	R782,70	
3409	Barium enema (control film of abdomen included)		18,300	R496,00	
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included		23,300	R631,00	
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included		15,500	R419,70	
	Note: For items 3415 and 3416: Endoscopy (see item 1778)				
3417	Gastric/oesophageal/duodenal intubation control		5,900	R160,00	
3419	Gastric/oesophageal intubation insertion of tube: ADD		5,600	R151,50	
3421	Duodenal intubation: Insertion of tube: ADD		11,000	R297,80	
19.3	Biliary tract				
3425	Oral cholecystography		15,700	R425,20	
3427	Cholangiography: Intravenous		22,000	R595,70	
3431	Operative cholangiography: First series: ADD item 3607 only when the Radiologist attends personally in theatre		21,000	R569,00	
3433	Post operative: T-tube		16,700	R452,30	
3435	Introduction of contrast medium: ADD		5,600	R151,50	
3437	Trans hepatic, percutaneous		18,300	R496,00	
3439	Introduction of contrast medium: ADD		33,100	R896,40	
3441	Tomography of biliary tract: ADD		9,400	R254,50	
19.4	Chest				
3443	Larynx (Tomography included)		12,500	R338,40	
3445	Chest (item 3601 included)		9,400	R254,50	
3447	Chest and cardiac studies (item 3601)		12,600	R341,20	
3449	Ribs				
3451	Sternum or sterno-clavicular joints				
3453	Bronchography: Unilateral		12,600	R341,20	

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3455	Bronchography: Bilateral		22,100	R598,70	
3461	Pleurography				
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		15,700	R425,20	
19.6	Urinary tract				
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)		25,100	R679,80	
3493	Waterload test: ADD		12,200	R330,50	
3497	Cystography only or urethrography only (retrograde)		19,300	R522,70	
3499	Cysto-urethrography: Retrograde		31,900	R863,80	
3503	Cysto-urethrography: Introduction of contrast medium		3,700	R100,60	
3505	Retrograde-prograde pyelography		18,300	R496,00	
3511	Aspiration renal cyst		18,400	R498,20	
19.7	Gynaecology and obstetrics				
3515	Pregnancy				
3517	Pelvimetry				
3519	Hystero-salpingography				
3521	Introduction of contrast medium: ADD				
19.8	Vascular studies				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	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)				
	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)				
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		16,500	R447,10	
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)		166,800	R4 282,40	

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3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram		48,600	R1 316,30	
3558	Translumbar aortic puncture, with full study		69,600	R1 885,20	
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram		57,000	R1 544,00	
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram		65,400	R1 771,50	
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram		73,200	R1 982,70	
3564	Direct femoral arterial or venous or jugular venous puncture		37,200	R1 007,70	
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)		85,800	R2 323,90	
3569	Intravascular pressure studies, arterial or venous, once off per case		19,800	R536,30	
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)		130,800	R3 542,80	
3572	Transcatheter selective blood sampling, arterial or venous		32,400	R877,40	
3574	Spinal angiogram (global fee) including all selective catheterisations		480,000	R13 001,00	
19.8.2	Vascular studies: Introduction of contrast medium				
3563	Direct intravenous for limb		7,400	R200,30	
3575	Cut-downs for venography: ADD		11,000	R297,80	
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				
6404	CT limb with contrast only				
6405	CT limb pre- AND post contrast				
6406	CT joint uncontrasted				
6407	CT joint with contrast only				
6408	CT joint pre AND post contrast				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6409	CT brain uncontrasted (including posterior fossa)				
6410	CT brain with contrast only (including posterior fossa)				
6411	CT brain pre AND post contrast (including posterior fossa)				
6412	CT orbits complete study, axial OR coronal, uncontrasted				
6413	CT orbits complete study, axial AND coronal, uncontrasted				
6414	CT orbits complete study, axial OR coronal pre AND post contrast				
6415	CT orbits complete study, axial AND coronal pre AND post contrast				
6416	CT paranasal sinuses limited study axial OR coronal				
6417	CT paranasal sinuses limited study axial AND coronal				
6418	CT paranasal sinuses complete study, axial or coronal, uncontrasted				
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted				
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast				
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast				
6422	CT pituitary fossa, uncontrasted				
6423	CT pituitary fossa, pre AND post contrast				
6424	CT internal auditory meati, uncontrasted				
6425	CT internal audiory meati, pre AND post contrast				
6426	CT mastoids				
6427	CT ear structures, limited study				
6428	CT middle AND inner ear, complete study including reconstructions				
6429	CT facial bones				
6430	CT neck soft tissue, uncontrasted				
6431	CT neck soft tissue with contrast only				
6432	CT neck pre AND post contrast				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6433	CT cervical spine uncontrasted				
6434	CT cervical spine pre AND post contrast				
6435	CT cervical spine post myelogram				
6436	CT dorsal spine uncontrasted				
6437	CT dorsal spine pre AND post contrast				
6438	CT dorsal spine post myelogram				
6439	CT lumbar spine uncontrasted				
6440	CT lumbar spine pre AND post contrast				
6441	CT lumbar spine post myelogram				
6442	CT pelvimetry (topogram only)				
6443	CT chest uncontrasted				
6444	CT chest with contrast				
6445	CT chest pre AND post contrast				
6446	CT chest high resolution lungs, limited study				
6447	CT high resolution lungs, complete study				
6448	CT abdomen uncontrasted				
6449	CT abdomen with contrast				
6450	CT abdomen pre AND post contrast				
6451	CT abdomen triphasic study				
6452	CT pelvis uncontrasted				
6453	CT pelvis with contrast				
6454	CT pelvis pre AND post contrast				
6455	CT abdomen AND pelvis uncontrasted				
6456	CT abdomen AND pelvis with contrast				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6457	CT abdomen AND pelvis pre AND post contrast				
6458	CT chest, abdomen AND pelvis with contrast				
6459	CT base of skull to symphysis pubis with contrast				
6460	CT for dental implants maxilla OR mandible				
6461	CT for dental implants maxilla AND mandible				
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)				
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)				
6464	CT limited study, any region. Region to be identified on the account				
6465	CT guidance for aspiration, biopsy or drainage				
6467	CT stereotactic localisation for biopsy				
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast				
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast				
19.10	Radiology: Miscellaneous				
3594	Mammogram of surgically removed breast biopsy specimen				
3600	Peripheral bone densitometry utilizing ionizing radiation	40	13,000	R352,20	
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445 and 3447)		7,700	R208,80	
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD		10,700	R289,90	
3603	Sinography		18,400	R498,20	
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	40	77,000	R2 085,00	
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		33,000	R894,00	
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour		21,000	R569,00	
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)				

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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		40,000	R1 083,40	
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		3,300	R89,50	
5029	Mammotome - stereotaxis: Hand held		59,000	R1 597,90	
5034	Fine needle aspiration or biopsy or core biopsy of mamma		25,000	R677,10	
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	60	30,000	R546,90	
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	60	110,000	R2 004,40	
3612	Ultrasonic bone densitometry	60	19,000	R346,10	
3614	Transvaginal aspiration of ova	60	110,000	R2 004,40	
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment	60	50,000	R911,10	
3616	Contrast media: General Rule Y applies				
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment	60	50,000	R911,10	
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)	60	40,000	R729,10	
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	60	30,000	R546,90	
3620	Cardiac examination plus Doppler colour mapping	60	50,000	R911,10	
3621	Cardiac examination (MMode)	60	25,000	R455,90	

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3622	Cardiac examination: 2 Dimensional	60	50,000	R911,10	
3623	Cardiac examination + effort	60	10,000	R182,40	
3624	Cardiac examinations + contrast	60	10,000	R182,40	
3625	Cardiac examinations + doppler	60	50,000	R911,10	
3626	Cardiac examination + phonocardiography	60	10,000	R182,40	
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)	60	60,000	R1 093,20	
3628	Renal tract	60	50,000	R911,10	
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	60	50,000	R911,10	
3631	Ophthalmic examination	60	50,000	R911,10	
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034	60	50,000	R911,10	
3633	Neonatal head scan	60	50,000	R911,10	
3634	Peripheral vascular study, B mode only	60	39,000	R710,80	
3635	+ Doppler	60	39,000	R710,80	
3636	Trans-oesophageal echocardiography including passing the device	60	100,000	R1 822,30	
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)	60	78,000	R1 421,30	
5026	Ultrasound guided amniocentesis	60	39,000	R710,80	
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	60	50,000	R911,10	
5101	Pleural space ultrasound	60	50,000	R911,10	
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	60	50,000	R911,10	
5103	Ultrasound soft tissue, any region	60	50,000	R911,10	
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	60	25,000	R455,90	
5107	Ultrasound after 24 weeks - motivation required	60	25,000	R455,90	

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5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)	60	50,000	R911,10	
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy	60	128,000	R2 332,40	
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)	60	206,000	R3 753,60	
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	60	117,000	R2 132,00	
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis	60	117,000	R2 132,00	
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	60	178,000	R3 243,60	
5115	Intra-operative ultrasound study	60	50,000	R911,10	
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure	60	88,000	R1 603,60	
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	60	44,000	R801,80	
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS				
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units				
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units	60	6,000	R109,40	
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	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		7,000	R189,60	
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	40	33,200	R899,40	
3642	Repeat of further tracer tests for same investigation: Half of above fee	40	16,600	R449,40	
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	40	82,200	R2 226,00	
3645	Other organ scanning with use of relevant radio isotopes	40	82,200	R2 226,00	
3646	Thyroid scanning	40	28,800	R780,20	
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				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	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		102,600	R2 779,10	
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel		102,600	R2 779,10	
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial		102,600	R2 779,10	
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial		139,200	R3 770,20	
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic		139,200	R3 770,20	
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral - stand alone procedure		172,200	R4 664,10	
5014	Atherectomy (per vessel)		204,600	R5 541,80	
5016	Aspiration thrombectomy (per vessel)				
5017	Endoscopic ultrasound: Colon		79,900	R1 527,00	
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite		106,800	R2 892,60	
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy		100,700	R1 924,60	
5021	Proctosigmoidoscopy with endoscopic ultrasound examination		41,900	R800,90	
5022	Embolisation non-intracranial, per vessel		106,800	R2 892,60	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy		64,100	R1 225,10	
5024	Endoscopic ultrasound: Oesophagus		50,900	R972,90	
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy		70,200	R1 341,60	
5030	Percutaneous nephrostomy for further procedure or drainage		73,800	R1 999,00	
5031	Antegrade ureteric stent insertion		69,600	R1 885,20	
5033	Percutaneous cystostomy in radiology suite		30,000	R812,50	
5035	Urethral balloon dilatation in radiology suite		22,800	R617,80	
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality		34,200	R926,40	
5037	Urethral stenting in radiology suite		102,600	R2 779,10	
5038	Intracranial/spinal AVM embolisation (per session)		335,400	R9 084,40	
5039	Intracranial thrombolysis (on-table) per session		139,200	R3 770,20	
5040	Intracranial aneurysm occlusion		286,800	R7 768,20	
5041	Balloon occlusion/Wada test		106,800	R2 892,60	
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation		286,800	R7 768,20	
5043	Intracranial angioplasty		204,600	R5 541,80	
5044	Transhepatic portogram		139,200	R3 770,20	
5045	Hepatic arterial infusion catheter insertion		156,000	R4 225,20	
5046	Percutaneous biliary drainage (external)		102,600	R2 779,10	
5047	Combined internal/external biliary drainage		102,600	R2 779,10	
5048	Biliary stent insertion		139,200	R3 770,20	
5049	Percutaneous gall bladder drainage		69,600	R1 885,20	
5050	Percutaneous or renal gall bladder stone removal		172,200	R4 664,10	
5058	Stent insertion: Aortic/IVC - including percutaneous transluminal angioplasty (PTA)		139,200	R3 770,20	
5060	Stent insertion: Iliac/subclavian/AV fistula - including percutaneous transluminal angioplasty (PTA)		139,200	R3 770,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial - including percutaneous transluminal angioplasty (PTA)		139,200	R3 770,20	
5064	Stent insertion: Sub-popliteal - including percutaneous transluminal angioplasty (PTA)		172,200	R4 664,10	
5066	Stent insertion: Renal/visceral/brachiocephalic - including percutaneous transluminal angioplasty (PTA)		204,600	R5 541,80	
5068	Stent insertion: Extracranial carotid/vertebral - including percutaneous transluminal angioplasty (PTA) - stand alone procedure		204,600	R5 541,80	
5070	Stent insertion: Aorto-iliac stent graft - including percutaneous transluminal angioplasty (PTA)		311,400	R8 435,00	
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite		82,200	R2 226,40	
5074	IVC filter insertion jugular or femoral route		156,000	R4 225,20	
5076	Intravascular foreign body removal, arterial or venous, any route		204,600	R5 541,80	
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)		70,200	R1 901,50	
5080	Transjugular intrahepatic porto-systemic shunt		335,400	R9 084,40	
5082	Transjugular liver biopsy		69,600	R1 885,20	
5084	Endoluminal fallopian tube recanalisation				
5086	Renal cyst aspiration/ablation		22,800	R617,80	
5088	Oesophageal stent insertion in radiology suite		102,600	R2 779,10	
5090	Tracheal stent insertion		102,600	R2 779,10	
5091	GIT balloon dilatation under fluoroscopy		66,600	R1 803,90	
5092	Other GIT stent insertion		102,600	R2 779,10	
5093	Percutaneous gastrostomy in radiology suite		85,800	R2 323,90	
5094	Cutting needle biopsy with image guidance		22,800	R617,80	
5095	Chest drain insertion in radiology suite		32,400	R877,40	
5096	Percutaneous cyst or tumour ablation (non aspiration)		54,600	R1 478,90	
5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation - PROFESSIONAL COMPONENT		61,900	R1 183,20	
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal - PROFESSIONAL COMPONENT		84,000	R1 605,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		132,520	R2 532,70	
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)		81,490	R1 557,30	
5974	Stent placement,branch pulmonary artery: First vessel		132,520	R2 532,70	
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)		76,980	R1 471,10	
5976	Stent placement coarctation of the aorta		132,520	R2 532,70	
5980	Stent patent ductus arteriosus and interatrial communication		132,520	R2 532,70	
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		132,520	R2 532,70	
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		310,800	R5 939,80	
5986	VSD closure, percutaneous, device placement		412,400	R7 881,60	
5987	PFO closure with device		310,800	R5 939,80	
5989	PDA closure-coil or ductal device		276,500	R5 284,30	
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		276,500	R5 284,30	
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		276,500	R5 284,30	
5992	Closure interatrial communication (Fontan fenestration etc)		310,800	R5 939,80	
5995	Rapid right ventricular pacing for percutaneous procedure		51,000	R974,60	
5996	Removal of embolised device/materials		80,600	R1 540,50	
5998	Biopsy: Endomyocardial		236,100	R4 512,20	
6000	Actigraphy: Patient monitored for a minimum of 72 hours (includes equipment fee and interpretation)		47,300	R904,10	
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level				
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate		81,400	R1 555,70	
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy		113,800	R2 174,90	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	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				
6201	Magnetic Resonance Imaging: Per anatomical region: Orbitae				
6202	Magnetic Resonance Imaging: Per anatomical region: Paranasal sinuses				
6203	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Face/skull				
6204	Magnetic Resonance Imaging: Per anatomical region: Skull basis/cranio-cervical joint				
6205	Magnetic Resonance Imaging: Per anatomical region: Middle and internal ears				
6206	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Neck				
6207	Magnetic Resonance Imaging: Per anatomical region: Thyroid/para-thyroid				
6208	Magnetic Resonance Imaging: Per anatomical region: Hypophysis (see modifiers 6104 and 6105 for limited examinations)				
6209	Magnetic Resonance Imaging: Per anatomical region: Bone tumour (see modifier 6103)				
6210	Magnetic Resonance Imaging: Per anatomical region: Cervical vertebrae				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6211	Magnetic Resonance Imaging: Per anatomical region: Thoracic vertebrae				
6212	Magnetic Resonance Imaging: Per anatomical region: Lumbar vertebrae				
6213	Magnetic Resonance Imaging: Per anatomical region: Sacrum				
6214	Magnetic Resonance Imaging: Per anatomical region: Pelvis				
6215	Magnetic Resonance Imaging: Per anatomical region: Pelvic organs				
6216	Magnetic Resonance Imaging: Per anatomical region: Abdomen				
6217	Magnetic Resonance Imaging: Per anatomical region: Thorax wall				
6218	Magnetic Resonance Imaging: Per anatomical region: Mediastinum				
6219	Magnetic Resonance Imaging: Per anatomical region: Soft tissue: Back				
6220	Magnetic Resonance Imaging: Per anatomical region: Left shoulder				
6221	Magnetic Resonance Imaging: Per anatomical region: Right shoulder				
6222	Magnetic Resonance Imaging: Per anatomical region: Both hips				
6223	Magnetic Resonance Imaging: Per anatomical region: Left hip				
6224	Magnetic Resonance Imaging: Per anatomical region: Right hip				
6225	Magnetic Resonance Imaging: Per anatomical region: Left upper-arm				
6226	Magnetic Resonance Imaging: Per anatomical region: Right upper-arm				
6227	Magnetic Resonance Imaging: Per anatomical region: Left elbow				
6228	Magnetic Resonance Imaging: Per anatomical region: Right elbow				
6229	Magnetic Resonance Imaging: Per anatomical region: Left fore-arm				
6230	Magnetic Resonance Imaging: Per anatomical region: Right fore-arm				
6231	Magnetic Resonance Imaging: Per anatomical region: Left wrist and hand				
6232	Magnetic Resonance Imaging: Per anatomical region: Right wrist and hand				
6233	Magnetic Resonance Imaging: Per anatomical region: Left upper-leg				
6234	Magnetic Resonance Imaging: Per anatomical region: Right upper-leg				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
6235	Magnetic Resonance Imaging: Per anatomical region: Left knee				
6236	Magnetic Resonance Imaging: Per anatomical region: Right knee				
6237	Magnetic Resonance Imaging: Per anatomical region: Left lower-leg				
6238	Magnetic Resonance Imaging: Per anatomical region: Right lower-leg				
6239	Magnetic Resonance Imaging: Per anatomical region: Left ankle				
6240	Magnetic Resonance Imaging: Per anatomical region: Right ankle				
6241	Magnetic Resonance Imaging: Per anatomical region: Left foot				
6242	Magnetic Resonance Imaging: Per anatomical region: Right foot				
6250	Magnetic Resonance angiography (See modifiers 6106 to 6108): Brain				
6251	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Neck				
6252	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Chest				
6253	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Abdomen				
6254	Magnetic Resonance angiography (See modifiers 6106 to 6108): Large vessels: Legs				
6255	Magnetic Resonance angiography (See modifiers 6106 to 6108): Heart				
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				
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				
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values				
20.1	Kilovolt therapy				
20.2	Radium therapy				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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)	20	42,950	R631,50	
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	20	24,490	R360,10	
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	20	30,610	R450,30	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
	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)	20	159,470	R2 345,00	
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	20	90,030	R1 323,90	
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	20	112,540	R1 654,90	
	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	50	42,560	R760,70	
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest -TECHNICAL COMPONENT	50	99,320	R1 775,00	
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	50	56,180	R1 004,10	
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	50	131,100	R2 342,90	
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	50	76,620	R1 369,40	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	50	178,770	R3 194,80	
20.11.2	Conventional Radiotherapy Planning Procedures				
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	50	170,260	R3 042,70	
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	50	397,270	R7 100,00	
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	50	238,360	R4 259,80	
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	50	556,180	R9 940,20	
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	50	297,950	R5 325,10	
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	50	695,220	R12 425,20	
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)	50	240,230	R4 293,40	
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)	50	977,200	R17 464,50	
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)	50	407,750	R7 287,50	
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)	50	1368,070	R24 450,70	
5822	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	554,330	R9 907,00	
5622	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1710,090	R30 563,00	
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)	50	642,920	R11 490,40	
5623	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1916,810	R34 257,60	

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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)	50	232,180	R4 149,70	
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)	50	958,400	R17 128,60	
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)	50	753,350	R13 464,00	
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)	50	2174,480	R38 862,80	
20.11.5	Kilovolt Radiation Treatment				
5834	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT	50	49,080	R877,30	
5634	Kilovolt Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT	50	114,520	R2 046,90	
20.11.6	Short Course Radiation Treatment				
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	50	105,740	R1 889,90	
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	50	246,730	R4 410,00	
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	50	148,040	R2 645,90	
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	50	345,410	R6 173,40	
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	50	190,330	R3 401,60	
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	50	444,110	R7 937,20	
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	50	193,860	R3 464,70	
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	50	452,330	R8 083,90	
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	50	246,730	R4 410,00	

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5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	50	575,690	R10 288,80	
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	50	317,220	R5 669,40	
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	50	740,180	R13 228,40	
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	50	236,240	R4 222,20	
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	50	551,210	R9 851,20	
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	50	330,730	R5 910,90	
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	50	771,710	R13 792,30	
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	50	425,230	R7 599,80	
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	50	992,190	R17 732,40	
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	50	348,870	R6 235,10	
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	50	814,030	R14 548,40	
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	50	826,830	R14 777,20	
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	50	1929,260	R34 479,90	
20.11.8	Stereotactic Radiation				
5860	Stereotactic Radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee - PROFESSIONAL COMPONENT	50	3719,340	R66 472,70	
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT	50	8678,460	R155 102,60	

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5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT	50	4277,240	R76 443,30	
5661	Stereotactic Radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee - TECHNICAL COMPONENT	50	9980,230	R178 367,80	
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	50	108,400	R1 937,50	
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	50	216,800	R3 874,80	
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	50	601,160	R10 744,20	
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	50	216,800	R3 874,80	
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	50	786,800	R14 061,90	
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	50	1049,070	R18 749,00	
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	50	613,040	R10 956,40	
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	50	415,960	R7 434,00	
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	50	970,560	R17 346,10	

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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	50	156,770	R2 801,90	
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				
3705	Alkali resistant haemoglobin	80	4,500	R76,30	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	80	3,650	R61,90	
3710	Antibody titration	80	7,200	R122,40	
3712	Antibody identification	80	8,450	R143,50	
3713	Bleeding time (does not include the cost of the simplate device)	80	6,940	R117,80	
3714	Blood volume, dye method	80	7,200	R122,40	
3715	Buffy layer examination	80	19,900	R338,50	
3716	Mean Cell Volume	80	2,250	R38,50	
3717	Bone marrow cytological examination only	80	19,900	R338,50	
3719	Bone marrow: Aspiration	80	8,400	R142,80	
3720	Bone marrow trephine biopsy	80	32,600	R554,40	
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	80	36,800	R625,50	
3722	Capillary fragility: Hess	80	2,020	R34,40	
3723	Circulating anticoagulants	80	5,850	R99,30	
3724	Coagulation factor inhibitor assay	80	57,560	R978,70	

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3726	Activated protein C resistance	80	26,000	R441,90	
3727	Coagulation time	80	3,160	R53,80	
3728	Anti-factor Xa Activity	80	53,600	R911,10	
3729	Cold agglutinins	80	3,600	R61,40	
3730	Protein S: Functional	80	37,500	R637,50	
3731	Compatibility for blood transfusion	80	3,600	R61,40	
3732	Cryoglobulin	80	3,600	R61,40	
3734	Protein C (chromogenic)	80	30,290	R515,00	
3735	Anti-thrombin III (chromogenic)	80	22,000	R373,90	
3736	Plasminogen (chromogenic)	80	61,650	R1 048,20	
3737	Lupus Russel Viper method	80	17,000	R289,20	
3738	Lupus Kaolin Exner method	80	25,000	R425,10	
3739	Erythrocyte count	80	2,250	R38,50	
3740	Factors V and VII: Qualitative	80	7,200	R122,40	
3741	Coagulation factor assay: Functional	80	9,450	R160,80	
3743	Erythrocyte sedimentation rate	80	3,000	R51,10	
3744	Fibrin stabilizing factor (urea test)	80	4,500	R76,30	
3746	Fibrin monomers	80	2,700	R46,00	
3748	Plasminogen activator inhibitor (PAI-I)	80	65,950	R1 121,20	
3750	Tissue plasminogen Activator (tPA)	80	67,790	R1 152,40	
3753	Osmotic fragility (before and after incubation)	80	18,000	R306,20	
3754	ABO Reverse Group	80	3,600	R61,40	
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	80	10,500	R178,60	
3756	Full cross match	80	7,200	R122,40	

CONTRACTED PHYSICIANS ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3757	Coagulation factors: Quantitative	80	32,200	R547,20	
3758	Factor VIII related antigen	80	60,460	R1 027,90	
3759	Coagulation factor correction study	80	11,720	R199,30	
3761	Factor XIII related antigen	80	61,110	R1 038,60	
3762	Haemoglobin estimation	80	1,800	R30,50	
3763	Contact activated product assay	80	16,200	R275,40	
3764	Grouping: A B and O antigens	80	3,600	R61,40	
3765	Grouping: Rh antigen	80	3,600	R61,40	
3766	PIVKA	80	43,490	R739,30	
3767	Euglobulin Lysis time	80	25,580	R435,00	
3768	Haemoglobin A2 (column chromatography)	80	15,000	R255,00	
3769	Haemoglobin electrophoresis	80	26,820	R455,90	
3770	Haemoglobin-S (solubility test)	80	3,600	R61,40	
3772	Haptoglobin: Quantitative	80	9,450	R160,80	
3773	Ham's acidified serum test	80	8,000	R136,00	
3775	Heinz bodies	80	2,250	R38,50	
3776	Haemosiderin in urinary sediment	80	2,250	R38,50	
3783	Leucocyte differential count	80	6,200	R105,50	
3785	Leucocytes: Total count	80	1,800	R30,50	
3786	QBC malaria concentration and fluorescent staining	80	25,000	R425,10	
3787	LE-cells	80	8,300	R141,10	
3789	Neutrophil alkaline phosphatase	80	28,000	R476,00	
3791	Packed cell volume: Haematocrit	80	1,800	R30,50	
3792	Plasmodium falciparum: Monoclonal immunological identification	80	9,000	R153,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3793	Plasma haemoglobin	80	6,750	R114,70	
3794	Platelet sensitivities	80	18,640	R317,00	
3795	Platelet aggregation per aggregant	80	12,140	R206,30	
3797	Platelet count	80	2,250	R38,50	
3799	Platelet adhesiveness	80	4,500	R76,30	
3801	Prothrombin consumption	80	5,850	R99,30	
3803	Prothrombin determination (two stages)	80	5,850	R99,30	
3805	Prothrombin index	80	6,000	R101,90	
3806	Therapeutic drug level: Dosage	80	4,500	R76,30	
3809	Reticulocyte count	80	3,000	R51,10	
3810	Schumm's test	80	3,600	R61,40	
3811	Sickling test	80	2,250	R38,50	
3814	Sucrose lysis test for PNH	80	3,600	R61,40	
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	80	21,100	R358,80	
3820	Thrombo - Elastogram	80	26,000	R441,90	
3825	Fibrinogen titre	80	3,600	R61,40	
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	80	8,000	R136,00	
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	80	16,000	R272,10	
3832	Red cell pyruvate kinase: Quantitative	80	16,000	R272,10	
3834	Red cell Rhesus phenotype	80	9,900	R168,30	
3835	Haemoglobin F in blood smear	80	5,850	R99,30	
3837	Partial thromboplastin time	80	5,850	R99,30	
3841	Thrombin time (screen)	80	7,160	R121,70	
3843	Thrombin time (serial)	80	7,650	R130,20	

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3847	Haemoglobin H	80	2,250	R38,50	
3851	Fibrin degeneration products (diffusion plate)	80	10,350	R176,20	
3853	Fibrin degeneration products (latex slide)	80	4,500	R76,30	
3854	XDP (Dimer test or equivalent latex slide test)	80	8,500	R144,50	
3855	Haemagglutination inhibition	80	9,900	R168,30	
3856	D-Dimer (quantitative)	80	27,520	R468,10	
3857	Ristocetin Cofactor	80	35,530	R603,90	
3858	Heparin removal	80	28,880	R491,10	
3718	Quantitative reverse transcriptase polymerase chain reaction (QR-PCR) for monitoring minimal residual disease (MRD) in leukaemia patients			R0,00	
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	80	12,600	R214,10	
3864	Entomological examination	80	20,700	R351,90	
3865	Parasites in blood smear	80	5,600	R95,20	
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	80	4,900	R83,50	
3868	Fungus identification	80	8,300	R141,10	

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3869	Faeces (including parasites)	80	4,900	R83,50	
3873	Transmission electron microscopy	80	85,000	R1 444,90	
3874	Scanning electron microscopy	80	100,000	R1 700,00	
3875	Inclusion bodies	80	4,500	R76,30	
3878	Crystal identification polarized light microscopy	80	4,500	R76,30	
3879	Campylobacter in stool: Fastidious culture	80	9,900	R168,30	
3880	Antigen detection with polyclonal antibodies	80	4,500	R76,30	
3881	Mycobacteria	80	3,000	R51,10	
3882	Antigen detection with monoclonal antibodies	80	10,800	R183,40	
3883	Concentration techniques for parasites	80	3,000	R51,10	
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	80	6,300	R107,00	
3885	Cytochemical stain	80	5,450	R92,50	
3872	Automated urine microscopy			R0,00	
21.3	Bacteriology				
3887	Antibiotic susceptibility test: Per organism	80	8,000	R136,00	
3888	Adhesive tape preparation	80	2,700	R46,00	
3889	Clostridium difficile toxin: Monoclonal immunological	80	12,400	R210,90	
3890	Antibiotic assay of tissues and fluids	80	13,900	R236,40	
3891	Blood culture: Aerobic	80	5,850	R99,30	
3892	Blood culture: Anaerobic	80	5,850	R99,30	
3893	Bacteriological culture: Miscellaneous	80	6,300	R107,00	
3894	Radiometric blood culture	80	10,800	R183,40	
3895	Bacteriological culture: Fastidious organisms	80	9,900	R168,30	
3896	In vivo culture: Bacteria	80	16,000	R272,10	

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3897	In vivo culture: Virus	80	16,000	R272,10	
3899	Bacterial exotoxin production (in vivo assay)	80	20,700	R351,90	
3901	Fungal culture	80	4,500	R76,30	
3902	Clostridium difficile (cytotoxicity neutralisation)	80	30,000	R510,00	
3903	Antibiotic level: Biological fluids	80	11,700	R198,90	
3904	Rotavirus latex slide test	80	5,620	R95,80	
3905	Identification of virus or rickettsia	80	20,700	R351,90	
3906	Identification: Chlamydia	80	16,000	R272,10	
3908	Anaerobe culture: Comprehensive	80	9,900	R168,30	
3909	Anaerobe culture: Limited procedure	80	4,500	R76,30	
3911	Beta-lactamase assay	80	4,500	R76,30	
3914	Sterility control test: Biological method	80	4,500	R76,30	
3915	Mycobacterium culture	80	4,500	R76,30	
3916	Radiometric tuberculosis culture	80	10,800	R183,40	
3918	Mycoplasma culture: Comprehensive	80	9,900	R168,30	
3919	Identification of mycobacterium	80	9,900	R168,30	
3920	Mycobacterium: Antibiotic sensitivity	80	9,900	R168,30	
3921	Antibiotic synergistic study	80	20,700	R351,90	
3922	Viable cell count	80	1,350	R22,90	
3923	Biochemical identification of bacterium: Abridged	80	3,150	R53,70	
3924	Biochemical identification of bacterium: Extended	80	12,500	R212,50	
3925	Serological identification of bacterium: Abridged	80	3,150	R53,70	
3926	Serological identification of bacterium: Extended	80	10,200	R173,30	
3927	Grouping for streptococci	80	7,300	R124,10	

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3928	Antimicrobic substances	80	3,800	R64,70	
3929	Radiometric mycobacterium identification	80	14,000	R238,20	
3930	Radiometric mycobacterium antibiotic sensitivity	80	25,000	R425,10	
3931	Helicobacter: Monoclonal immunological	80	12,400	R210,90	
4650	Antibiotic MIC per organism per antibiotic	80	8,000	R136,00	
4651	Non-radiometric automated blood cultures	80	13,900	R236,40	
4652	Rapid automated bacterial identification per organism	80	15,000	R255,00	
4653	Rapid automated antibiotic susceptibility per organism	80	17,000	R289,20	
4654	Rapid automated MIC per organism per antibiotic	80	17,000	R289,20	
4655	Mycobacteria: MIC determination - E Test	80	16,500	R280,30	
4656	Mycobacteria: Identification HPLC	80	35,000	R595,20	
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	80	9,900	R168,30	
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/la2 Ab	80	67,950	R1 155,20	
3959	Rose Waaler agglutination test	80	4,500	R76,30	
3960	Gonococcal, listeria or echinococcus agglutination	80	9,500	R161,50	
3961	Slide agglutination test	80	2,630	R44,50	
3963	Serum complement level: Each component	80	3,150	R53,70	
3965	Anti la2 Antibodies	80	36,000	R611,90	
3966	Anti Gad Antibodies	80	36,000	R611,90	
3967	Auto-antibody: Sensitized erythrocytes	80	4,500	R76,30	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3968	Herpes virus typing: Monoclonal immunological	80	20,690	R351,70	
3969	Western blot technique	80	74,000	R1 258,20	
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	80	14,100	R239,70	
3933	IgE: Total: EMIT or ELISA	80	11,700	R198,90	
3934	Auto antibodies by labelled antibodies	80	16,000	R272,10	
3935	Sperm antibodies	80	16,000	R272,10	
3936	Virus neutralisation test: First antibody	80	75,000	R1 275,20	
3937	Virus neutralisation test: Each additional antibody	80	15,000	R255,00	
3938	Precipitation test per antigen	80	4,500	R76,30	
3939	Agglutination test per antigen	80	5,500	R93,60	
3940	Haemagglutination test: Per antigen	80	9,900	R168,30	
3941	Modified Coombs' test for brucellosis	80	4,500	R76,30	
3942	Hepatitis Rapid Viral Ab	80	12,240	R207,90	
3943	Antibody titer to bacterial exotoxin	80	3,600	R61,40	
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	80	12,400	R210,90	
3945	Complement fixation test	80	5,850	R99,30	
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	80	14,050	R238,80	
3947	C-reactive protein	80	10,840	R184,20	
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	80	12,950	R220,30	
3949	Qualitative Kahn, VDRL or other flocculation	80	2,250	R38,50	
3950	Neutrophil phagocytosis	80	25,200	R428,50	
3951	Quantitative Kahn, VDRL or other flocculation	80	3,600	R61,40	
3952	Neutrophil chemotaxis	80	67,950	R1 155,20	
3953	Tube agglutination test	80	4,150	R70,70	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
3955	Paul Bunnell: Presumptive	80	2,250	R38,50	
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	80	8,500	R144,50	
3971	Immuno-diffusion test: Per antigen	80	3,150	R53,70	
3972	Respiratory syncytial virus (ELISA technique)	80	35,000	R595,20	
3973	Immuno electrophoresis: Per immune serum	80	9,450	R160,80	
3974	Polymerase chain reaction	80	75,000	R1 275,20	
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	80	12,000	R203,90	
3978	Lymphocyte transformation	80	51,700	R878,90	
3980	Bilharzia Ag Serum/Urine	80	14,500	R246,60	
3982	Histone Ab	80	16,000	R272,10	
4600	Anti-CCP	80	17,460	R296,80	
4601	Panel typing: Antibody detection: Class I	80	36,000	R611,90	
4602	Panel typing: Antibody detection: Class II	80	44,000	R747,90	
4603	HLA test for specific locus/antigen - serology	80	27,000	R459,00	
4604	HLA typing: Class I - serology	80	52,000	R884,10	
4605	HLA typing: Class II - serology	80	52,000	R884,10	
4606	HLA typing: Class I & II - serology	80	90,000	R1 530,00	
4607	Cross matching T-cells (per tray)	80	18,000	R306,20	
4608	Cross matching B-cells	80	38,000	R646,00	
4609	Cross matching T- & B-cells	80	48,000	R816,00	
4610	Helicobacter: Pylori antigen test	80	34,600	R588,10	
4611	Erythropoietin	80	20,000	R340,00	
4612	HTLV I/II	80	20,000	R340,00	
4613	Anti-Gm1 Antibody Assay	80	75,000	R1 275,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4614	HIV Ab - Rapid Test	80	12,000	R203,90	
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				
3991	Abnormal pigments: Qualitative	80	4,500	R76,30	
3993	Abnormal pigments: Quantitative	80	9,000	R153,20	
3995	Acid phosphate	80	5,180	R88,00	
3998	Amino acids Quantitative (Post derivatisation HPLC)	80	78,120	R1 328,10	
3999	Albumin	80	4,800	R81,40	
4000	Alcohol	80	12,400	R210,90	
4001	Alkaline phosphatase	80	5,180	R88,00	
4002	Alkaline phosphatase-iso-enzymes	80	11,700	R198,90	
4003	Ammonia: Enzymatic	80	7,710	R131,10	
4004	Ammonia: Monitor	80	4,500	R76,30	
4005	Alpha-1-antitrypsin: Total	80	7,200	R122,40	
4006	Amylase	80	5,180	R88,00	
4007	Arsenic in blood, hair or nails	80	36,250	R616,30	
4008	Bilirubin - Reflectance	80	4,770	R81,00	
4009	Bilirubin: Total	80	4,770	R81,00	

CONTRACTED PHYSICIANS ALL OPTIONS

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4010	Bilirubin: Conjugated	80	3,620	R61,60	
4011	Breath Hydrogen Test	80	21,560	R366,40	
4012	CSF Nicotinic Acid	80	12,420	R211,20	
4013	CSF Glutamine	80	11,250	R191,00	
4014	Cadmium: Atomic absorption	80	18,120	R308,00	
4016	Calcium: Ionized	80	6,750	R114,70	
4017	Calcium: Spectrophotometric	80	3,620	R61,60	
4018	Calcium: Atomic absorption	80	7,250	R123,30	
4019	Carotene	80	2,250	R38,50	
4020	Carnitine (Total or free) in biological fluid: Each	80	11,690	R198,70	
4021	Carnitine (Total or free) in muscle: Each	80	23,380	R397,50	
4022	Acyl Carnitine	80	23,380	R397,50	
4023	Chloride	80	2,590	R44,00	
4025	Chol/HDL/LDL/Trig	80	27,070	R460,30	
4026	LDL cholesterol (chemical determination)	80	6,900	R117,20	
4027	Cholesterol total	80	5,340	R90,80	
4028	HDL cholesterol	80	6,900	R117,20	
4029	Cholinesterase: Serum or erythrocyte: Each	80	7,480	R127,00	
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	80	9,000	R153,20	
4031	Total CO2	80	5,180	R88,00	
4032	Creatinine	80	3,620	R61,60	
4033	CSF-Immunoglobulin G	80	9,450	R160,80	
4034	C1-Esterase Inhibitor	80	9,450	R160,80	
4035	CSF-Albumin	80	9,450	R160,80	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4036	CSF-IgG Index	80	22,050	R374,90	
4038	Glutamic acid	80	29,060	R494,10	
4040	Homocysteine (random)	80	15,300	R260,10	
4041	Homocysteine (after Methionine load)	80	18,100	R307,70	
4042	D-Xylose absorption test: Two hours	80	13,150	R223,60	
4045	Fibrinogen: Quantitative	80	3,600	R61,40	
4049	Glucose tolerance test (2 specimens)	80	8,970	R152,60	
4050	Glucose strip-test with photometric reading	80	1,800	R30,50	
4051	Galactose	80	11,250	R191,00	
4052	Glucose tolerance test (3 specimens)	80	13,170	R223,90	
4053	Glucose tolerance test (4 specimens)	80	17,370	R295,10	
4057	Glucose: Quantitative	80	3,620	R61,60	
4061	Glucose tolerance test (5 specimens)	80	21,560	R366,40	
4062	Galactose-1-phosphate uridyl transferase	80	16,000	R272,10	
4063	Fructosamine	80	7,200	R122,40	
4064	HbA1C	80	14,250	R242,20	
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46,880	R797,00	
4067	Lithium: Flame ionisation	80	5,180	R88,00	
4068	Lithium: Atomic absorption	80	7,480	R127,00	
4071	Iron	80	6,750	R114,70	
4073	Iron-binding capacity	80	7,650	R130,20	
4076	Blood gases: Astrup/pO2 and ancillary tests - can only be charged to a maximum of 6 times per patient per day	80	19,100	R324,60	
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	80	6,750	R114,70	
4079	Ketones in plasma: Qualitative	80	2,250	R38,50	

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4081	Drug level-biological fluid: Quantitative	80	10,800	R183,40	
4082	Tacrolimus assay	80	20,100	R341,70	
4083	Lysosomal enzyme assay	80	36,560	R621,50	
4084	Thymidine kinase	80	20,000	R340,00	
4085	Lipase	80	5,180	R88,00	
4086	Lactate	80	16,000	R272,10	
4091	Lipoprotein electrophoresis	80	9,000	R153,20	
4092	Orosmucoid	80	9,450	R160,80	
4093	Osmolality: Serum or urine	80	6,750	R114,70	
4094	Magnesium: Spectrophotometric	80	3,620	R61,60	
4095	Magnesium: Atomic absorption	80	7,250	R123,30	
4096	Mercury: Atomic absorption	80	18,120	R308,00	
4098	Copper: Atomic absorption	80	18,120	R308,00	
4105	Protein electrophoresis	80	9,000	R153,20	
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	80	20,000	R340,00	
4109	Phosphate	80	3,620	R61,60	
4113	Potassium	80	3,620	R61,60	
4114	Sodium	80	3,620	R61,60	
4117	Protein: Total	80	3,110	R52,80	
4121	pH, pCO2 or pO2: Each	80	6,750	R114,70	
4123	Pyruvic acid	80	4,500	R76,30	
4125	Salicylates	80	4,500	R76,30	
4127	Caeruloplasmin	80	4,500	R76,30	
4128	Phenylalanine: Quantitative	80	11,250	R191,00	

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4130	Aspartate aminotransferase (AST)	80	5,400	R91,80	
4131	Alanine aminotransferase (ALT)	80	5,400	R91,80	
4132	Creatine kinase (CK)	80	5,400	R91,80	
4133	Lactate dehidrogenase (LD)	80	5,400	R91,80	
4134	Gamma glutamyl transferase (GGT)	80	5,400	R91,80	
4135	Aldolase	80	5,400	R91,80	
4136	Angiotensin converting enzyme (ACE)	80	9,000	R153,20	
4137	Lactate dehydrogenase isoenzyme	80	10,800	R183,40	
4138	CK-MB: Immunoinhibition/precipitation	80	10,800	R183,40	
4139	Adenosine deaminase	80	5,400	R91,80	
4143	Serum/plasma enzymes	80	5,400	R91,80	
4144	Transferrin	80	11,700	R198,90	
4146	Lead: Atomic absorption	80	15,000	R255,00	
4147	Triglyceride	80	7,930	R135,00	
4148	Tay - Sachs Study	80	36,560	R621,50	
4149	Red cell magnesium	80	11,700	R198,90	
4151	Urea	80	3,620	R61,60	
4152	CK-MB: Mass determination: Quantitative (Automated)	80	12,400	R210,90	
4153	CK-MB: Mass determination: Quantitative (Not automated)	80	17,470	R297,10	
4154	Myoglobin quantitative: Monoclonal immunological	80	12,400	R210,90	
4155	Uric acid	80	3,780	R64,20	
4156	Vitamin D3	80	12,420	R211,20	
4157	Vitamin A-saturation test	80	15,300	R260,10	
4158	Vitamin E (tocopherol)	80	3,600	R61,40	

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4159	Vitamin A	80	6,300	R107,00	
4161	Troponin isoforms: Each	80	20,000	R340,00	
4163	Apoprotein AI: Turbidometric method	80	8,280	R140,70	
4165	Apoprotein AII: Turbidometric method	80	8,280	R140,70	
4167	Apoprotein B: Turbidometric method	80	8,280	R140,70	
4170	Lipoprotein (a)(Lp(a)) assay	80	12,420	R211,20	
4171	Sodium + potassium + chloride + CO2 + urea	80	15,840	R269,40	
4172	ELISA/EMIT technique	80	12,420	R211,20	
4173	Sirolimus Assay	80	78,000	R1 326,00	
4181	Quantitative protein estimation: Mancini method	80	7,760	R131,70	
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	80	8,280	R140,70	
4183	Quantitative protein estimation: Labelled antibody	80	12,420	R211,20	
4184	C-reactive protein (Ultra sensitive)	80	11,680	R198,50	
4185	Lactose	80	10,800	R183,40	
4186	Vitamin B6	80	15,300	R260,10	
4187	Zinc: Atomic absorption	80	18,120	R308,00	
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	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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)	80	1,500	R25,40	
4189	Abnormal pigments	80	4,500	R76,30	
4193	Alkapton test: Homogentisic acid	80	4,500	R76,30	
4194	Amino acids: Quantitative (Post derivatisation HPLC)	80	78,120	R1 328,10	
4195	Amino laevulinic acid	80	18,000	R306,20	
4197	Amylase	80	5,180	R88,00	
4198	Arsenic	80	18,120	R308,00	
4199	Ascorbic acid	80	2,250	R38,50	
4201	Bence-Jones protein	80	2,700	R46,00	
4204	Calcium: Atomic absorption	80	7,250	R123,30	
4205	Calcium: Spectrophotometric	80	3,620	R61,60	
4209	Lead: Atomic absorption	80	15,000	R255,00	
4210	Urine collagen telopeptides	80	36,500	R620,60	
4211	Bile pigments: Qualitative	80	2,250	R38,50	
4213	Protein: Quantitative	80	2,250	R38,50	
4216	Mucopolysaccharides: Qualitative	80	3,600	R61,40	
4217	Oxalate	80	9,380	R159,60	
4218	Glucose: Quantitative	80	2,250	R38,50	
4219	Steroids: Chromatography (each)	80	7,200	R122,40	
4221	Creatinine	80	3,620	R61,60	
4223	Creatinine clearance	80	7,650	R130,20	
4227	Electrophoresis: Qualitative	80	4,500	R76,30	

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4228	Fetal Lung Maturity	80	36,560	R621,50	
4230	Urine/Fluid - Specific Gravity	80	0,900	R15,20	
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	80	37,500	R637,50	
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	80	46,800	R795,60	
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	80	37,500	R637,50	
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	80	46,800	R795,60	
4237	5-Hydroxy-indole-acetic acid: Screen test	80	2,700	R46,00	
4238	5HIAA (Hplc)	80	78,120	R1 328,10	
4247	Ketones: Excluding dip-stick method	80	2,250	R38,50	
4248	Reducing substances	80	1,800	R30,50	
4251	Metanephrines: Column chromatography	80	22,050	R374,90	
4252	Metanephrine (Hplc)	80	78,120	R1 328,10	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	80	27,000	R459,00	
4254	Nitrosonaphtol test for tyrosine	80	2,250	R38,50	
4255	Orotic Acid - Urine	80	9,450	R160,80	
4256	Very long Chain Fatty Acids	80	129,380	R2 199,50	
4261	Micro Albumin: Quantitative	80	12,420	R211,20	
4262	Micro Albumin: Qualitative	80	4,500	R76,30	
4263	pH: Excluding dip-stick method	80	0,900	R15,20	
4265	Thin layer chromatography: One way	80	6,750	R114,70	
4266	Thin layer chromatography: Two way	80	11,250	R191,00	
4268	Organic acids: Quantitative: GCMS	80	109,380	R1 859,60	
4269	Phenylpyruvic acid: Ferric chloride	80	2,250	R38,50	
4270	Chromium Total Urine	80	18,120	R308,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4271	Phosphate excretion index	80	22,050	R374,90	
4272	Porphobilinogen qualitative screen: Urine	80	5,000	R85,00	
4273	Porphobilinogen/ALA: Quantitative each	80	15,000	R255,00	
4283	Magnesium: Spectrophotometric	80	3,620	R61,60	
4284	Magnesium: Atomic absorption	80	7,250	R123,30	
4285	Identification of carbohydrate	80	7,650	R130,20	
4287	Identification of drug: Qualitative	80	4,500	R76,30	
4288	Identification of drug: Quantitative	80	10,800	R183,40	
4293	Urea clearance	80	5,400	R91,80	
4297	Copper: Spectrophotometric	80	3,620	R61,60	
4298	Copper: Atomic absorption	80	18,120	R308,00	
4301	Chloride	80	2,590	R44,00	
4309	Urobilinogen: Quantitative	80	6,750	R114,70	
4313	Phosphates	80	3,620	R61,60	
4315	Potassium	80	3,620	R61,60	
4316	Sodium	80	3,620	R61,60	
4319	Urea	80	3,620	R61,60	
4321	Uric acid	80	3,620	R61,60	
4323	Total protein and protein electrophoresis	80	11,250	R191,00	
4325	VMA: Quantitative	80	11,250	R191,00	
4326	Catecholamines (HPLC)	80	78,120	R1 328,10	
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46,880	R797,00	
4328	Immunoglobulin D	80	9,450	R160,80	
4335	Cystine: Quantitative	80	12,600	R214,10	

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4336	Dinitrophenol hydrazine test: Ketoacids	80	2,250	R38,50	
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	
4322	Fluoride			R0,00	
4337	Hydroxyproline: Quantitative			R0,00	
4220	Klinolab Newborn Screen			R0,00	
21.8	Biochemical tests: Faeces				
4339	Chloride	80	2,590	R44,00	
4343	Fat: Qualitative	80	3,150	R53,70	
4345	Fat: Quantitative	80	22,050	R374,90	
4347	Ph	80	0,900	R15,20	
4351	Occult blood: Chemical test	80	2,250	R38,50	
4352	Occult blood: Monoclonal antibodies	80	10,000	R170,20	
4357	Potassium	80	3,620	R61,60	
4358	Sodium	80	3,620	R61,60	
4359	Secretory IgA	80	9,450	R160,80	
4362	Elastase quantitative ELISA	80	47,000	R799,10	
4363	Stercobilinogen: Quantitative	80	6,750	R114,70	

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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	80	5,000	R85,00	
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	80	20,000	R340,00	
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	80	20,000	R340,00	
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	80	30,000	R510,00	
4370	Drug level in biological fluid: Monoclonal immunological	80	12,400	R210,90	
4371	Amylase in exudate	80	5,180	R88,00	
4372	Fluoride in biological fluids and water	80	15,620	R265,70	
4374	Trace metals in biological fluid: Atomic absorption	80	18,130	R308,30	
4375	Calcium in fluid: Spectrophotometric	80	3,620	R61,60	
4376	Calcium in fluid: Atomic absorption	80	7,250	R123,30	
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	80	21,880	R372,00	
4378	Urea breath test	80	58,000	R986,10	
4380	Lecithin in amniotic fluid: L/S ratio	80	27,000	R459,00	
4381	Lamellar body count in amniotic fluid	80	10,000	R170,20	
4390	Foam test: Amniotic fluid	80	3,150	R53,70	
4391	Renal calculus: Chemistry	80	5,400	R91,80	
4392	Renal calculus: Crystallography	80	16,250	R276,30	
4395	Sweat: Sodium	80	3,620	R61,60	
4396	Sweat: Potassium	80	3,620	R61,60	
4397	Sweat: Chloride	80	2,590	R44,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4399	Sweat collection by iontophoresis (excluding collection material)	80	4,500	R76,30	
4400	Tryptophane loading test	80	22,050	R374,90	
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-isotope technique			R0,00	
4388	Gastric contents: Maximal stimulation test			R0,00	
4389	Gastric fluid: Ttoal acid per specimen			R0,00	
4393	Saliva: Ptoassium			R0,00	
4394	Saliva: Sodium			R0,00	
21.10	Cerebrospinal fluid				
4401	Cell count	80	3,450	R59,00	
4407	Cell count, protein, glucose and chloride	80	7,650	R130,20	
4409	Chloride	80	2,590	R44,00	
4416	Sodium	80	3,620	R61,60	
4417	Protein: Qualitative	80	0,900	R15,20	
4419	Protein: Quantitative	80	3,110	R52,80	
4421	Glucose	80	3,620	R61,60	
4423	Urea	80	3,620	R61,60	
4425	Protein electrophoresis	80	12,600	R214,10	
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	80	36,000	R611,90	
4426	HLA typing low resolution Class I DNA-PCR per locus	80	100,000	R1 700,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4427	HLA typing low resolution Class II DNA-PCR per locus	80	74,000	R1 258,20	
4428	HLA typing high resolution Class I or II DNA-PCR per locus	80	66,000	R1 122,10	
4429	Quantitative PCR (DNA/RNA)	80	84,300	R1 432,90	
4430	Recombinant DNA technique	80	25,000	R425,10	
4431	Ribosomal RNA targeting for bacteriological identification	80	35,000	R595,20	
4432	Ribosomal RNA amplification for bacteriological identification	80	75,000	R1 275,20	
4433	Bacteriological DNA identification (LCR)	80	25,000	R425,10	
4434	Bacteriological DNA identification (PCR)	80	75,000	R1 275,20	
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	80	150,000	R2 550,10	
21.11.2	RNA/DNA based tests and andrology: Andrology				
4435	Mixed antiglobulin reaction: Semen	80	6,600	R112,10	
4436	Friberg test: Semen	80	14,500	R246,60	
4437	Kremer test: Semen	80	3,600	R61,40	
4440	Semen analysis: Cell count	80	7,650	R130,20	
4441	Semen analysis: Cytology	80	7,200	R122,40	
4442	Semen analysis: Viability + motility - 6 hours	80	6,000	R101,90	
4443	Semen analysis: Supravital stain	80	5,440	R92,30	
4445	Seminal fluid: Alpha glucosidase	80	20,000	R340,00	
4446	Seminal fluid fructose	80	3,150	R53,70	
4447	Seminal fluid: Acid phosphatase	80	5,180	R88,00	
21.12	Immunology				
4448	HCG: Latex agglutination: Qualitative (side room)	80	4,000	R67,80	
4449	HCG: Latex agglutination: Semi-quantitative (side room)	80	9,310	R158,20	
4450	HCG: Monoclonal immunological: Qualitative	80	10,000	R170,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4451	HCG: Monoclonal immunological: Quantitative	80	12,400	R210,90	
4452	Bone Specific Alk Phosphatase	80	20,000	R340,00	
4455	Anti IgE receptor antibody test (10 samples and dilution)	80	161,560	R2 746,40	
4456	Eosinophil cationic protein	80	27,810	R472,80	
4457	Mast cell tryptase	80	96,870	R1 647,00	
4458	Micro-albuminuria: Radio-isotope method	80	12,420	R211,20	
4459	Acetyl choline receptor antibody	80	158,120	R2 688,20	
4460	CA-199 tumour marker	80	20,000	R340,00	
4461	Nuclear Matrix Protein 22	80	35,000	R595,20	
4462	CA-125 tumour marker	80	20,000	R340,00	
4463	C6 complement functional essay	80	45,000	R765,00	
4466	Beta-2-microglobulin	80	12,420	R211,20	
4467	Chromograqnin A	80	47,000	R799,10	
4468	CA-549	80	20,000	R340,00	
4469	Tumour markers: Monoclonal immunological (each)	80	20,000	R340,00	
4470	CA-195 tumour marker	80	20,000	R340,00	
4471	Carcino-embryonic antigen	80	20,000	R340,00	
4473	TSH Receptor Ab	80	17,480	R297,20	
4474	Cast Per Allergen	80	27,810	R472,80	
4475	CA-724	80	20,000	R340,00	
4477	Neuron specific enolase	80	20,000	R340,00	
4478	Osteocalcin	80	31,400	R533,80	
4479	Vitamin B12-absorption: Shilling test	80	11,700	R198,90	
4480	Serotonin	80	18,750	R319,00	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4482	Free thyroxine (FT4)	80	17,480	R297,20	
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	80	37,080	R630,30	
4485	Insulin	80	12,420	R211,20	
4486	C-Peptide	80	12,420	R211,20	
4487	Calcitonin	80	18,900	R321,50	
4488	B-Type Natriuretic Peptide	80	47,040	R799,60	
4490	Releasing hormone response	80	50,000	R850,20	
4491	Vitamin B12	80	12,420	R211,20	
4492	Vitamin D3: Calcitroil (RIA)	80	75,000	R1 275,20	
4493	Drug concentration: Quantitative	80	12,420	R211,20	
4494	Free hormone assay	80	17,480	R297,20	
4495	Growth hormone	80	12,420	R211,20	
4496	Hormone concentration: Quantitative	80	12,420	R211,20	
4497	Carbohydrate deficient transferrin	80	29,060	R494,10	
4499	Cortisol	80	12,420	R211,20	
4500	DHEA sulphate	80	12,420	R211,20	
4501	Testosterone	80	12,420	R211,20	
4502	Free testosterone	80	17,480	R297,20	
4503	Oestradiol	80	12,420	R211,20	
4505	Oestriol	80	10,800	R183,40	
4506	Multiple antigen specific IgE screening test for Atopy	80	37,260	R633,50	
4507	Thyrotropin (TSH)	80	19,600	R333,40	
4508	Combined antigen specific IgE	80	24,480	R416,00	
4509	Free tri-iodothyronine (FT3)	80	17,480	R297,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4511	Renin activity	80	18,900	R321,50	
4512	Parathormone	80	17,080	R290,30	
4513	IgE: Total	80	12,420	R211,20	
4514	Antigen specific IgE	80	12,420	R211,20	
4515	Aldosterone	80	12,420	R211,20	
4516	Follitropin (FSH)	80	12,420	R211,20	
4517	Lutropin (LH)	80	12,420	R211,20	
4518	Soluble transferrin receptor	80	11,250	R191,00	
4519	Prostate specific antigen	80	14,490	R246,40	
4520	17 Hydroxy progesterone	80	12,420	R211,20	
4521	Progesterone	80	12,420	R211,20	
4522	Alpha-feto protein	80	12,420	R211,20	
4523	ACTH	80	21,740	R369,60	
4524	Free PSA	80	20,000	R340,00	
4526	Sex hormone binding globulin	80	12,420	R211,20	
4527	Gastrin	80	12,420	R211,20	
4528	Ferritin	80	12,420	R211,20	
4529	Anti-DNA antibodies	80	12,420	R211,20	
4530	Antiplatelet antibodies	80	15,300	R260,10	
4531	Hepatitis: Per antigen or antibody	80	14,490	R246,40	
4532	Transcobalamine	80	12,420	R211,20	
4533	Folic acid	80	12,420	R211,20	
4534	Prostatic acid phosphatase	80	12,420	R211,20	
4536	Erythrocyte folate	80	17,480	R297,20	

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
4537	Prolactin	80	12,420	R211,20	
4538	Procalcitonin: Semi-quantitative	80	32,000	R544,20	
4539	Procalcitonin: Quantitative	80	46,000	R782,20	
4540	HCG: Quantitative as used for Down's screen	80	15,000	R255,00	
4546	First trimester Downs screen	80	53,500	R909,60	
4552	Second Trimester Down's screen	80	33,620	R571,80	
4553	Thyroglubulin	80	20,000	R340,00	
4554	SCC marker	80	20,000	R340,00	
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	80	27,000	R459,00	
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				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
22.1	Exfoliative cytology				
4561	Sputum, all body fluids and tumour aspirates: First unit	90	13,400	R262,70	
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	90	7,800	R153,20	
4564	Performance of fine-needle aspiration for cytology	90	15,000	R294,20	
4565	Examination of fine needle aspiration in theatre	90	90,000	R1 764,20	
4566	Vaginal or cervical smears, each	90	11,000	R215,80	
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	
22.2	Histology				
4567	Histology per sample	95	20,000	R371,20	
4571	Histology per additional block, each	95	11,600	R215,40	
4575	Histology and frozen section in laboratory	95	22,700	R421,30	
4577	Histology and frozen section in theatre	95	90,000	R1 670,50	
4578	Second and subsequent frozen sections, each	95	20,000	R371,20	
4579	Attendance in theatre - no frozen section performed	95	45,000	R835,10	
4582	Serial step sections (including item 4567)	95	23,300	R432,30	
4584	Serial step sections per additional block, each	95	13,500	R250,50	
4587	Histology consultation	95	10,100	R187,60	
4589	Special stains	95	6,700	R124,30	
4591	Immunofluorescence studies	95	20,700	R384,20	
4592	Immunoperoxidase studies	95	40,000	R742,50	
4593	Electron microscopy	95	94,000	R1 744,50	
4595	Foetal autopsy excluding histology	95	73,000	R1 354,80	
4590	Special procedures (special procedures are confined to polarization, decalcification and submission of blocks for radiological examination to identify microcalcifications)				Refer Rule C

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
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	100	15,000	R261,10	
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	100	45,000	R783,50	
4752	Cell culture: Chorionic villi	100	60,000	R1 044,90	
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	100	135,000	R2 350,60	
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	100	270,000	R4 701,10	
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	100	70,000	R1 218,70	
4760	FISH procedure, including cell culture	100	115,000	R2 002,40	
4761	FISH analysis per probe system	100	35,000	R609,30	
23.2	DNA-testing				
4763	Blood: DNA extraction	100	45,000	R783,50	
4764	Blood: Genotype per person: Southern blotting	100	89,000	R1 549,70	
4765	Blood: Genotype per person: PCR	100	60,000	R1 044,90	
4766	HIV Drug Resistance Testing	100	513,000	R8 932,00	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	100	90,000	R1 567,00	
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	100	188,000	R3 273,40	
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	100	120,000	R2 089,50	
IV.	Travelling Expenses				

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TARIFF CODE	DESCRIPTION OF TARIFF CODE	CF	UNITS	TARIFF VALUE	FLAG
P.	Travelling fees: (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. (b) If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. (c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. (d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). (e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). (f) For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.				
5003	The indicated amount for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16=3 X Indicated amount	20	1,000	R19,00	
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof	20	18,000	R344,00	
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				
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.				