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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

GENERAL NOTICE 148 OF 2021

DENTAL GAZETTE 2021.

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(ACT 130 OF 1993 as amended by Act 61 of 1997)

NOTICE ON ANNUAL INCREASE IN MEDICAL TARIFFS PAYABLE UNDER SECTION 76 OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT AS AMENDED

1.

I, Thembelani Thulas Nxesi, Minister of Employment & Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2021.

2.

Medical Tariffs increase for **2021** is **5.47%**

3.

The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2021** and Exclude **15% Vat.**

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 2021/01/25

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted, as long as it is exercised reasonably and without prejudice to the employee or to the Compensation Fund. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act, the Compensation Fund may refer an injured employee to a specialist medical practitioner designated by the Director General for a medical examination and report. Special fees are payable when this service is requested.

In terms of section 76,3(b) of the Compensation for Occupational Injuries and Diseases Act, no amount in respect of medical expenses shall be recoverable from the employee.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online.** The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner.

3. If a claim is **rejected (repudiated)**, medical expenses for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment.

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information.

BILLING PROCEDURE

1. All service providers should be registered on the Compensation Fund claims system in order to capture invoices and medical reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury and related ICD 10 Code.
   1.2 In a case where a surgical procedure is done, an operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   1.5 Referrals to another medical service provider should be indicated on the medical report.
   1.6 Medical reports, referral letters and all necessary documents should be uploaded on the Compensation Fund claims system.

NOTE: Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.
   2.3 Service providers may capture and submit medical invoices directly on the Compensation Fund system online application.

3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

MINIMUM REQUIREMENTS FOR INVOICE RENDERED

Minimum information to be indicated on invoices submitted to the Compensation Fund

- Name of employee and ID number
- Name of employer and registration number if available
- Compensation Fund claim number
- DATE OF ACCIDENT (not only the service date)
- Service provider's **invoice number**
- The practice number (changes of address should be reported to BHF)
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account)
- Date of service (the actual service date must be indicated: the invoice date is not acceptable)
- Item codes according to the officially published tariff guides
- Amount claimed per item code and total of account
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication accounts must be accompanied by the original scripts
    - The referral letter from the treating practitioner must accompany the medical service providers' invoice.

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

Medical service providers treating COIDA patients must comply with the following requirements before submitting medical invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Render medical treatment to in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit medical invoices with gazetted COIDA medical tariffs, relevant ICD10 codes and additional medical tariffs specified by the Fund when submitting medical invoices.
- All medical invoices must be submitted with invoice numbers to prevent system rejections. Duplicate invoices should not be submitted.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.
- The name of the switching house that submit invoices on behalf of the medical service provider. The Fund must be notified in writing when changing from one switching house to another.

All medical service providers will be subjected to the Compensation Fund vetting processes.

The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette.

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

1. Registration requirements as an employer with the Compensation Fund.
2. Host a secure FTP server to ensure encrypted connectivity with the Fund.
3. Submit and complete a successful test file before switching the invoices.
4 Validate medical service providers' registration with the Health Professional Council of South Africa.
5 Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.
15. Only Pharmacies should claim from the Nappi codes file.

Failure to comply with the above requirements will result in deregistration of the switching house.

MSP's PAID BY THE COMPENSATION FUND	
Discipline Code :	Discipline Description :
4	Chiropractors
9	Ambulance Services - advanced
10	Anesthetists
11	Ambulance Services - Intermediate
12	Dermatology
13	Ambulance Services - Basic
14	General Medical Practice
15	General Medical Practice
16	Obstetrics and Gynecology (work related injuries)
17	Pulmonology
18	Specialist Physician
19	Gastroenterology
20	Neurology
22	Psychiatry
23	Rediation/Medical Oncology
24	Neurosurgery
25	Nuclear Medicine
26	Ophthalmology
28	Orthopedics
30	Otorhinolaryngology
34	Physical Medicine
36	Plastic and Reconstructive Surgery
38	Diagnostic Radiology
39	Radiographers
40	Radiotherapy/Nuclear Medicine/Oncologist
42	Surgery Specialist
44	Cardio Thoracic Surgery
46	Urology
49	Sub-Acute Facilities
52	Pathology
54	General Dental Practice
55	Mental Health Institutions
56	Provincial Hospitals
57	Private Hospitals
58	Private Hospitals
59	Private Rehab Hospital (Acute)
60	Pharmacies
62	Maxillo-facial and Oral Surgery
64	Orthodontics
66	Occupational Therapy
70	Optometrists
72	Physiotherapists
75	Clinical technology (Renal Dialysis only)
76	Unattached operating theatres / Day clinics
77	Approved U O T U / Day clinics
78	Blood transfusion services
82	Speech therapy and Audiology
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses
89	Social workers
90	Manufacturers of assisstive devices

GENERAL GUIDELINES

COIDA FEES FOR DENTAL SERVICES FROM 1 APRIL 2021

RULES

1. The following Rules apply to all practitioners

001 Code 8101 refers to a Full Mouth Examination, charting and treatment planning and no further examination fees shall be chargeable until the treatment plan resulting from this consultation is completed with the exception of code 8102. This includes the issuing of a prescription where only medication is prescribed Item code 8104 refers to a consultation for a specific problem and not to a full mouth examination, charting and treatment planning. This includes the issuing of a prescription where only medication is prescribed

002 Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in this schedule shall be based on the fee in respect of a comparable service that is listed therein and Rule 002 must be indicated together with the tariff code

003 In the case of a prolonged or costly dental service or procedure, the dental practitioner shall ascertain beforehand from the Commissioner whether financial responsibility in respect of such treatment will be accepted

004 In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the Commissioner may be charged and Rule 004 must be indicated together with the tariff code

005 Except in exceptional cases the service of a specialist shall be available only on the recommendation of the attending dental or medical practitioner. Referring practitioners shall indicate to the specialist that the patient is being treated in terms of the Compensation for Occupational Injuries and Diseases Act

007 "Normal consulting hours" are between 08:00 and 17:00 on weekdays, and between 08:00 and 13:00 on Saturdays

008 A dental practitioner shall submit his account for treatment to the employer of the employee concerned

(M/W) 009 Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment that is not listed in the schedule for dentists in general practice and Modifier 8004 must be shown against any such item code

Benefits in respect of specialists charging treatment procedures not listed in the schedule for that specialty, shall be allocated as follows

General Dental Practitioners Schedule 100%

Other Dental Specialists Schedules 2/3

010 Fees charged by dental technicians for their services (PLUS L) shall be indicated on the dentist's invoice against the code 8099. Such dentist's invoice shall be accompanied by the actual invoice of the dental technician (or a copy thereof) and the invoice of the dental technician shall bear the signature of the dentist (or the person authorised by him) as proof that it has been compiled correctly. "L" comprises the fee charged by the dental technician for his services as well as the cost of gold and of teeth. For example, code 8231 is specified as follows (gold only applicable with prior authorization)

		Rc
8231	.....	X
8099 (8231)	.....	Y
Total	.....	R(X+Y)

011 Modifiers may only be used where (M/W) appears against the item code in the schedule.

8001 33 1/3% of the appropriate scheduled fee (see Note 4 - preamble to maxillo-facial

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and oral surgery schedule)

8002 The appropriate scheduled fee + 50% (see Note 1 - preamble to maxillo-facial and oral surgery schedule)

8003 The appropriate scheduled fee + 10% (see Note 5 - preamble to periodontal schedule)

8004 Two-thirds of appropriate scheduled fee (see Rule 009)

8005 The appropriate scheduled fee up to a maximum of **R613.09**(see Note 2 - preamble to maxillo-facial and oral surgery schedule)

8006 50% of the appropriate scheduled fee (see Note 3 – preample to maxillo-facial and oral surgery schedule)

8007 15% of the appropriate scheduled fee with a minimum of **R312.18** (See preamble(s) under "oral surgery" in the schedule for GPs and the schedule for specialists in maxillo-facial and oral surgery

8008 The appropriate scheduled fee + 25% (see Note 5 – preamble to maxillo-facial and oral surgery schedule, GPs' schedule)

8009 75% of the appropriate scheduled fee (see Note 3 under the preamble of the maxillo-facial and oral surgery schedule

8010 The appropriate shedule fee plus 75%

012 In cases where treatment is not listed in the schedule for dentists in general practice or specialists, the appropriate fee listed in the medical schedules shall be charged and the relevant code in the medical schedules indicated

013 Cost of material (VAT inclusive): This item provides for the charging of material costs where indicated against the relative item codes by the words "(See Rule 013)". Material should be charged for at cost plus a handling fee not exceeding 35%, up to **R5143.42** A maximum handling fee of 10% shall apply above a cost of **R5143.42.** A maximum handling fee of **R7715.01** will apply

Note: Item 8220 (suture) is applicable to all registered practitioners

EXPLANATIONS

2. Additions, deletions and revisions

A summary listing all additions, deletions and revisions applicable to this Schedule is found in Appendix A

New codes added to the Schedule are identified with the symbol • placed before the code

In instances where a code has been revised, the symbol * is placed before the code

3. Tooth identification

Tooth identification is compulsory for all invoices rendered. Tooth identification is only applicable to procedures identified with the letter "(T)" in the mouth part (MP) column. The designated system for teeth and areas of the oral cavity of the International Standards Organisation (ISO) in collaboration with the FDI, should be used

4. Abbreviations used in the Schedule

+D	Add fee for denture
+L	Add laboratory fee
GP	General practitioner
M/W	Modifier
MP	Mouth part
na	not applicable

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T Tooth

5. VAT

Fees are VAT exclusive

	I. GENERAL DENTAL PRACTITIONERS
	PREAMBLE
(1)	The dental procedure codes for general dental practitioners are divided into twelve (12) categories of services. The procedures have been grouped according to the category with which the procedures are most frequently identified. The categories are created solely for convenience in using the Schedule and should not be interpreted as excluding certain types of Oral Care Providers from performing or reporting such procedures. These categories are similar to that in the "*Current Dental Terminology" Third Edition (CDT-3).*
(2) (M/W)	Procedures not described in the general practitioner's schedule should be reported by referring to the relevant specialist's schedule. Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment codes that are not listed in the schedule for dentists in general practice and Modifier 8004 must be shown against any such item code (See Rules 009 and 011). There are no specific codes for orthodontic treatment in the current general practitioner's schedule, and the general practitioner must refer to the specialist orthodontist's schedule.
(3) (M/W)	Oral and maxillofacial surgery (Section J of the Schedule): The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum (see Modifier 8007). The Compensation Fund must be informed beforehand that another dentist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the Compensation Fund.

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	A. DIAGNOSTIC			
	Clinical oral evaluation			
8101	Full mouth examination, charting and treatment planning (see Rule 001)	320.72		
8102	Comprehensive consultation	418.64		
	A comprehensive consultation shall include treatment planning at a separate appointment where a diagnosis is made with the help of study models, full-mouth x-rays and other relevant diagnostic aids. Following on such a consultation, the patient must be supplied with a comprehensive written treatment plan which must also be recorded on the patient's file and which must include the following: • Soft tissue examination • Hard tissue examination • Screening / probing of periodontal pockets • Mucogingival examination • Plaque index • Bleeding index • Occlusal Analysis • TMJ examination • Vitality screening of complete dentition			
8104	Examination or consultation for a specific problem not requiring a full mouth examination, charting and treatment planning	126.63		
	Radiographs / Diagnostic imaging			
8107	Intra-oral radiographs, per film	122.56		
8108	Maximum for 8107	920.27		
8113	Occlusal radiographs	190.62		
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA) The fee is chargeable to a maximum of two films per treatment plan.	503.76		
	Tests and laboratory examinations			
8117	Study model – unmounted or mounted on a hinge articulator	137.49	+L	
8119	Study model – mounted on a movable condyle articulator	353.50	+L	
8121	Photograph (for diagnostic, treatment or dento-legal purposes) per photograph	137.49		
8122	Bacteriological studies for determination of pathologic agents May inlcude, but is not limited to tests for susceptability to periodontal disease If requested, a periodontal risk assessment must be made available at no charge (The use of this code is limited to general dental practitiones and specialist in community dentistry)	129.73		
	B. PREVENTIVE This schedule, applicable to occupational injuries and diseases, excludes preventive services			

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	C. RESTORATIVE			
	Amalgam restorations (including polishing)			
	All adhesives, liners and bases are included as part of the restoration. If pins are used, they should be reported separately.			
	See Codes 8345, 8347 and 8348 for post and / or pin retention			
8346	Restorative material factor Note / Nota: Restorative material factor - an additional 10% can be added to codes 8341, 8342, 8343, 8344, 8351, 8352, 8353, 8354, 8355, 8367, 8368, 8369 and 8370 by general dental practitioners only.	M/W800 3 + 10%		
8341	Amalgam - one surface	327.31		T
8342	Amalgam - two surfaces	409.73		T
8343	Amalgam - three surfaces	492.33		T
8344	Amalgam - four or more surfaces	490.97		T
	Resin restorations			
	Resin refers to a broad category of materials including but not limited to composites and may include bonded composite, light-cured composite, etc. Light-curing, acid etching and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers / compomers, when used as restorations should be reported with these codes. If pins are used, they should be reported separately.			
	See codes 8345, 8347 and 8348 for post and / or pin retention			
	The fees are inclusive of direct pulp capping (code 8301) and rubber dam application (code 8304)			
8351	Resin - one surface, anterior	320.14		T
8352	Resin - two surfaces, anterior	408.95		T
8353	Resin - three surfaces, anterior	540.80		T
8354	Resin - four or more surfaces, anterior	600.51		T
8367	Resin - one surface, posterior	387.04		T
8368	Resin - two surfaces, posterior	530.33		T
8369	Resin - three surfaces, posterior	578.42		T
8370	Resin - four or more surfaces, posterior	613.51		T
	Inlay / Onlay restorations			
	METAL INLAYS			
	The fee for metal inlays on anterior teeth (incisors and canines) are determined 'by arrangement' with the Compensation Commissioner			
8358	Inlay, metallic - one surface, anterior	na / nvt	+L	T
8359	Inlay, metallic - two surfaces, anterior	na / nvt	+L	T
8360	Inlay, metallic - three surfaces, anterior	na / nvt	+L	T
8365	Inlay, metallic - four or more surfaces, anterior	na / nvt	+L	T
8361	Inlay, metallic - one surface, posterior	656.36	+L	T
8362	Inlay, metallic - two surfaces, posterior	849.10	+L	T
8363	Inlay, metallic - three surfaces, posterior	1751.12	+L	T
8364	Inlay, metallic - four or more surfaces, posterior	1751.32	+L	T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	CERAMIC AND / OR RESIN INLAYS Porcelain / ceramic inlays include either all ceramic or porcelain inlays. Composite / resin inlays must be laboratory processed NOTE: The fees exclude the application of a rubber dam (code 8304).			
8371	Inlay, ceramic / resin - one surface	594.31	+L	T
8372	Inlay, ceramic / resin - two surfaces	868.29	+L	T
8373	Inlay, ceramic / resin - three surfaces	1449.04	+L	T
8374	Inlay, ceramic / resin - four or more surfaces	1751.32	+L	T
(M/W)	NOTES 1. In some of the above cases (e.g. direct hybrid inlays) +L may not necessarily apply 2. In cases where direct hybrid inlays are used and +L does not apply, Modifier 8008 may be used 3. See the General Practitioner's Guideline to the correct use of treatment codes for computer generated inlays.			
	Crowns – single restorations The fees include the cost of temporary and / or intermediate crowns. See code 8193 (osseo integrated abutment restoration) in the 'fixed prosthodontic' category for crowns on osseo-integrated implants.			
8401	Cast full crown	2079.97	+L	T
8403	Cast three-quarter crown	2079.97	+L	T
8405	Acrylic jacket crown	Com Fee	+L	T
8407	Acrylic veneered crown	2220.36	+L	T
8409	Porcelain jacket crown	2220.36	+L	T
8411	Porcelain veneered crown	2220.36	+L	T
	Other restorative services			
8133	Re-cementing of inlays, crowns or bridges - per abutment In some cases where item code 8133 is used +L may not apply.	190.62	+L	T
8135	Removal of inlays and crowns (per unit) and bridges (per abutment) or sectioning of a bridge, part of which is to be retained as a crown following the failure of a bridge	374.43	+L	T
8137	Temporary crown placed as an emergency procedure Not applicable to temporary crowns placed during routine crown and bridge preparations i.e. where the impression for the final crown is taken at the same visit	640.47	+L	T
8330	Removal of fractured post or instrument and / or bypassing fractured endodontic instrument NOTE: The fee excludes the application of a rubber dam (code 8304)	250.73		T
8345	Preformed post retention, per post	276.90		T
8347	Pin retention for restoration, first pin	190.62		T
8348	Pin retention for restoration, each additional pin A maximum of two additional pins may be charged	164.63		T
8355	Composite veneers (direct)	607.11		T
8357	Preformed metal crown	403.13		T
8366	Pin retention as part of cast restoration, irrespective of number of pins	294.35		T
8376	Prefabricated post and core in addition to crown The core is built around a prefabricated post(s)	982.50		T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
8391	Cast post and core - single	446.17	+L	T
8393	Cast post and core - double	714.15	+L	T
8395	Cast post and core - triple	1029.43	+L	T
8396	Cast coping	291.00	+L	T
8397	Cast core with pins This service is usually provided on grossly broken down vital teeth, and may not be charged when a post has been inserted in the tooth in question	714.15	+L	T
8398	Core build-up, including any pins Refers to the building up of an anatomical crown when a restorative crown will be placed, irrespective of the number of pins used	714.15		T
8413	Facing replacement	436.02	+L	T
8414	Additional fee for provision of a crown within an existing clasp or rest	136.73	+L	T
	D. ENDODONTICS			
*	Preamble: 1. The Health Professions Council of SA has ruled that, with the exception of diagnostic intra-oral radiographs, fees for only three further intra-oral radiographs may be charged for each completed root canal therapy on a single-canal tooth; or a further five intra-oral radiographs for each completed root canal therapy on a multi-canal tooth 2. The fee for the application of a rubber dam (See code 8304 in the category "Adjunctive General Services") may only be charged concurrent with the following procedures • Gross pulpal debridement, primary and permanent teeth, for the relief of pain (code 8132 • Apexification of a root canal (code 8305) • Pulpotomy (code 8307) • Complete root canal therapy (codes 8328, 8329 and 8332 to 8340) • Removal or bypass of a fractured post or instrument (code 8330) • Bleaching of non vital teeth (codes 8325 and 8327) and • Ceramic and or resin inlays (codes 8371 to 8374) 3. After endodontic preparatory visits (codes 8332, 8333 and 8334) have been charged, fees for endodontic treatment completed at a single visit (codes 8329, 8338, 8339 and 8340) may not be levied			
	Pulp capping			
8301	Direct pulp capping	Com Fee		T
8303	Indirect pulp capping The permanent filling is not completed at the same visit	231.41		T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	Pulpotomy			
8307	Amputation of pulp (pulpotomy) No other endodontic procedure may, in respect of the same tooth, be charged concurrent to code 8307 and a completed root canal therapy should not be envisaged (code 8304 excluded)	148.92		T
	Endodontic therapy (including the treatment plan, clinical procedures and follow-up care)			
	PREPARATORY VISITS (OBTURATION NOT DONE AT SAME VISIT)			
8332	Single-canal tooth, per visit A maximum of four visits per tooth may be charged	190.62		T
8333	Multi-canal tooth, per visit A maximum of four visits per tooth may be charged	464.78		T
	OBTURATION OF ROOT CANALS AT A SUBSEQUENT VISIT			
8335	First canal - anteriors and premolars	868.49		T
8328	Each additional canal - anteriors and premolars	334.29		T
8336	First canal - molars	1193.27		T
8337	Each additional canal - molars	353.50		T
	PREPARATION AND OBTURATION OF ROOT CANALS COMPLETED AT A SINGLE VISIT			
8338	First canal - anteriors and premolars	1325.12		T
8329	Each additional canal - anteriors and premolars	421.16		T
8339	First canal - molars	1820.13		T
8340	Each additional canal - molars	443.85		T
	Endodontic retreatment			
8334	Re-preparation of previously obturated canal, per canal	281.94		T
	Apexification / recalcification procedures			
8305	Apexification of root canal, per visit No other endodontic procedures may, in respect of the same tooth, be charged concurrent with code 8305 at the same visit (code 8304 excluded)	239.10		T
	Apicoectomy / Periradicular services			
8229	Apicoectomy including retrograde filling where necessary – incisors and canines	948.57		T
	Other endodontic procedures			
8132	Gross pulpal debridement, primary and permanent teeth	307.92		
*	Where code 8132 is charged, no other endodontic procedures may be charged at the same visit on the same tooth. Codes 8338, 8329, 8339 and 8340 (single visit) may be charged at the subsequent visit, even if code 8132 was used for the initial relief of pain (See note 2 in the preamble above)			T
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	148.54		T
8306	Cost of Mineral Trioxide Aggregate	Reël 013		
8325	Bleaching of non-vital teeth, per tooth as a separate procedure	429.70		T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
8327	Each additional visit for bleaching of non-vital tooth as a separate procedure A maximum of two additional visits may be charged	204.19		T
	E. PERIODONTICS This schedule, applicable to occupational injuries and diseases, do not include periodontic services.			
	F. PROSTHODONTICS (REMOVABLE)			
	Complete dentures (including routine post-delivery care)			
8231	Full upper **and** lower dentures inclusive of soft base or metal base, where applicable	3033.01	+L	
8232	Full upper **or** lower dentures inclusive of soft base or metal base, where applicable	1869.40	+L	
	Partial dentures (including routine post-delivery care)			
8233	Partial denture, one tooth	868.29	+L	
8234	Partial denture, two teeth	868.29	+L	
8235	Partial denture, three teeth	1297.97	+L	
8236	Partial denture, four teeth	1397.44	+L	
8237	Partial denture, five teeth	1297.97	+L	
8238	Partial denture, six teeth	1730.19	+L	
8239	Partial denture, seven teeth	1730.19	+L	
8240	Partial denture, eight teeth	1730.19	+L	
8241	Partial denture, nine or more teeth	1730.19	+L	
8281	Metal (e.g. chrome cobalt, etc.) base to partial denture, per denture The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., 8251, 8253, 8255 and 8257). See codes 8233 to 8241 for the resin denture base required concurrent to 8281	2309.95	+L	
	Adjustments to dentures			
8275	Adjustment of denture (After six months or for patient of another practitioner)	131.09	+L	
	Repairs to complete or partial dentures			
8269	Repair of denture or other intra-oral appliance A dentist may not charge professional fees for the repair of dentures if the patient was not personally examined; laboratory fees, however, may be recovered.	248.70	+L	
8270	Add clasp to existing partial denture (One or more clasps) Code 8270 is in addition to code 8269.	164.63	+L	
8271	Add tooth to existing partial denture (One or more teeth) Code 8271 is in addition to code 8269.	164.63	+L	
8273	Additional fee where one or more impressions are required for 8269, 8270 and 8271	131.06	+L	

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	Denture rebase procedures			
8259	Re-base of denture (laboratory)	714.15	+L	
8261	Re-model of denture	1172.72	+L	
	Denture reline procedures			
8263	Reline of denture in selfcuring acrylic (intra-oral)	446.17		
8267	Soft base re-line per denture (heat cured) Code 8267 may not be charged concurrent with codes 8231 to 8241.	1029.43	+L	
	Other removable prosthetic services			
8243	Soft base to new denture	Com Fee	+L	
8255	Stainless steel clasp or rest, per clasp or rest	179.17	+L	
8257	Lingual bar or palatal bar Code 8257 may not be charged concurrent with codes 8269 (repair of denture) or 8281 (metal framework).	216.79	+L	
8265	Tissue conditioner and soft self-cure interim re-line, per denture	296.29		
	G. MAXILLOFACIAL PROSTHETICS This schedule, applicable to occupational injuries and diseases, excludes maxillofacial prosthetic services.			
	H. IMPLANT SERVICES Report surgical implant procedures using codes in this section; prosthetic devices should be reported using existing fixed or removable prosthetic codes.			
	Endosteal implants Endosteal dental implants are placed into the alveolar and / or basal bone of the mandible or maxilla and transecting only one cortical plate.			
8194	Placement of a single osseo-integrated implant per jaw	1892.67		T
8195	Placement of a second osseo-integrated implant in the same jaw	1415.67		T
8196	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	927.82		T
8197	Cost of implants	Reël 013		
8198	Exposure of a single osseo-integrated implant and placement of a transmucosal element	701.34		T
8199	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	526.07		T
8200	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	350.78		T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
	Eposteal implants / Eposteale inplantate			
	Eposteal (subperiosteal) dental implants receive its primary bone support by means of resting on the alveolar bone.			
	Refer to the specialist maxillo-facial and oral surgeons schedule			
	Transosteal implants			
	Transosteal dental implants penetrate both cortical plates and pass through the full thickness of the alveolar bone.			
	Refer to the specialist maxillo-facial and oral surgeons schedule			
	I. PROSTHODONTICS, FIXED			
	The words 'bridge' and 'bridgework' have been replaced by the term 'fixed partial denture'			
	Each abutment and pontic constitute a unit in a fixed partial denture.			
	Fixed partial denture pontics			
8420	Sanitary pontic	1084.30	+L	T
8422	Posterior pontic	1449.04	+L	T
8424	Anterior pontic (including premolars)	1814.15	+L	T
	Fixed partial denture retainers – inlays / onlays			
	Refer to inlay / onlay restorations for inlay / onlay retainers			
8356	Bridge per abutment - only applicable to Maryland type bridges	804.31	+L	T
	Only applicable to Maryland type bridges. Report per abutment. Report pontics seperately (see codes 8420, 8422 and 8424)			
	Fixed partial denture retainers – crowns			
	Refer to crowns, single restorations for crown retainers			
8193	Osseo-integrated abutment restoration, per abutment	2942.45	+L	T
	Refer to the DASA's 'General Practioner's Guidelines to the correct use of treatment codes' for the application(s) of this code			
	J. ORAL AND MAXILLOFACIAL SURGERY			
	Refer to the specialist maxillo-facial and oral surgeon schedule for surgical services not listed in this schedule.			
	Extractions			
8201	Single tooth	190.62		T
	Code 8201 is charged for the first extraction in a quadrant.			
8202	Each additional tooth in the same quadrant	267.40		T
	Code 8202 is charged for each additional extraction in the same quadran.			
	Surgical extractions (includes routine postoperative care)			
8209	Surgical removal of a tooth requiring elevation of mucoperiosteal flap, removal of bone and / or section of tooth	585.98		T
	Includes cutting of gingiva and bone, removal of tooth structure and closure.			
8210	Removal of unerupted or impacted tooth – first tooth	1371.28		T
8211	Removal of unerupted or impacted tooth – second tooth	736.06		T

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
8212	Removal of unerupted or impacted tooth – each additional tooth	419.02		T
8213	Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.	845.41		T
8214	Surgical removal of residual tooth roots (cutting prcedure), each subsequent tooth Includes cutting of gingiva and bone, removal of tooth structure and closure.	599.15		T
	Other surgical procedures			
8188	Biopsy - intra-oral This item does not include the cost of the essential pathological evaluations.	461.10		
	Repair of traumatic wounds			
8192	Appositioning (i.e., suturing) of soft tissue injuries	955.17		
	K. ORTHODONTICS This schedule, applicable to occupational injuries and diseases, excludes orthodontic services.			
	L. ADJUNCTIVE GENERAL SERVICES			
	Unclassified treatment			
8131	Palliative [emergency] treatment for dental pain This is typically reported on a "per visit" basis for emerency treatment of dental pain where no other treatment item is applicable or applied for treatment of the same tooth	190.62		T
8221	Local treatment of post-extraction haemorrhage – initial visit (Excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)	133.79		
8223	Local treatment of post-extraction haemorrhage – each additional visit	85.91		
8225	Treatment of septic socket – initial visit	133.79		
8227	Treatment of septic socket – each additional visit	85.91		
	Anaesthesia			
8141	Inhalation sedation - first quarter-hour or part thereof	168.89		
8143	Inhalation sedation - each additional quarter-hour or part thereof No additional fee can be charged for gases used in the case of items 8141 and 8143	91.33		
8144	Intravenous sedation	88.81		
8145	Local anaesthetic, per visit	41.70		
*	Code 8145 includes the use of the wand			
8499	The relevant codes published in the Government Gazette for Medical Practitioners shall apply to general anaesthetics for dental procedures			
	Professional visits			
8129	Additional fee for emergency treatment rendered outside normal working hours (including emergency treatment carried out at hospital) Not applicable where a practice offers extended service hours as the norm	461.10		

I	GENERAL DENTAL PRACTITIONERS			
Code	Procedure description	Rc FEE		MP
8140	Fee for treatment at a venue other than the surgery, inclusive of hospital visits, treatment under general anaesthetic and home visits; per visit Code 8140 may be applied concurrent with codes 8101 or 8104, but in accordance with rule 001	294.15		
	Drugs, medication and materials			
8183	Intra-muscular or sub-cutaneous injection therapy, per injection (Not applicable to local anaesthetic)	79.50		
8220	Use of suture material provided by practitioner	Reël 013		
	Miscellaneous services			
8109	Infection control, per dentist, per hygienist, per dental assistant, per visit Code 8109 includes the provision by the dentist of new rubber gloves, masks, etc. for each patient	28.12		
8110	Provision of sterilized and wrapped instrumentation in consulting rooms The use of this code is limited to heat, autoclave or vapour sterilised and wrapped instruments	79.32		
8168	Behaviour management, by report May be reported in addition to treatment provided. Should be reported in 15 minute increments Notes: If requested, the report must be made available at no charge The use of this code is limited to general dental practitioners and specialists in community dentistry Limitation May be reported in addition to treatment provided, when the patient is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff utilising additional time, skill and / or assistance to render treatment. The code can only be billed where treatment requires extraordinary effort and is the only alternative to general anaesthesia. The fee includes all pharmacological, psychological and physical management adjuncts required or utilized. Notation and justification must be recorded in the patient record identifying the specific behavior problem and the technique used to manage it. Billed in 15-minute units. (maximum 4 units per visit and allowed once per patient per day). Limited to 12 units per year.	181.51		
8304	Rubber dam, per arch (Refer to the guidelines for the application of a rubber dam in the preamble to the category "Endodontics")	140.01		

II	SPECIALIST PROSTHODONTISTS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
	A. DIAGNOSTIC PROCEDURES			
8501	Consultation	353.50		
8503	Occlusal analysis on adjustable articulator	723.07		
8505	Pantographic recording	1054.82		
8506	Detailed clinical examination, recording, radiographic interpretation, diagnosis, treatment planning and case presentation. Note: Code 8506 is a separate procedure from 8507 and is applicable to craniomandibular disorders, implant placement or orthognatic surgery where extensive restorative procedures will be required	1172.92		
8507	Examination, diagnosis and treatment planning	723.07		
8508	Electrognathographic recording	1173.50		
8509	Electrognathographic recording with computer analysis.	1881.24		
	B. Preventive procedures This schedule, applicable to occupational injuries and diseases, excludes preventive services.			
	C. Treatment procedures			
	Emergency treatment			
8511	Emergency treatment for relief of pain (where no other tariff code is applicable)	436.10		
8513	Emergency crown (Not applicable to temporary crowns placed during routine crown and bridge preparation)	714.15	+L	T
8515	Re-cementing of inlay, crown or bridge, per abutment	276.90		T
8517	**RE-IMPLANTATION OF AN AVULSED TOOTH, INCLUDING FIXATION AS REQUIRED**	739.16	+L	T
	Provisional treatment			
8521	**PROVISIONAL SPLINTING – EXTRACORONAL WIRE, PER SEXTANT.**	594.31		
8523	**Provisional splinting – extracoronal wire plus resin, per sextant**	870.23		
8527	Provisional splinting – intercoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint	276.90	+L	
8529	Provisional crown Crown utilized as an interim restoration for at least six weeks during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy or cracked tooth syndrome. This code should not be utilised for a temporary crown in a routine prosthetic restoration.	714.15	+L	T
8530	Preformed metal crown	606.30		T
	Occlusal adjustment			
8551	**Major occlusal adjustment** This procedure can not be carried out without study models mounted on an adjustable articulator.	826.42		

II	SPECIALIST PROSTHODONTISTS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
8553	Minor occlusal adjustment	640.47		
	Ceramic and / or resin bonded inlays and veneers: In some of the procedures below (e.g. Direct hybrid inlays) +L may not apply.			
8554	Bonded veneers	2082.89	+L	T
8555	**One surface**	2684.76	+L	T
8556	Two surfaces	3876.27	+L	T
8557	Three surfaces	6246.72	+L	T
8558	Four or more surfaces	6246.72	+L	T
	Gold restorations (only applicable with prior authorization)			
8571	One surface	1289.26	+L	T
8572	Two surfaces	1863.98	+L	T
8573	Three surfaces	2885.44	+L	T
8574	Four or more surfaces	2885.44	+L	T
8577	Pin retention	430.66		T
	Posts and copings			
8581	**Single post**	715.66	+L	T
8582	Double post	1029.43	+L	T
8583	Triple post	1290.42	+L	T
8587	Copings	616.22	+L	T
8589	Cast core with pins	1016.82	+L	T
	Preformed posts and cores			
8591	**Core build-up, including all pins** Refers to the building up of an anatomical crown when a restorative crown will be placed, whether or not pins are used	714.15		T
8593	Prefabricated post and core in addition to crown Core is built around a prefabricated post(s).	1323.96		T
	Implants			
8592	Osseo-integrated abutment restoration, per abutment	4410.28	+L	T
8600	**Cost of implant components**	Reël 013		
9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	1047.84		
9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	785.70		
9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant.	523.15		
	Connectors			
8597	**Locks and milled rests**	292.21	+L	T

II	SPECIALIST PROSTHODONTISTS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
8599	Precision attachments	714.15	+L	T
	Crowns			
8601	Cast three-quarter crown	2885.44	+L	T
8603	Cast gold crown (authorization needed)	2885.44	+L	T
8605	Acrylic veneered gold crown	3211.77	+L	T
8607	**Porcelain jacket crown**	2885.44	+L	T
8609	Porcelain veneered metal crown	3602.87	+L	T
	Bridges **(Retainers as above)**			
8611	Sanitary pontic	2176.92	+L	T
8613	Posterior pontic	2682.82	+L	T
8615	Anterior pontic	2885.44	+L	T
	Resin bonded retainers			
8617	Per abutment **Per pontic (see 8611, 8613, 8615)**	888.84	+L	T
	Conservative treatment for temporo-mandibular joint dysfunction			
8625	Bite plate for TMJ dysfunction	1101.63	+L	
8621	First visit for treatment of TMJ dysfunction	251.11		
8623	Follow-up visit for TMJ dysfunction **The number of visits and fees therefore depend on the relationship between the practitioner and the patient, and the problems involved in the case.**	187.32		
	Endodontic procedures Root canal therapy **Procedure codes 8631, 8633 and 8636 include all X-rays and repeat visits**			
8631	Root canal therapy, first canal	2525.18		T
8633	Each additional canal	630.96		T
8636	Re-preparation of previously obturated canal, per canal	421.54		T
	Other endodontic procedures			
8635	**Apexification of root canal, per visit**	421.74		T
8637	HEMISECTION OF A TOOTH, RESECTION OF A ROOT OR TUNNEL PREPARATION (AS AN ISOLATED PROCEDURE)	1177.76		T
9015	Apicectomy including retrograde root filling where necessary - anterior tooth	1397.44		T
9016	Apicectomy including retrograde root filling where necessary - posterior tooth	2087.55		T
8640	Removal of fractured post or instrument from root canal	738.76		T
	Prosthetics (Removable)			
8641	COMPLETE UPPER **AND** LOWER DENTURES WITHOUT PRIMARY COMPLICATIONS	7212.14	+L	
8643	Complete upper **and** lower dentures without major complications	9360.76	+L	

II	SPECIALIST PROSTHODONTISTS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
8645	Complete upper **and** lower dentures with major complications	11513.24	+L	
8647	Complete upper **or** lower denture without primary complications	5045.49	+L	
8649	Complete upper **or** lower denture without major complications	5764.29	+L	
8651	Complete upper **or** lower denture with major complications	6482.70	+L	
8661	**Diagnostic dentures (inclusive of tissue conditioning treatment)**	**5764.29**	**+L**	
8662	Remounting and occlusal adjustment of dentures	829.71	+L	
8663	Chrome cobalt base base for full denture (extra charge)	1736.77	+L	
8664	Remount of crown or bridge for extensive prosthetics	845.41		
8665	Re-base, per denture	1163.40	+L	
8667	Soft base, per denture (heat cured)	1735.41	+L	
8668	Tissue conditioner, per denture	430.46		
8669	Intra-oral reline of complete or partial denture.	640.47		
8671	Metal (e.g. Chrome cobalt or gold) partial denture	5764.29	+L	
8672	Additional fee for altered cast technique for partial denture	225.70	+L	
8674	Additive partial denture	2612.04	+L	
8679	Repairs	292.21	+L	
8273	Additional fee where impression is required for 8679	133.79	+L	
8275	Adjustment of denture (After six months or for a patient of another practitioner)	133.79	+L	

	III. SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS
	PREAMBLE
	(See Rule 011)
1. (M/W)	If extractions (codes 8201 and 8202) are carried out by specialists in maxillo- facial and oral surgery, the fees shall be equal to the appropriate tariff fee plus 50 per cent (See Modifier 8002).
2. (M/W)	The fee for more than one operation or procedure performed through the same incision shall be calculated as the fee for the major operation plus the tariff fee for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (See Modifier 8005).
3. (M/W)	The fee for more than one operation or procedure performed under the same anaesthetic but through another incision shall be calculated on the tariff fee for the major operation plus: 75% for the second procedure / operation (Modifier 8009) 50% for the third and subsequent procedures / operations (Modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee for his operation. If, within four months, a second operation for the same condition or injury is performed, the fee for the second operation shall be half of that for the first operation. The fee for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not himself complete the post-operative care, he shall arrange for it to be completed without extra charge: provided that in the case of post-operative treatment of a prolonged or specialised nature, such fee as may be agreed upon between the practitioner and the Compensation Fund may be charged.
4. (M/W)	The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum (See Modifier 8007). The assistant's fee payable to a maxillo- facial and oral surgeon shall be calculated at 33,33% of the appropriate scheduled fee (Modifier 8001). The assistant's name must appear on the invoice rendered to the Compensation Fund.
5. (M/W)	The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (8008).
6.	In cases where treatment is not listed in this schedule for general practitioners or specialists, the appropriate fee listed in the medical schedule(s) shall be charged, and the relevant medical tariff code must be indicated (See Rule 012).

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
	CONSULTATIONS AND VISITS			
8901	Consultation at consulting rooms	349.80		
8902	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation Code 8902 is a separate procedure from code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction	980.76		
8903	Consultation at hospital, nursing home or house	390.52		
8904	Subsequent consultation at consulting rooms, hospital, nursing home or house	190.62		
8905	Weekend visits and night visits between 18h00 - 07h00 the following day	562.31		
8907	Subsequent consultations, per week, to a maximum of "Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation."	645.69		

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
	INVESTIGATIONS AND RECORDS			
8107	Intra-oral radiographs, per film	122.36		
8108	Maximum for 8107	975.92		
8113	Occlusal radiographs	190.62		
8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA) A maximum of two films per treatment plan may be charged for	503.76		
8117	Study models - unmounted	137.67	+L	
8119	Study models - mounted on adjustable articulator	353.50	+L	
8121	Diagnostic photographs - per photograph	137.67		
8917	Biopsies - intra-oral	674.77		
8919	Biopsy of bone - needle	1240.78		
8921	Biopsy of bone - open	1320.66		
	ORTHOGNATHIC SURGERY AND TREATMENT PLANNING			
(M/W)	In the case of treatment planning requiring the combined services of an Orthodontist and a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.			
8840	Treatment planning for orthognathic surgery	1535.69	+L	
	REMOVAL OF TEETH Modifier 8002 is applicable to codes 8201 and 8202			
	Extractions during a single visit			
8201	Single tooth Code 8201 is charged for the first extraction in a quadrant.	190.62		T
8202	Each additional tooth in the same quadrant Code 8202 is charged for each additional extraction in the same quadrant.	87.45		T
8957	Alveolotomy or alveolectomy - concurrent with or independent of extractions (per jaw)	1703.63		
8961 (M/W)	Auto-transplantation of tooth (See Rule 011 and Notes 2 and 3)	2792.57	+L	
8931	Local treatment of post-extraction haemorrhage (excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)	935.00		
8933	Treatment of haemorrhage in the case of blood dyscrasias, e.g. hemophilia, per week	3317.26		
8935	Treatment of post-extraction septic socket where patient is referred by another registered practitioner	247.61		
8937	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap, removal of bone and / or other section of tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure. Code 8220 is applicable when suture material is provided by the practitioner (Rule 013)	863.26		

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
	Removal of roots **Code 8220 is applicable when suture material is provided by the practitioner (Rule 013)**			
8953	Surgical removal of residual roots roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.	1241.36		T
8955 (M/W)	Surgical removal of residual tooth roots (cutting procedure), each subsequent tooth Includes cutting of gingiva and bone, removal of tooth structure and closure. (See Rule 011 and Notes 2 and 3)	na/nvt		T
	Unerupted or impacted teeth			
8941	First tooth	2056.33		T
8943	Second tooth	1104.47		T
8945	Third tooth	630.96		T
8947	Fourth and subsequent tooth	630.96		T
	DIVERSE PROCEDURES			
8908	Removal of roots from maxillary antrum involving Caldwell-Luc procedure and closure of oral-antral communication	4239.27		
8909	Closure of oral-antral fistula - acute or chronic	3255.99		
8911	Caldwell-Luc procedure	1277.42		
8965	Peripheral neurectomy	2792.57		
8966	Functional repair of oronasal fistula (local flaps)	3954.23		
8977	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage) (Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure)	6638.98		
8962	Harvest illiac crest graft	2815.44		
8963	Harvest rib graft	3239.12		
8964	Harvest cranium graft	2532.16		
8979	Harvesting of autogenous grafts (intra-oral)	456.84		
9048	Removal of internal fixation devices, per site	1467.07		
	SURGICAL PREPARATION OF JAWS FOR PROSTHETICS			
8987	Reduction of mylohyoid ridges, per side	2858.69	+L	
8989	Torus mandibularis reduction, per side	2858.69	+L	
8991	Torus palatinus reduction	2858.69	+L	
8993	Reduction of hypertrophic tuberosity, per side See procedure code 8971 for excision of denture granuloma	1270.83	+L	
8995	Gingivectomy, per jaw	2535.46	+L	
8997	Sulcoplasty / Vestibuloplasty	6401.06	+L	
9003	Repositioning mental foramen and nerve, per side	3879.95	+L	
9004	Lateralization of inferior dental nerve (including bone grafting)	7692.82		
9005	Total alveolar ridge augmentation by bone graft	6513.90	+L	

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
9007	Total alveolar ridge augmentation by alloplastic material	4200.29	+L	
9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites.	2684.76	+L	
9009	Alveolar ridge augmentation across 3 or more tooth sites	2994.22	+L	
9010	Sinus lift procedure	4239.27	+L	
	SEPSIS			
9011	Incision and drainage of pyogenic abscesses (intra-oral approach)	796.93		
9013	Extra-oral approach, e.g. Ludwig's angina	1084.30		
9015	Apicectomy including retrograde filling where necessary - anterior teeth	1397.44		T
9016	Apicectomy including retrograde filling where necessary, posterior teeth	2797.99		T
9017	Decortication, saucerisation and sequestrectomy for osteomyelitis of the mandible	5753.63		
9019	Sequestrectomy - intra-oral, per sextant and / or per ramus	1239.80		
	TRAUMA			
	Treatment of associated soft tissue injuries			
9021	Minor	1397.44		
9023	Major	2950.41		
9024	Dento-alveolar fracture, per sextant	1397.44	+L	
	Mandibular fractures			
9025	Treatment by closed reduction, with intermaxillary fixation	3100.87		
9027	Treatment of compound fracture, involving eyelet wiring	4352.31		
9029	Treatment by metal cap splintage or Gunning's splints	4825.03	+L	
9031	Treatment by open reduction with restoration of occlusion by splintage	7145.24	+L	
	Maxillary fractures with special attention to occlusion			
	• When open reduction is required for Items 9035 and 9037, Modifier 8010 may be applied			
9035	Le Fort I or Guerin fracture	4362.76	+L	
9037	Le Fort II or middle third of face fracture	7145.06	+L	
9039	Le Fort III or craniofacial dislocation or comminuted mid-facial fractures requiring open reduction and splintage	10243.19	+L	
	Zygoma / Orbit / Antral - complex fractures			
9041	Gillies or temporal elevation	3100.47		
9043	Unstable and / or comminuted zygoma fractures, treatment by open reduction or Caldwell-Luc operation	6210.46		
9045	Requiring multiple osteosynthesis and / or grafting	9310.53		
	FUNCTIONAL CORRECTION OF MALOCCLUSIONS			
	For items 9047 to 9072 the full fee may be charged i.e. notes 2 and 3 (re Rule 011) will not apply.			

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
9047	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation)	13035.76	+L	
9049	Anterior segmental osteotomy of mandible (Köle)	10860.77	+L	
9050	Total subapical osteotomy	21932.10		
9051	Genioplasty	6210.46		
9052	Midfacial exposure (for maxillary and nasal augmentation or pyramidal Le Fort II osteotomy)	10047.55		
9055	Maxillary posterior segment osteotomy (Schukardt) - 1 or 2 stage procedure	10860.77	+L	
9057	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure	10860.77	+L	
9059	Le Fort I osteotomy - one piece	20479.99	+L	
9062	Le Fort I osteotomy - multiple segments	26611.13	+L	
9060	Le Fort I osteotomy with inferior repositioning and inter-positional grafting	23816.64		
9061	Palatal osteotomy	7145.24		
9063	Le Fort II osteotomy for the correction of facial deformities or faciostenosis and post-traumatic deformities	25906.89	+L	
9069	Functional tongue reduction (partial glossectomy)	4661.57		
9071	Geniohyoidotomy	2792.57		
9072	Functional closure of a secondary oro-nasal fistula and associated structures with bone grafting (complete procedure)	20479.99	+L	
	TEMPORO-MANDIBULAR JOINT PROCEDURES			
	For Items 9081, 9083 and 9092 the full fee may be charged per side			
9073	Bite plate for TMJ dysfunction	1097.88	+L	
9074	Diagnostic arthroscopy	3141.97		
9075	Condylectomy or coronoidectomy or both (extra-oral approach)	6414.05		
9076	Arthrocentesis TMJ	1879.30		
9053	Coronoidectomy (intra-oral approach)	3879.95		
9077	Intra-articular injection, per injection	466.92		
9079	Trigger point injection, per injection	367.65		
9081	Condyle neck osteotomy (Ward / Kostecka)	3100.87		
9083	Temporo-mandibular joint arthroplasty	7761.26		
9085	Reduction of temporomandibular joint dislocation without anaesthetic	616.80		
9087	Reduction of temporo-mandibular joint dislocation, with anaesthetic	1240.78		
9089	Reduction of temporo-mandibular joint dislocation, with anaesthetic and immobilisation	3100.87		
9091	Reduction of temporo-mandibular joint dislocation requiring open reduction	6519.14		
9092	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy)	21077.40	+L	
	SALIVARY GLANDS			
9095	Removal of sublingual salivary gland	3728.71		
9096	Removal of salivary gland (extra-oral)	5445.51		

III	SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS (M) See Rule 009			
Code	Procedure description	Rc FEE		MP
	IMPLANTS			
	For codes 9180 to 9192 the full fee may be charged, i.e. note 2 of Rule 011 will not apply			
9180	Placement of sub-periosteal implant - Preparatory procedure / operation	4285.98		
9181	Placement of sub-periosteal implant prosthesis / operation	4285.98		
9182	Placement of endosteal implant, per implant	2151.21	+L	
9183	Placement of a single osseo-integrated implant, per jaw	2836.01		
9184	Placement of a second osseo-integrated implant in the same jaw	2125.15		
9185	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	1417.61		
9189	Cost of implants	Reël 013		
9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	1047.66		
9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	785.70		
9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	523.15		
9046	Placement of zygomaticus fixture, per fixture	7785.05		
9198	Implant removal This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant, and closure	1741.92		
8761	Masticatory mucosal autograft extending across not more than four teeth (isolated procedure)	1894.81		
8772	Submucosal connective tissue autograft (isolated procedure)	2156.95		
8767	Bone regenerative / repair procedure at a single site *Excluding cost of regenerative material - see code 8770*	2309.95		
8769	Subsequent removal of membrane used for guided tissue regeneration procedure Codes 8761, 8767 and 8769 should be claimed only as part of implant surgery	920.27		

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REPUBLIC OF SOUTH AFRICA

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

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

35	Treating Doctor BHF practice number	9	Alpha
36	Dosage duration (for medicine)	4	Alpha
37	Tooth numbers		Alpha
38	Gender (M ,F)	1	Alpha
39	HPCSA number	15	Alpha
40	Diagnostic code type	1	Alpha
41	Tariff code type	1	Alpha
42	CPT code / CDT code	8	Numeric
43	Free Text	250	Alpha
44	Place of service	2	Numeric
45	Batch number	10	Numeric
46	Switch Medical scheme identifier	5	Alpha
47	Referring Doctor's HPCSA number	15	Alpha
48	Tracking number	15	Alpha
49	Optometry: Reading additions	12	Alpha
50	Optometry: Lens	34	Alpha
51	Optometry: Density of tint	6	Alpha
52	Discipline code	7	Numeric
53	Employer name	40	Alpha
54	Employee number	15	Alpha

Field	Description	Max length	Data Type
55	Date of Injury (CCYYMMDD)	8	Date
56	IOD reference number	15	Alpha
57	Single Exit Price (Inclusive of VAT)	15	Numeric
58	Dispensing Fee	15	Numeric
59	Service Time	4	Numeric
60			
61			
62			
63			
64	Treatment Date from (CCYYMMDD)	8	Date
65	Treatment Time (HHMM)	4	Numeric
66	Treatment Date to (CCYYMMDD)	8	Date
67	Treatment Time (HHMM)	4	Numeric
68	Surgeon BHF Practice Number	15	Alpha
69	Anaesthetist BHF Practice Number	15	Alpha
70	Assistant BHF Practice Number	15	Alpha
71	Hospital Tariff Type	1	Alpha
72	Per diem (Y/N)	1	Alpha
73	Length of stay	5	Numeric
74	Free text diagnosis	30	Alpha

TRAILER

1	Trailer Identifier = Z	1	Alpha
2	Total number of transactions in batch	10	Numeric
3	Total amount of detail transactions	15	Decimal

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