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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 939 OF 2022

DOCTORS GAZETTE 2022

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASSES ACT, 1993 (ACT NO.130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Thembelani Waltermade 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 2022.**

2. Medical Tariffs increase for **2022 is 0%.**

3. The fees appearing in the Schedule are applicable in respect of all services rendered on or after **1 April 2022** and **Exclude 15% Vat.**

MR TW NXESI MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 03/03/2022

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his/her 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/her own risk. If an employee represented to a medical service provider that he/she 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/her 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 cannot 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 invoices 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 invoices 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 medical invoices and reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury.
   1.2 A progress medical report covering a period of 30 days will be required, with an exception where a procedure was performed during that period.
   1.3 In a case where a procedure is done, an operation report is required.
   1.4 Only one medical report is required when multiple procedures are done on the same service date.
   1.5 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.
   1.6 Referrals to another medical service provider should be indicated on the medical report.

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.

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.CI 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.CI 20, accompanied by the original invoice with unpaid services clearly indicated, 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 .

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice.

5.1 If a medical service provider claims an amount less than the published tariff amount for a code, the Compensation Fund will only pay the claimed amount and the short fall will not be paid.

6. Service providers should not generate the following:

6.1 Multiple invoices for services rendered on the same date i.e one invoice for medication and second invoices for other services.

6.2 Accumulative invoices – submit a separate invoice for every month.

*** Examples of the forms (W.Cl 4 / W.Cl 5 / W.Cl 5F) are available on the website www.labour.gov.za •**

MINIMUM REQUIREMENTS FOR INVOICES RENDERED

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

- Compensation Fund claim number
- Name of employee and ID number
- Name of employer and registration number if available
- 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 invoice)
- 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 the invoice
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication invoices 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
84	Dieticians
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses
89	Social workers
90	Manufacturers of assisstive devices

GENERAL PRACTITIONER AND SPECIALIST TARIFF OF FEES AS FROM 1 APRIL 2022	
	GENERAL RULES
	PLEASE NOTE: The interpretations/comments as published in the SAMA Medical Doctors' Coding Manual (MDCM) must also be adhered to when rendering health care services under the Compensation for Occupational Injuries and Diseases Act, 1993
RULE	**DESCRIPTION**
A.	**Consultations: Definitions** (a) **New and established patients:** A consultation/visit refers to a clinical situation where a medical doctor 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 receives 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 not be coded(unless otherwise indicated). Where no procedure or operation was carried out, a hospital visit according to the appropriate hospital or inpatient follow-up visit may be coded.
B.	**Normal hours and after hours:** Normal working hours comprise the periods 08:00 to 17:00 on Mondays to Fridays, 08:00 to 13:00 on Saturdays, and all other periods voluntarily scheduled (even when for the convenience of the patient) by a medical practitioner for the rendering of services. All other periods are regarded as after hours. Public holidays are not regarded as normal working days and work performed on these days is regarded as after-hours work. Services are scheduled involuntarily for a specific time, if for medical reasons the doctor should not render the service at an earlier or later opportunity. Please note: Items 0146 and 0147 (emergency consultations) as well as modifier 0011 (emergency theatre procedures) are only applicable in the after hours period)
C.	**Comparable services:** The fee that may be charged in respect of the rendering of a service not listed in this tariff of fees or in the SAMA guideline, shall be based on the fee in respect of a comparable service. For procedures/services not in this tariff of fees but in the SAMA guideline, item 6999 (unlisted procedure or service code), should be used with the SAMA code. Motivation for the use of a comparable item must be provided. Note: Rule C and item 6999 may not be used for comparable pathology services (sections 21, 22 and 23)
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 an injured employee, the relevant consultation fee is payable by the employee.) 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 consultation may be coded for all pre-operative visits with the exception of a routine pre-operative visit at the hospital, since that routine pre-operative visit is included in the global surgical period for the procedure.
F.	**Administering of injections and/or infusions:** Where applicable, administering injections and/or infusions may only be coded when done by the medical doctor him-/herself.
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 THREE (3)months (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 the service to be rendered without extra charge. (c) When the care of post-operative treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the Compensation Fund may be charged. (d) Normal aftercare refers to uncomplicated post-operative period not requiring any further surgical incision. (e) Abnormal aftercare refers to post-operative complications and treatment not requiring any further incisions and will be considered for payment.
H.	**Removal of lesions:** Items involving removal of lesions include follow-up treatment for four months.
I.	**Pathological investigations performed by clinicians**: Fees for all pathological investigations performed by members of other disciplines (where permissible) - refer to modifier 0097: Items that resort under Clinical and Anatomical Pathology: See section for Pathology.
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. Conversely, if the fee is disproportionately high in relation to the actual services rendered, a lower fee than that in the tariff should be charged .

GENERAL PRACTITIONER AND SPECIALIST TARIFF OF FEES AS FROM 1 APRIL 2022	
	GENERAL RULES
K.	**Services of a specialist, upon referral:** Save in exceptional cases the services of a specialist shall be available only on the recommendation of the attending general practitioner. Medical practitioners referring cases to other medical practitioners shall, if known to them, indicate in the referral letter that the patient was injured in an "accident" and this shall also apply 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.	**Surgical procedure planned to be performed later:** In cases where, during a consultation/visit, a surgical procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion.
N.	**Rendering of invoices for occupational injuries and diseases**
	(a) "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
	(b) Where a fee for a service is prescribed in this guideline, the medical practitioner shall not be entitled to payment calculated on a basis of the number of visits or examinations made where such calculation would result in the prescribed fee being exceeded.
	(c) The number of consultations/visits must be in direct relation to the seriousness of the injury and should more than 20 visits be necessary, the Compensation Fund must be furnished with a detailed motivation.
	(d) A single fee for a consultation/visit shall be paid to a medical practitioner for the once-off treatment of an injured employee who thereafter passes into the permanent care of another medical practitioner, not a partner or assistant of the first. The responsibility of furnishing the First Medical Report in such a case rests with the second practitioner.
O.	**Costly or prolonged medical services or procedures**
	(a) An employee should be hospitalised only when and for the length of period that his condition justifies full-time medical assistance
	(b) Occupational therapy/Physiotherapy: The same principals as set out in modifier 0077: Two areas treated simultaneously for totally different conditions, will apply when an employee is referred to a therapist.
	(c) In case of costly or prolonged medical services or procedures the medical practitioner shall first ascertain in writing from the Compensation Fund if liability is accepted for such treatment.
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 the practitioner had to travel more than 16 kilometres in total.
	(b) If more than one patient is 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 is more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such a hospital, 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).
	INTENSIVE CARE
	RULES GOVERNING THIS SPECIFIC SECTION OF THE TARIFF CODE
Q.	**Intensive care/High care:** Units in respect of item codes 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 fee for the initial assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive care/high care unit
	(b) Cost of any drugs and/or materials
	(c) Any other cost that may be incurred before, during or after the consultation/visit and/or the therapy
	(d) Blood gases and chemistry tests, including arterial puncture to obtain specimens
	(e) Procedural item codes 1202 and 1212 to 1221
	but INCLUDE the following
	(f) Performing and interpreting of a resting ECG (g) Interpretation of blood gases, chemistry tests and x-rays
	(h) Intravenous treatment (item codes 0206 and 0207)
R.	**Multiple organ failure:** Units for item codes 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include item 1211: Cardio-respiratory resuscitation

GENERAL PRACTITIONER AND SPECIALIST TARIFF OF FEES AS FROM 1 APRIL 2022	
	GENERAL RULES
S.	**Ventilation:** Units for item codes 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) Setting up and coupling patient to machine: setting machine, synchronising patient with machine (d) Instruction to nursing staff (e) All subsequent visits for the first 24 hours
T.	Ventilation (item codes 1212 to 1214) does not form part of normal post-operative care, but may not be added to item code 1204: Catogory 1: Cases requiring intensive monitoring.
	RULES GOVERNING THE SECTION RADIOLOGY: MAGNETIC RESONANCE IMAGING
NOTE	In the event of Complex medical cases(Poly-trauma, Traumatic Brain injury, Spinal injuries, etc.), the first Radiological investigations(e.g MRI, CT scan, Ultrasound and Angiography), Authorisation will not be required provided there was a valid indication. All second and Subsequent specialised Radiological investigations for Complex medical cases,will need a pre-authorisation. Non-Complex medical cases/elective cases will need pre-authorisation for all specialised radiological investigations.
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY
	Note (a) Prior approval must be obtained from the Compensation Fund before any treatment resorting under this section is carried out (b) Where approval has been obtained, treatment must be limited to 12 sessions only, after which the patient must be referred back to the referring doctor for an evaluation and report to the Compensation Fund.
Va.	**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.
Vb.	When adding psychotherapy items to a first or follow-up consultation item, the clinician must ensure that the time stipulated in the psychotherapy items are adhered to (i.e. item 2957 - minimum 10 minutes, item 2974 - minimum 30 minutes, and item 2975 - minimum 50 minutes)
	RULES GOVERNING THE SECTION RADIOLOGY
Z.	No fee is to subject to more than one reduction
	RULE GOVERNING THE SUBSECTION ON DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIO-ISOTOPES
AA.	Procedures exclude the cost of isotope used
	RULE GOVERNING THE SECTION RADIATION ONCOLOGY
BB.	The units in the radiation oncology section do NOT include the cost of radium or isotopes.
	RULE GOVERNING ULTRASOUND EXAMINATIONS
EE.	(a) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner performing the scan. A copy of the letter of motivation must be attached to the first account rendered to the Compensation Fund by the Radiologist. (b) In case of a referral to a Radiologist, no motivation is required from the Radiologist himself/herself.
	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 transuretral (T U R) prostatectomy. (b) When a cystoscopy preceeds 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 code 1949: Cystoscopy, when performed together with any of item codes 1951 to 1973**
	RULE GOVERNING THE SECTION RADIOLOGY
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.

MODIFIER DESCRIPTIONS AND STANDARDS	
Addition Modifier (AM)	This modifier will add a value by using a percentage value or a unit value to a procedure code. The modifier should be quoted on a separate line with its own value instead of adding its value to the code.
Compound modifiers (CM)	The modifier should be quoted on a separate line with its own value at the end of the invoice instead of adding its value to the code. It should be indicated on each procedure code where the modifier is applicable.
Reduction Modifiers (RM)	This modifier reduces the value of a procedure code/s by using a percentage or unit value.It should be quoted on the procedure codes where the modifier is applicable.
Information Modifier (IM)	Information Modifier (IM)

MODIFIER	DESCRIPTION		Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R	T
	MODIFIER GOVERNING THE RADIOLOGY AND RADIATION ONCOLOGY SECTIONS OF THE TARIFF CODES							
0001	**Emergency or unscheduled radiological services:** For emergency or unscheduled radiological services (Refer to rule B) the additional fee shall be 50% of the fee for the particular service (section 19.12: Portable unit examinations excluded). Emergency and unscheduled MR scans, a maximum levy of 100.00 Radiological units is applicable.	*100*	2 967.00					
	MODIFIER GOVERNING A RADIOLOGIST REQUESTED TO PROVIDE A REPORT ON X-RAYS							
0002	**Written report on X-rays:** The lowest level item code for a new patient (consulting rooms) consultation is applicable only when a radiologist is requested to provide a written report on X-rays taken elsewhere and submitted to him. The above mentioned item code and the lowest level item code for an initial hospital consultation are not to be utilised for the routine reporting on X-rays taken elsewhere.							
0005	**Multiple therapeutic procedures/operations under the same anaesthetic** (a) Unless otherwise identified in the tariff structure , when multiple procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identifiable 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 case of multiple fractures and/or dislocations the above values also prevail . (c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedure 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 procedures and provide a diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other therapeutic procedures performed under the same anaesthetic. (d) Please note: When more than one small procedure is performed and the tariff makes provision for item codes 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) Plus ("+") 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) **APPLICATION OF MODIFIER 0005 IN CASES WHERE BONE GRAFT PROCEDURES AND INSTRUMENTATION ARE PERFORMED IN COMBINATION WITH ARTHRODESIS (FUSION)** (f) 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 additionally. (g) Modifier 0005 (Multiple procedures/operations under the same anaesthetic) would be applicable when an arthrodesis is performed in addition to another procedure, e.g. osteotomy or laminectomy.							

0006	A 25% reduction in the fee for a subsequent operation for the same condition within one month shall be applicable if the operations are performed by the same surgeon (an operation subsequent to a diagnostic procedure is excluded). After a period of one month the full fee is applicable.							
0007	(a) **Use of own monitoring equipment in the rooms:** Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – Add 15.00 clinical procedure units irrespective of the number of items of equipment provided [Modifier 0074 and modifier 0075 may be used in conjunction with modifier 0007(a)].	15	**425.55**	15	**425.55**			
	(b) **Use of own equipment in hospital or unattached theatre unit:** Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - Add 15.00 clinical procedure units irrespective of the number of items of equipment provided [Modifier 0074 and modifier 0075 may not be used in conjucttion with modifier 0007(b)].							
	(c) Use of own equipment by **Audiologists** in the rooms: Basic sound booth. - Used once per claim for compensation purposes. - To be added to the consultation fee, with a descriptor.	4.76	**135.04**	4.76	**135.04**			
0008	**Specialist surgeon assistant:** The units of the procedure(s) for a specialist surgeon acting as assistant surgeon in procedures of specialised nature, is 40% of the units for the procedure(s) performed by specialist surgeon.							
0009	**Assistant:** The units for an assistant are 20% of the units of that of a specialist surgeon, with a minimum of 36.00 clinical procedure units. The minimum units payable may not be less than 36.00 clinical procedures units.	36	**1 021.32**	36	**1 021.32**			
0010	**Local anaesthesic**							
	(a) A fee for a local anaesthetic administered by the practitioner may only be charged for (1) an operation or a procedure with a value of 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 of greater than 50.00 clinical procedure units.	31	**879.47**	31	**879.47**			
	(b) The fee for a local anaesthetic administered 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 0035: Anaesthetic administered by an anaesthesiologist/ anaesthetist, shall be applicable in such a case.	50	**1 418.50**	50	**1 418.50**			
	(c) The fee for a local anaesthetic administered is not applicable to radiological procedures such as angiography and myelography.							
	(d) No fee may be levied for the topical application of local anaesthetic.							
	(e) Please note: Modifier 0010: Local anaesthetic administered by the operator may not be added onto the surgeon's account for procedures that were performed under general anaesthetic.							
0011	**Theatre procedures for emergency surgery:** 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. (Definition: 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).	12	**340.44**	12	**340.44**	12	**340.44**	

0013	**Endoscopic examinations done at operations**: Where a related endoscopic examination is performed at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be coded.							
0014	**Operations previously performed by other surgeons** (a) Use modifier 0014(a) for information only as an indicator that the operation was previously performed by another surgeon. (b) Where an operation is performed which has previously been performed by another surgeon, e.g. a revision or repeat operation, the fee maybe calculated according to the tariff for the full operation plus an additional fee to be negotiated under general rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff structure.							
	INJECTIONS, INFUSIONS AND INHALATION SEDATION MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF CODE							
0015	**Intravenous infusions**: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after an operation, no extra fees shall be charged as the after-treatment is included in the global fee for the procedure. Should the practitioner performing the operation prefer to request another practitioner to perform post-operative intravenous infusions, the practitioner himself (and not the Compensation Fund) shall be responsible for remunerating such practitioner for the infusions.							
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections <u>as part of a planned series of injections</u> for the same condition should be charged according to item 0131 (not coded together with a consultation item).							

	MODIFIER GOVERNING SURGERY ON PERSONS WITH A BODY MASS INDEX (BMI) OF MORE THAN 35							
0018	Surgical modifier for persons with a BMI of higher than 35 (calculated according to kg/m2 = weight in kilograms divided by height in metres squared): Fee for the procedure +50% of the fee for surgeons; 50% increase in anaesthetic time units for anaesthesiologists.							
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHESIA FOR ALL THE PROCEDURES AND OPERATIONS INCLUDED IN THIS GUIDE TO TARIFFS							
0021	**Determination of anaesthetic fees:** Anaesthetic fees are determined by adding the basic anaesthetic units (allocated to each procedure that can be performed under anaesthesia indicated in the anaesthetic column[refer to modifier 0027 for more than one procedure under the same anaesthetic])) and the time units (calculated according to the formula in modifier 0023) and the appropriate modifers (see modifiers 0037-0044). In case of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures or dislocations, add units as laid down by modifiers 5441 to 5448.							
0023	The basic anaesthetic units are laid down in the guide to tariffs and are reflected in the anaesthetic column. These basic anaesthetic units reflect the 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 anaesthesia, at 2.00 anaesthetic units is per 15 minute period or part thereof for the first hour. Should the duration of the anaesthesia be longer than one (1) hour the number of units shall be increased to 3.00 anaesthetic units per 15 minute period or part thereof after the first hour.			2	**265.12**	2	**265.12**	
0024	**Pre-operative assessment not followed by a procedure:** If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, the assessment will be regarded as a consultation at a hospital or nursing home and the appropriate hospital consultation fee should be charged.			3	**397.68**	3	**397.68**	
0025	**Calculation of anaesthesia time:** Anaesthesia time is calculated from the time that 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 nursing supervision. Where prolonged personal professional attention is necessary for the well-being and safety of a patient, the additional time spent can be charged for at the same rate as indicated above for anaesthesia time. The anaesthesiologist/anaesthetist must record the exact anaesthesia time and the additional time spent supervising the patient on the invoice submitted.							
0027	**More than one procedure under the same anaesthesia:** Where more than one operation is performed under the same anaesthesia, the basic anaesthetic units will be that of the operation/procedure with the highest number of anaesthetic units.							
0029	**Assistant anaesthesiologists:** When it is required by the scope of the anaesthesia, an assistant anaesthesiologist/anaesthetist may be employed. The units for the assistant anaesthesiologist/anaesthetist shall be calculated on the same basis as in the case where a general practitioner administered the anaesthesia.							
0031	Intravenous infusion and transfusions:Treatment with intravenous drips and transfusions rendered either prior to, or during actual theatre or operating time, is considered part of the normal treatment in administering an anaesthetic.							
0032	Patients in the prone position: Anaesthesia administered to patients in the prone position shall carry a minimum of 5.00 basic anaesthetic units. When the basic anaesthetic units for the procedure are 3.00, two additional anaesthetic units should be added. If the basic anaesthetic units for the procedure are 5.00 or more, no additional units should be added.							

0033	**Participating in the 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 anaesthesia, such services may be remunerated at full anaesthetic rate, subject to the provisions of modifier 0035: Anaesthetic administered by a specialist anaesthesiologist/ anaesthetist and modifier 0036: Anaesthetic administered by a general practitioner			2	265.12	2	265.12	
0034	**Head and neck procedures:** All anaesthesia administered for diagnostic, surgical or X-ray procedures on the head and neck shall carry a minimum of 4.00 basic anaesthetic units. When the basic anaesthetic units for the procedure are 3.00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure are 4.00 or more, no extra units should be added.			1	132.56	1	132.56	
0035	**Anaesthesia administered by an anaesthesiologist/ anaesthetist:** No anaesthesia administered by an anaesthesiologist/anaesthetist shall carry a total value of less than 7.00 anaesthetic units comprising basic units, time units and the appropriate modifiers.		TO	4 7	530.24 927.92	4 7	530.24 927.92	
0036	**Anaesthesia administered by general practitioners:** The anaesthetic units (basic units plus time units plus the appropriate modifiers) used to calculate the fee for anaesthesia administered by a general practitioner lasting one hour or less shall be the same as that for an anaesthesiologist. For anaesthesia lasting more than one hour, the units used to calculate the fee for anaesthesia administered by a general practitioner will be 4/5 (80%) of that applicable to a specialist anaesthesiologist, provided that no anaesthesia lasting longer than one hour shall carry a total value of less than 7.00 anaesthetic unit. Please note that the 4/5 (80%) principle will be applied to all anaesthesia administered by general practitioners with the provision that no anaesthesia totalling more than 11.00 units would be reduced to less than 11.00 units in total. The monetary value of the unit is the same for both anaesthesiologists/anaesthetists. **Note:** Modifying units may be added to the basic anaesthetic unit value according to the following modifiers (0037-0044, 5441-5448).			7	927.92	7	927.92	
0037	**Body hypothermia:** Utilisation of total body hypothermia: Add 3.00 anaesthetic units.			3	397.68	3	397.68	
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.			4	530.24	4	530.24	
0039	Deliberate control of blood pressure: All cases up to one hour: Add 3.00 anaesthetic units, thereafter add 1 (one) additional anaesthetic unit per quarter hour (15 Min) or part thereof (PLEASE INDICATE THE TIME IN MINUTES).			3	397.68	3	397.68	
0041	**Hyperbaric pressurisation:** Utilisation of hyperbaric pressurisation: Add 3.00 anaesthetic units .		+	1 3	132.56 397.68	1 3	132.56 397.68	
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3.00 anaesthetic units.			3	397.68	3	397.68	
	MUSCULO-SKELETAL SYSTEM **MODIFIERS GOVERNING ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS** **Modifiers 5441 to 5448** Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items).							
5441	Add one (1.00) anaesthetic unit, except where the procedure refers to the skeletal bones named in modifiers 5442 to 5448.			1	132.56	1	132.56	
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.			2	265.12	2	265.12	
5443	Maxillary and orbital bones: Add three (3.00) anaesthetic units.			3	397.68	3	397.68	
5444	Shaft of femur: Add four (4.00) anaesthetic units			4	530.24	4	530.24	
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5.00) anaesthetic units.			5	662.80	5	662.80	
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8.00) anaesthetic units.			8	1060.48	8	1060.48	

0045	**Post-operative alleviation of pain** (a) When a regional or nerve block is performed in theatre for post-operative pain relief, the appropriate procedure item (items 2799-2804) will be charged, provided that it was not the primary anaesthetic technique (b) When a regional or nerve block procedure is performed in the ward or nursing facility, the appropriate procedure item (items 2799-2804) will be charged, provided that it was not the primary anaesthetic technique. (c) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain in the ward or nursing facility, it will be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. (d) None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID's (non-steroidal anti-inflammatory drugs).										

	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST UTILISING AN INTRA-AORTIC BALLOON PUMP (CARDIOVASCULAR SYSTEM)							
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.					75	**2 127.75**	
	MUSCULO-SKELETAL SYSTEM							
	MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF							
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, the full fee for the initial treatment is applicable.							
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis PROVIDED that the cumulative amount does NOT exceed the fee for a reduction.							
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).	27	**765.99**	27	**765.99**			
0049	Except where otherwise specified, in cases of compound [open] fractures, 77.00 clinical procedure units (specialists and general practitioners) are to be added to the units for the fractures including debridement [a fee for the debridement may not be charged for separately].	77	**2 184.49**	77	**2 184.49**			
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists and general practitioners add 77.00 clinical procedure units.	77	**2 184.49**	77	**2 184.49**			
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 to the appropriate procedure code.	81.1	**2 300.81**	81.1	**2 300.81**			
0053	Fractures requiring percutaneous internal fixation [insertion and removal of fixatives (wires) into of fingersand toes]: Specialists and general practitioners add 32.00 clinical procedure units.	32	**907.84**	32	**907.84**			
0055	Dislocation requiring open reduction: Units for the specific joint plus 77.00 clinical procedure units for specialists and general practitioners.	77	**2 184.49**	77	**2 184.49**			
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 by 50% and add to the total for the first foot.							
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers)							
	MODIFIER GOVERNING COMBINED PROCEDURES ON THE SPINE							
0061	**Combined procedures on the spine:** In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full units for the relevant part of the operation performed by him/her. Each surgeon may be remunerated as an assistant for the procedures performed by the other surgeon, at general practitioner units (refer to modifier 0009).							
	MODIFIERS GOVERNING THE SUBSECTION REPLANTATION SURGEY							
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the units for the procedure.							
0064	Where a replantation procedure (or toe to thumb transfer) is unsuccessful no further surgical fee is payable for amputation of the non-viable parts.							

	MODIFIER GOVERNING THE SECTION LARYNX							
0067	Microsurgery of the larynx: Add 25% to the fee for the procedure performed. (For other operations requiring the use of an operation microscope, the fee shall include the use of the microscope, except where otherwise specified in the Tariff Guide).							
	MODIFIERS GOVERNING NASAL SURGERY							
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee for the procedure performed. Only applicable to items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.							
	MODIFIER GOVERNING OPEN PROCEDURE(S) WHEN PERFORMED THROUGH THORACOSCOPE							
0070	Add 45.00 clinical procedure units to procedure(s) performed through a thoracoscope.	45	**1 276.65**	45	**1 276.65**			
	MODIFIER GOVERNING FEES FOR ENDOSCOPIC PROCEDURES							
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33,33% (1/3) of that fee (plus ("+") codes excluded) will apply where endoscopic procedures are performed with own equipment.							
0075	Endoscopic procedures performed in own procedure room: (a)The units plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in own procedure rooms. (b)This modifier is chargeable by medical doctors who own or rent the facility. (c)Please note:Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff guide	21	**595.77**	21	**595.77**			
	MODIFIER GOVERNING THE SECTION ON PHYSICAL TREATMENT							
0077	(a) When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatment modalities for which separate fees may be charged (Only applicable if services are provided by a specialist in physical medicine). (b) The number of treatment sessions for a patient for which the Commissioner shall accept responsibility is limited to 20. If further treatment sessions are necessary liability for payment must be arranged in advance with the Compensation Fund. **Note**: Physiotherapy administered by a non-specialist medical practitioner who is already in charge of the general treatment of the employee concerned, or by any partner, assistant or employee of such practitioner, or any other practitioner or radiologist should be embarked upon only with the express approval of the Commissioner. Such approval should be requested in advance.							
	MODIFIER GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY							
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (Items 2957, 2974 or 2975): Individual psychotherapy (specify type).							
	MODIFIERS GOVERNING THE SECTION DIAGNOSTIC RADIOLOGY							
0080	Multiple examinations: Full Fee **Note in respect of fees payable when X-rays are taken by general practitioners** If the services of a radiologist were normally available, it is expected that these should be utilised. Should circumstances be unfavourable for obtaining such services at the time of the first consultation, the general practitioner may take the initial X-ray photograph himself provided he submitted a report to the effect that it was in the best interest of the employee for him to have done so. Subsequent X-ray photographs of the same injury, however, must be taken by a radiologist who has to submit the relevant reports in the normal manner. 1. When a general practitioner takes X-ray photographs with his own equipment, if the services of a specialist radiologist were not available, he may claim at the prescribed fee.							

	2. (i) If a general practitioner ordered an X-ray examination at a provincial hospital where the services of a specialist radiologist are available, it is expected that the radiologist shall read the photographs for which he is entitled to one third of the prescribed fee. (ii) If the radiographer of the hospital was not available and the general practitioner had to take the X-ray photographs himself, he may claim 50% of the prescribed fee for the service. In that case, however, he should get written confirmation of his X-ray findings from the radiologist as soon as possible. The radiologist may then claim one third of the prescribed fee for such service. 3. If a general practitioner ordered an X-ray examination at a provincial hospital where no specialist radiological services are available, the general practitioner will not be paid for reading the X-ray photographs as such a service is considered to be an integral part of routine diagnosis, but if he was requested by the Compensation Fund to submit a written report on the X-ray findings, he may claim two thirds of the prescribed fee in respect thereof. 4. If a general practitioner had to take and read X-ray photographs at a provincial hospital where the services of a radiographer and a specialist radiologist are not available he/she may claim 50% of the prescribed fee for such service.								
0084	**Charging for films and thermal paper by non-radiologists:** 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@lafrica.com).								
0085	**Left side:** Add to items 6500-6519 as appropriate when the left side is examined. The absence of the modifier indicates that the right side is examined.								
	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 an increase in terms of modifier 0080: Multiple examinations. **PLEASE NOTE**: Modifier 0083 is not applicable to Section 19.8 of the tariff. **Rules applicable to vascular studies** (a) The machine fee (items 3536 to 3550) includes the cost of the following All runs (runs may not be billed for separately) All film costs (modifier 0084 is not applicable) All fluoroscopies (item 3601 does not apply) All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, anti-embolic agents, drugs and contrast media). (b) The machine fee (item codes 3536 to 3550) may only be charged for once per case per day by the owner of the equipment and is only applicable to radiology practices. (c) If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the theam should charge at their respective full rates as per modifiers and the applicable codes.								
	MODIFIERS GOVERNING THE SECTION PATHOLOGY								
0097	**Pathology tests performed by non-pathologists:** Where item codes resorting under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee should be charged at two-thirds of the pathologists tariff								

CODE	DESCRIPTION		Specialist U	Specialist R	General Practitioner U	General Practitioner R	Anaesthetic U	Anaesthetic R	Anaesthetic T
I. CONSULTATIONS									
	The amounts in this section are calculated according to the **Consultation Services** unit values, 0181, 0182, 0183, 0184, 0186 and 0151								
GENERAL PRACTITIONERS AND ALL SPECIALISTS									
	a. Only one of items 0181-0186 as appropriate may be charged for a single service and not combinations thereof b. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration c. Only item 0146 may be charged as appropriate thereof d. A subsequent visit refers to a voluntarily scheduled visit performed for the same condition within four (4) months after the first visit (although the symptoms or complains may differ from those presented during the first visit e. Items 0181,0182, 0183, 0184 and 0186 include renumeration for the completion of the first, progress and final medical reports. Item 0186 may be charged for a visit to complete a final medical report								
	NEW PATIENT (NB: Indicate time in minutes)								
0181	Visit for a new problem / new patient with problem focused history, examination and management up **20 minutes**		*16.5*	**476.85**	*15*	**433.50**			
0182	Visit for a new problem / new patient with problem focused history, examination and management up **30 minutes**		*31.5*	**910.35**	*30*	**867.00**			
0183	Visit for a new problem / new patient with problem focused history, examination and management up **45 minutes**		*36*	**1 040.40**	*33*	**953.70**			
	FOLLOW-UP VISIT								
0184	Follow-up visit for the evaluation and management of a patient		*16.5*	**476.85**	*15*	**433.50**			
	FINAL VISIT								
0186	Follow-up visit for the evaluation and management of a patient with a Final Medical Report **(Rule G not applicable)**		*31.5*	**910.35**	*30*	**867.00**			
CONSULTATIONS: SPECIALISTS AND GENERAL PRACTITIONERS									
0145	For consultation / visit away from the doctor's home or rooms: ADD to item 0181. Confirm where visit took place. Please note that item 0145 not applicable for pre-anaesthetic assessments and may not be added to items 0151	+	*6*	**170.22**	*6*	**170.22**			
0146	Emergency or unscheduled consultation/visit at the doctors home or rooms: ADD to items 0181, 0182 and 0183 as appropriate **(General Rule B refers)**	+	*8*	**226.96**	*8*	**226.96**			
0147	For after hours emergency or unscheduled consultation/ visit away from the doctor's home or rooms: ADD to items 0181, 0182 and 0183 appropriate **(General Rule B refers)**	+	*14*	**397.18**	*14*	**397.18**			
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 0146 or ICU items 1204-1214)		*15*	**425.55**	*15*	**425.55**			
	PRE-ANAESTHETIC ASSESSMENT a. Pre-anaesthetic consultations for all major vascular, cardio-thorack and orthopaedic cases will attract a unit value of at least 32.00 units b. Only item 0146 may be charged								
0151	Pre-anaesthetic assessment of patient(all hours). Problem focused history, clinical examination and decision making		*32*	**924.80**	*32*	**924.80**			
	GENERAL								
0136	Special medical examination requested by the Compensation Commissioner (Section 42) **Note :** - Amount applicable from 2003/03/03 until 2005/01/27 (VAT inclusive) - Amount applicable from 2005/01/28 until 31/03/2014 (VAT inclusive) - Amount applicable from 2014/04/01 until 31/03/2019 (VAT inclusive)		*200*	**5 674.00** **1 100.00** **1 850.00** **3 500.00**					

CODE	DESCRPTION	Specialist U	Specialist R	General Practitioner U	General Practitioner R	Anaesthetic U	Anaesthetic R	Anaesthetic T
II. MEDICINE, MATERIAL, AND SUPPLIES								
0201	Medicine, material and/or unregistered/unscheduled products used during treatment: To be used for all medicine, material and/or unregistered/unscheduled products using in treatment.							
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 l charged for according to item 0201	*10*	**283.70**	*10*	**283.70**			
0194	Procurement cost for human donor material. No mark up is allowed. Only applicable to Opthalmologist, invoice to be attached							

		Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R T
III.	**PROCEDURES** The amounts in this section are calculated according to the **Clinical Procedure** unit values						
	UNLISTED PROCEDURE/SERVICE						
6999	Unlisted procedure/service code: A procedure/service may be provided that is not listed in the Compensation Fund tariffs.Please quote the correct SAMA code with item 6999						
1.	**INTRAVENOUS TREATMENT**						
1.1	**Injections and Infusions**						
0206	Intravenous infusions (push-in) Insertion of cannula - chargeable once per 24 hour	*6*	**170.22**	*6*	**170.22**		
0207	Intravenous infusions (cut-down): Cut-down and insertion of cannula - chargeable once per 24 hours	*8*	**226.96**	*8*	**226.96**		
	Note: How to charge for Intravenous Infusions Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours) For managing the infusion as such e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultation						
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	3.25	**92.20**	3.25	**92.20**		
2.	**INTEGUMENTARY SYSTEM**						
2.1	**Allergy**						
0217	Allergy: Patch tests: First patch	*4*	**113.48**	*4*	**113.48**		
0219	Allergy: Patch tests: Each additional patch. Add to code 0217, code cannot be billed alone	*2*	**56.74**	*2*	**56.74**		
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs	*2.8*	**79.44**	*2.8*	**79.44**		
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens. Only a maximum of five can be charged.	*1.9*	**53.90**	*1.9*	**53.90**		
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen Only a maximum of five can be charged.	*2.8*	**79.44**	*2.8*	**79.44**		
2.2	**Skin (general)**						
0255	Drainage of subcutaneous abscess, onychia, paronychia, pulp space or avulsion of nail	*20*	**567.40**	*20*	**567.40**	*3*	**397.68** +T
0257	Drainage of major hand or foot infection; drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	*87*	**2 468.19**	*87*	**2 468.19**	*3*	**397.68** +T
0259	Removal of foreign body superficial to deep fascia (except hands)	*20*	**567.40**	*20*	**567.40**	*3*	**397.68** +T
0260	Incision/removal of foreign body: Subcutaneous tissue, complicated	*55.50*	**1 574.54**	*55.50*	**1 574.54**	*3*	**397.68** +T
0261	Removal of foreign body deep to deep fascia (except hands). **Note:** See item 0922 and 0923 for removal of foreign bodies in hands	*31*	**879.47**	*31*	**879.47**	*3*	**397.68** +T
2.3	**Major plastic repair** **Note:** The tariff does not cover elective or cosmetic operations, since these procedures may not have the effect of reducing the percentage of permanent disablement as laid down in the Second Schedule to the Act. It is incumbent upon the treating doctor to obtain the prior consent of the Commissioner before embarking upon such treatment						
0288	Harvesting of graft: Fascia lata graft, complex or sheet	127.40	**3 614.34**	120	**3 404.40**	*4*	**530.24** +T
0289	Large skin graft, composite skin graft, large full thickness free skin graft	*234*	**6 638.58**	*187.2*	**5 310.86**	*4*	**530.24** +T
0290	Reconstructive procedures (including all stages) and skingraft by myo-cutaneous or fascio-cutaneous flap	*410*	**11 631.70**	*328*	**9 305.36**	*4*	**530.24** +T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	*800*	**22 696.00**	*640*	**18 156.80**	*4*	**530.24** +T
0292	Distant flaps: First stage	*206*	**5 844.22**	*164.8*	**4 675.38**	*4*	**530.24** +T
0293	Contour grafts (excluding cost of material)	*206*	**5 844.22**	*164.8*	**4 675.38**	*4*	**530.24** +T
0294	Vascularised bone graft with or without soft tissue with one or more sets micro-vascular anastomoses	*1200*	**34 044.00**	*960*	**27 235.20**	*6*	**795.36** +T
0295	Local skin flaps (large, complicated)	*206*	**5 844.22**	*164.8*	**4 675.38**	*4*	**530.24** +T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0296	Other procedures of major technical nature		206	5 844.22	164.8	4 675.38	4	530.24	+T
4862	Full thickness graft of the trunk, freegrafting including direct closure of donor site <=20cm ^{2}		136.50	3 872.51	120.00	3 404.40	5	662.80	+T
4863	Full thickness graft of the trunk, freegrafting including closure of donor site, each addditional 20cm ^{2} (modifier 0005 not applicable)		25.60	726.27	25.60	726.27	5	662.80	+T
4864	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site <=20cm ^{2}		140.30	3 980.31	120.00	3 404.40	5	662.80	+T
4865	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site, each addditional 20cm ^{2} (modifier 0005 not applicable)		23.00	652.51	23.00	652.51	5	662.80	+T
4866	Full thickness graft of the face, neck,axilla, genitalia, hands and /or feet , free grafting including donor site:<=20cm ^{2}		163.40	4 635.66	130.72	3 708.53	5	662.80	+T
4867	Full thickness graft of the face, neck,axilla, genitalia, hands and /or feet , free grafting including direct closure of donor site, each additional 20cm ^{2} (modifier 0005 not applicable)		36.20	1 026.99	36.20	1 026.99	5	662.80	+T
4868	Full thickness graft of the nose,ears, eyelids, and /or lips free grafting including direct closure of donor site: <=20cm ^{2} ●		183.50	5 205.90	146.80	4 164.72	5	662.80	+T
4869	Full thickness graft of the nose,ears, eyelids, and /or lips free grafting including direct closure of donor site; each additional 20cm ^{2} (modifier 0005 not applicable)		43.10	1 222.75	43.10	1 222.75	5	662.80	+T
2.4	**Lacerations, scars, cysts and other skin lesions**								
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care		14	397.18	14	397.18	3	397.68	+T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)		7	198.59	7	198.59	3	397.68	+T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage		64	1 815.68	64	1 815.68	4	530.24	+T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage		128	3 631.36	120	3 404.40	4	530.24	+T
0304	Major debridement of wound, sloughectomy or secondary suture		50	1 418.50	50	1 418.50	3	397.68	+T
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		13.9	394.34	13.9	394.34	3	397.68	+T
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof	+	5.3	150.36	5.3	150.36	3	397.68	+T
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		36	1 021.32	36	1 021.32	5	662.80	+T
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof	+	11.2	317.74	11.2	317.74	5	662.80	+T
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		62.5	1 773.13	62.5	1 773.13	6	795.36	+T+M
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof	+	19.5	553.22	19.5	553.22	6	795.36	+T+M
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude		27	765.99	27	765.99	3	397.68	+T
0308	Each additional small procedure done at the same time		14	397.18	14	397.18	3	397.68	+T
0310	Radical excision of nailbed		38	1 078.06	38	1 078.06	3	397.68	+T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude		104	2 950.48	104	2 950.48	4	530.24	+T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude		55	1 560.35	55	1 560.35	3	397.68	+T
4856	Split thickness autograft of the trunk, arms and/or legs <=100 ^{2} cm		153.6	4 357.63	122.88	3 486.11	5	662.80	+T
4857	Split thickness autograft of the trunk, arms and/or legs; each additional 100^2 cm or part thereof (modifier 0005 not applicable)	+	31.5	893.66	31.5	893.66	5	662.80	+T
4858	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100^2 cm		172	4 879.64	137.6	3 903.71	5	662.80	+T
4859	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 ^{2} cm or part thereof (modifier 0005 not applicable) vingers of tone	+	51.6	1 463.89	51.6	1 463.89	5	662.80	+T
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100 ^{2} cm		66.3	1 880.93	66.3	1 880.93	5	662.80	+T
4873	Acellular dermal allograft of the trunk, arms and/or legs; each additional 100 ^{2} cm or part thereof (modifier 0005 not applicable)	+	15.3	434.06	15.3	434.06	5	662.80	+T
4874	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 ^{2} cm		74	2 099.38	74	2 099.38	5	662.80	+T
4875	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 ^{2} cm or part thereof (modifier 0005 not applicable)	+	21.8	618.47	21.8	618.47	5	662.80	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
2.6	**Burns**							
0345	Minor burns (Discontinued)							
0347	Moderate burns (Discontinued)							
0351	Major burns: Resuscitation (including supervision and intravenous therapy - first 48 hours)	*276*	**7 830.12**	*220.8*	**6 264.10**	*5*	**662.80**	+T
0353	Tangential excision and grafting: Small	*100*	**2 837.00**	*100*	**2 837.00**	*5*	**662.80**	+T
0354	Tangential excision and grafting: Large ●	*200*	**5 674.00**	*160*	**4 539.20**	*5*	**662.80**	+T
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 flap e.g. Cutler	*147.40*	**4 181.74**	*120*	**3 404.40**	*4*	**530.24**	+T
0357	Small skin graft in acute hand injury	*45*	**1 276.65**	*45*	**1 276.65**	*3*	**397.68**	+T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	*192*	**5 447.04**	*153.6*	**4 357.63**	*3*	**397.68**	+T
0361	Z-plasty	*220.1*	**6 244.24**	*176.08*	**4 995.39**	*3*	**397.68**	+T
0363	Local flap and skin graft	*150*	**4 255.50**	*120*	**3 404.40**	*3*	**397.68**	+T
0365	Cross finger flap (all stages)	*192*	**5 447.04**	*153.6*	**4 357.63**	*3*	**397.68**	+T
0367	Palmarflap (all stages)	*192*	**5 447.04**	*153.6*	**4 357.63**	*3*	**397.68**	+T
0369	Distant flap: First stage	*158*	**4 482.46**	*126.4*	**3 585.97**	*3*	**397.68**	+T
0371	Distant flap: Subsequent stage (not subject to General Modifier 0005)	*77*	**2 184.49**	*77*	**2 184.49**	*3*	**397.68**	+T
0373	Transfer neurovascular island flap	*230.5*	**6 539.29**	*184.4*	**5 231.43**	*3*	**397.68**	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3. MUSCULO-SKELETAL SYSTEM								
3.1	**Bones**							
3.1.1	**Fractures**							
0383	Fracture (reduction under general anaesthetic): Scapula	112.30	3 185.95	112.30	3 185.95	3	397.68	+T+M
0384	Fracture: Scapula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	284.2	8 062.75	227.36	6 450.20	3	397.68	+T+M
0386	Fracture: Clavicle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	209.4	5 940.68	167.52	4 752.54	3	397.68	+T+M
0387	Fracture (reduction under general anaesthetic): Clavicle	93.80	2 661.11	93.80	2 661.11	3	397.68	+T+M
0388	Percutaneous pinning supracondylar fracture elbow - stand alone procedure	175.70	4 984.61	140.56	3 987.69	3	397.68	+T+M
0389	Fracture (reduction under general anaesthetic): Humerus	129.60	3 676.75	129.60	3 676.75	3	397.68	+T+M
0390	Fracture: Humerus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	255.3	7 242.86	204.24	5 794.29	3	397.68	+T+M
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	135.7	3 849.81	120	3 404.40	3	397.68	+T+M
0392	Open reduction of both radius and ulna (Modifier 0051 not applicable)	193.50	5 489.60	154.80	4 391.68	3	397.68	+T+M
0401	Fracture: Carpal bone: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	208.7	5 920.82	166.96	4 736.66	3	397.68	+T+M
0402	Fracture (reduction under general anaesthetic): Carpal bone	64	1 815.68	64	1 815.68	3	397.68	+T+M
0403	Bennett's fracture-dislocation	84.50	2 397.27	84.50	2 397.27	3	397.68	+T+M
0404	Fracture: Bennett fracture/dislocation: Open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)	179.80	5 100.93	143.84	4 080.74	3	397.68	+T+M
0405	Fracture reduction under general anaesthetic: Open treatment of Metacarpal: Simple	75.40	2 139.10	75.40	2 139.10	3	397.68	+T+M
0406	Fracture: Metacarpal bone: Open reduction and internal fixation (modifier 0052 not applicable)	163.60	4 641.33	130.88	3 713.07	3	397.68	+T+M
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	77	2 184.49	77	2 184.49	3	397.68	+T+M
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (modifier 0052 not applicable)	141.10	4 003.01	120	3 404.40	3	397.68	+T+M
0413	Fracture (reduction under general anaesthetic): Finger phalanx: Proximal or middle	50.50	1 432.69	50.50	1 432.69	3	397.68	+T
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifier 0052 not applicable)	169.90	4 820.06	135.92	3 856.05	3	397.68	+T
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed (modifier 0051 is applicable)	137.20	3 892.36	120	3 404.40	3	397.68	+T
0419	Fracture (reduction under general anaesthetic): Pelvis: Open reduction and internal fixation (modifier 0051 not applicable)	354.49	10 056.88	283.59	8 045.45	3	397.68	+T+M
0420	Fracture: Acetabulum: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	560	15 887.20	448	12 709.76	3	397.68	+T+M
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	279.10	7 918.07	223.28	6 334.45	3	397.68	+T+M
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	392.3	11 129.55	313.84	8 903.64	3	397.68	+T+M
0425	Fracture (reduction under general anaesthetic) Patella	82.50	2 340.53	82.50	2 340.53	3	397.68	+T+M
0426	Fracture: Patella: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	219.5	6 227.22	175.6	4 981.77	3	397.68	+T+M
0429	Fracture (reduction under general anaesthetic Tibia with or without Fibula	128	3 631.36	120	3 404.40	3	397.68	+T+M
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	293.2	8 318.08	234.56	6 654.47	3	397.68	+T+M
0433	Fracture (reduction under general anaesthetic) Fibula shaft	112.40	3 188.79	112.40	3 188.79	3	397.68	+T+M
0434	Fracture: Fibula shaft: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	207	5 872.59	165.6	4 698.07	3	397.68	+T+M
0435	Fracture (reduction under general anaesthetic: Malleolus of ankle	126.80	3 597.32	120	3 404.40	3	397.68	+T+M
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)	207.1	5 875.43	165.68	4 700.34	3	397.68	+T+M
0437	Fracture-dislocation of ankle	128	3 631.36	120	3 404.40	3	397.68	+T+M
0438	Open reduction Talus fracture (Modifier 0051 not applicable)	311.60	8 840.09	249.28	7 072.07	3	397.68	+T+M
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	76.60	2 173.14	76.60	2 173.14	3	397.68	+T+M
0440	Open reduction Calcaneus fracture (Modifier 0051, 0052 not applicable)	403.50	11 447.30	322.5	9 149.33	3	397.68	+T+M
0441	Fracture (reduction under general anaesthetic): Metatarsal	66.80	1 895.12	66.80	1 895.12	3	397.68	+T+M
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)	154.7	4 388.84	123.76	3 511.07	3	397.68	+T+M
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal: Simple	66.8	1 895.12	66.80	1 895.12	3	397.68	+T
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (modifier 0052 not applicable)	144.5	4 099.47	120	3 404.40	3	397.68	+T
0446	Fracture: Tarsal bones (excluding talus and calcaneus): Open reduction with internal fixation (modifiers 0051, 0052 not applicable)	178.2	5 055.53	142.56	4 044.43	3	397.68	+T+M
0447	Fracture (reduction under general anaesthetic): Other: Simple	26	737.62	26	737.62	3	397.68	+T
0448	Fracture: Calcaneus (reduction under general anaesthetic)	103.3	2 930.62	103.3	2 930.62	3	397.68	+T+M

		Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R T
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	230	6 525.10	184	5 220.08	3	397.68 +T+M
3.1.1.1	**Operations for fractures**						
0465	Fractures involving large joints (includes the item for the relative bone). This item may not be used as a modifier	288	8 170.56	230.4	6 536.45	3	397.68 +T+M
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (modifier 0052 not applicable)	210.90	5 983.23	168.72	4 786.59	3	397.68 +T+M
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pin (Not subject to rule G) (Modifier 0005 not applicable)	43	1 219.91	43	1 219.91	3	397.68 +T
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	328.20	9 311.03	262.56	7 448.83	3	397.68 +T+M
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones (not applicable to fingers and toes)	154	4 368.98	123.2	3 495.18	3	397.68 +T+M
3.1.2	**Bony operations**						
3.1.2.1	**Bone grafting**						
0499	Grafts to cysts: Large bones	192	5 447.04	153.6	4 357.63	3	397.68 +T+M
0501	Grafts to cysts: Small bones	128	3 631.36	120	3 404.40	3	397.68 +T+M
0503	Grafts to cysts: Cartilage graft	206	5 844.22	164.8	4 675.38	3	397.68 +T+M
0505	Grafts to cysts: Inter-metacarpal bone graft	147	4 170.39	120	3 404.40	3	397.68 +T+M
0506	Harvesting of graft: Cartilage graft, costochondral	91.1	2 584.51	91.1	2 584.51	6	795.36 +T
0507	Removal of autogenous bone for grafting (not subject to modifier 0005)	50	1 418.50	50	1 418.50	3	397.68 +T+M
3.1.2.2	**Acute/chronic osteomyelitis**						
0512	Sternum sequestrectomy and drainage: Including FOUR weeks after-care	128	3 631.36	120	3 404.40	3	397.68 +T+M
3.1.2.3	**Osteotomy**						
0516	Osteotomy: Pelvic	320	9 078.40	256	7 262.72	3	397.68 +T+M
0521	Osteotomy: Femoral: Proximal (Modifier 0051 is applicable)	320	9 078.40	256	7 262.72	3	397.68 +T+M
0527	Osteotomy: Knee region (Modifier 0051 is applicable)	320	9 078.40	256	7 262.72	3	397.68 +T+M
0528	Osteotomy: Os Calcis (Dwyer operation) (Modifier 0051 is applicable)	115	3 262.55	115	3 262.55	3	397.68 +T+M
0530	Osteotomy: Metacarpal and phalanx: Corrective for mal-union or rotation (Modifier 0051 is applicable)	120	3 404.40	120	3 404.40	3	397.68 +T+M
0531	Rotational osteotomy tibia and fibula - stand alone procedure	278.90	7 912.39	223.12	6 329.91	3	397.68 +T+M
0532	Rotation osteotomy of the Radius, Ulna or Humerus(modifier 0051 is applicable)	160	4 539.20	128	3 631.36	3	397.68 +T+M
0533	Osteotomy single metatarsal (modifier 0051 is applicable)	60	1 702.20	60	1 702.20	3	397.68 +T+M
0534	Multiple metatarsal osteotomies (modifier 0051 is applicable)	150	4 255.50	120	3 404.40	3	397.68 +T+M
3.2	**Joints**						
3.2.1	**Dislocations**						
0547	Dislocation: Clavicle: either end	96.5	2 737.71	96.5	2 737.71	3	397.68 +T+M
0549	Dislocation: Shoulder	112.10	3 180.28	112.10	3 180.28	3	397.68 +T+M
0551	Dislocation: Elbow	133.60	3 790.23	120	3 404.40	3	397.68 +T+M
0552	Dislocation: Wrist	115.50	3 276.74	115.50	3 276.74	3	397.68 +T+M
0553	Dislocation: Perilunar transscaphoid fracture dislocation	130	3 688.10	120	3 404.40	3	397.68 +T+M
0555	Dislocation: Lunate	136.30	3 866.83	120.00	3 404.40	3	397.68 +T+M
0556	Dislocation: Carpo-metacarpo dislocation	117.20	3 324.96	117.20	3 324.96	3	397.68 +T+M
0557	Dislocation: Metacarpo-phalangeal or interphalangeal joints (hand)	107.30	3 044.10	107.30	3 044.10	3	397.68 +T+M
0559	Dislocation: Hip	220.50	6 255.59	176.40	5 004.47	3	397.68 +T+M
0561	Dislocation: Knee, with manipulation	181.20	5 140.64	144.96	4 112.52	3	397.68 +T+M
0563	Dislocation: Patella	136.90	3 883.85	120	3 404.40	3	397.68 +T+M
0565	Dislocation: Ankle	98.60	2 797.28	98.60	2 797.28	3	397.68 +T+M
0567	Dislocation: Sub-Talar dislocation	92	2 610.04	92	2 610.04	3	397.68 +T+M
0569	Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	77	2 184.49	77	2 184.49	3	397.68 +T+M
0571	Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	39.40	1 117.78	39.40	1 117.78	3	397.68 +T+M
3.2.2	**Operations for dislocations**						
0578	Recurrent dislocation of shoulder	200	5 674.00	160	4 539.20	3	397.68 +T+M
0579	Recurrent dislocation of all other joints	161	4 567.57	128.8	3 654.06	3	397.68 +T+M
3.2.3	**Capsular operations**						
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (Including three weeks after-care)	51	1 446.87	51	1 446.87	3	397.68 +T+M
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	96	2 723.52	96	2 723.52	3	397.68 +T+M
0585	Capsulotomy or arthrotomy or biopsy or drainage of joint: Capsulectomy digital joint	64	1 815.68	64	1 815.68	3	397.68 +T+M
0586	Multiple percutaneous capsulotomies of metacarpo-phalangeal joints	90	2 553.30	90	2 553.30	3	397.68 +T+M
0587	Release of digital joint contracture	128	3 631.36	120	3 404.40	3	397.68 +T+M
3.2.4	**Synovectomy**						

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0589	Synovectomy: Digital joint	77	2 184.49	77	2 184.49	3	397.68	+T+M
0592	Synovectomy: Large joint	160	4 539.20	128	3 631.36	3	397.68	+T+M
0593	Tendon synovectomy	203.7	5 778.97	162.96	4 623.18	3	397.68	+T+M
3.2.5	**Arthrodesis**							
0597	Arthrodesis: Shoulder	224	6 354.88	179.2	5 083.90	3	397.68	+T+M
0598	Arthrodesis: Elbow	180	5 106.60	144	4 085.28	3	397.68	+T+M
0599	Arthrodesis: Wrist	180	5 106.60	144	4 085.28	3	397.68	+T+M
0600	Arthrodesis: Digital joint	128	3 631.36	120	3 404.40	3	397.68	+T+M
0601	Arthrodesis: Hip	320	9 078.40	256	7 262.72	3	397.68	+T+M
0602	Arthrodesis: Knee	180	5 106.60	144	4 085.28	3	397.68	+T+M
0603	Arthrodesis: Ankle	180	5 106.60	144	4 085.28	3	397.68	+T+M
0604	Arthrodesis: Sub-talar	130	3 688.10	120	3 404.40	3	397.68	+T+M
0605	Arthrodesis: Stabilization of foot (triple-arthrodeses)	180	5 106.60	144	4 085.28	3	397.68	+T+M
0607	Arthrodesis: Mid-tarsal wedge resection	180	5 106.60	144	4 085.28	3	397.68	+T+M
3.2.6	**Arthroplasty**							
0614	Arthroplasty: Debridement large joints	160	4 539.20	128	3 631.36	3	397.68	+T+M
0615	Arthroplasty: Excision medial or lateral end of clavicle	116	3 290.92	116	3 290.92	3	397.68	+T+M
0617	Shoulder: Acromioplasty	192	5 447.04	153.6	4 357.63	3	397.68	+T+M
0619	Shoulder: Partial replacement	277	7 858.49	221.6	6 286.79	5	662.80	+T+M
0620	Shoulder: Total replacement	416	11 801.92	332.8	9 441.54	5	662.80	+T+M
0621	Elbow: Excision head of radius	96	2 723.52	96	2 723.52	3	397.68	+T+M
0622	Elbow: Excision	192	5 447.04	153.6	4 357.63	3	397.68	+T+M
0623	Elbow: Partial replacement	188	5 333.56	150.4	4 266.85	3	397.68	+T+M
0624	Elbow: Total replacement	282	8 000.34	225.6	6 400.27	3	397.68	+T+M
0625	Wrist: Excision distal end of ulna	96	2 723.52	96	2 723.52	3	397.68	+T+M
0626	Wrist: Excision single bone	110	3 120.70	110	3 120.70	3	397.68	+T+M
0627	Wrist: Excision proximal row	166	4 709.42	132.8	3 767.54	3	397.68	+T+M
0631	Wrist: Total replacement	249	7 064.13	199.2	5 651.30	3	397.68	+T+M
0635	Digital joint: Total replacement	192	5 447.04	153.6	4 357.63	3	397.68	+T+M
0637	Hip: Total replacement	416	11 801.92	332.8	9 441.54	3	397.68	+T+M
0641	Hip: Prosthetic replacement of femoral head	288	8 170.56	230.4	6 536.45	3	397.68	+T+M
0643	Hip: Girdlestone	320	9 078.40	256	7 262.72	3	397.68	+T+M
0645	Knee: Partial replacement	277	7 858.49	221.6	6 286.79	3	397.68	+T+M
0646	Knee: Total replacement	416	11 801.92	332.8	9 441.54	3	397.68	+T+M
0649	Ankle:Total replacement	290.4	8 238.65	232.32	6 590.92	3	397.68	+T+M
0650	Ankle: Astragalectomy	154	4 368.98	123.2	3 495.18	3	397.68	+T+M
3.2.7	**Miscellaneous (Joints)**							
0658	Aspiration and/or injection: Small joint, bursa (e.g. fingers, toes) (excluding aftercare, modifier 0005 not applicable)	11.40	323.42	11.40	323.42	3	397.68	+T+M
0659	Aspiration and/or injection: Intermediate joint, bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (excluding aftercare, modifier 0005 not applicable)	12	340.44	12	340.44	3	397.68	+T+M
0660	Aspiration and/or injection: Major joint, bursa (e.g. shoulder, hip, knee joint, subacromial bursa) (excluding aftercare, modifier 0005 not applicable)	14.60	414.20	14.60	414.20	3	397.68	+T+M
0661	Aspiration of joint or intra-articular injection (not subject to rule G) (Modifier 0005 not applicable)	9	255.33	9	255.33	3	397.68	+T
0668	Manipulation of knee joint under general anaesthesia (includes application of traction or other fixation devices) (excluding aftercare) (modifier 0005 is not applicable)	43.10	1 222.75	43.10	1 222.75	3	397.68	+T
0667	Arthroscopy (excluding after-care), modifiers 0005 and 0013 not applicable	60	1 702.20	60	1 702.20	3	397.68	+T
0669	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)	14	397.18	14	397.18	4 3	530.24 397.68	Hip+T Knee / Should
0673	Menisectomy or operation for other internal derangement of knee: Medial OR lateral	185.70	5 268.31	148.56	4 214.65	3	397.68	+T+M
3.2.8	**Joint ligament reconstruction or suture**							
0675	Joint ligament reconstruction or suture: Ankle: Collateral	160	4 539.20	128	3 631.36	3	397.68	+T+M
0676	Joint ligament reconstruction or suture: Ankle (e.g. Watson-Jones type)	191.50	5 432.86	153.20	4 346.28	3	397.68	+T+M
0677	Joint ligament reconstruction or suture: Knee: Collateral	196.80	5 583.22	157.44	4 466.57	3	397.68	+T+M
0678	Joint ligament reconstruction or suture: Knee: Cruciate	227.60	6 457.01	182.08	5 165.61	3	397.68	+T+M
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	324.40	9 203.23	259.52	7 362.58	3	397.68	+T+M
0680	Joint ligament reconstruction or suture: Digital joint ligament	229.80	6 519.43	183.84	5 215.54	3	397.68	+T+M
3.3	**Amputations**							
3.3.1	**Specific amputations**							
0681	Amputation: Humerus, includes primary closure	211.6	6 003.09	169.28	4 802.47	4	530.24	+T+M
0682	Amputation: Fore-quarter amputation	397.80	11 285.59	318.24	9 028.47	9	1193.04	+T+M
0683	Amputation: Through shoulder	323	9 163.51	258.40	7 330.81	5	662.80	+T+M
0684	Amputation: Forearm	213.5	6 057.00	170.48	4 836.52	3	397.68	+T+M
0686	Amputation: Ankle (eg., Syme, Pirogoff type)	204.1	5 790.32	163.28	4 632.25	4	530.24	+T+M
0687	Amputation: Metacarpal: One ray	206.10	5 847.06	164.88	4 677.65	3	397.68	+T+M
0688	Amputation: Foot, midtarsal (Chopart type)	165.7	4 700.91	132	3 744.84	3	397.68	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0691	Amputation: Finger or thumb	183.90	5 217.24	146.40	4 153.37	3	397.68	+T+M
0692	Scar revision/secondary closure: amputated thigh, through femur, any level	150.7	4 275.36	120.56	3 420.29	3	397.68	+T+M
0693	Hindquarter amputation	470.70	13 353.76	376.56	10 683.01	6	795.36	+T+M
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level	173.9	4 933.54	139.12	3 946.83	3	397.68	+T+M
0695	Amputation: Through hip joint region	373.10	10 584.85	298.48	8 467.88	6	795.36	+T+M
0696	Re-amputation: Thigh, through femur, any level	217.3	6 164.80	173.84	4 931.84	3	397.68	+T+M
0697	Amputation: Through thigh	245	6 950.65	196	5 560.52	6	795.36	+T+M
0698	Re-amputation: Leg, through tibia and fibula	198.2	5 622.93	158.56	4 498.35	3	397.68	+T+M
0699	Amputation: Below knee, through knee/Syme	277.20	7 864.16	221.76	6 291.33	5	662.80	+T+M
0701	Amputation: Trans-metatarsal or trans-tarsal	223.80	6 349.21	179.04	5 079.36	3	397.68	+T+M
0705	Amputation: Toe (skin flap included)	167.10	4 740.63	133.68	3 792.50	3	397.68	+T+M
3.3.2	**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 **Note:** If not performed on thumb or index finger it must be motivated	186.30	5 285.33	149.04	4 228.26	3	397.68	+T+M
0707	Post-amputation reconstruction: Krukenberg reconstruction	331.70	9 410.33	265.36	7 528.26	3	397.68	+T+M
0711	Post-amputation reconstruction: Pollicization of the finger (Prior permission must be obtained from the Commissioner at all times)	455.90	12 933.88	364.72	10 347.11	3	397.68	+T+M
0712	Post-amputation reconstruction: Toe to thumb transfer (Prior permission must be obtained from the Commissioner at all times)	800	22 696.00	640	18 156.80	3	397.68	+T+M
0700	Scar revision/secondary closure: Amputated shoulder	128.1	3 634.20	120	3 404.40	3	397.68	+T
0702	Scar revision/secondary closure: Amputated humerus	163.1	4 627.15	130.48	3 701.72	3	397.68	+T
0704	Scar revision/secondary closure: Amputated forearm	184.1	5 222.92	147.28	4 178.33	3	397.68	+T
0708	Re-amputation: Humerus	223.1	6 329.35	178.48	5 063.48	6	795.36	+T+M
0710	Re-amputation: Through forearm	206	5 844.22	164.8	4 675.38	3	397.68	+T+M
3.4	**Muscles, tendons and fascias**							
3.4.1	**Investigations**							
0715	Strength duration curve per session	10.5	297.89	10.5	297.89	3	397.68	+T
0727	Cranial reflex study (both early and late responses) supra occulofacial, corneofacial or flabellofacial: Unilateral	8	226.96	8	226.96	3	397.68	+T
0728	Cranial reflex study (both early and late responses) supra occulofacial, corneofacial or flabellofacial: Bilateral	14	397.18	14	397.18	3	397.68	+T
0729	Tendon reflex time	7	198.59	7	198.59	3	397.68	+T
0730	Limb-brain somatosensory studies (per limb)	49	1 390.13	49	1 390.13	3	397.68	+T
0731	Vision and audiosensory studies	49	1 390.13	49	1 390.13			
0733	Motor nerve conduction studies (single nerve)	26	737.62	26	737.62			
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	31	879.47	31	879.47	3	397.68	+T
3.4.2	**Decompression Operations**							
5550	Decompression fasciotomy: Buttock compartment(s): Unilateral	243	6 893.91	194.4	5 515.13	5	662.80	+T+M
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve	151.9	4 309.40	121.52	3 447.52	3	397.68	+T+M
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve	253.1	7 180.45	202.48	5 744.36	3	397.68	+T+M
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve	123.7	3 509.37	120	3 404.40	3	397.68	+T+M
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/or nerve	162.1	4 598.78	129.68	3 679.02	3	397.68	+T+M
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve	130.8	3 710.80	120	3 404.40	3	397.68	+T+M
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve	171.5	4 865.46	137.2	3 892.36	3	397.68	+T+M
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial	137.3	3 895.20	120	3 404.40	4	530.24	+T+M
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe	86.6	2 456.84	86.6	2 456.84	3	397.68	+T+M
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve	226.3	6 420.13	181.04	5 136.10	3	397.68	+T+M
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve	354.5	10 057.17	283.6	8 045.73	3	397.68	+T+M
5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve	166.8	4 732.12	133.44	3 785.69	3	397.68	+T+M
5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve	321.1	9 109.61	256.88	7 287.69	3	397.68	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
5563	Decompression fasciotomy: Fingers and/or hand	165.6	4 698.07	132.48	3 758.46	3	397.68	+T+M
3.4.3	**Muscle and tendon repair**							
0745	Muscle and tendon repair: Biceps humeri	109	3 092.33	109	3 092.33	3	397.68	+T
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	96	2 723.52	96	2 723.52	3	397.68	+T+M
0747	Muscle and tendon repair: Rotator cuff	134	3 801.58	120	3 404.40	4	530.24	+T
0748	Muscle and tendon repair: Debridement rotator cuff	139.7	3 963.29	120	3 404.40	4	530.24	+T
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	271.90	7 713.80	217.52	6 171.04	4	530.24	+T
0755	Muscle and tendon repair: Infrapatellar or quadriceps tendon	128	3 631.36	120	3 404.40	3	397.68	+T
0757	Muscle and tendon repair: Achilles tendon repair	197.6	5 605.91	158.08	4 484.73	4	530.24	+T
0759	Muscle and tendon repair: Other single tendon	77	2 184.49	77	2 184.49	3	397.68	+T
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (modifier 0005 applicable)	220.3	6 249.91	176.24	4 999.93	3	397.68	+T
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (modifier 0005 applicable)	249.6	7 081.15	199.68	5 664.92	3	397.68	+T
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (modifier 0005 applicable)	191.30	5 427.18	153.04	4 341.74	3	397.68	+T
0763	Muscle and tendon repair: Tendon or ligament injection	9	255.33	9	255.33	3	397.68	+T
0764	Hand: Flexor tendon repair: Secondary, zone 1	243.9	6 919.44	195.12	5 535.55	3	397.68	+T
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)	249.6	7 081.15	199.68	5 664.92	3	397.68	+T
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)	190.6	5 407.32	152.48	4 325.86	3	397.68	+T
0768	Repair: Intrinsic muscles of hand (each) (modifier 0005 applicable)	125.3	3 554.76	100.24	2 843.81	3	397.68	+T
0771	Extensor tendon suture: Primary (per tendon, Modifier 0005 not applicable)	129.7	3 679.59	120	3 404.40	3	397.68	+T
0773	Extensor tendon suture: Secondary (per tendon, Modifier 0005 not applicable)	170.00	4 822.90	136	3 858.32	3	397.68	+T
0774	Repair of Boutonniére deformity or Mallet Finger with graft	216.60	6 144.94	216.60	6 144.94	3	397.68	+T
3.4.4	**Tendon graft**							
0775	Free tendon graft	160	4 539.20	128	3 631.36	3	397.68	+T
0776	Reconstruction of pulley for flexor tendon	180.20	5 112.27	144.16	4 089.82	3	397.68	+T
0777	Tendon graft: Finger: Flexor	192	5 447.04	153.6	4 357.63	3	397.68	+T
0779	Tendon graft: Finger: Extensor	122	3 461.14	120	3 404.40	3	397.68	+T
0780	Two stage flexor tendon graft using silastic rod	240	6 808.80	192	5 447.04	3	397.68	+T
3.4.5	**Tenolysis**							
0781	Tendon freeing operation, except where specified elsewhere	64	1 815.68	64	1 815.68	3	397.68	+T
0782	Carpal tunnel syndrome	123	3 489.51	120	3 404.40	3	397.68	+T
0783	Tenolysis: De Quervain	38	1 078.06	38	1 078.06	3	397.68	+T
0784	Trigger finger	38	1 078.06	38	1 078.06	3	397.68	+T
0785	Flexor tendon freeing operation following free tendon graft or suture	276.10	7 832.96	220.88	6 266.37	3	397.68	+T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm	212.20	6 020.11	170	4 822.90	3	397.68	+T
0788	Intrinsic tendon release per finger	64	1 815.68	64	1 815.68	3	397.68	+T
3.4.6	**Tenodesis**							
0790	Tenodesis: Digital joint (each) (modifier 0005 applicable)	176.20	4 998.79	140.96	3 999.04	3	397.68	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3.4.7	**Muscle, tendon and fascia transfer**								
0791	Single tendon transfer		96	2 723.52	96	2 723.52	3	397.68	+T
0792	Multiple tendon transfer		128	3 631.36	120	3 404.40	3	397.68	+T
0793	Hamstring to quadriceps transfer		141	4 000.17	120	3 404.40	3	397.68	+T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon		320	9 078.40	256	7 262.72	5	662.80	+T
0795	Tendon transfer at elbow		116	3 290.92	116	3 290.92	3	397.68	+T
0803	Hand tendons: Single transfer (each) (modifier 0005 applicable)		216.20	6 133.59	172.96	4 906.88	3	397.68	+T
0809	Hand tendons: Substitution for intrinsic paralysis of hand/hand tendon (all four fingers)		330.60	9 379.12	264.48	7 503.30	3	397.68	+T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)		220.6	6 258.42	176.48	5 006.74	3	397.68	+T
3.4.8	**Muscle slide operations and tendon lengthening**								
0812	Percutaneous Tenotomy: All sites		140.50	3 985.99	120	3 404.40	3	397.68	+T
0813	Torticollis		96	2 723.52	96	2 723.52	5	662.80	+T
0822	Open release elbow (Mitals) - stand alone procedure		278.20	7 892.53	222.56	6 314.03	3	397.68	+T+M
0823	Excision or slide for Volksmann's Contracture		192	5 447.04	153.6	4 357.63	3	397.68	+T
0825	Hip: Open muscle release		116	3 290.92	116	3 290.92	7	927.92	+T
0829	Knee: Quadriceps plasty		160	4 539.20	128	3 631.36	3	397.68	+T
0831	Knee: Open tenotomy		141	4 000.17	120	3 404.40	3	397.68	+T
0835	Calf		96	2 723.52	96	2 723.52	4	530.24	+T
0837	Open Elongation Tendon Achilles		96	2 723.52	96	2 723.52	4	530.24	+T
0838	Percutaneous "Hoke" elongation tendoachillies - stand alone procedure		79.30	2 249.74	79.30	2 249.74	4	530.24	+T
3.6	**Musculo-skeletal system: Miscellaneous**								
3.6.1	**Musculo-skeletal system: Miscellaneous: Removal of internal fixatives or prosthesis**								
0883	Readily accessible		44.40	1 259.63	44.40	1 259.63		As per bone	
0884	Less accessible		127	3 602.99	120	3 404.40		+ M	
0885	Removal of prosthesis for infection soon after operation		128	3 631.36	120	3 404.40		As per bone	+M
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the item for total joint replacement of the specific joint	+	64	1 815.68	64	1 815.68	6	795.36	+T+M
3.6.2	**Musculo-skeletal system: Miscellaneous: Removal of foreign bodies**								
0644	Removal of foreign body: Shoulder, subcutaneous Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		49.70	1 409.99	49.70	1 409.99	3	397.68	+T
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		41.70	1 183.03	41.70	1 183.03	3	397.68	+T
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		109	3 092.33	109	3 092.33	3	397.68	+T
0651	Exploration with removal of deep foreign body: Forearm or wrist Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		122.80	3 483.84	120	3 404.40	3	397.68	+T
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		45.30	1 285.16	45.30	1 285.16	6	795.36	+T
0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		186.90	5 302.35	149.52	4 241.88	6	795.36	+T
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		120.60	3 421.42	120	3 404.40	4	530.24	+T
0655	Removal of foreign body: Foot, subcutaneous Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		40	1 134.80	40	1 134.80	3	397.68	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0656	Removal of foreign body: Foot, deep Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		94.20	2 672.45	94.20	2 672.45	3	397.68	+T
0657	Removal of foreign body: Foot, complicated Use item 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0055 and 0058 is not applicable.		110.50	3 134.89	110.50	3 134.89	3	397.68	+T
3.7	**Plasters (not subject to rule G)** **Note:** The initial application of a plaster cast is included in the scheduled fee **Note:** The Commissioner will only consider payment i.r.o. splinting material (Scotschcast, Dynacast, etc.) in the following cases (not applicable when Plaster of Paris is used): Where extremity splints are applied for at least five weeks: A maximum of one application for an upper extremity injury A maximum of two applications for a lower extremity injury								
0887	Long limb cast (excluding after-care) (modifier 0005 not applicable)		29.5	836.92	29.5	836.92	3	397.68	+T
0888	Short limb cast (excluding after-care) (modifier 0005 not applicable)		18.40	522.01	18.40	522.01	3	397.68	+T
0889	Spica, plaster jacket or hinged cast brace (excluding aftercare)		41.40	1 174.52	41.40	1 174.52	4	530.24	+T
0892	Application of cast: Revision (walker, window, bivalve) (excluding aftercare)		18.90	536.19	18.90	536.19	5	662.80	+T
0971	Halo-splint and POP jacket including two weeks aftercare		116	3 290.92	116	3 290.92			
3.8	**Specific areas**								
3.8.1	**Replantation**								
0912	Replantation of amputated upper limb proximal to wrist joint		730	20 710.10	584	16 568.08	3	397.68	+T+M
0913	Replantation of thumb		670	19 007.90	536	15 206.32	3	397.68	+T+M
0914	Replantation of a single digit (to be motivated), for multiple digits, modifier 0005 applicable		580	16 454.60	464	13 163.68	3	397.68	+T+M
0915	Replantation operation through the palm		1270	36 029.90	1016	28 823.92	3	397.68	+T+M
3.8.2	**Hands: (Note: Skin: See Integumentary system)**								
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		37 to 110	1 049.69 3 120.70	37 to 110	1 049.69 3 120.70	3	397.68	+T+M
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic		16	453.92	16	453.92	3	397.68	+T+M
0926	Initial treatment of fractures, tendons, nerves, loss of skin and blood vessels, including removal of dead tissue under general anaesthesia and six weeks after-care		269	7 631.53	215.2	6 105.22	3	397.68	+T+M
3.8.3	**Spine**								
0929	Manipulation of spine with anaesthetic (no after-care), modifier 0005 not applicable		14	397.18	14	397.18	5	662.80	+T+M
0930	Posterior osteotomy of spine: One vertebral segment		339	9 617.43	271.2	7 693.94	3	397.68	+T+M
0931	Posterior spinal fusion: One level		385	10 922.45	308	8 737.96	3	397.68	+T+M
0932	Posterior osteotomy of spine: Each additional vertebral segment	+	103	2 922.11	103	2 922.11	3	397.68	+T+M
0933	Anterior spinal osteotomy with disc removal: One vertebral segment		315	8 936.55	252	7 149.24	3	397.68	+T+M
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	+	+103	2 922.11	+103	2 922.11	3	397.68	+T+M
0938	Anterior fusion base of skull to C2		449	12 738.13	359.2	10 190.50	4	530.24	+T+M
0939	Trans-abdominal anterior exposure of the spine for spinal-fusion only if done by a second surgeon		160	4 539.20	128	3 631.36	3	397.68	+T+M
0940	Transthoracic anterior exposure of the spine if done by a second surgeon		160	4 539.20	128	3 631.36	3	397.68	+T+M
0941	Anterior interbody fusion: One level I Anterior tussenwerwel fusie:		360	10 213.20	288	8 170.56	3	397.68	+T+M
0942	Anterior interbody fusion: Each additional level	+	+ 102	2 893.74	+102	2 893.74	3	397.68	+T+M
0943	Laminectomy with decompression of nerve roots and disc removal: One level		240	6 808.80	192	5 447.04	3	397.68	+T+M
0944	Posterior fusion: Occiput to C2		390	11 064.30	312	8 851.44	4	530.24	+T+M
0946	Posterior spinal fusion: Each additional level	+	+111	3 149.07	+111	3 149.07	3	397.68	+T+M
0948	Posterior interbody lumbar fusion: One level		364	10 326.68	291.2	8 261.34	3	397.68	+T+M
0950	Posterior interbody lumbar fusion: Each additional interspace	+	+ 95	2 695.15	+ 95	2 695.15	3	397.68	+T+M
0959	Excision of coccyx		96	2 723.52	96	2 723.52	3	397.68	+T+M
0960	Posterior non-segmental instrumentation		167	4 737.79	133.6	3 790.23	5	662.80	+T+M
0961	Costo-transversectomy		198	5 617.26	158.4	4 493.81	3	397.68	+T+M
0962	Posterior segmental instrumentation: 2 to 6 vertebrae		176	4 993.12	140.8	3 994.50	5	662.80	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0963	Antero-lateral decompression of spinal cord or anterior debridement	326	9 248.62	260.8	7 398.90	3	397.68	+T+M
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	201	5 702.37	160.8	4 561.90	5	662.80	+T+M
0966	Posterior segmental instrumentation: 13 or more vertebrae	245	6 950.65	196	5 560.52	5	662.80	+T+M
0968	Anterior instrumentation: 2 to 3 vertebrae	159	4 510.83	127.2	3 608.66	5	662.80	+T+M
0969	Skull or skull-femoral traction including two weeks after-care	64	1 815.68	64	1 815.68	--		
0970	Anterior instrumentation: 4 to 7 vertebrae	185	5 248.45	148	4 198.76	5	662.80	+T+M
0972	Anterior instrumentation: 8 or more vertebrae	206	5 844.22	164.8	4 675.38	5	662.80	+T+M
0974	Additional pelvic fixation of instrumentation other than sacrum	108	3 063.96	108	3 063.96	5	662.80	+T+M
5750	Reinsertion of instrumentation	276	7 830.12	220.8	6 264.10	6	795.36	+T+M
5751	Removal of posterior non-segmental instrumentation	173	4 908.01	138.4	3 926.41	6	795.36	+T+M
5752	Removal of posterior segmental instrumentation	175	4 964.75	140	3 971.80	6	795.36	+T+M
5753	Removal of anterior instrumentation	204	5 787.48	163.2	4 629.98	6	795.36	+T+M
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	295	8 369.15	236	6 695.32	3	397.68	+T+M
5757	Laminectomy for decompression without foraminotomy or diskectomy more than two levels	321	9 106.77	256.8	7 285.42	3	397.68	+T+M
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	63	1 787.31	63	1 787.31	3	397.68	+T+M
5759	Laminectomy for decompression diskectomy etc., revision operation	352	9 986.24	281.6	7 988.99	4	530.24	+T+M
5763	Anterior disc removal and spinal decompression cervical: One level	344	9 759.28	275.2	7 807.42	3	397.68	+T+M
5764	Anterior disc removal and spinal decompression cervical: Each additional level	81	2 297.97	81	2 297.97	3	397.68	+T+M
5765	Vertebral corpectomy for spinal decompression: One level	466	13 220.42	372.8	10 576.34	3	397.68	+T+M
5766	Vertebral corpectomy for spinal decompression: Each additional level	88	2 496.56	88	2 496.56	3	397.68	+T+M
5770	Use of microscope in spinal and intercranial procedures (modifier 0005 not applicable)	71	2 014.27	71	2 014.27			
3.9	**Facial bone procedures** **Please note:** Modifers 0046 to 0058 are not applicable to section 3.9 of the tariff							
0987	Repair of orbital floor (blowout fracture)	184.6	5 237.10	147.68	4 189.68	4	530.24	+T+M
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort	202.2	5 736.41	161.76	4 589.13	4	530.24	+T+M
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	302	8 567.74	241.6	6 854.19	4	530.24	+T+M
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	433	12 284.21	346.4	9 827.37	4	530.24	+T+M
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort	970	27 518.90	776	22 015.12	4	530.24	+T+M
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	302	8 567.74	241.6	6 854.19	4	530.24	+T+M
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	1103	31 292.11	882.4	25 033.69	4	530.24	+T+M
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	1654	46 923.98	1323.2	37 539.18	4	530.24	+T+M
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement		Φ		Φ			
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation	302	8 567.74	241.6	6 854.19	3	397.68	+T+M
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation	184	5 220.08	147.2	4 176.06	3	397.68	+T+M
1000	Excision facial bone, e.g. osteomyelitis, abscess	144.30	4 093.79	120	3 404.40	5	662.80	+T+M
1003	Manipulation: Immobilisation and follow-up of fractured nose	35	992.95	35	992.95	3	397.68	+T+M
1005	Nasal fracture without manipulation		Φ		Φ			
1006	Fracture: Nose and septum, open reduction	177.4	5 032.84	141.92	4 026.27	5	662.80	+T+M
1007	Mandibulectomy	320	9 078.40	256	7 262.72	5	662.80	+T+M
1009	Maxillectomy	382.5	10 851.53	306	8 681.22	4	530.24	+T+M
1011	Bone graft to mandible	206	5 844.22	164.8	4 675.38	4	530.24	+T+M
1013	Fracture of arch of zygoma without displacement							
1015	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures; recent fractures (within four weeks)	131	3 716.47	120	3 404.40	3	397.68	+T+M
1017	Fracture of arch of zygomawith displacement requiring operative manipulation (not including associated fractures) (after four weeks)	262	7 432.94	209.6	5 946.35	3	397.68	+T+M
4.	**RESPIRATORY SYSTEM**							
4.1	**Nose and sinuses**							
1018	Flexible nasopharyngolaryngoscope examination	51.94	1 473.54					
1019	ENT endoscopy in rooms with rigid endoscope	12	340.44					
1020	Repair of perforated septum: Any method	141.9	4 025.70	120	3 404.40	4	530.24	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1022	Functional reconstruction of nasal septum	121.2	3 438.44	120	3 404.40	4	530.24	+T
1023	Harvesting of graft: Cartilage graft of nasal septum	124.8	3 540.58	120	3 404.40	5	662.80	+T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	30	851.10	30	851.10	4	530.24	+T
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	64.6	1 832.70	64.6	1 832.70	4	530.24	+T
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	62.6	1 775.96	62.6	1 775.96	4	530.24	+T
1034	Autogenous nasal bone transplant: Bone removal included	100	2 837.00	100	2 837.00	4	530.24	+T
1035	Unilateral functional endoscopic sinus surgery (unilateral)	140	3 971.80	120	3 404.40	4	530.24	+T
1036	Bilateral functional endoscopic sinus surgery	245	6 950.65	196	5 560.52	4	530.24	+T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	8	226.96	8	226.96			
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	35	992.95	35	992.95	4	530.24	+T
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach (modifier 0069 is not applicable)	365.50	10 369.24	292.40	8 295.39	5	662.80	+T+M
1045	Ligation anterior ethmoidal artery	135.4	3 841.30	120	3 404.40	6	795.36	+T
1047	Cladwell-Luc operation (unilateral)	137.3	3 895.20	120	3 404.40	4	530.24	+T
1049	Ligation internal maxillary artery	196	5 560.52	156.8	4 448.42	6	795.36	+T
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	37.3	1 058.20	--		--		
1055	External frontal ethmoidectomy	190.7	5 410.16	152.56	4 328.13	4	530.24	+T
1057	External ethmoidectomy and/or sphenoidectomy (unilateral)	199.4	5 656.98	159.52	4 525.58	4	530.24	+T
1059	Craniectomy: For osteomyelitis (total procedure)	341.60	9 691.19	273.28	7 752.95	4	530.24	+T
1061	Lateral rhinotomy	164	4 652.68	131.2	3 722.14	4	530.24	+T
1063	Removal of foreign bodies from nose at rooms	10	283.70	10	283.70			
1065	Removal of foreign body from nose under general anaesthetic	38.6	1 095.08	38.6	1 095.08	4	530.24	+T
1067	Proof puncture, unilateral at rooms	10	283.70	10	283.70	4	530.24	+T
1069	Proof puncture, uni- or bilateral under general anaesthetic	35	992.95	35	992.95	4	530.24	+T
1075	Multiple intranasal procedures: Not to exceed (see Modifier 0068)	194	5 503.78	155.2	4 403.02	4	530.24	+T
1077	Septum abscess, at room, including after-care	8	226.96	8	226.96			
1079	Septum abscess, under general anaesthetic	35	992.95	35	992.95	4	530.24	+T
1081	Oro-antral fistula (without Caldwell-Luc)	111.8	3 171.77	111.8	3 171.77	4	530.24	+T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septumplasty) nasal pyramid (osteotomy) and nasal tip	350	9 929.50	280	7 943.60	5	662.80	+T
1087	Subtotal reconstruction consisting of any two of the following: Septumplasty, osteotomy, nasal tip reconstruction	210	5 957.70	168	4 766.16	5	662.80	+T
4.3	**Larynx**							
1117	Laryngeal intubation	10	283.70	10	283.70			
1118	Laryngeal stroboscopy with video capture	39	1 106.43	39	1 106.43	6	795.36	+T
1119	Laryngectomy without block dissection of the neck	430	12 199.10	344	9 759.28	7	927.92	+T
1120	Intubation, endotracheal, emergency procedure Applicable to only situations where intubation does not form part of anaethesia a) Routine intubation during anaesthesia b) A second intubation during anaesthesia c) Intubation during resuscitation d) Difficult intubation	34	964.58	34	964.58			
4904	Laryngectomy: Total, with radical neck dissection Cannot be used with item 1471	508.7	14 431.82	406.96	11 545.46	7	927.92	+T
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection Cannot be used with item 1471	434.8	12 335.28	347.84	9 868.22	7	927.92	+T
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection Cannot be used with item 1471	563.2	15 977.98	450.56	12 782.39	7	927.92	+T
4907	Laryngectomy: Hemilaryngectomy, horizontal Cannot be used with item 1471	429.7	12 190.59	343.76	9 752.47	7	927.92	+T
4908	Laryngectomy: Hemilaryngectomy, laterovertical Cannot be used with item 1471	391	11 092.67	312.8	8 874.14	7	927.92	+T
4909	Laryngectomy: Hemilaryngectomy, anterovertical	405.1	11 492.69	324.08	9 194.15	7	927.92	+T
4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical Cannot be used with items 1471	414.2	11 750.85	331.36	9 400.68	7	927.92	+T
1126	Post laryngectomy for voice restoration	139.5	3 957.62	120	3 404.40	9	1193.04	+T
4913	Pharyngolaryngectomy: With radical neck dissection, without reconstruction Cannot be used with item 1471	571.1	16 202.11	456.88	12 961.69	7	927.92	+T
4914	Pharyngolaryngectomy: With radical neck dissection, with reconstruction Cannot be used with item 1471	667.5	18 936.98	534	15 149.58	7	927.92	+T
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy	427.6	12 131.01	342.08	9 704.81	9	1193.04	+T
4918	Laryngoplasty: Open reduction of fracture	367.2	10 417.46	293.76	8 333.97	8	1060.48	+T
4919	Laryngoplasty: Cricoid split	230.3	6 533.61	184.24	5 226.89	8	1060.48	+T

			Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1127	Tracheostomy	90	2 553.30	90	2 553.30	9	1193.04	+T
4922	Tracheostoma: Revision, without flap rotation, simple	102.4	2 905.09	102.4	2 905.09	9	1193.04	+T
4923	Tracheostoma: Revision, with flap rotation, complex Cannot be used with item 4922	167.3	4 746.30	133.84	3 797.04	9	1193.04	+T
4926	Tracheostomy: Fenestration with skin flaps	180.4	5 117.95	144.32	4 094.36	9	1193.04	+T
4927	Tracheostomy: Revision of scar Not applicable for cosmetic indications	104.5	2 964.67	104.5	2 964.67	9	1193.04	+T
4928	Tracheostomy/fistula: Closure, without plastic repair	104	2 950.48	104	2 950.48	9	1193.04	+T
4929	Tracheostomy/fistula: Closure, with plastic repair Cannot be used with item 4928	149.8	4 249.83	120	3 404.40	9	1193.04	+T
4932	Tracheobronchoscopy: Through established tracheostomy incision Cannot be used with item 1132	37.7	1 069.55	37.7	1 069.55	6	795.36	+T
4933	Tracheoplasty: Cervical	260.1		208.08		8	1060.48	+T
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage	329		263.2		8	1060.48	+T
1129	External laryngeal operation, e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngofissure	294.4	8 352.13	235.52	6 681.70	8	1060.48	+T
1130	Diagnostic laryngoscopy including biopsy	41.4	1 174.52	41.4	1 174.52	6	795.36	+T
1131	Direct laryngoscopy plus foreign body removal	64.6	1 832.70	64.6	1 832.70	6	795.36	+T
4.4	**Bronchial procedure**							
1132	Bronchoscopy: Diagnostic bronchoscopy without removal of foreign object	65	1 844.05	65	1 844.05	6	795.36	+T
1133	Bronchoscopy: With removal of foreign body	80	2 269.60	80	2 269.60	8	1060.48	+T
1134	Bronchoscopy: Bronchoscopy with laser	75	2 127.75	--		8	1060.48	+T
1136	Nebulisation (in rooms)	12	340.44	12	340.44		Fees as for	
1137	Bronchial lavage	--		--		8	1060.48	+T
1138	Thoracotomy: for bronchopleural fistula (including ruptured bronchus, any cause)	350	9 929.50	280	7 943.60	12	1590.72	+T
4.5	**Pleura**							
1139	Pleural needle biopsy (not including aftercare): modifier 0005 not applicable	50	1 418.50	50	1 418.50	3	397.68	+T
1141	Insertion of intercostal catheter (under water drainage)	50	1 418.50	50	1 418.50	6	795.36	+T
1143	Paracentesis chest: Diagnostic	8	226.96	8	226.96	3	397.68	+T
1145	Paracentesis chest: Therapeutic	13	368.81	13	368.81	3	397.68	+T
1147	Pneumothorax: Induction (diagnostic)	25	709.25	25	709.25			
1149	Pleurectomy	250	7 092.50	200	5 674.00	11	1458.16	+T
1151	Decortication of lung	350	9 929.50	280	7 943.60	11	1458.16	+T
1153	Chemical pleurodesis (instillation silver nitrate, tetracycline, talc, etc)	55	1 560.35	55	1 560.35	3	397.68	+T
4.6	**Pulmonary procedures**							
4.6.1	**Surgical**							
1155	Needle biopsy lung (not including after-care): modifier 0005 not applicable	32	907.84	32	907.84	5	662.80	+T
1157	Pneumonectomy	350	9 929.50	280	7 943.60	11	1458.16	+T
1159	Pulmonary lobectomy	388.5	11 050.12	311.6	8 840.09	11	1458.16	+T
1161	Segmental lobectomy	365	10 355.05	292	8 284.04	11	1458.16	+T
1163	Excision tracheal stenosis: Cervical	375	10 638.75	300	8 511.00	8	1060.48	+T
1164	Excision tracheal stenosis: Intra-thoracic	350	9 929.50	280	7 943.60	12	1590.72	+T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within FOUR weeks	215	6 099.55	172	4 879.64	12	1590.72	+T
1168	Thoracoplasty: Complete Cannot be used with item 1167 and 1169	250	7 092.50	200	5 674.00	11	1458.16	+T
1169	Thoracoplasty: Limited (osteoplastic) Cannot be used with item 1167	200	5 674.00	160	4 539.20	11	1458.16	+T
1171	Drainage empyema (including six weeks after-treatment)	170	4 822.90	136	3 858.32	11	1458.16	+T
1173	Drainage of lung abscess (including six weeks after-treatment)	170	4 822.90	136	3 858.32	11	1458.16	+T
1175	Thoracotomy (limited): Limited: For lung or pleural biopsy	115	3 262.55	115	3 262.55	11	1458.16	+T
1177	Thoracotomy: Major: Diagnostic	215	6 099.55	172	4 879.64	11	1458.16	+T
1179	Thoracoscopy	89	2 524.93	89	2 524.93	11	1458.16	+T
4.6.2	**Pulmonary function tests**							
1186	Flow volume test: Inspiration/expiration	30	851.10	30	851.10		Fees as for	
1188	Flow volume test: Inspiration/expiration pre- and post-bronchodilator (to be charged for only with first consultation -thereafter item 1186 applies)	50	1 418.50	50	1 418.50		Fees as for specialist	
1189	Forced expirogram only	10	283.70	10	283.70			
1191	N2 single breath distribution	10	283.70	10	283.70			
1192	Peak expiratory flow only	5	141.85	5	141.85			
1197	Compliance and resistance, using oesophageal balloon	24	680.88	24	680.88		Fees as for specialist	
1198	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent or after excercise, with subsequent spirometry	55.89	1 585.60	55.89	1 585.60			
1199	Pulmonary stress testing: For determination of VO2 max	96.5	2 737.71	96.5	2 737.71			

			Specialist		General Practitioner		Anaesthetic	
			U	R	U	R	U	R T
1201	Maximum inspiratory/expiratory pressure		5	141.85	5	141.85		Fees as for specialist

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
		Pulmonologists and Practitioners accredited to SATS		Other Specialists and General practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1193	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method	*37.76*	**1 071.25**					
1195	Thoracic gas volume	*37.93*	**1 076.07**					
1196	Determination of resistance to airflow, oscillatory or plethysmographic methods	*45.31*	**1 285.44**					
1200	Carbon monoxide diffusing capacity, any method	*38.06*	**1 079.76**					
		Specialist		General practitioner		Anaesthetic		
		U/E	R	U/E	R	U/E	R	T/M
4.7	**Intensive care (in intensive care or high care unit): Respiratory, cardiac, general**							
4.7.1	**Tariff items for intensive care** **Category 1**:Cases requiring intensive monitoring (to include cases where physiological instability is anticipated, e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc). Please note that item 1204 may not be charged by the responsible surgeon for monitoring a patient post-operatively in ICU or in the high-care unit since post-operative monitoring is included in the fee for the procedure							
1204	Category 1: Per day	*30*	**851.10**	*30*	**851.10**			Fees as for specialist
	Category 2 Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction; diabetic coma, head injury, severe asthma, acute pancreatius, eclampsia, flail chest, etc.) Ventilation may or may not be part of the active system support							
1205	Category 2: First day	*100*	**2 837.00**	*100*	**2 837.00**			Fees as for specialist
1206	Category 2: Subsequent days, per day	*50*	**1 418.50**	*50*	**1 418.50**			Fees as for specialist
1207	Category 2: After two weeks, per day	*30*	**851.10**	*30*	**851.10**			Fees as for specialist
	Category 3 Cases with multiple organ failure or Category 2 patients that may require multidisciplinary intervention							
1208	Category 3: First day (principal practitioner)	*137*	**3 886.69**	*120*	**3 404.40**			Fees as for specialist
1209	Category 3: First day (per involved practitioner)	*58*	**1 645.46**	*58*	**1 645.46**			Fees as for specialist
1210	Category 3:Subsequent days (per involved practitioner)	*50*	**1 418.50**	*50*	**1 418.50**			Fees as for specialist
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.							
		50	**1 418.50**	*50*	**1 418.50**			Fees as for specialist
		25	**709.25**	*25*	**709.25**			
		150	**4 255.50**	*150*	**4 255.50**			
1212	Ventilation: First day	*75*	**2 127.75**	*75*	**2 127.75**			Fees as for specialist
1213	Ventilation: Subsequent days	*50*	**1 418.50**	*50*	**1 418.50**			Fees as for specialist
1214	Ventilation: After two weeks, per day	*25*	**709.25**	*25*	**709.25**			Fees as for specialist
1215	Insertion of arterial pressure cannula	*25*	**709.25**	*25*	**709.25**			Fees as for specialist

		Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R T
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	50	1 418.50	50	1 418.50		Fees as for specialist
1217	Insertion of central venous line via peripheral vein	10	283.70	10	283.70		Fees as for specialist
1218	Insertion of central venous line via subclavian or jugular veins	25	709.25	25	709.25		Fees as for specialist
1219	Hyperalimentation (daily fee)	15	425.55	15	425.55		Fees as for specialist
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient)	30	851.10	30	851.10		Fees as for specialist
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charge appropriate hospital follow-up consultation)	30	851.10	30	851.10		Fees as for specialist
4.8	**Hyperbaric Oxygen Treatment**						
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): **Low pressure table (1,5-1,8 ATA x 45-60 min)**PROFESSIONAL COMPONENT	30	851.10	30	851.10		
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT	101.13	2 869.06	101.13	2 869.06		
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): Routine HBO table (2-2.5 ATA x 90-120 min) PROFESSIONAL COMPONENT	60	1 702.20	60	1 702.20		
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT	131.26	3 723.85	131.26	3 723.85		
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment monitoring during treatment and post treatment evaluation): **Emergency HBO table (2.5 3 ATA x 90-120 min)**PROFESSIONAL COMPONENT	80	2 269.60	80	2 269.60		
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT	131.26	3 723.85	131.26	3 723.85		
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT5 (2.8 ATA x 135 min) PROFESSIONAL COMPONENT	90	2 553.30	90	2 553.30		
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT	214.18	6 076.29	214.18	6 076.29		
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT6 (2.8 ATA x 285 min) PROFESSIONAL COMPONENT	190	5 390.30	190	5 390.30		
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	386.42	10 962.74	386.42	10 962.74		
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT6ext/6A or Cx 30 (2.8-6 ATA x 305-490 min) PROFESSIONAL COMPONENT	327	9 276.99	327	9 276.99		
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	680.85	19 315.71	680.85	19 315.71		
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	678.28	19 242.80	678.28	19 242.80		
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	671.85	19 060.38	671.85	19 060.38		
4815	Prolonged attendance inside a hyperbaric chamber: 40 clinical procedure units per half hour or part thereof for the first hour. Thereafter 20 clinical procedure units per half hour; minimum 40 clinical procedure units; maximum 320 clinical procedure units (Please indicate time in minutes and not per half hour)						
5.	**MEDIASTINAL PROCEDURES**						
1223	Mediastinoscopy	95	2 695.15	95	2 695.15	5	662.80 +T
1224	Mediastinotomy	115	3 262.55	115	3 262.55	11	1458.16 +T
6.	**CARDIOVASCULAR SYSTEM**						
6.1	**General** **General practitioner's fee for the taking of an ECG only** Where an ECG is done by a general practitioner and interpreted by a physician, the general practitioner is entitled to his full consultation fee, plus half of fee determined for ECG						
1228	General Practitioner's fee for the taking of an ECG only: Without effort: (1232)			4.5	127.67		

			Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R T
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: 1/2 (item 1233)			6.5	184.41		
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added						
	Physician's fee for interpreting an ECG						
	A specialist physician is entitled to the following fees for interpretation of an ECG tracing referred for interpretation						
1230	Physician's fee for interpreting an ECG: Without effort	6	170.22				
1231	Physician's fee for interpreting an ECG: With and without effort	10	283.70				
1232	Electrocardiogram: Without effort	9	255.33	9	255.33		
1233	Electrocardiogram: With and without effort	13	368.81	13	368.81		
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	40	1 134.80	40	1 134.80		
1235	Multi-stage treadmill	60	1 702.20	60	1 702.20		
1245	Angiography cerebral: First two series	34.3	973.09	34.3	973.09	4	530.24 +T
1246	Angiography peripheral: Per limb	25	709.25	25	709.25	4	530.24 +T
1248	Paracentesis of pericardium	50	1 418.50	50	1 418.50	9	1193.04 +T
6.3	**Cardiac surgery**						
1311	Pericardial drainage	140	3 971.80	120	3 404.40	13	1723.28 +T
6.4	**Peripheral vascular system**						
6.4.1	**Peripheral vascular system: Investigations**						
1357	Skin temperature test: Response to reflex heating	15	425.55	15	425.55		
1359	Skin temperature test: Response to reflex cooling	15	425.55	15	425.55		
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	26.3	746.13	26.3	746.13		
1367	Doppler blood tests	6	170.22	6	170.22		
5369	Doppler arterial pressures	6	170.22	6	170.22		
5371	Doppler arterial pressures with exercise	10	283.70	10	283.70		
5373	Doppler segmental pressures and wave forms	12	340.44	12	340.44		
5375	Venous doppler examination (both limbs)	9	255.33	9	255.33		
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	594	16 851.78	475.2	13 481.42		
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**						
1373	Abdominal aorta and iliac artery: Ruptured	600	17 022.00	480	13 617.60	15	1988.40 +T
6.4.3.3	**Peripheral**						
1385	Prosthetic grafting	255	7 234.35	204	5 787.48	5	662.80 +T
1387	Vein grafting proximal to knee joint	300	8 511.00	240	6 808.80	5	662.80 +T
1388	Vein grafting distal to knee joint	444	12 596.28	355.2	10 077.02	5	662.80 +T
1393	Embolectomy: Peripheral embolectomy transfemoral	168	4 766.16	134.4	3 812.93	5	662.80 +T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	125	3 546.25	100	2 837.00	5	662.80 +T
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, illiac artery, common femoral and popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure)	264	7 489.68	211.2	5 991.74	15	1988.40 +T
1397	Profundoplasty	210	5 957.70	168	4 766.16	5	662.80 +T
1399	Distal tibial (ankle region)	456	12 936.72	364.8	10 349.38	5	662.80 +T
1401	Femoro-femoral	254	7 205.98	203.2	5 764.78	5	662.80 +T
1402	Carotid-subclavian	288	8 170.56	230.4	6 536.45	8	1060.48 +T
1403	Axillo-femoral (Bifemoral + 50% of the fee)	288	8 170.56	230.4	6 536.45	8	1060.48 +T
6.4.4	**Veins**						
1408	Placement of Hickman catheter or similar	91	2 581.67	91	2 581.67	4	530.24 +T
1410	Litigation of inferior vena cava: Abdominal	180	5 106.60	144	4 085.28	8	1060.48 +T
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	240	6 808.80	192	5 447.04	11	1458.16 +T
1427	Thrombectomy: Ilio-femoral	175	4 964.75	140	3 971.80	6	795.36 +T
7.	**LYMPHO RETICULAR SYSTEM**						
7.1	**Spleen**						
1435	Splenectomy (trauma)	221.3	6 278.28	177.04	5 022.62	9	1193.04 +T
1436	Splenorrhaphy	231.80	6 576.17	185.44	5 260.93	9	1193.04 +T
7.2	**Lymph nodes and lymphatic channels**						
1439	Excision of lymph node for biopsy: Neck or axilla	65	1 844.05	65	1 844.05		
1441	Excision of lymph node for biopsy: Groin	65	1 844.05	65	1 844.05	4	530.24 +T
1443	Simple excision of lymph nodes for tuberculosis	91	2 581.67	91	2 581.67	5	662.80 +T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
8.	**DIGESTIVE SYSTEM**								
8.1	**Oral cavity**								
1462	Removal of embedded foreign body: Vestibule of mouth, simple		*41.1*	**1 166.01**	*41.1*	**1 166.01**	*5*	**662.80**	+T
1464	Removal of embedded foreign body: Vestibule of mouth; complicated		*73.1*	**2 073.85**	*73.1*	**2 073.85**	*5*	**662.80**	+T
1466	Removal of embedded foreign body: Dentoalveolar structures, soft tissues		*52.8*	**1 497.94**	*52.8*	**1 497.94**	*5*	**662.80**	+T
1467	Drainage of intra-oral abscess		*31*	**879.47**	*31*	**879.47**	*4*	**530.24**	+T
1469	Local excision of mucosal lesion of oral cavity		*23*	**652.51**	*23*	**652.51**	*4*	**530.24**	+T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure		*549*	**15 575.13**	*439.2*	**12 460.10**	*7*	**927.92**	+T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)		*240*	**6 808.80**	*192*	**5 447.04**	*6*	**795.36**	+T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)		*227*	**6 439.99**	*181.6*	**5 151.99**	*6*	**795.36**	+T
1480	Repair of oronasal fistula (large), e.g. distant flap Item 1480 canot be used with items 1481 and 1482.		*227*	**6 439.99**	*181.6*	**5 151.99**	*6*	**795.36**	+T
1481	Repair of oronasal fistula (small), e.g. trapdoor: One stage or first stage Item 1481 canot be used with items 1480 and 1482.		*138*	**3 915.06**	*120*	**3 404.40**	*5*	**662.80**	+T
1482	Repair of oronasal fistula (large): Second stage Item 1482 canot be used with items 1480 and 1481.		*138*	**3 915.06**	*120*	**3 404.40**	*5*	**662.80**	+T
1483	Alveolar periosteal or other flaps for arch closure		*138*	**3 915.06**	*120*	**3 404.40**	*4*	**530.24**	+T
1486	Closure of anterior nasal floor		*138*	**3 915.06**	*120*	**3 404.40**	*5*	**662.80**	+T
8.2	**Lips**								
1485	Local excision of benign lesion of lip		*27*	**765.99**	*27*	**765.99**	*4*	**530.24**	+T
1499	Lip reconstruction following an injury: Directed repair		*105.6*	**2 995.87**	*105.6*	**2 995.87**	*4*	**530.24**	+T
1501	Lip reconstruction following an injury only: Flap repair		*206*	**5 844.22**	*164.8*	**4 675.38**	*4*	**530.24**	+T
1503	Lip reconstruction following an injury only: Total reconstruction (first stage)		*206*	**5 844.22**	*164.8*	**4 675.38**	*4*	**530.24**	+T
1504	Lip reconstruction following an injury only: Subsequent stages (see item 0297)		*104*	**2 950.48**	*104*	**2 950.48**	*4*	**530.24**	+T
8.3	**Tongue**								
1505	Partial glossectomy		*225*	**6 383.25**	*180*	**5 106.60**	*6*	**795.36**	+T
1507	Local excision of lesion of tongue		*27*	**765.99**	*27*	**765.99**	*4*	**530.24**	+T
8.4	**Palate, uvula and salivary gland**								
1531	Drainage of parotid abscess		*25*	**709.25**	*25*	**709.25**	*4*	**530.24**	+T
8.5	**Oesophagus**								
1545	Oesophagoscopy with rigid instrument: First and subsequent		*47*	**1 333.39**	*47*	**1 333.39**	*4*	**530.24**	+T
1550	Oesophagoscopy with removal of foreign body		*70*	**1 985.90**	*70*	**1 985.90**	*4*	**530.24**	+T
1557	Oesophageal dilatation Can be used with item 1587		*40*	**1 134.80**	*40*	**1 134.80**	*4*	**530.24**	+T
8.6	**Stomach**								
1587	Upper gastro-intestinal endoscopy: Using hospital equipment		*48.75*	**1 383.04**	*48.75*	**1 383.04**	*4*	**530.24**	+T
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection of vasoconstrictor and/or schlerosis (endoscopic haemostasis) to be added to gastroscopy (item 1587) or colonoscopy (item 1653)	+	*34*	**964.58**	*34*	**964.58**	*6*	**795.36**	+T
1591	Plus removal of foreign bodies (stomach): ADD to gastro-intestinal endoscopy (item 1587)	+	*+25*	**709.25**	*+25*	**709.25**	*4*	**530.24**	+T
1597	Gastrostomy or Gastrotomy		*147.5*	**4 184.58**	*120*	**3 404.40**	*6*	**795.36**	+T
1613	Gastroenterostomy		*203.60*	**5 776.13**	*162.88*	**4 620.91**	*6*	**795.36**	+T
1615	Suture of perforated gastric or duedenal ulcer or wound or injury		*200*	**5 674.00**	*160*	**4 539.20**	*7*	**927.92**	+T
1617	Partial gastrectomy		*328.3*	**9 313.87**	*262.64*	**7 451.10**	*7*	**927.92**	+T
1619	Total gastrectomy		*384.43*	**10 906.28**	*307.54*	**8 724.91**	*7*	**927.92**	+T
1621	Revision of gastrectomy or gastro-enterostomy		*375*	**10 638.75**	*300*	**8 511.00**	*7*	**927.92**	+T
8.7	**Duodenum**								
1626	Endoscopic examination of the small bowel beyond the duodenojejunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)		*120*	**3 404.40**	*120*	**3 404.40**	*6*	**795.36**	+T
1627	Duodenal intubation (under X-ray screening)		*8*	**226.96**					
8.8	**Intestines**								
1634	Enterotomy or Enterostomy		*202.6*	**5 747.76**	*162.08*	**4 598.21**	*6*	**795.36**	+T
1637	Operation for relief of intestinal obstruction		*240*	**6 808.80**	*192*	**5 447.04**	*7*	**927.92**	+T
1639	Resection of small bowel with enterostomy or ananstomosis		*244.9*	**6 947.81**	*195.92*	**5 558.25**	*6*	**795.36**	+T

			Specialist		General Practitioner		Anaesthetic	
			U	R	U	R	U	R T
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)		150	4 255.50	120	3 404.40		
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report		90	2 553.30	90	2 553.30		
1645	Suture of intestine (small or large): Wound or injury		185.2	5 254.12	148.16	4 203.30	6	795.36 +T
1647	Closure of intestinal fistula		258	7 319.46	206.4	5 855.57	6	795.36 +T
1653	Total colonoscopy with hospital equipment		90	2 553.30	90	2 553.30	4	530.24 +T
1656	Left-sided colonoscopy		60	1 702.20	60	1 702.20	4	530.24 +T
1657	Right or left hemicolectomy or segmental colectomy		325	9 220.25	260	7 376.20	6	795.36 +T
1661	Colotomy: including removal of foreign body		205.7	5 835.71	164.56	4 668.57	6	795.36 +T
1663	Total colectomy		390	11 064.30	312	8 851.44	6	795.36 +T
1665	Colostomy or ileostomy isolated procedure		233.8	6 632.91	187.04	5 306.32	6	795.36 +T
1666	Continent ileostomy pouch (all types)		300	8 511.00	240	6 808.80	6	795.36 +T
1667	Colostomy: Closure		179.1	5 081.07	143.28	4 064.85	5	662.80 +T
1668	Revision of ileostomy pouch		375	10 638.75	300	8 511.00	6	795.36 +T
1676	Flexible sigmoidoscopy (including rectum and anus): Using hospital equipment		48.75	1 383.04	48.75	1 383.04	3	397.68 +T
8.9	**Rectum and anus**							
1705	Incision and drainage of submucous abscess		40	1 134.80	40	1 134.80	3	397.68 +T
1707	Drainage of submucous abscess		40	1 134.80	40	1 134.80	3	397.68 +T
8.10	**Liver**							
1744	Extensive debridement, haemostasis and packing of liver wound or injury		483.80	13 725.41	387.04	10 980.32	13	1723.28 +T
1747	Drainage of liver abscess		179.1	5 081.07	143.28	4 064.85	7	927.92 +T
1749	Hemi-hepatectomy: Right		564	16 000.68	451.2	12 800.54	9	1193.04 +T
1751	Hemi-hepatectomy: Left		521.1	14 783.61	416.88	11 826.89	9	1193.04 +T
1752	Extended right or left hepatectomy		570.9	16 196.43	456.72	12 957.15	9	1193.04 +T
1753	Partial or segmental hepatectomy		378	10 723.86	302.4	8 579.09	9	1193.04 +T
1757	Suture of liver wound or injury		214.2	6 076.85	171.36	4 861.48	9	1193.04 +T
1758	Complex suture of liver wound or injury, including hepatic artery ligation Cannot be used with item 1757		296.60	8 414.54	237.28	6 731.63	13	1723.28 +T
8.11	**Pancreas**							
1780	Gastric and duodenal intubation Code is not appropriate if gastric intubation forms part of anaesthetic indications		8	226.96	8	226.96		
8.12	**Peritoneal cavity**							
1797	Pneumo-peritoneum: First		13	368.81	13	368.81	4	530.24 +T
1799	Pneumo-peritoneum: Repeat		6	170.22	6	170.22	4	530.24 +T
1800	Peritoneal lavage		20	567.40	20	567.40		
1801	Diagnostic paracentesis: Abdomen		8	226.96	8	226.96		
1803	Therapeutic paracentesis: Abdomen		13	368.81	13	368.81		
1807	Add to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	+	45	1 276.65	45	1 276.65	5	662.80 +T
1809	Laparotomy		196	5 560.52	156.8	4 448.42	4	530.24 +T
1811	Suture of burst abdomen		188.3	5 342.07	150.64	4 273.66	7	927.92 +T
1812	Laparotomy for control of surgical haemorrhage		105	2 978.85	105	2 978.85	9	1193.04 +T
1813	Drainage of sub-phrenic abscess		180	5 106.60	144	4 085.28	7	927.92 +T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal		248.4	7 047.11	198.72	5 637.69	5	662.80 +T
1817	Transrectal drainage of pelvic abscess		75	2 127.75	75	2 127.75	4	530.24 +T
9.	**HERNIA**							
1819	Inguinal or femoral hernia +		125	3 546.25	120	3 404.40	4	530.24 +T
1825	Recurrent inguinal or femoral hernia		155	4 397.35	124	3 517.88	4	530.24 +T
1827	Strangulated hernia or femoral hernia		238	6 752.06	190.4	5 401.65	7	927.92 +T
1831	Umbilical hernia		140	3 971.80	120	3 404.40	4	530.24 +T
1835	Incisional hernia		166.8	4 732.12	133.44	3 785.69	4	530.24 +T
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair)	+	77	2 184.49	77	2 184.49	4	530.24 +T
10.	**URINARY SYSTEM**							
10.1	**Kidney**							
1839	Renal biopsy, per kidney, open		71	2 014.27	71	2 014.27	5	662.80 +T
1841	Renal biopsy (needle)		30	851.10	30	851.10	3	397.68 +T
1843	Peritoneal dialysis: First day		33	936.21	33	936.21		
1845	Peritoneal dialysis: Every subsequent day		33	936.21	33	936.21		
1847	Haemodialysis: Per hour or part thereof		21	595.77	21	595.77		
1849	Haemodialysis: Maximum: Eight hours		168	4 766.16	134.4	3 812.93		
1851	Haemodialysis: Thereafter per week		55	1 560.35	55	1 560.35		

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1852	Continuous haemodiafiltration per day in intensive or high care unit		33	936.21	33	936.21			
1853	Primary nephrectomy		225	6 383.25	180	5 106.60	5	662.80	+T
1855	Secondary nephrectomy		267	7 574.79	213.6	6 059.83	5	662.80	+T
1863	Nephro-ureterectomy		305	8 652.85	244	6 922.28	5	662.80	+T
1865	Nephrotomy with drainage nephrostomy		189	5 361.93	151.2	4 289.54	6	795.36	+T
1873	Suture renal laceration (renorraphy)		193	5 475.41	154.4	4 380.33	6	795.36	+T
1879	Closure of renal fistula		189	5 361.93	151.2	4 289.54	5	662.80	+T
1881	Pyeloplasty		252	7 149.24	201.6	5 719.39	5	662.80	+T
1883	Pyelostomy		189	5 361.93	151.20	4 289.54	5	662.80	+T
1891	Perinephric abscess or renal abscess: Drainage		200	5 674.00	160	4 539.20	7	927.92	+T
10.2	**Ureter**								
1897	Ureterorraphy: Suture of ureter		147	4 170.39	120	3 404.40	5	662.80	+T
1898	Ureterorraphy: Lumbar approach		189	5 361.93	151.2	4 289.54	5	662.80	+T
1899	Ureteroplasty		181	5 134.97	144.8	4 107.98	5	662.80	+T
1903	Ureterectomy only		137	3 886.69	120	3 404.40	5	662.80	+T
1907	Cutaneous ureterostomy: Unilateral		108	3 063.96	108	3 063.96	5	662.80	+T
1911	Uretero-enterostomy: Unilateral		137	3 886.69	120	3 404.40	5	662.80	+T
1915	Uretero-ureterostomy		137	3 886.69	120	3 404.40	5	662.80	+T
1925	Uretero-pyelostomy		252	7 149.24	201.6	5 719.39	5	662.80	+T
1941	Ureterostomy-in-situ: Unilateral		100	2 837.00	100	2 837.00	5	662.80	+T
10.3	**Bladder**								
1949	Cystoscopy: Hospital equipment		44	1 248.28	44	1 248.28	3	397.68	+T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	+	10	283.70	10	283.70	3	397.68	+T
1954	Ureteroscopy	+	35	992.95			3	397.68	+T
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time Add to item 1949 or 1954 if appropriate	+	35	992.95	35	992.95	3	397.68	+T
1961	With removal of foreign body or calculus from urethra or bladder	+	20	567.40	20	567.40	3	397.68	+T
1964	And control of haemorrhage and blood clot evacuation	+	15	425.55	15	425.55	3	397.68	+T
1995	Percutaneous aspiration of bladder		10	283.70	10	283.70	3	397.68	+T
1996	Bladder catheterisation - male (not at operation)		6	170.22	6	170.22	3	397.68	+T
1997	Bladder catheterisation - female (not at operation)		3	85.11	3	85.11			
1999	Percutaneous cystostomy		24	680.88	24	680.88	3	397.68	+T
2015	Suprapubic cystostomy		67	1 900.79	67	1 900.79	5	662.80	+T
2035	Cutaneous vesicostomy		118	3 347.66	118	3 347.66	5	662.80	+T
2039	Operation for ruptured bladder		137	3 886.69	120	3 404.40	6	795.36	+T
2047	Drainage of perivesical or prevesical abscess		105	2 978.85	105	2 978.85	5	662.80	+T
2049	Evacuation of clots from bladder: Other than post-operative		132.10	3 747.68	120	3 404.40	3	397.68	+T
2050	Evacuation of clots from bladder: Post-operative						4	530.24	+T
2051	Simple bladder lavage: Including catheterisation		12	340.44	12	340.44	3	397.68	+T
10.4	**Urethra**								
2071	Urethrorraphy: Suture of urethral wound or injury		139	3 943.43	120	3 404.40	4	530.24	+T
2081	Reconstruction or repair of male anterior urethra (one stage)		261.6	7 421.59	209.28	5 937.27	4	530.24	+T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage		168	4 766.16	134.4	3 812.93	6	795.36	+T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage		168	4 766.16	134.4	3 812.93	6	795.36	+T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage		294	8 340.78	235.2	6 672.62	6	795.36	+T
2103	Simple urethral meatotomy		26.3	746.13	26.3	746.13	3	397.68	+T
2105	Incision of deep peri-urethral abscess: Female		123.1	3 492.35	120	3 404.40	3	397.68	+T
2107	Incision of deep peri-urethral abscess: Male		123.1	3 492.35	120	3 404.40	3	397.68	+T
2116	Urethral meatoplasty		101.5	2 879.56	101.50	2 879.56	3	397.68	+T
2117	Closure of urethrostomy or urethrocutaneous fistula (independent procedure)		150.3	4 264.01	120.24	3 411.21	3	397.68	+T
11.	**MALE GENITAL SYSTEM**								
11.1	**Penis**								
2147	Reconstructive operation of penis: for injury: Including fracture of penis and skin graft if required		168	4 766.16	134.4	3 812.93	3	397.68	+T
2161	Total amputation of penis: Without gland dissection		210	5 957.70	168	4 766.16	4	530.24	+T
2167	Partial amputation of penis: Without gland-dissection		84	2 383.08	84	2 383.08	4	530.24	+T
2172	Removal foreign body: Deep penile tissue (e.g. plastic implant)		123.1	3 492.35	120	3 404.40	3	397.68	+T
2228	Removal of foreign body: Scrotum		104.9	2 976.01	104.9	2 976.01	3	397.68	+T
11.2	**Testis and epididymis**								
2191	Orchidectomy (total or subcapsular): Unilateral		98	2 780.26	98	2 780.26	3	397.68	+T
2213	Suture or repair of testicular injury		110.3	3 129.21	110.3	3 129.21	4	530.24	+T
2215	Incision and Drainage of testis or epididymis e.g. abscess or haematoma		90	2 553.30	90	2 553.30	4	530.24	+T
2227	Incision and drainage of scrotal wall abscess		42.7	1 211.40	42.7	1 211.40	3	397.68	+T
14.	**NERVOUS SYSTEM**								
14.1	**Diagnostic procedures**								

			Specialist		General Practitioner		Anaesthetic	
			U	R	U	R	U	R T
2685	Electro-oculography: Unilateral		30	851.10				
2686	Electro-oculography: Bilateral Cannot be used with item 2685		53	1 503.61				
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus		80	2 269.60				
2709	Full spinogram including bilateral median and posterior-tibial studies		140	3 971.80				
2711	Electro-encephalogram (EEG): 20-40 minutes record: Equipment cost for taking of record (Technical component) (refer to item 2712 for interpretation and report)		105.60	2 995.87	105.60	2 995.87		
2712	Clinical interpretation and report of item 2711: Electro-encephalogram (EEG): 20-40 minutes record (Professional component)		16.60	470.94	16.60	470.94		
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications		18.4	522.01	18.4	522.01		
2714	Cisternal or lateral cervical (C1-C2) puncture: Without injection - stand-alone procedure		32	907.84	32	907.84		
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician		31.50	893.66				
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen		7	198.59	7	198.59		
2739	Ventricular needling without burring: Tapping only		16	453.92	16	453.92	4	530.24 +T
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography		43	1 219.91	43	1 219.91	4	530.24 +T
2743	Subdural tapping: First sitting		15	425.55	15	425.55	4	530.24 +T
14.2	**Introduction of burr holes for**							
2747	Burr hole(s): Ventricular puncture, includes injection of gas, contrast media, dye or radioactive material		223.80	6 349.21	179.04	5 079.36	8	1060.48 +T
2749	Catheterisation for ventriculography and/or drainage		150	4 255.50	120	3 404.40	8	1060.48 +T
2752	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for evacuation and/or drainage of subdural haematoma		272.20	7 722.31	217.76	6 177.85	9	1193.04 +T
2753	Burr hole(s). Includes evacuation and/or drainage of haematoma: Extradural or subdural		379.40	10 763.58	303.52	8 610.86	9	1193.04 +T
2754	Burr hole(s) or trephine: Includes subsequent tapping (aspiration) of intracranial abscess		296.40	8 408.87	237.12	6 727.09	9	1193.04 +T
2755	Burr hole(s): Includes aspiration of haematoma or cyst, intracerebral (total procedure)		369.90	10 494.06	295.92	8 395.25	9	1193.04 +T
2757	Burr hole(s) or trephine: Includes drainage of brain abscess or cyst (total procedure)		402.80	11 427.44	322.24	9 141.95	9	1193.04 +T
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery		255.90	7 259.88	204.72	5 807.91	9	1193.04 +T
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral Use once per service		218.90	6 210.19	175.12	4 968.15	9	1193.04 +T
14.3	**Nerve procedures**							
2765	Nerve conduction studies (see items 0733 and 3285)		26	737.62	26	737.62	4	530.24 +T
14.3.1	**Nerve repair of suture**							
2767	Suture Brachial Plexus (see also items 2837 and 2839)		379	10 752.23	303.20	8 601.78	6	795.36 +T
2769	Suture: Large nerve: Primary		297.70	8 445.75	238.16	6 756.60	5	662.80 +T
2771	Suture: Large nerve: Secondary		202	5 730.74	161.60	4 584.59	5	662.80 +T
2773	Suture: Digital nerve: Primary		199	5 645.63	159.20	4 516.50	3	397.68 +T
2775	Suture: Digital nerve: Secondary		96	2 723.52	96	2 723.52	3	397.68 +T
2777	Nerve graft: Simple		309	8 766.33	247.20	7 013.06	4	530.24 +T
2779	Fascicular: First fasciculus		202	5 730.74	161.6	4 584.59	4	530.24 +T
2781	Fascicular: Each additional fasciculus		50	1 418.50	50	1 418.50	4	530.24 +T
2782	Nerve pedicle transfer: First stage (not to be used together with item 2783)		309.10	8 769.17	247.28	7 015.33	4	530.24 +T
2783	Fascicular: Nerve flap: To include all stages		224	6 354.88	179.2	5 083.90	4	530.24 +T
2784	Nerve pedicle transfer: Second stage (not to be used together with item 2783)		338.30	9 597.57	270.64	7 678.06	4	530.24 +T
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis		124	3 517.88	120	3 404.40	6	795.36 +T
2787	Fascicular: Grafting of facial nerve		215	6 099.55	172	4 879.64	5	662.80 +T
14.3.2	**Neurectomy**							
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)		45.4	1 288.00	45.4	1 288.00	5	662.80 +T
2796	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, each additional level each additional level (unilateral or bilateral)	+	16.3	462.43	16.3	462.43	5	662.80 +T
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)		44	1 248.28	44	1 248.28	5	662.80 +T
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)	+	15	425.55	15	425.55	5	662.80 +T
2799	Intrathecal injections for pain		36	1 021.32	36	1 021.32	4	530.24 +T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
2800	Plexus nerve block - as part of treatment **refer to annexture c on the back of this gazette**(motivation to be supplied by treating doctor)		36	1 021.32	36	1 021.32		Fees as for specialist	
2801	Epidural injection, plexus nerve block or peripheral nerve block for pain **refer to annexture c on the back of this gazette**motivation to be supplied by treating doctor (see modifier 0045 for post-operative pain relief) (refer to modifier 0021 for epidural anaesthetic)		36	1 021.32	36	1 021.32		Fees as for specialist	
2802	Peripheral nerve block - as part of treatment (motivation to be supplied)		25	709.25	25	709.25		Fees as for specialist	
2803	Alcohol injection in peripheral nerves for pain: Unilateral		20	567.40	20	567.40	3	397.68	+T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique) To be used only with items 2799, 2800, 2801 or 2802	+	10	283.70	10	283.70		Fees as for specialist	
2805	Alcohol injection in peripheral nerves for pain: Bilateral		35	992.95	35	992.95	3	397.68	+T
2809	Peripheral nerve section for pain		45	1 276.65	45	1 276.65	3	397.68	+T
2913	Obturator or Stoffels		96	2 723.52	96	2 723.52	3	397.68	+T
2815	Excision interdigital neuroma - Morton		82.3	2 334.85	82.3	2 334.85	3	397.68	+T
14.3.3	**Other nerve procedures**								
2827	Transposition of ulnar nerve		170	4 822.90	136	3 858.32	3	397.68	+T
2829	Neurolysis: Minor		51	1 446.87	51	1 446.87	3	397.68	+T
2831	Neurolysis: Major		141	4 000.17	120	3 404.40	3	397.68	+T
2833	Neurolysis: Digital		141	4 000.17	120	3 404.40	3	397.68	+T
2837	Brachial plexus, suture or neurolysis (item 2767)		300	8 511.00	240	6 808.80	6	795.36	+T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation		895.2	25 396.82	716.16	20 317.46	6	795.36	+T
2849	Sympathetic block: Other levels: Unilateral		20	567.40	20	567.40	3	397.68	+T
2851	Sympathetic block: Other levels: Bilateral		35	992.95	35	992.95	3	397.68	+T
14.4	**Skull procedures**								
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)		377.90	10 721.02	302.32	8 576.82	9	1193.04	+T
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)		307.10	8 712.43	245.68	6 969.94	9	1193.04	+T
2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debridement of brain (total procedure)		455.10	12 911.19	364.08	10 328.95	11	1458.16	+T
2863	Cranioplasty: Skull defect =<5 cm diameter: With/without prosthesis		309.10	8 769.17	247.28	7 015.33	9	1193.04	+T
2875	Theco-peritoneal C.S.F. shunt		280	7 943.60	224	6 354.88	8	1060.48	+T
6043	Cranioplasty: Skull defect; >5 cm diameter		340.80	9 668.50	272.64	7 734.80	9	1193.04	+T
6044	Removal of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/infection or inflammatory reaction due to device, implant and/or graft		264.90	7 515.21	211.92	6 012.17	9	1193.04	+T
6045	Replacement of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/open fracture /late effect of fracture/ infection or inflammatory reaction due to device, implant or graft (total procedure)		311.40	8 834.42	249.12	7 067.53	9	1193.04	+T
6046	Cranioplasty: Skull defect, with reparative brain surgery: With/without prosthesis Cannot be used with items 6047 to 6048		421.70	11 963.63	337.36	9 570.90	11	1458.16	+T
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =<5 cm diameter (total procedure) Cannot be used with items 6046 and 6048		371.40	10 536.62	297.12	8 429.29	9	1193.04	+T
6048	Cranioplasty: Includes autograft and obtaining bone grafts; >5 cm diameter (total procedure) Cannot be used with items 6046 to 6047		432.70	12 275.70	346.16	9 820.56	9	1193.04	+T
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure 6046 to 6048		37.30	1 058.20	37.30	1 058.20			+T
6061	Creation of subarachnoid/subdural-peritoneal shunt: Pleural or peritoneal space or other terminus, through burr hole and directing and tunneling the distal end of the shunt subcutaneously towards the draining site (non-neuroendoscopic procedure) (total procedure)		290.80	8 250.00	232.64	6 600.00	10	1325.60	+T
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (total procedure)		111.40	3 160.42	111.40	3 160.42	10	1325.60	+T
6063	Ventriculocisternostomy of the third ventricle: Stereotactic, neuroendoscopic method (under CT guidance for stereotactic positioning) (items 6055 and 6148 may not be added)		358.80	10 179.16	287.04	8 143.32	10	1325.60	+T
6064	Replacement/irrigation: Previously placed intraoperative ventricular catheter		158.30	4 490.97	126.64	3 592.78	10	1325.60	+T
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		252.30	7 157.75	201.84	5 726.20	10	1325.60	+T
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit		26.00	737.62	26.00	737.62	10	1325.60	+T
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)		180.00	5 106.60	144.00	4 085.28	10	1325.60	+T
6068	Cerebrospinal fluid (CSF) shunt system: Complete removal, with replacement by similar or other shunt at same operation		335.50	9 518.14	268.40	7 614.51	10	1325.60	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
14.6	**Shunt procedures and neuroendoscopy**							
2869	Ventriculocistemostomy: From the third ventricle to the cisterna magna (total procedure)	*409.00*		*327.20*				
2871	Creation of shunt: Ventriculo-atrial, -jugular, -auricular Cannot be used with item 2873	*307.20*		*245.76*				
2873	Creation of shunt: Ventriculo-peritoneal, -pleural, other terminus Cannot be used with item 2871	*315.40*		*252.32*				
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure	*56.00*		*56.00*				
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body	*364.80*	**10 349.38**	*291.84*	**8 279.50**			
14.7	**Posterior fossa surgery**							
2879	Glosso-pharyngeal nerve	*480*	**13 617.60**	*384*	**10 894.08**	*6*	**795.36**	+T
2881	Eighth nerve: Intracranial	*480*	**13 617.60**	*384*	**10 894.08**	*8*	**1060.48**	+T
14.7.1	**Supratentorial procedures**							
2892	Micro vascular decompression of cranial nerve (suboccipital)	553	**15 688.61**	442	**12 539.54**	*6*	**795.36**	+T
2893	Craniectomy for excision of brain abscess: Infratentorial or posterior fossa for excision of brain abscess	648.30	**18 392.27**	518.64	**14 713.82**	*13*	**1723.28**	+T
2899	Craniectomy for extra-dural haematoma or empyema	*375*	**10 638.75**	*300*	**8 511.00**	*11*	**1458.16**	+T
14.8	**Craniotomy for**							
6085	Craniectomy/craniotomy: With exploration of the infratentorial area (below the tentorium of the cerebellum), posterior fossa (total procedure)	596.40	**16 919.87**	**477.12**	**13 535.89**	*13*	**1723.28**	+T
6086	Craniectomy/craniotomy: With evacuation of infratentorial, intracerebellar haematoma (total procedure)	614.30	**17 427.69**	491.44	**13 942.15**	*13*	**1723.28**	+T
6087	Craniectomy/craniotomy: With drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)	631.80	**17 924.17**	505.44	**14 339.33**	*13*	**1723.28**	+T
6088	Cranial decompression caused by excess fluid (e.g. blood and pathological tissue), using posterior fossa approach by drilling/sawing through the occipital bone (total procedure)	605.10	**17 166.69**	484.08	**13 733.35**	*13*	**1723.28**	+T
6090	Craniectomy at base of skull (suboccipital): With freeing and section of one or more cranial nerves (total procedure)	624	**17 702.88**	499.20	**14 162.30**	*11*	**1458.16**	+T
6115	Craniectomy/craniotomy: Supratentorial exploration	487.1	**13 819.03**	389.68	**11 055.22**	*11*	**1458.16**	+T
6116	Incision and subcutaneous placement of cranial bone graft (e.g. split- or full thickness); shaving graft or bone dust; with donor site already exposed for the main procedure.	25.9	**734.78**	25.9	**734.78**	*11*	**1458.16**	+T
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)	564.7	**16 020.54**	451.76	**12 816.43**	*11*	**1458.16**	+T
6118	Decompressive craniectomy/craniotomy: With or without duraplasty, for treating intracranial hypertension (most commonly caused by severe closed-head trauma) without evacuation of associated intraparenchymal haematoma or lobectomy	705.1	**20 003.69**	564.08	**16 002.95**	*11*	**1458.16**	+T
6120	Decompression of (roof of) orbit only: Transcranial approach (total procedure)	548.6	**15 563.78**	438.88	**12 451.03**	*11*	**1458.16**	+T
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess	566.2	**16 063.09**	452.96	**12 850.48**	*11*	**1458.16**	+T
6141	Craniectomy/craniotomy: Excision of foreign body from brain	554.3	**15 725.49**	443.44	**12 580.39**	*11*	**1458.16**	+T
6142	Craniectomy/craniotomy: Treatment of penetrating wound of brain	589.9	**16 735.46**	471.92	**13 388.37**	*11*	**1458.16**	+T
2904	Craniectomy/craniotomy: With evacuation of supratentorial, intracerebral haematoma	*590.20*	**16 743.97**	*472.16*	**13 395.18**	*11*	**1458.16**	+T
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery	*489*	**13 872.93**	*391.20*	**11 098.34**	*11*	**1458.16**	+T
2909	CSF-leaks	*450*	**12 766.50**	*360*	**10 213.20**	*11*	**1458.16**	+T
14.8.1	**Stereo-tactic cerebral and spinal cord procedures**							
2918	*(code moved to consultation section)*							
14.8.2	**Repair and/or Reconstruction of Surgical Defects of Skull Base**							
6196	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary repair, anterior, middle or posterior cranial fossa following surgery of the skull base, by free tissue graft (e.g. pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts) Cannot be used with item 6197	*388.7*	**11 027.42**	*310.96*	**8 821.94**	*11*	**1458.16**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
6197	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalised vascularised pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle) Cannot be used with item 6196		*437.8*	**12 420.39**	*350.24*	**9 936.31**	*11*	**1458.16**	+T
14.9	**Spinal operations** **Note: See section 3.8.7 for laminectomy procedures**								
2923	Chordotomy: Unilateral		*178*	**5 049.86**	*142.4*	**4 039.89**	*3*	**397.68**	+T+M
2925	Chordotomy: Open		*350*	**9 929.50**	*280*	**7 943.60**	*3*	**397.68**	+T+M
2927	Rhizotomy: Extradural, but intraspinal		*320*	**9 078.40**	*256*	**7 262.72**	*3*	**397.68**	+T+M
2928	Rhizotomy: Intradural		*350*	**9 929.50**	*280*	**7 943.60**	*3*	**397.68**	+T+M
14.10	**Arterial ligations**								
2951	Carotis: Trauma		*120*	**3 404.40**	*120*	**3 404.40**	*8*	**1060.48**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
			Psychiatrist		Other Specialists and General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.11	**Medical Psychotherapy**								
2957	Individual psychotherapy (specific psychotherapy with approved evidence based method) - per short session (10-20 minutes)		20	567.40	16	453.92			
2968	Group therapy: Adults (5 per group): Code per person per 60-minute session Use once per day only.		8	226.96	8	226.96			
2974	Individual psychotherapy (specific psychotherapy with approved evidence based method) - per intermediate session (21-40 minutes)		40	1 134.80	32	907.84			
2975	Individual psychotherapy (specific psychotherapy with approved evidence based method) - per extended session (41 minutes or longer)		60	1 702.20	48	1 361.76			
14.12	**Physical treatment methods**								
2970	Electro-convulsive treatment (ECT) - each time (see rule Va)		17	482.29	17	482.29	3	397.68	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
			Specialist		General practitioner		Anaesthetic		
			U	R	U	R	U	R	T
15.	GENERAL								
16.	EYE								
16.1	**Procedures performed in rooms**								
16.1.1	**Eye investigations**								
	Note: Not more that three (3) items in this section may be charge during one visit								
	Eye investigations and photography refer to one or both eyes except where otherwise indicated								
	Material used is excluded								
	The tariff for photography is not related to the number of photographs taken								
3003	Fundus contact lens or 90D lens examination(**not to be charged with item 3004 and/or item 3012**)		7	198.59	7	198.59			
3004	Peripheral fundus examination with indirect ophthalmoscope (**not to be charged with item 3003 and/or item 302**)		7	198.59	7	198.59			
3008	Contrast sensitivity test		7	198.59	7	198.59			
3009	Basic capital equipment used in own rooms by Ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	+	11.68	331.36	-				
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens in pathological corneal conditions such as: corneal erosion, ulcer, abrasion or corneal wound Cannot be used with item 3113		12.2	346.11	12.2	346.11			
16.1.2	**Special eye investigations**								
3029	Anterior segment microphotography		21	595.77	21	595.77			-
3032	Eyelid and orbit photography		9	255.33	9	255.33			-
3034	Determination of lens implant power per eye		15	425.55	15	425.55			-
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		22	624.14	22	624.14			As per procedure
16.2	**Retina**								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy		306.9	8 706.75	245.52	6 965.40	6	795.36	+T
16.3	**Cataract**								
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)		4	113.48					
16.4	**Intra-ocular foreign body**								
3071	Intra-ocular foreign body: Anterior to iris		127	3 602.99	120	3 404.40	4	530.24	+T
3073	Intra-ocular foreign body: Posterior to iris (including prophylactic thermal treatment to retina)		210	5 957.70	168	4 766.16	6	795.36	+T
16.5	**Globe**								
3080	Examination of eyes under general anaesthetic where no surgery is done		80	2 269.60	80	2 269.60	4	530.24	+T
3081	Treatment of minor perforating injury		161.6	4 584.59	129.28	3 667.67	6	795.36	+T
3083	Treatment of major perforating injury		267.5	7 588.98	214	6 071.18	6	795.36	+T
3085	Enucleation or Evisceration		105	2 978.85	105	2 978.85	5	662.80	+T
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis		160	4 539.20	128	3 631.36	5	662.80	+T
3088	Hydroxyapetite insertion (Additional to item 3087)	+	40	1 134.80	40	1 134.80	5	662.80	+T
3089	Subconjunctival injection if not done at time of operation		10	283.70	10	283.70	5	662.80	+T
3091	Retrobulbar injection (if not done at time of operation)		16	453.92	16	453.92	4	530.24	+T
3097	Anterior vitrectomy		280	7 943.60	224	6 354.88	6	795.36	+T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement		419	11 887.03	335.2	9 509.62	6	795.36	+T
3100	Lensectomy done at time of posterior vitrectomy		30	851.10	30	851.10	7	927.92	+T
16.6	**Orbit**								
3101	Drainage of orbital abscess		105	2 978.85	105	2 978.85	5	662.80	+T
3104	Removal orbital prosthesis		212.7	6 034.30	170.16	4 827.44	5	662.80	+T
3105	Exenteration		275	7 801.75	220	6 241.40	5	662.80	+T
3107	Orbitotomy requiring bone flap		393	11 149.41	314.40	8 919.53	5	662.80	+T
3108	Eye socket reconstruction		206	5 844.22	164.8	4 675.38	5	662.80	+T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously		300	8 511.00	240	6 808.80	5	662.80	+T
3110	Second stage hydroxyapetite implantation		110	3 120.70	110	3 120.70	5	662.80	+T
16.7	**Cornea**								

		Specialist		General Practitioner		Anaesthetic	
		U	R	U	R	U	R T
3111	Contact lenses: Assessment involving preliminary fittings and tolerance	15	425.55	10	283.70		
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fittings of the contact lenses and further post-fitting visits for one year	200	5 674.00	160	4 539.20		
3115	Fitting of only one cantact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	166	4 709.42	132.8	3 767.54		
3117	Removal of foreign body: On the basis of fee per consultation	31.5	893.66	30	851.10	4	530.24 +T
3118	Curettage of cornea after removal of foreign body(aftercare excluded)	10	283.70	10	283.70		
3119	Tattooing	26	737.62	26	737.62	4	530.24 +T
3121	Corneal graft (Lamellar or full thickness)	289	8 198.93	231.2	6 559.14	6	795.36 +T
3136	Conjunctival flap or graft. Not for use with pterigium surgery	95.7	2 715.01	95.7	2 715.01	6	795.36 +T
16.8	**Ducts**						
3145	Repair of caniculus: Primary procedure	132	3 744.84	120	3 404.40	4	530.24 +T
3147	Repair of caniculus: Secondary procedure	175	4 964.75	140	3 971.80	4	530.24 +T
16.9	**Iris**						
3157	Division of anterior synechiae as isolated procedure	132	3 744.84	120	3 404.40	4	530.24 +T
3158	Repair iris as in dialysis. Anterior chamber reconstruction	142.4	4 039.89	120	3 404.40	4	530.24 +T
16.10	**Lids**						
3165	Repair of skin laceration of the lid. Simple	27.3	774.50	27.3	774.50	4	530.24 +T
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	187	5 305.19	149.6	4 244.15	4	530.24 +T
16.10.1	**Reconstruction of eyelid**						
3185	Staged procedure for partial or total loss of eyelid: First stage	259	7 347.83	207.2	5 878.26	4	530.24 +T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	206	5 844.22	164.8	4 675.38	4	530.24 +T
3189	Full thickness eyelid laceration for injury: Direct repair	136.5	3 872.51	120	3 404.40	4	530.24 +T
16.10.2	**Ptosis**						
3193	Repair by superior rectus, levator or frontalis muscle, brow ptosis or lower lid ptosis operation	190	5 390.30	152	4 312.24	4	530.24 +T
3195	Ptosis: By lesser procedure, e.g. sling operation: Unilateral	137.6	3 903.71	120	3 404.40	4	530.24 +T
3197	Ptosis: By lesser procedure, e.g. sling operation: Bilateral	166	4 709.42	132.8	3 767.54	4	530.24 +T
16.11	**Conjunctiva**						
3199	Repair of conjuctiva by grafting	132	3 744.84	120	3 404.40	4	530.24 +T
3200	Repair of lacerated conjunctiva	47	1 333.39	47	1 333.39	4	530.24 +T
16.12	**General**						
3196	Diamond knife: Use of own diamond knife during intraocular surgery	12	340.44				
3203	Vitrectomy apparatus (hire fee)	120	3 404.40				
17.	**EAR**						
17.1	**External Ear (Pinna)**						
5170	Drainage: Haematoma or abscess of external ear	34.80	987.28	34.80	987.28	5	662.80 +T
5171	Drainage: Abscess of external auditory canal	21	595.77	21	595.77	5	662.80 +T
17.2	**External ear canal**						
3204	Removal of foreign body at rooms with the use of a microscope (excludes loupe) - not to be used combined with item 3206	21.58	612.22				
3205	External ear canal: Removal of foreign body: Under general anaesthetic	21	595.77	21	595.77	4	530.24 +T
17.3	**Middle ear**						
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	255	7 234.35	204	5 787.48	5	662.80 +T
3237	Explaratory tympanotomy	158.9	4 507.99	127.12	3 606.39	5	662.80 +T
3245	Functional reconstruction of tympanic membrane	277	7 858.49	221.6	6 286.79	5	662.80 +T
17.4	**Facial nerve**						
17.4.1	**Facial nerve tests**						
3223	Percutaneous stimulation of the facial nerve	9	255.33	9	255.33	4	530.24 +T
3224	Electroneurography (ENOG)	75	2 127.75	75	2 127.75	4	530.24 +T
17.4.2	**Facial nerve surgery**						
3227	Exploration of facial nerve: Exploration of tympano mastoid segment	297	8 425.89	237.6	6 740.71	5	662.80 +T
3228	Exploration of facial nerve: Grafting of the tympano mastoid segment (including item 3227)	436	12 369.32	348.8	9 895.46	5	662.80 +T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve		436	12 369.32	348.8	9 895.46	5	662.80	+T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis		124	3 517.88	120	3 404.40	6	795.36	+T
17.5	**Inner ear**								
17.5.1	**Audiometry**								
3273	Pure tone audiometry (air conduction)		6.5	184.41	6.5	184.41			
3274	Pure tone audiometry (bone conduction with masking)		6.5	184.41	6.5	184.41			
3275	Impedance audiometry (tympanometry)		6.5	184.41	6.5	184.41			
3276	Impedance audiometry (stapedial reflex) - no code for volume, compliance etc.		6.5	184.41	6.5	184.41			
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score		10	283.70	10	283.70			
17.5.2	**Inner ear: Balance tests**								
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral		50.00	1 418.50					
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral Cannot be used with item 2691		88.00	2 496.56					
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels		60.00	1 702.20					
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels Cannot be used with item 2693		105.00	2 978.85					
2695	Audiology 40Hz response: Unilateral		30.00	851.10					
2696	Audiology 40Hz response: Bilateral		53.00	1 503.61					
2697	Mid- and long latency auditory evoked potentials: Unilateral		30.00	851.10					
2698	Mid- and long latency auditory evoked potentials: Bilateral		53.00	1 503.61					
2702	Total code for audiological evaluation including bilateral AEP and bilateral electro-cochleography		140.00	3 971.80			4	530.20	+T
3273	Pure tone audiometry (air conduction)		6.50	184.41	6.50	184.41			
17.6	**Microsurgery of the skull base** **Note:** Skull base surgery, used for the management of lesions, often requires the skills of medical doctors of different disciplines working together during the operation. The procedures are categorised in three parts: 1. The approach in order to expose the area in which the lesion is situated. 2. The definitive procedure which involves the repair, biopsy, resection or excision of the lesion. It also involves the primary closure of the dura, mucous membranes and skin. 3. Repair/reconstruction procedure: Is coded separately if extensive dural grafting cranioplasty, local or regional myocutaneous pedical flaps, or extensive skin grafts are performed. Note codes for repair and closure with local, pedicled or free flaps and grafts can be found in the relevant sections of the coding structure								
17.6.1	**Middle fossa approach (i.e. transtemporal or supralabyrinthine)**								
3229	Facial nerve: Exploration of the labyrinthine segment		420	11 915.40	336	9 532.32	5	662.80	+T
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)		510	14 468.70	408	11 574.96	11	1458.16	+T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)		620	17 589.40	496	14 071.52	11	1458.16	+T
17.6.2	**Subtotal petrosectomy**								
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mestoid cavity		480	13 617.60	384	10 894.08	11	1458.16	+T

			Confined to specialist in Physical Medicine		Other Specialists and General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
18.	**PHYSICAL TREATMENT**								
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	+	0.75	21.28					

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)		13.5	383.00					
3281	Ultrasonic therapy		10	283.70					
3282	Shortwave diathermy		10	283.70					
3284	Sensory nerve conduction studies		31	879.47					
3285	Motor nerve conduction studies		26	737.62					
3287	Spinal joint and ligament injection		20	567.40	20	567.40			
3288	Epidural injection		36	1 021.32					
3289	Multiple injections - First joint		7.5	212.78					
3290	Each additional joint		4.5	127.67					
3291	Tendon or ligament injection		9	255.33					
3292	Aspiration of joint or interarticular injection		9	255.33					
3293	Aspiration or injection of bursa or ganglion		9	255.33					
3294	Paracervical (neck) nerve block		20	567.40	20	567.40			
3295	Paravertebral root block - unilateral		20	567.40		-			
3296	Paravertebral root block - bilateral		30	851.10					
3297	Manipulation of spine performed by a specialist in Physical Medicine		14	397.18					
3298	Spinal traction		6	170.22					
3299	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)		14	397.18	14	397.18	4	530.24	Hip+T
							3	397.68	Knee / Shoulder + T
3300	Manipulation of large joints without anaesthetic		*		*	*			
3302	Strength duration curve per session		10.5	297.89					
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 intial treatment: A fee for the treatment only is applicable: See rules L and M)		10	283.70	10	283.70			

			Specialist Radiologist		General Practitioner		Anaesthetic	
			U	R	U	R	U	R T
19.	**RADIOLOGY**							
	The amounts in this section are calculated according to the **Radiology** unit values (unless otherwise specified)							
19.1	**Skeleton**							
19.1.1	**Limbs**							
3305	Finger, toe				6.3	186.92		
6500	Hand				7.7	228.46		
6501	Wrist (specify region)				7.7	228.46		
6503	Scaphoid				7.7	228.46		
6504	Radius and Ulna				7.7	228.46		
6505	Elbow				7.7	228.46		
6506	Humerus				7.7	228.46		
6507	Shoulder				7.7	228.46		
6508	Acromio-Clavicula joint				7.7	228.46		
6509	Clavicle				7.7	228.46		
6510	Scapula				7.7	228.46		
6511	Foot				7.7	228.46		
6512	Ankle				7.7	228.46		
6513	Calcaneus				7.7	228.46		
6514	Tibia and fibula				7.7	228.46		
6515	Knee				7.7	228.46		
6516	Patella				7.7	228.46		
6517	Femur				7.7	228.46		
6518	Hip				7.7	228.46		
6519	Sesamoid Bone				7.7	228.46		
3309	Smith-Petersen or equivalent controle, in theatre				38.7	1 148.23		
3311	Stress studies, e.g. joint				7.7	228.46		
3313	Full length study, both legs				15.5	459.89		
3317	Skeletal survey				28	830.76		
3319	Arthrography per joint				15.4	456.92		
3320	Introduction of contrast medium or air: Add	+			13.8	409.45		
19.1.2	**Spinal column**							
3321	Per region, cervical, sacral, coccygeal, one region thoracic				11	326.37		
3325	Stress studies				11	326.37		
3331	Pelvis (Sacro-iliac or hip joints to be added where an extra set of views is required)				11	326.37		
3333	Myelography: Lumbar				28.9	857.46	4	530.24 +T
3334	Myelography: Thoracic				22.2	658.67	4	530.24 +T
3335	Myelography: Cervical				35.5	1 053.29	4	530.24 +T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)						4	530.24 +T
3344	Introduction of contrast medium	+			18.7	554.83		
3345	Discography				34.6	1 026.58	4	530.24 +T
3347	Introduction of contrast medium per disc level: Add	+			28.2	836.69		-
19.1.3	**Skull**							
3349	Skull studies				15.7	465.82		
3351	Paranasal sinuses				11	326.37		
3353	Facial bones and/or orbits				12.6	373.84		
3355	Mandible				9.4	278.90		
3357	Nasal bone				7.8	231.43		
3359	Mastoid: Bilateral				18	534.06		
3361	Teeth: One quadrant				3.7	109.78		
3363	Teeth: Two quadrants				6.3	186.92		
3365	Teeth: Full mouth				11	326.37		
3366	Teeth: Rotation tomography of the teeth and jaws				13.3	394.61		
3367	Teeth:Temporo-mandibular joints: Per side				11	326.37		
3369	Teeth:Tomography: Per side				11	326.37		
3371	Localisation of foreign body in the eye				15.7	465.82		
3381	Ventriculography				27.3	809.99	4	530.24 +T
3385	Post-nasal studies: Lateral neck				6.3	186.92		
3391	For introduction of contrast medium add	+			11	326.37		

			Specialist Radiologist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
19.2	**Alimentary tract**								
3397	Introduction of contrast medium (plus 80% for each additional gland - add)	+			*11*	**326.37**			
3399	Pharynx and oesophagus				*12.7*	**376.81**			
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through				*20*	**593.40**			
3405	Double contrast: Add	+			*7.3*	**216.59**			
3406	Small bowel meal (control film of abdomen included except when part of item 3408)				*20*	**593.40**			
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)				*28.9*	**857.46**			
3409	Barium enema (control film of abdomen included)				*18.3*	**542.96**			
3411	Air contrast study (add)	+			*19.3*	**572.63**			
	Note: For items 3415 and 3416: Endoscopy (See item 1778) ●								
3417	Gastric/oesophageal/duodenal intubation control				*5.9*	**175.05**			
3419	Gastric/oesophageal intubation insertion of tube (add)	+			*5.6*	**166.15**			
3421	Duodenal intubation: Insertion of tube (add)	+			*11*	**326.37**			
3423	Hypotonic duodenography (3403 and 3405 included) (add)	+			*29.3*	**869.33**			
19.4	**Chest**								
3443	Larynx (Tomography included)				*12.5*	**370.88**			
3445	Chest (item 3601 included)				*9.4*	**278.90**			
3449	Ribs				*12.3*	**364.94**			
3451	Sternum or sternoclavicular joints				*12.6*	**373.84**			
3453	Bronchography: Unilateral				*12.6*	**373.84**	8	1060.48	+T
3455	Bronchography: Bilateral				*22.1*	**655.71**	8	1060.48	+T
3457	Introduction of contrast medium included				*35.7*	**1 059.22**			
3461	Pleurography				*12.6*	**373.84**	3	397.68	+T
3463	For introduction of contrast medium: Add	+			*2.8*	**83.08**			
3465	Laryngography				*11*	**326.37**			
3467	For introduction of contrast medium: Add	+			*10*	**296.70**			
3468	Thoracic Inlet				*6.3*	**186.92**			
19.5	**Abdomen**								
3477	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)				*9.4*	**278.90**			
3479	Acute abdomen or equivalent studies				*15.7*	**465.82**			
19.6	**Urinary tract**								
3487	Excretonary urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)				*25.1*	**744.72**			
3493	Waterload test: Add	+			*12.2*	**361.97**			
3497	Cystography only or urethrography only (retrograde)				*19.3*	**572.63**			
3499	Cysto-urethrography: Retrograde				*31.9*	**946.47**			
3503	Cysto-urethrography: Introduction of contrast medium: Add	+			*3.7*	**109.78**			
3505	Retrograde-prograde pyelography				*18.3*	**542.96**	3	397.68	+T
3513	Tomography of renal tract: Add	+			*9.4*	**278.90**			
19.8.1	**Vascular Studies**								
3545	Venography: Per limb				*16.5*	**489.56**			
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram				*48.6*	**1 441.96**	4	530.24	+T
3558	Translumbar aortic puncture, with full study				*69.6*	**2 065.03**	5	662.80	+T
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram				*57*	**1 691.19**	4	530.24	+T
3560	Selective second order catheterisation, arterial or venous, with angiogram/venogram				*65.4*	**1 940.42**	4	530.24	+T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram				*73.2*	**2 171.84**	4	530.24	+T
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)				*130.8*	**3 880.84**	5	662.80	+T
3574	Spinal angiogram (global fee) including all selective catheterisations				*480*	**14 241.60**	5	662.80	+T

			Specialist Radiologist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
19.8.2	Introduction of contrast medium Section 19.8.2 has been discontinued.								

			Specialist Radiologist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
			Specialist		General practitioner		Anaesthetic		
			U	R	U	R	U	R	T
19.11	**Ultrasonic investigations** The amounts in this section are calculated according to the **Ultrasound** unit values (unless otherwise specified)								
3612	Ultrasonic bone densitometry				*19*	**532.57**			
3596	Intravascular ultrasound per case, arterial or venous, for intervention				*30*	**840.90**			
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*	**1 681.80**			
5102	Ultrasound of joints (eg shoulder hip knee), per joint				*50*	**1 401.50**			
5103	Ultrasound soft tissue, any region				*50*	**1 401.50**			
3628	Renal tract				*50*	**1 401.50**			
3631	Ophthalmic examination				*50*	**1 401.50**			
3632	Axial length measurement and calculation of intra-ocular lens power. Per eye. Not to be used with item 3034				*50*	**1 401.50**			
3634	Peripheral vascular study, B mode only				*39*	**1 093.17**			
5110	Carotid ultrasound vascular study; B mode, pulsed and colour doppler; bilateral study, internal, external and common carotid flow and anatomy				*120*	**3 363.60**			
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, 5114)				*164.8*	**4 619.34**			
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				*117*	**3 279.51**			
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour doppler; to evaluate deep vein thrombosis				*117*	**3 279.51**			
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				*142.4*	**3 991.47**			
3635	Plus (+) Doppler				*39*	**1 093.17**			
3637	Plus (+) Colour Doppler (may be added onto any other regional exam, but not to be added to items 5110, 5111, 5112, 5113 or 5114)				*78*	**2 186.34**			
			Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
19.12	**Portable unit examinations**								
3639	Where X-ray unit is kept and used in the hospital: Add	+			*7*	**207.69**			
3640	Theatre investigations (with fixed installation): Add	+			*3*	**89.01**			
3641	Tracer test				*22.1*	**655.71**			
3642	Repeat of further tracer tests for same investigation: half of tracer test (item 3641) fee				*11.1*	**329.34**			
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee								

			Specialist Radiologist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3645	Other organ scanning with use of relevant radio isotopes				*54.8*	1 625.92			

			Specialist Radiologist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
			Specialist Radiologist with own facility		Non-radiologist or specialist radiologist without own facility (calculate at 60% of the fee)		Anaesthetic		
			U	R	U	R	U	R	T
19.14	**Interventional radiological procedures**								
5016	Aspiration thrombectomy (per vessel)				*131.4*	3 898.64			
5018	On-table thrombolysis/transcatheter infusion performed in				*106.8*	3 168.76	5	662.80	+T
5033	Percutaneous cystostomy in radiology suite				*30*	890.10			
5036	Percutaneous Abdominal / pelvic / other drain insertion, any modality				*34.2*	1 014.71			
5041	Balloon occlusion / Wada test				*106.8*	3 168.76	9	1193.04	+T
5072	Tunnelled/Subcutaneous arteria/venous line performed in radiology suite				*82.2*	2 438.87	5	662.80	+T
5074	IVC filter insertion jugular or femoral route				*156*	4 628.52	9	1193.04	+T
5076	Intravascular foreign body removal, arterial or venous, any route				*204.6*	6 070.48	9	1193.04	+T
5088	Oesophageal stent insertion in radiology suite				*102.6*	3 044.14	6	795.36	+T
5090	Trachial stent insertion				*102.6*	3 044.14	6	795.36	+T
5091	GIT Balloon dilatation under fluoroscopy				*66.6*	1 976.02	6	795.36	+T
5092	Other GIT stent insertion				*102.6*	3 044.14	6	795.36	+T
5093	Percutaneous gastrostomy in radiology suite				*85.8*	2 545.69			
5095	Chest drain insertion in radiology suite				*32.4*	961.31			

	This schedule must be used in conjunction with the Radiological Society of S A Guidelines. Please refer to the PET guidelines in Annexure D. This schedule is for the exclusive use of registered specialist radiology practices (Pr No \"038\") and nuclear medicine practices (Pr No \"025\"). "025" practices may only charge the codes with a 3rd digit of 9. "038" practices may charge all codes except codes with a 3rd digit of 9. Practitioners registered as both radiologists and nuclear physicians may charge all codes. Neurosurgeons accredited by the RSSA may charge for the neuro-interventional studies at 100% of the published radiology rate subject to preauthorisation and this excludes equipment fees or any other claims for the same event. **Code Structure Framework** a.The tariff code consists of 5 digits i.1st digit indicates the main anatomical region or procedural category. •0 = General (non specific) •1 = Head •2 = Neck •3 = Thorax •4 = Abdomen and Pelvis (soft tissue) •5 = Spine, Pelvis and Hips •6 = Upper limbs •7 = Lower limbs •8 = Interventional •9 = Soft tissue regions (nuclear medicine) •eg "Head" = 1xxxx ii.2nd digit indicates the sub region within a main region or category eg. •"Head / Skull and Brain" = 10xxx iii.3rd digit indicates modality •1 = General (Black and White) x-rays •2 = Ultrasound •3 = Computed Tomography •4 = Magnetic Resonance Imaging •5 = Angiography •6 = Interventional radiology •9 = Nuclear Medicine (Isotopes) eg: "Head / Skull and Brain / General x-ray" = 101xx iv.4th and 5th digits are specific to a procedure / examination, eg "Head / Skull and Brain / General / X-ray of the skull" = 10100. **Guidelines for use of coding structure** •The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory. •Some codes may have multiple applications and their use is described in notes associated with each code •Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA. •The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs) •Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%. **Consumables** •Contrast Medium oPrior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up. oAfter the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up. •Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are to be billed at net acquisition cost, without mark up, until the implementation of Act 90. •All other consumables are to be billed at net acquisition price, until the implementation of Act 90. Thereafter Act 90 regulations apply. •The cost of film is included in the comprehensive procedure codes and is not billed for separately. •Appropriate codes must be provided for consumables. **General Comments on Procedural Codes** •All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115. •Setting of sterile tray is included in all appropriate procedure codes. •Where introduction of contrast is necessary eg. sialography, arthrography, angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes. •The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study. •CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies). •Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures. Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies **General Codes** **Modifiers**	
00091	Radiology and nuclear medicine services rendered to hospital inpatients	
00092	Radiology and nuclear medicine services rendered to outpatients	
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used	
	Equipment / Diagnostic	
00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).	
	Appropriate code to be provided. See separate codes for contrast and isotopes	
00110	X-ray skeletal survey under five years	6.26

				025 - Nuclear Medicine		038 - Radiology	
				U	R	U	R
00090	Consumables used in radiology procedures						
00091	Radiology and nuclear medicine services rendered to hospital inpatients						
00092	Radiology and nuclear medicine services rendered to outpatients						
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used						
00115	X-ray skeletal survey over five years				-	10.40	2 012.30
00120	X-ray sinogram any region				-	10.89	2 107.11
00130	X-ray with mobile unit in other facility				-	1.90	367.63
	To be added to applicable procedure codes eg 30100.				-		
00135	X-ray control view in theatre any region				-	5.26	1 017.76
00140	X-ray fluoroscopy any region			-	-	2.26	437.29
	May only be added to the examination when fluoroscopy is not included in the standard procedure code. May not be added to: • any angiography, venography, lymphangiography or interventional codes. • any contrasted fluoroscopy examination.						
00145	X-ray fluoroscopy guidance for biopsy, any region			-	-	5.30	1 025.50
	Add to the procedure eg. 80600, 80605, 80610.			-	-		
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour			-	-	2.42	468.25
	Only to be used if equipment is owned by the radiologist.			-	-		
00155	X-ray C-arm fluoroscopy in theatre per half hour (procedure only)			-	-	2.30	445.03
00160	X-ray fixed theatre installation (equipment fee only)			-	-	2.26	437.29
	Only to be used if equipment is owned by the radiologist.			-	-		
00190	X-ray examination contrast material			-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.			-	-		
00210	Ultrasound with mobile unit in other facility			-	-	1.84	356.02
	Add to the relevant ultrasound examination codes eg 10200.			-	-		
00220	Ultrasound intra-operative study			-	-	7.32	1 416.35
	Covers all regions studied. Single code per operative procedure.			-	-		
00230	Ultrasound guidance			-	-	12.10	2 341.23
	guidance. Guided procedure code to be added eg. 80600, 80605, 80610.			-	-		
00240	Ultrasound guidance for tissue ablation			-	-	11.24	2 174.83
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure code to be added if performed by a radiologist. 80620 or 80630.						
00250	Ultrasound limited Doppler study any region			-	-	6.50	1 257.69
	Stand alone code may not be added to any other code.			-	-		
00290	Ultrasound examination contrast material			-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.			-	-		
00310	CT planning study for radiotherapy			-	-	21.37	4 134.88
00320	CT guidance (separate procedure)			-	-	16.92	3 273.85
	Comprehensive CT code including regional study and guidance. Guided procedure code to be added eg 80600, 80605, and 80610.						
00330	CT guidance, with diagnostic procedure			-	-	8.46	1 636.93
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.			-	-		
00340	CT guidance and monitoring for tissue ablation			-	-	21.15	4 092.31
	May only be used once per procedure for a region. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. If performed by radiologist, add procedural code 80620, or 80630.						
00390	CT examination contrast material			-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.			-	-		
00420	MR Spectroscopy any region			-	-	28.90	5 591.86
	May be added to the regional study, once only.			-	-		
00430	MR guidance for needle replacement			-	-	42.56	8 234.93
	Comprehensive MRI code including region studied and guidance. Guided procedure code to be added eg 80600, 80605, 80610.						
00440	MR low field strength imaging of peripheral joint any region			-	-	12.00	2 321.88
00450	MR planning study for radiotherapy or surgical procedure			-	-	38.00	7 352.62

				025 - Nuclear Medicine		038 - Radiology	
				U	R	U	R
00455	MR planning study for radiotherapy or surgical procedure, with contrast			-	-	47.00	9 094.03
00490	MR examination contrast material			-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.			-	-		
00510	Analogue monoplane screening table			-	-	41.01	7 935.02
	A machine code may be added once per complete procedure / patient visit.			-	-		
00520	Analogue monoplane table with DSA attachment			-	-	47.50	9 190.78
	A machine code may be added once per complete procedure / patient visit.			-	-		
00530	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.			-	-	47.50	9 190.78
	A machine code may be added once per complete procedure / patient visit.			-	-		
00540	Digital monoplane screening table			-	-	79.92	15 463.72
	A machine code may be added once per complete procedure / patient visit.			-	-		
00550	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.			-	-	93.03	18 000.37
	A machine code may be added once per complete procedure / patient visit.			-	-		
00560	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment.			-	-	125.00	24 186.25
	A machine code may be added once per complete procedure / patient visit.			-	-		
00590	Angiography and interventional examination contrast material			-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.			-	-		
00900	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton			34.92	6 756.67		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT			48.33	9 351.37		
00906	Nuclear Medicine study - Venous thrombosis regional			21.54	4 167.77		
00909	Nuclear Medicine study - Tumour whole body			-	-	34.15	6 607.68
00912	Nuclear Medicine study - Tumour whole body multiple studies			-	-	47.56	9 202.38
00915	Nuclear Medicine study - Tumour whole body and SPECT			-	-	47.56	9 202.38
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT			-	-	60.98	11 799.02
00921	Nuclear Medicine study – Infection whole body			31.45	6 085.26	-	-
00924	Nuclear Medicine study – infection whole body with SPECT			44.86	8 679.96	-	-
00927	Nuclear Medicine study – infection whole body multiple studies			44.86	8 679.96	-	-
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies			58.27	11 274.66	-	-
00933	Nuclear Medicine study - Bone marrow imaging limited area			24.10	4 663.11	-	-
00936	Nuclear Medicine study - Bone marrow imaging whole body			37.51	7 257.81	-	-
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies			37.51	7 257.81	-	-
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies			50.92	9 852.51	-	-
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic			24.10	4 663.11	-	-
00960	Nuclear Medicine therapy – Hyperthyroidism			11.99	2 319.95	-	-
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases			6.47	1 251.88	-	-
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy			6.47	1 251.88	-	-
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy			6.47	1 251.88	-	-
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate			6.47	1 251.88	-	-
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy			6.47	1 251.88	-	-
00990	Nuclear Medicine Isotope			-	-	-	-
	Identification code for the use of isotope with a procedure. Appropriate codes to be supplied.			-	-	-	-
00991	Nuclear Medicine Substrate			-	-	-	-
00956	PET/CT scan whole body without contrast			165.13	31 951.00	-	-
00957	PET/CT scan whole body with contrast			163.19	31 575.63	-	-
00951	PET/CT local			120.00	23 218.80	-	-
00952	PET/CT local with contrast			124.68	24 124.33	-	-
	Call and assistance			-	-	-	-

				025 - Nuclear Medicine		038 - Radiology	
				U	R	U	R
	•Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. •Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. •Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. •Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. •Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.			-	-		
01010	Emergency call out fee, first case			-	-	3.00	580.47
01020	Emergency call out fee, subsequent cases same trip			-	-	2.00	386.98
01030	Radiologist assistance in theatre, per half hour			-	-	6.00	1 160.94
01040	Radiographer attendance in theatre, per half hour			-	-	1.60	309.58
01050	Written report on study done elsewhere, short			-	-	1.50	290.24
01055	Written report on study done elsewhere, extensive			-	-	4.20	812.66
01060	Written report for medico legal purposes, per hour			-	-	9.72	1 880.72
01070	Consultation for pre-assessment of interventional procedure			-	-	4.86	940.36
01100	X-ray procedure after hours, per procedure			-	-	2.00	386.98
01200	Ultrasound procedure after hours, per procedure			-	-	4.00	773.96
01300	CT procedure after hours, per procedure			-	-	10.00	1 934.90
01400	MR procedure after hours, per procedure			-	-	14.00	2 708.86
01500	Angiography procedure after hours, per procedure			-	-	20.00	3 869.80
01600	Interventional procedure after hours, per procedure			-	-	26.00	5 030.74
01970	Consultation for nuclear medicine study			2.20	425.68		
	Monitoring			-	-		
	•ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.			-	-		
02010	ECG/pulse Oximeter monitoring			-	-	2.00	386.98
	Head			-	-		
	Skull and Brain			-	-		
	Codes 10100 (skull) and 10110 (tomography) may be combined.			-	-		
10100	X-ray of the skull			-	-	3.86	746.87
10110	X-ray tomography of the skull			-	-	4.30	832.01
10120	X-ray shuntogram for VP shunt			-	-	15.36	2 972.01
10200	Ultrasound of the brain – Neonatal			-	-	7.38	1 427.96
10210	Ultrasound of the brain including doppler			-	-	13.22	2 557.94
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler			-	-	15.04	2 910.09
10300	CT Brain uncontrasted			-	-	22.65	4 382.55
10310	CT Brain with contrast only			-	-	33.28	6 439.35
10320	CT Brain pre and post contrast			-	-	40.48	7 832.48
10325	CT brain pre and post contrast for perfusion studies			-	-	49.10	9 500.36
	Stand alone code may not be added to any other CT studies of the brain, except for code 10330			-	-		
10330	CT angiography of the brain			-	-	77.58	15 010.95
10335	CT of the brain pre and post contrast with angiography			-	-	97.91	18 944.61
10340	CT brain for cranio-stenosis including 3D			-	-	34.16	6 609.62
10350	CT Brain stereotactic localisation			-	-	19.36	3 745.97
10360	CT base of skull coronal high resolution study for CSF leak			-	-	34.90	6 752.80
10400	MR of the brain, limited study			-	-	43.56	8 428.42
10410	MR of the brain uncontrasted			-	-	63.80	12 344.66
10420	MR of the brain with contrast			-	-	75.94	14 693.63
10430	MR of the brain pre and post contrast			-	-	104.04	20 130.70
10440	MR of the brain pre and post contrast, for perfusion studies			-	-	107.44	20 788.57
10450	MR of the brain plus angiography			-	-	92.20	17 839.78
10460	MR of the brain pre and post contrast plus angiography			-	-	121.23	23 456.79
10470	MR angiography of the brain uncontrasted			-	-	58.50	11 319.17
10480	MR angiography of the brain contrasted			-	-	74.02	14 322.13

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10485	MR of the brain, with diffusion studies			-	-	79.00	15 285.71
10490	MR of the brain, pre and post contrast, with diffusion studies,			-	-	110.64	21 407.73
10492	MR study of the brain plus angiography plus diffusion, uncontrasted			-	-	95.00	18 381.55
10495	MR of the brain pre and post contrast plus angiography and diffusion			-	-	125.44	24 271.39
10500	Arteriography of intracranial vessels: 1 - 2 vessels			-	-	48.60	9 403.61
10510	Arteriography of intracranial vessels: 3 - 4 vessels			-	-	82.33	15 930.03
10520	Arteriography of extra-cranial (non-cervical) vessels			-	-	48.44	9 372.66
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels			-	-	118.09	22 849.23
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography			-	-	97.57	18 878.82
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography			-	-	37.29	7 215.24
10560	Venography of dural sinuses			-	-	52.23	10 105.98
10900	Nuclear Medicine study – Bone regional, static			21.50	4 160.04		
10905	Nuclear Medicine study – Bone regional, static, with flow			27.53	5 326.78		
10910	Nuclear Medicine study – Bone regional, static with SPECT			34.92	6 756.67		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT			40.94	7 921.48		
10920	Nuclear Medicine study – Brain, planar, complete, static			16.92	3 273.85		
10925	Nuclear Medicine study – Brain complete static with vascular flow			22.95	4 440.60		
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT			30.33	5 868.55		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT			36.36	7 035.30		
10940	Nuclear Medicine study - CSF flow imaging cisternography			21.60	4 179.38		
10945	Nuclear Medicine study – Ventriculography			13.41	2 594.70		
10950	Nuclear Medicine study - Shunt evaluation static, planar			13.41	2 594.70		
10955	Nuclear Medicine study - CFS leakage detection and localisation			13.41	2 594.70		
10960	Nuclear medicine study - CSF SPECT			13.41	2 594.70		
10971	PET/CT scan of the brain uncontrasted			-	-	110.12	21 307.12
10972	PET/CT of the brain contrasted			-	-	116.11	22 466.12
10981	PET/CT perfusion scan of the brain			-	-	131.07	25 360.73
	Facial bones and nasal bones			-	-		
	Codes 11100 (facial bones) and 11110 (tomography) may be combined			-	-		
11100	X-ray of the facial bones			-	-	3.93	760.42
11110	X-ray tomography of the facial bones			-	-	4.30	832.01
11120	X-ray of the nasal bones			-	-	2.39	462.44
11300	CT of the facial bones			-	-	20.96	4 055.55
11310	CT of the facial bones with 3D reconstructions			-	-	30.40	5 882.10
11320	CT of the facial bones/soft tissue, pre and post contrast			-	-	41.26	7 983.40
11400	MR of the facial soft tissue			-	-	62.40	12 073.78
11410	MR of the facial soft tissue pre and post contrast			-	-	100.60	19 465.09
11420	MR of the facial soft tissue plus angiography, with contrast			-	-	110.30	21 341.95
11430	MR angiography of the facial soft tissue			-	-	74.02	14 322.13
	Orbits, lacrimal glands and tear ducts			-	-		
	Code 12130 (tomography) may be added to 12100 or 12110 or 12120 (orbits) or 12140 (dacrocystography).			-	-		
12100	X-ray orbits less than three views			-	-	3.56	688.82
12110	X-ray of the orbits, three or more views, including foramina			-	-	5.30	1 025.50
12120	X-ray of the orbits for foreign body			-	-	3.56	688.82
12130	X-ray tomography of the orbits			-	-	4.30	832.01
12140	X-ray dacrocystography			-	-	11.20	2 167.09
12200	Ultrasound of the orbit/eye			-	-	5.13	992.60
12210	Ultrasound of the orbit/eye including doppler			-	-	10.97	2 122.59
12300	CT of the orbits single plane			-	-	15.70	3 037.79
12310	CT of the orbits, more than one plane			-	-	20.59	3 983.96
12320	CT of the orbits pre and post contrast single plane			-	-	36.03	6 971.44
12330	CT of the orbits pre and post contrast multiple planes			-	-	39.70	7 681.55
12400	MR of the orbits			-	-	62.46	12 085.39
12410	MR of the orbitae, pre and post contrast			-	-	100.64	19 472.83
12900	Nuclear Medicine study – Dacrocystography			-	-	20.77	4 018.79
	Paranasal sinuses			-	-		
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).			-	-		
13100	X-ray of the paranasal sinuses, single view			-	-	2.74	530.16

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13110	X-ray of the paranasal sinuses, two or more views			-	-	3.66	708.17
13120	X-ray tomography of the paranasal sinuses			-	-	4.30	832.01
13130	X-ray of the naso-pharyngeal soft tissue			-	-	2.74	530.16
13300	CT of the paranasal sinuses single plane, limited study			-	-	7.20	1 393.13
13310	CT of the paranasal sinuses, two planes, limited study			-	-	12.40	2 399.28
13320	CT of the paranasal sinuses, any plane, complete study			-	-	15.42	2 983.62
13330	CT of the paranasal sinuses, more than one plane, complete study			-	-	20.77	4 018.79
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast			-	-	34.74	6 721.84
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast			-	-	41.01	7 935.02
13400	MR of the paranasal sinuses			-	-	60.27	11 661.64
13410	MR of the paranasal sinuses, pre and post contrast			-	-	96.59	18 689.20
	Mandible, teeth and maxilla			-	-		
	Code 14110 (orthopantomogram) may be combined with 14100 (mandible) if two separate studies are performed. Code 14110 (orthopantomogram) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14160 (tomography) may be combined with 14130 or 14140 or 14150 (teeth). Code 14160 (tomography) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14330 and 14340 (Dental implants) may be combined if mandible and maxilla are examined at the same visit.						
14100	X-ray of the mandible			-	-		
14110	X-ray orthopantomogram of the jaws and teeth			-	-	3.66	708.17
14120	X-ray maxillofacial cephalometry			-	-	4.06	785.57
14130	X-ray of the teeth single quadrant			-	-	2.77	535.97
14140	X-ray of the teeth more than one quadrant			-	-	2.00	386.98
14150	X-ray of the teeth full mouth			-	-	2.53	489.53
14160	X-ray tomography of the teeth per side			-	-	3.62	700.43
14300	CT of the mandible			-	-	3.23	624.97
14310	CT of the mandible, pre and post contrast			-	-	22.28	4 310.96
14320	CT mandible with 3D reconstructions			-	-	41.26	7 983.40
14330	CT for dental implants in the mandible			-	-	30.40	5 882.10
14340	CT for dental implants in the maxilla			-	-	27.45	5 311.30
14400	MR of the mandible/maxilla			-	-	27.45	5 311.30
14410	MR of the mandible/maxilla, pre and post contrast			-	-	63.80	12 344.66
	TM Joints			-	-	98.64	19 085.85
	Code 15100 (TM joint) and 15120 (tomography) may be combined. Code 15110 (TM joint) and 15130 (tomography) may be combined. Code 15140 (arthrography) and 15120 (tomography) may be combined. Code 15150 (arthrography) and 15130 (tomography)may be combined. Codes 15320 (CT arthrogram) and 15420 (MR arthrogram) include introduction of contrast (00140 may not be added).						
15100	X-ray tempero-mandibular joint, left			-	-		
15110	X-ray tempero-mandibular joint, right			-	-	3.56	688.82
15120	X-ray tomography tempero-mandibular joint, left			-	-	3.56	688.82
15130	X-ray tomography tempero-mandibular joint, right			-	-	4.30	832.01
15140	X-ray arthrography of the tempero-mandibular joint, left			-	-	4.30	832.01
15150	X-ray arthrography of the tempero-mandibular joint, right			-	-	15.41	2 981.68
15200	Ultrasound tempero-mandibular joints, one or both sides			-	-	15.41	2 981.68
15300	CT of the tempero-mandibular joints			-	-	6.56	1 269.29
15310	CT of the tempero-mandibular joints plus 3D reconstructions			-	-	25.38	4 910.78
15320	CT arthrogram of the tempero-mandibular joints			-	-	34.50	6 675.41
15400	MR of the tempero-mandibular joints			-	-	35.96	6 957.90
15410	MR of the tempero-mandibular joints, pre and post contrast			-	-	63.80	12 344.66
15420	MR arthrogram of the tempero-mandibular joints			-	-	100.84	19 511.53
	Mastoids and internal auditory canal			-	-	74.71	14 455.64
	Code 16100 (mastoids) and 16120 (tomography) may be combined. Code 16110 (mastoids bilat) and 16130 (tomography) may be combined Code 16140 (IAM's) and 16150 (tomography) may be combined.						
16100	X-ray of the mastoids, unilateral			-	-	3.59	694.63

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16110	X-ray of the mastoids, bilateral			-	-	7.18	1 389.26
16120	X-ray tomography of the petro-temporal bone, unilateral			-	-	4.30	832.01
16130	X-ray tomography of the petro-temporal bone, bilateral			-	-	8.60	1 664.01
16140	X-ray internal auditory canal, bilateral			-	-	5.23	1 011.95
16150	X-ray tomography of the internal auditory canal, bilateral			-	-	4.30	832.01
16300	CT of the mastoids			-	-	12.60	2 437.97
16310	CT of the internal auditory canal			-	-	21.47	4 154.23
16320	CT of the internal auditory canal, pre and post contrast			-	-	34.20	6 617.36
16330	CT of the ear structures, limited study			-	-	13.40	2 592.77
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes			-	-	43.35	8 387.79
16400	MR of the internal auditory canals, limited study			-	-	43.56	8 428.42
16410	MR of the internal auditory canals, pre and post contrast, limited study			-	-	68.93	13 337.27
16420	MR of the internal auditory canals, pre and post contrast, complete study			-	-	102.64	19 859.81
16430	MR of the ear structures			-	-	64.40	12 460.76
16440	MR of the ear structures, pre and post contrast			-	-	102.64	19 859.81
	Sella turcica			-	-		
	Code 17100 (sella) and 17110 (tomography) may be combined.			-	-		
17100	X-ray of the sella turcica			-	-	3.08	595.95
17110	X-ray tomography of the sella turcica			-	-	4.30	832.01
17300	CT of the sella turcica/hypophysis			-	-	17.45	3 376.40
17310	CT of the sella turcica/hypophysis, pre and post contrast			-	-	42.26	8 176.89
	Salivary glands and floor of the mouth			-	-		
	Neck			-	-		
	Code 20120 (laryngography) includes fluoroscopy (00140 may not be added). Code 20130 (speech) includes tomography and cinematography (00140 may not be added). Code 20450 (MR Angiography) may be combined with 10410 (MR brain).			-	-		
20100	X-ray of soft tissue of the neck			-	-	2.74	530.16
20110	X-ray of the larynx including tomography			-	-	9.39	1 816.87
20120	X-ray laryngography			-	-	8.28	1 602.10
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording			-	-	8.30	1 605.97
20200	Ultrasound of the thyroid			-	-	6.56	1 269.29
20210	Ultrasound of soft tissue of the neck			-	-	6.56	1 269.29
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler			-	-	15.00	2 902.35
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler			-	-	21.84	4 225.82
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler			-	-	10.80	2 089.69
20300	CT of the soft tissues of the neck			-	-	18.25	3 531.19
20310	CT of the soft tissues of the neck, with contrast			-	-	38.15	7 381.64
20320	CT of the soft tissues of the neck, pre and post contrast			-	-	43.81	8 476.80
20330	CT angiography of the extracranial vessels in the neck			-	-	79.36	15 355.37
20340	intracranial vessels of the brain			-	-	107.50	20 800.18
20350	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain plus a pre and post contrast study of the brain			-	-	124.43	24 075.96
20400	Mr of the soft tissue of the neck			-	-	63.60	12 305.96
20410	MR of the soft tissue of the neck, pre and post contrast			-	-	102.04	19 743.72
20420	MR of the soft tissue of the neck and uncontrasted angiography			-	-	92.60	17 917.17
20430	MR angiography of the extracranial vessels in the neck, without contrast			-	-	59.60	11 532.00
20440	MR angiography of the extracranial vessels in the neck, with contrast			-	-	74.02	14 322.13
20450	MR angiography of the extra and intracranial vessels with contrast			-	-	116.05	22 454.51
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast			-	-	135.17	26 154.04
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast			-	-	156.05	30 194.11
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels			-	-	44.43	8 596.76
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels			-	-	50.73	9 815.75
20520	Arteriography of cervical vessels: carotid and vertebral			-	-	77.63	15 020.63
20530	Arteriography of aortic arch and cervical vessels			-	-	91.97	17 795.28

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20540	Arteriography of aortic arch, cervical and intracranial vessels			-	-	108.87	21 065.26
20550	Venography of jugular and vertebral veins			-	-	48.95	9 471.34
	Thyroid (Nuclear Medicine)			-	-		
21900	Nuclear Medicine study - Thyroid, single uptake			9.68	1 872.98	-	-
21910	Nuclear medicine study - Thyroid, multiple uptake			14.69	2 842.37	-	-
21920	Nuclear medicine study - Thyroid imaging with uptake			17.72	3 428.64	-	-
21930	Nuclear medicine study - Thyroid imaging			12.72	2 461.19	-	-
21940	Nuclear medicine study - Thyroid imaging with vascular flow			18.74	3 626.00	-	-
21950	Nuclear medicine study - Thyroid suppression/stimulation			12.72	2 461.19	-	-
29920	Nuclear medicine study - Tumour localisation planar, static			18.04	3 490.56	-	-
29925	Nuclear medicine study - Infection localisation planar, static, multiple			31.45	6 085.26	-	-
29930	Nuclear medicine study - Infection localisation planar, static and			31.45	6 085.26	-	-
29935	Nuclear medicine study - Infection localisation planar, static, multiple			44.86	8 679.96	-	-
29961	PET/CT scan of the soft tissue of the neck uncontrasted			-	-	105.87	20 484.79
29962	PET/CT scan of the soft tissue of the neck contrasted			-	-	111.69	21 610.90
	Thorax			-	-		
	Chest wall, pleura, lungs and mediastinum			-	-		
	Code 30140 (tomography) may be combined with 30100 or 30110 (chest) or 30150 or 30155 (ribs) or 30160 (thoracic inlet). Codes 30170 (Sterno-clavicular) and 30175 (tomography) may be combined. Code 30180 (sternum) and 30185 (tomography) may be combined. Code 30340 (CT limited high resolution) may be combined with 30310 or 30320 or 30330 (CT chest). Motivation may be required. Code 30350 (high resolution) is a stand alone study. Code 30360, (CT chest for pulmonary embolism) is a complete examination and includes the preceding uncontrasted CT scan of the chest, and may not be combined with 40330 or 40333 (CT abdomen and pelvis). Code 30370 (CT pulmonary embolism plus CT venography) may not be combined with 70230 (Doppler).			-	-		
30100	X-ray of the chest, single view			-	-	3.04	588.21
30110	X-ray of the chest two views, PA and lateral			-	-	3.84	743.00
30120	X-ray of the chest complete with additional views			-	-	4.24	820.40
30130	X-ray of the chest complete including fluoroscopy			-	-	4.48	866.84
30140	X-ray tomography of the chest			-	-	4.30	832.01
30150	X-ray of the ribs			-	-	4.79	926.82
30155	X-ray of the chest and ribs			-	-	6.42	1 242.21
30160	X-ray of the thoracic inlet			-	-	2.56	495.33
30170	X-ray of the sterno-clavicular joints			-	-	4.21	814.59
30175	X-ray tomography of the sterno-clavicular joint			-	-	4.30	832.01
30180	X-ray of the sternum			-	-	4.21	814.59
30185	X-ray tomography of the sternum			-	-	4.30	832.01
30200	Ultrasound of the chest wall, any region			-	-	6.56	1 269.29
30210	Ultrasound of the pleural space			-	-	6.56	1 269.29
30220	Ultrasound of the mediastinal structures			-	-	6.56	1 269.29
30300	CT of the chest, limited study			-	-	9.50	1 838.16
30310	CT of the chest uncontrasted			-	-	26.60	5 146.83
30320	CT of the chest contrasted			-	-	42.43	8 209.78
30330	CT of the chest, pre and post contrast			-	-	45.70	8 842.49
30340	CT of the chest, limited high resolution study			-	-	11.20	2 167.09
30350	CT of the chest, complete high resolution study			-	-	24.01	4 645.69
30355	and expiratory studies			-	-	33.30	6 443.22
30360	CT of the chest for pulmonary embolism			-	-	57.12	11 052.15
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs			-	-	80.28	15 533.38
30400	MR of the chest			-	-	63.60	12 305.96
30410	MR of the chest with uncontrasted angiography			-	-	92.60	17 917.17
30420	MR of the chest, pre and post contrast			-	-	102.04	19 743.72
30900	Nuclear Medicine study - Lung perfusion			21.54	4 167.77		
30910	Nuclear Medicine study - Lung ventilation, aerosol			21.50	4 160.04		
30920	Nuclear Medicine study - Lung perfusion and ventilation			42.03	8 132.38		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas			14.17	2 741.75		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas			34.69	6 712.17		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic			26.51	5 129.42		

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30960	Nuclear medine study - alveolar permeabillity			26.51	5 129.42		
	Stand alone code. Not to be combined with 30910.			-	-		
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation			6.02	1 164.81		
	Stand alone code. Not to be combined with 30920.			-	-		0.00
30981	PET/CT scan of the chest uncontrasted			-	-	111.44	21 562.53
30982	PET/CT scan of the chest contrasted			-	-	117.42	22 719.60
30983	PET/CT scan of the chest pre and post contrast			-	-	148.32	28 698.44
	Oesophagus			-	-		
	may not be added).			-	-		
31100	X-ray barium swallow			-	-	6.60	1 277.03
31105	Xray 3 phase dynamic contrasted swallow			-	-	12.60	2 437.97
31110	X-ray barium swallow, double contrast			-	-	7.92	1 532.44
31120	X-ray barium swallow with cinematography			-	-	10.07	1 948.44
	Aorta and large vessels			-	-		
	Codes 32210 and 32220 (ivus) may be combined			-	-		
32200	intervention, once per complete procedure			-	-	4.20	812.66
32210	Ultrasound intravascular (IVUS) first vessel			-	-	8.44	1 633.06
32220	Ultrasound intravascular (IVUS) subsequent vessels			-	-	5.30	1 025.50
32300	CT angiography of the aorta and branches			-	-	79.08	15 301.19
32305	CT angiography of the thoracic and abdominal aorta and branches			-	-	105.50	20 413.20
32310	CT angiography of the pulmonary vasculature			-	-	79.08	15 301.19
32400	MR angiography of the aorta and branches			-	-	78.50	15 188.97
32410	MR angiography of the pulmonary vasculature			-	-	105.27	20 368.69
32500	Arteriography of thoracic aorta			-	-	28.26	5 468.03
32510	Arteriography of bronchial intercostal vessels alone			-	-	50.15	9 703.52
32520	Arteriography of thoracic aorta, bronchial and intercostal vesseis			-	-	67.43	13 047.03
32530	Arteriography of pulmonary vessels			-	-	63.27	12 242.11
32540	Arteriography of heart chambers, coronary arteries			-	-	44.27	8 565.80
32550	Venography of thoracic vena cava			-	-	28.38	5 491.25
32560	Venography of vena cava, azygos system			-	-	56.31	10 895.42
32570	Venography patency of A-port or other central line			-	-	19.64	3 800.14
	Heart			-	-		
	Codes 33300 (CT anatomy / function) and 33310 (CT Angiography) may be done as stand alone studies or as additive studies if both are performed at the same time.			-	-		
	or 33210. This code is intended for paediatric and foetal cases only			-	-		
33200	Ultrasound study of the heart, including Doppler			-	-	8.20	1 586.62
33210	Ultrasound study of the heart trans-oesophageal			-	-	10.52	2 035.51
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel			-	-	5.20	1 006.15
33300	CT anatomical/functional study of the heart			-	-	34.61	6 696.69
33310	CT angiography of heart vessels			-	-	81.28	15 726.87
33970	Nuclear Medicine study - Multi stage treadmill ECG test			-	-	6.66	1 288.64
	Mamma						
34200	Ultrasound study of the breast					7.90	1 528.57
	Abdomen and Pelvis			-	-		
	Abdomen/stomach/bowel			-	-		
	Code 40120 (tomography) may be combined with 40100 or 40105 or 40110 (abdomen). Codes 40140 to 40190 (barium studies) include fluoroscopy (00140 may not be added). Code 40190 (intussusception) is a stand alone code and may not be combined with 40160 or 40165 (barium enema), (00140 may not be added).			-	-		
40100	X-ray of the abdomen			-	-	3.32	642.39
40105	X-ray of the abdomen supine and erect, or decubitus			-	-	5.36	1 037.11
40110	X-ray of the abdomen multiple views including chest			-	-	8.10	1 567.27
40120	X-ray tomography of the abdomen			-	-	4.30	832.01
40140	X-ray barium meal single contrast			-	-	8.87	1 716.26
40143	X-ray barium meal double contrast			-	-	11.99	2 319.95
40147	X-ray barium meal double contrast with follow through			-	-	15.80	3 057.14
40150	X-ray small bowel enteroclysis (meal)			-	-	25.45	4 924.32
	intubation) may be added.			-	-		
40153	X-ray small bowel meal follow through single contrast			-	-	19.55	3 782.73
40157	X-ray small bowel meal with pneumocolon			-	-	25.63	4 959.15
40160	X-ray large bowel enema single contrast			-	-	12.97	2 509.57
40165	X-ray large bowel enema double contrast			-	-	19.63	3 798.21
40170	X-ray guided gastro oesophageal intubation			-	-	1.60	309.58
40175	X-ray guided duodenal intubation			-	-	2.80	541.77

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40180	X-ray defaecogram			-	-	12.97	2 509.57
40190	X-ray guided reduction of intussusception			-	-	16.27	3 148.08
40200	Ultrasound study of the abdominal wall			-	-	5.54	1 071.93
40210	Ultrasound study of the whole abdomen including the pelvis			-	-	8.24	1 594.36
40300	CT study of the abdomen			-	-	26.41	5 110.07
40310	CT study of the abdomen with contrast			-	-	44.82	8 672.22
40313	CT study of the abdomen pre and post contrast			-	-	52.99	10 253.04
40320	CT of the pelvis			-	-	26.13	5 055.89
40323	CT of the pelvis with contrast			-	-	47.48	9 186.91
40327	CT of the pelvis pre and post contrast			-	-	53.87	10 423.31
40330	CT of the abdomen and pelvis			-	-	38.50	7 449.37
40333	CT of the abdomen and pelvis with contrast			-	-	62.17	12 029.27
40337	CT of the abdomen and pelvis pre and post contrast			-	-	67.43	13 047.03
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast			-	-	74.11	14 339.54
40345	CT of the chest, abdomen and pelvis without contrast			-	-	70.12	13 567.52
40350	CT of the chest, abdomen and pelvis with contrast			-	-	88.35	17 094.84
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast			-	-	93.05	18 004.24
40360	CT of the base of skull to symphysis pubis with contrast			-	-	102.73	19 877.23
40365	CT colonoscopy			-	-	34.78	6 729.58
	Stand alone study, may not be added to any code between 40300 and 40360			-	-		
40400	MR of the abdomen			-	-	64.58	12 495.58
40410	MR of the abdomen pre and post contrast			-	-	100.84	19 511.53
40420	MR of the pelvis, soft tissue			-	-	64.58	12 495.58
40430	MR of the pelvis, soft tissue, pre and post contrast			-	-	102.04	19 743.72
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying			21.50	4 160.04	-	-
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies			34.92	6 756.67	-	-
40910	Nuclear Medicine study - Gastro intestinal protein loss			21.50	4 160.04	-	-
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies			34.92	6 756.67	-	-
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic			21.50	4 160.04	-	-
40925	Nuclear medicine study – Acute GIT bleed multiple studies			34.92	6 756.67	-	-
40930	Nuclear medicine study - Meckel's localisation			20.77	4 018.79	-	-
40935	Nuclear medicine study - Gastric mucosa imaging			20.77	4 018.79	-	-
40940	Nuclear medicine study - colonic transit multiple studies			44.86	8 679.96	-	-
	Stand alone code			-	-		
40951	PET/CT scan of the abdomen and pelvis uncontrasted			-	-	119.53	23 127.86
40952	PET/CT scan of the abdomen and pelvis contrasted			-	-	129.31	25 020.19
40953	PET/CT scan of the abdomen and pelvis pre and post contrast			-	-	140.50	27 185.35
	Liver, spleen, gall bladder and pancreas			-	-		
	Code 41110, 41120 and 41130 (cholangiography) include fluoroscopy (00140 may not be added).			-	-		
41100	X-ray ERCP including screening			-	-	18.90	3 656.96
41105	X-ray ERCP reporting on images done in theatre			-	-	2.40	464.38
41110	X-ray cholangiography intra-operative			-	-	8.45	1 634.99
41120	X-ray T-tube cholangiography post operative			-	-	14.05	2 718.53
41130	X-ray transhepatic percutaneous cholangiography			-	-	32.34	6 257.47
41200	Ultrasound study of the upper abdomen			-	-	7.00	1 354.43
41300	CT of the abdomen triphasic study – liver			-	-	54.90	10 622.60
41400	MR study of the liver/pancreas			-	-	64.78	12 534.28
41410	MR study of the liver/pancreas pre and post contrast			-	-	100.84	19 511.53
41420	MRCP			-	-	49.20	9 519.71
41430	MR study of the abdomen with MRCP			-	-	92.98	17 990.70
41440	MR study of the abdomen pre and post contrast with MRCP			-	-	133.60	25 850.26
41900	Nuclear Medicine study - Liver and spleen, planar views only			21.50	4 160.04	-	-
41905	Nuclear Medicine study - Liver and spleen, with flow study			27.53	5 326.78	-	-
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT			34.92	6 756.67	-	-
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT			40.94	7 921.48	-	-
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic			21.50	4 160.04	-	-
41925	Nuclear Medicine study – hepatobiliary tract including flow			26.51	5 129.42	-	-
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies			34.92	6 756.67	-	-
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies			39.92	7 724.12	-	-

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41940	Nuclear medicine study - Gall bladder ejection fraction			6.02	1 164.81	-	-
41945	Nuclear medicine study – Biliary gastric reflux study			20.77	4 018.79	-	-
	Renal tract			-	-		
42100	X-ray tomography of the renal tract			-	-	4.30	832.01
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP). Codes 42115 (IVP), 42120 (cystography), 42130 (urethography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).			-	-		
42110	X-ray excretory urogram including tomography			-	-	24.86	4 810.16
42115	X-ray excretory urogram including tomography with micturating study			-	-	32.86	6 358.08
42120	X-ray cystography			-	-	15.05	2 912.02
42130	X-ray urethrography			-	-	15.37	2 973.94
42140	X-ray micturating cysto-urethrography			-	-	19.30	3 734.36
42150	X-ray retrograde/prograde pyelography			-	-	12.53	2 424.43
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre			-	-	2.41	466.31
42160	X-ray prograde pyelogram – percutaneous			-	-	32.67	6 321.32
42200	Ultrasound study of the renal tract including bladder			-	-	7.42	1 435.70
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney			-	-	3.80	735.26
	Code 42205 is a stand alone study and may not be added to 42200			-	-		
42210	Ultrasound study of the renal arteries including Doppler			-	-	10.60	2 050.99
42400	MR of the renal tract for obstruction			-	-	47.00	9 094.03
42410	MR of the kidneys without contrast			-	-	64.58	12 495.58
42420	MR of the kidneys pre and post contrast			-	-	102.24	19 782.42
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)			21.94	4 245.17		
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow			27.96	5 409.98		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT			35.35	6 839.87		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT			41.37	8 004.68		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow			26.51	5 129.42		
42930	Nuclear Medicine study – Renovascular study, baseline			26.51	5 129.42		
42940	Nuclear Medicine study – Renovascular study, with intervention			26.51	5 129.42		
42950	Nuclear medicine study - indirect voiding cystogram			6.02	1 164.81		
	Reproductive system						
43200	Ultrasound study of the pelvis transabdominal.					5.70	1 102.89
43220	Ultrasound study of the testes.					7.38	1 427.96
	Aorta and vessels			-	-		
	Code 44400 (MR Angiography) may be combined with 40400 (MR abdomen).			-	-		
44200	Ultrasound study of abdominal aorta and branches including doppler			-	-	18.32	3 544.74
44205	Ultrasound study of the IVC and pelvic veins including Doppler			-	-	14.00	2 708.86
	This is a stand alone code and may not be added to 44200.			-	-		0.00
44300	CT angiography of abdominal aorta and branches			-	-	76.72	14 844.55
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen			-	-	94.32	18 249.98
44310	CT angiography of the pelvis			-	-	78.64	15 216.05
44320	CT angiography of the abdominal aorta and pelvis			-	-	89.54	17 325.09
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis			-	-	119.15	23 054.33
44330	CT portogram			-	-	74.40	14 395.66
44400	MR angiography of abdominal aorta and branches			-	-	76.64	14 829.07
44500	Arteriography of abdominal aorta alone			-	-	28.12	5 440.94
44503	Arteriography of aorta plus coeliac, mesenteric branches			-	-	75.63	14 633.65
44505	Arteriography of aorta plus renal, adrenal branches			-	-	63.01	12 191.80
44507	Arteriography of aorta plus non-visceral branches			-	-	60.79	11 762.26
44510	Arteriography of coeliac, mesenteric vessels alone			-	-	64.35	12 451.08
44515	Arteriography of renal, adrenal vessels alone			-	-	49.49	9 575.82
44517	Arteriography of non-visceral abdominal vessels alone			-	-	54.91	10 624.54
44520	Arteriography of internal and external iliac vessels alone			-	-	56.72	10 974.75
44525	Venography of internal and external iliac veins alone			-	-	62.11	12 017.66
44530	Corpora cavernosography			-	-	25.06	4 848.86
44535	Vasography, vesiculography			-	-	29.19	5 647.97

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44540	Venography of inferior vena cava			-	-	26.12	5 053.96
44543	Venography of hepatic veins alone			-	-	53.77	10 403.96
44545	Venography of inferior vena cava and hepatic veins			-	-	68.91	13 333.40
44550	Venography of lumbar azygos system alone			-	-	43.89	8 492.28
44555	Venography of inferior vena cava and lumbar azygos veins			-	-	65.46	12 665.86
44560	Venography of renal, adrenal veins alone			-	-	43.99	8 511.63
44565	Venography of inferior vena cava and renal/adrenal veins			-	-	68.39	13 232.78
44570	Venography of spermatic, ovarian veins alone			-	-	40.39	7 815.06
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins			-	-	73.99	14 316.33
44580	Venography indirect splenoportogram			-	-	48.67	9 417.16
44583	Venography direct splenoportogram			-	-	31.59	6 112.35
44587	Venography transhepatic portogram			-	-	66.75	12 915.46
	Soft Tissue			-	-		
	Spine, Pelvis and Hips			-	-		
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventianla myelography codes viz. 51160, 52150, 53160			-	-		
	General			-	-		
	Code 50130 (Lumbar puncture) and 50140 (cisternal puncture) include fluoroscopy and introduction of contrast (00140 may not be added).			-	-		
50100	X-ray of the spine scoliosis view AP only			-	-	7.00	1 354.43
50105	X-ray of the spine scoliosis view AP and lateral			-	-	12.00	2 321.88
50110	X-ray of the spine scoliosis view AP and lateral including stress views			-	-	18.54	3 587.30
50120	X-ray bone densitometry			-	-	11.52	2 229.00
50130	X-ray guided lumbar puncture			-	-	4.80	928.75
50140	X-ray guided cisternal puncture cisternogram			-	-	22.98	4 446.40
50300	CT quantitive bone mineral density			-	-	11.83	2 288.99
50500	Arteriogram of the spinal column and cord, all vessels			-	-	127.23	24 617.73
50510	Venography of the spinal, paraspinal veins			-	-	58.45	11 309.49
	Cervical			-	-		
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51140 (tomography) may be combined with 51110 or 51120 (spine). Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51300 (CT) limited - limited to a single cervical vertebral body. Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 51320 (CT) complete study - an extensive study of the cervical spine. Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).			-	-		
51100	X-ray f the cervical spine, stress views only			-	-	4.14	801.05
51110	X-ray of the cervical spine, one or two views			-	-	3.01	582.40
51120	X-ray of the cervical spine, more than two views			-	-	4.28	828.14
51130	X-ray of the cervical spine, more than two views including stress views			-	-	7.58	1 466.65
51140	X-ray Tomography cervical spine			-	-	4.30	832.01
51160	X-ray myelography of the cervical spine			-	-	27.46	5 313.24
51170	X-ray discography cervical spine per level			-	-	25.17	4 870.14
51300	CT of the cervical spine limited study			-	-	9.50	1 838.16
51310	CT of the cervical spine – regional study			-	-	13.91	2 691.45
51320	CT of the cervical spine – complete study			-	-	37.13	7 184.28
51330	CT of the cervical spine pre and post contrast			-	-	58.85	11 386.89
51340	CT myelography of the cervical spine			-	-	47.19	9 130.79
51350	CT myelography of the cervical spine following myelogram			-	-	21.69	4 196.80
51400	MR of the cervical spine, limited study			-	-	44.40	8 590.96
51410	MR of the cervical spine and cranio-cervical junction			-	-	64.82	12 542.02
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast			-	-	102.14	19 763.07
51900	Nuclear Medicine study – Bone regional cervical			21.50	4 160.04		
51910	Nuclear Medicine study – Bone tomography regional cervical			13.41	2 594.70		
51920	Nuclear Medicine study – with flow			6.02	1 164.81		

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				U	R	U	R
	Thoracic			-	-		
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine). Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52300 (CT) limited study – limited to a single thoracic vertebral body. Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. Code 52310 (CT) complete study - an extensive study of the thoracic spine. Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).			-	-		
52100	X-ray of the thoracic spine, one or two views			-	-	3.21	**621.10**
52110	X-ray of the thoracic spine, more than two views			-	-	4.00	**773.96**
52120	X-ray tomography thoracic spine			-	-	4.30	**832.01**
52140	X-ray of the thoracic spine, more that two views including stress views			-	-	6.64	**1 284.77**
52150	X-ray myelography of the thoracic spine			-	-	18.62	**3 602.78**
52300	CT of the thoracic spine limited study			-	-	9.50	**1 838.16**
52305	CT of the thoracic spine – regional study			-	-	13.91	**2 691.45**
52310	CT of the thoracic spine complete study			-	-	35.78	**6 923.07**
52320	CT of the thoracic spine pre and post contrast			-	-	58.85	**11 386.89**
52330	CT myelography of the thoracic spine			-	-	48.09	**9 304.93**
52340	CT myelography of the thoracic spine following myelogram			-	-	20.37	**3 941.39**
52400	MR of the thoracic spine, limited study			-	-	46.60	**9 016.63**
52410	MR of the thoracic spine			-	-	64.34	**12 449.15**
52420	MR of the thoracic spine pre and post contrast			-	-	101.42	**19 623.76**
52900	Nuclear Medicine study – Bone regional dorsal			21.50	**4 160.04**	-	-
52910	Nuclear Medicine study – Bone tomography regional dorsal			13.41	**2 594.70**	-	-
52920	Nuclear Medicine study – with flow			6.02	**1 164.81**	-	-
	Lumbar						
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53140 (tomography) may be combined with 53110 or 53120 (spine). Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 53300 (CT) limited study – limited to a single lumbar vertebral body. Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 53320 (CT) complete study - an extensive study of the lumbar spine. Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).			-	-		
53100	X-ray of the lumbar spine – stress study only			-	-	4.14	**801.05**
53110	X-ray of the lumbar spine, one or two views			-	-	3.56	**688.82**
53120	X-ray of the lumbar spine, more than two views			-	-	4.46	**862.97**
53130	X-ray of the lumbar spine, more that two views including stress views			-	-	7.52	**1 455.04**
53140	X-ray tomography lumbar spine			-	-	4.30	**832.01**
53160	X-ray myelography of the lumbar spine			-	-	23.94	**4 632.15**
53170	X-ray discography lumbar spine per level			-	-	25.17	**4 870.14**
53300	CT of the lumbar spine limited study			-	-	9.50	**1 838.16**
53310	CT of the lumbar spine – regional study			-	-	13.91	**2 691.45**
53320	Ct of the lumbar spine complete study			-	-	37.64	**7 282.96**
53330	CT of the lumbar spine pre and post contrast			-	-	58.85	**11 386.89**
53340	CT myelography of the lumbar spine			-	-	49.11	**9 502.29**
53350	CT myelography of the lumbar spine following myelogram			-	-	23.46	**4 539.28**
53400	MR of the lumbar spine, limited study			-	-	46.20	**8 939.24**
53410	MR of the lumbar spine			-	-	64.32	**12 445.28**
53420	MR of the lumbar spine pre and post contrast			-	-	103.29	**19 985.58**
53900	Nuclear medicine study – Bone regional lumbar			21.50	**4 160.04**		
53910	Nuclear medicine study – Bone tomography regional lumbar			13.41	**2 594.70**		
53920	Nuclear medicine study – with flow			6.02	**1 164.81**		
	Sacrum			-	-		

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				U	R	U	R
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints). Code 54300 (CT) limited study - limited to single sacral vertebral body. Code 54310 (CT) complete study - an extensive study of the sacral spine.			-	-		
54100	X-ray of the sacrum and coccyx			-	-	3.58	692.69
54110	X-ray of the sacro-iliac joints			-	-	4.10	793.31
54120	X-ray tomography – sacrum and/or coccyx			-	-	4.30	832.01
54300	CT of the sacrum – limited study			-	-	7.60	1 470.52
54310	CT of the sacrum – complete study – uncontrasted			-	-	25.61	4 955.28
54320	CT of the sacrum with contrast			-	-	46.93	9 080.49
54330	CT of the sacrum pre and post contrast			-	-	52.97	10 249.17
54400	MR of the sacrum			-	-	65.00	12 576.85
54410	MR of the sacrum pre and post contrast			-	-	101.04	19 550.23
	Pelvis			-	-		
	Codes 55110 (tomography) and 55100 (pelvis) may be combined. Code 55300 (CT) limited study – limited to a small region of interest of the pelvis eg. ascetabular roof or pubic ramus.			-	-		
55100	X-ray of the pelvis			-	-	3.66	708.17
55110	X-ray tomography – pelvis			-	-	4.30	832.01
55300	CT of the bony pelvis limited			-	-	9.50	1 838.16
55310	CT of the bony pelvis complete uncontrasted			-	-	25.61	4 955.28
55320	CT of the bony pelvis complete 3D recon			-	-	37.47	7 250.07
55330	CT of the bony pelvis with contrast			-	-	46.93	9 080.49
55340	CT of the bony pelvis – pre and post contrast			-	-	52.97	10 249.17
55400	MR of the bony pelvis			-	-	65.00	12 576.85
55410	MR of the bony pelvis pre and post contrast			-	-	102.24	19 782.42
55900	Nuclear medicine study – Bone regional pelvis			21.50	4 160.04		
55910	Nuclear medicine study – Bone tomography regional pelvis			13.41	2 594.70		
55920	Nuclear medicine study – with flow			6.02	1 164.81		
	Hips			-	-		
	Code 56130 (tomography) may be combined with 56100 or 56110 or 56120 (hip). Code 56140 (stress) may be combined with 56100 or 56110 or 56120 (hip). Code 56150 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 56160 (introduction of contrast into hip joint) to be used with 56310 (CT hip) and 56410 (MR hip) and includes fluoroscopy. The combination of 56150 and 56310 and 56410 is not supported except in exceptional circumstances with motivation. Code 56300 (CT) study limited to small region of interest eg part of femur head.			-	-		
56100	X-ray of the left hip			-	-	3.18	615.30
56110	X-ray of the right hip			-	-	3.18	615.30
56120	X-ray pelvis and hips			-	-	6.02	1 164.81
56130	X-ray tomography – hip			-	-	4.30	832.01
56140	X-ray of the hip/s – stress study			-	-	4.38	847.49
56150	X-ray arthrography of the hip joint including introduction contrast			-	-	15.75	3 047.47
56160	X-ray guidance and introduction of contrast into hip joint only			-	-	7.41	1 433.76
56200	Ultrasound of the hip joints			-	-	6.50	1 257.69
56300	CT of hip – limited			-	-	9.50	1 838.16
56310	CT of hip – complete			-	-	27.37	5 295.82
56320	CT of hip – complete with 3D recon			-	-	39.78	7 697.03
56330	CT of hip with contrast			-	-	43.26	8 370.38
56340	CT of hip pre and post contrast			-	-	47.88	9 264.30
56400	MR of the hip joint/s, limited study			-	-	44.90	8 687.70
56410	MR of the hip joint/s			-	-	64.10	12 402.71
56420	MR of the hip joint/s, pre and post contrast			-	-	101.64	19 666.32
56900	Nuclear medicine study – Bone regional pelvis			21.50	4 160.04		
56910	Nuclear medicine study – Bone limited static plus flow			27.53	5 326.78		
56920	Nuclear medicine study – Bone tomography regional			13.41	2 594.70		
	Upper limbs			-	-		
	General			-	-		

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				U	R	U	R
	Code 60100 (stress only) is a stand alone study and may not be combined with other codes. Code 60110 (tomography) may be combined with any one of the defined regional x-ray studies of the upper limb. Motivation may be required for more than one regional tomographic study per visit. Code 60200 (U/S) may only be used once per visit. Code 60300 (CT) limited study – limited to a small region of interest eg. part of humeral head. Code 60400 (MR limited) may only be used once per visit.			-	-		
60100	X-ray upper limbs - any region - stress studies only			-	-	4.52	874.57
60110	X-ray upper limbs - any region – tomography			-	-	4.30	832.01
60200	Ultrasound upper limb – soft tissue - any region			-	-	7.38	1 427.96
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler			-	-	13.64	2 639.20
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler			-	-	13.64	2 639.20
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler			-	-	17.26	3 339.64
60300	CT of the upper limbs limited study			-	-	9.50	1 838.16
60310	CT angiography of the upper limb			-	-	78.28	15 146.40
60400	MR of the upper limbs limited study, any region			-	-	44.80	8 668.35
60410	MR angiography of the upper limb			-	-	74.66	14 445.96
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral			-	-	45.67	8 836.69
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral			-	-	82.67	15 995.82
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral			-	-	56.75	10 980.56
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral			-	-	88.11	17 048.40
60540	Venography, antegrade of upper limb veins, unilateral			-	-	26.12	5 053.96
60550	Venography, antegrade of upper limb veins, bilateral			-	-	49.43	9 564.21
60560	Venography, retrograde of upper limb veins, unilateral			-	-	31.01	6 000.12
60570	Venography, retrograde of upper limb veins, bilateral			-	-	54.81	10 605.19
60580	Venography, shuntogram, dialysis access shunt			-	-	23.79	4 603.13
60900	Nuclear medicine study – Venogram upper limb			37.12	7 182.35		
	Shoulder			-	-		
	Code 61160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 61170 (introduction of contrast into the shoulder joint) may be combined with 61300 and 61305 (CT), or 61400 and 61405 (MR). The combination of 61160 (arthrography) and 61300 and 61305 (CT) or 61400 and 61405 (MR) is not supported except in exceptional circumstances with motivation.			-	-		
61100	X-ray of the left clavicle			-	-	3.04	588.21
61105	X-ray of the right clavicle			-	-	3.04	588.21
61110	X-ray of the left scapula			-	-	3.04	588.21
61115	X-ray of the right scapula			-	-	3.04	588.21
61120	X-ray of the left acromio-clavicular joint			-	-	3.14	607.56
61125	X-ray of the right acromio-clavicular joint			-	-	3.14	607.56
61128	X-ray of acromio-clavicular joints plus stress studies bilateral			-	-	7.68	1 486.00
61130	X-ray of the left shoulder			-	-	3.48	673.35
61135	X-ray of the right shoulder			-	-	3.48	673.35
61140	X-ray of the left shoulder plus subacromial impingement views			-	-	5.92	1 145.46
61145	X-ray of the right shoulder plus subacromial impingement views			-	-	5.92	1 145.46
61150	X-ray of the left subacromial impingement views only			-	-	3.24	626.91
61155	X-ray of the right subacromial impingement views only			-	-	3.24	626.91
61160	X-ray arthrography shoulder joint including introduction of contrast			-	-	15.83	3 062.95
61170	X-ray guidance and introduction of contrast into shoulder joint only			-	-	7.41	1 433.76
61200	Ultrasound of the left shoulder joint			-	-	6.50	1 257.69
61210	Ultrasound of the right shoulder joint			-	-	6.50	1 257.69
61300	CT of the left shoulder joint – uncontrasted			-	-	24.36	4 713.42
61305	CT of the right shoulder joint – uncontrasted			-	-	24.36	4 713.42
61310	CT of the left shoulder – complete with 3D recon			-	-	37.66	7 286.83
61315	CT of the right shoulder – complete with 3D recon			-	-	37.66	7 286.83
61320	CT of the left shoulder joint - pre and post contrast			-	-	48.63	9 409.42
61325	CT of the right shoulder joint - pre and post contrast			-	-	48.63	9 409.42
61400	MR of the left shoulder			-	-	64.64	12 507.19
61405	MR of the right shoulder			-	-	64.64	12 507.19
61410	MR of the left shoulder pre and post contrast			-	-	101.04	19 550.23
61415	MR of the right shoulder pre and post contrast			-	-	101.04	19 550.23
	Humerus			-	-		
62100	X-ray of the left humerus			-	-	2.94	568.86

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62105	X-ray of the right humerus			-	-	2.94	568.86
62300	CT of the left upper arm			-	-	24.36	4 713.42
62305	CT of the right upper arm			-	-	24.36	4 713.42
62310	CT of the left upper arm contrasted			-	-	39.97	7 733.80
62315	CT of the right upper arm contrasted			-	-	39.97	7 733.80
62320	CT of the left upper arm pre and post contrast			-	-	48.58	9 399.74
62325	CT of the right upper arm pre and post contrast			-	-	48.58	9 399.74
62400	MR of the left upper arm			-	-	64.20	12 422.06
62405	MR of the right upper arm			-	-	64.20	12 422.06
62410	MR of the left upper arm pre and post contrast			-	-	102.04	19 743.72
62415	MR of the right upper arm pre and post contrast			-	-	102.04	19 743.72
62900	Nuclear medicine study – Bone limited/regional static			21.50	4 160.04		
62905	Nuclear medicine study – Bone limited static plus flow			27.53	5 326.78		
62910	Nuclear medicine study – Bone tomography regional			13.41	2 594.70		
	Elbow			-	-		
	Code 63120 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 63130 (introduction of contrast) may be combined with 63300 and 63305 (CT) or 63400 and 63405 (MR). The combination of 63120 (arthrography) and 63300 and 63305 or 63400 and 63405 (MR) is not supported except in exceptional circumstances with motivation.			-	-		
63100	X-ray of the left elbow			-	-	3.14	607.56
63105	X-ray of the right elbow			-	-	3.14	607.56
63110	X-ray of the left elbow with stress			-	-	4.34	839.75
63115	X-ray of the right elbow with stress			-	-	4.34	839.75
63120	X-ray arthrography elbow joint including introduction of contrast			-	-	15.89	3 074.56
63130	X-ray guidance and introduction of contrast into elbow joint only			-	-	7.41	1 433.76
63200	Ultrasound of the left elbow joint			-	-	6.50	1 257.69
63205	Ultrasound of the right elbow joint			-	-	6.50	1 257.69
63300	CT of the left elbow			-	-	24.36	4 713.42
63305	CT of the right elbow			-	-	24.36	4 713.42
63310	CT of the left elbow – complete with 3D recon			-	-	37.66	7 286.83
63315	CT of the right elbow – complete with 3D recon			-	-	37.66	7 286.83
63320	CT of the left elbow contrasted			-	-	39.97	7 733.80
63325	CT of the right elbow contrasted			-	-	39.97	7 733.80
63330	CT of the left elbow pre and post contrast			-	-	48.63	9 409.42
63335	CT of the right elbow pre and post contrast			-	-	48.63	9 409.42
63400	MR of the left elbow			-	-	64.64	12 507.19
63405	MR of the right elbow			-	-	64.64	12 507.19
63410	MR of the left elbow pre and post contrast			-	-	101.04	19 550.23
63415	MR of the right elbow pre and post contrast			-	-	101.04	19 550.23
63905	Nuclear medicine study – Bone limited/regional static			21.50	4 160.04		
63910	Nuclear medicine study – Bone limited static plus flow			27.53	5 326.78		
63915	Nuclear medicine study – Bone tomography regional			13.41	2 594.70		
	Forearm			-	-		
64100	X-ray of the left forearm			-	-	2.94	568.86
64105	X-ray of the right forearm			-	-	2.94	568.86
64110	X-ray peripheral bone densitometry			-	-	1.96	379.24
64300	CT of the left forearm			-	-	24.36	4 713.42
64305	CT of the right forearm			-	-	24.36	4 713.42
64310	CT of the left forearm contrasted			-	-	39.97	7 733.80
64315	CT of the right forearm contrasted			-	-	39.97	7 733.80
64320	CT of the left forearm pre and post contrast			-	-	48.58	9 399.74
64325	CT of the right forearm pre and post contrast			-	-	48.58	9 399.74
64400	MR of the left forearm			-	-	64.20	12 422.06
64405	MR of the right forearm			-	-	64.20	12 422.06
64410	MR of the left forearm pre and post contrast			-	-	98.04	18 969.76
64415	MR of the right forearm pre and post contrast			-	-	98.04	18 969.76
64900	Nuclear medicine study – Bone limited/regional static			21.50	4 160.04		
64905	Nuclear medicine study – Bone limited static plus flow			27.53	5 326.78		
64910	Nuclear medicine study – Bone tomography regional			13.41	2 594.70		
	Hand and Wrist			-	-		

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	Code 65120 (finger) may not be combined with 65100 or 65105 (hands). Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done. Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added). Code 65170 (contrast) may be combined with 65300 and 65305 (CT) or 65400 and 65405 (MR). The combination of 65160 (arthrography) and 65300 and 65305 or 65400 and 65405 is not supported except in exceptional circumstances with motivation.			-	-		
65100	X-ray of the left hand			-	-	3.08	595.95
65105	X-ray of the right hand			-	-	3.08	595.95
65110	X-ray of the left hand – bone age			-	-	3.08	595.95
65120	X-ray of a finger			-	-	2.67	516.62
65130	X-ray of the left wrist			-	-	3.18	615.30
65135	X-ray of the right wrist			-	-	3.18	615.30
65140	X-ray of the left scaphoid			-	-	3.30	638.52
65145	X-ray of the right scaphoid			-	-	3.30	638.52
65150	X-ray of the left wrist, scaphoid and stress views			-	-	7.56	1 462.78
65155	X-ray of the right wrist, scaphoid and stress views			-	-	7.56	1 462.78
65160	X-ray arthrography wrist joint including introduction of contrast			-	-	15.93	3 082.30
65170	X-ray guidance and introduction of contrast into wrist joint only			-	-	7.41	1 433.76
65200	Ultrasound of the left wrist			-	-	6.50	1 257.69
65210	Ultrasound of the right wrist			-	-	6.50	1 257.69
65300	CT of the left wrist and hand			-	-	24.36	4 713.42
65305	CT of the right wrist and hand			-	-	24.36	4 713.42
65310	CT of the left wrist and hand - complete with 3D recon			-	-	37.66	7 286.83
65315	CT of the right wrist and hand - complete with 3D recon			-	-	37.66	7 286.83
65320	CT of the left wrist and hand contrasted			-	-	39.97	7 733.80
65325	CT of the right wrist and hand contrasted			-	-	39.97	7 733.80
65330	CT of the left wrist and hand pre and post contrast			-	-	48.63	9 409.42
65335	CT of the right wrist and hand pre and post contrast			-	-	48.63	9 409.42
65400	MR of the left wrist and hand			-	-	64.64	12 507.19
65405	MR of the right wrist and hand			-	-	64.64	12 507.19
65410	MR of the left wrist and hand pre and post contrast			-	-	101.04	19 550.23
65415	MR of the right wrist and hand pre and post contrast			-	-	101.04	19 550.23
65900	Nuclear Medicine study – bone limited/regional static			21.50	4 160.04	-	-
65905	Nuclear Medicine study – bone limited static plus flow			27.53	5 326.78	-	-
65910	Nuclear Medicine study – bone tomography regional			13.41	2 594.70	-	-
	Soft Tissue					-	-
69900	Nuclear medicine study – Tumour localisation planar, static			20.74	4 012.98	-	-
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies			35.17	6 805.04	-	-
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT			34.15	6 607.68	-	-
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT			47.56	9 202.38	-	-
69920	Nuclear medicine study – Infection localisation planar, static			18.04	3 490.56	-	-
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies			31.45	6 085.26	-	-
69930	Nuclear medicine study – Infection localisation planar, static and SPECT			31.45	6 085.26	-	-
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT			44.86	8 679.96	-	-
69940	Nuclear medicine study – Regional lymph node mapping dynamic			6.02	1 164.81	-	-
69945	Nuclear medicine study – Regional lymph node mapping, static, planar			24.10	4 663.11	-	-
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple			37.51	7 257.81	-	-
69955	Nuclear medicine study – Regional lymph node mapping SPECT			13.41	2 594.70	-	-
69960	Nuclear medicine study – Lymph node localisation with gamma probe			13.41	2 594.70	-	-
	Lower Limbs			-	-		
	General			-	-		

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	Code 70100 (stress) is a stand alone study and may not be combined with other codes. Code 70110 (tomography) may be combined with any one of the defined regional x-ray studies of the lower limb. Motivation may be required for more than one regional tomographic study per visit. Code 70200 (U/S) may only be billed once per visit. Code 70300 ((CT) limited study – limited to a small region of interest eg part of condyle of the knee. Codes 70310 and 70320 (CT angiography) may not be combined. Code 70400 (MR limited) may only be used once per visit. Code 70410 and 70420 (MR angiography) may not be combined.			-	-		
70100	X-ray lower limbs - any region- stress studies only			-	-	4.52	874.57
70110	X-ray lower limbs - any region-tomography			-	-	4.30	832.01
70120	X-ray of the lower limbs full length study			-	-	6.46	1 249.95
70200	Ultrasound lower limb – soft tissue - any region			-	-	7.38	1 427.96
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler			-	-	13.64	2 639.20
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler			-	-	13.64	2 639.20
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis			-	-	13.64	2 639.20
70240	Ultrasound peripheral venous system lower limbs including pulse and colour doppler in erect and supine position including all compression and reflux manoeuvres, deep and superficial systems bilaterally			-	-	19.66	3 804.01
70300	CT of the lower limbs limited study			-	-	9.50	1 838.16
70310	CT angiography of the lower limb			-	-	79.43	15 368.91
70320	CT angiography abdominal aorta and outflow lower limbs			-	-	98.34	19 027.81
70400	MR of the lower limbs limited study			-	-	46.40	8 977.94
70410	MR angiography of the lower limb			-	-	76.66	14 832.94
70420	MR angiography of the abdominal aorta and lower limbs			-	-	118.86	22 998.22
70500	Angiography of pelvic and lower limb arteries unilateral			-	-	40.59	7 853.76
70505	Angiography of pelvic and lower limb arteries bilateral			-	-	75.92	14 689.76
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral			-	-	61.23	11 847.39
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral			-	-	85.66	16 574.35
70520	Angiography translumbar aorta with full peripheral study			-	-	45.68	8 838.62
70530	Venography, antegrade of lower limb veins, unilateral			-	-	25.46	4 926.26
70535	Venography, antegrade of lower limb veins, bilateral			-	-	49.43	9 564.21
70540	Venography, retrograde of lower limb veins, unilateral			-	-	31.17	6 031.08
70545	Venography, retrograde of lower limb veins, bilateral			-	-	56.79	10 988.30
70560	Lymphangiography, lower limb, unilateral			-	-	51.04	9 875.73
70565	Lymphangiography, lower limb, bilateral			-	-	83.97	16 247.36
70900	Nuclear medicine study – Venogram lower limb			37.12	7 182.35		
	Femur			-	-		
71100	X-ray of the left femur			-	-	2.94	568.86
71105	X-ray of the right femur			-	-	2.94	568.86
71300	CT of the left femur			-	-	24.52	4 744.37
71305	CT of the right femur			-	-	24.52	4 744.37
71310	CT of the left upper leg contrasted			-	-	41.83	8 093.69
71315	CT of the right upper leg contrasted			-	-	41.83	8 093.69
71320	CT of the left upper leg pre and post contrast			-	-	49.71	9 618.39
71325	CT of the right upper leg pre and post contrast			-	-	49.71	9 618.39
71400	MR of the left upper leg			-	-	64.80	12 538.15
71405	MR of the right upper leg			-	-	64.80	12 538.15
71410	MR of the left upper leg pre and post contrast			-	-	102.04	19 743.72
71415	MR of the right upper leg pre and post contrast			-	-	102.04	19 743.72
71900	Nuclear Medicine study – bone limited/regional static			21.50	4 160.04		
71905	Nuclear Medicine study – Bone limited static plus flow			27.53	5 326.78		
71910	Nuclear Medicine study – Bone tomography regional			13.41	2 594.70		
	Knee			-	-		

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	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.			-	-		
72100	X-ray of the left knee one or two views			-	-	2.77	535.97
72105	X-ray of the right knee one or two views			-	-	2.77	535.97
72110	X-ray of the left knee, more than two views			-	-	3.32	642.39
72115	X-ray of the right knee, more than two views			-	-	3.32	642.39
72120	X-ray of the left knee including patella			-	-	4.62	893.92
72125	X-ray of the right knee including patella			-	-	4.62	893.92
72130	X-ray of the left knee with stress views			-	-	5.82	1 126.11
72135	X-ray of the right knee with stress views			-	-	5.82	1 126.11
72140	X-ray of left patella			-	-	2.77	535.97
72145	X-ray of right patella			-	-	2.77	535.97
72150	X-ray both knees standing – single view			-	-	2.80	541.77
72160	X-ray arthrography knee joint including introduction of contrast			-	-	15.81	3 059.08
72170	X-ray guidance and introduction of contrast into knee joint only			-	-	7.41	1 433.76
72200	Ultrasound of the left knee joint			-	-	6.50	1 257.69
72205	Ultrasound of the right knee joint			-	-	6.50	1 257.69
72300	CT of the left knee			-	-	24.52	4 744.37
72305	CT of the right knee			-	-	24.52	4 744.37
72310	CT of the left knee complete study with 3D reconstructions			-	-	35.93	6 952.10
72315	CT of the right knee complete study with 3D reconstructions			-	-	35.93	6 952.10
72320	CT of the left knee contrasted			-	-	41.83	8 093.69
72325	CT of the right knee contrasted			-	-	41.83	8 093.69
72330	CT of the left knee pre and post contrast			-	-	49.76	9 628.06
72335	CT of the right knee pre and post contrast			-	-	49.76	9 628.06
72400	MR of the left knee			-	-	64.10	12 402.71
72405	MR of the right knee			-	-	64.10	12 402.71
72410	MR of the left knee pre and post contrast			-	-	100.84	19 511.53
72415	MR of the right knee pre and post contrast			-	-	100.84	19 511.53
72900	Nuclear Medicine study – Bone limited/regional static			21.50	4 160.04		
72905	Nuclear Medicine study – Bone limited static plus flow			27.53	5 326.78		
72910	Nuclear Medicine study – Bone tomography regional			13.41	2 594.70		
	Lower Leg			-	-		
73100	X-ray of the left lower leg			-	-	2.94	568.86
73105	X-ray of the right lower leg			-	-	2.94	568.86
73300	CT of the left lower leg			-	-	24.52	4 744.37
73305	CT of the right lower leg			-	-	24.52	4 744.37
73310	CT of the left lower leg contrasted			-	-	41.83	8 093.69
73315	CT of the right lower leg contrasted			-	-	41.83	8 093.69
73320	CT of the left lower leg pre and post contrast			-	-	49.71	9 618.39
73325	CT of the right lower leg pre and post contrast			-	-	49.71	9 618.39
73400	MR of the left lower leg			-	-	64.20	12 422.06
73405	MR of the right lower leg			-	-	64.20	12 422.06
73410	MR of the left lower leg pre and post contrast			-	-	102.04	19 743.72
73415	MR of the right lower leg pre and post contrast			-	-	102.04	19 743.72
73900	Nuclear Medicine study – bone limited/regional static			21.50	4 160.04		
73905	Nuclear Medicine study – bone limited static plus flow			27.53	5 326.78		
73910	Nuclear Medicine study – bone tomography regional			13.41	2 594.70		
	Ankle and Foot Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and			-	-		
74100	X-ray of the left ankle			-	-	3.32	642.39
74105	X-ray of the right ankle			-	-	3.32	642.39
74110	X-ray of the left ankle with stress views			-	-	4.52	874.57
74115	X-ray of the right ankle with stress views			-	-	4.52	874.57

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74120	X-ray of the left foot			-	-	2.80	541.77
74125	X-ray of the right foot			-	-	2.80	541.77
74130	X-ray of the left calcaneus			-	-	2.74	530.16
74135	X-ray of the right calcaneus			-	-	2.74	530.16
74140	X-ray of both feet – standing – single view			-	-	2.80	541.77
74145	X-ray of a toe			-	-	2.67	516.62
74150	X-ray of the sesamoid bones one or both sides			-	-	2.80	541.77
74160	X-ray arthrography ankle joint including introduction of contrast			-	-	15.91	3 078.43
74170	X-ray guidance and introduction of contrast into ankle joint			-	-	7.41	1 433.76
74210	Ultrasound of the left ankle			-	-	6.50	1 257.69
74215	Ultrasound of the right ankle			-	-	6.50	1 257.69
74220	Ultrasound of the left foot			-	-	6.50	1 257.69
74225	Ultrasound of the right foot			-	-	6.50	1 257.69
74290	Ultrasound bone densitometry			-	-	2.04	394.72
74300	CT of the left ankle/foot			-	-	24.52	4 744.37
74305	CT of the right ankle/foot			-	-	24.52	4 744.37
74310	CT of the left ankle/foot – complete with 3D recon			-	-	37.81	7 315.86
74315	CT of the right ankle/foot – complete with 3D recon			-	-	37.81	7 315.86
74320	CT of the left ankle/foot contrasted			-	-	41.83	8 093.69
74325	CT of the right ankle/foot contrasted			-	-	41.83	8 093.69
74330	CT of the left ankle/foot pre and post contrast			-	-	49.71	9 618.39
74335	CT of the right ankle/foot pre and post contrast			-	-	49.71	9 618.39
74400	MR of the left ankle			-	-	64.10	12 402.71
74405	MR of the right ankle			-	-	64.10	12 402.71
74410	MR of the left ankle pre and post contrast			-	-	100.64	19 472.83
74415	MR of the right ankle pre and post contrast			-	-	100.64	19 472.83
74420	MR of the left foot			-	-	64.20	12 422.06
74425	MR of the right foot			-	-	64.20	12 422.06
74430	MR of the left foot pre and post contrast			-	-	102.04	19 743.72
74435	MR of the right foot pre and post contrast			-	-	102.04	19 743.72
74900	Nuclear Medicine study – Bone limited/regional static			21.50	4 160.04		
74905	Nuclear Medicine study – Bone limited static plus flow			27.53	5 326.78		
74910	Nuclear Medicine study – Bone tomography regional			13.41	2 594.70		
	Soft Tissue						
79900	Nuclear Medicine study – Tumour localisation planar, static			20.74	4 012.98	-	-
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies			35.17	6 805.04	-	-
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT			34.15	6 607.68	-	-
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT			47.56	9 202.38	-	-
79920	Nuclear Medicine study – Infection localisation planar, static			18.43	3 566.02	-	-
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies			31.84	6 160.72	-	-
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT			31.84	6 160.72	-	-
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT			45.25	8 755.42	-	-
79940	Nuclear Medicine study – Regional lymph node mapping dynamic			6.02	1 164.81	-	-
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar			24.10	4 663.11	-	-
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies			37.51	7 257.81	-	-
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT			13.41	2 594.70	-	-
79960	Nuclear Medicine study – Lymph node localisation with gamma probe			13.41	2 594.70	-	-
	Intervention						
	General						

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	Codes 80600, 80605, 80610, 80620, 80630, 81660, 81680, 82600, 84660, 85640, 85645, 86610, 86615, 86620, 86630, (aspiration / biopsy / ablations etc) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be combined with these codes. If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00510, 00520, 00530, 00540, 00550, 00560), it may not be billed for separately. Codes 80640, 80645, 87682, 87683 include fluoroscopy. Machine fees may not be added. All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.			-	-		
80600	Percutaneous abscess, cyst drainage, any region			-	-	9.37	1 813.00
80605	Fine needle aspiration biopsy, any region			-	-	4.22	816.53
80610	Cutting needle, trochar biopsy, any region			-	-	6.36	1 230.60
80620	Tumour/cyst ablation chemical			-	-	25.37	4 908.84
80630	Tumour ablation radio frequency, per lesion			-	-	21.21	4 103.92
80640	Insertion of CVP line in radiology suite			-	-	8.99	1 739.48
80645	Peripheral central venous line insertion			-	-	12.12	2 345.10
80650	Infiltration of a peripheral joint, any region			-	-	6.40	1 238.34
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.			-	-		
	Neuro intervention			-	-		
81600	Intracranial aneurysm occlusion, direct			-	-	214.52	41 507.47
81605	Intracranial arteriovenous shunt occlusion			-	-	254.82	49 305.12
81610	Dural sinus arteriovenous shunt occlusion			-	-	264.33	51 145.21
81615	Extracranial arteriovenous shunt occlusion			-	-	157.26	30 432.11
81620	Extracranial arterial embolisation (head and neck)			-	-	163.12	31 562.09
81625	Caroticocavernous fistula occlusion			-	-	192.29	37 206.19
81630	Intracranial angioplasty for stenosis, vasospasm			-	-	126.92	24 557.75
81632	Intracranial stent placement (including PTA)			-	-	133.72	25 873.48
81635	Temporary balloon occlusion test			-	-	83.42	16 140.94
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.			-	-		
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)			-	-	178.18	34 476.05
81645	Intracranial aneurysm occlusion with balloon remodelling			-	-	216.35	41 861.56
81650	Intracranial aneurysm occlusion with stent assistance			-	-	230.45	44 589.77
81655	Intracranial thrombolysis, catheter directed			-	-	58.94	11 404.30
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650			-	-		
81660	Nerve block, head and neck, per level			-	-	7.66	1 482.13
81665	Neurolysis, head and neck, per level			-	-	20.14	3 896.89
81670	Nerve block, head and neck, radio frequency, per level			-	-	19.04	3 684.05
81680	Nerve block, coeliac plexus or other regions, per level			-	-	9.28	1 795.59
	Thorax			-	-		
82600	Chest drain insertion			-	-	8.82	1 706.58
82605	Trachial, bronchial stent insertion			-	-	30.36	5 874.36
	Gastrointestinal			-	-		
83600	Oesophageal stent insertion			-	-	31.22	6 040.76
83605	GIT balloon dilation			-	-	24.36	4 713.42
83610	GIT stent insertion (non-oesophageal)			-	-	32.02	6 195.55
83615	Percutaneous gastrostomy, jejunostomy			-	-	25.36	4 906.91
	Hepatobiliary			-	-		
84600	Percutaneous biliary drainage, external			-	-	33.98	6 574.79
84605	Percutaneous external/internal biliary drainage			-	-	37.21	7 199.76
84610	Permanent biliary stent insertion			-	-	51.22	9 910.56
84615	Drainage tube replacement			-	-	20.22	3 912.37
84620	Percutaneous bile duct stone or foreign object removal			-	-	49.98	9 670.63
84625	Percutaneous gall bladder drainage			-	-	29.58	5 723.43
84630	Percutaneous gallstone removal, including drainage			-	-	69.25	13 399.18
84635	Transjugular liver biopsy			-	-	24.93	4 823.71
84640	Transjugular intrahepatic Portosystemic shunt			-	-	119.47	23 116.25
84645	Transhepatic Portogram including venous sampling, pressure studies			-	-	81.89	15 844.90

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84650	Transhepatic Portogram with embolisation of varices			-	-	100.81	19 505.73
84655	Percutaneous hepatic tumour ablation			-	-	15.68	3 033.92
84660	Percutaneous hepatic abscess, cyst drainage			-	-	13.20	2 554.07
84665	Hepatic chemoembolisation			-	-	59.44	11 501.05
84670	Hepatic arterial infusion catheter placement			-	-	60.30	11 667.45
	Urogenital			-	-		
85600	Percutaneous nephrostomy, external drainage			-	-	29.97	5 798.90
85605	Percutaneous double J stent insertion including access			-	-	40.82	7 898.26
85610	Percutaneous renal stone, foreign body removal including access			-	-	66.79	12 923.20
85615	Percutaneous nephrostomy tract establishment			-	-	29.27	5 663.45
85620	Change of nephrostomy tube			-	-	15.90	3 076.49
85625	Percutaneous cystostomy			-	-	16.52	3 196.45
85630	Urethral balloon dilatation			-	-	14.24	2 755.30
85635	Urethral stent insertion			-	-	31.22	6 040.76
85640	Renal cyst ablation			-	-	11.92	2 306.40
85645	Renal abscess, cyst drainage			-	-	15.16	2 933.31
85655	Fallopian tube recanalisation			-	-	45.06	8 718.66
	Spinal			-	-		
86600	Spinal vascular malformation embolisation			-	-	275.16	53 240.71
86605	Vertebroplasty per level			-	-	22.30	4 314.83
86610	Facet joint block per level, uni- or bilateral			-	-	9.54	1 845.89
	Code 86610 may only be billed once per level, and not per left and right side per level			-	-		
86615	Spinal nerve block per level, uni- or bilateral			-	-	8.16	1 578.88
86620	Epidural block			-	-	9.42	1 822.68
86625	Chemonucleolysis, including discogram			-	-	18.32	3 544.74
86630	Spinal nerve ablation per level			-	-	11.60	2 244.48
	Vascular			-	-		
	Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedure, 87650 (thrombolysis). If a balloon angioplasty and / or stent placement is performed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multiple balloon dilatations or stent placements at one defined site will only attract one procedure code.			-	-		
87600	Percutaneous transluminal angioplasty: aorta, IVC			-	-	56.56	10 943.79
87601	Percutaneous transluminal angioplasty: iliac			-	-	55.76	10 789.00
87602	Percutaneous transluminal angioplasty: femoropopliteal			-	-	60.16	11 640.36
87603	Percutaneous transluminal angioplasty: subpopliteal			-	-	73.34	14 190.56
87604	Percutaneous transluminal angioplasty: brachiocephalic			-	-	67.12	12 987.05
87605	Percutaneous transluminal angioplasty: subclavian, axillary			-	-	60.16	11 640.36
87606	Percutaneous transluminal angioplasty: extracranial carotid			-	-	71.62	13 857.75
87607	Percutaneous transluminal angioplasty: extracranial vertebral			-	-	73.30	14 182.82
87608	Percutaneous transluminal angioplasty: renal			-	-	87.69	16 967.14
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric			-	-	87.69	16 967.14
87620	Aorta stent-graft placement			-	-	120.75	23 363.92
87621	Stent insertion (including PTA): aorta, IVC			-	-	73.87	14 293.11
87622	Stent insertion (including PTA): iliac			-	-	76.37	14 776.83
87623	Stent insertion (including PTA): femoropopliteal			-	-	77.97	15 086.42
87624	Stent insertion (including PTA): subpopliteal			-	-	84.55	16 359.58
87625	Stent insertion (including PTA): brachiocephalic			-	-	98.47	19 052.96
87626	Stent insertion (including PTA): subclavian, axillary			-	-	86.69	16 773.65
87627	Stent insertion (including PTA): extracranial carotid			-	-	106.99	20 701.50
87628	Stent insertion (including PTA): extracranial vertebral			-	-	100.55	19 455.42
87629	Stent insertion (including PTA): renal			-	-	98.59	19 076.18
87630	Stent insertion (including PTA): coeliac, mesenteric			-	-	98.59	19 076.18
87631	Stent-graft placement: iliac			-	-	76.37	14 776.83
87632	Stent-graft placement: femoropopliteal			-	-	77.97	15 086.42
87633	Stent-graft placement: brachiocephalic			-	-	98.47	19 052.96
87634	Stent-graft placement: subclavian, axillary			-	-	82.77	16 015.17
87635	Stent-graft placement: extracranial carotid			-	-	120.43	23 302.00
87636	Stent-graft placement: extracranial vertebral			-	-	114.73	22 199.11
87637	Stent-graft placement: renal			-	-	98.59	19 076.18
87638	Stent-graft placement: coeliac, mesenteric			-	-	98.59	19 076.18
87650	Thrombolysis in angiography suite, per 24 hours			-	-	45.82	8 865.71

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
20.	**RADIATION ONCOLOGY** The amounts in this section are calculated according to the **Radiation Oncology** unit values (unless otherwise specified)							
20.10	**Chemotherapy**							
	Chemotherapy treatment (not in chemotherapy facilities) Note: When patients are not treated in chemotherapy facilities, items 0213, 0214 and 0215 are used instead of items 5790-5795 The amounts in this section are calculated according to the **Clinical Procedure** unit values							
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. For use by medical practiioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment (Applicable for RMA clients)	5	**156.05**	5	**156.05**			
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 For use by medical practiioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment. (Applicable for RMA clients)	9	**280.89**	9	**280.89**			
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 For use by medical practiioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment. (Applicable for RMA clients)	14	**436.94**	14	**436.94**			
5782	Isotope therapy: Administration of low dose surface applicator up to five applications. Typically an out patient procedure. Material is not included	77.81	**2 428.45**	62.25	**1 942.76**			
5783	Infusional pharmacotherapy: Item to be used for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be code separately)	42.65	**1 331.11**	42.65	**1 331.11**			
5790	Non Infusional Chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy or hormonal therapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology related drug administration per treatment day - for exclusive use by doctors with appropriate oncology training (consultations to be charged separately)	42.95	**1 340.47**	42.95	**1 340.47**			

			Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
20.	**RADIATION ONCOLOGY**								
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, 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) - only one of the parties are to charge this fee		24.49	**764.33**	24.49	**764.33**			
5792	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy or hormonal therapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy 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. These facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - only one of the parties are to charge this fee		30.61	**955.34**	30.61	**955.34**			
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)		159.47	**4 977.06**	127.58	**3 981.77**			
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		90.03	**2 809.84**	90.03	**2 809.84**			
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. These 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		112.54	**3 512.37**	112.54	**3 512.37**			
20.11	**Radiation Therapy**								
20.11.1	**Manual Radiotherapy Planning Procedures**								
5801	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT		42.56	**1 328.30**					
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest -TECHNICAL COMPONENT		99.32	**3 099.78**					
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT		56.18	**1 753.38**					
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT		131.10	**4 091.63**					

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
20.	**RADIATION ONCOLOGY**							
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	76.62	**2 391.31**					
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	178.77	**5 579.41**					
20.11.2	**Conventional Radiotherapy Planning Procedures**							
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	170.26	**5 313.81**					
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	397.27	**12 398.80**					
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	238.36	**7 439.22**					
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	556.18	**17 358.38**					
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	297.95	**9 299.02**					
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	695.22	**21 697.82**					
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)	240.23	**7 497.58**					
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)	977.20	**30 498.41**					
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)	407.75	**12 725.88**					
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)	1 368.07	**42 697.46**					
5822	Three Dimensional Radiotherapy Planning Procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	554.33	**17 300.64**					
5622	Three dimensional radiotherapy planning procedures: 3-dimensional simulation and graphic planning, special technique - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	1 710.09	**53 371.91**					
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)	642.92	**20 065.53**					
5623	Intensity modulated radiotherapy (IMRT) planning procedures: Intensity modulated radiotherapy simulation, inverse planning, radical course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	1 916.81	**59 823.64**					
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)	232.18	**7 246.34**					

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
20.	**RADIATION ONCOLOGY**							
5625	Intensity modulated radiotherapy (IMRT) 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)	958.40	**29 911.66**					
5626	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)	753.35	**23 512.05**					
5626	Intensity modulated radiotherapy (IMRT) 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)	2 174.48	**67 865.52**					
20.11.5	**Kilovolt Radiation Treatment**							
5834	Kilovoltage Radiation Treatment: Weekly Treatment, Kilovolt or Similar per week or part thereof - PROFESSIONAL COMPONENT	49.08	**1 531.79**					
5634	Kilovoltage Radiation Treatment: Weekly Treatment, Kilovolt or Similar per week or part thereof - TECHNICAL COMPONENT	114.52	**3 574.17**					

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
20.	**RADIATION ONCOLOGY**							
20.11.6	**Short course radiation treatment**							
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT							
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	246.73	**7 700.44**					
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	148.04	**4 620.33**					
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	345.41	**10 780.25**					
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	190.33	**5 940.20**					
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	444.11	**13 860.67**					
20.11.7	**Weekly radiation treatment sessions**							
20.11.7.1	**Conventional Techniques**							
5839	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	193.86	**6 050.37**					
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	452.33	**14 117.22**					
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	246.73	**7 700.44**					
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	575.69	**17 967.28**					
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	317.22	**9 900.44**					
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	740.18	**23 101.02**					
20.11.7.2	**Advanced Techniques**							
5849	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - PROFESSIONAL COMPONENT	236.24	**7 373.05**					
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	551.21	**17 203.26**					
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	330.73	**10 322.08**					
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	771.71	**24 085.07**					
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	425.23	**13 271.43**					
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	992.19	**30 966.25**					
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	348.87	**10 888.23**					
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	814.03	**25 406.88**					
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	826.83	**25 805.36**					
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	1 929.26	**60 212.20**					

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
21.	**PATHOLOGY** **Notes:** For fees for Histology and Cytology refer to items 4561 to 4595 under section 22: Anatomical Pathology The amounts in this section are calculated according to the **Clinical Pathology** unit values				
21.1	**Haematology**				
3705	Alkali resistant haemoglobin	4.5	132.84	3	88.56
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	3.65	107.75	2.45	72.32
3710	Antibody titration	7.2	212.54	4.8	141.70
3711	Ameth count	2.25	66.42	1.5	44.28
3712	Antibody identification	8.45	249.44	5.65	166.79
3713	Bleeding time (does not include the cost of the simplate device)	6.94	204.87	4.63	136.68
3715	Buffy Layer examination	19.9	587.45	13.27	391.73
3716	Mean Cell Volume	2.25	66.42	1.5	44.28
3717	Bone marrow cytological examination only	19.9	587.45	13.27	391.73
3719	Bone marrow: Aspiration	8.4	247.97	5.6	165.31
3720	Bone marrow trephine biopsy	32.6	962.35	21.7	640.58
3721	Bone marrow aspiration and trephine biopsy (excluding histological examination)	36.8	1 086.34	24.5	723.24
3722	Capillary fragility: Hess	2.02	59.63	1.35	39.85
3723	Circulating anticoagulants	5.85	172.69	3.9	115.13
3724	Coagulation factor inhibitor assay	57.56	1 699.17	38.37	1 132.68
3726	Activated protein C resistance	26	767.52	17.3	510.70
3727	Coagulation time	3.16	93.28	2.11	62.29
3728	Anti-factor Xa Activity	53.6	1 582.27	35.73	1 054.75
3729	Cold agglutinins	3.6	106.27	2.4	70.85
3730	Protein S: Functional	37.5	1 107.00	25	738.00
3731	Compatability for blood transfusion	3.6	106.27	2.4	70.85
3734	Protein C (chromogenic)	30.29	894.16	20.19	596.01
3739	Erythrocyte count	2.25	66.42	1.5	44.28
3740	Factors V and VII: Qualitative	7.2	212.54	4.8	141.70
3741	Coagulation factor assay: functional	9.45	278.96	6.3	185.98
3742	Coagulation factor assay: Immunological	4.5	132.84	3	88.56
3743	Erythrocyte sedimentation rate	2.5	73.80	1.67	49.30
3744	Fibrin stabilising factor (urea test)	4.5	132.84	3	88.56
3746	Fibrin monomers	2.7	79.70	1.8	53.14
3748	Plasminogen Activator Inhibitor (PAI-I)	65.95	1 946.84	43.97	1 297.99
3750	Tissue Plasminogen Activator (tPA)	67.79	2 001.16	45.19	1 334.01
3751	Osmotic fragility (screen)	2.25	66.42	1.5	44.28
3753	Osmotic fragility (before and after incubation)	18	531.36	12	354.24

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
3754	ABO Reverse Group	5.5	162.36	3.67	108.34
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	10.5	309.96	7	206.64
3756	Full cross match	7.2	212.54	4.8	141.70
3757	Coagulation factors (quantitative)	32.2	950.54	21.47	633.79
3758	Factor VIII related antigen	60.46	1 784.78	40.31	1 189.95
3759	Coagulation factor correction study	11.72	345.97	7.81	230.55
3761	Factor XIII related antigen	61.11	1 803.97	40.74	1 202.64
3762	Haemoglobin estimation	1.8	53.14	1.2	35.42
3763	Contact activated product essay	16.2	478.22	10.8	318.82
3764	Grouping: A-, B- and O-antigens	3.6	106.27	2.4	70.85
3765	Grouping; Rh antigens	3.6	106.27	2.4	70.85
3766	PIVKA	43.49	1 283.82	28.99	855.78
3767	Euglobulin lysis time	25.58	755.12	17.05	503.32
3768	Haemoglobin A2 (column chromatography)	15	442.80	10	295.20
3769	HB Electrophoresis	26.82	791.73	17.88	527.82
3770	Haemoglobin-S (solubility test)	3.6	106.27	2.4	70.85
3773	Ham's acidified serum test	8	236.16	5.33	157.34
3775	Heinz bodies	8	236.16	5.33	157.34
3776	Haemosiderin in urinary sediment	2.25	66.42	1.5	44.28
3777	DELETED 2009: Heparin estimation				
3781	Heparin tolerence	7.2	212.54	4.8	141.70
3783	Leucocyte differential count	6.2	183.02	4.15	122.51
3785	Leucocytes: total count	1.8	53.14	1.2	35.42
3786	QBC malaria concentration and fluorescent staining	25	738.00	16.7	492.98
3787	LE-cells	8.3	245.02	5.55	163.84
3789	Neutrophil alkaline phosphatase	28	826.56	18.7	552.02
3791	Packed cell volume: Haematocrit	1.8	53.14	1.2	35.42
3792	Plasmodium falciparum: Monoclonal immunological identification	9	265.68	6	177.12
3793	Plasma haemoglobin	6.75	199.26	4.5	132.84
3794	Platelet Sensitivities	18.64	550.25	12.43	366.93
3795	Platelet aggregation per aggregant	12.14	358.37	8.09	238.82
3796	Platelet antibodies: agglutination	5.4	159.41	3.6	106.27
3797	Platelet count	2.25	66.42	1.5	44.28
3799	Platelet adhesiveness	4.5	132.84	3	88.56
3801	Prothrombin consumption	5.85	172.69	3.9	115.13
3803	Prothrombin determination (two stages)	5.85	172.69	3.9	115.13
3805	Prothrombin index	6	177.12	4	118.08
3806	Therapeutic drug level: Dosage	4.5	132.84	3	88.56
3807	Recalcification time	2.25	66.42	1.5	44.28
3809	Reticulocyte count	3	88.56	2	59.04
3811	Sickling test	2.25	66.42	1.5	44.28
3814	Sucrose lysis test for PNH	3.6	106.27	2.4	70.85

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	21.1	622.87	14.07	415.35
3820	Thrombo-Elastogram	26	767.52	17.33	511.58
3825	Fibrinogen titre	3.6	106.27	2.4	70.85
3829	Glucose 6-phosphate-dehydragenase: Qualitative	8	236.16	5.33	157.34
3830	Glucose 6-phosphate-dehydrogenase: quantitative	16	472.32	10.7	315.88
3832	Red cell pyruvate kinase: quantitative	16	472.32	10.7	315.88
3834	Red cell Rhesus phenotype	9.9	292.25	6.6	194.83
3835	Haemoglobin F in blood smear	5.85	172.69	3.9	115.13
3837	Partial thromboplastin time	5.85	172.69	3.9	115.13
3841	Thrombin time (screen)	5.85	172.69	3.9	115.13
3843	Thrombin time (serial)	7.65	225.83	5.1	150.55
3847	Haemoglobin H	2.25	66.42	1.5	44.28
3851	Fibrin degeneration products (diffusion plate)	10.35	305.63	6.9	203.69
3853	Fibrin degeneration products (latex slide)	4.5	132.84	3	88.56
3854	XDP (Dimer test or equivalent latex slide test)	8.5	250.92	5.67	167.38
3856	D-Dimer	27.52	812.39	18.35	541.69
3855	Hemagglutination inhibition	9.9	292.25	6.6	194.83
3858	Heparin Removal	28.88	852.64	19.25	568.26
'21.2	**Microscopic examinations**				
3863	Autogenous vaccine	12.6	371.95	8.4	247.97
3864	Entomological examination	20.7	611.06	13.8	407.38
3865	Parasites in blood smear	5.6	165.31	3.73	110.11
3867	Miscellaneous (body fluids. urine. exudate. fungi. Pusscrapings, etc.)	4.9	144.65	3.3	97.42
3868	Fungus identification	8.3	245.02	5.5	162.36
3869	Faeces (including parasites)	4.9	144.65	3.27	96.53
3872	Automated urine microscopy	8.72	257.41	5.81	171.51
3873	Transmission electron microscopy	85	2 509.20	57	1 682.64
3874	Scanning electron microscopy	100	2 952.00	67	1 977.84
3875	Inclusion bodies	4.5	132.84	3	88.56
3878	Crystal identification polarised light microscopy	4.5	132.84	3	88.56
3879	Compylobacter in stool: fastidious culture	9.9	292.25	6.6	194.83
3880	Antigen detection with polyclonal antibodies	4.5	132.84	3	88.56
3881	Mycobacteria	3	88.56	2	59.04
3882	Antigen detection with monoclonal antibodies	10.8	318.82	7.2	212.54
3883	Concentration techniques for parasites	3	88.56	2	59.04
3884	Dark field. Phase- or interference contrast microscopy. Nomarski or Fontana	6.3	185.98	4.2	123.98
3885	Cytochemical stain	5.45	160.88	3.65	107.75
21.3	**Bacteriology (culture and biological examination**				
3886	DELETED 2009: Antibiotic MIC per organism per antibiotic				
3887	Antibiotic susceptibility test. per organism	8	236.16	5.33	157.34
3889	Clostridium difficile toxin: Monccional immunological	12.4	366.05	8.27	244.13
3890	Antibiotic assay of tissues and fluids	13.9	410.33	9.27	273.65
3891	Blood culture: aerobic s	5.85	172.69	3.9	115.13
3892	Blood culture: anaerobic	5.85	172.69	3.9	115.13
3893	Bacteriological culture: miscellaneous	6.3	185.98	4.2	123.98
3894	Radiometric blood culture	10.8	318.82	7.2	212.54
3895	Bacteriological culture: fastidious organisms	9.9	292.25	6.6	194.83
3896	In vivo culture: bacteria	16	472.32	10.65	314.39
3897	In vivo culture: virus	16	472.32	10.65	314.39
3898	Bacterial exotoxin production (in vitro assay)	4.5	132.84	3	88.56
3899	Bacterial exotoxin production (in vivo assay)	20.7	611.06	13.8	407.38
3901	Fungal culture	4.5	132.84	3	88.56
3903	Antibiotic level: biological fluids	11.7	345.38	7.8	230.26
3905	Identification of virus or rickettsia	20.7	611.06	13.8	407.38
3906	Identification: chlamydia	16	472.32	10.65	314.39
3907	Culture for staphylococcus aureus **[Discontinued 2020]**				
3908	Anaerobic culture: comprehensive	9.9	292.25	6.6	194.83
3909	Anaerobic culture: limited procedure	4.5	132.84	3	88.56
3911	B-Lactamase	4.5	132.84	3	88.56
3915	Mycobacterium culture	4.5	132.84	3	88.56
3917	Mycoplasma culture: limited	2.25	66.42	1.5	44.28
3918	Mycoplasma culture: comprehensive	9.9	292.25	6.6	194.83
3919	Identification of mycobacterium	9.9	292.25	6.6	194.83
3920	Mycobacterium: antibiotic sensitivity	9.9	292.25	6.6	194.83
3921	Antibiotic synergistic study	20.7	611.06	13.8	407.38
3922	Viable cell count	1.35	39.85	0.9	26.57
3923	Staph ID Abr (Yeast ID)	3.15	92.99	2.1	61.99
3924	Biochemical ident of bacterium: extended	12.5	369.00	8.33	245.90
3925	Serological ident of bacterium: abridged	3.15	92.99	2.1	61.99
3926	Serological ident of bacterium: extended	10.2	301.10	6.8	200.74
3927	Grouping of streptococci	7.3	215.50	4.85	143.17

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
3928	Antimicrobic substances	3.8	112.18	2.5	73.80
3929	Radiometric mycobacterium identification	14	413.28	9.3	274.54
3930	Radiometric mycobacterium antibiotic sensitivity	25	738.00	16.7	492.98

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
4652	Rapid automated bacterial identification per organism	15	442.80	10	295.20
4653	Rapid aotomated antibiotic susceptibility per organism	17	501.84	11.33	334.46
4654	Rapid automated MIC per organism per antibiotic	17	501.84	11.33	334.46
4655	Mycobacteria: MIC determination - E Test	16.50	487.08	11.00	324.72
4656	Mycobacteria: Identification HPLC	35.00	1 033.20	23.33	688.70
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	9.90	292.25	6.60	194.83
21.4	**Serology**				
3932	HIV Elisa Type I and II (Screening tests only)	14.1	416.23	9.4	277.49
3933	IgE: Total; EMIT or ELISA	11.7	345.38	7.8	230.26
3934	Auto antibodies by labelled antibodies	16	472.32	10.65	314.39
3938	Precipitatin test per antigen	4.5	132.84	3	88.56
3939	Agglutination test per antigen	5.5	162.36	3.67	108.34
3940	Haemagglutinationtest: per antigen	9.9	292.25	6.6	194.83
3941	Modified Coombs' test for brucellosis	4.5	132.84	3	88.56
3942	Hepatitis Rapid Viral Ab	12.24	361.32	8.16	240.88
3943	Antibody titer to bacterial exotoxin	3.6	106.27	2.4	70.85
3944	IgE: Specific antibody titer: ELISA/EMIT: per Ag	12.4	366.05	8.27	244.13
3945	Complement fixation test	5.85	172.69	3.9	115.13
3946	IgM: Specific antibody titer: ELISA or EMIT: per Ag	14.05	414.76	9.37	276.60
3947	C-reactive protein	3.6	106.27	2.4	70.85
3948	IgG: Specific antibody titer: ELISA/EMIT: per Ag	12.95	382.28	8.63	254.76
3949	Qualitative Kahn. VDRL or other flocculation	2.25	66.42	1.5	44.28
3950	Neutrophil phagocytosis	25.2	743.90	16.8	495.94
3951	Quantitative Kahn. VDRL or other flocculation	3.6	106.27	2.4	70.85
3952	Neutrophil chemotaxis	67.95	2 005.88	45.3	1 337.26
3953	Tube agglutination test	4.15	122.51	2.76	81.48
3955	Paul Bunnell: presumptive	2.25	66.42	1.5	44.28
3956	Infectious Mononucleasis latex slide test (Monospot or equivalent)	8.5	250.92	5.67	167.38
3957	Paul Bunnell: Absorption	4.5	132.84	3	88.56
4601	Panel typing: Antibody detection: Class 1	36	1 062.72	24	708.48
4602	Panel typing: Antibody detection: Class II	44	1 298.88	29.3	864.94
4607	Cross matching T-cells (per tray)	18	531.36	12	354.24
4608	Cross matching B-cells	38	1 121.76	25.3	746.86
4609	Cross matching T- & B-cells	48	1 416.96	32	944.64
4610	Helicobacter pylori antigen test	34.6	1 021.39	23.07	681.03
4613	Anti-Gm1 Antibody Assay	75	2 214.00	50	1 476.00

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
4014	HIV Ab - Rapid Test	12	354.24	8	236.16
3959	Rose Waaler Agglutination test	4.5	132.84	3	88.56
3961	Slide agglutination test	2.63	77.64	1.75	51.66
3962	Rebuck skin window	5.4	159.41	3.6	106.27
3963	Serum complement level: each component	3.15	92.99	2.1	61.99
3967	Auto-antibody: Sensitised erythrocytes	4.5	132.84	3	88.56
3969	Western blot technique	74	2 184.48	49	1 446.48
3971	Immuno-diffusion test: per antigen	3.15	92.99	2.1	61.99
3973	Immuno electrophoresis: per immune serum	9.45	278.96	6.3	185.98
3975	Indirect immuno-fluorescence test (Bacterial, viral, parasitic)	12	354.24	8	236.16
3977	Counter immuno-electrophoresis	6.75	199.26	4.5	132.84
3978	Lymphocyte transformation	51.7	1 526.18	34.5	1 018.44
3980	Bilharzia Ag Serum/Urine	14.5	428.04	9.67	285.46
21.5	**Skin tests** For skin-prick allergy tests, please refer to items 0218 to 0221 in the Integumentary Section				
21.6	**Biochemical tests: Blood**				
3991	Abnormal pigments: qualitative	4.5	132.84	3	88.56
3993	Abnormal pigments: quantitative	9	265.68	6	177.12
3995	Acid phosphatase	5.18	152.91	3.45	101.84
3996	Serum Amyloid A	8.28	244.43	5.52	162.95
3997	Acid phosphatase fractionation	1.8	53.14	1.2	35.42
3998	Amino acits: Quantitative (Post derivatisation HPLC)	78.12	2 306.10	52.08	1 537.40
3999	Albumin	4.8	141.70	3.2	94.46
4000	Alcohol	12.4	366.06	8.27	244.13
4001	Alkaline phosphatase	5.18	152.91	3.45	101.84
4002	Alkaline Phosphatase-iso-enzymes	11.7	345.38	7.8	230.26
4003	Ammonia: enzymatic	7.71	227.60	5.14	151.73
4004	Ammonia: monitor	4.5	132.84	3	88.56
4005	Alpha-1-antitrypsin	7.2	212.54	4.8	141.70
4006	Amylase	5.18	152.91	3.45	101.84
4007	Arsenic in blood, hair or nails	36.25	1 070.10	24.17	713.50
4008	Bilirubin – Reflectance	4.77	140.81	3.18	93.87
4009	Bilirubin: total	4.77	140.81	3.18	93.87
4010	Bilirubin: conjugated	3.62	106.86	2.41	71.14
4014	Cadmium: atomic absorp	18.12	534.90	12.08	356.60
4016	Calcium: ionized	6.75	199.26	4.5	132.84
4017	Calcium: spectrophotometric	3.62	106.86	2.41	71.14
4018	Calcium: atomic absorption	7.25	214.02	4.83	142.58
4019	Carotene	2.25	66.42	1.5	44.28
4023	Chloride	2.59	76.46	1.73	51.07
4026	LDL cholesterol (chemical determination)	6.9	203.69	4.6	135.79
4027	Cholesterol total	5.34	157.64	3.56	105.09

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
4029	Cholinesterase: serum or erythrocyte: each	7.48	220.81	4.99	147.30
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	9	265.68	6	177.12
4031	Total CO2	5.18	152.91	3.45	101.84
4032	Creatinine	3.62	106.86	2.41	71.14
4035	CSF-Albumin	9.45	278.96	6.3	185.98
4036	CSF-IgG Index	22.05	650.92	14.7	433.94
4040	Homocysteine (random)	15.3	451.66	10.2	301.10
4041	Homocysteine (after Methionine load)	18.1	534.31	12.06	356.01
4042	D-Xylose absorption test: two hours	13.15	388.19	8.75	258.30
4045	Fibrinogen: quantitative	3.6	106.27	2.4	70.85
4047	Hollander test	24.75	730.62	16.5	487.08
4049	Glucose tolerance test (2 specimens)	8.97	264.79	5.98	176.53
4050	Glucose strip-test with photometric reading	1.8	53.14	1.2	35.42
4051	Galactose	11.25	332.10	7.5	221.40
4052	Glucose tolerance test (3 specimens)	13.17	388.78	8.78	259.19
4053	Glucose tolerance test (4 specimens)	17.37	512.76	11.58	341.84
4057	Glucose Quantitative	3.62	106.86	2.41	71.14
4061	Glucose tolerance test (5 specimens)	21.56	636.45	14.37	424.20
4063	Fructosamine	7.2	212.54	4.8	141.70
4064	Glycated haemoglobin: chromatography/HbA1C	14.25	420.66	9.5	280.44
4067	Lithium: flame ionisation	5.18	152.91	3.45	101.84
4068	Lithium: atomic absorption	7.48	220.81	4.99	147.30
4071	Iron	6.75	199.26	4.5	132.84
4073	Iron-binding capacity	7.65	225.83	5.1	150.55
4076	Carboxy haemoglobin (6x per 24 hrs)	19.1	563.83	12.73	375.79
4078	Oximetry analysis: MetHb, COHb, O_2Hb, RHb, SulfHb	6.75	199.26	4.5	132.84
4079	Ketones in plasma: qualitative	2.25	66.42	1.5	44.28
4081	Drug level-biological fluid: Quantitative	10.8	318.82	7.2	212.54
4086	Plasma Lactate				
4085	Lipase				
4091	Lipoprotein electrophoresis	9	265.68	6	177.12
4093	Osmolality: Serum or urine	6.75	199.26	4.5	132.84
4094	Magnesium: Spectrophotometric	3.62	106.86	2.41	71.14
4095	Magnesium: Atomic absorption	7.25	214.02	4.83	142.58
4096	Mercury: Atomic absorption	18.12	534.90	12.08	356.60
4098	Copper: Atomic absorption	18.12	534.90	12.08	356.60
4105	Protein electrophoresis	9	265.68	6	177.12
4106	IgG sub-class 1.2. 3 or 4: Per sub-class	20	590.40	13.2	389.66
4109	Phosphate	3.62	106.86	2.41	71.14

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
4111	Phospholipids	3.15	92.99	2.1	61.99
4113	Potassium	3.62	106.86	2.41	71.14
4114	Sodium	3.62	106.86	2.41	71.14
4117	Protein: total	3.11	91.81	2.07	61.11
4121	pH. pCO_2 or $p0_2$ each	6.75	199.26	4.5	132.84
4123	Pyruvic acid	4.5	132.84	3	88.56
4125	Salicylates	4.5	132.84	3	88.56
4126	Secretin-pancreozymin responds	26.1	770.47	17.4	513.65
4127	Caeruloplasmin	4.5	132.84	3	88.56
4128	Phenylalannine: Quantitative	11.25	332.10	7.5	221.40
4129	Glutamate dehydrogenase (GDH)	5.4	159.41	3.6	106.27
4130	Aspartate amino transferase (AST)	5.4	159.41	3.6	106.27
4131	Alanine amino transferase (ALT)	5.4	159.41	3.6	106.27
4132	Cretine kinase (CK)	5.4	159.41	3.6	106.27
4133	Lactate dehidrogenase (LD)	5.4	159.41	3.6	106.27
4134	Gamma glutamyl transferase (GGT)	5.4	159.41	3.6	106.27
4135	Aldolase	5.4	159.41	3.6	106.27
4136	Angiotensin converting enzyme (ACE)	9	265.68	6	177.12
4137	Lactate dehydrogenase isoenzyme	10.8	318.82	7.2	212.54
4138	CK-MB: immunoinhibition/precipetation	10.8	318.82	7.2	212.54
4139	Adenosine deaminase	5.4	159.41	3.6	106.27
4142	Red cell enzymes: each	7.8	230.26	5.2	153.50
4143	Serum/plasma enzymes: each	5.4	159.41	3.6	106.27
4144	Transferrin	11.7	345.38	7.8	230.26
4146	Lead: atomic absorption	15	442.80	10	295.20
4151	Urea	3.62	106.86	2.41	71.14
4152	CK-MB	12.4	366.05	8.27	244.13
4154	Myoglobin quantitative: Monoclonal immunological	12.4	366.05	8.27	244.13
4155	Uric acid	3.78	111.59	2.52	74.39
4157	Vitamin A-saturation test	15.3	451.66	10.2	301.10
4158	Vitamin E (tocopherol)	3.6	106.27	2.4	70.85
4159	Vitamin A	6.3	185.98	4.2	123.98
4160	Vitamin C (ascorbic acid)	2.25	66.42	1.5	44.28
4161	Trop T	20	590.40	13.33	393.50
4171	Sodium + potassium + cloride + $C0_2$ + urea	15.84	467.60	10.56	311.73
4172	ELIZA or EMIT technique	12.42	366.64	8.28	244.43
4181	Quantitative protein estimation: Mancini method	7.76	229.08	5.17	152.62
4182	Quantitative protein estimation: nephelometer	8.28	244.43	5.52	162.95
4183	Quantitative protein estimation: labelled antibody	12.42	366.64	8.28	244.43
4185	Lactose	10.8	318.82	7.2	212.54
4187	Zinc: atomic absorption	18.12	534.90	12.08	356.60

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
21.7	**Biochemical tests: Urine**				
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	1.5	44.28	1	29.52
4189	Abnormal pigments	4.5	132.84	3	88.56
4193	Alkapton test: homogentisic acid	4.5	132.84	3	88.56
4194	Amino acids: quantitative (Post derivatisation HPLC)	78.12	2 306.10	52.08	1 537.40
4195	Amino laevulinic acid	18	531.36	12	354.24
4197	Amylase	5.18	152.91	3.45	101.84
4199	Ascorbic acid	2.25	66.42	1.5	44.28
4201	Bence-Jones protein	2.7	79.70	1.8	53.14
4203	Phenol	3.6	106.27	2.4	70.85
4204	Calcium: atomic absorption	7.25	214.02	4.83	142.58
4205	Calcium: spectrophotometric	3.62	106.86	2.41	71.14
4206	Calcium: absorption and excretion studies	25	738.00	16.7	492.98
4209	Lead: atomic absorption	15	442.80	10	295.20
4211	Bile pigments: qualitative	2.25	66.42	1.5	44.28
4213	Protein: quantitative	2.25	66.42	1.5	44.28
4216	Mucopolysaccharides: qualitative	3.6	106.27	2.4	70.85
4217	Oxalate/Citrate: enzymatic each	9.38	276.90	6.25	184.50
4218	Glucose: quantitative	2.25	66.42	1.5	44.28
4219	Steroids: chromatography (each)	7.2	212.54	4.8	141.70
4221	Creatinine	3.62	106.86	2.41	71.14
4223	Creatinine clearance	7.65	225.83	5.1	150.55
4227	Electrophoreses: qualitative	4.5	132.84	3	88.56
4229	Uric acid clearance	7.65	225.83	5.1	150.55
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	37.50	1 107.00	25.00	738.00
4232	Metobolites (Gaschromatography/Mass spectrophotometry)	46.80	1 381.54	31.20	921.02
4233	Pharmacological/Drugs of abuse: Metobolites HPLC (High Pressure Liquid Chromatography)	37.50	1 107.00	25.00	738.00
4234	Pharmacological/Drugs of abuse: Metobolites (Gaschromatography/Mass spectrophotometry)	46.80	1 381.54	31.20	921.02
4237	5-Hydroxy-indole-acetic acid: screen test	2.7	79.70	1.8	53.14
4239	5-Hydroxy-indole-acetic acid: quantitative	6.75	199.26	4.5	132.84
4241	DELETED 2009: Indican or indole: qualitative				
4247	Ketones: excluding dip-stick method	2.25	66.42	1.5	44.28
4248	Reducing substances	1.8	53.14	1.2	35.42
4251	Metanephrines: column chromatography	22.05	650.92	14.7	433.94
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	27	797.04	18	531.36
4254	Nitrosonaphtol test for tyrosine	2.25	66.42	1.5	44.28
4262	Micro Albumin-Qualitative	4.5	132.84	3	88.56
4263	pH: Excluding dip-stick method	0.9	26.57	0.6	17.71
4265	Thin layer chromatography: one way	6.75	199.26	4.5	132.84
4266	Thin layer chromatography: two way	11.25	332.10	7.5	221.40
4267	Total organic matter screen: Infrared	31.25	922.50	20.83	614.90
4268	Organic acids: quantitative: GCMS	109.38	3 228.90	72.92	2 152.60
4269	Phenylpyruvic acid: ferric chloride	2.25	66.42	1.5	44.28
4271	Phosphate excretion index	22.05	650.92	14.7	433.94
4272	Porphobilinogen qualitative screen: urine	5	147.60	3.33	98.30
4273	Porphobilinogen/ALA: quantitative each	15	442.80	10	295.20
4283	Magnesium: spectrophotometric	3.62	106.86	2.41	71.14
4284	Magnesium: atomic absorption	7.25	214.02	4.83	142.58
4285	Identification of carbohydrate	7.65	225.83	5.1	150.55
4287	Identification of drug: qualitative	4.5	132.84	3	88.56
4288	Identification of drug: quantitative	10.8	318.82	7.2	212.54
4293	Urea clearance	5.4	159.41	3.6	106.27
4297	Copper: spectrophotometric	3.62	106.86	2.41	71.14
4298	Copper: Atomic absorption	18.12	534.90	12.08	356.60
4300	Indican or Indole: Qualitative	3.15	92.99	2.1	61.99
4301	Chloride	2.59	76.46	1.73	51.07
4307	Ammonium chloride loading test	22.05	650.92	14.7	433.94
4309	Urobilonogen: quantitative	6.75	199.26	4.5	132.84
4313	Phosphates	3.62	106.86	2.41	71.14
4315	Potassium	3.62	106.86	2.41	71.14
4316	Sodium	3.62	106.86	2.41	71.14
4319	Urea	3.62	106.86	2.41	71.14
4321	Uric acid	3.62	106.86	2.41	71.14
4322	Fluoride	5.18	152.91	3.45	101.84
4323	Total protein and protein electrophoreses	11.25	332.10	7.5	221.40
4325	VMA: quantitative	11.25	332.10	7.5	221.40
4327	Immunofixation: Total Protein, IgG, IgA, IgM, Kappa, Lambda	46.88	1 383.90	31.25	922.50
4335	Cystine: quantitative	12.6	371.95	8.4	247.97
4336	Dinitrophenal hydrazine test: ketoacids	2.25	66.42	1.5	44.28
4337	Hydroxyproline: quantitative	18.9	557.93	12.6	371.95

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
21.8	**Biochemical tests: Faeces**				
4339	Chloride	2.59	76.46	1.73	51.07
4343	Fat: qualitative	3.15	92.99	2.1	61.99
4345	Fat: quantitative	22.05	650.92	14.7	433.94
4347	pH	0.9	26.57	0.6	17.71
4351	Occult blood: chemical test	2.25	66.42	1.5	44.28
4352	Occult blood (monoclonal antibodies)	10	295.20	6.67	196.90
4357	Potassium	3.62	106.86	2.41	71.14
4358	Sodium	3.62	106.86	2.41	71.14
4361	Stercobilin	2.25	66.42	1.5	44.28
4363	Stercobilinogen: quantitative	6.75	199.26	4.5	132.84
21.9	**Biochemical tests: Miscellaneous**				
4370	Vancomycin, Phenytoin, Theophylline	12.4	366.05	8.27	244.13
4371	Amylase in exudate	5.18	152.91	3.45	101.84
4374	Trace metals in biological fluid: Atomic absorption	18.13	535.20	12.08	356.60
4375	Calcium in fluid: Spectrophotometric	3.62	106.86	2.41	71.14
4376	Calcium in fluid: Atomic absorption	7.25	214.02	4.83	142.58
4388	Gastric contents: Maximal stimulation	27	797.04	18	531.36
4389	Gastric fluid: Total acid per specimen	2.25	66.42	1.5	44.28
4391	Renal calculus: Chemistry	5.4	159.41	3.6	106.27
4392	Renal calculus: Crystallography	16.25	479.70	10.8	318.82
4393	Saliva: Potassium	3.62	106.86	2.41	71.14
4394	Saliva: Sodium	3.62	106.86	2.41	71.14
4395	Sweat: Sodium	3.62	106.86	2.41	71.14
4396	Sweat: Potassium	3.62	106.86	2.41	71.14
4397	Sweat: Chloride	2.59	76.46	1.73	51.07
4399	Sweat collection by iontophoresis (excluding collection material)	4.5	132.84	3	88.56
4400	Triptophane loading test	22.05	650.92	14.7	433.94
21.10	**Cerebrospinal fluid**				
4401	Cell count	3.45	101.84	2.3	67.90
4407	Cell count, protein, glucose and chloride	7.65	225.83	5.1	150.55
4409	Chloride	2.59	76.46	1.73	51.07
4415	Potassium	3.62	106.86	2.41	71.14
4416	Sodium	3.62	106.86	2.41	71.14
4417	Protein: Qualitative	0.9	26.57	0.6	17.71
4419	Protein: Quantitative	3.11	91.81	2.07	61.11
4421	Glucose	3.62	106.86	2.41	71.14
4423	Urea	3.62	106.86	2.41	71.14
4425	Protein electrophoresis	12.6	371.95	8.4	247.97
4434	Bacteriological DNA identification (PCR)	75	2 214.00	50	1 476.00

		Pathologist		Other Specialists and General Practioners	
		U	R	U	R
21.12	**Isotopes**				
4451	HCG: Monoclonal immunological: Quantitative	12.4	366.05	8.27	244.13
4458	Micro-albuminuria: radio-isotope method	12.42	366.64	8.3	245.02
4459	Acetyl choline receptor antibody	158.12	4 667.70	105.41	3 111.70
4463	C6 complement functional essay	45	1 328.40	30	885.60
4466	Beta-2-microglobulin	12.42	366.64	8.28	244.43
4469	S-S100	20	590.40	13.33	393.50
4452	Bone-Specific Alk. Phosphatase	20	590.40	13.33	393.50
4479	Vitamin B12-absorption: Shilling test	11.7	345.38	7.8	230.26
4480	Serotonin	18.75	553.50	12.5	369.00
4482	Free thyroxine (FT4)	17.48	516.01	11.65	343.91
4484	Thyroid profile (only with special motivation)	37.8	1 115.86	24.72	729.73
4485	Insulin	12.42	366.64	8.28	244.43
4488	NT Pro BNP	47.04	1 388.62	33.35	984.49
4491	Vitamin B12	12.42	366.64	8.28	244.43
4493	Drug concentration: quantitative	12.42	366.64	8.28	244.43
4497	Carbohydrate deficient transferrin	29.06	857.85	19.37	571.80
4499	Cortisol	12.42	366.64	8.28	244.43
4500	DHEA sulphate	12.42	366.64	8.28	244.43
4507	Thyrotropin (TSH)	19.6	578.59	13.07	385.83
4509	Free tri-iodothyronine (FT3)	17.48	516.01	11.65	343.91
4511	Renin activity	18.9	557.93	12.6	371.95
4516	Follitropin (FSH)	12.42	366.64	8.28	244.43
4517	Lutropin (LH)	12.42	366.64	8.28	244.43
4522	Alpha-Feto protein	12.42	366.64	8.28	244.43
4523	ACTH	21.74	641.76	14.49	427.74
4524	Free PSA	14.49	427.74	9.66	285.16
4527	Gastrin	12.42	366.64	8.28	244.43
4528	Ferritin	12.42	366.64	8.28	244.43
4530	Antiplatelet antibodies	15.3	451.66	10.2	301.10
4531	Hepatitis: per antigen or antibody	14.49	427.74	9.66	285.16
4532	Transcobalamine	12.42	366.64	8.28	244.43
4533	Folic acid	12.42	366.64	8.28	244.43
4536	Erythrocyte folate	17.48	516.01	11.65	343.91
4537	Prolactin	12.42	366.64	8.28	244.43
4538	Procalcitonin: Qualitative	32	944.64	21.33	629.66
4539	Procalcitonin: Quantitative	46	1 357.92	30.67	905.38
21.13	**After hour service and travelling fees (applicable to pathologists only)**				
	Miscellaneous				
4544	Attendance in theatre	27	797.04		-
4547	After hour service: (Monday to Friday) 17:00 to 08:00. Saturday 13:00 to Monday 08:00 and public holidays	Tariff/Tarief + 50%	Tariff/Tarief + 50%		
4549	Minimum fee for after hour service	6.3	185.98		-
4551	Fees not detailed in the above Pathology Schedule (section 21) are obtainable from the National Pathology Group of the SAMA. and will be based on the fee for a comparable service in the Tariff of fees		-		-
22.	**ANATOMICAL PATHOLOGY**				
	The amounts in this section are calculated according to the **Anatomical Pathology** unit values				
22.1	**Exfoliative cytology**				
4561	Sputum and all body fluids: First unit	13.4	390.48	8.9	259.35
4563	Sputum and all body fluids: Each additional unit	7.8	227.29	5.2	151.53
4564	Performance of fine-needle aspiration for cytology	15	437.10		
22.2	**Histology**				
4567	Histology per sample/specimen each	20	582.80	13.3	387.56
4571	Histology per additional block each	11.6	338.02	7.7	224.38
4575	Histology and frozen section in laboratory	22.7	661.48	15.1	440.01
4577	Histology and frozen section in theatre	90	2 622.60	60	1 748.40
4578	Second and subsequent frozen sections, each	20	582.80	13.4	390.48
4579	Attendance in theatre - no frozen section performed	26.3	766.38	17.5	509.95
4582	Serial step sections (including 4567)	23.3	678.96	15.6	454.58
4584	Serial step sections per additional block each	13.5	393.39	9	262.26
4587	Histology consultation	10.1	294.31	6.7	195.24
4589	Special stains	6.7	195.24	4.5	131.13
4591	Immuno-fluorescence/studies	20.7	603.20	13.8	402.13
4593	Electron microscopy	94	2 739.16	63	1 835.82
4650	Autogenous vaccine	8	233.12	5.33	155.32
4651	Entomological examination	13.9	405.05	9.27	270.13

		Specialist		General practitioner	
		U	R	U	R
	IV. TRAVELLING EXPENSES				
	Refer to General Rule P				
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 more than 16 kilometres in total had to be travelled				
	(b) If more than one patient are 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 is 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)				
	When in cases of emergency (refer to general rule P), a doctor has to travel more than 16 kilometres in total to visit an employee, travelling costs can be charged and shall be calculated as follows				
	Consultation, visit or surgical fee PLUS				
5001	Cost of public transport and travelling time or item 5003				
5003	R4.12 per km for each kilometre travelled in own car: 19 kmtotal = 19 x R4.12 = R78.28 (no travelling time)				
	Travelling time (Only applicable when public transport is used)				
5005	Specialist 18,00 clinical procedure units per hour or part thereof	*18*	**510.66**		
5007	General Practitioner: 12,00 clinical procedure units per hour or part thereof			*12*	**340.44**
5009	After hours: Specialist: 27,00 clinical procedure units per hour or part thereof	*27*	**765.99**		
5011	After hours: General Practitioners: 18,00 clinical procedure units per hour or part thereof			*18*	**510.66**
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them				
5015	Travelling expenses may be charged from the medical practitioner's residence for calls received at night or during weekends in cases where travelling fees are allowed				

COIDA Tariff for Medical Practitioners

THE UNIT VALUES FOR THE VARIOUS GROUPS AND SECTIONS AS FROM 1 APRIL 2022 ARE AS FOLLOWS:

	Groups and Sections	Unit Value
1.	Consultation Services codes 0146 & 0109	R 28.37
	Consultation Services: codes 0181; 0182; 0183, 0184, 0186, 0151	R 28.90
2.	Clinical procedures	R 28.37
3.	Anaesthetics	R 132.56
4.	Radiology & MRI	R 29.67
5.	Radiation Oncology	R 31.21
6.	Ultrasound	R 28.03
7.	Computed Tomography	R 28.51
8.	Clinical Pathology	R 29.52
9.	Anatomical Pathology	R 29.14
10	5 Digit Radiology (SP)	R 193.49

Note : The unit value and amounts published in the tariff is **VAT Exclusive**

SYMBOLS USED IN THIS PUBLICATION

*	Per service (specify)
ß	Per service
Φ	Per consultation

COIDA & RSSA INDICATIONS FOR MRI OF INJURY ON DUTY PATIENTS.

Select the appropriate injury, modality and indication to be used in conjuction with a MRI.

Annexure A ⟶ *MRI motivation form.*

Annexure B ⟶ *COIDA & RSSA indication for MRI.*

Annexure C ⟶ *Indications for plexus and peripheral nerve block.*

Annexure D ⟶ *System format.*

Annexure: A
The Department of Labour: Compensation Fund

MRI Motivation Form for Employee's Injured on Duty

Claim Number:

Employee's Name:

Employees ID No:

Name of Employer:

Date of Accident / Injury:

Type of Injury:

Brief description of how injury occurred:

Previous clinic / imaging investigations done, and dates:

Imaging investigation required:

Motivation / Clinical indications for the investigation:

Requesting Doctors Name:

Practice Number:

Date of Referral

This form should preferably be typed.

ANNEXURE :B

COIDA & RSSA– Indications for MR Imaging of Injury on Duty Patients

Select the appropriate injury, modality and indication. To be used in conjunction with a MRI / CT motivation. Refer also to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients"

☐ **Head Injury - Acute** (1) (Acute regarded as within first week of date of injury)

- ☐ CT
  - ☐ Reduced level of consciousness (1.i.a)
  - ☐ Seizures (1.i.b)
  - ☐ Neurological deficit (1.i.c)
  - ☐ Skull or facial bone fractures (1.i.d)

☐ **Head + Cervical Spine Injury – Acute** (2)

- ☐ CT
  - ☐ Head as above (2.i)
  - ☐ CT Spine (bone or joint injury) depending on result spine x-ray (2.ii)
- ☐ MRI – in selected cases following a CT (2.iii)

☐ **Head Injury – Sub acute**

- ☐ MRI
  - ☐ Rotational axonal injury (2.d)
  - ☐ Chronic subdural haemorrhage

☐ **Head Injury - long term sequela** (3)

- ☐ CT
  - ☐ If convulsions present in semi acute phase, do CT first (3.b)
- ☐ MRI
  - ☐ Epilepsy (contrast and additional sequences often required) (3.a)
  - ☐ Long term structural changes (3.c)

☐ **Spine – Acute**

- ☐ CT
  - ☐ Bone or joint injury (4.i)
- ☐ MRI
  - ☐ Cord compression (5.i)
  - ☐ Neurological signs (nerve root) (5.ii)
  - ☐ Vertebral body fracture (selected cases) (5.iii)

☐ **Spine – sub acute and long term sequela**

- ☐ MRI
  - ☐ Cord injury (6.i)
  - ☐ Disc herniation (6.ii)
  - ☐ Post operative assessment (selected cases) (6.iii)

☐ **Chest / Body Injury** (7)

- ☐ CT
  - ☐ Sternal fracture
  - ☐ Vascular of lung
  - ☐ Other organs / soft tissue

☐ **Extremities**

- ☐ CT
  - ☐ Complicated fractures and dislocations (10)
- ☐ MRI
  - ☐ Muscle distal biceps insertion (9)
  - ☐ Cartilage, tendons, labrum, soft tissue of, joints (8.iii.a)
  - ☐ Planning repair of joints (8.iii.b)
  - ☐ Knee, elbow, ankle (usually no contrast) (8.iii.d)
  - ☐ Shoulder, wrist, hip (usually with contrast) (8.iii.c)

The numbers after the indications refer to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients". The above indications are not exhaustive, and are merely a selection of the more common indications.

ANNEXURE: C

Item 2800 and 2802 as part of anaesthesia

2800 – Plexus nerve block
2802 – Peripheral nerve block

The motivation for the use of one of these codes in addition to that for the "normal" anaesthesia is that it controls post operative pain and minimises the use of pain injections / medication and encourages early mobilisation.

It is reasonable if the injury / surgery is of sufficient nature to expect much pain post operatively, such as in the fracture of a long bone that was surgically reduced and fixated.

It is however not reasonable in cases of a simple fracture to a hand bone / foot bone or uncomplicated amputation of a finger / toe or other simple procedures.

Examples of claims where the use is reasonable:

- open reduction / internal fixation of a femur / tibia – fibula / humerus / radius – ulna
- total knee replacement / total hip replacement

Examples where the use of the codes is not reasonable:

- one fracture in the hand / foot treated surgically
- amputation finger / toe or part of finger / toe
- arthroscopy of the ankle / knee / shoulder

The use of this codes could also be reasonable were a "crushed foot" injury because of many fractures and multiple procedures in one operation.

Item 2800 and 2802 as part of treatment

There also are instances where the use of the codes is part of the treatment (no surgery performed and is not part of general anaesthesia as such). This is why the codes were put into the tariff structure in the first place.
Multiple rib fractures are treated with a nerve block for pain management and that would be acceptable.

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	Member surname	20	Alpha
7	Member initials	4	Alpha
8	Member first name	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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