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GOVERNMENT NOTICES • GOEWERMENTSKENNISGEWINGS

DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. 7279

20 March 2026

**DOCTORS
GAZETTE
2026**



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GOVERNMENT NOTICE

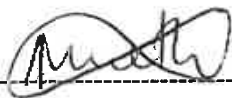
DEPARTMENT OF EMPLOYMENT AND LABOUR

No.

DATE:

**COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(ACT No. 130 OF 1993), AS AMENDED****ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES
PROVIDERS.**

1. I, Nomakhosazana Meth, Minister of Employment and 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 2026.
2. Medical Tariffs will increase by 6% for the financial year 2026/27.
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2026 and exclude 15% VAT



Ms. N Meth, MP**MINISTER OF EMPLOYMENT AND LABOUR**



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GENERAL INFORMATION

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

- The Compensation Fund requires that any Medical Service Provider, treating patients in terms of the COID Act, must be registered with The Compensation Fund through the submission of copies of the following documents to the nearest labour centre:
 - a. A duly completed original Banking Details form (WAC 33) (download in PDF from www.labour.gov.za)
 - b. The latest copy of valid BHF certificate
 - c. Recent bank statement with bank stamp or bank letter
 - d. Proof of practice address not older than 3 months.
 - e. SARS VAT registration number/ certificate if VAT registered. (If this is not provided the medical practitioner will be registered as a non-VAT vendor)
 - f. A power of attorney is required if the MSP has appointed a third party to do their administration of their COID claims.

2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

- To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:
 - a. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)
 - b. Register on the CompEasy application having the following documents to upload
 - A certified copy of identity document (not older than a month from the date of application)
 - Latest copy of valid BHF certificate
 - Proof of address not older than 3 months
- In the case where a medical service provider has appointed a third party to administer their COID claims with the Fund, the following ADDITIONAL documents must be uploaded:
 - An appointment letter for proxy (the template is available online)
 - The proxy's certified identity document (not older than a month from the date of application)
 - There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)



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3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

- Third Parties that provide administration services on behalf of medical service providers must take note of the following:
 - a. They must be able to obtain and make available copies of the original claim documents and medical invoices from medical service providers.
 - b. They must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.
- The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information relates to a period prior to them being contracting to a third party.

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

Medical Service Providers are encouraged to take note of the following guidance when treating patients in terms of the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

- a. Employees as defined in the COID Act of 1993, are generally free to choose their preferred Medical Service Provider, provided that such choice is exercised reasonably and without prejudice to the employee or the Compensation Fund.
 - An exception applies where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to its employees, e.g. Hospital, nursing and other medical services, as contemplated in Section 78 of the COID Act, in such cases, treatment arrangements may differ.
- b. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report. Medical Service providers should cooperate with such referrals where they occur.
- c. Medical Service Providers are reminded that in accordance with section 76(3)(b) of the COID Act, medical expenses may not be recovered from the employee. Providers should therefore avoid billing employees directly for services that fall within accepted COID claims.
- d. Where a change of Medical Service Providers occurs, the first treating doctor is generally regarded as the principal treating doctor, unless the case is transferred to a specialist.
- e. To promote continuity of care and avoid disputes, Medical Service Providers are encouraged not to treat an employee who is already under the care of another practitioner without first consulting or informing the principal treating doctor.
- f. Any changes of medical service providers should be supported by sufficient reasons, and such reasons should be communicated to the Compensation Fund to ensure clarity and proper case management.
- g. In line to section 5 of the National Health Act no 61 of 2003, a health care provider may not refuse a person emergency medical treatment. In emergency situations, Medical Service Providers are not required to obtain prior authorisation from the Compensation Fund before rendering such treatment even if the claim has not yet been registered or accepted.



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- h. Employees who seek medical treatment do so at their own risk where they have not informed their employer and/or the Compensation Fund of possible grounds for a COID claim. Medical Service Providers should be aware that, under such circumstances, The Compensation Fund may not accept responsibility for the settlements of the medical expenses incurred.
- i. Where a claim is repudiated by the Compensation Fund, the employee is regarded in the same position as any other member of the public in respect of payment for medical services rendered.

5. OVERVIEW OF THE COID CLAIMS PROCESS

- All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:
 - a. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details and progress of the claim can be viewed on the online processing system for registered users of the system.
 - b. Proof of identity is required through the submission of a copy of an Identity document/card, will be required for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.
 - c. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.
 - d. Once an incident is reported to the Fund a claims number will be allocated to acknowledge receipt, but this does not imply acceptance of liability for the claim.
 - e. On acceptance of liability for claims in terms of the COID Act, all reasonable medical expenses, arising from the related medical condition shall be paid to medical service providers, and in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.
 - f. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable. The employer and the employee will be informed of this decision, and the injured employee will be liable for payment of medical costs incurred.
 - g. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.
 - h. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.
 - All medical invoices for accepted claims must be submitted, in the prescribed manner within 36 months of the date of acceptance of liability.
 - And or within 36 months from the date of service, which ever may apply.
 - Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.
 - i. All service providers should be registered on the Compensation Fund claims processing system to capture medical invoices and medical reports for medical services rendered.
 - j. Submission of medical reports and invoices is permitted solely for claims where liability has been accepted by the Compensation Fund and where payment of reasonable medical expenses is authorised.



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6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED OR DISEASED EMPLOYEES

Submission of Medical Reports

- In terms of section 74(1)– (5) of the Compensation for Occupational Injuries and Diseases Act, 1993 (COIDA Act), every Medical Service Provider shall submit the prescribed medical reports when claiming from the Compensation Fund.
- The First Medical Report (W.CL 4), completed after the initial consultation, shall:
 - Confirm the clinical description of the injury or disease.
 - Detail all procedures performed; and
 - Record all referrals to other medical service providers, where applicable.
- All follow up consultations shall be recorded on a Progress Medical Report (W.CL 5). Any procedure or operation performed during the reporting period shall be clearly detailed, including all referrals, where applicable.
- A Progress Medical Report shall cover a maximum period of thirty (30) days, except where a procedure has been performed during that period, in which case an additional operation report shall be submitted.
- Where multiple procedures are performed on the same date of service, only one medical report shall be submitted in respect of that service date.
- Upon stabilisation of the injury or disease, a Final Medical Report (W.CL 5F) shall be completed and submitted
- Medical Service Providers shall attach a medical report or other appropriate medical documentation to every claim submitted to the Compensation Fund.
- Medical Service Providers shall retain copies of all submitted medical reports and shall make such records available to the Compensation Commissioner upon request.
- With effect from 1 April 2025, **ALL** medical practitioners shall submit relevant patient records together with medical invoices for services rendered. **(This includes hospitals, anaesthetists and any other practitioners that have not previously been required to do so)**

Submission of Medical Invoices

- Medical invoices shall be submitted only in respect of claims for which liability has been formally accepted by the Compensation Fund and where payment of reasonable medical expenses has been authorised.
- The submission of medical invoices without the required accompanying medical documentation shall be strictly prohibited and shall result in rejection of the invoice.
- Duplicate invoices shall not be submitted under any circumstances.
- Running accounts or statements shall not be accepted and shall be rejected at system level.

Minimum Information Requirements for Medical Invoices

Every medical invoice submitted to the Compensation Fund shall, at a minimum, include the following information:

- The allocated Compensation Fund claim number.
- The full name, surname and identity number of the employee.
- The name and Compensation Fund registration number of the employer, as reflected on the Employer's Report of Accident (W.CL 2);



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- The date of accident.
- The date(s) of service rendered.
- The Medical Service Provider's BHF practice number.
- The VAT registration number of the Medical Service Provider, where applicable.
- The applicable tariff code(s) as published in the approved tariff gazettes.
- The amount claimed per tariff code, quantity, total amount claimed including the correct sequencing of modifiers where applicable.
- A unique invoice number.

(Medical invoices that do not comply with the prescribed minimum information requirements shall be rejected and shall not be processed for payment).

VAT and Tariff Application

- Published tariff amounts shall be assessed exclusive of VAT.
- VAT shall be applied only where the Medical Service Provider is a registered VAT vendor and has supplied a valid VAT registration number on the invoice.
- Where no VAT registration number is provided, the Medical Service Provider shall be regarded as a non-VAT vendor and VAT shall not be applied.
- Notwithstanding the above, the following tariffs shall be processed as VAT inclusive:
 - Per diem tariffs applicable to private hospitals; and
 - VAT exempt tariff codes applicable to private ambulance services.

Pharmaceuticals and Referrals

- All pharmaceutical claims shall be submitted in accordance with the NAPPI file and shall be accompanied by the original prescription(s).
- Where a referral is required, the referring practitioner's referral letter shall accompany the medical invoice.

Enforcement and Non-Compliance

- The Compensation Fund shall withhold payment of any medical invoice that fails to comply with the billing and submission requirements prescribed in this document and as published in the Government Gazette.
- Noncompliance with these billing requirements shall result in rejection of claims and may result in further remedial or enforcement action by the Compensation Fund.

7. INVOICING REQUIREMENT ON MEDICAL CLAIMS FOR ICD-10 CODES

As part of improved delivery service and efficiency, The Compensation Fund has implemented ICD-10 rules that must be adhered to when submitting medical invoices. This will be rolled out in a phased approach. The first phase currently active on the system is outlined below:

ICD-10 Validations

ICD-10 validations will apply in accordance with the national ICD-10 Phase 3 and Phase 4.1 requirements and include the following:

- Valid ICD-10 codes as per the SA ICD-10 Master Industry Table
- Maximum level of specificity: ICD-10 codes must be valid at the correct 3-, 4-, or 5-character level
- Valid ICD-10 primary codes (codes not valid as primary will be rejected)
- Compliance with the dagger and asterisk rule



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- Compliance with sequelae coding rules
- Age edits for ICD-10 codes with age requirements
- Gender edits
- All injury and poisoning codes must be accompanied by external cause codes

Please ensure that you are familiar with the above requirements to avoid unnecessary claim rejections. The date and requirements for the next phase will be communicated in due course.

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the **following** requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COIDA Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund.
This requires that they ensure the following:
 - a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
 - b. Use Strong Encryption and Hashing.
 - c. Place Behind a Gateway.
 - d. Implement IP Blacklists and Whitelists.
 - e. Harden Your FTPS Server.
 - f. Utilize Good Account Management.
 - g. Use Strong Passwords.
 - h. Implement File and Folder Security.
 - i. Secure your administrator and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
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. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE: Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.



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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

* Mandatory fields

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
BATCH HEADER				
1	Header identifier = 1	1	Numeric	*
2	Switch internal Medical aid reference number	5	Alpha	
3	Transaction type = M	1	Alpha	
4	Switch administrator number	3	Numeric	
5	Batch number	9	Numeric	*
6	Batch date (CCYYMMDD)	8	Date	*
7	Scheme name	40	Alpha	*
8	Switch internal	1	Numeric	
DETAIL LINES				
1	Transaction identifier = M	1	Alpha	*
2	Batch sequence number	10	Numeric	*
3	Switch transaction number	10	Numeric	*
4	Switch internal	3	Numeric	
5	CF Claim number	20	Alpha	*
6	Employee surname	20	Alpha	*
7	Employee initials	4	Alpha	*
8	Employee Names	20	Alpha	*
9	BHF Practice number	15	Alpha	*
10	Switch ID	3	Numeric	
11	Patient reference number (account number)	11	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	*
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	*



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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
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	*
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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MSPs PAID BY THE COMPENSATION FUND

Discipline Code:	Discipline Description:
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists)
076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics



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078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services: (Wheelchairs and Gases only)
094	Prosthodontic

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

DOCTORS RULES 2026

GENERAL MEDICAL DOCTOR AND SPECIALIST TARIFF OF FEES AS FROM 01 APRIL 2026	
GENERAL RULES	
	<p>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</p>
RULE	RULE DESCRIPTION
A.	<p><u>Consultation Definitions:</u> (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 fees may be charged (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or in patient follow up visit code.</p>
B.	<p><u>Normal hours and after hours:</u> 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 medical doctor 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. Note: Items 0146 and 0147 (emergency consultations) as well as modifier 0011 (emergency theatre procedures) are only applicable in the after hours period.</p>
C.	<p><u>Comparable services:</u> 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) To be pre-authorised by the Fund.</p>
D.	<p><u>Cancellation of appointments:</u> 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 medical doctor "timely" shall mean two hours and in the case of a specialist two 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.</p>
E.	<p><u>Pre-operative visits:</u> The appropriate consultation may be charged 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.</p>
F.	<p><u>Administering of injections and/or infusions:</u> Where applicable, administering injections and/or infusions may only be coded when done by the medical doctor him-/herself.</p>

G.	<p>Post-operative care:</p> <p>(a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding FOUR (4) months (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed) .</p> <p>(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.</p> <p>(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.</p> <p>(d) Aftercare refers to all treatment and the post -operative period not requiring any further surgical intervention.</p> <p>(e) Abnormal aftercare refers to post-operative complications and treatment not requiring any further incisions and will be considered for payment.</p>
H.	<p>Removal of lesions:</p> <p>Items involving removal of lesions include follow-up treatment for four months.</p>
I.	<p>Pathological investigations performed by clinicians:</p> <p>Fees for all pathological investigations performed by members of other disciplines (where permissible) - refer to modifier 0097:</p> <p>Items that resort under Clinical and Anatomical Pathology: See section for Pathology.</p>
K.	<p>Services of a specialist, upon referral:</p> <p>In exceptional cases the services of a specialist shall be available only on the recommendation of the attending general medical doctor.</p> <p>Medical medical doctors referring cases to other medical medical doctors 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.</p>
L.	<p>Procedures performed at time of visits:</p> <p>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.</p>
M.	<p>Surgical procedure planned to be performed later:</p> <p>In cases where, during a consultation/visit, a surgical procedure is planned to be performed at a later occasion, a routine pre-operative visit may not be charged for again at such later occasion, since that routine pre-operative visit is included in the global surgical period for the procedure.</p>
N.	<p>Rendering of invoices for occupational injuries and diseases:</p> <p>(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.</p> <p>(b) Where a fee for a service is prescribed in this guideline, the medical medical doctor 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.</p> <p>(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.</p> <p>(d) A single fee for a consultation/visit shall be paid to a medical medical doctor for the once-off treatment of an injured employee who thereafter passes into the permanent care of another medical medical doctor, not a partner or assistant of the first. The responsibility for furnishing the First Medical Report in such a case rests with the second medical doctor.</p>

O.	<p>Costly or prolonged medical services or procedures:</p> <p>(a) An employee should be hospitalised only when and for the length of period that his condition justifies full-time medical assistance.</p> <p>(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.</p> <p>(c) In case of costly or prolonged medical services or procedures the medical medical doctor shall first ascertain in writing from the Compensation Fund if liability is accepted for such treatment.</p>
P.	<p>Travelling fees:</p> <p>(a) Where, in cases of emergency, a medical doctor 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 medical doctor had to travel more than 16 kilometres in total.</p> <p>(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.</p> <p>(c) A medical doctor is not entitled to charge for any travelling expenses or travelling time to his rooms.</p> <p>(d) Where a medical doctor'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).</p> <p>(e) Where a medical doctor conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled).</p>
INTENSIVE CARE	
RULES GOVERNING THIS SPECIFIC SECTION OF THE TARIFF CODE	
Q.	<p>Intensive Care/High Care:</p> <p>Units in respect of item codes 1204 to 1210 (Categories 1 to 3) EXCLUDE the following:</p> <p>(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.</p> <p>(b) Cost of any drugs and/or materials.</p> <p>(c) Any other cost that may be incurred before, during or after the consultation/visit and/or the therapy.</p> <p>(d) Blood gases and chemistry tests, including arterial puncture to obtain specimens.</p> <p>(e) Procedural item codes 1202 and 1212 to 1221.</p> <p>But INCLUDE the following</p> <p>(f) Performing and interpreting of a resting ECG.</p> <p>(g) Interpretation of blood gases, chemistry tests and x-rays.</p> <p>(h) Intravenous treatment (item codes 0206 and 0207).</p>
R.	<p>Multiple organ failure:</p> <p>Units for item codes 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include item 1211: Cardio-respiratory resuscitation.</p>
S.	<p>Ventilation:</p> <p>Units for item codes 1212, 1213 and 1214 (ventilation) include the following:</p> <p>(a) Measurement of minute volume, vital capacity, time and vital capacity studies.</p> <p>(b) Testing and connecting the machine.</p> <p>(c) Setting up and coupling patient to machine: setting machine, synchronising patient with machine.</p> <p>(d) Instruction to nursing staff.</p> <p>(e) All subsequent visits for the first 24 hours.</p>
T.	<p>Ventilation:</p> <p>Item codes 1212 to 1214 does not form part of normal post-operative care, but may not be added to item code 1204: Category 1: Cases requiring intensive monitoring.</p>

	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.
V.	Electro-convulsive treatment: (a) Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. (b) 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: 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.
W.	Magnetic Resonance Imaging: (a) Complete Annexure A and Annexure B, submit report of the investigation and an invoice. (b) Item code 6270- Proper motivation must be submitted upon which the Compensation Fund will consider approval for payment.
	RULES GOVERNING THE SECTION RADIOLOGY
Y.	Contrast material: Except where otherwise indicated, radiologists are entitled to charge for contract material used.
	RULE GOVERNING THE SUBSECTION ON DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIO-ISOTOPES
AA.	Radio-Isotopes: Procedures exclude the cost of isotope used.
	RULE GOVERNING THE SECTION RADIATION ONCOLOGY
BB.	Oncology: The fees in the radiation oncology section do NOT include the cost of radium or isotopes.
	RULE GOVERNING ULTRASOUND EXAMINATIONS
EE.	Ultrasound examinations: (a) In case of a referral, the referring doctor must submit a letter of motivation to the Radiologist or other medical doctor 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.
	RULES GOVERNING THE SECTION URINARY SYSTEM

FF.	<p>Cystoscopy:</p> <p>(a) When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (T U R) prostatectomy.</p> <p>(b) When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair.</p> <p>(c) No modifier applies to item code 1949: Cystoscopy, when performed together with any of item codes 1951 to 1973.</p>
RULE GOVERNING THE SECTION RADIOLOGY	
GG.	<p>Capturing and recording of examinations:</p> <p>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.</p>
RR.	<p>The radiology section in this list:</p> <p>Is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general medical doctors.</p> <p>A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").</p>
XX.	<p>Diagnostic services rendered to hospital inpatients:</p> <p>Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic.</p>
YY.	<p>Diagnostic services rendered to outpatients:</p> <p>Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital).</p>

DOCTORS MODIFIERS 2026

MODIFIER DESCRIPTIONS AND STANDARDS							
AM	<p>Addition Modifier 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. Note: This modifiers should follow a procedure code on a separate line.</p>						
CM	<p>Compound Modifier 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. Note: This modifiers should follow a procedure code on a separate line.</p>						
RM	<p>Reduction Modifier 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. Note: This modifier should be quoted on the same line with procedure code where applicable.</p>						
IM	<p>Information Modifier This modifier provides additional information to a procedure code and carries no financial value. Note: This modifier should be quoted on the same line with procedure code where applicable.</p>						
			Specialist		General Practitioner		Anaesthetic
MODIFIER	MODIFIER DESCRIPTION	U	R	U	R	U	R
MODIFIERS GOVERNING THE CODING STRUCTURE							
MODIFIER GOVERNING THE RADIOLOGY AND RADIATION ONCOLOGY SECTIONS OF THE CODING STRUCTURE							
0001	<p>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.</p>	100	3,654.00				
MODIFIER GOVERNING A RADIOLOGIST REQUESTED TO PROVIDE A REPORT ON X-RAYS							
0002	<p>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.</p>						

0005	<p>Multiple therapeutic procedures/operations under the same anaesthetic:</p> <p>(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.</p> <p>(b) In case of multiple fractures and/or dislocations the above values also prevail.</p> <p>(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.</p> <p>(d) Please note: When more than one small procedure are performed and the tariff code provides 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.</p> <p>(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 bonegraft procedures and instrumentation are performed in combination with arthrodesis (fusion).</p> <p>(f) Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together</p> <ol style="list-style-type: none"> 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. <p>(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.</p>
0006	<p>IM:</p> <p>Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use.</p> <p>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.</p>

0007	<p>AM: (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)].</p> <p>(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 conjunction with modifier 0007(b)].</p> <p>NOTE: Equipment is included in hospital fee and therefore modifier is not payable. Medical Doctors to make payment arrangement with the hospital for using own equipment during theatre procedures.</p>	15	524.10	15	524.10	
0008	<p>CM: 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.</p>					
0009	<p>CM: Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units</p>	36	1,257.84	36	1,257.84	
0010	<p>AM: Local anaesthetic</p> <p>(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.</p> <p>(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.</p> <p>(c) The fee for a local anaesthetic administered is not applicable to radiological procedures such as angiography and myelography.</p> <p>(d) No fee may be levied for the topical application of local anaesthetic.</p> <p>(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.</p>					

0011	<p>CM: Theatre procedures for emergency surgery: Any bona fide, justifiable emergency procedure only applicable during after hour periods-see general Rule B undertaken in an operating theatre will justify the charging of 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 to patients on scheduled lists. (Note: 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).</p>	12	419.28	12	419.28	12	419.28
0013	<p>RM: 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 charged.</p>						
0014	<p>IM: 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 be 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.</p>						
INJECTIONS, INFUSIONS AND INHALATION SEDATION: MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF STRUCTURE							
0015	<p>IM: 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 (and not the Compensation Fund) shall be responsible for remunerating such practitioner for the infusions.</p>						
0017	<p>RM: Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for same condition should be charged at 7.50 consultative service units using modifier 0017 to reflect the amount. (not claimed together with a consultation item).</p>						
MODIFIER GOVERNING SURGERY ON PERSONS WITH A BODY MASS INDEX (BMI) OF MORE THAN 35							
0018	<p>Surgical modifier for persons with a BMI of higher than 35 (calculated according to $\text{kg/m}^2 = \text{weight in kilograms} / \text{height in metres squared}$): Fee for the procedure +50% of the fee for surgeons; 50% increase in anaesthetic time units for anaesthesiologists.</p>						

MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHESIA FOR ALL THE PROCEDURES AND OPERATIONS INCLUDED IN THIS GUIDE TO TARIFF STRUCTURE					
0021	<p>IM:</p> <p>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 modifiers (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.</p>				
0023	<p>AM:</p> <p>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.</p>				
	<p>Anaesthetic time:</p> <p>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.</p>		2	326.54	2 326.54
0024	<p>IM:</p> <p>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.</p>		3	489.81	3 489.81
0025	<p>IM:</p> <p>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.</p>				
0027	<p>IM:</p> <p>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.</p>				
0029	<p>CM:</p> <p>Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthesia, an assistant anaesthesiologist/anaesthetist may be employed. The remuneration of the assistant anaesthesiologist/anaesthetist may be employed. The remuneration of the assistant anaesthesiologist/anaesthetist shall be calculated on the same basis as in the case where a general practitioner administered the anaesthesia.</p>				

0031	IM: Intravenous infusion and transfusions: Administering intravenous infusions and transfusions are considered to a normal part of administering anaesthesia. No Additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.						
0032	AM: 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.			2	326.54	2	326.54
0033	IM: 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 anaesthesiologist/ anaesthetist and modifier 0036: Anaesthetic administered by a general practitioner.			2	326.54	2	326.54
0034	AM: 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	163.27	1	163.27
0035	AM: 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.			7	1,142.89	7	1,142.89

0036	<p>AM: 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 shall have a total value of less than 7.00 anaesthetic units. 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.</p> <p>NOTE: Modifying units may be added to the basic anaesthetic unit value according to the following modifiers (0037-0044, 5441-5448).</p>			7	1,142.89	7	1,142.89
0037	<p>AM: Body hypothermia: Utilisation of total body hypothermia: Add 3.00 anaesthetic units.</p>			3	489.81	3	489.81
0038	<p>AM: Peri-operative blood salvage: Add 4.00 anaesthetic units for intra-operative blood salvage and 4.00 anaesthetic units for post-operative blood salvage.</p>			4	653.08	4	653.08
0039	<p>AM: 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).</p>			3	489.81	3	489.81
0041	<p>AM: Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation: Add 3.00 anaesthetic units.</p>			3	489.81	3	489.81
0042	<p>AM: Extracorporeal circulation: Utilisation of extracorporeal circulation: Add 3.00 anaesthetic units.</p>			3	489.81	3	489.81

MUSCULO-SKELETAL SYSTEM : MODIFIERS GOVERNING ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS							
Modifiers 5441 to 5448							
Note: 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	AM: Add one (1.00) anaesthetic unit, except where the procedure refers to the bones named in modifiers 5442 to 5448.			1	163.27	1	163.27
5442	AM: Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and temporo-mandibular joint: Add two (2.00) anaesthetic units. Note: Not appropriate where arthroscopy only is performed.			2	326.54	2	326.54
5443	AM: Maxillary and orbital bones: Add three (3.00) anaesthetic units.			3	489.81	3	489.81
5444	AM: Shaft of femur: Add four (4.00) anaesthetic units			4	653.08	4	653.08
5445	AM: Spine (except coccyx), pelvis, hip, neck of femur: Add five (5.00) anaesthetic units.			5	816.35	5	816.35
5448	AM: Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8.00) anaesthetic units.			8	1306.16	8	1306.16
MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST UTILISING AN INTRA-AORTIC BALLOON PUMP (CARDIOVASCULAR SYSTEM)							
0100	AM: 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	2,620.50
MUSCULO-SKELETAL SYSTEM MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF							
0046	RM: 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%. Note: This reduction does not include the assistant's fee where applicable. After one month, a full fee for the initial treatment is applicable.						
0047	IM: 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	AM: 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	943.38	27	943.38		
0049	AM: 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	2,690.38	77	2,690.38		
0051	AM: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists and general practitioners add 77.00 clinical procedure units.	77	2,690.38	77	2,690.38		
0052	AM: Except where otherwise specified, fracture (traumatic or surgical, ie. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixation and/or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as long bone or pelvis fracture/osteotomy (refer to modifier 0051) for specialist and general practitioners for HAND or FOOT fracture/osteotomy: Add to the appropriate procedure code.	81.1	2,833.63	81	2,833.63		
0053	AM: Fractures requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes]: Specialists and general practitioners add 32.00 clinical procedure units.	32	1,118.08	32	1,118.08		
0055	AM: Dislocation requiring open reduction: Units for the specific joint plus 77.00 clinical procedure units for specialists and general practitioners.	77	2,690.38	77	2,690.38		
0057	RM: Multiple procedures on feet: In multiple procedures of feet, the units for the first foot are calculated according to modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate units for the second foot in the same way. The total units for the second foot are reduce the total to 50% and add to the total for the first foot.						
0058	AM: Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100% of the fee.						
MODIFIER GOVERNING COMBINED PROCEDURES ON THE SPINE							
0061	IM: 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 SURGERY					
0063	RM: Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.				
0064	RM: 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	AM: 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 include the use of the microscope, except where otherwise specified in the Tariff Guide).				
MODIFIER GOVERNING NASAL SURGERY					
0069	AM: 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	AM: Add 45.00 clinical procedure units to procedure(s) performed through a thoracoscope.	45	1,572.30	45	1,572.30
MODIFIERS GOVERNING FEES FOR ENDOSCOPIC PROCEDURES					
0074	AM: 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	AM: Endoscopic procedures performed in own procedure room: (a) The fee 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	733.74	21	733.74

	MODIFIER GOVERNING THE SECTION ON PHYSICAL TREATMENT
0077	<p>IM: (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.</p> <p>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.</p>
	MODIFIER GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY
0079	<p>IM: 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).</p>
	MODIFIERS GOVERNING THE SECTION DIAGNOSTIC RADIOLOGY
	<p>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.</p> <ol style="list-style-type: none"> 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.

0080	Multiple examinations: Full Fee
0081	IM: Repeat examinations: No reduction
0082	IM: Plus ("+") Means that this item is complementary to a preceding item and is therefore not subject to reduction The amount for plus ("+") procedures must not be added to the amount for the definitive item and must appear on a separate line on the invoice.
0083	RM: A reduction of 33,33% (1/3) in the fee apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used. NOTE: Modifier 0083 is not applicable to Section 19.8 of the tariff
0084	IM: 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@iafrica.com).
0085	IM: Left side: Add to items 6500-6519 as appropriate when the left side is examined. NOTE: The absence of the modifier indicates that the right side is examined.
MODIFIER GOVERNING VASCULAR STUDIES	
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 team should charge at their respective full rates as per modifiers and the applicable codes.	

0086	IM: 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.
6300	RM: If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on invoice).
6302	RM: When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)
6303	RM: When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.
6305	RM: When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20.00 radiological units for each procedure after the initial catheterisation. The first catheterisation is coded at 100% of the unit value.
MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES	
MODIFIERS GOVERNING DIAGNOSTIC SERVICES	
0091	IM: Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all Invoices for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)
0092	IM: Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)
MODIFIERS GOVERNING THE RADIATION ONCOLOGY SECTION	
0095	IM: Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials.
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.

MODIFIERS GOVERNING ULTRASOUND INVESTIGATIONS	
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units
MODIFIERS GOVERNING MAGNETIC RESONANCE IMAGING	
6106	IM: Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.
6107	RM: Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.
6108	RM: Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series".

DOCTORS CONSULTATIONS 2026

CONSULTATIVE SERVICES AS FROM 01 APRIL 2026 (GENERAL PRACTITIONERS and ALL SPECIALISTS)							
I. CONSULTATIVE SERVICES							
Code	Code Description	Specialist		General Practitioner		Anaesthetist	
		U	R	U	R	U	R
CONSULTATION CODES							
<p>Notes: Items 0190-0192 and items 0173-0175 (as appropriate) should be used by all medical doctors, except for psychiatrists who should use items 0161-0163 and items 0166-0169 (as appropriate) for basic consultative services. The below applies: (a) Only one of items 0190-0192 and items 0173-0175 (as appropriate), may be used for a single service and not combinations thereof. (b) The ICD-10 codes should appear on the invoice. (c) These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive addition. (d) Only one of the add-on items 0145, 0146 or 0147 (as appropriate) and not combinations thereof. (e) 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 complaints may differ from those presented during the first visit). (f) Use item 0186 as a single service and not combinations with other consultation items (0190, 0191 and 0192). (g) Items 0190 - 0192 include the remuneration for a visit and /or to complete the first and progress reports. (h) Item 0186 include the remuneration for a visit and /or to complete a final medical report.</p> <p>NB!! Item code 0184 has been discontinued.</p>							
OUT OF HOSPITAL CONSULTATION							
0190	New and established patient: Consultation/visit of established patient of an average duration and/or complexity . Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure.	17	605.03	15	533.85	16.5	587.24
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure.	32	1,138.88	30	1,067.70	31.5	1,121.09
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity . Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure.	36	1,281.24	33	1,174.47	36	1,281.24

HOSPITAL CONSULTATION / VISITS						
0173	First hospital consultation/visit of an average duration and/or complexity . Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	16.5	576.51	15	524.10	16.5 576.51
0174	First hospital consultation/visit: Consultation/visit of a moderately above average duration and/or complexity . Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient.(not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	31.5	1,100.61	30	1,048.20	31.5 1,100.61
0175	First hospital consultation/visit of long duration and/or high complexity . Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	36	1,257.84	33	1,153.02	36 1,257.84
FOLLOW-UP VISIT						
Note: For follow up visits use items (0190 ,0191 and 0192)						
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	1,121.09	30	1,067.70	31.5 1,121.09
ADD-ON CONSULTATIONS SERVICES						
0145	For consultation / visit away from the doctor's home or rooms: ADD to item 0190. Confirm where visit took place. Please note that item 0145 is not applicable for pre-anaesthetic assessments and may not be added to items 0151/ 0152	6	209.64	6	209.64	
0146	Emergency or unscheduled consultation/visit at the doctors home or rooms: ADD to items 0164-0169 or 0190-0192 or 0173-0175 as appropriate. (General Rule B refers)	8	279.52	8	279.52	
0147	For after hours emergency or unscheduled consultation/ visit away from the doctor's home or rooms: ADD to items 0164-0169 or 0190-0192 as appropriate (General Rule B refers)	14	489.16	14	489.16	
HOSPITAL CONSULTATION/VISIT						
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	524.10	15	524.10	
PRE- ANAESTHETIC ASSESSMENT						
<p>a. Pre-anaesthetic consultations for all major vascular, cardio-thoracic and orthopaedic cases will attract a unit value of at least 32.00 units</p> <p>b. Only item 0146 may be charged by PR:10</p> <p>c. Items 0151 may not be billed with 0152</p> <p>d. The ICD-10 codes should appear on the invoice.</p>						
0151	Pre-anaesthetic assessment of patient (all hours), Problem focused history , clinical examination and decision making	32	1,138.88	32	1,138.88	32 1,138.88
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours), Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35min	31.5	1,121.09	30	1,067.70	30 1,067.70

PSYCHIATRY (22) ONLY						
<p>NOTE: a. Applicable to PR 22 only . b. A subsequent visit refers to a voluntary scheduled visit performed for the same condition within (four) 4 months after the 1st visit. c. Hospital follow-up visits: Items 0109 may not be used for psychiatrists</p>						
0164	In rooms Consultation/ visit: Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient for between 46 and 60 minutes (for hospital consultation/visit by psychiatrist - refer to items 0167 and 0169) Use code once per event only for first day in hospital. Can be billed together with psychotherapy and other treatment modalities.	52.5	1868.48			
0167	Follow up in hospital: Psychiatry : New and established patients: Hospital consultation/visit with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient for between 21 to 35 minutes.	27.5	960.85			
0169	First day in hospital: Psychiatry : New and established patients: Hospital consultation/visit with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies the doctor personally with the patient for between 45 to 60 minutes.	52.5	1,834.35			
GENERAL						
0136	Special medical examination requested by The Compensation Commissioner (Section 42).	200	6,988.00			
0199	Completion of chronic medication forms by medical doctors with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent.	21.43	748.76	21.43	748.76	
II. MEDICINE, MATERIAL AND SUPPLIES						
0201	(a) Cost of material: This item provides for a charge for material and special medicine used in treatment. Material to be charged for at cost price plus 35%. Charges for medicine used in treatment not to exceed the retail Ethical Price List (b) External fixation apparatus (disposable): An amount equivalent to 25% of the purchase price of the apparatus may be charged where such apparatus is used (c) External fixation apparatus (non-disposable): An amount equivalent to 20% of the purchase price of the apparatus may be charged where such apparatus is used (d) In case of minor injuries requiring additional material (e.g. suturing material) payment shall be considered provided the claim is motivated (e) Medicine, bandages and other essential material for home-use by the patient must be obtained from a chemist on prescription or, if a chemist is not readily available, the practitioner may supply it from his own stock provided a relevant prescription is attached to his account. Charges for medicine used in treatment not to exceed the retail Ethical Price List (f) Unless otherwise stated (attach invoice), for hospitalised patients, medication is included in per diem hospital tariff. Medical practitioners cannot claim for medication for such patients. (g) Medicine, material and/or unregistered/unscheduled products used during treatment: To be used for all medicine, material and/or unregistered/unscheduled products using in treatment. The appropriate NAPPI code(s), where applicable, must be provided /reflected in the invoice.					
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201 (Cost of material used in treatment) as appropriate.	10	349.40	10	349.40	
0194	Procurement cost for human donor material. No mark up is allowed. Procurement cost for such as harvesting, preservation, transportation. No fee for donor material is appropriate as trading in human tissue is unlawful. Type of human tissue to be reflected Pre-Authorization is required.					

DOCTORS CLINICAL PROCEDURES 2026

		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 tariff code 6999 (Refer to General Rule C) Note: To be authorised by the Fund.							
1.	GENERAL							
1.1	Note: How to charge for intravenous infusions Practitioners are entitled to charge according to the appropriate tariff code 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.							
0206	Intravenous infusions (push-in) Insertion of cannula - chargeable once per 24 hours. Not appropriate for managing infusion in daily hospital, High Care and Intensive Care patients (code 0109, 1204 -1206 and 1208- 1210). Tariff code is considered part of anaesthetic administration		6	209.64	6	209.64		
0207	Intravenous infusions (cut-down): Cut-down and insertion of cannula - chargeable once per 24 hours . Not appropriate for managing infusion in daily hospital, High Care and Intensive Care patients (code 0109, 1204 -1206 and 1208 -1210). Tariff code is considered part of anaesthetic administration		8	279.52	8	279.52		
0208	Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)		6	209.64	6	209.64		
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)		3.25	113.56	3.25	113.56		
2.	INTEGUMENTARY SYSTEM							
2.1	Allergy Note: Fees for reading allergy patch tests as per subsequent consultations.							
0217	Allergy: Patch tests: First patch		4	139.76	4	139.76		
0219	Allergy: Patch tests: Each additional patch. Add to code 0217, code may not be billed alone	+	2	69.88	2	69.88		
0218	Allergy: Skin-prick tests: Skin-prick testing: insect venom, latex and drugs		2.8	97.83	2.8	97.83		

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
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	66.39	1.9	66.39			
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen Only a maximum of five can be charged.	2.8	97.83	2.8	97.83			
2.2 Skin (general)								
0222	Intralesional injection into areas of pathology, e.g. Keloid: Single Pre-authorisation with motivational letter detailing how the lesion affects functionality is required.	4	139.76	4	139.76			
0223	Intralesional injection into areas of pathology, e.g. Keloids: Multiple. Tariff code inappropriate to use with tariff code 0222 Pre-authorisation with motivational letter detailing how the lesion affects functionality is required.	8	279.52	8	279.52			
0244	Repair of nail bed	30	1,048.20	30	1,048.20	3	489.81	
0255	Drainage of subcutaneous abscess, onychia, paronychia, pulp space or avulsion of nail .	20	698.80	20	698.80	3	489.81	+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	3,039.78	87	3,039.78	3	489.81	+T
0259	Removal of foreign body: Muscle or tendon sheath, simple Not appropriate for orthopaedic wires and pins removal.	20	698.80	20	698.80	3	489.81	+T
0260	Incision/removal of foreign body: Subcutaneous tissue, complicated	55.5	1,939.17	55.5	1,939.17	3	489.81	+T
0261	Removal of foreign body: Muscle or tendon sheath, deep/complicated. Not appropriate for orthopaedic wires and pins removal	31	1,083.14	31	1,083.14	3	489.81	+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	127.4	4,451.36	120	4,192.80	4	653.08	+T
0289	Large skin graft, composite skin graft, large full thickness free skin graft	234	8,175.96	187.2	6,540.77	4	653.08	+T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	410	14,325.40	328	11,460.32	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	800	27,952.00	640	22,361.60	4	653.08	+T	
0292	Distant flaps: First stage	206	7,197.64	164.8	5,758.11	4	653.08	+T	
0293	Contour grafts (excluding cost of material)	206	7,197.64	164.8	5,758.11	4	653.08	+T	
0294	Vascularised bone graft with or without soft tissue with one or more sets micro-vascular anastomoses	1200	41,928.00	960	33,542.40	6	979.62	+T	
0295	Local skin flaps (large, complicated)	206	7,197.64	164.8	5,758.11	4	653.08	+T	
0296	Other procedures of major technical nature	206	7,197.64	164.8	5,758.11	4	653.08	+T	
0297	Subsequent major procedure for repair of same lesion (modifier 0006 not applicable)	104	3,633.76	104	3,633.76	4	653.08	+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	489.16	14	489.16	3	489.81	+T	
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	+	7	244.58	7	244.58	3	489.81	+T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	64	2,236.16	64	2,236.16	4	653.08	+T	
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	128	4,472.32	120	4,192.80	4	653.08	+T	
0304	Major debridement of wound, sloughectomy or secondary suture	50	1,747.00	50	1,747.00	3	489.81	+T	
0305	Needle biopsy - soft tissue	25	873.50	25	873.50	3	489.81	+T	
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm	13.9	485.67	13.9	485.67	3	489.81	+T	
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof	+	5.3	185.18	5.3	185.18	3	489.81	+T
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm	36	1,257.84	36	1,257.84	5	816.35	+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	391.33	11.2	391.33	5	816.35	+T
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm	62.5	2,183.75	62.5	2,183.75	6	979.62	+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	681.33	19.5	681.33	6	979.62	+T+M
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	27	943.38	27	943.38	3	489.81	+T	

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0308	Each additional small procedure done at the same time	14	489.16	14	489.16	3	489.81	+T
0310	Radical excision of nailbed	38	1,327.72	38	1,327.72	3	489.81	+T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	104	3,633.76	104	3,633.76	4	653.08	+T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	55	1,921.70	55	1,921.70	3	489.81	+T
4856	Split thickness autograft of the trunk, arms and/or legs <=100 ² cm	153.6	5,366.78	122.88	4,293.43	5	816.35	+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	1,100.61	31.5	1,100.61	5	816.35	+T
4858	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 ² cm	172	6,009.68	137.6	4,807.74	5	816.35	+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)	+ 51.6	1,802.90	51.6	1,802.90	5	816.35	+T
4862	Full thickness graft of the trunk, freegrafting including direct closure of donor site <=20cm ²	136.5	4,769.31	120	4,192.80	5	816.35	+T
4863	Full thickness graft of the trunk, freegrafting including closure of donor site, each additional 20cm ² (modifier 0005 not applicable)	+ 25.6	894.46	25.6	894.46	5	816.35	+T
4864	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site: <=20cm ²	140.3	4,902.08	120	4,192.80	5	816.35	+T
4865	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site, each additional 20cm ² (modifier 0005 not applicable)	+ 23	803.62	23	803.62	5	816.35	+T
4866	Full thickness graft of the face, neck, axilla, genitalia, hands and /or feet , free grafting including donor site: <=20cm ²	163.4	5,709.20	130.72	4,567.36	5	816.35	+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)	+ 36.2	1,264.83	36.2	1,264.83	5	816.35	+T
4868	Full thickness graft of the nose, ears, eyelids, and /or lips free grafting including direct closure of donor site: <=20cm ²	183.5	6,411.49	146.8	5,129.19	5	816.35	+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)	+ 43.1	1,505.91	43.1	1,505.91	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100 ² cm Use code once only		66.3	2,316.52	66.3	2,316.52	5	816.35	+T
4873	Acellular dermal allograft of the trunk, arms and/or legs; each additional 100 ² cm or part thereof (modifier 0005 not applicable) Use in conjunction with primary code 4872	+	15.3	534.58	15.3	534.58	5	816.35	+T
4874	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 ² cm		74	2,585.56	74	2,585.56	5	816.35	+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	761.69	21.8	761.69	5	816.35	+T
2.6 Burns									
0345	Minor burns Note: Only one of the items 0345, 0347 or 0351 can be claimed.								
0347	Moderate burns Note: Only one of the items 0345, 0347 or 0351 can be claimed								
0351	Major burns: Resuscitation (including supervision and intravenous therapy - first 48 hours) Note: Only one of the items 0345, 0347 or 0351 can be claimed		276	9,643.44	220.8	7,714.75	5	816.35	+T
0353	Tangential excision and grafting: Small		100	3,494.00	100	3,494.00	5	816.35	+T
0354	Tangential excision and grafting: Large		200	6,988.00	160	5,590.40	5	816.35	+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		147.4	5,150.16	120	4,192.80	4	653.08	+T
0357	Small skin graft in acute hand injury		45	1,572.30	45	1,572.30	3	489.81	+T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing		192	6,708.48	153.6	5,366.78	3	489.81	+T
0361	Z-plasty		220.1	7,690.29	176.08	6,152.24	3	489.81	+T
0363	Local flap and skin graft		150	5,241.00	120	4,192.80	3	489.81	+T
0365	Cross finger flap (all stages)		192	6,708.48	153.6	5,366.78	3	489.81	+T
0367	Palmarflap (all stages)		192	6,708.48	153.6	5,366.78	3	489.81	+T
0369	Distant flap: First stage		158	5,520.52	126.4	4,416.42	3	489.81	+T
0371	Distant flap: Subsequent stage (not subject to Modifier 0005)		77	2,690.38	77	2,690.38	3	489.81	+T
0373	Transfer neurovascular island flap		230.5	8,053.67	184.4	6,442.94	3	489.81	+T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)		242.4	8,469.46	193.92	6,775.56	3	489.81	+T
0375	Dupuytren's contracture: Fasciotomy		51	1,781.94	51	1,781.94	3	489.81	+T
0376	Dupuytren's contracture: Fasciectomy		218	7,616.92	174.4	6,093.54	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3	MUSCULO-SKELETAL SYSTEM							
3.1	Bones							
3.1.1	Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047)							
	Note: Surgeons are not entitled to coding for taking and interpretation of x-rays. All fracture items are considered complete procedures.							
0383	Fracture (reduction under general anaesthetic): Scapula	112.3	3,923.76	112.3	3,923.76	3	489.81	+T+M
0384	Fracture: Scapula: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	284.2	9,929.95	227.36	7,943.96	3	489.81	+T+M
0386	Fracture: Clavicle: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	209.4	7,316.44	167.52	5,853.15	3	489.81	+T+M
0387	Fracture (reduction under general anaesthetic): Clavicle	93.8	3,277.37	93.8	3,277.37	3	489.81	+T+M
0388	Percutaneous pinning supracondylar fracture elbow - stand alone procedure	175.7	6,138.96	140.56	4,911.17	3	489.81	+T+M
0389	Fracture (reduction under general anaesthetic): Humerus	129.6	4,528.22	129.6	4,528.22	3	489.81	+T+M
0390	Fracture: Humerus: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	255.3	8,920.18	204.24	7,136.15	3	489.81	+T+M
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	135.7	4,741.36	120	4,192.80	3	489.81	+T+M
0392	Open reduction of both radius and ulna (Modifier 0051 not applicable)	193.5	6,760.89	154.8	5,408.71	3	489.81	+T+M
0401	Fracture: Carpal bone: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	208.7	7,291.98	166.96	5,833.58	3	489.81	+T+M
0402	Fracture (reduction under general anaesthetic): Carpal bone	64	2,236.16	64	2,236.16	3	489.81	+T+M
0403	Bennett's fracture-dislocation	84.5	2,952.43	84.5	2,952.43	3	489.81	+T+M
0404	Fracture: Bennett's fracture/dislocation: Open reduction and internal fixation (Modifiers 0051, 0052, 0055 not applicable)	179.8	6,282.21	143.84	5,025.77	3	489.81	+T+M
0405	Fracture reduction under general anaesthetic: Open treatment of Metacarpal: Simple	75.4	2,634.48	75.4	2,634.48	3	489.81	+T+M
0406	Fracture: Metacarpal bone: Open reduction and internal fixation (Modifier 0052 not applicable)	163.6	5,716.18	130.88	4,572.95	3	489.81	+T+M
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal: Simple	77	2,690.38	77	2,690.38	3	489.81	+T+M
0410	Fracture: Finger phalanx, distal, simple: Open reduction and internal fixation (Modifier 0052 not applicable)	141.1	4,930.03	120	4,192.80	3	489.81	+T+M
0413	Fracture (reduction under general anaesthetic): Finger phalanx: Proximal or middle Replaces tariff code 0415	50.5	1,764.47	50.5	1,764.47	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (Modifier 0052 not applicable) Replaces tariff code 0411	169.9	5,936.31	135.92	4,749.04	3	489.81	+T
0417	Fracture (reduction under general anaesthetic): Pelvis fracture: Closed (Modifier 0051 is applicable) Rule G does not apply	137.2	4,793.77	120	4,192.80	3	489.81	+T
0419	Fracture (reduction under general anaesthetic): Pelvis: Open reduction and internal fixation (Modifier 0051 not applicable)	354.49	12,385.88	283.59	9,908.63	3	489.81	+T+M
0420	Fracture: Acetabulum: Open reduction and internal fixation (Modifiers 0051 not applicable)	560	19,566.40	448	15,653.12	3	489.81	+T+M
0421	Fracture (reduction under general anaesthetic): Femur: Neck or Shaft	279.1	9,751.75	223.3	7,802.10	3	489.81	+T+M
0422	Fracture: Femur neck or shaft: Open reduction and internal fixation (Modifier 0051 not applicable)	392.3	13,706.96	313.84	10,965.57	3	489.81	+T+M
0425	Fracture (reduction under general anaesthetic) Patella	82.5	2,882.55	82.5	2,882.55	3	489.81	+T+M
0426	Fracture: Patella: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	219.5	7,669.33	175.6	6,135.46	3	489.81	+T+M
0429	Fracture (reduction under general anaesthetic): Tibia with or without Fibula	128	4,472.32	120	4,192.80	3	489.81	+T+M
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (Modifiers 0051 not applicable)	293.2	10,244.41	234.56	8,195.53	3	489.81	+T+M
0433	Fracture (reduction under general anaesthetic) Fibula shaft	112.4	3,927.26	112.4	3,927.26	3	489.81	+T+M
0434	Fracture: Fibula shaft: Open reduction and internal fixation (Modifier 0051 not applicable)	207	7,232.58	165.6	5,786.06	3	489.81	+T+M
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	126.8	4,430.39	120	4,192.80	3	489.81	+T+M
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (Modifiers 0051, 0052 not applicable)	207.1	7,236.07	165.68	5,788.86	3	489.81	+T+M
0437	Fracture-dislocation of ankle	128	4,472.32	120	4,192.80	3	489.81	+T+M
0438	Open reduction Talus fracture (Modifiers 0051, 0052 not applicable)	311.6	10,887.30	249.3	8,710.54	3	489.81	+T+M
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	76.6	2,676.40	76.6	2,676.40	3	489.81	+T+M
0440	Open reduction Calcaneus fracture (Modifiers 0051, 0052 not applicable)	403.5	14,098.29	322.5	11,268.15	3	489.81	+T+M
0441	Fracture (reduction under general anaesthetic): Metatarsal	66.8	2,333.99	66.8	2,333.99	3	489.81	+T+M
0442	Fracture: Metatarsal bones: Open reduction with internal fixation (Modifier 0052 not applicable)	154.7	5,405.22	123.76	4,324.17	3	489.81	+T+M
0443	Fracture (reduction under general anaesthetic): Toe phalanx: Distal: Simple	66.8	2,333.99	66.8	2,333.99	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (Modifier 0052 not applicable) Replaces tariff code 0445	144.5	5,048.83	120	4,192.80	3	489.81	+T
0446	Fracture: Tarsal bones (excluding talus and calcaneus): Open reduction with internal fixation (Modifier 0052 not applicable)	178.2	6,226.31	142.56	4,981.05	3	489.81	+T+M
0447	Fracture (reduction under general anaesthetic): Other: Simple	26	908.44	26	908.44	3	489.81	+T
0448	Fracture: Calcaneus (reduction under general anaesthetic)	103.3	3,609.30	103.3	3,609.30	3	489.81	+T+M
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest Replaces tariff code 0451	230	8,036.20	184	6,428.96	3	489.81	+T+M
3.1.1.1 Bones: Fractures (reduction under general anaesthetic - refer to modifier 0047): Operations for fractures								
0465	Fractures involving large joints: Includes the metaphysis of the relative bone. Modifiers 0051, 0052 applicable when open reduction and internal fixation are performed.	288	10,062.72	230.4	8,050.18	3	489.81	+T+M
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (Modifier 0052 not applicable).	210.9	7,368.85	168.72	5,895.08	3	489.81	+T+M
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pin (Not subject to rule G) (Modifier 0005 not applicable).	43	1,502.42	43	1,502.42	3	489.81	+T
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, Tibia, Humerus, Radius and Ulna	328.2	11,467.31	262.6	9,175.24	3	489.81	+T+M
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones (not applicable to fingers and toes).	154	5,380.76	123.2	4,304.61	3	489.81	+T+M
3.1.2 Bony Operations								
3.1.2.1 Bone Grafting								
0497	Resection of bone or tumour with or without grafting (benign).	282	9,853.08	225.6	7,882.46	3	489.81	+T+M
0498	Resection of bone or tumour (malignant) with or without grafting (does not include digits).	340	11,879.60	272	9,503.68	3	489.81	+T+M
0499	Grafts to cysts: Large bones.	192	6,708.48	153.6	5,366.78	3	489.81	+T+M
0501	Grafts to cysts: Small bones.	128	4,472.32	120	4,192.80	3	489.81	+T+M
0503	Grafts to cysts: Cartilage graft.	206	7,197.64	164.8	5,758.11	3	489.81	+T+M
0505	Grafts to cysts: Inter-metacarpal bone graft.	147	5,136.18	120	4,192.80	3	489.81	+T+M
0506	Harvesting of graft: Cartilage graft, costochondral.	91.1	3,183.03	91.1	3,183.03	6	979.62	+T
0507	Removal of autogenous bone for grafting (not subject to Modifier 0005).	50	1,747.00	50	1,747.00	3	489.81	+T+M
3.1.2.2 Acute/Chronic Osteomyelitis								

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0512	Sternum sequestrectomy and drainage: Including FOUR weeks after-care.	128	4,472.32	120	4,192.80	3	489.81	+T+M
3.1.2.3 Osteotomy								
0514	Osteotomy: Sternum: Repair of pectus-excavatum.	330	11,530.20	264	9,224.16	3	489.81	+T+M
0515	Osteotomy: Sternum: Repair of pectus carinatum.	330	11,530.20	264	9,224.16	3	489.81	+T+M
0516	Osteotomy: Pelvic	320	11,180.80	256	8,944.64	3	489.81	+T+M
0521	Osteotomy: Femoral: Proximal (Modifier 0051 is applicable).	320	11,180.80	256	8,944.64	3	489.81	+T+M
0527	Osteotomy: Knee region (Modifier 0051 is applicable)	320	11,180.80	256	8,944.64	3	489.81	+T+M
0528	Osteotomy: Os Calcis (Dwyer operation) (Modifier 0051 is applicable).	115	4,018.10	115	4,018.10	3	489.81	+T+M
0530	Osteotomy: Metacarpal and phalanx: Corrective for mal-union or rotation (Modifier 0051 is applicable).	120	4,192.80	120	4,192.80	3	489.81	+T+M
0531	Rotational osteotomy tibia and fibula - stand alone procedure	278.9	9,744.77	223.12	7,795.81	3	489.81	+T+M
0532	Rotation osteotomy of the Radius, Ulna or Humerus (Modifier 0051 is applicable).	160	5,590.40	128	4,472.32	3	489.81	+T+M
0533	Osteotomy single metatarsal (Modifier 0051 is applicable).	60	2,096.40	60	2,096.40	3	489.81	+T+M
0534	Multiple metatarsal osteotomies (Modifier 0051 is applicable).	150	5,241.00	120	4,192.80	3	489.81	+T+M
3.1.2.4 Exostosis								
0535	Exostosis: Excision: Readily accessible sites	60	2,096.40	60	2,096.40	3	489.81	+T+M
0537	Exostosis: Excision: Less accessible sites	96	3,354.24	96	3,354.24	3	489.81	+T+M
3.1.2.5 Biopsy								
0539	Needle Biopsy: Spine (no after-care), Modifier 0005 not applicable.	50	1,747.00	50	1,747.00	4	653.08	+T+M
0541	Needle Biopsy: Other sites (no after-care), Modifier 0005 not applicable	32	1,118.08	32	1,118.08	4	653.08	+T+M
0543	Biopsy: Open (Modifier 0005 is not applicable): Readily accessible site.	64	2,236.16	64	2,236.16			As per bone
0545	Biopsy: Open (Modifier 0005 is not applicable): Less accessible site.	96	3,354.24	96	3,354.24			As per bone
3.2 Joints								
3.2.1 Dislocations								
0547	Dislocation: Clavicle either end	96.5	3,371.71	96.5	3,371.71	3	489.81	+T+M
0549	Dislocation: Shoulder	112.1	3,916.77	112.1	3,916.77	3	489.81	+T+M
0551	Dislocation: Elbow	133.6	4,667.98	120	4,192.80	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0552	Dislocation: Wrist	115.5	4,035.57	115.5	4,035.57	3	489.81	+T+M
0553	Dislocation: Perilunar transscaphoid fracture dislocation	130	4,542.20	120	4,192.80	3	489.81	+T+M
0555	Dislocation: Lunate	136.3	4,762.32	120	4,192.80	3	489.81	+T+M
0556	Dislocation: Metacarpo-metacarpo joint	117.2	4,094.97	117.2	4,094.97	3	489.81	+T+M
0557	Dislocation: Metacarpo-phalangeal or interphalangeal joints (hand)	107.3	3,749.06	107.3	3,749.06	3	489.81	+T+M
0559	Dislocation: Hip	220.5	7,704.27	176.4	6,163.42	3	489.81	+T+M
0561	Dislocation: Knee, with manipulation	181.2	6,331.13	145	5,066.30	3	489.81	+T+M
0563	Dislocation: Patella	136.9	4,783.29	120	4,192.80	3	489.81	+T+M
0565	Dislocation: Ankle	98.6	3,445.08	98.6	3,445.08	3	489.81	+T+M
0567	Dislocation: Sub-Talar dislocation	92	3,214.48	92	3,214.48	3	489.81	+T+M
0569	Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal	77	2,690.38	77	2,690.38	3	489.81	+T+M
0571	Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)	39.4	1,376.64	39.4	1,376.64	3	489.81	+T+M
3.2.2 Operations for dislocations								
0578	Recurrent dislocation of shoulder	200	6,988.00	160	5,590.40	3	489.81	+T+M
0579	Recurrent dislocation of all other joints	161	5,625.34	128.8	4,500.27	3	489.81	+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	1,781.94	51	1,781.94	3	489.81	+T+M
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	96	3,354.24	96	3,354.24	3	489.81	+T+M
0585	Capsulotomy or arthrotomy or biopsy or drainage of joint: Capsulectomy digital joint	64	2,236.16	64	2,236.16	3	489.81	+T+M
0586	Multiple percutaneous capsulotomies of metacarpo-phalangeal joints	90	3,144.60	90	3,144.60	3	489.81	+T+M
0587	Release of digital joint contracture	128	4,472.32	120	4,192.80	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3.2.4	Synovectomy							
0589	Synovectomy: Digital joint	77	2,690.38	77	2,690.38	3	489.81	+T+M
0592	Synovectomy: Large joint	160	5,590.40	128	4,472.32	3	489.81	+T+M
0593	Tendon synovectomy	203.7	7,117.28	162.96	5,693.82	3	489.81	+T+M
3.2.5	Arthrodesis							
0597	Arthrodesis: Shoulder	224	7,826.56	179.2	6,261.25	3	489.81	+T+M
0598	Arthrodesis: Elbow	180	6,289.20	144	5,031.36	3	489.81	+T+M
0599	Arthrodesis: Wrist	180	6,289.20	144	5,031.36	3	489.81	+T+M
0600	Arthrodesis: Digital joint	128	4,472.32	120	4,192.80	3	489.81	+T+M
0601	Arthrodesis: Hip	320	11,180.80	256	8,944.64	3	489.81	+T+M
0602	Arthrodesis: Knee	180	6,289.20	144	5,031.36	3	489.81	+T+M
0603	Arthrodesis: Ankle	180	6,289.20	144	5,031.36	3	489.81	+T+M
0604	Arthrodesis: Sub-talar	130	4,542.20	120	4,192.80	3	489.81	+T+M
0605	Arthrodesis: Stabilization of foot (triple-arthrodeses)	180	6,289.20	144	5,031.36	3	489.81	+T+M
0607	Arthrodesis: Mid-tarsal wedge resection	180	6,289.20	144	5,031.36	3	489.81	+T+M
3.2.6	Arthroplasty							
0614	Arthroplasty: Debridement large joints	160	5,590.40	128	4,472.32	3	489.81	+T+M
0615	Arthroplasty: Excision medial or lateral end of clavicle	116	4,053.04	116	4,053.04	3	489.81	+T+M
0617	Shoulder: Acromioplasty	192	6,708.48	153.6	5,366.78	3	489.81	+T+M
0619	Shoulder: Partial replacement	277	9,678.38	221.6	7,742.70	5	816.35	+T+M
0620	Shoulder: Total replacement	416	14,535.04	332.8	11,628.03	5	816.35	+T+M
0621	Elbow: Excision head of radius	96	3,354.24	96	3,354.24	3	489.81	+T+M
0622	Elbow: Excision	192	6,708.48	153.6	5,366.78	3	489.81	+T+M
0623	Elbow: Partial replacement	188	6,568.72	150.4	5,254.98	3	489.81	+T+M
0624	Elbow: Total replacement	282	9,853.08	225.6	7,882.46	3	489.81	+T+M
0625	Wrist: Excision distal end of ulna	96	3,354.24	96	3,354.24	3	489.81	+T+M
0626	Wrist: Excision single bone	110	3,843.40	110	3,843.40	3	489.81	+T+M
0627	Wrist: Excision proximal row	166	5,800.04	132.8	4,640.03	3	489.81	+T+M
0631	Wrist: Total replacement	249	8,700.06	199.2	6,960.05	3	489.81	+T+M
0635	Digital joint: Total replacement	192	6,708.48	153.6	5,366.78	3	489.81	+T+M
0637	Hip: Total replacement	416	14,535.04	332.8	11,628.03	3	489.81	+T+M
0641	Hip: Prosthetic replacement of femoral head	288	10,062.72	230.4	8,050.18	3	489.81	+T+M
0643	Hip: Girdlestone	320	11,180.80	256	8,944.64	3	489.81	+T+M
0645	Knee: Partial replacement	277	9,678.38	221.6	7,742.70	3	489.81	+T+M
0646	Knee: Total replacement	416	14,535.04	332.8	11,628.03	3	489.81	+T+M
0649	Ankle: Total replacement	290.4	10,146.58	232.32	8,117.26	3	489.81	+T+M
0650	Ankle: Astragalectomy	154	5,380.76	123.2	4,304.61	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3.2.7	Miscellaneous (Joints)							
0658	Aspiration and/or injection: Small joint, bursa (e.g. fingers, toes) (excluding aftercare, Modifier 0005 not applicable)	11.4	398.32	11.4	398.32	3	489.81	+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	419.28	12	419.28	3	489.81	+T+M
0660	Aspiration and/or injection: Major joint, bursa (e.g. shoulder, hip, knee joint, subacromial bursa) (excluding aftercare, Modifier 0005 not applicable)	14.6	510.12	14.6	510.12	3	489.81	+T+M
0661	Aspiration of joint or intra-articular injection (not subject to rule G) (Modifier 0005 not applicable)	9	314.46	9	314.46	3	489.81	+T
0668	Manipulation of knee joint under general anaesthesia (includes application of traction or other fixation devices) (excluding aftercare) (Modifier 0005 is not applicable)	43.1	1,505.91	43.1	1,505.91	3	489.81	+T
0667	Arthroscopy (excluding after-care), Modifiers 0005 and 0013 not applicable	60	2,096.40	60	2,096.40	3	489.81	+T
0669	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)-Anaesthetic: Knee/Shoulder.	14	489.16	14	489.16	3	489.81	Hip+T
0669(a)	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)-Anaesthetic: Hip					4	653.08	Knee / Shoulder + T
0673	Meniscectomy or operation for other internal derangement of knee: Medial OR lateral	185.7	6,488.36	148.6	5,192.08	3	489.81	+T+M
3.2.8	Joint ligament reconstruction or suture							
0675	Joint ligament reconstruction or suture: Ankle: Collateral	160	5,590.40	128	4,472.32	3	489.81	+T+M
0676	Joint ligament reconstruction or suture: Ankle (e.g. Watson-Jones type)	191.5	6,691.01	153.2	5,352.81	3	489.81	+T+M
0677	Joint ligament reconstruction or suture: Knee: Collateral	196.8	6,876.19	157.44	5,500.95	3	489.81	+T+M
0678	Joint ligament reconstruction or suture: Knee: Cruciate	227.6	7,952.34	182.1	6,362.57	3	489.81	+T+M
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	324.4	11,334.54	259.5	9,066.93	3	489.81	+T+M
0680	Joint ligament reconstruction or suture: Digital joint ligament	229.8	8,029.21	183.84	6,423.37	3	489.81	+T+M
3.3	Amputations							
3.3.1	Specific Amputations							
0681	Amputation: Humerus, includes primary closure	211.6	7,393.30	169.28	5,914.64	4	653.08	+T+M
0682	Amputation: Fore-quarter amputation	397.8	13,899.13	318.24	11,119.31	9	1469.43	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0683	Amputation: Through shoulder	323	11,285.62	258.4	9,028.50	5	816.35	+T+M
0684	Amputation: Forearm	213.5	7,459.69	170.48	5,956.57	3	489.81	+T+M
0686	Amputation: Ankle (eg., Syme, Pirogoff type)	204.1	7,131.25	163.28	5,705.00	4	653.08	+T+M
0687	Amputation: Metacarpal: One ray	206.1	7,201.13	164.9	5,761.61	3	489.81	+T+M
0688	Amputation: Foot, midtarsal (Chopart type)	165.7	5,789.56	132	4,612.08	3	489.81	+T+M
0691	Amputation: Finger or thumb	183.9	6,425.47	146.4	5,115.22	3	489.81	+T+M
0692	Scar revision/secondary closure: amputated thigh, through femur, any level	150.7	5,265.46	120.56	4,212.37	3	489.81	+T+M
0693	Hindquarter amputation	470.7	16,446.26	376.6	13,158.40	6	979.62	+T+M
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level	173.9	6,076.07	139.12	4,860.85	3	489.81	+T+M
0695	Amputation: Through hip joint region	373.1	13,036.11	298.5	10,429.59	6	979.62	+T+M
0696	Re-amputation: Thigh, through femur, any level	217.3	7,592.46	173.84	6,073.97	3	489.81	+T+M
0697	Amputation: Through thigh	245	8,560.30	196	6,848.24	6	979.62	+T+M
0698	Re-amputation: Leg, through tibia and fibula	198.2	6,925.11	158.56	5,540.09	3	489.81	+T+M
0699	Amputation: Below knee, through knee/Syme	277.2	9,685.37	221.8	7,749.69	5	816.35	+T+M
0701	Amputation: Trans-metatarsal or trans-tarsal	223.8	7,819.57	179.04	6,255.66	3	489.81	+T+M
0705	Amputation: Toe (skin flap included)	167.1	5,838.47	133.68	4,670.78	3	489.81	+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	186.3	6,509.32	149.04	5,207.46	3	489.81	+T+M
Note: If not performed on thumb or index finger it must be motivated.								
0707	Post-amputation reconstruction: Krukenberg reconstruction	331.7	11,589.60	265.4	9,273.08	3	489.81	+T+M
0711	Post-amputation reconstruction: Pollicization of the finger (Prior permission must be obtained from the Commissioner at all times)	455.9	15,929.15	364.72	12,743.32	3	489.81	+T+M
0712	Post-amputation reconstruction: Toe to thumb transfer (Prior permission must be obtained from the Commissioner at all times)	800	27,952.00	640	22,361.60	3	489.81	+T+M
0700	Scar revision/secondary closure: Amputated shoulder	128.1	4,475.81	120	4,192.80	3	489.81	+T
0702	Scar revision/secondary closure: Amputated humerus	163.1	5,698.71	130.48	4,558.97	3	489.81	+T
0704	Scar revision/secondary closure: Amputated forearm	184.1	6,432.45	147.28	5,145.96	3	489.81	+T
0708	Re-amputation: Humerus	223.1	7,795.11	178.48	6,236.09	6	979.62	+T+M
0710	Re-amputation: Through forearm	206	7,197.64	164.8	5,758.11	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3.4	Muscles, Tendons and Fascias							
3.4.1	Investigations							
0713	Electromyography	75	2,620.50	75	2,620.50	3	489.81	+T
0714	Electro-myographic neuro-muscular junctional study, including edrophonium response (cannot to be used with tariff code 2730)	57	1,991.58	57	1,991.58	3	489.81	+T
0715	Strength duration curve per session	10.5	366.87	10.5	366.87	3	489.81	+T
0717	Electrical examination of single nerve or muscle	9	314.46	9	314.46	3	489.81	+T
0721	Voltage integration during isometric contraction	12	419.28	12	419.28	3	489.81	+T
0723	Tonometry with edrophonium	8	279.52	8	279.52	3	489.81	+T
0725	Isometric tension studies with edrophonium	10	349.40	10	349.40	3	489.81	+T
0727	Cranial reflex study (both early and late responses) supra occulofacial, comeofacial or flabellofacial: Unilateral	8	279.52	8	279.52	3	489.81	+T
0728	Cranial reflex study (both early and late responses) supra occulofacial, comeofacial or flabellofacial: Bilateral	14	489.16	14	489.16	3	489.81	+T
0729	Tendon reflex time	7	244.58	7	244.58	3	489.81	+T
0730	Limb-brain somatosensory studies (per limb)	49	1,712.06	49	1,712.06	3	489.81	+T
0731	Vision and audiosensory studies	49	1,712.06	49	1,712.06			
0733	Motor nerve conduction studies (single nerve)	26	908.44	26	908.44			
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	31	1,083.14	31	1,083.14	3	489.81	+T
0737	Biopsy for motor nerve terminals and end plates	20	698.80	20	698.80	3	489.81	+T
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	34	1,187.96	34	1,187.96	8	1306.16	+T
0740	Muscle fatigue studies	20	698.80	20	698.80	3	489.81	+T
0741	Muscle biopsy	20	698.80	20	698.80	8	1306.16	+T
0742	Global fee for all muscle studies, including histochemical studies	262	9,154.28					
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	20.25	707.54					
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	33.3	1,163.50					
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	5.7	199.16					
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	1.6	55.90					
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	9.9	345.91					
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	13.7	478.68					

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	25.9	904.95					
4715	Biochemical estimations on muscle biopsy specimens: Enolase	32.7	1,142.54					
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	37.7	1,317.24					
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	15.75	550.31					
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 Phosphate Dehydrogenase	11.06	386.44					
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	34.7	1,212.42					
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	40.3	1,408.08					
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose isomerase	28.8	1,006.27					
3.4.2 Decompression Fasciotomies								
5550	Decompression fasciotomy: Buttock compartment(s): Unilateral	243	8,490.42	194.4	6,792.34	5	816.35	+T+M
5551	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve.	151.9	5,307.39	121.52	4,245.91	3	489.81	+T+M
5552	Decompression fasciotomy: Leg: Anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve.	253.1	8,843.31	202.48	7,074.65	3	489.81	+T+M
5553	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve	123.7	4,322.08	120	4,192.80	3	489.81	+T+M
5554	Decompression fasciotomy: Leg: Anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/or nerve	162.1	5,663.77	129.68	4,531.02	3	489.81	+T+M
5555	Decompression fasciotomy: Leg: Posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve	130.8	4,570.15	120	4,192.80	3	489.81	+T+M
5556	Decompression fasciotomy: Leg: Posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve	171.5	5,992.21	137.2	4,793.77	3	489.81	+T+M
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial	137.3	4,797.26	120	4,192.80	4	653.08	+T+M
5558	Decompression fasciotomy: Fasciotomy: Foot and/or toe	86.6	3,025.80	86.6	3,025.80	3	489.81	+T+M
5559	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve	226.3	7,906.92	181.04	6,325.54	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
5560	Decompression fasciotomy: Forearm and/or wrist: Flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve	354.5	12,386.23	283.6	9,908.98	3	489.81	+T+M
5561	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve	166.8	5,827.99	133.44	4,662.39	3	489.81	+T+M
5562	Decompression fasciotomy: Forearm and/or wrist: Flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve	321.1	11,219.23	256.88	8,975.39	3	489.81	+T+M
5563	Decompression fasciotomy: Fingers and/or hand	165.6	5,786.06	132.48	4,628.85	3	489.81	+T+M
3.4.3 Muscle and Tendon Repair								
0745	Muscle and tendon repair: Biceps humeri	109	3,808.46	109	3,808.46	3	489.81	+T
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	96	3,354.24	96	3,354.24	3	489.81	+T+M
0747	Muscle and tendon repair: Rotator cuff	134	4,681.96	120	4,192.80	4	653.08	+T
0748	Muscle and tendon repair: Debridement rotator cuff	139.7	4,881.12	120	4,192.80	4	653.08	+T
0749	Muscle and tendon repair: Scapulopexy - stand alone procedure	271.9	9,500.19	217.52	7,600.15	4	653.08	+T
0755	Muscle and tendon repair: Infrapatellar or quadriceps tendon	128	4,472.32	120	4,192.80	3	489.81	+T
0757	Muscle and tendon repair: Achilles tendon repair	197.6	6,904.14	158.08	5,523.32	4	653.08	+T
0759	Muscle and tendon repair: Other single tendon	77	2,690.38	77	2,690.38	3	489.81	+T
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) (Modifier 0005 applicable)	220.3	7,697.28	176.24	6,157.83	3	489.81	+T
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) (Modifier 0005 applicable)	249.6	8,721.02	199.68	6,976.82	3	489.81	+T
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm) (each) (Modifier 0005 applicable)	191.3	6,684.02	153.04	5,347.22	3	489.81	+T
0763	Muscle and tendon repair: Tendon or ligament injection	9	314.46	9	314.46	3	489.81	+T
0764	Hand: Flexor tendon repair: Secondary, zone 1	243.9	8,521.87	195.12	6,817.49	3	489.81	+T
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)	249.6	8,721.02	199.68	6,976.82	3	489.81	+T
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)	190.6	6,659.56	152.48	5,327.65	3	489.81	+T
0768	Repair: Intrinsic muscles of hand (each) (Modifier 0005 applicable)	125.3	4,377.98	100.24	3,502.39	3	489.81	+T
0771	Extensor tendon suture: Primary (per tendon, Modifier 0005 not applicable)	129.7	4,531.72	120	4,192.80	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0773	Extensor tendon suture: Secondary (per tendon, Modifier 0005 not applicable)	170	5,939.80	136	4,751.84	3	489.81	+T
0774	Repair of Boutonnière deformity or Mallet Finger with graft	216.6	7,568.00	216.6	7,568.00	3	489.81	+T
3.4.4 Tendon Graft								
0775	Free tendon graft	160	5,590.40	128	4,472.32	3	489.81	+T
0776	Reconstruction of pulley for flexor tendon (modifier 0005 applicable)	180.2	6,296.19	144.16	5,036.95	3	489.81	+T
0777	Tendon graft: Finger: Flexor	192	6,708.48	153.6	5,366.78	3	489.81	+T
0779	Tendon graft: Finger: Extensor	122	4,262.68	120	4,192.80	3	489.81	+T
0780	Two stage flexor tendon graft using silastic rod	240	8,385.60	192	6,708.48	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3.4.5	Tenolysis							
0781	Tendon freeing operation, except where specified elsewhere	64	2,236.16	64	2,236.16	3	489.81	+T
0782	Carpal tunnel syndrome	123	4,297.62	120	4,192.80	3	489.81	+T
0783	Tenolysis: De Quervain	38	1,327.72	38	1,327.72	3	489.81	+T
0784	Trigger finger	38	1,327.72	38	1,327.72	3	489.81	+T
0785	Flexor tendon freeing operation following free tendon graft or suture	276.1	9,646.93	220.88	7,717.55	3	489.81	+T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm	212.2	7,414.27	170	5,939.80	3	489.81	+T
0788	Intrinsic tendon release per finger	64	2,236.16	64	2,236.16	3	489.81	+T
0789	Central tendon tenotomy for Boutonnière deformity	64	2,236.16	64	2,236.16	3	489.81	+T
3.4.6	Tenodesis							
0790	Tenodesis: Digital joint	176.2	6,156.43	140.96	4,925.14	3	489.81	+T
3.4.7	Muscle, Tendon and Fascia Transfer							
0791	Single tendon transfer	96	3,354.24	96	3,354.24	3	489.81	+T
0792	Multiple tendon transfer	128	4,472.32	120	4,192.80	3	489.81	+T
0793	Hamstring to quadriceps transfer	141	4,926.54	120	4,192.80	3	489.81	+T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	320	11,180.80	256	8,944.64	5	816.35	+T
0795	Tendon transfer at elbow	116	4,053.04	116	4,053.04	3	489.81	+T
0803	Hand tendons: Single transfer (each) (modifier 0005 applicable)	216.2	7,554.03	172.96	6,043.22	3	489.81	+T
0809	Hand tendons: Substitution for intrinsic paralysis of hand/hand tendon (all four fingers)	330.6	11,551.16	264.48	9,240.93	3	489.81	+T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	220.6	7,707.76	176.48	6,166.21	3	489.81	+T
3.4.8	Muscle slide operations and Tendon lengthening							
0812	Percutaneous Tenotomy: All sites	140.5	4,909.07	120	4,192.80	3	489.81	+T
0813	Torticollis	96	3,354.24	96	3,354.24	5	816.35	+T
0815	Scalenotomy	132	4,612.08	120	4,192.80	5	816.35	+T
0817	Scalenotomy with excision of first rib	190	6,638.60	152	5,310.88	3	489.81	+T+M
0821	Tennis elbow	96	3,354.24	96	3,354.24	3	489.81	
0822	Open release elbow (Mitals) - stand alone procedure	278.2	9,720.31	222.56	7,776.25	3	489.81	+T+M
0823	Excision or slide for Volkmann's Contracture	192	6,708.48	153.6	5,366.78	3	489.81	+T
0825	Hip: Open muscle release	116	4,053.04	116	4,053.04	7	1142.89	+T
0829	Knee: Quadriceps plasty	160	5,590.40	128	4,472.32	3	489.81	+T
0831	Knee: Open tenotomy	141	4,926.54	120	4,192.80	3	489.81	+T
0835	Calf	96	3,354.24	96	3,354.24	4	653.08	+T
0837	Open Elongation Tendon Achilles	96	3,354.24	96	3,354.24	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0838	Percutaneous "Hoke" elongation tendoachilles - stand alone procedure	79.3	2,770.74	79.3	2,770.74	4	653.08	+T
0845	Foot: Plantar fasciotomy	70	2,445.80	70	2,445.80	3	489.81	+T
3.5	Bursae and Ganglia							
0847	Excision: Semi-membranosus	90	3,144.60	90	3,144.60	4	653.08	+T
0849	Excision: Prepatellar	45	1,572.30	45	1,572.30	3	489.81	+T
0851	Excision: Olecranon	81.8	2,858.09	81.8	2,858.09	3	489.81	+T
0853	Excision: Small bursa or ganglion	80.9	2,826.65	80.9	2,826.65	3	489.81	+T
0855	Excision: Compound palmar ganglion or synovectomy	128	4,472.32	120	4,192.80	3	489.81	+T
0857	Bursae and ganglia: Aspiration or injection (not subject to rule G) (Modifier 0005 not applicable)	9	314.46	9	314.46	3	489.81	+T
3.6	Musculo Skeletal System: Miscellaneous							
3.6.1	Miscellaneous: Leg Lengthening							
0861	Leg equalisation, congenital hips and feet: Leg lengthening	416	14,535.04	332.8	11,628.03	3	489.81	+T+M
3.6.2	Miscellaneous: Removal of Internal Fixatives or Prosthesis							
0883	Removal: Implant, e.g. buried wire/pin/rod, superficial (Readily accessible).	44.4	1,551.34	44.4	1,551.34	3	489.81	+T
0884	Removal: Implant, e.g. buried wire/pin/screw/metal band/nail/rod/plate, deep (Less accessible).	127	4,437.38	120	4,192.80	5	816.35	+T
0885	Removal of prosthesis for infection soon after operation	128	4,472.32	120	4,192.80			As per bone +M
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): ADD to the tariff code for total joint replacement of the specific joint.	+ 64	2,236.16	64	2,236.16	6	979.62	+T+M
3.6.3	Miscellaneous: Removal of Foreign Bodies							
0644	Removal of foreign body: Shoulder, subcutaneous Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifiers 0049- 0051, 0053, 0055 and 0058 is not applicable.	49.7	1,736.52	49.7	1,736.52	3	489.81	+T
0647	Removal of foreign body: Upper arm or elbow area, subcutaneous Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifiers 0049- 0051, 0053, 0055 and 0058 is not applicable.	41.7	1,457.00	41.7	1,457.00	3	489.81	+T
0648	Removal of foreign body: Upper arm or elbow area, subfascial or intramuscular Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	109	3,808.46	109	3,808.46	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0651	Exploration with removal of deep foreign body: Forearm or wrist Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	122.8	4,290.63	120	4,192.80	3	489.81	+T
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	45.3	1,582.78	45.3	1,582.78	6	979.62	+T
0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053,0055 and 0058 is not applicable.	186.9	6,530.29	149.52	5,224.23	6	979.62	+T
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	120.6	4,213.76	120	4,192.80	4	653.08	+T
0655	Removal of foreign body: Foot, subcutaneous Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	40	1,397.60	40	1,397.60	3	489.81	+T
0656	Removal of foreign body: Foot, deep Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	94.2	3,291.35	94.2	3,291.35	3	489.81	+T
0657	Removal of foreign body: Foot, complicated Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.	110.5	3,860.87	110.5	3,860.87	3	489.81	+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 (Scotchcast, 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.							

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0887	Application of long leg cast (femur to toes, humerus) (excluding aftercare) (first cast included in procedure) Appropriate to use tariff code 0887 as an independent procedure without reduction of fracture under anaesthetic Modifier 0011 is not appropriate if procedure is performed in rooms as an emergency Modifier 0005 does not apply.	29.5	1,030.73	29.5	1,030.73	3	489.81	+T
0888	Application of short limb cast (forearm, lower leg) (excluding aftercare) (first cast included in procedure) Modifier 0005 does not apply.	18.4	642.90	18.4	642.90	3	489.81	+T
0889	Application of spica, plaster jacket or hinged cast brace (excluding aftercare) (first cast included in procedure) Modifier 0005 does not apply.	41.4	1,446.52	41.4	1,446.52	4	653.08	+T
0892	Application of cast: Revision (walker, window, bivalve) (excluding aftercare) Modifier 0005 does not apply.	18.9	660.37	18.9	660.37	5	816.35	+T
0971	Halo-splint and POP jacket including two weeks aftercare	116	4,053.04	116	4,053.04			
3.8	Special Areas							
3.8.1	Foot and Ankle							
0900	Excision tarsal coalition - stand alone procedure	141.5	4,944.01	120	4,192.80	3	489.81	+T+M
0901	Tenotomy single tendon	63.3	2,211.70	63.3	2,211.70	3	489.81	+T+M
0903	Hammer toe: one toe	99.5	3,476.53	99.5	3,476.53	3	489.81	+T+M
0905	Fillet of toe or Ruiz-Mora procedure	99.5	3,476.53	99.5	3,476.53	3	489.81	+T+M
0906	Arthrodesis Hallux	148	5,171.12	120	4,192.80	3	489.81	+T+M
0909	Excision arthroplasty	145.2	5,073.29	120	4,192.80	3	489.81	+T+M
0910	Cheilectomy or metatarsophangeal implant Hallux	183	6,394.02	146.4	5,115.22	3	489.81	+T+M
0911	Metatarsal osteotomy or Lapidus or similar or Chevron - stand alone procedure	189.2	6,610.65	151.36	5,288.52	3	489.81	+T+M
5730	Hallux valgus double osteotomy etc	182.6	6,380.04	146.08	5,104.04	3	489.81	+T+M
5731	Distal soft tissue procedure for Hallux Valgus	173.6	6,065.58	138.88	4,852.47	3	489.81	+T+M
5732	Aitkin procedure or similar	166.8	5,827.99	133.44	4,662.39	3	489.81	+T+M
5734	Removal bony prominence foot (bunionette not applicable to COID)	91	3,179.54	91	3,179.54	3	489.81	+T+M
5735	Repair angular deformity toe (lesser toes)	97.2	3,396.17	97.2	3,396.17	3	489.81	+T+M
5736	Sesamoidectomy	97.8	3,417.13	97.8	3,417.13	3	489.81	+T+M
5737	Repair major foot tendons e.g. Tib Post	147.3	5,146.66	120	4,192.80	3	489.81	+T
5738	Repair of dislocating peroneal tendons	173.2	6,051.61	138.56	4,841.29	3	489.81	+T
5740	Steindler strip – plantar fascia	97.2	3,396.17	97.2	3,396.17	3	489.81	+T
5742	Tendon transfer foot	172	6,009.68	137.6	4,807.74	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
5743	Capsulotomy metatarsophalangeal joints – foot	86.8	3,032.79	86.8	3,032.79	3	489.81	+T	
3.8.2 Replantation									
0912	Replantation of amputated upper limb proximal to wrist joint	730	25,506.20	584	20,404.96	3	489.81	+T+M	
0913	Replantation of thumb	670	23,409.80	536	18,727.84	3	489.81	+T+M	
0914	Replantation of a single digit (to be motivated), for multiple digits, modifier 0005 applicable	580	20,265.20	464	16,212.16	3	489.81	+T+M	
0915	Replantation operation through the palm	1270	44,373.80	1016	35,499.04	3	489.81	+T+M	
3.8.3 Hands: (Note: Skin: See Integumentary system)									
0919	Tumours: Epidermoid cysts	35	1,222.90	35	1,222.90	3	489.81	+T+M	
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	19	663.86	19	663.86	3	489.81	+T+M	
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	32	1,118.08	32	1,118.08	3	489.81	+T+M	
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)	37	1,292.78	37	1,292.78	3	489.81	+T+M	
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)	110	3,843.40	110	3,843.40	3	489.81	+T+M	
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	16	559.04	16	559.04	3	489.81	+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	9,398.86	215.2	7,519.09	3	489.81	+T+M	
3.8.4 Spine									
<p>Note: Notes regarding the use of Modifier 0005 in cases where bone graft procedures and instrumentation are performed in combination with arthrodesis (fusion):</p> <p>i. Modifier 0005 (multiple therapeutic procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together:</p> <ul style="list-style-type: none"> - Bone graft procedures and instrumentation are to be coded in addition to arthrodesis (fusion). - When vertebral procedures are performed by arthrodesis (fusions), bone grafts and instrumentation may be coded for additionally. <p>ii. Modifier 0005 (multiple therapeutic procedures/operations under the same anaesthetic) would be applicable when arthrodesis (fusion) is performed in addition to another procedure, e.g. osteotomy, laminectomy.</p>									
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	207	7,232.58	165.6	5,786.06	3	489.81	+T+M	
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression).	+	42	1,467.48	42	1,467.48	3	489.81	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0929	Manipulation of spine under general anaesthetic (no aftercare) (Modifier 0005 is not applicable). Tariff code may not be used with spinal manipulation done in rooms because such manipulation is considered part of visit/consultation.		14 489.16	14 489.16	5 816.35			+T+M
0930	Posterior osteotomy of spine: One vertebral segment Appropriate tariff codes for instrumentation and bone graft may be added.		339 11,844.66	271.2 9,475.73	3 489.81			+T+M
0931	Posterior spinal fusion: One level Tariff code 0946 can be added		385 13,451.90	308 10,761.52	3 489.81			+T+M
0932	Posterior osteotomy of spine: Each additional vertebral segment Appropriate tariff codes for instrumentation and bone graft may be added Modifier 0005 does not apply Add to tariff code 0930	+	103 3,598.82	103 3,598.82	3 489.81			+T+M
0933	Anterior spinal osteotomy with disc removal: One vertebral segment Tariff code 0936 can be added Appropriate tariff codes for instrumentation and bone graft may be added		315 11,006.10	252 8,804.88	3 489.81			+T+M
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment Modifier 0005 does not apply Appropriate tariff codes for instrumentation and bone graft may be added	+	103 3,598.82	103 3,598.82	3 489.81			+T+M
0938	Anterior fusion base of skull to C2		449 15,688.06	359.2 12,550.45	4 653.08			+T+M
0939	Trans-abdominal anterior exposure of the spine for spinal-fusion only if done by a second surgeon		160 5,590.40	128 4,472.32	3 489.81			+T+M
0940	Transthoracic anterior exposure of the spine if done by a second surgeon		160 5,590.40	128 4,472.32	3 489.81			+T+M
0941	Anterior interbody fusion: One level Tariff code 0942 can be added		360 12,578.40	288 10,062.72	3 489.81			+T+M
0942	Anterior interbody fusion: Each additional level Modifier 0005 does not apply	+	102 3,563.88	102 3,563.88	3 489.81			+T+M
0943	Laminectomy with decompression of nerve roots and disc removal: One level		240 8,385.60	192 6,708.48	3 489.81			+T+M
0944	Posterior fusion: Occiput to C2		390 13,626.60	312 10,901.28	4 653.08			+T+M
0946	Posterior spinal fusion: Each additional level	+	111 3,878.34	111 3,878.34	3 489.81			+T+M
0948	Posterior interbody lumbar fusion: One level Tariff code 0950 can be added		364 12,718.16	291.2 10,174.53	3 489.81			+T+M
0950	Posterior interbody lumbar fusion: Each additional interspace	+	95 3,319.30	95 3,319.30	3 489.81			+T+M
0959	Excision of coccyx		96 3,354.24	96 3,354.24	3 489.81			+T+M
0960	Posterior non-segmental instrumentation		167 5,834.98	133.6 4,667.98	5 816.35			+T+M
0961	Costo-transversectomy		198 6,918.12	158.4 5,534.50	3 489.81			+T+M
0962	Posterior segmental instrumentation: 2 to 6 vertebrae		176 6,149.44	140.8 4,919.55	5 816.35			+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
0963	Antero-lateral decompression of spinal cord or anterior debridement	326	11,390.44	260.8	9,112.35	3	489.81	+T+M
0964	Posterior segmental instrumentation: 7 to 12 vertebrae Not to use with tariff code 0962 Modifier 0005 not applicable	201	7,022.94	160.8	5,618.35	5	816.35	+T+M
0966	Posterior segmental instrumentation: 13 or more vertebrae Not to use with tariff code 0962 and 0964 Modifier 0005 not applicable	245	8,560.30	196	6,848.24	5	816.35	+T+M
0968	Anterior instrumentation: 2 to 3 vertebrae	159	5,555.46	127.2	4,444.37	5	816.35	+T+M
0969	Skull or skull-femoral traction including two weeks after-care	64	2,236.16	64	2,236.16	--		
0970	Anterior instrumentation: 4 to 7 vertebrae Not to use with tariff code 0968 Modifier 0005 not applicable	185	6,463.90	148	5,171.12	5	816.35	+T+M
0972	Anterior instrumentation: 8 or more vertebrae Not to use with tariff code 0968 and 0970 Modifier 0005 not applicable	206	7,197.64	164.8	5,758.11	5	816.35	+T+M
0974	Additional pelvic fixation of instrumentation other than sacrum Modifier 0005 not applicable	108	3,773.52	108	3,773.52	5	816.35	+T+M
5750	Reinsertion of instrumentation Add appropriate instrumentation codes	276	9,643.44	220.8	7,714.75	6	979.62	+T+M
5751	Removal of posterior non-segmental instrumentation Add instrumentation codes if appropriate	173	6,044.62	138.4	4,835.70	6	979.62	+T+M
5752	Removal of posterior segmental instrumentation Add instrumentation codes if appropriate	175	6,114.50	140	4,891.60	6	979.62	+T+M
5753	Removal of anterior instrumentation Add instrumentation codes if appropriate	204	7,127.76	163.2	5,702.21	6	979.62	+T+M
5755	Laminectomy for spinal stenosis (exclude discectomy, foraminotomy and spondylolisthesis): One or two levels	295	10,307.30	236	8,245.84	3	489.81	+T+M
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	304	10,621.76	243.2	8,497.41	3	489.81	+T+M
5757	Laminectomy for decompression without foraminotomy or discectomy more than two levels	321	11,215.74	256.8	8,972.59	3	489.81	+T+M
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	63	2,201.22	63	2,201.22	3	489.81	+T+M
5759	Laminectomy for decompression discectomy etc., revision operation	352	12,298.88	281.6	9,839.10	4	653.08	+T+M
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	301	10,516.94	240.8	8,413.55	3	489.81	+T+M
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	68	2,375.92	68	2,375.92	3	489.81	+T+M
5763	Anterior disc removal and spinal decompression cervical: One level Tariff code 5764 can be added	344	12,019.36	275.2	9,615.49	3	489.81	+T+M

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
5764	Anterior disc removal and spinal decompression cervical: Each additional level	+	81	2,830.14	81	2,830.14	3	489.81	+T+M
5765	Vertebral corpectomy for spinal decompression: One level		466	16,282.04	372.8	13,025.63	3	489.81	+T+M
5766	Vertebral corpectomy for spinal decompression: Each additional level Tariff code 5766 can be added	+	88	3,074.72	88	3,074.72	3	489.81	+T+M
5770	Use of microscope in spinal and intercranial procedures (Modifier 0005 not applicable)		71	2,480.74	71	2,480.74			
3.9 Facial Bone Procedures									
Please note: Modifiers 0046 to 0058 are not applicable to section 3.9.									
0987	Repair of orbital floor (blowout fracture)		184.6	6,449.92	147.68	5,159.94	4	653.08	+T+M
0988	Genioplasty		263	9,189.22	210.4	7,351.38	4	653.08	+T+M
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I		202.2	7,064.87	161.76	5,651.89	4	653.08	+T+M
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Not to use with tariff code 0989		302	10,551.88	241.6	8,441.50	4	653.08	+T+M
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Not to use with tariff code 0989 to 0990		433	15,129.02	346.4	12,103.22	4	653.08	+T+M
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy Not to use with tariff code 0989 to 0991		970	33,891.80	776	27,113.44	4	653.08	+T+M
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy		302	10,551.88	241.6	8,441.50	4	653.08	+T+M
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee) Not to use with tariff code 0989 to 0991		1103	38,538.82	882.4	30,831.06	4	653.08	+T+M
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee) Not to use with tariff code 0989 to 0991 and 0994		1654	57,790.76	1323.2	46,232.61	4	653.08	+T+M
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement Not to use with tariff code 0989 to 0991 and 0994 to 0995			Φ		Φ			
0997	Mandible: Fractured nose and zygoma: Open reduction and fixation		302	10,551.88	241.6	8,441.50	3	489.81	+T+M
0999	Mandible: Fractured nose and zygoma: Closed reduction by inter-maxillary fixation Not to use with tariff code 0997		184	6,428.96	147.2	5,143.17	3	489.81	+T+M
1000	Excision facial bone, e.g. osteomyelitis, abscess		144.3	5,041.84	120	4,192.80	5	816.35	+T+M

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1001	Temporo-mandibular joint: Reconstruction for dysfunction	206	7,197.64	164.8	5,758.11	4	653.08	+T+M
1003	Manipulation: Immobilisation and follow-up of fractured nose	35	1,222.90	35	1,222.90	3	489.81	+T+M
1005	Nasal fracture without manipulation							
1006	Fracture: Nose and septum, open reduction Modifier 0049 to 0051 and 0053 do not apply	177.4	6,198.36	141.92	4,958.68	5	816.35	+T+M
1007	Mandibulectomy	320	11,180.80	256	8,944.64	5	816.35	+T+M
1009	Maxillectomy Modifier 0005 does not apply	382.5	13,364.55	306	10,691.64	4	653.08	+T+M
1011	Bone graft to mandible	206	7,197.64	164.8	5,758.11	4	653.08	+T+M
1012	Adjustment of occlusion by ramisection	227	7,931.38	181.6	6,345.10	4	653.08	+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	4,577.14	120	4,192.80	3	489.81	+T+M
1017	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures) (after four weeks)	262	9,154.28	209.6	7,323.42	3	489.81	+T+M
4. RESPIRATORY SYSTEM								
4.1 Nose and Sinuses								
1018	Flexible nasopharyngolaryngoscope examination	51.94	1,814.78	51.94	1,814.78			
1019	ENT endoscopy in rooms with rigid endoscope	12	419.28					
1020	Repair of perforated septum: Any method	141.9	4,957.99	120	4,192.80	4	653.08	+T
1022	Functional reconstruction of nasal septum Procedures of the septum including correction of caudal septal deflection is included. Tariff code 1087 may apply if a tip deformity and valve obstruction is present.	121.2	4,234.73	120	4,192.80	4	653.08	+T
1023	Harvesting of graft: Cartilage graft of nasal septum May not be used with tariff code 1034.	124.8	4,360.51	120	4,192.80	5	816.35	+T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material).	30	1,048.20	30	1,048.20	4	653.08	+T
1025	Intranasal antrostomy (Modifier 0005 to apply to opposite side of nose)	64.6	2,257.12	64.6	2,257.12	4	653.08	+T
1027	Dacryocystorhinostomy	210	7,337.40	168	5,869.92	5	816.35	+T
1029	Turbineotomy (Modifier 0005 to apply to opposite side of nose)	62.6	2,187.24	62.6	2,187.24	4	653.08	+T
1030	Endoscopic turbineotomy: laser or microdebrider	90	3,144.60	90	3,144.60	5	816.35	+T
1034	Autogenous nasal bone transplant: Bone removal included	100	3,494.00	100	3,494.00	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1035	Unilateral functional endoscopic sinus surgery (unilateral)	140	4,891.60	120	4,192.80	4	653.08	+T
1036	Bilateral functional endoscopic sinus surgery May not be used with tariff code 1035 Modifier 0005 applies	245	8,560.30	196	6,848.24	4	653.08	+T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	8	279.52	8	279.52			
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic May not be used with tariff code 1037	35	1,222.90	35	1,222.90	4	653.08	+T
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging (unilateral)	40	1,397.60	40	1,397.60	6	979.62	+T
1042	Repair of CSF leak: Sphenoid region, transnasal endoscopic approach (Modifier 0069 is not applicable)	365.5	12,770.57	292.4	10,216.46	5	816.35	+T+M
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging (unilateral)	60	2,096.40	60	2,096.40	6	979.62	+T
1045	Ligation anterior ethmoidal artery	135.4	4,730.88	120	4,192.80	6	979.62	+T
1047	Cladwell-Luc operation (unilateral)	137.3	4,797.26	120	4,192.80	4	653.08	+T
1049	Ligation internal maxillary artery	196	6,848.24	156.8	5,478.59	6	979.62	+T
1050	Vidian neurectomy (transantral or transnasal)	113	3,948.22	113	3,948.22	4	653.08	+T
1054	Antroscopy through the canine fossa (Modifier 0005 to apply to opposite side of nose)	37.3	1,303.26	--	--	--	--	
1055	External frontal ethmoidectomy	190.7	6,663.06	152.56	5,330.45	4	653.08	+T
1057	External ethmoidectomy and/or sphenoidectomy (unilateral)	199.4	6,967.04	159.52	5,573.63	4	653.08	+T
1059	Cranioectomy: For osteomyelitis (total procedure)	341.6	11,935.50	273.28	9,548.40	4	653.08	+T
1061	Lateral rhinotomy	164	5,730.16	131.2	4,584.13	4	653.08	+T
1063	Removal of foreign bodies from nose at rooms	10	349.40	10	349.40			
1065	Removal of foreign body from nose under general anaesthetic	38.6	1,348.68	38.6	1,348.68	4	653.08	+T
1067	Proof puncture, unilateral at rooms	10	349.40	10	349.40	4	653.08	+T
1069	Proof puncture, uni- or bilateral under general anaesthetic	35	1,222.90	35	1,222.90	4	653.08	+T
1075	Multiple intranasal procedures	194	6,778.36	155.2	5,422.69	4	653.08	+T
1077	Septum abscess, at room, including after-care	8	279.52	8	279.52			
1079	Septum abscess, under general anaesthetic	35	1,222.90	35	1,222.90	4	653.08	+T
1081	Oro-antral fistula (without Cladwell - Luc)	111.8	3,906.29	111.8	3,906.29	4	653.08	+T
1083	Choanal atresia: Intranasal approach	113	3,948.22	113	3,948.22	5	816.35	+T
1084	Choanal atresia: Transpalatal approach	194	6,778.36	155.2	5,422.69	7	1142.89	+T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septoplasty) nasal pyramid (osteotomy) and nasal tip	350	12,229.00	280	9,783.20	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1087	Subtotal reconstruction consisting of any two of the following: Septoplasty, osteotomy, nasal tip reconstruction	210	7,337.40	168	5,869.92	5	816.35	+T
1089	Forehead rhinoplasty (all stages): Total	552	19,286.88	441.6	15,429.50	5	816.35	+T
1091	Forehead rhinoplasty (all stages): Partial	414	14,465.16	331.2	11,572.13	5	816.35	+T
4.3 Larynx								
1117	Laryngeal intubation	10	349.40	10	349.40			
1118	Laryngeal stroboscopy with video capture	39	1,362.66	39	1,362.66	6	979.62	+T
1119	Laryngectomy without block dissection of the neck May not be used with tariff code 1471	430	15,024.20	344	12,019.36	7	1142.89	+T
1120	Intubation, endotracheal, emergency procedure Applicable to only situations where intubation does not form part of anaesthesia a) Routine intubation during anaesthesia b) A second intubation during anaesthesia c) Intubation during resuscitation d) Difficult intubation	34	1,187.96	34	1,187.96			
4904	Laryngectomy: Total, with radical neck dissection May not be used with tariff code 1471	508.7	17,773.98	406.96	14,219.18	7	1142.89	+T
4905	Laryngectomy: Subtotal, supraglottic without radical neck dissection May not be used with tariff code 1471	434.8	15,191.91	347.84	12,153.53	7	1142.89	+T
4906	Laryngectomy: Subtotal, supraglottic with radical neck dissection May not be used with tariff code 1471	563.2	19,678.21	450.56	15,742.57	7	1142.89	+T
4907	Laryngectomy: Hemilaryngectomy, horizontal May not be used with tariff code 1471	429.7	15,013.72	343.76	12,010.97	7	1142.89	+T
4908	Laryngectomy: Hemilaryngectomy, lateroververtical May not be used with tariff code 1471	391	13,661.54	312.8	10,929.23	7	1142.89	+T
4909	Laryngectomy: Hemilaryngectomy, anterovertical	405.1	14,154.19	324.08	11,323.36	7	1142.89	+T
4910	Laryngectomy: Hemilaryngectomy, antero-lateral-vertical May not be used with tariff codes 1471	414.2	14,472.15	331.36	11,577.72	7	1142.89	+T
1126	Post laryngectomy for voice restoration	139.5	4,874.13	120	4,192.80	9	1469.43	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
4913	Pharyngolaryngectomy: With radical neck dissection, without reconstruction May not be used with tariff code 1471	571.1	19,954.23	456.88	15,963.39	7	1142.89	+T
4914	Pharyngolaryngectomy: With radical neck dissection, with reconstruction May not be used with tariff code 1471	667.5	23,322.45	534	18,657.96	7	1142.89	+T
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy	427.6	14,940.34	342.08	11,952.28	9	1469.43	+T
4918	Laryngoplasty: Open reduction of fracture	367.2	12,829.97	293.76	10,263.97	8	1306.16	+T
4919	Laryngoplasty: Cricoid split	230.3	8,046.68	184.24	6,437.35	8	1306.16	+T
1127	Tracheostomy	90	3,144.60	90	3,144.60	9	1469.43	+T
4922	Tracheostoma: Revision, without flap rotation, simple	102.4	3,577.86	102.4	3,577.86	9	1469.43	+T
4923	Tracheostoma: Revision, with flap rotation, complex May not be used with tariff code 4922	167.3	5,845.46	133.84	4,676.37	9	1469.43	+T
4926	Tracheostomy: Fenestration with skin flaps	180.4	6,303.18	144.32	5,042.54	9	1469.43	+T
4927	Tracheostomy: Revision of scar Not applicable for cosmetic indications	104.5	3,651.23	104.5	3,651.23	9	1469.43	+T
4928	Tracheostomy/fistula: Closure, without plastic repair	104	3,633.76	104	3,633.76	9	1469.43	+T
4929	Tracheostomy/fistula: Closure, with plastic repair May not be used with tariff code 4928	149.8	5,234.01	120	4,192.80	9	1469.43	+T
4932	Tracheobronchoscopy: Through established tracheostomy incision May not be used with tariff code 1132	37.7	1,317.24	37.7	1,317.24	6	979.62	+T
4933	Tracheoplasty: Cervical	260.1	9,087.89	208.08	7,270.32	8	1306.16	+T
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage	329	11,495.26	263.2	9,196.21	8	1306.16	+T
1129	External laryngeal operation, e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngofissure	294.4	10,286.34	235.52	8,229.07	8	1306.16	+T
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	41.4	1,446.52	41.4	1,446.52	6	979.62	+T
1131	Direct laryngoscopy plus foreign body removal	64.6	2,257.12	64.6	2,257.12	6	979.62	+T
4.4	Bronchial Procedure							
1132	Bronchoscopy: Diagnostic bronchoscopy without removal of foreign object	65	2,271.10	65	2,271.10	6	979.62	+T
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body May not be used with tariff code 1132	80	2,795.20	80	2,795.20	8	1306.16	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1134	Bronchoscopy: Bronchoscopy with laser May not be used with tariff code 1132 and 4932	75	2,620.50	--		8	1306.16	+T
1136	Nebulisation (in rooms)	12	419.28	12	419.28			Fees as for specialist
1137	Bronchial lavage	--		--		8	1306.16	+T
1138	Thoracotomy: for bronchopleural fistula (including ruptured bronchus, any cause)	350	12,229.00	280	9,783.20	12	1959.24	+T
4.5	Pleura							
1139	Pleural needle biopsy (not including aftercare): Modifier 0005 not applicable	50	1,747.00	50	1,747.00	3	489.81	+T
1141	Insertion of intercostal catheter (under water drainage) May not be used with tariff code 1179 or any procedures done via thoracotomy	50	1,747.00	50	1,747.00	6	979.62	+T
1142	Intra-pleural block	36	1,257.84	36	1,257.84	3	489.81	+T
1143	Paracentesis chest: Diagnostic	8	279.52	8	279.52	3	489.81	+T
1145	Paracentesis chest: Therapeutic May not be used with tariff code 1143	13	454.22	13	454.22	3	489.81	+T
1147	Pneumothorax: Induction (diagnostic)	25	873.50	25	873.50			
1149	Pleurectomy	250	8,735.00	200	6,988.00	11	1795.97	+T
1151	Decortication of lung	350	12,229.00	280	9,783.20	11	1795.97	+T
1153	Chemical pleurodesis (instillation silver nitrate, tetracycline, talc, etc)	55	1,921.70	55	1,921.70	3	489.81	+T
4.6	Pulmonary Procedures							
4.6.1	Surgical							
1155	Needle biopsy lung (not including after-care): Modifier 0005 not applicable	32	1,118.08	32	1,118.08	5	816.35	+T
1157	Pneumonectomy	350	12,229.00	280	9,783.20	11	1795.97	+T
1159	Pulmonary lobectomy	389.5	13,609.13	311.6	10,887.30	11	1795.97	+T
1161	Segmental lobectomy Cannot be used with item 1159	365	12,753.10	292	10,202.48	11	1795.97	+T
1163	Excision tracheal stenosis: Cervical	375	13,102.50	300	10,482.00	8	1306.16	+T
1164	Excision tracheal stenosis: Intra-thoracic May not be used with tariff code 1163	350	12,229.00	280	9,783.20	12	1959.24	+T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within FOUR weeks	215	7,512.10	172	6,009.68	12	1959.24	+T
1168	Thoracoplasty: Complete May not be used with tariff code 1167 and 1169	250	8,735.00	200	6,988.00	11	1795.97	+T
1169	Thoracoplasty: Limited (osteoplastic) May not be used with tariff code 1167	200	6,988.00	160	5,590.40	11	1795.97	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1171	Drainage empyema (including six weeks after-treatment)	170	5,939.80	136	4,751.84	11	1795.97	+T
1173	Drainage of lung abscess (including six weeks after-treatment)	170	5,939.80	136	4,751.84	11	1795.97	+T
1175	Thoracotomy: Limited: For lung or pleural biopsy	115	4,018.10	115	4,018.10	11	1795.97	+T
1177	Thoracotomy: Major: Diagnostic, as for inoperable carcinoma	215	7,512.10	172	6,009.68	11	1795.97	+T
1179	Thoracoscopy	89	3,109.66	89	3,109.66	11	1795.97	+T
4.6.2	Pulmonary Function Tests							
4.6.2.1	Pulmonary function tests: General							
4.6.2.1	Note: When these procedures are performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.							
1186	Flow volume test: Inspiration/expiration May not be used with tariff codes 1189 and 1192	30	1,048.20	30	1,048.20			Fees as for specialist
1188	Flow volume test: Inspiration/expiration pre - and post - bronchodilator (to be charged for only with first consultation - thereafter tariff code 1186 applies)	50	1,747.00	50	1,747.00			Fees as for specialist
1189	Forced expirogram only	10	349.40	10	349.40			
1191	N2 single breath distribution	10	349.40	10	349.40			
1192	Peak expiratory flow only	5	174.70	5	174.70			
1197	Compliance and resistance, using oesophageal balloon	24	838.56	24	838.56			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 exercise, with subsequent spirometry	55.89	1,952.80	55.89	1,952.80			
1199	Pulmonary stress testing: For determination of VO2 max	96.5	3,371.71	96.5	3,371.71			
1201	Maximum inspiratory/expiratory pressure	5	174.70	5	174.70			Fees as for specialist
4.6.2.2	Pulmonary function tests: Specialised services	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	1,319.33					
1195	Thoracic gas volume	37.93	1,325.27					
1196	Determination of resistance to airflow, oscillatory or plethysmographic methods	45.31	1,583.13					
1200	Carbon monoxide diffusing capacity, any method	38.06	1,329.82					

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
		Specialist		General practitioner		Anaesthetic		
		U	R	U	R	U	R	T
4.7	INTENSIVE CARE (In intensive care or high care unit): Respiratory, Cardiac, General							
4.7.2	Intensive Care: Items for intensive care							
	Note: When these procedures are performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.							
	Note: Only one High Care or Intensive Care code 1204- 1206 and 1208- 1210 may be billed per day and not a combination thereof.							
4.7.2.1	Intensive Care :Category 1:Intensive Monitoring							
1204	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 tariff code 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 Per day.	30	1,048.20	30	1,048.20			Fees as for specialist
4.7.2.2	Intensive Care :Category 2:Active system support							
	Please note for category 2 and 3 patients: Doctors must please discuss amongst themselves who will be recognised as the Treating Doctor in each case. This will prevent non-payment or reversal of payment to doctors.							
1205	Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction; diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.) Ventilation may or may not be part of the active system support. First day	100	3,494.00	100	3,494.00			Fees as for specialist
1206	Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction; diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.) Ventilation may or may not be part of the active system support. Subsequent days, per day	50	1,747.00	50	1,747.00			Fees as for specialist
1207	Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction; diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.) Ventilation may or may not be part of the active system support. After two weeks, per day	30	1,048.20	30	1,048.20			Fees as for specialist

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1208	Category 3: Cases with multiple organ failure or Category 2 patients that may require multidisciplinary intervention. First day (Primary Medical Doctor)	137	4,786.78	120	4,192.80			Fees as for specialist
1209	Category 3: Cases with multiple organ failure or Category 2 patients that may require multidisciplinary intervention. First day (per involved medical doctor)	58	2,026.52	58	2,026.52			Fees as for specialist
4.7.2.3	Intensive Care :Category 3:Multi Organ Failure							
	Please note for category 2 and 3 patients: Doctors must please discuss amongst themselves who will be recognised as the Principle Doctor in each case. This will prevent non-payment or reversal of payment to doctors.							
1210	Category 3: Cases with multiple organ failure or Category 2 patients that may require multidisciplinary intervention. Subsequent days per calendar day (per involved medical doctor)	50	1,747.00	50	1,747.00			Fees as for specialist
4.7.3	Intensive Care: Procedures							
	Note: When these procedures are performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.							
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) 50,00 clinical procedure units per half hour or part thereof for the first hour per medical doctor, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per medical doctor. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.	50	1,747.00	50	1,747.00			Fees as for specialist
		25	873.50	25	873.50			
		150	5,241.00	150	5,241.00			
1212	Ventilation: First day Applicable to one medical doctor only	75	2,620.50	75	2,620.50			Fees as for specialist
1213	Ventilation: Subsequent days, per day Applicable to one medical doctor only	50	1,747.00	50	1,747.00			Fees as for specialist
1214	Ventilation: After two weeks, per day Applicable to one medical doctor only	25	873.50	25	873.50			Fees as for specialist
1215	Insertion of arterial pressure cannula Can be used with any of the ICU items	25	873.50	25	873.50			Fees as for specialist
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring Can be used with any of the ICU items	50	1,747.00	50	1,747.00			Fees as for specialist

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1217	Insertion of central venous line via peripheral vein Can be used with any of the ICU items	10	349.40	10	349.40			Fees as for specialist
1218	Insertion of central venous line via subclavian or jugular veins Can be used with any of the ICU items Appropriate for insertion or placement of a Quinton line or haemodialysis catheter Not to use with tariff code 3569	25	873.50	25	873.50			Fees as for specialist
1219	Hyperalimentation (daily fee)	15	524.10	15	524.10			Fees as for specialist
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to tariff code 0201 per patient)	30	1,048.20	30	1,048.20			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	1,048.20	30	1,048.20			Fees as for specialist

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
4.8	HYPERBARIC OXYGEN TREATMENT								
	<p>Note: Internationally recognised scientific indications for Hyperbaric Oxygen Therapy:</p> <p>a. Arterial gas embolism (traumatic or iatrogenic) b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis i. Bone and soft tissue radiation necrosis j. Compromised skin grafts and flaps k. Acute thermal burns l. Acute bloodloss anaemia (transfusion is contraindicated e.g. Jehovah's Witnesses or haemolytic anaemia) m. Cerebral abscesses</p>								
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	1,048.20	30	1,048.20			
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT		101.13	3,533.48	101.13	3,533.48			
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	2,096.40	60	2,096.40			
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT		131.26	4,586.22	131.26	4,586.22			
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	2,795.20	80	2,795.20			
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT		131.26	4,586.22	131.26	4,586.22			
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	3,144.60	90	3,144.60			
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT		214.18	7,483.45	214.18	7,483.45			

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
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	6,638.60	190	6,638.60			
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT	386.42	13,501.51	386.42	13,501.51			
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	11,425.38	327	11,425.38			
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	680.85	23,788.90	680.85	23,788.90			
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	678.28	23,699.10	678.28	23,699.10			
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT	671.85	23,474.44	671.85	23,474.44			
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	3,319.30	95	3,319.30	5	816.35	+T
1224	Mediastinotomy	115	4,018.10	115	4,018.10	11	1795.97	+T
6.	CARDIOVASCULAR SYSTEM							
6.1	General							
	General practitioner's fee for the taking of an ECG only							
	Note: Tariff codes 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added. 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	157.23			
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: 1/2 (tariff code 1233)			6.5	227.11			
	Note: Physician's fee for interpreting an ECG (Tariff Codes 1230 and 1231) A specialist physician is entitled to the following fees for interpretation of an ECG tracing referred for interpretation.							
1230	Professional component for a physician interpreting an ECG: Without effort	6	209.64					
1231	Physician's fee for interpreting an ECG: With and without effort	10	349.40					
1232	Electrocardiogram: Without effort (interpretation included)	9	314.46	9	314.46			
1233	Electrocardiogram: With and without effort (Interpretation included)	13	454.22	13	454.22			

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and the availability of associated apparatus (Interpretation included)	40	1,397.60	40	1,397.60			
1235	Multi-stage treadmill	60	2,096.40	60	2,096.40			
1241	X-ray screening (Chest)	4	139.76	4	139.76			
1245	Angiography cerebral: First two series (Replaces tariff code 2725 and 2729)	34.3	1,198.44	34.3	1,198.44	4	653.08	+T
1246	Angiography peripheral: Per limb	25	873.50	25	873.50	4	653.08	+T
1248	Paracentesis of pericardium	50	1,747.00	50	1,747.00	9	1469.43	+T
6.3 Cardiac Surgery								
1311	Pericardial drainage	140	4,891.60	120	4,192.80	13	2122.51	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
6.3.1	Open heart surgery							
1322	Attendance at other operations for monitoring at bedside, by physician heart block, etc: Per hour	20	698.80					
6.4	Peripheral Vascular System							
6.4.1	Peripheral vascular system: Investigations							
1357	Skin temperature test: Response to reflex heating	15	524.10	15	524.10			
1359	Skin temperature test: Response to reflex cooling	15	524.10	15	524.10			
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site	26.3	918.92	26.3	918.92			
1367	Doppler blood tests	6	209.64	6	209.64			
5369	Doppler arterial pressures	6	209.64	6	209.64			
5371	Doppler arterial pressures with exercise	10	349.40	10	349.40			
5373	Doppler segmental pressures and wave forms	12	419.28	12	419.28			
5375	Venous doppler examination (both limbs)	9	314.46	9	314.46			
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	20,964.00	480	16,771.20	15	2449.05	+T
1375	Grafting and/or thrombo-endarterectomy for thrombosis	444	15,513.36	355.20	12,410.69	15	2449.05	+T
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	594	20,754.36	475.2	16,603.49			
6.4.3.2	Iliac artery							
1379	Prosthetic grafting and/or Thrombo-endarterectomy	300	10,482.00	240	8,385.60	13	2122.51	+T
6.4.3.3	Peripheral Vascular System:Arteries:Peripheral							
1385	Prosthetic grafting	255	8,909.70	204	7,127.76	5	816.35	+T
1387	Vein grafting proximal to knee joint	300	10,482.00	240	8,385.60	5	816.35	+T
1388	Vein grafting distal to knee joint	444	15,513.36	355.2	12,410.69	5	816.35	+T
1389	Endarterectomy when not part of another specified procedure	264	9,224.16	211.2	7,379.33	5	816.35	+T
1393	Embolectomy: Peripheral embolectomy transfemoral	168	5,869.92	134.4	4,695.94	5	816.35	+T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	125	4,367.50	100	3,494.00	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure) - Anaesthetic: Except where a specific code already exist elsewhere	264	9,224.16	211.2	7,379.33	15	2449.05	+T
1397	Profundoplasty	210	7,337.40	168	5,869.92	5	816.35	+T
1399	Distal tibial (ankle region)	466	15,932.64	364.8	12,746.11	5	816.35	+T
1401	Femoro-femoral	254	8,874.76	203.2	7,099.81	5	816.35	+T
1402	Carotid-subclavian	288	10,062.72	230.4	8,050.18	8	1306.16	+T
1403	Axillo-femoral (Bifemoral + 50% of the fee)	288	10,062.72	230.4	8,050.18	8	1306.16	+T
6.4.4 Veins								
1407	Ligation of saphenous vein	50	1,747.00	50	1,747.00	3	489.81	+T
1408	Placement of Hickman catheter or similar May not be used for insertion or placement of a Quinton line or haemodialysis catheter	91	3,179.54	91	3,179.54	4	653.08	+T
1410	Ligation of inferior vena cava: Abdominal	180	6,289.20	144	5,031.36	8	1306.16	+T
1412	Umbrella operation on inferior vena cava: Abdominal	100	3,494.00	100	3,494.00	8	1306.16	+T
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral	141	4,926.54	120	4,192.80	3	489.81	+T
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral	247	8,630.18	197.6	6,904.14	3	489.81	+T
1417	Extensive sub-fascial ligation of perforating veins	125	4,367.50	120	4,192.80	3	489.81	+T
1419	Lesser varicose vein procedure	31	1,083.14	31	1,083.14	3	489.81	+T
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)	9	314.46	9	314.46			
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)	240	8,385.60	192	6,708.48	11	1795.97	+T
1427	Thrombectomy: Ilio-femoral	175	6,114.50	140	4,891.60	6	979.62	+T
7. LYMPHO RETICULAR SYSTEM								
7.1 Spleen								
1435	Splenectomy (trauma cases only)	221.3	7,732.22	177.04	6,185.78	9	1469.43	+T
1436	Splenorrhaphy	231.8	8,099.09	185.44	6,479.27	9	1469.43	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
7.2	Lymph nodes and lymphatic channels							
1439	Excision of lymph node for biopsy: Neck or axilla	65	2,271.10	65	2,271.10			
1441	Excision of lymph node for biopsy: Groin	65	2,271.10	65	2,271.10	4	653.08	+T
1443	Simple excision of lymph nodes for tuberculosis	91	3,179.54	91	3,179.54	5	816.35	+T
1445	Radical excision of lymph nodes of neck: Total: Unilateral	315	11,006.10	252	8,804.88	5	816.35	+T
7.3	Bone Marrow and Stem cell transplantation and harvesting							
1457	Bone marrow biopsy: By trephine	13	454.22	13	454.22	3	489.81	+T
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	8	279.52	8	279.52			

		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	1,436.03	41.1	1,436.03	5	816.35	+T
1464	Removal of embedded foreign body: Vestibule of mouth, complicated	73.1	2,554.11	73.1	2,554.11	5	816.35	+T
1466	Removal of embedded foreign body: Dentoalveolar structures, soft tissues	52.8	1,844.83	52.8	1,844.83	5	816.35	+T
1467	Drainage of intra-oral abscess	31	1,083.14	31	1,083.14	4	653.08	+T
1469	Local excision of mucosal lesion of oral cavity	23	803.62	23	803.62	4	653.08	+T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	549	19,182.06	439.2	15,345.65	7	1142.89	+T
1478	Velopharyngeal reconstruction with myoneurovascular transfer (dynamic repair) Pre-authorisation and motivation letter required	240	8,385.60	192	6,708.48	6	979.62	+T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	227	7,931.38	181.6	6,345.10	6	979.62	+T
1480	Repair of oronasal fistula (large), e.g. distant flap Tariff Code 1480 cannot be used with tariff codes 1481 and 1482.	227	7,931.38	181.6	6,345.10	6	979.62	+T
1481	Repair of oronasal fistula (small), e.g. trapdoor: One stage or first stage Tariff Code 1481 cannot be used with tariff codes 1480 and 1482.	138	4,821.72	120	4,192.80	5	816.35	+T
1482	Repair of oronasal fistula (large): Second stage Tariff Code 1482 cannot be used with tariff codes 1480 and 1481.	138	4,821.72	120	4,192.80	5	816.35	+T
1483	Alveolar periosteal or other flaps for arch closure	138	4,821.72	120	4,192.80	4	653.08	+T
1486	Closure of anterior nasal floor	138	4,821.72	120	4,192.80	5	816.35	+T
8.2	Lips							
1485	Local excision of benign lesion of lip	27	943.38	27	943.38	4	653.08	+T
1499	Lip reconstruction following an injury: Directed repair Cannot be used with tariff codes 1501 to 1504	105.6	3,689.66	105.6	3,689.66	4	653.08	+T
1501	Lip reconstruction following an injury only: Flap repair May not be used with tariff codes 1499, 1503 and 1504	206	7,197.64	164.8	5,758.11	4	653.08	+T
1503	Lip reconstruction following an injury only: Total reconstruction (first stage) Cannot be used with tariff codes 1499 and 1501	206	7,197.64	164.8	5,758.11	4	653.08	+T
1504	Lip reconstruction following an injury only: Subsequent stages (see tariff code 0297) Cannot be used with tariff codes 1499, 1501 and 1503	104	3,633.76	104	3,633.76	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
8.3	Tongue								
1505	Partial glossectomy	225	7,861.50	180	6,289.20	6	979.62	+T	
1507	Local excision of lesion of tongue	27	943.38	27	943.38	4	653.08	+T	
8.4	Palate, uvula and salivary gland								
1526	Total parotidectomy with preservation of facial nerve	358.5	12,525.99	286.8	10,020.79	5	816.35	+T	
1527	Total parotidectomy	358.5	12,525.99	286.8	10,020.79	5	816.35	+T	
1531	Drainage of parotid abscess	25	873.50	25	873.50	4	653.08	+T	
8.5	Oesophagus								
1545	Oesophagoscopy with rigid instrument: First and subsequent	47	1,642.18	47	1,642.18	4	653.08	+T	
1550	Oesophagoscopy with removal of foreign body Cannot be used with tariff code 1545	70	2,445.80	70	2,445.80	4	653.08	+T	
1557	Oesophageal dilatation Can be used with tariff code 1587	40	1,397.60	40	1,397.60	4	653.08	+T	
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	300	10,482.00	240	8,385.60	11	1795.97	+T	
1565	Hiatus hernia and diaphragmatic hernia repair: With Collins Nissen oesophageal lengthening procedure	350	12,229.00	280	9,783.20	11	1795.97	+T	
8.6	Stomach								
1587	Upper gastro-intestinal endoscopy: Using hospital equipment	48.75	1,703.33	48.75	1,703.33	4	653.08	+T	
1589	Endoscopic control of gastro-intestinal haemorrhage from upper gastro-intestinal tract, intestine or large bowel, by injection, ligation or application of energy devices (endoscopic haemostasis): ADD to gastroscopy (tariff code 1587), small bowel endoscopy (tariff code 1626) or colonoscopy (tariff code 1653 or tariff code 1656)	+	34	1,187.96	34	1,187.96	6	979.62	+T
1591	Plus removal of foreign body (stomach or small bowel): ADD to gastro-intestinal endoscopy (tariff code 1587) or small bowel endoscopy (tariff code 1626)	+	+25	873.50	+25	873.50	4	653.08	+T
1597	Gastrostomy or gastrostomy For Percutaneous Endoscopic Gastrostomy (PEG), use tariff codes 1597 plus 1587 and 1780	147.5	5,153.65	120	4,192.80	6	979.62	+T	
1613	Gastroenterostomy	203.6	7,113.78	162.88	5,691.03	6	979.62	+T	
1615	Suture of perforated gastric wound or injury Use tariff code for suturing of the duodenum	200	6,988.00	160	5,590.40	7	1142.89	+T	
1617	Partial gastrectomy	328.3	11,470.80	262.64	9,176.64	7	1142.89	+T	
1619	Total gastrectomy	384.43	13,431.98	307.54	10,745.45	7	1142.89	+T	
1621	Revision of gastrectomy or gastro-enterostomy	375	13,102.50	300	10,482.00	7	1142.89	+T	

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
8.7	Duodenum							
1626	Endoscopic examination of the small bowel beyond the duodenojejunal flexure (enteroscopy), with or without biopsy: Hospital equipment used (refer to modifier 0074 for the use of own equipment)	120	4,192.80	120	4,192.80	6	979.62	+T
1627	Duodenal intubation (under X-ray screening)	8	279.52					
8.8	Intestines							
1634	Enterotomy or Enterostomy	202.6	7,078.84	162.08	5,663.08	6	979.62	+T
1637	Operation for relief of intestinal obstruction	240	8,385.60	192	6,708.48	7	1142.89	+T
1639	Resection of small bowel with enterostomy or anastomosis Cannot be used with tariff code 1634	244.9	8,556.81	195.92	6,845.44	6	979.62	+T
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (tariff code 0201 applicable for video capsule - disposable single patient use) - (Please note: All patients should have had a normal gastroscopy and colonoscopy)	150	5,241.00	120	4,192.80			
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	90	3,144.60	90	3,144.60			
1645	Suture of intestine (small or large): Wound or injury Appropriate for the suturing of small or large intestines and post operative repair of perforation	185.2	6,470.89	148.16	5,176.71	6	979.62	+T
1647	Closure of intestinal fistula	258	9,014.52	206.4	7,211.62	6	979.62	+T
1653	Total colonoscopy with hospital equipment	90	3,144.60	90	3,144.60	4	653.08	+T
1656	Left-sided colonoscopy	60	2,096.40	60	2,096.40	4	653.08	+T
1657	Right or left hemicolectomy or segmental colectomy	325	11,355.50	260	9,084.40	6	979.62	+T
1661	Colotomy: Including removal of foreign body	205.7	7,187.16	164.56	5,749.73	6	979.62	+T
1663	Total colectomy	390	13,626.60	312	10,901.28	6	979.62	+T
1665	Colostomy or ileostomy isolated procedure	233.8	8,168.97	187.04	6,535.18	6	979.62	+T
1666	Continent ileostomy pouch (all types)	300	10,482.00	240	8,385.60	6	979.62	+T
1667	Colostomy: Closure	179.1	6,257.75	143.28	5,006.20	5	816.35	+T
1668	Revision of ileostomy pouch	375	13,102.50	300	10,482.00	6	979.62	+T
8.10	Rectum and anus							
1676	Flexible sigmoidoscopy (including rectum and anus): Using hospital equipment	48.75	1,703.33	48.75	1,703.33	3	489.81	+T
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	13	454.22	13	454.22	3	489.81	+T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	445	15,548.30	356	12,438.64	8	1306.16	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1705	Incision and drainage of submucous abscess	40	1,397.60	40	1,397.60	3	489.81	+T
1707	Drainage of submucous abscess	40	1,397.60	40	1,397.60	3	489.81	+T
1737	Dilatation of ano-rectal stricture	12.5	436.75	12.5	436.75	3	489.81	+T
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	27	943.38	27	943.38			
8.11 Liver								
1743	Needle biopsy of liver	30.3	1,058.68	30.3	1,058.68	3	489.81	+T
1744	Extensive debridement, haemostasis and packing of liver wound or injury	483.8	16,903.97	387.04	13,523.18	13	2122.51	+T
1745	Biopsy of liver by laparotomy	125	4,367.50	120	4,192.80	4	653.08	+T
1747	Drainage of liver abscess or cyst	179.1	6,257.75	143.28	5,006.20	7	1142.89	+T
1748	Body composition measured by bio-electrical impedance	3	104.82	3	104.82			
1749	Hemi-hepatectomy: Right	564	19,706.16	451.2	15,764.93	9	1469.43	+T
1751	Hemi-hepatectomy: Left	521.1	18,207.23	416.88	14,565.79	9	1469.43	+T
1752	Extended right or left hepatectomy	570.9	19,947.25	456.72	15,957.80	9	1469.43	+T
1753	Partial or segmental hepatectomy	378	13,207.32	302.4	10,565.86	9	1469.43	+T
1757	Simple suture of liver wound or injury	214.2	7,484.15	171.36	5,987.32	9	1469.43	+T
1758	Complex suture of liver wound or injury, including hepatic artery ligation Cannot be used with tariff code 1757	296.6	10,363.20	237.28	8,290.56	13	2122.51	+T
8.12 Biliary tract								
1763	With exploration of common bile duct	264.5	9,241.63	211.6	7,393.30	6	979.62	+T
1765	Exploration of common bile duct: Secondary operation	327.7	11,449.84	262.16	9,159.87	6	979.62	+T
1767	Reconstruction of common bile duct	371.7	12,987.20	297.36	10,389.76	6	979.62	+T
8.13 Pancreas								
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + Catheterisation of pancreas duct or choledochus	105.9	3,700.15	105.9	3,700.15	4	653.08	+T
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. ADD to ERCP (tariff code 1778)	+ 15.82	552.75	15.82	552.75	4	653.08	+T
1780	Gastric and duodenal intubation Code is not appropriate if gastric intubation forms part of anaesthetic indications	8	279.52	8	279.52			
1791	Local, partial or subtotal pancreatectomy	351.3	12,274.42	281.04	9,819.54	8	1306.16	+T
1793	Distal pancreatectomy with internal drainage	377.4	13,186.36	301.92	10,549.08	8	1306.16	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
8.14	Peritoneal cavity							
1797	Pneumo-peritoneum: First Cannot be used with tariff codes 1807 and 1799	13	454.22	13	454.22	4	653.08	+T
1799	Pneumo-peritoneum: Repeat Cannot be used with tariff codes 1807 and 1797	6	209.64	6	209.64	4	653.08	+T
1800	Peritoneal lavage Appropriate when washing peritoneal cavity in cases of severe contamination	20	698.80	20	698.80			
1801	Diagnostic paracentesis: Abdomen	8	279.52	8	279.52			
1803	Therapeutic paracentesis: Abdomen Appropriate for draining ascitic fluid from abdomen	13	454.22	13	454.22			
1807	Add to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	+	45	1,572.30	45	1,572.30	5	816.35 +T
1809	Laparotomy If laparotomy is followed by an indicated intra-abdominal procedure, the tariff code with more RVUs should be used, and not both. Includes peritoneal lavage. No extra charge will be levied for the incision and closure of the abdomen for all intra-abdominal procedure.	196	6,848.24	156.8	5,478.59	4	653.08	+T
1811	Suture of burst abdomen Includes peritoneal lavage.	188.3	6,579.20	150.64	5,263.36	7	1142.89	+T
1812	Laparotomy for control of surgical haemorrhage Includes peritoneal lavage.	105	3,668.70	105	3,668.70	9	1469.43	+T
1813	Drainage of sub-phrenic abscess	180	6,289.20	144	5,031.36	7	1142.89	+T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal May be used with tariff code 1637 if appropriate.	248.4	8,679.10	198.72	6,943.28	5	816.35	+T
1817	Drainage of intraperitoneal abscess (excluding appendix abscess) Transrectal drainage of a pelvic abscess	75	2,620.50	75	2,620.50	4	653.08	+T
9.	HERNIA							
1819	Inguinal or femoral hernia adult	125	4,367.50	120	4,192.80	4	653.08	+T
1825	Recurrent inguinal or femoral hernia	155	5,415.70	124	4,332.56	4	653.08	+T
1827	Strangulated hernia or femoral hernia	238	8,315.72	190.4	6,652.58	7	1142.89	+T
1831	Umbilical hernia	140	4,891.60	120	4,192.80	4	653.08	+T
1835	Incisional hernia	166.8	5,827.99	133.44	4,662.39	4	653.08	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	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) ADD to tariff codes 1825 and 1835 where appropriate only (modifier 0005 does not apply) Does not apply to simple, primary or small hernia; applies to recurrent and complicated hernias only.	+	77	2,690.38	77	2,690.38	4	653.08	+T
10.	URINARY SYSTEM								
10.1	Kidney								
1839	Renal biopsy, per kidney, open		71	2,480.74	71	2,480.74	5	816.35	+T
1841	Renal biopsy (needle)		30	1,048.20	30	1,048.20	3	489.81	+T
1843	Peritoneal dialysis: First day Appropriate for the prescription and supervision of peritoneal dialysis May be used with tariff codes 1204 to 1210 and consultation codes		33	1,153.02	33	1,153.02			
1845	Peritoneal dialysis: Every subsequent day Appropriate for the prescription and supervision of peritoneal dialysis May be used with tariff codes 1204 to 1210 and consultation codes		33	1,153.02	33	1,153.02			
1847	Acute haemodialysis: Subsequent calendar day, per hour with a maximum of 4 hours per calendar day (e.g. Item 1847 x 4). Appropriate for haemodialysis in ICU or High Care Unit (the medical doctor does not have to be present for the duration of the treatment) a) Appropriate for the prescription and supervision of acute intermittent haemodialysis session in ICU or High Care Unit on subsequent days b) Cannot be used with item 1849 c) Use item once per hour up to a maximum of 4 hours of dialysis per day (1847 X 4). d) Applies to all form of haemodialysis provided in ICU or High Care Unit on the first day of dialysis, that is; intermittent, continuous and hybrid modalities. e) Can be used with items 1204 to 1210 and consultation codes		21	733.74	21	733.74			

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1849	Acute haemodialysis: First calendar day: Appropriate for haemodialysis in intensive or high care unit (the medical doctor does not have to be present for the duration of the treatment) a) Appropriate for the prescription and supervision of acute intermittent haemodialysis session in ICU or High Care Unit on first day of dialysis. b) Applies to all form of haemodialysis provided in ICU or High Care Unit on the first day of dialysis, that is; intermittent, continuous and hybrid modalities. c) Use item up to a maximum of 8 hours of dialysis per day. d) Can be used with items 1204 to 1210 and consultation codes	168	5,869.92	134.4	4,695.94			
1851	Chronic haemodialysis: Per week (in general ward or out-patient dialysis unit) a) Appropriate for the prescription and supervision of acute chronic haemodialysis provided in a general ward or dialysis unit. b) Item can only be used once per week. c) Use item once per hour up to a maximum of 4 hours of dialysis per day (1847 X 4). d) Applies to all form of haemodialysis provided in ICU or High Care Unit on the first day of dialysis, that is; intermittent, continuous and hybrid modalities. e) Can be used with items 0173 to 0175 and code 0109 f) Item cannot be used with items 0190- 0192 g) Dialysis prescriptions and supervision can be provided by a nephrologist or medical practitioner with appropriate training in nephrology. h) Hemodialysis provided in a dialysis unit applies to both outpatients and stabilised in-hospital patients in a general ward.	55	1,921.70	55	1,921.70			
1852	Continuous haemodialysis per calendar day in intensive or high care unit a) Appropriate for the prescription and supervision of continuous haemodialysis provided in ICU or High Care Unit on subsequent days. b) Item can only be used once per calendar day c) Use item once per hour up to a maximum of 4 hours of dialysis per day (1847 X 4). d) Applies to all form of haemodialysis provided in ICU or High Care Unit on the first day of dialysis, that is; intermittent, continuous and hybrid modalities. e) Can be used with items 1204- 1210 and code 0109 as appropriate	33	1,153.02	33	1,153.02			
1853	Primary nephrectomy	225	7,861.50	180	6,289.20	5	816.35	+T
1855	Secondary nephrectomy	267	9,328.98	213.6	7,463.18	5	816.35	+T
1863	Nephro-ureterectomy	305	10,656.70	244	8,525.36	5	816.35	+T
1865	Nephrotomy with drainage nephrostomy	189	6,603.66	151.2	5,282.93	6	979.62	+T
1869	Nephrolithotomy	227	7,931.38	181.6	6,345.10	5	816.35	

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1871	Staghorn stone: Surgical	341	11,914.54	272.8	9,531.63	6	979.62	
1873	Suture renal laceration (renorrhaphy)	193	6,743.42	154.4	5,394.74	6	979.62	+T
1879	Closure of renal fistula	189	6,603.66	151.2	5,282.93	5	816.35	+T
1881	Pyeloplasty	252	8,804.88	201.6	7,043.90	5	816.35	+T
1883	Pyelostomy	189	6,603.66	151.2	5,282.93	5	816.35	+T
1885	Pyelolithotomy	189	6,603.66	151.2	5,282.93	5	816.35	+T
1891	Perinephric abscess or renal abscess: Drainage	200	6,988.00	160	5,590.40	7	1142.89	+T
10.2 Ureter								
1897	Ureterorrhaphy: Suture of ureter	147	5,136.18	120	4,192.80	5	816.35	+T
1898	Ureterorrhaphy: Lumbar approach	189	6,603.66	151.2	5,282.93	5	816.35	+T
1899	Ureteroplasty	181	6,324.14	144.8	5,059.31	5	816.35	+T
1903	Ureterectomy only	137	4,786.78	120	4,192.80	5	816.35	+T
1905	Ureterolithotomy	265.8	9,287.05	212.64	7,429.64	5	816.35	
1907	Cutaneous ureterostomy: Unilateral	108	3,773.52	108	3,773.52	5	816.35	+T
1911	Uretero-enterostomy: Unilateral	137	4,786.78	120	4,192.80	5	816.35	+T
1915	Uretero-ureterostomy	137	4,786.78	120	4,192.80	5	816.35	+T
1919	Closure of ureteric fistula	147	5,136.18	120	4,192.80	5	816.35	+T
1921	Immediate deligation of ureter	147	5,136.18	120	4,192.80	5	816.35	+T
1925	Uretero-pyelostomy	252	8,804.88	201.6	7,043.90	5	816.35	+T
1941	Ureterostomy-in-situ: Unilateral	100	3,494.00	100	3,494.00	5	816.35	+T
10.3 Bladder								
1945	Installation of radio-opaque material for cystography or urethrocytography	5	174.70	5	174.70	3	489.81	+T
1949	Cystoscopy: Hospital equipment	44	1,537.36	44	1,537.36	3	489.81	+T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral Add to tariff code 1949 if appropriate	+ 10	349.40	10	349.40	3	489.81	+T
1952	J J Stent catheter	+ 44	1,537.36	44	1,537.36	3	489.81	+T
1954	Ureteroscopy	+ 35	1,222.90			3	489.81	+T
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time Add to tariff code 1949 or 1954 if appropriate	+ 35	1,222.90	35	1,222.90	3	489.81	+T
1959	With manipulation of ureteral calculus	+ 20	698.80	20	698.80	3	489.81	+T
1961	With removal of foreign body from urethra or bladder Add to tariff code 1949 or 1954 if appropriate	+ 20	698.80	20	698.80	3	489.81	+T
1964	And control of haemorrhage and blood clot evacuation Add to tariff code 1949 or 1954 if appropriate	+ 15	524.10	15	524.10	3	489.81	+T
1976	Optic urethrotomy	80	2,795.20	80	2,795.20	3	489.81	+T
1979	Internal urethrotomy: Female	50	1,747.00	50	1,747.00	3	489.81	+T
1981	Internal urethrotomy: Male	76.2	2,662.43	76.2	2,662.43	3	489.81	+T
1985	Transurethral resection of bladder neck: Female	105	3,668.70	105	3,668.70	5	816.35	+T
1986	Transurethral resection of bladder neck: Male	125	4,367.50	120	4,192.80	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
1987	Litholapaxy	80	2,795.20	80	2,795.20	3	489.81	+T
1989	Cystometrogram	25	873.50	25	873.50	3	489.81	+T
1991	Flometric bladder studies with videocystography	40	1,397.60	40	1,397.60	3	489.81	+T
1992	Without videocystography	25	873.50	25	873.50	3	489.81	+T
1993	Voiding cystro-urethrogram	21	733.74	21	733.74	3	489.81	+T
1995	Percutaneous aspiration of bladder	10	349.40	10	349.40	3	489.81	+T
1996	Bladder catheterisation - male (not at operation)	6	209.64	6	209.64	3	489.81	+T
1997	Bladder catheterisation - female (not at operation)	3	104.82	3	104.82			
1999	Percutaneous cystostomy	24	838.56	24	838.56	3	489.81	+T
2013	Diverticulectomy (independent procedure): Multiple or single	137	4,786.78	120	4,192.80	5	816.35	+T
2015	Suprapubic cystostomy	67	2,340.98	67	2,340.98	5	816.35	+T
2035	Cutaneous vesicostomy	118	4,122.92	118	4,122.92	5	816.35	+T
2039	Operation for ruptured bladder	137	4,786.78	120	4,192.80	6	979.62	+T
2043	Cysto-lithotomy	132	4,612.08	120	4,192.80	5	816.35	
2047	Drainage of perivesical or prevesical abscess	105	3,668.70	105	3,668.70	5	816.35	+T
2049	Evacuation of clots from bladder: Other than post-operative	132.1	4,615.57	120	4,192.80	3	489.81	+T
2050	Evacuation of clots from bladder: Post-operative					4	653.08	+T
2051	Simple bladder lavage: Including catheterisation	12	419.28	12	419.28	3	489.81	+T
10.4	Urethra							
2063	Dilatation of urethra stricture: By passage sound: Initial (male)	20	698.80	20	698.80	3	489.81	+T
2065	Dilatation of urethra stricture: By passage sound: Subsequent (male)	10	349.40	10	349.40	3	489.81	+T
2067	Dilatation of urethra stricture: By passage sound: By passage of filiform and follower (male)	20	698.80	20	698.80	3	489.81	+T
2071	Urethrorraphy: Suture of urethral wound or injury	139	4,856.66	120	4,192.80	4	653.08	+T
2075	Urethraplasty: Pendulous urethra: First stage	71	2,480.74	71	2,480.74	4	653.08	+T
2077	Urethraplasty: Pendulous urethra: Second stage	145	5,066.30	120	4,192.80	4	653.08	+T
2081	Reconstruction or repair of male anterior urethra (one stage)	261.6	9,140.30	209.28	7,312.24	4	653.08	+T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage Cannot be used with tariff codes 2085 to 2086	168	5,869.92	134.4	4,695.94	6	979.62	+T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage Cannot be used with tariff codes 2083 and 2086	168	5,869.92	134.4	4,695.94	6	979.62	+T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	294	10,272.36	235.2	8,217.89	6	979.62	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
2095	Drainage of simple localised perineal urinary extravasation	128.8	4,500.27	120	4,192.80	5	816.35	+T
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	137	4,786.78	120	4,192.80	5	816.35	+T
2103	Simple urethral meatotomy	26.3	918.92	26.3	918.92	3	489.81	+T
2105	Incision of deep peri-urethral abscess: Female	123.1	4,301.11	120	4,192.80	3	489.81	+T
2107	Incision of deep peri-urethral abscess: Male	123.1	4,301.11	120	4,192.80	3	489.81	+T
2109	Badenoch pull-through for intractable stricture or incontinence	181	6,324.14	144.8	5,059.31	5	816.35	+T
2111	External sphincterotomy	108	3,773.52	108	3,773.52	5	816.35	+T
2115	Operation for correction of male urinary incontinence with or without introduction of prosthesis (excluding cost of prosthesis)	168	5,869.92	134.4	4,695.94	5	816.35	+T
2116	Urethral meatoplasty	101.5	3,546.41	101.5	3,546.41	3	489.81	+T
2117	Closure of urethrostomy or urethrocutaneous fistula (independent procedure)	150.3	5,251.48	120.24	4,201.19	3	489.81	+T
11. MALE GENITAL SYSTEM								
11.1 Penis								
2141	Reconstructive operation for insertion of prosthesis	101	3,528.94	101	3,528.94	3	489.81	+T
2147	Reconstructive operation of penis: for injury: Including fracture of penis and skin graft if required	168	5,869.92	134.4	4,695.94	3	489.81	+T
2161	Total amputation of penis: Without gland dissection	210	7,337.40	168	5,869.92	4	653.08	+T
2167	Partial amputation of penis: Without gland-dissection	84	2,934.96	84	2,934.96	4	653.08	+T
2172	Removal foreign body: Deep penile tissue (e.g. plastic implant)	123.1	4,301.11	120	4,192.80	3	489.81	+T
11.2 Testis and epididymis								
2191	Orchidectomy (total or subcapsular): Unilateral	98	3,424.12	98	3,424.12	3	489.81	+T
2193	Orchidectomy (total or subcapsular): Bilateral	147	5,136.18	120	4,192.80	3	489.81	+T
2213	Suture or repair of testicular injury	110.3	3,853.88	110.3	3,853.88	4	653.08	+T
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	90	3,144.60	90	3,144.60	4	653.08	+T
2227	Incision and drainage of scrotal wall abscess	42.7	1,491.94	42.7	1,491.94	3	489.81	+T
2228	Removal of foreign body: Scrotum	104.9	3,665.21	104.9	3,665.21	3	489.81	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
11.3	Prostate							
2245	Trans-urethral resection of prostate	252.00	8,804.88	201.60	7,043.90	6	979.62	+T
14.	NERVOUS SYSTEM							
14.1	Diagnostic procedures							
2685	Electro-oculography: Unilateral	30	1,048.20					
2686	Electro-oculography: Bilateral Cannot be used with tariff code 2685	53	1,851.82					
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	80	2,795.20					
2709	Full spinogram including bilateral median and posterior-tibial studies	140	4,891.60					
2711	Electro-encephalogram (EEG): 20-40 minutes record: Equipment cost for taking of record (Technical component) (refer to tariff code 2712 for interpretation and report)	105.60	3,689.66	105.6	3,689.66			
2712	Clinical interpretation and report of tariff code 2711: Electro-encephalogram (EEG): 20-40 minutes record (Professional component)	16.6	580.00	16.6	580.00			

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	18.4	642.90	18.4	642.90	3	489.81	+T
2714	Cisternal or lateral cervical (C1-C2) puncture: Without injection - stand-alone procedure (Replaces tariff code 2731)	32	1,118.08	32	1,118.08	5	816.35	
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	31.5	1,100.61					
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	7	244.58	7	244.58			
2739	Ventricular puncture: Fontanelle, suture or implanted ventricular catheter/reservoir, without injection, through excising burr hole	16	559.04	16	559.04	4	653.08	+T
2741	Ventricular puncture: Fontanelle, suture, or implanted ventricular catheter/reservoir, with injection of medication or other substance for diagnosis or treatment, through excising burr hole	43	1,502.42	43	1,502.42	4	653.08	+T
2743	Subdural tapping: First sitting	15	524.10	15	524.10	4	653.08	+T
2745	Subdural tapping: Subsequent	10	349.40	10	349.40	4	653.08	+T
2679	Cisternal or lateral cervical (C1-C2) puncture: Injection of medication/other substance, diagnosis/treatment	40.50	1,415.07	40.50	1,415.07			
2688	Shunt tubing or reservoir puncture: For aspiration or injection procedure	25.90	904.95	25.90	904.95	5	816.35	+T
14.2	Introduction of burr holes for							
2747	Burr hole(s): Ventricular puncture, includes injection of gas, contrast media, dye or radioactive material.	223.8	7,819.57	179.04	6,255.66	8	1306.16	+T
2749	Catheterisation for ventriculography and /or drainage	150	5,241.00	120	4,192.80	8	1306.16	+T
2752	Twist drill hole(s): Includes subdural, intracerebral or ventricular puncture for evacuation and/or drainage of subdural haematoma.	272.2	9,510.67	217.76	7,608.53	9	1469.43	+T
2753	Burr hole(s). Includes evacuation and/or drainage of haematoma: Extradural or subdural	379.4	13,256.24	303.52	10,604.99	9	1469.43	+T
2754	Burr hole(s) or trephine: Includes subsequent tapping (aspiration) of intracranial abscess.	296.4	10,356.22	237.12	8,284.97	9	1469.43	+T
2755	Burr hole(s): Includes aspiration of haematoma or cyst, intracerebral (total procedure).	369.9	12,924.31	295.92	10,339.44	9	1469.43	+T
2757	Burr hole(s) or trephine: Includes drainage of brain abscess or cyst (total procedure).	402.8	14,073.83	322.24	11,259.07	9	1469.43	+T
2760	Burr hole(s) or trephine: Supratentorial, exploratory, not followed by other surgery.	255.9	8,941.15	204.72	7,152.92	9	1469.43	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
2761	Burr hole(s) or trephine: Infratentorial, unilateral or bilateral Use once per service.	218.9	7,648.37	175.12	6,118.69	9	1469.43	+T
14.3	Nerve procedures							
2765	Nerve conduction studies (see tariff codes 0733 and 3285)	26	908.44	26	908.44	4	653.08	+T
14.3.1	Nerve repair or suture							
2767	Suture Brachial Plexus (see also tariff codes 2837 and 2839)	379	13,242.26	303.2	10,593.81	6	979.62	+T
2769	Suture: Large nerve: Primary	297.7	10,401.64	238.16	8,321.31	5	816.35	+T
2771	Suture: Large nerve: Secondary	202	7,057.88	161.6	5,646.30	5	816.35	+T
2773	Suture: Digital nerve: Primary	199	6,953.06	159.2	5,562.45	3	489.81	+T
2775	Suture: Digital nerve: Secondary	96	3,354.24	96	3,354.24	3	489.81	+T
2777	Nerve graft: Simple	309	10,796.46	247.2	8,637.17	4	653.08	+T
2779	Fascicular: First fasciculus	202	7,057.88	161.6	5,646.30	4	653.08	+T
2781	Fascicular: Each additional fasciculus	+ 50	1,747.00	50	1,747.00	4	653.08	+T
2782	Nerve pedicle transfer: First stage (not to be used together with tariff code 2783)	309.1	10,799.95	247.28	8,639.96	4	653.08	+T
2783	Fascicular: Nerve flap: To include all stages	224	7,826.56	179.2	6,261.25	4	653.08	+T
2784	Nerve pedicle transfer: Second stage (not to be used together with tariff code 2783)	338.3	11,820.20	270.64	9,456.16	4	653.08	+T
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	124	4,332.56	120	4,192.80	6	979.62	+T
2787	Fascicular: Grafting of facial nerve	215	7,512.10	172	6,009.68	5	816.35	+T
14.3.2	Neurectomy							
2789	Destruction by neurolytic agent: Trigeminal nerve, second and third division branches at foramen ovale (includes radiological monitoring) (total procedure)	143.80	5,024.37	120.00	4,192.80	8	1306.16	+T
2795	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, one level (unilateral or bilateral)	45.4	1,586.28	45.4	1,586.28	5	816.35	+T
2796	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, lumbar spine/sacral, each additional level (unilateral or bilateral)	+ 16.3	569.52	16.3	569.52	5	816.35	+T
2797	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, one level (unilateral or bilateral)	44	1,537.36	44	1,537.36	5	816.35	+T
2798	Procedures for pain relief: Paravertebral facet joint nerve: Destruction by neurolytic agent, cervical/thoracic, each additional level (unilateral or bilateral)	+ 15	524.10	15	524.10	5	816.35	+T
2799	Procedures for pain relief: Intrathecal injections for pain When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units.	36	1,257.84	36	1,257.84	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
2800	Procedures for pain relief: Plexus nerve block When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units. Refer to Annexure C attached to this gazette (motivation to be supplied by treating medical Doctor)	36	1,257.84	36	1,257.84			Fees as for specialist
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief). For epidural anaesthetic refer to modifier 0021. When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units. Refer to Annexure C attached to this gazette (motivation to be supplied by treating medical Doctor)	36	1,257.84	36	1,257.84			Fees as for specialist
2802	Procedures for pain relief: Peripheral nerve block When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units. Refer to Annexure C attached to this gazette (motivation to be supplied by treating medical Doctor)	25	873.50	25	873.50			Fees as for specialist
2803	Alcohol injection in peripheral nerves for pain: Unilateral Cannot be used with tariff code 2805 When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units.	20	698.80	20	698.80	3		489.81 +T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) (not for bolus technique) To be used only with tariff codes 2799, 2800, 2801 or 2802	+	10	349.40	10	349.40		Fees as for specialist
2805	Alcohol injection in peripheral nerves for pain: Bilateral Cannot be used with tariff code 2803 When this procedure is performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be coded and not the anaesthetic units.	35	1,222.90	35	1,222.90	3		489.81 +T
2809	Peripheral nerve section for pain	45	1,572.30	45	1,572.30	3		489.81 +T
2813	Obturator or Stoffels	96	3,354.24	96	3,354.24	3		489.81 +T
2815	Interdigital	82.3	2,875.56	82.3	2,875.56	3		489.81 +T
2825	Excision: Neuroma: Peripheral	213	7,442.22	170.4	5,953.78	3		489.81 +T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
14.3.3	Other nerve procedures							
2827	Transposition of ulnar nerve	170	5,939.80	136	4,751.84	3	489.81	+T
2829	Neurolysis: Minor Cannot be used with tariff code 2831	51	1,781.94	51	1,781.94	3	489.81	+T
2831	Neurolysis: Major Cannot be used with tariff code 2829	141	4,926.54	120	4,192.80	3	489.81	+T
2833	Neurolysis: Digital	141	4,926.54	120	4,192.80	3	489.81	+T
2835	Scalenotomy	132	4,612.08	120	4,192.80	6	979.62	+T
2837	Neuroplasty: Brachial plexus	300	10,482.00	240	8,385.60	6	979.62	+T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	895.2	31,278.29	716.16	25,022.63	6	979.62	+T
2843	Lumbar sympathectomy: Unilateral	153	5,345.82	122.4	4,276.66	4	653.08	+T
2845	Lumbar sympathectomy: Bilateral	268	9,363.92	214.4	7,491.14	6	979.62	+T
2849	Sympathetic block: Other levels: Unilateral	20	698.80	20	698.80	3	489.81	+T
2851	Sympathetic block: Other levels: Bilateral Cannot be used with tariff code 2849	35	1,222.90	35	1,222.90	3	489.81	+T
14.4	Skull procedures							
2855	Cranectomy: Includes excision of tumour or other bone lesion of skull (total procedure)	396	13,836.24	317.2	11,082.97	11	1795.97	+T
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)	377.9	13,203.83	302.32	10,563.06	9	1469.43	+T
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)	307.1	10,730.07	245.68	8,584.06	9	1469.43	+T
2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debridement of brain (total procedure) Replaces tariff code 2861	455.1	15,901.19	364.08	12,720.96	11	1795.97	+T
2863	Cranioplasty: Skull defect =<5 cm diameter: With/without prosthesis	309.1	10,799.95	247.28	8,639.96	9	1469.43	+T
6043	Cranioplasty: Skull defect; >5 cm diameter	340.80	11,907.55	272.64	9,526.04	9	1469.43	+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	9,255.61	211.92	7,404.48	9	1469.43	+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	10,880.32	249.12	8,704.25	9	1469.43	+T
6046	Cranioplasty: Skull defect, with reparative brain surgery: With/without prosthesis Cannot be used with tariff codes 6047 and 6048	421.70	14,734.20	337.36	11,787.36	11	1795.97	+T
6047	Cranioplasty: Includes autograft and obtaining bone grafts: =<5 cm diameter (total procedure) Cannot be used with tariff codes 6046 and 6048	371.40	12,976.72	297.12	10,381.37	9	1469.43	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
6048	Cranioplasty: Includes autograft and obtaining bone grafts; >5 cm diameter (total procedure) Cannot be used with tariff codes 6046 to 6047	432.70	15,118.54	346.16	12,094.83	9	1469.43	+T
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure 6046 to 6048	+ 37.30	1,303.26	37.30	1,303.26			
14.5	Shunt procedures and neuroendoscopy							
2869	Ventriculocisternostomy: From the third ventricle to the cisterna magna (total procedure)	409.00	14,290.46	327.20	11,432.37	10	1632.70	+T
2871	Creation of shunt: Ventriculo-atrial, -jugular, -auricular Cannot be used with tariff code 2873	307.20	10,733.57	245.76	8,586.85	10	1632.70	+T
2873	Creation of shunt: Ventriculo-peritoneal, -pleural, other terminus Cannot be used with tariff code 2871	315.40	11,020.08	252.32	8,816.06	10	1632.70	+T
2875	Theco-peritoneal cerebrospinal fluid (CSF) shunt	280	9,783.20	224	7,826.56	8	1306.16	+T
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure	+ 56.00	1,956.64	56.00	1,956.64	8	1306.16	+T
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body	364.80	12,746.11	291.84	10,196.89	11	1795.97	+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	10,160.55	232.64	8,128.44	10	1632.70	+T
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (total procedure)	111.40	3,892.32	111.40	3,892.32	10	1632.70	+T
6063	Ventriculocisternostomy of the third ventricle: Stereotactic, neuroendoscopic method (under CT guidance for stereotactic positioning) (tariff codes 6055 and 6148 cannot be added)	358.80	12,536.47	287.04	10,029.18	10	1632.70	+T
6064	Replacement/irrigation: Previously placed intraoperative ventricular catheter	158.30	5,531.00	126.64	4,424.80	10	1632.70	+T
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system	252.30	8,815.36	201.84	7,052.29	10	1632.70	+T
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit	26.00	908.44	26.00	908.44	10	1632.70	+T
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)	180.00	6,289.20	144.00	5,031.36	10	1632.70	+T
6068	Cerebrospinal fluid (CSF) shunt system: Complete removal, with replacement by similar or other shunt at same operation	335.50	11,722.37	268.40	9,377.90	10	1632.70	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
14.6	Aneurism Repair							
2876	Repair of aneurism or arteriovenous anomalies(Intracranial)	700.00	24,458.00	560.00	19,566.40	15	2449.05	+T
14.7	Craniectomy or Craniotomy							
2879	Glosso-pharyngeal nerve	480	16,771.20	384	13,416.96	6	979.62	+T
2881	Eighth nerve: Intracranial	480	16,771.20	384	13,416.96	8	1306.16	+T
2887	Vestibular nerve	480	16,771.20	384	13,416.96	9	1469.43	+T
2891	Craniectomy for excision of brain tumour: Infratentorial or posterior fossa for excision of brain tumour. Excludes meningioma, cerebellopontine angle tumour or midline tumour at base of skull	819	28,615.86	655.76	22,912.25	13	2122.51	+T
2892	Micro vascular decompression of cranial nerve (suboccipital)	553	19,321.82	442	15,443.48	6	979.62	+T
2893	Craniectomy for excision of brain abscess: Infratentorial or posterior fossa for excision of brain abscess	648.3	22,651.60	518.64	18,121.28	13	2122.51	+T
2899	Craniectomy/craniotomy: With evacuation of infratentorial haematoma, subdural or extradural	375	13,102.50	300	10,482.00	11	1795.97	+T
2900	Craniotomy for extra-dural orbital decompression	700	24,458.00	560	19,566.40	11	1795.97	+T
6085	Craniectomy/craniotomy: With exploration of the infratentorial area (below the tentorium of the cerebellum), posterior fossa (total procedure)	596.4	20,838.22	477.12	16,670.57	13	2122.51	+T
6086	Craniectomy/craniotomy: With evacuation of infratentorial, intracerebellar haematoma (total procedure)	614.3	21,463.64	491.44	17,170.91	13	2122.51	+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)	631.8	22,075.09	505.44	17,660.07	13	2122.51	+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)	605.1	21,142.19	484.08	16,913.76	13	2122.51	+T
6090	Craniectomy at base of skull (suboccipital): With freeing and section of one or more cranial nerves (total procedure)	624	21,802.56	499.2	17,442.05	11	1795.97	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
14.8	Craniotomy							
2903	Craniectomy for abscess, glioma	450	15,723.00	360	12,578.40	11	1795.97	+T
2904	Craniectomy/craniotomy: With evacuation of supratentorial, intracerebral haematoma	590.2	20,621.59	472.16	16,497.27	11	1795.97	+T
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery	489	17,085.66	391.2	13,668.53	11	1795.97	+T
2906	Craniotomy: Skull based repair of encephalocele (total procedure)	493.5	17,242.89	394.8	13,794.31	11	1795.97	+T
2909	Craniotomy: Repair of dural/cerebrospinal fluid (CSF) leak. Includes surgery for rhinorrhea/otorrhea Cannot be used with tariff codes 6196 and 6197	450	15,723.00	360	12,578.40	11	1795.97	+T
6115	Craniectomy/craniotomy: Supratentorial exploration	487.1	17,019.27	389.68	13,615.42	11	1795.97	+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	904.95	25.9	904.95			
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)	564.7	19,730.62	451.76	15,784.49	11	1795.97	+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	24,636.19	564.08	19,708.96	11	1795.97	+T
6120	Decompression of (roof of) orbit only: Transcranial approach (total procedure)	548.6	19,168.08	438.88	15,334.47	11	1795.97	+T
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess	566.2	19,783.03	452.96	15,826.42	11	1795.97	+T
6141	Craniectomy/craniotomy: Excision of foreign body from brain	554.3	19,367.24	443.44	15,493.79	11	1795.97	+T
6142	Craniectomy/craniotomy: Treatment of penetrating wound of brain	589.9	20,611.11	471.92	16,488.88	11	1795.97	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
14.8.2	Surgery of skull base							
14.8.2.1	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 tariff code 6197		388.7 13,581.18	310.96 10,864.94	11 1795.97			+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 tariff code 6196		437.8 15,296.73	350.24 12,237.39	11 1795.97			+T
14.9	Spinal operations							
	Note: See section 3.8.7 for laminectomy procedures							
2923	Chordotomy: Unilateral		178 6,219.32	142.4 4,975.46	3 489.81			+T+M
2925	Chordotomy: Open		350 12,229.00	280 9,783.20	3 489.81			+T+M
2927	Rhizotomy: Extradural, but intraspinal		320 11,180.80	256 8,944.64	3 489.81			+T+M
2928	Rhizotomy: Intradural		350 12,229.00	280 9,783.20	3 489.81			+T+M
2940	Lumbar osteophyte removal		187 6,533.78	149.6 5,227.02	3 489.81			+T+M
2941	Cervical or thoracic osteophyte removal		285 9,957.90	228 7,966.32	3 489.81			+T+M
14.10	Arterial ligations							
2951	Carotis: Trauma		120 4,192.80	120 4,192.80	8 1306.16			+T
14.11	Medical Psychotherapy							
2957	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per short session (20 minutes)		20 698.80	16 559.04	20 698.80			
2974	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per intermediate session (40 minutes)		40 1,397.60	32 1,118.08	40 1,397.60			
2975	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per extended session (60 minutes and longer)		60 2,096.40	48 1,677.12	60 2,096.40			
2968	Group therapy: Adults (specify number): Code per person per 80-minute session.		8 279.52	8 279.52				

		Specialist		General Practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
14.12	Physical treatment methods								
2970	Electro-convulsive treatment (ECT) : Each time; inpatient (may be combined with Consultations/Treatment) Therapy) (C/T) codes if both performed on the same day)		17	593.98	17	593.98	17	593.98	+T
14.13	Psychiatric examination methods								
2972	Narco-analysis (maximum of 3 sessions per treatment) - per session						24	838.56	
2973	Psychometry by Psychiatrist (specify examination) - per session (maximum of 3 sessions per examination)						24	838.56	
		Specialist		General practitioner		Anaesthetic			
		U	R	U	R	U	R	T	
15.	ENDOCRINE SYSTEM								
15.1	Endocrine system: General								
3001	Implantation of pellets (excluding cost of material) (excluding aftercare)		3	104.82	3	104.82			
16.	EYE								
16.1	Procedures performed in rooms								
16.1.1	Eye investigations								
	<p>Note: Not more than three (3) tariff codes in this section may be charged during one visit.</p> <p>a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra item may be coded where each eye is examined separately on two different occasions.</p> <p>b. Material used is excluded.</p> <p>c. The cost for photography is not related to the number of photographs taken.</p>								
3002	Gonioscopy		7	244.58	7	244.58			
3003	Fundus contact lens or 90D lens examination(not to be charged with tariff code 3004 and/or tariff code 3012)		7	244.58	7	244.58			
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with tariff code 3003 and/or tariff code 3012)		7	244.58	7	244.58			
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	408.10	-				
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for patients over 7 years of age		12	419.28	12	419.28			
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)		7	244.58	7	244.58			
3021	Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations		9	314.46	9	314.46			-

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
16.1.2	Special eye investigations							
3008	Contrast sensitivity test	7	244.58	7	244.58			
3015	Charting of visual field with manual perimeter	28	978.32	28	978.32			
3016	Retinal threshold test without storage facilities	30	1,048.20	30	1,048.20			
3017	Retinal threshold test inclusive of computer disc storage for Delta or Statpak programs	74	2,585.56	74	2,585.56			
3018	Retinal threshold trend evaluation (additional to 3017)	16	559.04	16	559.04			-
3020	Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	46	1,607.24	46	1,607.24			-
3025	Electronic tonography	19	663.86	19	663.86			-
3027	Fundus photography	21	733.74	21	733.74			-
3029	Anterior segment microphotography	21	733.74	21	733.74			-
3031	Fluorescein angiography: One or both eyes	45	1,572.30	45	1,572.30	4		653.08 +T
3032	Eyelid and orbit photography	9	314.46	9	314.46			-
3033	Interpretation of items 3031 referred by other clinicians	15	524.10	15	524.10			-
3034	Determination of lens implant power per eye	15	524.10	15	524.10			-
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	768.68	22	768.68			As per procedure
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	36	1,257.84	36	1,257.84			
16.2	Retina							
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	306.9	10,723.09	245.52	8,578.47	6		979.62 +T
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	105	3,668.70	105	3,668.70	6		979.62 +T
3041	Pan retinal photocoagulation (per eye): Done in one session (aftercare excluded) (Subsequent sittings: Modifier 0005)	150	5,241.00	120	4,192.80	6		979.62 +T
3044	Removal of encircling band and/or buckling material	105	3,668.70	105	3,668.70	6		979.62 +T
16.3	Cataract							
3045	Cataract: Intra-capsular extraction	210	7,337.40	168	5,869.92	7		1142.89 +T
3047	Cataract: Extra-capsular (including capsulotomy)	210	7,337.40	168	5,869.92	7		1142.89 +T
3049	Insertion of lenticulus in addition to 3045 or 3047 (cost of lens excluded) Modifier 0005 not applicable	57	1,991.58	57	1,991.58	7		1142.89 +T
3050	Repositioning of intra ocular lens	171.1	5,978.23	136.88	4,782.59	7		1142.89 +T
3051	Needling or capsulotomy	130	4,542.20	120	4,192.80	4		653.08 +T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3052	Laser capsulotomy (aftercare excluded)	105	3,668.70	105	3,668.70	4	653.08	+T
3057	Removal of lenticulus	210	7,337.40	168	5,869.92	7	1142.89	+T
3058	Exchange of intra ocular lens	236	8,245.84	188.8	6,596.67	7	1142.89	+T
3059	Insertion of lenticulus when 3045 or 3047 was not executed (cost of lens excluded)	210	7,337.40	168	5,869.92	7	1142.89	+T
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) (for use by ophthalmologists only)	4	139.76					
16.4 Glaucoma								
3061	Drainage operation	247.6	8,651.14	198.08	6,920.92	6	979.62	+T
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to tariff code 3061)	60	2,096.40	60	2,096.40	6	979.62	+T
3063	Cyclorotherapy or cyclodiathermy	105	3,668.70	105	3,668.70	6	979.62	+T
3064	Laser trabeculoplasty	105	3,668.70	105	3,668.70	6	979.62	+T
3065	Removal of blood anterior chamber	105	3,668.70	105	3,668.70	4	653.08	+T
3067	Goniotomy	210	7,337.40	168	5,869.92	7	1142.89	+T
16.5 Intra-ocular foreign body								
3071	Intra-ocular foreign body: Anterior to Iris	127	4,437.38	120	4,192.80	4	653.08	+T
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	210	7,337.40	168	5,869.92	6	979.62	+T
16.6 Strabismus								
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	175.6	6,135.46	140.48	4,908.37	5	816.35	+T
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	200	6,988.00	160	5,590.40	5	816.35	+T
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	120	4,192.80	120	4,192.80	5	816.35	+T
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three of four muscles	150	5,241.00	120	4,192.80	5	816.35	+T
16.7 Globe								
3080	Examination of eyes under general anaesthetic where no surgery is done	80	2,795.20	80	2,795.20	4	653.08	+T
3081	Treatment of minor perforating injury	161.6	5,646.30	129.28	4,517.04	6	979.62	+T
3083	Treatment of major perforating injury	267.5	9,346.45	214	7,477.16	6	979.62	+T
3085	Enucleation or Evisceration	105	3,668.70	105	3,668.70	5	816.35	+T
3087	Enucleation or evisceration with mobile implant: Excluding cost of implant and prosthesis Cannot be used with tariff code 3085	160	5,590.40	128	4,472.32	5	816.35	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3088	Hydroxyapatite insertion (Additional to tariff code 3087)	+	40	1,397.60	40	1,397.60	5	816.35	+T
3089	Subconjunctival injection if not done at time of operation		10	349.40	10	349.40	5	816.35	+T
3091	Retrolubar injection (if not done at time of operation)		16	559.04	16	559.04	4	653.08	+T
3092	External laser treatment for superficial lesions		53	1,851.82	53	1,851.82			
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumoretinopexy		130	4,542.20	120	4,192.80	7	1142.89	+T
3097	Anterior vitrectomy		280	9,783.20	224	7,826.56	6	979.62	+T
3098	Removal of silicon from globe		280	9,783.20	224	7,826.56	6	979.62	+T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement Cannot be used with tariff code 3097		419	14,639.86	335.2	11,711.89	6	979.62	+T
3100	Lensectomy done at time of posterior vitrectomy		30	1,048.20	30	1,048.20	7	1142.89	+T
16.8	Orbit								
3101	Drainage of orbital abscess		105	3,668.70	105	3,668.70	5	816.35	+T
3104	Removal orbital prosthesis		212.7	7,431.74	170.16	5,945.39	5	816.35	+T
3105	Exenteration		275	9,608.50	220	7,686.80	5	816.35	+T
3107	Orbitotomy requiring bone flap		393	13,731.42	314.4	10,985.14	5	816.35	+T
3108	Eye socket reconstruction		206	7,197.64	164.8	5,758.11	5	816.35	+T
3109	Hydroxyapatite implantation in eye cavity when evisceration or enucleation was done previously		300	10,482.00	240	8,385.60	5	816.35	+T
3110	Second stage hydroxyapatite implantation		110	3,843.40	110	3,843.40	5	816.35	+T
16.9	Cornea								
3111	Contact lenses: Assessment involving preliminary fittings and tolerance		15	524.10	10	349.40			
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.		12	419.28	12	419.28			
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	6,988.00	160	5,590.40			
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included		166	5,800.04	132.8	4,640.03			
3116	Astigmatic correction with T cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty		135.2	4,723.89	120	4,192.80	6	979.62	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3117	Removal of foreign body: On the basis of fee per consultation	31.5	1,100.61	30	1,048.20	4	653.08	+T
3118	Curettage of cornea after removal of foreign body (aftercare excluded)	10	349.40	10	349.40			
3119	Tattooing	26	908.44	26	908.44	4	653.08	+T
3121	Corneal graft (Lamellar or full thickness)	289	10,097.66	231.2	8,078.13	6	979.62	+T
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	470.8	16,449.75	376.64	13,159.80	6	979.62	+T
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). For use of sterile tray, add tariff code 0202	9	314.46	9	314.46	6	979.62	+T
3125	Keratectomy	127	4,437.38	120	4,192.80	6	979.62	+T
3127	Cauterization of Cornea (by chemical, thermal or cryotherapy methods)	10	349.40	10	349.40	4	653.08	+T
3130	Pterygium or conjunctival cyst. No conjunctival flap or graft used	96.9	3,385.69	96.9	3,385.69	4	653.08	+T
3131	Paracentesis	53	1,851.82	53	1,851.82	4	653.08	+T
3136	Conjunctival flap or graft. Not for use with pterygium surgery	95.7	3,343.76	95.7	3,343.76	6	979.62	+T
16.10	Ducts							
3133	Probing and/or syringing, per duct	10	349.40	10	349.40	4	653.08	+T
3135	Insert polythene tubes/stent: Unilateral: Additional	51.8	1,809.89	51.8	1,809.89	4	653.08	+T
3137	Excision of lacrimal sac: Unilateral	132	4,612.08	120	4,192.80	4	653.08	+T
3139	Dacryocystorhinostomy (single) with or without polythene tube	210	7,337.40	168	5,869.92	5	816.35	+T
3141	Sealing Punctum surgical/cautery per eye	24.9	870.01	24.9	870.01	4	653.08	+T
3142	Sealing Punctum with plugs. Per eye	20	698.80	20	698.80	4	653.08	+T
3143	Three-snip operation	10	349.40	10	349.40	4	653.08	+T
3145	Repair of caniculus: Primary procedure	132	4,612.08	120	4,192.80	4	653.08	+T
3147	Repair of caniculus: Secondary procedure Cannot be used with tariff code 3145	175	6,114.50	140	4,891.60	4	653.08	+T
16.11	Iris							
3149	Iridectomy or iridotomy by open operation as isolated procedure	132	4,612.08	120	4,192.80	4	653.08	+T
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	105	3,668.70	105	3,668.70	4	653.08	+T
3157	Division of anterior synechiae as isolated procedure	132	4,612.08	120	4,192.80	4	653.08	+T
3158	Repair iris as in dialysis. Anterior chamber reconstruction	142.4	4,975.46	120	4,192.80	4	653.08	+T
16.12	Lids							
3161	Tarsorrhaphy	47	1,642.18	47	1,642.18	4	653.08	+T
3165	Repair of skin laceration of the lid. Simple	27.3	953.86	27.3	953.86	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	187	6,533.78	149.6	5,227.02	4	653.08	+T
16.12.1 Entropion or ectropion by								
3177	Entropion or ectropion by cautery	10	349.40	10	349.40	4	653.08	+T
3179	Entropion or ectropion by suture	49.4	1,726.04	49.4	1,726.04	4	653.08	+T
3181	Entropion or ectropion by open operation	111.5	3,895.81	111.5	3,895.81	4	653.08	+T
3183	Entropion or ectropion by free skin, mucosal grafting or flap	122.6	4,283.64	120	4,192.80	4	653.08	+T
16.12.2 Reconstruction of eyelid								
3172	Blepharoplasty lower eyelid plus fat pad	125.8	4,395.45	120	4,192.80	4	653.08	+T
3185	Staged procedure for partial or total loss of eyelid: First stage	259	9,049.46	207.2	7,239.57	4	653.08	+T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	206	7,197.64	164.8	5,758.11	4	653.08	+T
3189	Full thickness eyelid laceration for injury: Direct repair	136.5	4,769.31	120	4,192.80	4	653.08	+T
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	150.2	5,247.99	120.16	4,198.39	4	653.08	+T
16.12.3 Ptosis								
3193	Repair by superior rectus, levator or frontalis muscle, brow ptosis or lower lid ptosis operation Motivation letter with pictures required	190	6,638.60	152	5,310.88	4	653.08	+T
3195	Ptosis: By lesser procedure, e.g. sling operation: Unilateral	137.6	4,807.74	120	4,192.80	4	653.08	+T
3197	Ptosis: By lesser procedure, e.g. sling operation: Bilateral Cannot be used with tariff code 3195	166	5,800.04	132.8	4,640.03	4	653.08	+T
16.13 Conjunctiva								
3199	Repair of conjunctiva by grafting	132	4,612.08	120	4,192.80	4	653.08	+T
3200	Repair of lacerated conjunctiva	47	1,642.18	47	1,642.18	4	653.08	+T
16.14 Eye: General								
3196	Diamond knife: Use of own diamond knife during intraocular surgery	12	419.28					
3198	Eximer laser: Hire fee	284.13	9,927.50					
3201	Laser apparatus (ophthalmic): hire fee for one or both eyes treated in one sitting (not to be used with IOL master)	109	3,808.46					
3202	PHAKO emulcification apparatus (hire fee)	109	3,808.46					
3203	Vitreotomy apparatus (hire fee)	120	4,192.80					
17. EAR								
17.1 External Ear (Pinna)								
3267	Partial or total reconstruction for traumatic absence of external ear: Unilateral	138	4,821.72	120	4,192.80	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3269	Partial or total reconstruction for traumatic absence of external ear: Bilateral	242	8,455.48	193.6	6,764.38	5	816.35	+T
5170	Drainage: Haematoma or abscess of external ear	34.8	1,215.91	34.8	1,215.91	5	816.35	+T
5171	Drainage: Abscess of external auditory canal	21	733.74	21	733.74	5	816.35	+T
5175	Excision: External ear, partial, simple repair	63.50	2,218.69	63.50	2,218.69	5	816.35	+T
5176	Excision: External ear, complete	66.80	2,333.99	66.80	2,333.99	5	816.35	+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 tariff code 3206	21.58	754.01					
3205	External ear canal: Removal of foreign body: Under general anaesthetic Cannot be used with tariff code 3204	21	733.74	21	733.74	4	653.08	+T
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	164	5,730.16	131.2	4,584.13	4	653.08	+T
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	77	2,690.38	77	2,690.38	4	653.08	+T
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) - not to be used combined with tariff code 3206	23.14	808.51	23.14	808.51			
3221	Removal of osteoma from meatus: Multiple	215	7,512.10	172	6,009.68	4	653.08	+T
17.3 Middle ear								
3209	Bilateral myringotomy	46	1,607.24	46	1,607.24	4	653.08	+T
3211	Unilateral myringotomy with insertion ventilation tube	38	1,327.72	38	1,327.72	4	653.08	+T
3212	Bilateral myringotomy with insertion ventilation tube	57	1,991.58	57	1,991.58	4	653.08	+T
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	255	8,909.70	204	7,127.76	5	816.35	+T
3237	Exploratory tympanotomy	158.9	5,551.97	127.12	4,441.57	5	816.35	+T
3243	Myringoplasty	138	4,821.72	120	4,192.80	5	816.35	+T
3245	Functional reconstruction of tympanic membrane	277	9,678.38	221.6	7,742.70	5	816.35	+T
3264	Tympanomastoidectomy	375	13,102.50	300	10,482.00	5	816.35	+T
3265	Reconstruction of posterior canal wall, following radical mastoidectomy	320	11,180.80	256	8,944.64	5	816.35	+T
17.4 Facial nerve								
17.4.1 Facial nerve tests								
3223	Percutaneous stimulation of the facial nerve	9	314.46	9	314.46	4	653.08	+T
3224	Electroneurography (ENOG)	75	2,620.50	75	2,620.50	4	653.08	+T
17.4.2 Facial nerve surgery								
3227	Exploration of facial nerve: Exploration of tympano mastoid segment	297	10,377.18	237.6	8,301.74	5	816.35	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3228	Exploration of facial nerve: Grafting of the tympano mastoid segment (including tariff code 3227)	436	15,233.84	348.8	12,187.07	5	816.35	+T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	436	15,233.84	348.8	12,187.07	5	816.35	+T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	124	4,332.56	120	4,192.80	6	979.62	+T
17.5 Inner ear								
17.5.1 Audiometry								
3273	Pure tone audiometry (air conduction)	6.5	227.11	6.5	227.11			
3274	Pure tone audiometry (bone conduction with masking)	6.5	227.11	6.5	227.11			
3275	Impedance audiometry (tympanometry)	6.5	227.11	6.5	227.11			
3276	Impedance audiometry (stapedial reflex) - no code for volume, compliance etc.	6.5	227.11	6.5	227.11			
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	10	349.40	10	349.40			
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	50.00	1,747.00					
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral Cannot be used with tariff code 2691	88.00	3,074.72					
2693	AEP: Audiological examination: Unilateral at a minimum of 4 decibels	60.00	2,096.40					
2694	AEP: Audiological examination: Bilateral at a minimum of 4 decibels Cannot be used with tariff code 2693	105.00	3,668.70					
2695	Audiology 40Hz response: Unilateral	30.00	1,048.20					
2696	Audiology 40Hz response: Bilateral	53.00	1,851.82					
2697	Mid- and long latency auditory evoked potentials: Unilateral	30.00	1,048.20					
2698	Mid- and long latency auditory evoked potentials: Bilateral	53.00	1,851.82					
2702	Total code for audiological evaluation including bilateral AEP and bilateral electro-cochleography	140.00	4,891.60			4	653.10	+T
17.5.2 Inner ear: Balance tests								
3260	Computerized static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	71.48	2,497.51	71.48	2,497.51			
3251	Minimal caloric test (excluding consultation fee)	10	349.40	10	349.40			
3256	Video nystagmoscopy (binocular)	50	1,747.00	50	1,747.00			
3258	Otolith repositioning manoeuvre	14	489.16	14	489.16	4	653.08	+T

		Specialist		General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
17.6	Microsurgery of the skull base							
	<p>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:</p> <p>1. The approach in order to expose the area in which the lesion is situated.</p> <p>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.</p> <p>3. Repair/reconstruction procedure: Is coded separately if extensive dural grafting cranioplasty, local or regional myocutaneous pedical flaps, or extensive skin grafts are performed.</p> <p>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</p>							
17.6.1	Middle fossa approach (i.e. transtemporal or supralabyrinthine)							
3229	Facial nerve : Exploration of the Labyrinthine segment.		420	14,674.80	336	11,739.84	5	816.35 +T
5221	Facial Nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)		510	17,819.40	408	14,255.52	11	1795.97 +T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)		620	21,662.80	496	17,330.24	11	1795.97 +T
17.6.7	Subtotal petrosectomy							
5247	Petrous apicectomy: Includes radical mastoidectomy through postaural or endaural incision		480	16,771.20	384	13,416.96	11	1795.97 +T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	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	26.21					
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)		13.5	471.69					
3281	Ultrasonic therapy		10	349.40					
3282	Shortwave diathermy		10	349.40					
3284	Sensory nerve conduction studies		31	1,083.14					
3285	Motor nerve conduction studies		26	908.44					
3287	Spinal joint and ligament injection		20	698.80	20	698.80			
3288	Epidural injection (Other specialists/General practitioners use tariff code 2801)		36	1,257.84					
3289	Multiple injections - First joint		7.5	262.05					
3290	Each additional joint	+	4.5	157.23					
3291	Tendon or ligament injection		9	314.46					
3292	Aspiration of joint or interarticular injection		9	314.46					
3293	Aspiration or injection of bursa or ganglion		9	314.46					
3294	Paracervical (neck) nerve block		20	698.80	20	698.80			
3295	Paravertebral root block - unilateral		20	698.80		-			
3296	Paravertebral root block - bilateral		30	1,048.20					
3297	Manipulation of spine performed by a specialist in Physical Medicine (Pr "034")		14	489.16					
3298	Spinal traction		6	209.64					
3299	Manipulation large joint under general anaesthetic-Anaesthetic: Knee/Shoulder		14	489.16			3	489.81	Hip+T
3299a	Manipulation of large Joints:Under general anaesthesia-Anaesthetic: Hip						4	653.08	Knee / Shoulder + T
3300	Manipulation of large joints without anaesthetic		*		*	*			
3301	Muscle fatigue studies		20	698.80					
3302	Strength duration curve per session		10.5	366.87					
3303	Electromyography		75	2,620.50					
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (for subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment: A fee for the treatment only is applicable: See Rules L and M)		10	349.40	10	349.40			

**RADIOLOGY
4 DIGITS CODES
2026**

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
19.	RADIOLOGY							
	Applicable to non-radiologists and general practitioners only							
	RULES GOVERNING THE SECTION RADIOLOGY							
Rule RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No "038") or nuclear medicine practices (Pr No "025"), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No "038") and nuclear medicine practices (Pr No "025").							
Rule YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital).							
	Note in respect of fees payable when X-rays are taken by general practitioners							
	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	230.20			
6500	Hand			7.7	281.36			
6501	Wrist (specify region)			7.7	281.36			
6503	Scaphoid			7.7	281.36			
6504	Radius and Ulna			7.7	281.36			
6505	Elbow			7.7	281.36			
6506	Humerus			7.7	281.36			
6507	Shoulder			7.7	281.36			
6508	Acromio-Clavicular joint			7.7	281.36			
6509	Clavicle			7.7	281.36			
6510	Scapula			7.7	281.36			
6511	Foot			7.7	281.36			
6512	Ankle			7.7	281.36			
6513	Calcaneus			7.7	281.36			
6514	Tibia and fibula			7.7	281.36			
6515	Knee			7.7	281.36			
6516	Patella			7.7	281.36			
6517	Femur			7.7	281.36			
6518	Hip			7.7	281.36			
6519	Sesamoid Bone			7.7	281.36			
3309	Smith-Petersen or equivalent control, in theatre			38.7	1,414.10			
3311	Stress studies, e.g. joint			7.7	281.36			
3313	Full length study, both legs			15.5	566.37			
3317	Skeletal survey			28	1,023.12			
3319	Arthrography per joint			15.4	562.72			
3320	Introduction of contrast medium or air: Add			13.8	504.25			
19.1.2	Skeleton: Spinal column							
3321	Per region, e.g. cervical, sacral, coccygeal, one region thoracic			11	401.94			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3325	Stress studies			11	401.94			
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of views is required)			11	401.94			
3333	Myelography: Lumbar			28.9	1,056.01	4	653.08	+T
3334	Myelography: Thoracic			22.2	811.19	4	653.08	+T
3335	Myelography: Cervical			35.5	1,297.17	4	653.08	+T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)					4	653.08	+T
3344	Introduction of contrast medium			18.7	683.30			
3345	Discography			34.6	1,264.28	4	653.08	+T
3347	Introduction of contrast medium per disc level: Add			28.2	1,030.43			-
19.1.3	Skeleton: Skull							
3349	Skull studies			15.7	573.68			
3351	Paranasal sinuses			11	401.94			
3353	Facial bones and/or orbits			12.6	460.40			
3355	Mandible			9.4	343.48			
3357	Nasal bone			7.8	285.01			
3359	Mastoid: Bilateral			18	657.72			
3361	Teeth: One quadrant			3.7	135.20			
3363	Teeth: Two quadrants			6.3	230.20			
3365	Teeth: Full mouth			11	401.94			
3366	Teeth: Rotation tomography of the teeth and jaws			13.3	485.98			
3367	Teeth:Temporo-mandibular joints: Per side			11	401.94			
3369	Teeth:Tomography: Per side			11	401.94			
3371	Localisation of foreign body in the eye			15.7	573.68			
3381	Ventriculography			27.3	997.54	4	653.08	+T
3385	Post-nasal studies: Lateral neck			6.3	230.20			
3391	For introduction of contrast medium add			11	401.94			
19.2	Alimentary tract							
3397	Introduction of contrast medium (plus 80% for each additional gland - add)			11	401.94			
3399	Pharynx and oesophagus			12.7	464.06			
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through			20	730.80			
3405	Double contrast: Add			7.3	266.74			
3406	Small bowel meal (control film of abdomen included except when part of item 3408)			20	730.80			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and			28.9	1,056.01			
3409	Barium enema (control film of abdomen included)			18.3	668.68			
3411	Air contrast study (add)			19.3	705.22			
	Note: For items 3415 and 3416: Endoscopy (See item 1778) ●							
3417	Gastric/oesophageal/duodenal intubation control			5.9	215.59			
3419	Gastric/oesophageal intubation insertion of tube			5.6	204.62			
3421	Duodenal intubation: Insertion of tube (add)			11	401.94			
3423	Hypotonic duodenography (3403 and 3405 included) (add)			29.3	1,070.62			
19.4	Chest							
3443	Larynx (Tomography included)			12.5	456.75			
3445	Chest (item 3601 included)			9.4	343.48			
3449	Ribs			12.3	449.44			
3451	Sternum or sternoclavicular joints			12.6	460.40			
3453	Bronchography: Unilateral			12.6	460.40	8	1306.16	+T
3455	Bronchography: Bilateral			22.1	807.53	8	1306.16	+T
3457	Introduction of contrast medium included			35.7	1,304.48			
3461	Pleurography			12.6	460.40	3	489.81	+T
3463	For introduction of contrast medium: Add			2.8	102.31			
3465	Laryngography			11	401.94			
3467	For introduction of contrast medium: Add			10	365.40			
3468	Thoracic Inlet			6.3	230.20			
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	343.48			
3479	Acute abdomen or equivalent studies			15.7	573.68			
19.6	Urinary tract							
3487	Excretory urogram: Control film included and bladder views before and after micturition (Intravenous pyelogram) (item 0206 not applicable)			25.1	917.15			
3493	Waterload test: Add			12.2	445.79			
3497	Cystography only or urethrography only (retrograde)			19.3	705.22			
3499	Cysto-urethrography: Retrograde			31.9	1,165.63			
3503	Cysto-urethrography: Introduction of contrast			3.7	135.20			
3505	Retrograde-prograde pyelography			18.3	668.68			
3513	Tomography of renal tract: Add			9.4	343.48			
19.8	Vascular Studies							
19.8.1	Vascular Studies: Film Series							

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3545	Venography: Per limb			16.5	602.91			
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram			48.6	1,775.84	4	653.08	+T
3558	Translumbar aortic puncture, with full study			69.6	2,543.18	5	816.35	+T
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram			57	2,082.78	4	653.08	+T
3560	Selective second order catheterisation, arterial or venous, with angiogram/venogram			65.4	2,389.72	4	653.08	+T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram			73.2	2,674.73	4	653.08	+T
3564	Direct femoral arterial or venous or jugular venous puncture			37.2	1,359.29			
3569	Intravascular pressure studies, arterial or venous, once off per case			19.8	723.49			
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)			130.8	4,779.43	5	816.35	+T
3574	Spinal angiogram (global fee) including all selective catheterisations			480	17,539.20	5	816.35	+T
19.8.2	Vascular Studies: Introduction of contrast							
3563	Direct intravenous for limb			7.8	285.01			
3575	Cut-downs for venography: ADD			11	401.94			
19.10	Radiology: Miscellaneous							
3600	Peripheral bone densitometry utilizing ionizing radiation (to be charged once only for one or more levels done at the same session). Motivation letter required.			13	475.02			
3601	Fluoroscopy: Per half hour: ADD (not applicable for items 3445)			7.7	281.36			
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: ADD			10.7	390.98			
3603	Sinography			18.4	672.34			
3604	Bone densitometry (to be charged once only for one or more levels done at the same session) Motivation letter required			77	2,813.58			
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except item 3309): Per half hour: Plus fee or examination performed (Only to be used by radiological technical staff)			5.6	204.62			
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series and add fluoroscopy fee if this is done							
3611	Foreign body localisation: Introduction of sterile needle markers: ADD			11	401.94			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
3613	Setting of sterile trays			3.3	120.58			
5034	Fine needle aspiration or biopsy	25	913.50	25	913.50			
		Specialist		Other Specialists and 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 Motivation letter required			19	655.88			
3621	Cardiac Examination (MMode) Tariff code 3621 may be used in conjunction with tariff code 3622 If Doppler is also performed, tariff code 3625 may be added to tariff code 3621 Registered Cardiologist (Pr '21') may use these tariff codes (3621,3622 and 3625) simultaneously when complex ultrasound, e.g Valvular Heart Disease, Complex right sided disease assessment for cardiac re-synchronisation therapy are performed Tariff code 3621 may be used by other medical doctors (e.g Physicians and General Practitioners) as appropriate	25	863.00	25	863.00			
3622	Cardiac Examination; 2 Dimensional Tariff code 3622 may be used in conjunction with tariff code 3621 If Doppler is also performed, tariff code 3625 may be added to tariff code 3622 Registered Cardiologist (Pr '21') may use these tariff codes (3621, 3622 and 3625) simultaneously when complex ultrasound are performed Tariff code 3622 may be used by other medical doctors (e.g Physicians and General Practitioners) as appropriate	50	1,726.00	50	1,726.00			
3624	Cardiac Examination + Contrast; ADD	10	345.20	10	345.20			
3625	Cardiac Examination + Doppler Registered Cardiologist (Pr '21') may use these tariff codes (3621, 3622 and 3625) when assessing complex conditions Tariff code 3625 may be used by other medical doctors (e.g Physicians and general practitioners) as appropriate	50	1,726.00	50	1,726.00			
3596	Intravascular ultrasound per case, arterial or venous, for intervention			30	1,035.60			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
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	2,071.20			
5101	Pleural space ultrasound			50	1,726.00			
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint			50	1,726.00			
5103	Ultrasound soft tissue, any region			50	1,726.00			
3628	Renal tract			50	1,726.00			
3631	Ophthalmic examination			50	1,726.00			
3632	Axial length measurement and calculation of intra-ocular lens power. Per eye. Not to be used with item 3034			50	1,726.00			
3634	Peripheral vascular study, B mode only			39	1,346.28			
3636	Trans-oesophageal echocardiography including passing the device			100	3,452.00			
5110	Carotid ultrasound vascular study; B mode, pulsed and colour doppler; bilateral study, internal, external and common carotid flow and anatomy			120	4,142.40			
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree; carotids, vertebral and subclavian vessels (not to be used together with items 5110, 5112, 5113, 5114)			164.8	5,688.90			
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	4,038.84			
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour doppler; to evaluate deep vein thrombosis			117	4,038.84			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
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	4,915.65			
5115	Intra-operative ultrasound study			50	1,726.00	3	489.81	
3635	Plus (+) Doppler			39	1,346.28			
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	2,692.56			
19.12	Portable unit examinations							
3639	Where X-ray unit is kept and used in the hospital or theatre: Add to Primary procedure.			7	255.78			
3640	Theatre investigations (with fixed installation): Add to primary procedure.			3	109.62			
19.13	Diagnostic procedures requiring the use of radio-isotopes							
3641	Tracer test			22.1	807.53			
3642	Repeat of further tracer tests for same investigation: half of tracer test (item 3641) fee			11.1	405.59			
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee							
3645	Other organ scanning with use of relevant radio isotopes			54.8	2,002.39			
3646	Thyroid scanning Motivation letter required			19.2	701.57			
		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	4,801.36			
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite			106.8	3,902.47	5	816.35	+T
5030	Percutaneous nephrostomy for further procedure or drainage			73.8	2,696.65			
5033	Percutaneous cystostomy in radiology suite			30	1,096.20			
5036	Percutaneous Abdominal / pelvic / other drain insertion, any modality			34.2	1,249.67			

		Specialist Radiologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	T
5039	Intracranial thrombolysis (on-table) per session			139.2	5,086.37			
5041	Balloon occlusion/Wada test Motivation letter required			106.8	3,902.47	9	1469.43	+T
5072	Tunnelled/Subcutaneous arteria/venous line performed in radiology suite			82.2	3,003.59	5	816.35	+T
5074	IVC filter insertion jugular or femoral route			156	5,700.24	9	1469.43	+T
5076	Intravascular foreign body removal, arterial or venous, any route			204.6	7,476.08	9	1469.43	+T
5088	Oesophageal stent insertion in radiology suite			102.6	3,749.00	6	979.62	+T
5090	Trachial stent insertion			102.6	3,749.00	6	979.62	+T
5091	GIT Balloon dilatation under fluoroscopy			66.6	2,433.56	6	979.62	+T
5092	Other GIT stent insertion			102.6	3,749.00	6	979.62	+T
5093	Percutaneous gastrostomy in radiology suite			85.8	3,135.13			
5095	Chest drain insertion in radiology suite			32.4	1,183.90			

RADIATION ONCOLOGY 2026

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
	General rules regarding this section (a) Unless specifically stated in this section, the general descriptors between the professional and technical component apply to both components of the services.						
Rule BB	The fees in this section (Radiation Oncology) do NOT include the cost of radium or isotopes						
	Please note: The calculated amounts in this section are calculated according to the Radiation Oncology unit values						
20.7	Technical aids						
	Modifier						
0095	IM: Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. Please note that item 0201 should not be used for these materials						
5141	Radiation materials (see modifier 0095)						
20.10	Chemotherapy						
	Where patients are not treated in chemotherapy facilities, items 0213, 0214 and 0215 are used instead of items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.						
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities						
	The amounts in this section are calculated according to the Clinical Procedure unit values						

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
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 practitioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment (Applicable for RMA clients)	5	192.20	5	192.20		
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 practitioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment. (Applicable for RMA clients)	9	345.96	9	345.96		
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 practitioners who do not make use of recognised chemotherapy facilities or are not responsible for managing the chemotherapy treatment. (Applicable for RMA clients)	14	538.16	14	538.16		
5782	Isotope therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. Material is not included	77.81	2,991.02	62.25	2,392.81		
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 coded separately)	42.65	1,639.47	42.65	1,639.47		

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
5790	Non Infusional Chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day - for exclusive use by doctors with appropriate oncology training (consultations to be charged separately) - (not applicable to oral hormonal therapy)	42.95	1,651.00	42.95	1,651.00		
5791	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are procured or scripted for oral chemotherapy, intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	24.49	941.40	24.49	941.40		
5792	Non Infusional Chemotherapy Facility Fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5790) - (not applicable to oral hormonal therapy) - only one of the parties are to charge this fee	30.61	1,176.65	30.61	1,176.65		

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
	Non-infusional chemotherapy: Consultations are charged separately.						
	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.						
5793	Infusional Chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day - for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities (consultations to be charged separately)	159.47	6,130.03	127.58	4,904.18		
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	3,460.75	90.03	3,460.75		
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	4,326.04	112.54	4,326.04		

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
	Note: Item 5795 is chargeable in addition to item 5793 by the Oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to item 5793 if own or rented facility is used).						
20.11	Radiation Therapy Planning						
20.11.1	Manual Radiotherapy Planning Procedures						
5801	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	42.56	1,636.01				
5601	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	99.32	3,817.86				
5802	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	56.18	2,159.56				
5602	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	131.10	5,039.48				
5803	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	76.62	2,945.27				
5603	Manual Radiotherapy Planning Procedures: No Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	178.77	6,871.92				
20.11.2	Conventional Radiotherapy Planning Procedures						
5808	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - PROFESSIONAL COMPONENT	170.26	6,544.79				
5608	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Single Volume of Interest - TECHNICAL COMPONENT	397.27	15,271.06				

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
5809	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	238.36	9,162.56				
5609	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest - TECHNICAL COMPONENT	556.18	21,379.56				
5810	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - PROFESSIONAL COMPONENT	297.95	11,453.20				
5610	Conventional Radiotherapy Planning: Simulation, Limited Graphic Planning, Special Technique - TECHNICAL COMPONENT	695.22	26,724.26				
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	9,234.44				
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	37,563.57				
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	15,673.91				
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	52,588.61				

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		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
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	21,308.45				
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	65,735.86				
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	24,713.84				
5623	Intensity Modulated Radiotherapy Planning Procedures: Intensity modulated radiotherapy simulation, inverse planning, radical course - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	1,916.81	73,682.18				
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	8,925.00				
5625	Intensity Modulated Radiotherapy Planning Procedures: Intensity modulated radiotherapy simulation, inverse planning, booster volumes (not for use with other IMRT planning codes) - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	958.40	36,840.90				
5826	Intensity Modulated Radiotherapy Planning Procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques - PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	753.35	28,958.77				

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
5626	Intensity Modulated Radiotherapy Planning Procedures: Intensity modulated radiotherapy simulation, inverse planning, CT scan with magnetic resonance imaging or other similar imaging fusion techniques - TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	2,174.48	83,587.01				
20.11.5	Kilovolt Radiation Treatment						
5834	Kilovoltage Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - PROFESSIONAL COMPONENT	49.08	1,886.64				
5634	Kilovoltage Radiation Treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof - TECHNICAL COMPONENT	114.52	4,402.15				
20.11.6	Short course radiation treatment						
5835	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	105.74	4,064.65				
5635	Short Course Radiation Treatment: Short course treatment, Single Volume of Interest - TECHNICAL COMPONENT	246.73	9,484.30				
5836	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	148.04	5,690.66				
5636	Short Course Radiation Treatment: Short course treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	345.41	13,277.56				
5837	Short Course Radiation Treatment: Short course Treatment, Special Technique - PROFESSIONAL COMPONENT	190.33	7,316.29				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique - TECHNICAL COMPONENT	444.11	17,071.59				

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
20.11.7	Weekly Radiation Treatment Sessions						
20.11.7.1	Weekly Radiation Treatment Sessions - Conventional Techniques						
5839	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - PROFESSIONAL COMPONENT	193.86	7,451.98				
5639	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Single Volume of Interest - TECHNICAL COMPONENT	452.33	17,387.57				
5840	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	246.73	9,484.30				
5640	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest - TECHNICAL COMPONENT	575.69	22,129.52				
5841	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - PROFESSIONAL COMPONENT	317.22	12,193.94				
5641	Weekly Radiation Treatment Sessions - Conventional Techniques: Weekly Treatment, Special Technique - TECHNICAL COMPONENT	740.18	28,452.52				
20.11.7.2	Weekly Radiation Treatment Sessions - Advanced Techniques						
5849	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - PROFESSIONAL COMPONENT	236.24	9,081.07				
5649	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest - TECHNICAL COMPONENT	551.21	21,188.51				
5850	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - PROFESSIONAL COMPONENT	330.73	12,713.26				
5650	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest - TECHNICAL COMPONENT	771.71	29,664.53				

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic	
		U	R	U	R	U	R
20	RADIATION ONCOLOGY (Practice Type 23 and 40)						
5851	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - PROFESSIONAL COMPONENT	425.23	16,345.84				
5651	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique - TECHNICAL COMPONENT	992.19	38,139.78				
5854	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - PROFESSIONAL COMPONENT	348.87	13,410.56				
5654	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Intensity Modulated Radiotherapy - TECHNICAL COMPONENT	814.03	31,291.31				
5855	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - PROFESSIONAL COMPONENT	826.83	31,783.35				
5655	Weekly Radiation Treatment Sessions - Advanced Techniques: Weekly Treatment, Total Body Radiotherapy or Similar - TECHNICAL COMPONENT	1,929.26	74,160.75				
20.11.8	Stereotactic Radiation						
5860	Stereotactic Radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee - PROFESSIONAL COMPONENT	3,719.34	142,971.43				
5660	Stereotactic Radiation: Stereotactic Radiation, Single Fraction, Global Fee - TECHNICAL COMPONENT	8,678.46	333,600.00				
5861	Stereotactic Radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee - PROFESSIONAL COMPONENT	4,277.24	164,417.11				
5661	Stereotactic Radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee - TECHNICAL COMPONENT	9,980.23	383,640.04				

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	
20	RADIATION ONCOLOGY (Practice Type 23 and 40)							
20.12	Brachytherapy							
20.12.1	Isotope/Applicator Therapy							
5870	Isotope/Applicator Therapy: Isotopes - Low Complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included	108.40	4,166.90					
5872	Isotope/Applicator Therapy: Isotopes - Intermediate Complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included	216.80	8,333.79					
5873	Isotope/Applicator Therapy: Isotopes - High Complexity, surface application of seed arrays requiring dosimetric assessment and/or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included	601.16	23,108.59					
20.12.2	Brachytherapy Implants							
5882	Brachytherapy Implants: Implants - Low Complexity, placement of a single guide tube for the administration of brachytherapy requiring < 8 dwell points. The cost of materials are not included	216.80	8,333.79					
5883	Brachytherapy Implants: Implants - Intermediate Complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included	786.80	30,244.59					
5885	Brachytherapy Implants: Implants - High Complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included	1,049.07	40,326.25					

		Specialist Medical or Radiation Oncologist		Other Specialists and General Practitioner		Anaesthetic		
		U	R	U	R	U	R	
20	RADIATION ONCOLOGY (Practice Type 23 and 40)							
20.12.3	Brachytherapy Treatment							
5890	Brachytherapy Treatment: Global fee for manual afterloading - includes storage, handling, calibration, planning (manual or computerized), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included	613.04	23,565.26					
5892	Brachytherapy Treatment: Global fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - PROFESSIONAL COMPONENT	415.96	15,989.50					
5893	Global Fee for remote afterloading - includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included - TECHNICAL COMPONENT	970.56	37,308.33					
20.12.4	Brachytherapy Imaging							
5895	Brachytherapy Imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than items 5883 or 5885	156.77	6,026.27					

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

Select the appropriate injury, modality and indication to be used in conjunction 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: A
The Department of Labour: Compensation Fund

MRI Motivation Form for Employee's Injured on Duty

Claim Number:	<input type="text"/>		
Employee's Name:	<input type="text"/>		
Employees ID No:	<input type="text"/>		
Name of Employer:	<input type="text"/>		
Date of Accident / Injury:	<input type="text"/>		
Type of Injury:	<input type="text"/>		
Brief description of how injury occurred:	<input type="text"/>		
Previous clinic / imaging investigations done, and dates:	<input type="text"/>		
Imaging investigation required:	<input type="text"/>		
Motivation / Clinical indications for the investigation:	<input type="text"/>		
Requesting Doctors Name:	<input type="text"/>		
Practice Number:	<input type="text"/>	Date of Referral	<input type="text"/>

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 these 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.

CLINICAL PATHOLOGY 2026

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
21.	PATHOLOGY (PRACTICE TYPE 52)				
	Notes: 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	163.62	3	109.08
3709	Antiglobulin test (Coombs' or trypsinized red cells)	3.65	132.71	2.45	89.08
3710	Antibody titration	7.2	261.79	4.8	174.53
3711	Armeth count	2.25	81.81	1.5	54.54
3712	Antibody identification	8.45	307.24	5.65	205.43
3713	Bleeding time (does not include the cost of the simplate device)	6.94	252.34	4.63	168.35
3715	Buffy Layer examination	19.9	723.56	13.27	482.50
3716	Mean Cell Volume	2.25	81.81	1.5	54.54
3717	Bone marrow cytological examination only	19.9	723.56	13.27	482.50
3719	Bone marrow: Aspiration	8.4	305.42	5.6	203.62
3720	Bone marrow trephine biopsy	32.6	1,185.34	21.7	789.01
3721	Bone marrow aspiration and trephine biopsy (excluding histological examination)	36.8	1,338.05	24.5	890.82
3722	Capillary fragility: Hess	2.02	73.45	1.35	49.09
3723	Circulating anticoagulants	5.85	212.71	3.9	141.80
3724	Coagulation factor inhibitor assay	57.56	2,092.88	38.37	1,395.13
3726	Activated protein C resistance	26	945.36	17.3	629.03
3727	Coagulation time	3.16	114.90	2.11	76.72
3728	Anti-factor Xa Activity	53.6	1,948.90	35.73	1,299.14
3729	Cold agglutinins	3.6	130.90	2.4	87.26
3730	Protein S: Functional	37.5	1,363.50	25	909.00
3731	Compatibility for blood transfusion	3.6	130.90	2.4	87.26
3734	Protein C (chromogenic)	30.29	1,101.34	20.19	734.11
3739	Erythrocyte count	2.25	81.81	1.5	54.54
3740	Factors V and VII: Qualitative	7.2	261.79	4.8	174.53
3741	Coagulation factor assay: functional	9.45	343.60	6.3	229.07
3742	Coagulation factor assay: Immunological	4.5	163.62	3	109.08
3743	Erythrocyte sedimentation rate	2.5	90.90	1.67	60.72
3744	Fibrin stabilising factor (urea test)	4.5	163.62	3	109.08
3746	Fibrin monomers	2.7	98.17	1.8	65.45
3748	Plasminogen Activator Inhibitor (PAI-I)	65.95	2,397.94	43.97	1,598.75

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
3750	Tissue Plasminogen Activator (tPA)	67.79	2,464.84	45.19	1,643.11
3751	Osmotic fragility (screen)	2.25	81.81	1.5	54.54
3753	Osmotic fragility (before and after incubation)	18	654.48	12	436.32
3754	ABO Reverse Group	5.5	199.98	3.67	133.44
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	10.5	381.78	7	254.52
3756	Full cross match	7.2	261.79	4.8	174.53
3757	Coagulation factors (quantitative)	32.2	1,170.79	21.47	780.65
3758	Factor VIII related antigen	60.46	2,198.33	40.31	1,465.67
3759	Coagulation factor correction study	11.72	426.14	7.81	283.97
3761	Factor XIII related antigen	61.11	2,221.96	40.74	1,481.31
3762	Haemoglobin estimation	1.8	65.45	1.2	43.63
3763	Contact activated product essay	16.2	589.03	10.8	392.69
3764	Grouping: A- B- and O-antigens	3.6	130.90	2.4	87.26
3765	Grouping; Rh antigens	3.6	130.90	2.4	87.26
3766	PIVKA	43.49	1,581.30	28.99	1,054.08
3767	Euglobulin lysis time	25.58	930.09	17.05	619.94
3768	Haemoglobin A2 (column chromatography)	15	545.40	10	363.60
3769	HB Electrophoresis	26.82	975.18	17.88	650.12
3770	Haemoglobin-S (solubility test)	3.6	130.90	2.4	87.26
3773	Ham's acidified serum test	8	290.88	5.33	193.80
3775	Heinz bodies	8	290.88	5.33	193.80
3776	Haemosiderin in urinary sediment	2.25	81.81	1.5	54.54
3781	Heparin tolerance	7.2	261.79	4.8	174.53
3783	Leucocyte differential count	6.2	225.43	4.15	150.89
3785	Leucocytes: total count	1.8	65.45	1.2	43.63
3786	QBC malaria concentration and fluorescent staining	25	909.00	16.7	607.21
3787	LE-cells	8.3	301.79	5.55	201.80
3789	Neutrophil alkaline phosphatase	28	1,018.08	18.7	679.93
3791	Packed cell volume: Haematocrit	1.8	65.45	1.2	43.63
3792	Plasmodium falciparum: Monoclonal immunological identification	9	327.24	6	218.16
3793	Plasma haemoglobin	6.75	245.43	4.5	163.62
3794	Platelet Sensitivities	18.64	677.75	12.43	451.95
3795	Platelet aggregation per aggregant	12.14	441.41	8.09	294.15
3796	Platelet antibodies: agglutination	5.4	196.34	3.6	130.90
3797	Platelet count	2.25	81.81	1.5	54.54
3799	Platelet adhesiveness	4.5	163.62	3	109.08
3801	Prothrombin consumption	5.85	212.71	3.9	141.80
3803	Prothrombin determination (two stages)	5.85	212.71	3.9	141.80
3805	Prothrombin index	6	218.16	4	145.44

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
3806	Therapeutic drug level: Dosage	4.5	163.62	3	109.08
3807	Recalcification time	2.25	81.81	1.5	54.54
3809	Reticulocyte count	3	109.08	2	72.72
3811	Sickling test	2.25	81.81	1.5	54.54
3814	Sucrose lysis test for PNH	3.6	130.90	2.4	87.26
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	21.1	767.20	14.07	511.59
3820	Thrombo-Elastogram	26	945.36	17.33	630.12
3825	Fibrinogen titre	3.6	130.90	2.4	87.26
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	8	290.88	5.33	193.80
3830	Glucose 6-phosphate-dehydrogenase: quantitative	16	581.76	10.7	389.05
3832	Red cell pyruvate kinase: quantitative	16	581.76	10.7	389.05
3834	Red cell Rhesus phenotype	9.9	359.96	6.6	239.98
3835	Haemoglobin F in blood smear	5.85	212.71	3.9	141.80
3837	Partial thromboplastin time	5.85	212.71	3.9	141.80
3841	Thrombin time (screen)	5.85	212.71	3.9	141.80
3843	Thrombin time (serial)	7.65	278.15	5.1	185.44
3847	Haemoglobin H	2.25	81.81	1.5	54.54
3851	Fibrin degeneration products (diffusion plate)	10.35	376.33	6.9	250.88
3853	Fibrin degeneration products (latex slide)	4.5	163.62	3	109.08
3854	XDP (Dimer test or equivalent latex slide test)	8.5	309.06	5.67	206.16
3855	Hemagglutination inhibition	9.9	359.96	6.6	239.98
3856	D-Dimer	27.52	1,000.63	18.35	667.21
3858	Heparin Removal	28.88	1,050.08	19.25	699.93
21.2	Microscopic examinations				
3863	Autogenous vaccine	12.6	458.14	8.4	305.42
3864	Entomological examination	20.7	752.65	13.8	501.77
3865	Parasites in blood smear	5.6	203.62	3.73	135.62
3867	Miscellaneous (body fluids, urine, exudate, fungi, Pus scrapings, etc.)	4.9	178.16	3.3	119.99
3868	Fungus identification	8.3	301.79	5.5	199.98
3869	Faeces (including parasites)	4.9	178.16	3.27	118.90
3872	Automated urine microscopy	8.72	317.06	5.81	211.25
3873	Transmission electron microscopy	85	3,090.60	57	2,072.52
3874	Scanning electron microscopy	100	3,636.00	67	2,436.12
3875	Inclusion bodies	4.5	163.62	3	109.08
3878	Crystal identification polarised light microscopy	4.5	163.62	3	109.08
3879	Compylobacter in stool: fastidious culture	9.9	359.96	6.6	239.98
3880	Antigen detection with polyclonal antibodies	4.5	163.62	3	109.08
3881	Mycobacteria	3	109.08	2	72.72

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
3882	Antigen detection with monoclonal antibodies	10.8	392.69	7.2	261.79
3883	Concentration techniques for parasites	3	109.08	2	72.72
3884	Dark field. Phase- or interference contrast microscopy. Nomarski or Fontana	6.3	229.07	4.2	152.71
3885	Cytochemical stain	5.45	198.16	3.65	132.71
21.3	Bacteriology (culture and biological examination)				
3887	Antibiotic susceptibility test. per organism	8	290.88	5.33	193.80
3889	Clostridium difficile toxin: Monoclonal immunological	12.4	450.86	8.27	300.70
3890	Antibiotic assay of tissues and fluids	13.9	505.40	9.27	337.06
3891	Blood culture: aerobics	5.85	212.71	3.9	141.80
3892	Blood culture: anaerobic	5.85	212.71	3.9	141.80
3893	Bacteriological culture: miscellaneous	6.3	229.07	4.2	152.71
3894	Radiometric blood culture	10.8	392.69	7.2	261.79
3895	Bacteriological culture: fastidious organisms	9.9	359.96	6.6	239.98
3896	In vivo culture: bacteria	16	581.76	10.65	387.23
3897	In vivo culture: virus	16	581.76	10.65	387.23
3898	Bacterial exotoxin production (in vitro assay)	4.5	163.62	3	109.08
3899	Bacterial exotoxin production (in vivo assay)	20.7	752.65	13.8	501.77
3901	Fungal culture	4.5	163.62	3	109.08
3902	Clostridium difficile (cytotoxicity neutralisation)	30	1,090.80	20	727.20
3903	Antibiotic level: biological fluids	11.7	425.41	7.8	283.61
3904	Rotavirus latex slide test	5.62	204.34	3.75	136.35
3905	Identification of virus or rickettsia	20.7	752.65	13.8	501.77
3906	Identification: chlamydia	16	581.76	10.65	387.23
3908	Anaerobic culture: comprehensive	9.9	359.96	6.6	239.98
3909	Anaerobic culture: limited procedure	4.5	163.62	3	109.08
3911	B-Lactamase	4.5	163.62	3	109.08
3915	Mycobacterium culture	4.5	163.62	3	109.08
3916	Radiometric tuberculosis culture	10.8	392.69	7.2	261.79
3917	Mycoplasma culture: limited	2.25	81.81	1.5	54.54
3918	Mycoplasma culture: comprehensive	9.9	359.96	6.6	239.98
3919	Identification of mycobacterium	9.9	359.96	6.6	239.98
3920	Mycobacterium: antibiotic sensitivity	9.9	359.96	6.6	239.98
3921	Antibiotic synergistic study	20.7	752.65	13.8	501.77
3922	Viable cell count	1.35	49.09	0.9	32.72
3923	Staph ID Abr (Yeast ID)	3.15	114.53	2.1	76.36
3924	Biochemical ident of bacterium: extended	12.5	454.50	8.33	302.88
3925	Serological ident of bacterium: abridged	3.15	114.53	2.1	76.36
3926	Serological ident of bacterium: extended	10.2	370.87	6.8	247.25
3927	Grouping of streptococci	7.3	265.43	4.85	176.35

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
3928	Antimicrobial substances	3.8	138.17	2.5	90.90
3929	Radiometric mycobacterium identification	14	509.04	9.3	338.15
3930	Radiometric mycobacterium antibiotic sensitivity	25	909.00	16.7	607.21
3931	Helicobacter: Monoclonal immunological	12.4	450.86	8.27	300.70
4652	Rapid automated bacterial identification per organism	15	545.40	10	363.60
4653	Rapid automated antibiotic susceptibility per organism	17	618.12	11.33	411.96
4654	Rapid automated MIC per organism per antibiotic	17	618.12	11.33	411.96
4655	Mycobacteria: MIC determination - E Test	16.50	599.94	11.00	399.96
4656	Mycobacteria: Identification HPLC	35.00	1,272.60	23.33	848.28
4657	Mycobacteria: Liquified, concentrated, fluorochrome stain	9.90	359.96	6.60	239.98
21.4	Serology				
3932	HIV Elisa Type I and II (Screening tests only)	14.1	512.68	9.4	341.78
3933	IgE: Total; EMIT or ELISA	11.7	425.41	7.8	283.61
3934	Auto antibodies by labelled antibodies	16	581.76	10.65	387.23
3936	Virus neutralisation test: First antibody	75	2,727.00	50	1,818.00
3937	Virus neutralisation test: Each additional antibody	15	545.40	10	363.60
3938	Precipitin test per antigen	4.5	163.62	3	109.08
3939	Agglutination test per antigen	5.5	199.98	3.67	133.44
3940	Haemagglutination test: per antigen	9.9	359.96	6.6	239.98
3941	Modified Coombs' test for brucellosis	4.5	163.62	3	109.08
3942	Hepatitis Rapid Viral Ab	12.24	445.05	8.16	296.70
3943	Antibody titer to bacterial exotoxin	3.6	130.90	2.4	87.26
3944	IgE: Specific antibody titer: ELISA/EMIT: per Ag	12.4	450.86	8.27	300.70
3945	Complement fixation test	5.85	212.71	3.9	141.80
3946	IgM: Specific antibody titer: ELISA or EMIT: per Ag	14.05	510.86	9.37	340.69
3947	C-reactive protein	3.6	130.90	2.4	87.26
3948	IgG: Specific antibody titer: ELISA/EMIT: per Ag	12.95	470.86	8.63	313.79
3949	Qualitative Kahn. VDRL or other flocculation	2.25	81.81	1.5	54.54
3950	Neutrophil phagocytosis	25.2	916.27	16.8	610.85
3951	Quantitative Kahn. VDRL or other flocculation	3.6	130.90	2.4	87.26
3952	Neutrophil chemotaxis	67.95	2,470.66	45.3	1,647.11
3953	Tube agglutination test	4.15	150.89	2.76	100.35
3955	Paul Bunnell: presumptive	2.25	81.81	1.5	54.54
3956	Infectious Mononucleosis latex slide test (Monospot or equivalent)	8.5	309.06	5.67	206.16
3957	Paul Bunnell: Absorption	4.5	163.62	3	109.08
3958	Anti Gad/la2 Ab	67.95	2,470.66	45.3	1,647.11
4600	Anti-CCP	17.46	634.85	11.64	423.23
4601	Panel typing: Antibody detection: Class I	36	1,308.96	24	872.64

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4602	Panel typing: Antibody detection: Class II	44	1,599.84	29.3	1,065.35
4604	HLA typing: Class I - serology	52	1,890.72	34.7	1,261.69
4605	HLA typing: Class II - serology	52	1,890.72	34.7	1,261.69
4606	HLA typing: Class I & II - serology	90	3,272.40	60	2,181.60
4607	Cross matching T-cells (per tray)	18	654.48	12	436.32
4608	Cross matching B-cells	38	1,381.68	25.3	919.91
4609	Cross matching T- & B-cells	48	1,745.28	32	1,163.52
4610	Helicobacter pylori antigen test	34.6	1,258.06	23.07	838.83
4611	Erythropoietin	20	727.20	13.33	484.68
4612	HTLV I/II	20	727.20	13.33	484.68
4613	Anti-Gm1 Antibody Assay	75	2,727.00	50	1,818.00
4614	HIV Ab - Rapid Test	12	436.32	8	290.88
3959	Rose Waaler Agglutination test	4.5	163.62	3	109.08
3960	Gonococcal, listeria or echinococcus agglutination	9.5	345.42	6.3	229.07
3961	Slide agglutination test	2.63	95.63	1.75	63.63
3962	Rebuck skin window	5.4	196.34	3.6	130.90
3963	Serum complement level: each component	3.15	114.53	2.1	76.36
3965	Anti Ia2 Antibodies	36	1,308.96	24	872.64
3967	Auto-antibody: Sensitised erythrocytes	4.5	163.62	3	109.08
3968	Herpes virus typing: Monoclonal immunological	20.69	752.29	13.79	501.40
3969	Western blot technique	74	2,690.64	49	1,781.64
3970	Epstein-Barr virus antibody titer	6.75	245.43	4.5	163.62
3971	Immuno-diffusion test: per antigen	3.15	114.53	2.1	76.36
3972	Respiratory syncytial virus (ELISA technique)	35	1,272.60	23	836.28
3973	Immuno electrophoresis: per immune serum	9.45	343.60	6.3	229.07
3974	Polymerase chain reaction	75	2,727.00	50	1,818.00
3975	Indirect immuno-fluorescence test (Bacterial, viral, parasitic)	12	436.32	8	290.88
3977	Counter immuno-electrophoresis	6.75	245.43	4.5	163.62
3978	Lymphocyte transformation	51.7	1,879.81	34.5	1,254.42
3979	SARS- COV-2	16.93	615.57	16.93	615.57
3980	Bilharzia Ag Serum/Urine	14.5	527.22	9.67	351.60
21.5	Skin tests				
21.6	Biochemical tests: Blood				
3991	Abnormal pigments: qualitative	4.5	163.62	3	109.08
3993	Abnormal pigments: quantitative	9	327.24	6	218.16
3995	Acid phosphatase	5.18	188.34	3.45	125.44
3996	Serum Amyloid A	8.28	301.06	5.52	200.71
3997	Acid phosphatase fractionation	1.8	65.45	1.2	43.63
3998	Amino acids: Quantitative (Post derivatisation HPLC)	78.12	2,840.44	52.08	1,893.63

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
3999	Albumin	4.8	174.53	3.2	116.35
4000	Alcohol	12.4	450.86	8.27	300.70
4001	Alkaline phosphatase	5.18	188.34	3.45	125.44
4002	Alkaline Phosphatase-iso-enzymes	11.7	425.41	7.8	283.61
4003	Ammonia: enzymatic	7.71	280.34	5.14	186.89
4004	Ammonia: monitor	4.5	163.62	3	109.08
4005	Alpha-1-antitrypsin	7.2	261.79	4.8	174.53
4006	Amylase	5.18	188.34	3.45	125.44
4007	Arsenic in blood, hair or nails	36.25	1,318.05	24.17	878.82
4008	Bilirubin – Reflectance	4.77	173.44	3.18	115.62
4009	Bilirubin: total	4.77	173.44	3.18	115.62
4010	Bilirubin: conjugated	3.62	131.62	2.41	87.63
4014	Cadmium: atomic absorp	18.12	658.84	12.08	439.23
4016	Calcium: Ionized	6.75	245.43	4.5	163.62
4017	Calcium: spectrophotometric	3.62	131.62	2.41	87.63
4018	Calcium: atomic absorption	7.25	263.61	4.83	175.62
4019	Carotene	2.25	81.81	1.5	54.54
4023	Chloride	2.59	94.17	1.73	62.90
4026	LDL cholesterol (chemical determination)	6.9	250.88	4.6	167.26
4027	Cholesterol total	5.34	194.16	3.56	129.44
4029	Cholinesterase: serum or erythrocyte: each	7.48	271.97	4.99	181.44
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	9	327.24	6	218.16
4031	Total CO2	5.18	188.34	3.45	125.44
4032	Creatinine	3.62	131.62	2.41	87.63
4033	CSF-Immunoglobulin G	9.45	343.60	6.3	229.07
4035	CSF-Albumin	9.45	343.60	6.3	229.07
4036	CSF-IgG Index	22.05	801.74	14.7	534.49
4040	Homocysteine (random)	15.3	556.31	10.2	370.87
4041	Homocysteine (after Methionine load)	18.1	658.12	12.06	438.50
4042	D-Xylose absorption test: two hours	13.15	478.13	8.75	318.15
4045	Fibrinogen: quantitative	3.6	130.90	2.4	87.26
4047	Hollander test	24.75	899.91	16.5	599.94
4049	Glucose tolerance test (2 specimens)	8.97	326.15	5.98	217.43
4050	Glucose strip-test with photometric reading	1.8	65.45	1.2	43.63
4051	Galactose	11.25	409.05	7.5	272.70
4052	Glucose tolerance test (3 specimens)	13.17	478.86	8.78	319.24
4053	Glucose tolerance test (4 specimens)	17.37	631.57	11.58	421.05
4057	Glucose Quantitative	3.62	131.62	2.41	87.63
4061	Glucose tolerance test (5 specimens)	21.56	783.92	14.37	522.49
4063	Fructosamine	7.2	261.79	4.8	174.53
4064	Glycated haemoglobin: chromatography/HbA1C	14.25	518.13	9.5	345.42

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	46.88	1,704.56	31.25	1,136.25
4067	Lithium: flame ionisation	5.18	188.34	3.45	125.44
4068	Lithium: atomic absorption	7.48	271.97	4.99	181.44
4071	Iron	6.75	245.43	4.5	163.62
4073	Iron-binding capacity	7.65	278.15	5.1	185.44
4076	Carboxy haemoglobin (6x per 24 hrs)	19.1	694.48	12.73	462.86
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	6.75	245.43	4.5	163.62
4079	Ketones in plasma: qualitative	2.25	81.81	1.5	54.54
4081	Drug level-biological fluid: Quantitative	10.8	392.69	7.2	261.79
4086	Plasma Lactate	9.32	338.88	6.59	239.61
4085	Lipase	3.01	109.44	2.14	77.81
4091	Lipoprotein electrophoresis	9	327.24	6	218.16
4093	Osmolality: Serum or urine	6.75	245.43	4.5	163.62
4094	Magnesium: Spectrophotometric	3.62	131.62	2.41	87.63
4095	Magnesium: Atomic absorption	7.25	263.61	4.83	175.62
4096	Mercury: Atomic absorption	18.12	658.84	12.08	439.23
4098	Copper: Atomic absorption	18.12	658.84	12.08	439.23
4105	Protein electrophoresis	9	327.24	6	218.16
4106	IgG sub-class 1.2. 3 or 4: Per sub-class	20	727.20	13.2	479.95
4109	Phosphate	3.62	131.62	2.41	87.63
4111	Phospholipids	3.15	114.53	2.1	76.36
4113	Potassium	3.62	131.62	2.41	87.63
4114	Sodium	3.62	131.62	2.41	87.63
4117	Protein: total	3.11	113.08	2.07	75.27
4121	pH. pCO ₂ or pO ₂ each	6.75	245.43	4.5	163.62
4123	Pyruvic acid	4.5	163.62	3	109.08
4125	Salicylates	4.5	163.62	3	109.08
4126	Secretin-pancreozymin responds	26.1	949.00	17.4	632.66
4127	Caeruloplasmin	4.5	163.62	3	109.08
4128	Phenylalanine: Quantitative	11.25	409.05	7.5	272.70
4129	Glutamate dehydrogenase (GDH)	5.4	196.34	3.6	130.90
4130	Aspartate amino transferase (AST)	5.4	196.34	3.6	130.90
4131	Alanine amino transferase (ALT)	5.4	196.34	3.6	130.90
4132	Cretine kinase (CK)	5.4	196.34	3.6	130.90
4133	Lactate dehydrogenase (LD)	5.4	196.34	3.6	130.90
4134	Gamma glutamyl transferase (GGT)	5.4	196.34	3.6	130.90
4135	Aldolase	5.4	196.34	3.6	130.90
4136	Angiotensin converting enzyme (ACE)	9	327.24	6	218.16
4137	Lactate dehydrogenase isoenzyme	10.8	392.69	7.2	261.79
4138	CK-MB: immunoinhibition/precipitation	10.8	392.69	7.2	261.79

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4139	Adenosine deaminase	5.4	196.34	3.6	130.90
4142	Red cell enzymes: each	7.8	283.61	5.2	189.07
4143	Serum/plasma enzymes: each	5.4	196.34	3.6	130.90
4144	Transferrin	11.7	425.41	7.8	283.61
4146	Lead: atomic absorption	15	545.40	10	363.60
4149	Red cell magnesium	11.7	425.41	7.8	283.61
4151	Urea	3.62	131.62	2.41	87.63
4152	CK-MB	12.4	450.86	8.27	300.70
4153	CK-MB: Mass determination: Quantitative (Not automated)	17.47	635.21	11.65	423.59
4154	Myoglobin quantitative: Monoclonal immunological	12.4	450.86	8.27	300.70
4155	Uric acid	3.78	137.44	2.52	91.63
4156	Vitamin D3	12.42	451.59	8.28	301.06
4157	Vitamin A-saturation test	15.3	556.31	10.2	370.87
4158	Vitamin E (tocopherol)	3.6	130.90	2.4	87.26
4159	Vitamin A	6.3	229.07	4.2	152.71
4160	Vitamin C (ascorbic acid)	2.25	81.81	1.5	54.54
4161	Trop T	20	727.20	13.33	484.68
4171	Sodium + potassium + chloride + CO ₂ + urea	15.84	575.94	10.56	383.96
4172	ELIZA or EMIT technique	12.42	451.59	8.28	301.06
4181	Quantitative protein estimation: Mancini method	7.76	282.15	5.17	187.98
4182	Quantitative protein estimation: nephelometer	8.28	301.06	5.52	200.71
4183	Quantitative protein estimation: labelled antibody	12.42	451.59	8.28	301.06
4184	C-reactive protein (Ultra sensitive)	11.68	424.68	7.79	283.24
4185	Lactose	10.8	392.69	7.2	261.79
4186	Vitamin B6	15.3	556.31	10.2	370.87
4187	Zinc: atomic absorption	18.12	658.84	12.08	439.23
21.7	Biochemical tests: Urine				
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	1.5	54.54	1	36.36
4189	Abnormal pigments	4.5	163.62	3	109.08
4193	Alkapton test: homogentisic acid	4.5	163.62	3	109.08
4194	Amino acids: quantitative (Post derivatisation HPLC)	78.12	2,840.44	52.08	1,893.63
4195	Amino laevulinic acid	18	654.48	12	436.32
4197	Amylase	5.18	188.34	3.45	125.44
4198	Arsenic	18.12	658.84	12.08	439.23
4199	Ascorbic acid	2.25	81.81	1.5	54.54
4201	Bence-Jones protein	2.7	98.17	1.8	65.45
4203	Phenol	3.6	130.90	2.4	87.26
4204	Calcium: atomic absorption	7.25	263.61	4.83	175.62

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4205	Calcium: spectrophotometric	3.62	131.62	2.41	87.63
4206	Calcium: absorption and excretion studies	25	909.00	16.7	607.21
4209	Lead: atomic absorption	15	545.40	10	363.60
4211	Bile pigments: qualitative	2.25	81.81	1.5	54.54
4213	Protein: quantitative	2.25	81.81	1.5	54.54
4216	Mucopolysaccharides: qualitative	3.6	130.90	2.4	87.26
4217	Oxalate/Citrate: enzymatic each	9.38	341.06	6.25	227.25
4218	Glucose: quantitative	2.25	81.81	1.5	54.54
4219	Steroids: chromatography (each)	7.2	261.79	4.8	174.53
4221	Creatinine	3.62	131.62	2.41	87.63
4223	Creatinine clearance	7.65	278.15	5.1	185.44
4227	Electrophoreses: qualitative	4.5	163.62	3	109.08
4229	Uric acid clearance	7.65	278.15	5.1	185.44
4230	Urine/Fluid - Specific Gravity	0.9	32.72	0.6	21.82
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	37.50	1,363.50	25.00	909.00
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	46.80	1,701.65	31.20	1,134.43
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	37.50	1,363.50	25.00	909.00
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	46.80	1,701.65	31.20	1,134.43
4237	5-Hydroxy-indole-acetic acid: screen test	2.7	98.17	1.8	65.45
4238	5HIAA (Hplc)	78.12	2,840.44	52.08	1,893.63
4239	5-Hydroxy-indole-acetic acid: quantitative	6.75	245.43	4.5	163.62
4247	Ketones: excluding dip-stick method	2.25	81.81	1.5	54.54
4248	Reducing substances	1.8	65.45	1.2	43.63
4251	Metanephrines: column chromatography	22.05	801.74	14.7	534.49
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	27	981.72	18	654.48
4254	Nitrosonaphtol test for tyrosine	2.25	81.81	1.5	54.54
4262	Micro Albumin-Qualitative	4.5	163.62	3	109.08
4263	pH: Excluding dip-stick method	0.9	32.72	0.6	21.82
4265	Thin layer chromatography: one way	6.75	245.43	4.5	163.62
4266	Thin layer chromatography: two way	11.25	409.05	7.5	272.70
4267	Total organic matter screen: Infrared	31.25	1,136.25	20.83	757.38
4268	Organic acids: quantitative: GCMS	109.4	3,977.06	72.92	2,651.37
4269	Phenylpyruvic acid: ferric chloride	2.25	81.81	1.5	54.54
4271	Phosphate excretion index	22.05	801.74	14.7	534.49
4272	Porphobilinogen qualitative screen: urine	5	181.80	3.33	121.08
4273	Porphobilinogen/ALA: quantitative each	15	545.40	10	363.60
4283	Magnesium: spectrophotometric	3.62	131.62	2.41	87.63
4284	Magnesium: atomic absorption	7.25	263.61	4.83	175.62

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4285	Identification of carbohydrate	7.65	278.15	5.1	185.44
4287	Identification of drug: qualitative	4.5	163.62	3	109.08
4288	Identification of drug: quantitative	10.8	392.69	7.2	261.79
4293	Urea clearance	5.4	196.34	3.6	130.90
4297	Copper: spectrophotometric	3.62	131.62	2.41	87.63
4298	Copper: Atomic absorption	18.12	658.84	12.08	439.23
4300	Indican or Indole: Qualitative	3.15	114.53	2.1	76.36
4301	Chloride	2.59	94.17	1.73	62.90
4307	Ammonium chloride loading test	22.05	801.74	14.7	534.49
4309	Urobilinogen: quantitative	6.75	245.43	4.5	163.62
4313	Phosphates	3.62	131.62	2.41	87.63
4315	Potassium	3.62	131.62	2.41	87.63
4316	Sodium	3.62	131.62	2.41	87.63
4319	Urea	3.62	131.62	2.41	87.63
4321	Uric acid	3.62	131.62	2.41	87.63
4322	Fluoride	5.18	188.34	3.45	125.44
4323	Total protein and protein electrophoreses	11.25	409.05	7.5	272.70
4325	VMA: quantitative	11.25	409.05	7.5	272.70
4327	Immunofixation: Total Protein, IgG, IgA, IgM, Kappa, Lambda	46.88	1,704.56	31.25	1,136.25
4335	Cystine: quantitative	12.6	458.14	8.4	305.42
4336	Dinitrophenal hydrazine test: ketoacids	2.25	81.81	1.5	54.54
4337	Hydroxyproline: quantitative	18.9	687.20	12.6	458.14
4339	Chloride	2.59	94.17	1.73	62.90
21.8	Biochemical tests: Faeces				
4343	Fat: qualitative	3.15	114.53	2.1	76.36
4345	Fat: quantitative	22.05	801.74	14.7	534.49
4347	pH	0.9	32.72	0.6	21.82
4351	Occult blood: chemical test	2.25	81.81	1.5	54.54
4352	Occult blood (monoclonal antibodies)	10	363.60	6.67	242.52
4357	Potassium	3.62	131.62	2.41	87.63
4358	Sodium	3.62	131.62	2.41	87.63
4361	Stercobilin	2.25	81.81	1.5	54.54
4363	Stercobilinogen: quantitative	6.75	245.43	4.5	163.62
21.9	Biochemical tests: Miscellaneous				
4370	Vancomycin, Phenytoin, Theophylline	12.4	450.86	8.27	300.70
4371	Amylase in exudate	5.18	188.34	3.45	125.44
4374	Trace metals in biological fluid: Atomic absorption	18.13	659.21	12.08	439.23
4375	Calcium in fluid: Spectrophotometric	3.62	131.62	2.41	87.63
4376	Calcium in fluid: Atomic absorption	7.25	263.61	4.83	175.62

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4388	Gastric contents: Maximal stimulation	27	981.72	18	654.48
4389	Gastric fluid: Total acid per specimen	2.25	81.81	1.5	54.54
4391	Renal calculus: Chemistry	5.40	196.34	3.60	130.90
4392	Renal calculus: Crystallography	16.25	590.85	10.80	392.69
4393	Saliva: Potassium	3.62	131.62	2.41	87.63
4394	Saliva: Sodium	3.62	131.62	2.41	87.63
4395	Sweat: Sodium	3.62	131.62	2.41	87.63
4396	Sweat: Potassium	3.62	131.62	2.41	87.63
4397	Sweat: Chloride	2.59	94.17	1.73	62.90
4399	Sweat collection by iontophoresis (excluding collection material)	4.5	163.62	3	109.08
4400	Tryptophane loading test	22.05	801.74	14.7	534.49
21.10	Cerebrospinal fluid				
4401	Cell count	3.45	125.44	2.3	83.63
4407	Cell count. Protein, glucose and chloride	7.65	278.15	5.1	185.44
4416	Sodium	3.62	131.62	2.41	87.63
4417	Protein: Qualitative	0.9	32.72	0.6	21.82
4421	Glucose	3.62	131.62	2.41	87.63
4423	Urea	3.62	131.62	2.41	87.63
4424	HLA test for specific allele DNA-PCR	36	1,308.96	24	872.64
4425	Protein electrophoresis	12.60	458.14	8.40	305.42
4426	HLA typing low resolution Class I DNA-PCR per locus	100	3,636.00	67	2,436.12
4427	HLA typing low resolution Class II DNA-PCR per locus	74	2,690.64	44	1,599.84
4428	HLA typing high resolution Class I or II DNA-PCR per locus	66	2,399.76	56.2	2,043.43
4429	Quantitative PCR (DNA/RNA)	84.3	3,065.15	16.67	606.12
4430	Recombinant DNA technique	25	909.00	23.33	848.28
4431	Ribosomal RNA targeting for bacteriological identification	35	1,272.60	50	1,818.00
4432	Ribosomal RNA amplification for bacteriological identification	75	2,727.00	16.67	606.12
4433	Bacteriological DNA identification (LCR)	25	909.00	50	1,818.00
4434	Bacteriological DNA identification (PCR)	75	2,727.00	50	1,818.00
4439	Quantitative PCR - viral load (not HIV) - hepatitis C, hepatitis B, CMV, etc.	150	5,454.00	100	3,636.00

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
21.12	Isotopes				
4450	HCG: Monoclonal immunological: Qualitative	10	363.60	6.67	242.52
4451	HCG: Monoclonal immunological: Quantitative	12.4	450.86	8.27	300.70
4452	Bone-Specific Alk. Phosphatase	20	727.20	13.33	484.68
4458	Micro-albuminuria: radio-isotope method	12.42	451.59	8.3	301.79
4459	Acetyl choline receptor antibody	158.1	5,749.24	105.4	3,832.71
4460	CA-199 tumour marker	20	727.20	13.33	484.68
4462	CA-125 tumour marker	20	727.20	13.33	484.68
4463	C6 complement functional essay	45	1,636.20	30	1,090.80
4466	Beta-2-microglobulin	12.42	451.59	8.28	301.06
4468	CA-549	20	727.20	13.3	483.59
4469	S-S100	20	727.20	13.33	484.68
4470	CA-195 tumour marker	20	727.20	13.33	484.68
4471	Carcino-embryonic antigen	20	727.20	13.33	484.68
4472	MCA antigen tumour marker	20	727.20	13.33	484.68
4473	TSH Receptor Ab	17.48	635.57	11.65	423.59
4475	CA-724	20	727.20	13.33	484.68
4478	Osteocalcin	31.4	1,141.70	20.93	761.01
4479	Vitamin B12-absorption: Shilling test	11.7	425.41	7.8	283.61
4480	Serotonin	18.75	681.75	12.5	454.50
4482	Free thyroxine (FT4)	17.48	635.57	11.65	423.59
4484	Thyroid profile (only with special motivation)	37.8	1,374.41	24.72	898.82
4485	Insulin	12.42	451.59	8.28	301.06
4486	C-Peptide	12.42	451.59	8.28	301.06
4487	Calcitonin	18.9	687.20	12.6	458.14
4488	NT Pro BNP	47.04	1,710.37	33.35	1,212.61
4490	Releasing hormone response	50	1,818.00	33.35	1,212.61
4491	Vitamin B12	12.42	451.59	8.28	301.06
4492	Vitamin D3: Calcitriol (RIA)	75	2,727.00	50	1,818.00
4493	Drug concentration: quantitative	12.42	451.59	8.28	301.06
4494	Free hormone assay	17.48	635.57	11.65	423.59
4496	Hormone concentration: Quantitative	12.42	451.59	8.28	301.06
4497	Carbohydrate deficient transferrin	29.06	1,056.62	19.37	704.29
4499	Cortisol	12.42	451.59	8.28	301.06
4500	DHEA sulphate	12.42	451.59	8.28	301.06
4507	Thyrotropin (TSH)	19.6	712.66	13.07	475.23
4509	Free tri-iodothyronine (FT3)	17.48	635.57	11.65	423.59
4511	Renin activity	18.9	687.20	12.6	458.14
4512	Parathormone	17.08	621.03	11.39	414.14
4515	Aldosterone	12.42	451.59	8.28	301.06
4516	Folliotropin (FSH)	12.42	451.59	8.28	301.06

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
4517	Lutropin (LH)	12.42	451.59	8.28	301.06
4522	Alpha-Feto protein	12.42	451.59	8.28	301.06
4523	ACTH	21.74	790.47	14.49	526.86
4524	Free PSA	14.49	526.86	9.66	351.24
4527	Gastrin	12.42	451.59	8.28	301.06
4528	Ferritin	12.42	451.59	8.28	301.06
4530	Antiplatelet antibodies	15.3	556.31	10.2	370.87
4531	Hepatitis: per antigen or antibody	14.49	526.86	9.66	351.24
4532	Transcobalamine	12.42	451.59	8.28	301.06
4533	Folic acid	12.42	451.59	8.28	301.06
4536	Erythrocyte folate	17.48	635.57	11.65	423.59
4538	Procalcitonin: Qualitative	32	1,163.52	21.33	775.56
4539	Procalcitonin: Quantitative	46	1,672.56	30.67	1,115.16
21.13	After hour service and travelling fees (applicable to pathologists only)				
	Miscellaneous				
4544	Attendance in theatre	27	981.72		-
4549	Minimum fee for after hour service	6.3	229.07		-

ANATOMICAL PATHOLOGY 2026

		Pathologist		Other Specialists and General Practitioners	
		U	R	U	R
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	480.93	8.9	319.42
4563	Sputum and all body fluids: Each additional unit	7.8	279.94	5.2	186.63
4564	Performance of fine-needle aspiration for cytology	15	538.35		
22.2	Histology				
4567	Histology per sample/specimen each	20	717.80	13.3	477.34
4571	Histology per additional block each	11.6	416.32	7.7	276.35
4575	Histology and frozen section in laboratory	22.7	814.70	15.1	541.94
4577	Histology and frozen section in theatre	90	3,230.10	60	2,153.40
4578	Second and subsequent frozen sections, each	20	717.80	13.4	480.93
4579	Attendance in theatre - no frozen section performed	26.3	943.91	17.5	628.08
4582	Serial step sections (including 4567)	23.3	836.24	15.6	559.88
4584	Serial step sections per additional block each	13.5	484.52	9	323.01
4587	Histology consultation	10.1	362.49	6.7	240.46
4589	Special stains	6.7	240.46	4.5	161.51
4591	Immuno-fluorescence/studies	20.7	742.92	13.8	495.28
4593	Electron microscopy	94	3,373.66	63	2,261.07
4650	Antibiotic MIC per organism per antibiotic	8	287.12	5.33	191.29
4651	Non-radiometric automated blood cultures	13.90	505.40	9.27	337.06

RADIOLOGY 5 DIGITS RULES 2026

RADIOLOGY 5 DIGITS CODE RULES
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
<p>a. The tariff code consists of 5 digits</p> <p>i. 1st digit indicates the main anatomical region or procedural category.</p> <ul style="list-style-type: none"> •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 <p>ii. 2nd digit indicates the sub region within a main region or category eg.</p> <ul style="list-style-type: none"> •"Head / Skull and Brain" = 10xxx <p>iii. 3rd digit indicates modality</p> <ul style="list-style-type: none"> •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) <p>eg:</p> <ul style="list-style-type: none"> •"Head / Skull and Brain / General x-ray" = 101xx <p>iv. 4th and 5th digits are specific to a procedure / examination, eg</p> <ul style="list-style-type: none"> •"Head / Skull and Brain / General / X-ray of the skull" = 10100.
Guidelines for use of coding structure
<ul style="list-style-type: none"> •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%.

<p>Consumables</p> <ul style="list-style-type: none"> • Contrast Medium <ul style="list-style-type: none"> o Prior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up. o After 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 tariff codes must be provided for consumables. 								
<p>General Comments on Procedural Codes</p> <ul style="list-style-type: none"> • 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. 								
<p>Guidance Studies</p> <p>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</p>								
<p>Billing Practice for Pan Scan CT</p> <ul style="list-style-type: none"> • Pan Scan (standard trauma protocol): 10300 + 40360 • Pan Scan with clinical suspicion of neck injury: 10300 + 51320 + 40350 <p>Tariff Code -- Description</p> <table border="0"> <tr> <td>10300</td> <td>– CT Brain uncontrasted</td> </tr> <tr> <td>40360</td> <td>– CT of the base of skull to symphysis pubis with contrast</td> </tr> <tr> <td>51320</td> <td>– CT of the cervical spine – complete study</td> </tr> <tr> <td>40350</td> <td>– CT of the chest, abdomen and pelvis with contrast</td> </tr> </table>	10300	– CT Brain uncontrasted	40360	– CT of the base of skull to symphysis pubis with contrast	51320	– CT of the cervical spine – complete study	40350	– CT of the chest, abdomen and pelvis with contrast
10300	– CT Brain uncontrasted							
40360	– CT of the base of skull to symphysis pubis with contrast							
51320	– CT of the cervical spine – complete study							
40350	– CT of the chest, abdomen and pelvis with contrast							
<p>ANNEXURE A</p> <p>Radiology tariff Contrast price effective 1 January 2004 PER VIAL For use in conjunction with tariff codes:</p> <p>00190 X-ray examination contrast material 00290 Ultrasound examination contrast material 00390 CT examination contrast material 00490 MR examination contrast material 00590 Angiography and interventional examination contrast material</p>								
<p>ANNEXURE B</p> <p>Radiology tariff Contrast price effective 1 Jan 2004 PER VIAL</p> <p>Contrast Index Price Range - 2004 contrast prices</p>								
<p>ANNEXURE C</p> <p>Recommended Isotope and Kit Prices for Nuclear Medicine for 2004 by the Association of Nuclear Medicine Physicians For use in conjunction with tariff codes:</p> <p>00990 Nuclear Medicine Isotope 00991 Nuclear Medicine Substrate</p>								

ANNEXURE D. PET GUIDELINES	
INDICATIONS	
For the purposes of this guideline, only established indications for PET-CT are included and this relates to the more common types of malignancies as seen in practice. While some of the less common forms of cancer may also yield advantages with PET-CT imaging, there is as yet insufficient published data to support the general use and these have been excluded in the list below. This situation may change as new research and information becomes available.	
<p>1. Non-small cell lung carcinoma (NSCC)</p> <p>a) Primary diagnosis of lesions</p> <p>i. >10mm diameter lesions where conventional imaging and biopsy have been inconclusive.</p> <p>b) Staging especially where curative surgery is planned</p> <p>i. Evaluation of primary tumour (T-stage).</p> <p>ii. Suspected nodal disease or characterization of nodal disease</p> <p>iii. Suspected distal metastases of determining extent of metastases.</p> <p>iv. Solitary distal metastasis where metastatectomy is considered. PET-CT is used to exclude additional lesions which would preclude surgery.</p> <p>c) Investigation of suspected recurrence (restaging)</p> <p>i. Local or regional recurrence</p> <p>ii. Nodal or distal recurrence</p> <p>iii. Determine the extent of proven recurrent disease</p> <p>iv. Differentiate fibrotic mass from active disease</p> <p>d) All patients with proven carcinoma of the lung, who are considered for curative resection, should be imaged with PET-CT prior to surgery.</p> <p>e) Current available literature confirms that PET-CT is more accurate than CT or PET alone for staging and restaging of NSCC.</p>	
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 is 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 tariff code to be provided. See separate tariff codes for contrast and isotopes

**RADIOLOGY
5 DIGITS CODES
2026**

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
00115	X-ray skeletal survey over five years		-	10.40	2,478.53
00120	X-ray sinogram any region		-	10.89	2,595.30
00130	X-ray with mobile unit in other facility		-	1.90	452.81
	To be added to applicable procedure codes eg 30100.		-		
00135	X-ray control view in theatre any region		-	5.26	1,253.56
00140	X-ray fluoroscopy any region	-	-	2.26	538.60
	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	1,263.10
	Add to the procedure eg. 80600, 80605, 80610.	-	-		
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour	-	-	2.42	576.73
	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	548.14
00160	X-ray fixed theatre installation (equipment fee only)	-	-	2.26	538.60
	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	438.51
	Add to the relevant ultrasound examination codes eg 10200.	-	-		
00220	Ultrasound intra-operative study	-	-	7.32	1,744.50
	Covers all regions studied. Single code per operative procedure.	-	-		
00230	Ultrasound guidance	-	-	12.10	2,883.67
	Comprehensive ultrasound code including regional study and guidance. Guided procedure code to be added eg. 80600, 80605, 80610.	-	-		
00240	Ultrasound guidance for tissue ablation	-	-	11.24	2,678.72
	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	1,549.08
	Stand alone code may not be added to any other code.	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
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	5,092.90
00320	CT guidance (separate procedure)	-	-	16.92	4,032.37
	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	2,016.19
	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	5,040.47
	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	6,887.45
	May be added to the regional study, once only.	-	-		
00430	MR guidance for needle replacement	-	-	42.56	10,142.90
	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	2,859.84
00450	MR planning study for radiotherapy or surgical procedure	-	-	38.00	9,056.16
00455	MR planning study for radiotherapy or surgical procedure, with contrast	-	-	47.00	11,201.04
00490	MR examination contrast material	-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	-	-		
00510	Analogue monoplaner screening table	-	-	41.01	9,773.50
	A machine code may be added once per complete procedure / patient visit.	-	-		
00520	Analogue monoplaner table with DSA attachment	-	-	47.50	11,320.20
	A machine code may be added once per complete procedure / patient visit.	-	-		
00530	Dedicated angiography suite: Analogue monoplaner unit. Once off charge per patient by owner of equipment.	-	-	47.50	11,320.20
	A machine code may be added once per complete procedure / patient visit.	-	-		
00540	Digital monoplaner screening table	-	-	79.92	19,046.53

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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	22,170.91
	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	29,790.00
	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	8,322.13		
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT	48.33	11,518.01		
00906	Nuclear Medicine study - Venous thrombosis regional	21.54	5,133.41		
00909	Nuclear Medicine study - Tumour whole body Clinical motivation needed	34.15	8,138.63	-	-
00912	Nuclear Medicine study - Tumour whole body multiple studies Clinical motivation needed	47.56	11,334.50	-	-
00915	Nuclear Medicine study - Tumour whole body and SPECT	47.56	11,334.50	-	-
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT	60.98	14,532.75	-	-
00921	Nuclear Medicine study – Infection whole body	31.45	7,495.16	-	-
00924	Nuclear Medicine study – infection whole body with SPECT	44.86	10,691.04	-	-
00927	Nuclear Medicine study – infection whole body multiple studies	44.86	10,691.04	-	-
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies	58.27	13,886.91	-	-
00933	Nuclear Medicine study - Bone marrow imaging limited area Clinical motivation needed	24.10	5,743.51	-	-
00936	Nuclear Medicine study - Bone marrow imaging whole body Clinical motivation needed	37.51	8,939.38	-	-
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies Clinical motivation needed	37.51	8,939.38	-	-
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies Clinical motivation needed	50.92	12,135.25	-	-

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic	24.10	5,743.51	-	-
00960	Nuclear Medicine therapy – Hyperthyroidism	11.99	2,857.46	-	-
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases	6.47	1,541.93	-	-
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy	6.47	1,541.93	-	-
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy	6.47	1,541.93	-	-
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate	6.47	1,541.93	-	-
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy	6.47	1,541.93	-	-
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 Clinical motivation needed	-	-	165.13	39,353.78
00957	PET/CT scan whole body with contrast Clinical motivation needed	-	-	163.19	38,891.44
00951	PET/CT local	-	-	120.00	28,598.40
00952	PET/CT local with contrast	-	-	124.68	29,713.74
	Call and assistance	-	-	-	-
	<ul style="list-style-type: none"> •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	714.96

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
01020	Emergency call out fee, subsequent cases same trip	-	-	2.00	476.64
01030	Radiologist assistance in theatre, per half hour	-	-	6.00	1,429.92
01040	Radiographer attendance in theatre, per half hour	-	-	1.60	381.31
01050	Written report on study done elsewhere, short	-	-	1.50	357.48
01055	Written report on study done elsewhere, extensive	-	-	4.20	1,000.94
01060	Written report for medico legal purposes, per hour	-	-	9.72	2,316.47
01070	Consultation for pre-assessment of interventional procedure	-	-	4.86	1,158.24
01100	X-ray procedure after hours, per procedure	-	-	2.00	476.64
01200	Ultrasound procedure after hours, per procedure	-	-	4.00	953.28
01300	CT procedure after hours, per procedure	-	-	10.00	2,383.20
01400	MR procedure after hours, per procedure	-	-	14.00	3,336.48
01500	Angiography procedure after hours, per procedure	-	-	20.00	4,766.40
01600	Interventional procedure after hours, per procedure	-	-	26.00	6,196.32
01970	Consultation for nuclear medicine study	2.20	524.30		
	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	476.64
	Head	-	-		
	Skull and Brain	-	-		
	Codes 10100 (skull) and 10110 (tomography) may be combined.	-	-		
10100	X-ray of the skull	-	-	3.86	919.92
10110	X-ray tomography of the skull	-	-	4.30	1,024.78
10120	X-ray shuntogram for VP shunt	-	-	15.36	3,660.60
10210	Ultrasound of the brain including doppler	-	-	13.22	3,150.59
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	-	-	15.04	3,584.33
10300	CT Brain uncontrasted	-	-	22.65	5,397.95
10310	CT Brain with contrast only	-	-	33.28	7,931.29
10320	CT Brain pre and post contrast	-	-	40.48	9,647.19
10325	CT brain pre and post contrast for perfusion studies	-	-	49.10	11,701.51
	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	18,488.87

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
10335	CT of the brain pre and post contrast with angiography	-	-	97.91	23,333.91
10340	CT brain for cranio-stenosis including 3D	-	-	34.16	8,141.01
10350	CT Brain stereotactic localisation	-	-	19.36	4,613.88
10360	CT base of skull coronal high resolution study for CSF leak	-	-	34.90	8,317.37
10400	MR of the brain, limited study	-	-	43.56	10,381.22
10410	MR of the brain uncontrasted	-	-	63.80	15,204.82
10420	MR of the brain with contrast	-	-	75.94	18,098.02
10430	MR of the brain pre and post contrast	-	-	104.04	24,794.81
10440	MR of the brain pre and post contrast, for perfusion studies	-	-	107.44	25,605.10
10450	MR of the brain plus angiography	-	-	92.20	21,973.10
10460	MR of the brain pre and post contrast plus angiography	-	-	121.23	28,891.53
10470	MR angiography of the brain uncontrasted	-	-	58.50	13,941.72
10480	MR angiography of the brain contrasted	-	-	74.02	17,640.45
10485	MR of the brain, with diffusion studies	-	-	79.00	18,827.28
10490	MR of the brain, pre and post contrast, with diffusion studies,	-	-	110.64	26,367.72
10492	MR study of the brain plus angiography plus diffusion, uncontrasted	-	-	95.00	22,640.40
10495	MR of the brain pre and post contrast plus angiography and diffusion	-	-	125.44	29,894.86
10500	Arteriography of intracranial vessels: 1 - 2 vessels	-	-	48.60	11,582.35
10510	Arteriography of intracranial vessels: 3 - 4 vessels	-	-	82.33	19,620.89
10520	Arteriography of extra-cranial (non-cervical) vessels	-	-	48.44	11,544.22
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels	-	-	118.09	28,143.21
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography	-	-	97.57	23,252.88
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography	-	-	37.29	8,886.95
10560	Venography of dural sinuses	-	-	52.23	12,447.45
10900	Nuclear Medicine study – Bone regional, static	21.50	5,123.88		
10905	Nuclear Medicine study – Bone regional, static, with flow	27.53	6,560.95		
10910	Nuclear Medicine study – Bone regional, static with SPECT	34.92	8,322.13		
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT	40.94	9,756.82		
10920	Nuclear Medicine study – Brain, planar, complete, static	16.92	4,032.37		
10925	Nuclear Medicine study – Brain complete static with vascular flow	22.95	5,469.44		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT	30.33	7,228.25		
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT	36.36	8,665.32		
10940	Nuclear Medicine study - CSF flow imaging cisternography	21.60	5,147.71		
10945	Nuclear Medicine study – Ventriculography	13.41	3,195.87		
10950	Nuclear Medicine study - Shunt evaluation static, planar	13.41	3,195.87		
10955	Nuclear Medicine study - CFS leakage detection and localisation	13.41	3,195.87		
10960	Nuclear medicine study - CSF SPECT	13.41	3,195.87		
10971	PET/CT scan of the brain uncontrasted	-	-	110.12	26,243.80
10972	PET/CT of the brain contrasted	-	-	116.11	27,671.34
10981	PET/CT perfusion scan of the brain	-	-	131.07	31,236.60
	Facial bones and nasal bones	-	-		
	Codes 11100 (facial bones) and 11110 (tomography) may be combined	-	-		
11100	X-ray of the facial bones	-	-	3.93	936.60
11110	X-ray tomography of the facial bones	-	-	4.30	1,024.78
11120	X-ray of the nasal bones	-	-	2.39	569.58
11300	CT of the facial bones	-	-	20.96	4,995.19
11310	CT of the facial bones with 3D reconstructions	-	-	30.40	7,244.93
11320	CT of the facial bones/soft tissue, pre and post contrast	-	-	41.26	9,833.08
11400	MR of the facial soft tissue	-	-	62.40	14,871.17
11410	MR of the facial soft tissue pre and post contrast	-	-	100.60	23,974.99
11420	MR of the facial soft tissue plus angiography, with contrast	-	-	110.30	26,286.70
11430	MR angiography of the facial soft tissue	-	-	74.02	17,640.45
	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	848.42
12110	X-ray of the orbits, three or more views, including foramina	-	-	5.30	1,263.10
12120	X-ray of the orbits for foreign body	-	-	3.56	848.42
12130	X-ray tomography of the orbits	-	-	4.30	1,024.78
12140	X-ray dacrocystography	-	-	11.20	2,669.18
12200	Ultrasound of the orbit/eye	-	-	5.13	1,222.58
12210	Ultrasound of the orbit/eye including doppler	-	-	10.97	2,614.37
12300	CT of the orbits single plane	-	-	15.70	3,741.62

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
12310	CT of the orbits, more than one plane	-	-	20.59	4,907.01
12320	CT of the orbits pre and post contrast single plane	-	-	36.03	8,586.67
12330	CT of the orbits pre and post contrast multiple planes	-	-	39.70	9,461.30
12400	MR of the orbits	-	-	62.46	14,885.47
12410	MR of the orbitae, pre and post contrast	-	-	100.64	23,984.52
12900	Nuclear Medicine study – Dacrocystography	20.77	4,949.91	-	-
	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	653.00
13110	X-ray of the paranasal sinuses, two or more views	-	-	3.66	872.25
13120	X-ray tomography of the paranasal sinuses	-	-	4.30	1,024.78
13130	X-ray of the naso-pharyngeal soft tissue	-	-	2.74	653.00
13300	CT of the paranasal sinuses single plane, limited study	-	-	7.20	1,715.90
13310	CT of the paranasal sinuses, two planes, limited study	-	-	12.40	2,955.17
13320	CT of the paranasal sinuses, any plane, complete study	-	-	15.42	3,674.89
13330	CT of the paranasal sinuses, more than one plane, complete study	-	-	20.77	4,949.91
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast	-	-	34.74	8,279.24
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast	-	-	41.01	9,773.50
13400	MR of the paranasal sinuses	-	-	60.27	14,363.55
13410	MR of the paranasal sinuses, pre and post contrast	-	-	96.59	23,019.33
	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.	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
14100	X-ray of the mandible	-	-	3.66	872.25
14110	X-ray orthopantomogram of the jaws and teeth	-	-	4.06	967.58
14120	X-ray maxillofacial cephalometry	-	-	2.77	660.15
14130	X-ray of the teeth single quadrant	-	-	2.00	476.64
14140	X-ray of the teeth more than one quadrant	-	-	2.53	602.95
14150	X-ray of the teeth full mouth	-	-	3.62	862.72
14160	X-ray tomography of the teeth per side	-	-	3.23	769.77
14300	CT of the mandible	-	-	22.28	5,309.77
14310	CT of the mandible, pre and post contrast	-	-	41.26	9,833.08
14320	CT mandible with 3D reconstructions	-	-	30.40	7,244.93
14330	CT for dental implants in the mandible	-	-	27.45	6,541.88
14340	CT for dental implants in the maxilla	-	-	27.45	6,541.88
14400	MR of the mandible/maxilla	-	-	63.80	15,204.82
14410	MR of the mandible/maxilla, pre and post contrast	-	-	98.64	23,507.88
	TM Joints	-	-		
	Code 15100 (TM joint) and 15120 (tomography) may be combined. Code 15110 (TM joint) and 15130 (tomography) may be combined. Code 15140 (arthrography) and 15120 (tomography) may be combined. Code 15150 (arthrography) and 15130 (tomography) may be combined. Codes 15320 (CT arthrogram) and 15420 (MR arthrogram) include introduction of contrast (00140 may not be added).	-	-		
15100	X-ray temporo-mandibular joint, left	-	-	3.56	848.42
15110	X-ray temporo-mandibular joint, right	-	-	3.56	848.42
15120	X-ray tomography temporo-mandibular joint, left	-	-	4.30	1,024.78
15130	X-ray tomography temporo-mandibular joint, right	-	-	4.30	1,024.78
15140	X-ray arthrography of the temporo-mandibular joint, left	-	-	15.41	3,672.51
15150	X-ray arthrography of the temporo-mandibular joint, right	-	-	15.41	3,672.51
15200	Ultrasound temporo-mandibular joints, one or both sides	-	-	6.56	1,563.38
15300	CT of the temporo-mandibular joints	-	-	25.38	6,048.56
15310	CT of the temporo-mandibular joints plus 3D reconstructions	-	-	34.50	8,222.04
15320	CT arthrogram of the temporo-mandibular joints	-	-	35.96	8,569.99
15400	MR of the temporo-mandibular joints	-	-	63.80	15,204.82
15410	MR of the temporo-mandibular joints, pre and post contrast	-	-	100.84	24,032.19
15420	MR arthrogram of the temporo-mandibular joints	-	-	74.71	17,804.89

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
Mastoids and internal auditory canal		-	-		
Code 16100 (mastoids) and 16120 (tomography) may be combined. Code 16110 (mastoids bilat) and 16130 (tomography) may be combined Code 16140 (IAM's) and 16150 (tomography) may be combined.		-	-		
16100	X-ray of the mastoids, unilateral	-	-	3.59	855.57
16110	X-ray of the mastoids, bilateral	-	-	7.18	1,711.14
16120	X-ray tomography of the petro-temporal bone, unilateral	-	-	4.30	1,024.78
16130	X-ray tomography of the petro-temporal bone, bilateral	-	-	8.60	2,049.55
16140	X-ray internal auditory canal, bilateral	-	-	5.23	1,246.41
16150	X-ray tomography of the internal auditory canal, bilateral	-	-	4.30	1,024.78
16300	CT of the mastoids	-	-	12.60	3,002.83
16310	CT of the internal auditory canal	-	-	21.47	5,116.73
16320	CT of the internal auditory canal, pre and post contrast	-	-	34.20	8,150.54
16330	CT of the ear structures, limited study	-	-	13.40	3,193.49
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes	-	-	43.35	10,331.17
16400	MR of the internal auditory canals, limited study	-	-	43.56	10,381.22
16410	MR of the internal auditory canals, pre and post contrast, limited study	-	-	68.93	16,427.40
16420	MR of the internal auditory canals, pre and post contrast, complete study	-	-	102.64	24,461.16
16430	MR of the ear structures	-	-	64.40	15,347.81
16440	MR of the ear structures, pre and post contrast	-	-	102.64	24,461.16
Sella turcica		-	-		
Code 17100 (sella) and 17110 (tomography) may be combined.		-	-		
17100	X-ray of the sella turcica	-	-	3.08	734.03
17110	X-ray tomography of the sella turcica	-	-	4.30	1,024.78
17300	CT of the sella turcica/hypophysis	-	-	17.45	4,158.68
17310	CT of the sella turcica/hypophysis, pre and post contrast	-	-	42.26	10,071.40
Salivary glands and floor of the mouth		-	-		
Neck		-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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).	-	-		
19920	Nuclear medicine study - Infection localisation planar, static	18.04	4,299.29		
19925	Nuclear medicine study - Infection localisation planar, static, multiple studies	31.45	7,495.16		
19930	Nuclear medicine study - Infection localisation planar, static and SPECT	31.45	7,495.16		
19935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	44.86	10,691.04		
20100	X-ray of soft tissue of the neck	-	-	2.74	653.00
20110	X-ray of the larynx including tomography	-	-	9.39	2,237.82
20120	X-ray laryngography	-	-	8.28	1,973.29
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording	-	-	8.30	1,978.06
20200	Ultrasound of the thyroid	-	-	6.56	1,563.38
20210	Ultrasound of soft tissue of the neck	-	-	6.56	1,563.38
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler	-	-	15.00	3,574.80
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler	-	-	21.84	5,204.91
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler	-	-	10.80	2,573.86
20300	CT of the soft tissues of the neck	-	-	18.25	4,349.34
20310	CT of the soft tissues of the neck, with contrast	-	-	38.15	9,091.91
20320	CT of the soft tissues of the neck, pre and post contrast	-	-	43.81	10,440.80
20330	CT angiography of the extracranial vessels in the neck	-	-	79.36	18,913.08
20340	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain	-	-	107.50	25,619.40
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	29,654.16
20400	MR of the soft tissue of the neck	-	-	63.60	15,157.15
20410	MR of the soft tissue of the neck, pre and post contrast	-	-	102.04	24,318.17
20420	MR of the soft tissue of the neck and uncontrasted angiography	-	-	92.60	22,068.43
20430	MR angiography of the extracranial vessels in the neck, without contrast	-	-	59.60	14,203.87
20440	MR angiography of the extracranial vessels in the neck, with contrast	-	-	74.02	17,640.45

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
20450	MR angiography of the extra and intracranial vessels with contrast	-	-	116.05	27,657.04
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast	-	-	135.17	32,213.71
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast	-	-	156.05	37,189.84
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels	-	-	44.43	10,588.56
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels	-	-	50.73	12,089.97
20520	Arteriography of cervical vessels: carotid and vertebral	-	-	77.63	18,500.78
20530	Arteriography of aortic arch and cervical vessels	-	-	91.97	21,918.29
20540	Arteriography of aortic arch, cervical and intracranial vessels	-	-	108.87	25,945.90
20550	Venography of jugular and vertebral veins	-	-	48.95	11,665.76
	Thyroid (Nuclear Medicine)	-	-		
21900	Nuclear Medicine study - Thyroid, single uptake	9.68	2,306.94	-	-
21910	Nuclear medicine study - Thyroid, multiple uptake	14.69	3,500.92	-	-
21920	Nuclear medicine study - Thyroid imaging with uptake	17.72	4,223.03	-	-
21930	Nuclear medicine study - Thyroid imaging	12.72	3,031.43	-	-
21940	Nuclear medicine study - Thyroid imaging with vascular flow	18.74	4,466.12	-	-
21950	Nuclear medicine study - Thyroid suppression/stimulation	12.72	3,031.43	-	-
	Soft Tissue				
29920	Nuclear medicine study - Tumour localisation planar, static	18.04	4,299.29	-	-
29925	Nuclear medicine study - Infection localisation planar, static, multiple studies	31.45	7,495.16	-	-
29930	Nuclear medicine study - Infection localisation planar, static and SPECT	31.45	7,495.16	-	-
29935	Nuclear medicine study - Infection localisation planar, static, multiple studies and SPECT	44.86	10,691.04	-	-
29961	PET/CT scan of the soft tissue of the neck uncontrasted	-	-	105.87	25,230.94
29962	PET/CT scan of the soft tissue of the neck contrasted	-	-	111.69	26,617.96
	Thorax	-	-		
	Chest wall, pleura, lungs and mediastinum	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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	724.49
30110	X-ray of the chest two views, PA and lateral	-	-	3.84	915.15
30120	X-ray of the chest complete with additional views	-	-	4.24	1,010.48
30130	X-ray of the chest complete including fluoroscopy	-	-	4.48	1,067.67
30140	X-ray tomography of the chest	-	-	4.30	1,024.78
30150	X-ray of the ribs	-	-	4.79	1,141.55
30155	X-ray of the chest and ribs	-	-	6.42	1,530.01
30160	X-ray of the thoracic inlet	-	-	2.56	610.10
30170	X-ray of the sterno-clavicular joints	-	-	4.21	1,003.33
30175	X-ray tomography of the sterno-clavicular joint	-	-	4.30	1,024.78
30180	X-ray of the sternum	-	-	4.21	1,003.33
30185	X-ray tomography of the sternum	-	-	4.30	1,024.78
30200	Ultrasound of the chest wall, any region	-	-	6.56	1,563.38
30210	Ultrasound of the pleural space	-	-	6.56	1,563.38
30220	Ultrasound of the mediastinal structures	-	-	6.56	1,563.38
30300	CT of the chest, limited study	-	-	9.50	2,264.04
30310	CT of the chest uncontrasted	-	-	26.60	6,339.31
30320	CT of the chest contrasted	-	-	42.43	10,111.92
30330	CT of the chest, pre and post contrast	-	-	45.70	10,891.22
30340	CT of the chest, limited high resolution study	-	-	11.20	2,669.18
30350	CT of the chest, complete high resolution study	-	-	24.01	5,722.06
30355	CT of the chest, complete high resolution study with additional prone and expiratory studies	-	-	33.30	7,936.06
30360	CT of the chest for pulmonary embolism	-	-	57.12	13,612.84
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	-	-	80.28	19,132.33
30400	MR of the chest	-	-	63.60	15,157.15

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
30410	MR of the chest with uncontrasted angiography	-	-	92.60	22,068.43
30420	MR of the chest, pre and post contrast	-	-	102.04	24,318.17
30900	Nuclear Medicine study - Lung perfusion	21.54	5,133.41		
30910	Nuclear Medicine study - Lung ventilation, aerosol	21.50	5,123.88		
30920	Nuclear Medicine study - Lung perfusion and ventilation	42.03	10,016.59		
30930	Nuclear Medicine study - Lung ventilation using radio-active gas	14.17	3,376.99		
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio-active gas	34.69	8,267.32		
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic	26.51	6,317.86		
30960	Nuclear medicine study - alveolar permeability	26.51	6,317.86		
	Stand alone code. Not to be combined with 30910.	-	-		
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation	6.02	1,434.69		
	Stand alone code. Not to be combined with 30920.	-	-		
30981	PET/CT scan of the chest uncontrasted	-	-	111.44	26,558.38
30982	PET/CT scan of the chest contrasted	-	-	117.42	27,983.53
30983	PET/CT scan of the chest pre and post contrast	-	-	148.32	35,347.62
	Oesophagus	-	-		
	Codes 31100, 31110, 31120 (swallow) include fluoroscopy (00140 may not be added).	-	-		
31100	X-ray barium swallow	-	-	6.60	1,572.91
31105	Xray 3 phase dynamic contrasted swallow	-	-	12.60	3,002.83
31110	X-ray barium swallow, double contrast	-	-	7.92	1,887.49
31120	X-ray barium swallow with cinematography	-	-	10.07	2,399.88
	Aorta and large vessels	-	-		
	Codes 32210 and 32220 (Ivus) may be combined	-	-		
32200	Ultrasound intravascular arterial or venous assessment for intervention, once per complete procedure	-	-	4.20	1,000.94
32210	Ultrasound intravascular (IVUS) first vessel	-	-	8.44	2,011.42
32220	Ultrasound intravascular (IVUS) subsequent vessels	-	-	5.30	1,263.10
32300	CT angiography of the aorta and branches	-	-	79.08	18,846.35
32305	CT angiography of the thoracic and abdominal aorta and branches	-	-	105.50	25,142.76
32310	CT angiography of the pulmonary vasculature	-	-	79.08	18,846.35
32400	MR angiography of the aorta and branches	-	-	78.50	18,708.12

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
32410	MR angiography of the pulmonary vasculature	-	-	105.27	25,087.95
32500	Arteriography of thoracic aorta	-	-	28.26	6,734.92
32510	Arteriography of bronchial intercostal vessels alone	-	-	50.15	11,951.75
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels	-	-	67.43	16,069.92
32530	Arteriography of pulmonary vessels	-	-	63.27	15,078.51
32540	Arteriography of heart chambers, coronary arteries	-	-	44.27	10,550.43
32550	Venography of thoracic vena cava	-	-	28.38	6,763.52
32560	Venography of vena cava, azygos system	-	-	56.31	13,419.80
32570	Venography patency of A-port or other central line	-	-	19.64	4,680.60
	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.	-	-		
33200	Ultrasound study of the heart, including Doppler	-	-	8.20	1,954.22
33210	Ultrasound study of the heart trans-oesophageal	-	-	10.52	2,507.13
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel	-	-	5.20	1,239.26
33300	CT anatomical/functional study of the heart	-	-	34.61	8,248.26
33310	CT angiography of heart vessels	-	-	81.28	19,370.65
33970	Nuclear Medicine study - Multi stage treadmill ECG test	6.66	1,587.21	-	-
	Mamma				
34200	Ultrasound study of the breast			7.90	1,882.73
	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	791.22
40105	X-ray of the abdomen supine and erect, or decubitus	-	-	5.36	1,277.40
40110	X-ray of the abdomen multiple views including chest	-	-	8.10	1,930.39
40120	X-ray tomography of the abdomen	-	-	4.30	1,024.78
40140	X-ray barium meal single contrast	-	-	8.87	2,113.90

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
40143	X-ray barium meal double contrast	-	-	11.99	2,857.46
40147	X-ray barium meal double contrast with follow through	-	-	15.80	3,765.46
40150	X-ray small bowel enteroclysis (meal)	-	-	25.45	6,065.24
	Code 40150 excludes duodenal intubation and 40175 (Duodenal intubation) may be added.	-	-		
40153	X-ray small bowel meal follow through single contrast	-	-	19.55	4,659.16
40157	X-ray small bowel meal with pneumocolon	-	-	25.63	6,108.14
40160	X-ray large bowel enema single contrast	-	-	12.97	3,091.01
40165	X-ray large bowel enema double contrast	-	-	19.63	4,678.22
40170	X-ray guided gastro oesophageal intubation	-	-	1.60	381.31
40175	X-ray guided duodenal intubation	-	-	2.80	667.30
40180	X-ray defaecogram	-	-	12.97	3,091.01
40190	X-ray guided reduction of intussusception	-	-	16.27	3,877.47
40200	Ultrasound study of the abdominal wall	-	-	5.54	1,320.29
40210	Ultrasound study of the whole abdomen including the pelvis	-	-	8.24	1,963.76
40300	CT study of the abdomen	-	-	26.41	6,294.03
40310	CT study of the abdomen with contrast	-	-	44.82	10,681.50
40313	CT study of the abdomen pre and post contrast	-	-	52.99	12,628.58
40320	CT of the pelvis	-	-	26.13	6,227.30
40323	CT of the pelvis with contrast	-	-	47.48	11,315.43
40327	CT of the pelvis pre and post contrast	-	-	53.87	12,838.30
40330	CT of the abdomen and pelvis	-	-	38.50	9,175.32
40333	CT of the abdomen and pelvis with contrast	-	-	62.17	14,816.35
40337	CT of the abdomen and pelvis pre and post contrast	-	-	67.43	16,069.92
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast	-	-	74.11	17,661.90
40345	CT of the chest, abdomen and pelvis without contrast	-	-	70.12	16,711.00
40350	CT of the chest, abdomen and pelvis with contrast	-	-	88.35	21,055.57
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast	-	-	93.05	22,175.68
40360	CT of the base of skull to symphysis pubis with contrast	-	-	102.73	24,482.61
40365	CT colonoscopy	-	-	34.78	8,288.77
	Stand alone study, may not be added to any code between 40300 and 40360	-	-		
40400	MR of the abdomen	-	-	64.58	15,390.71
40410	MR of the abdomen pre and post contrast	-	-	100.84	24,032.19
40420	MR of the pelvis, soft tissue	-	-	64.58	15,390.71

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
40430	MR of the pelvis, soft tissue, pre and post contrast	-	-	102.04	24,318.17
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying	21.50	5,123.88	-	-
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies	34.92	8,322.13	-	-
40910	Nuclear Medicine study - Gastro intestinal protein loss	21.50	5,123.88	-	-
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies	34.92	8,322.13	-	-
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic	21.50	5,123.88	-	-
40925	Nuclear medicine study – Acute GIT bleed multiple studies	34.92	8,322.13	-	-
40930	Nuclear medicine study - Meckel's localisation	20.77	4,949.91	-	-
40935	Nuclear medicine study - Gastric mucosa imaging	20.77	4,949.91	-	-
40940	Nuclear medicine study - colonic transit multiple studies	44.86	10,691.04	-	-
	Stand alone code	-	-		
40951	PET/CT scan of the abdomen and pelvis uncontrasted	-	-	119.53	28,486.39
40952	PET/CT scan of the abdomen and pelvis contrasted	-	-	129.31	30,817.16
40953	PET/CT scan of the abdomen and pelvis pre and post contrast	-	-	140.50	33,483.96
	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	4,504.25
41105	X-ray ERCP reporting on images done in theatre	-	-	2.40	571.97
41110	X-ray cholangiography intra-operative	-	-	8.45	2,013.80
41120	X-ray T-tube cholangiography post operative	-	-	14.05	3,348.40
41130	X-ray transhepatic percutaneous cholangiography	-	-	32.34	7,707.27
41200	Ultrasound study of the upper abdomen	-	-	7.00	1,668.24
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis			9.80	2,335.54
41300	CT of the abdomen triphasic study – liver	-	-	54.90	13,083.77
41400	MR study of the liver/pancreas	-	-	64.78	15,438.37
41410	MR study of the liver/pancreas pre and post contrast	-	-	100.84	24,032.19
41420	MRCP	-	-	49.20	11,725.34
41430	MR study of the abdomen with MRCP	-	-	92.98	22,158.99

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
41440	MR study of the abdomen pre and post contrast with MRCP	-	-	133.60	31,839.55
41900	Nuclear Medicine study - Liver and spleen, planar views only	21.50	5,123.88	-	-
41905	Nuclear Medicine study - Liver and spleen, with flow study	27.53	6,560.95	-	-
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT	34.92	8,322.13	-	-
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT	40.94	9,756.82	-	-
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic	21.50	5,123.88	-	-
41925	Nuclear Medicine study – Hepatobiliary tract including flow	26.51	6,317.86	-	-
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies	34.92	8,322.13	-	-
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies	39.92	9,513.73	-	-
41940	Nuclear medicine study - Gall bladder ejection fraction	6.02	1,434.69	-	-
41945	Nuclear medicine study – Biliary gastric reflux study	20.77	4,949.91	-	-
	Renal tract	-	-		
42100	X-ray tomography of the renal tract	-	-	4.30	1,024.78
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP). Codes 42115 (IVP), 42120 (cystography), 42130 (urethrography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).	-	-		
42110	X-ray excretory urogram including tomography	-	-	24.86	5,924.64
42115	X-ray excretory urogram including tomography with micturating study	-	-	32.86	7,831.20
42120	X-ray cystography	-	-	15.05	3,586.72
42130	X-ray urethrography	-	-	15.37	3,662.98
42140	X-ray micturating cysto-urethrography	-	-	19.30	4,599.58
42150	X-ray retrograde/prograde pyelography	-	-	12.53	2,986.15
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre	-	-	2.41	574.35
42160	X-ray prograde pyelogram – percutaneous	-	-	32.67	7,785.91
42200	Ultrasound study of the renal tract including bladder	-	-	7.42	1,768.33
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney	-	-	3.80	905.62
	Code 42205 is a stand alone study and may not be added to 42200	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
42210	Ultrasound study of the renal arteries including Doppler	-	-	10.60	2,526.19
42400	MR of the renal tract for obstruction	-	-	47.00	11,201.04
42410	MR of the kidneys without contrast	-	-	64.58	15,390.71
42420	MR of the kidneys pre and post contrast	-	-	102.24	24,365.84
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)	21.94	5,228.74		
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow	27.96	6,663.43		
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT	35.35	8,424.61		
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT	41.37	9,859.30		
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow	26.51	6,317.86		
42930	Nuclear Medicine study – Renovascular study, baseline	26.51	6,317.86		
42940	Nuclear Medicine study – Renovascular study, with intervention	26.51	6,317.86		
42950	Nuclear medicine study - Indirect voiding cystogram	6.02	1,434.69		
	Reproductive system				
43200	Ultrasound study of the pelvis transabdominal. Pre-authorisation and motivation letter from the referring doctor is required			5.70	1,358.42
43220	Ultrasound study of the testes. Pre-authorisation and motivation letter from the referring doctor is required			7.38	1,758.80
	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	4,366.02
44205	Ultrasound study of the IVC and pelvic veins including Doppler	-	-	14.00	3,336.48
	This is a stand alone code and may not be added to 44200.	-	-		
44300	CT angiography of abdominal aorta and branches	-	-	76.72	18,283.91
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen	-	-	94.32	22,478.34
44310	CT angiography of the pelvis	-	-	78.64	18,741.48
44320	CT angiography of the abdominal aorta and pelvis	-	-	89.54	21,339.17
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis	-	-	119.15	28,395.83
44330	CT portogram	-	-	74.40	17,731.01

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
44400	MR angiography of abdominal aorta and branches	-	-	76.64	18,264.84
44500	Arteriography of abdominal aorta alone	-	-	28.12	6,701.56
44503	Arteriography of aorta plus coeliac, mesenteric branches	-	-	75.63	18,024.14
44505	Arteriography of aorta plus renal, adrenal branches	-	-	63.01	15,016.54
44507	Arteriography of aorta plus non-visceral branches	-	-	60.79	14,487.47
44510	Arteriography of coeliac, mesenteric vessels alone	-	-	64.35	15,335.89
44515	Arteriography of renal, adrenal vessels alone	-	-	49.49	11,794.46
44517	Arteriography of non-visceral abdominal vessels alone	-	-	54.91	13,086.15
44520	Arteriography of internal and external iliac vessels alone	-	-	56.72	13,517.51
44525	Venography of internal and external iliac veins alone	-	-	62.11	14,802.06
44530	Corpora cavemosography	-	-	25.06	5,972.30
44535	Vasography, vesciculography	-	-	29.19	6,956.56
44540	Venography of inferior vena cava	-	-	26.12	6,224.92
44543	Venography of hepatic veins alone	-	-	53.77	12,814.47
44545	Venography of inferior vena cava and hepatic veins	-	-	68.91	16,422.63
44550	Venography of lumbar azygos system alone	-	-	43.89	10,459.86
44555	Venography of inferior vena cava and lumbar azygos veins	-	-	65.46	15,600.43
44560	Venography of renal, adrenal veins alone	-	-	43.99	10,483.70
44565	Venography of inferior vena cava and renal/adrenal veins	-	-	68.39	16,298.70
44570	Venography of spermatic, ovarian veins alone	-	-	40.39	9,625.74
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins	-	-	73.99	17,633.30
44580	Venography indirect splenoportogram	-	-	48.67	11,599.03
44583	Venography direct splenoportogram	-	-	31.59	7,528.53
44587	Venography transhepatic portogram	-	-	66.75	15,907.86
	Soft Tissue	-	-		
49920	Nuclear medicine study – Infection localisation planar, static	18.04	4,299.29		
49930	Nuclear medicine study – Infection localisation planar, static, multiple studies	31.45	7,495.16		
49940	Nuclear medicine study – Infection localisation planar, static and SPECT	31.45	7,495.16		
49950	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	44.86	10,691.04		
	Spine, Pelvis and Hips	-	-		
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventional myelography codes viz. 51160, 52150, 53160	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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	1,668.24
50105	X-ray of the spine scoliosis view AP and lateral	-	-	12.00	2,859.84
50110	X-ray of the spine scoliosis view AP and lateral including stress views	-	-	18.54	4,418.45
50120	X-ray bone densitometry	-	-	11.52	2,745.45
50130	X-ray guided lumbar puncture	-	-	4.80	1,143.94
50140	X-ray guided cisternal puncture cisternogram	-	-	22.98	5,476.59
50300	CT quantitative bone mineral density	-	-	11.83	2,819.33
50500	Arteriogram of the spinal column and cord, all vessels	-	-	127.23	30,321.45
50510	Venography of the spinal, paraspinal veins	-	-	58.45	13,929.80
	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 of the cervical spine, stress views only	-	-	4.14	986.64
51110	X-ray of the cervical spine, one or two views	-	-	3.01	717.34
51120	X-ray of the cervical spine, more than two views	-	-	4.28	1,020.01
51130	X-ray of the cervical spine, more than two views including stress views	-	-	7.58	1,806.47
51140	X-ray Tomography cervical spine	-	-	4.30	1,024.78
51160	X-ray myelography of the cervical spine	-	-	27.46	6,544.27
51170	X-ray discography cervical spine per level	-	-	25.17	5,998.51
51300	CT of the cervical spine limited study	-	-	9.50	2,264.04
51310	CT of the cervical spine – regional study	-	-	13.91	3,315.03
51320	CT of the cervical spine – complete study	-	-	37.13	8,848.82
51330	CT of the cervical spine pre and post contrast	-	-	58.85	14,025.13
51340	CT myelography of the cervical spine	-	-	47.19	11,246.32

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
51350	CT myelography of the cervical spine following myelogram	-	-	21.69	5,169.16
51400	MR of the cervical spine, limited study	-	-	44.40	10,581.41
51410	MR of the cervical spine and cranio-cervical junction	-	-	64.82	15,447.90
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	-	-	102.14	24,342.00
51900	Nuclear Medicine study – Bone regional cervical	21.50	5,123.88		
51910	Nuclear Medicine study – Bone tomography regional cervical	13.41	3,195.87		
51920	Nuclear Medicine study – with flow	6.02	1,434.69		
	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 spaces. 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	765.01
52110	X-ray of the thoracic spine, more than two views	-	-	4.00	953.28
52120	X-ray tomography thoracic spine	-	-	4.30	1,024.78
52140	X-ray of the thoracic spine, more than two views including stress views	-	-	6.64	1,582.44
52150	X-ray myelography of the thoracic spine	-	-	18.62	4,437.52
52300	CT of the thoracic spine limited study	-	-	9.50	2,264.04
52305	CT of the thoracic spine – regional study	-	-	13.91	3,315.03
52310	CT of the thoracic spine complete study	-	-	35.78	8,527.09
52320	CT of the thoracic spine pre and post contrast	-	-	58.85	14,025.13
52330	CT myelography of the thoracic spine	-	-	48.09	11,460.81
52340	CT myelography of the thoracic spine following myelogram	-	-	20.37	4,854.58
52400	MR of the thoracic spine, limited study	-	-	46.60	11,105.71
52410	MR of the thoracic spine	-	-	64.34	15,333.51
52420	MR of the thoracic spine pre and post contrast	-	-	101.42	24,170.41
52900	Nuclear Medicine study – Bone regional dorsal	21.50	5,123.88	-	-
52910	Nuclear Medicine study – Bone tomography regional dorsal	13.41	3,195.87	-	-
52920	Nuclear Medicine study – with flow	6.02	1,434.69	-	-
	Lumbar				

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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	986.64
53110	X-ray of the lumbar spine, one or two views	-	-	3.56	848.42
53120	X-ray of the lumbar spine, more than two views	-	-	4.46	1,062.91
53130	X-ray of the lumbar spine, more than two views including stress views	-	-	7.52	1,792.17
53140	X-ray tomography lumbar spine	-	-	4.30	1,024.78
53160	X-ray myelography of the lumbar spine	-	-	23.94	5,705.38
53170	X-ray discography lumbar spine per level	-	-	25.17	5,998.51
53300	CT of the lumbar spine limited study	-	-	9.50	2,264.04
53310	CT of the lumbar spine – regional study	-	-	13.91	3,315.03
53320	CT of the lumbar spine complete study	-	-	37.64	8,970.36
53330	CT of the lumbar spine pre and post contrast	-	-	58.85	14,025.13
53340	CT myelography of the lumbar spine	-	-	49.11	11,703.90
53350	CT myelography of the lumbar spine following myelogram	-	-	23.46	5,590.99
53400	MR of the lumbar spine, limited study	-	-	46.20	11,010.38
53410	MR of the lumbar spine	-	-	64.32	15,328.74
53420	MR of the lumbar spine pre and post contrast	-	-	103.29	24,616.07
53900	Nuclear medicine study – Bone regional lumbar	21.50	5,123.88		
53910	Nuclear medicine study – Bone tomography regional lumbar	13.41	3,195.87		
53920	Nuclear medicine study – with flow	6.02	1,434.69		
	Sacrum	-	-		
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints). Code 54300 (CT) limited study - limited to single sacral vertebral body. Code 54310 (CT) complete study - an extensive study of the sacral spine.	-	-		
54100	X-ray of the sacrum and coccyx	-	-	3.58	853.19
54110	X-ray of the sacro-iliac joints	-	-	4.10	977.11

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
54120	X-ray tomography – sacrum and/or coccyx	-	-	4.30	1,024.78
54300	CT of the sacrum – limited study	-	-	7.60	1,811.23
54310	CT of the sacrum – complete study – uncontrasted	-	-	25.61	6,103.38
54320	CT of the sacrum with contrast	-	-	46.93	11,184.36
54330	CT of the sacrum pre and post contrast	-	-	52.97	12,623.81
54400	MR of the sacrum	-	-	65.00	15,490.80
54410	MR of the sacrum pre and post contrast	-	-	101.04	24,079.85
	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 e.g. acetabular roof or pubic ramus.	-	-		
55100	X-ray of the pelvis	-	-	3.66	872.25
55110	X-ray tomography – pelvis	-	-	4.30	1,024.78
55300	CT of the bony pelvis limited	-	-	9.50	2,264.04
55310	CT of the bony pelvis complete uncontrasted	-	-	25.61	6,103.38
55320	CT of the bony pelvis complete 3D recon	-	-	37.47	8,929.85
55330	CT of the bony pelvis with contrast	-	-	46.93	11,184.36
55340	CT of the bony pelvis – pre and post contrast	-	-	52.97	12,623.81
55400	MR of the bony pelvis	-	-	65.00	15,490.80
55410	MR of the bony pelvis pre and post contrast	-	-	102.24	24,365.84
55900	Nuclear medicine study – Bone regional pelvis	21.50	5,123.88		
55910	Nuclear medicine study – Bone tomography regional pelvis	13.41	3,195.87		
55920	Nuclear medicine study – with flow	6.02	1,434.69		
	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 e.g. part of femur head.	-	-		
56100	X-ray of the left hip	-	-	3.18	757.86
56110	X-ray of the right hip	-	-	3.18	757.86
56120	X-ray pelvis and hips	-	-	6.02	1,434.69
56130	X-ray tomography – hip	-	-	4.30	1,024.78
56140	X-ray of the hip/s – stress study	-	-	4.38	1,043.84

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
56150	X-ray arthrography of the hip joint including introduction contrast	-	-	15.75	3,753.54
56160	X-ray guidance and introduction of contrast into hip joint only	-	-	7.41	1,765.95
56200	Ultrasound of the hip joints	-	-	6.50	1,549.08
56300	CT of hip – limited	-	-	9.50	2,264.04
56310	CT of hip – complete	-	-	27.37	6,522.82
56320	CT of hip – complete with 3D recon	-	-	39.78	9,480.37
56330	CT of hip with contrast	-	-	43.26	10,309.72
56340	CT of hip pre and post contrast	-	-	47.88	11,410.76
56400	MR of the hip joint/s, limited study	-	-	44.90	10,700.57
56410	MR of the hip joint/s	-	-	64.10	15,276.31
56420	MR of the hip joint/s, pre and post contrast	-	-	101.64	24,222.84
56900	Nuclear medicine study – Bone regional pelvis	21.50	5,123.88		
56910	Nuclear medicine study – Bone limited static plus flow	27.53	6,560.95		
56920	Nuclear medicine study – Bone tomography regional	13.41	3,195.87		
	Upper limbs	-	-		
	General	-	-		
	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 e.g. 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	1,077.21
60110	X-ray upper limbs - any region – tomography	-	-	4.30	1,024.78
60200	Ultrasound upper limb – soft tissue - any region	-	-	7.38	1,758.80
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler	-	-	13.64	3,250.68
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler	-	-	13.64	3,250.68
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis			12.54	2,988.53
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler	-	-	17.26	4,113.40
60300	CT of the upper limbs limited study	-	-	9.50	2,264.04

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
60310	CT angiography of the upper limb	-	-	78.28	18,655.69
60400	MR of the upper limbs limited study, any region	-	-	44.80	10,676.74
60410	MR angiography of the upper limb	-	-	74.66	17,792.97
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral	-	-	45.67	10,884.07
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral	-	-	82.67	19,701.91
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral	-	-	56.75	13,524.66
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral	-	-	88.11	20,998.38
60540	Venography, antegrade of upper limb veins, unilateral	-	-	26.12	6,224.92
60550	Venography, antegrade of upper limb veins, bilateral	-	-	49.43	11,780.16
60560	Venography, retrograde of upper limb veins, unilateral	-	-	31.01	7,390.30
60570	Venography, retrograde of upper limb veins, bilateral	-	-	54.81	13,062.32
60580	Venography, shuntogram, dialysis access shunt	-	-	23.79	5,669.63
60900	Nuclear medicine study – Venogram upper limb	37.12	8,846.44		
	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	724.49
61105	X-ray of the right clavicle	-	-	3.04	724.49
61110	X-ray of the left scapula	-	-	3.04	724.49
61115	X-ray of the right scapula	-	-	3.04	724.49
61120	X-ray of the left acromio-clavicular joint	-	-	3.14	748.32
61125	X-ray of the right acromio-clavicular joint	-	-	3.14	748.32
61128	X-ray of acromio-clavicular joints plus stress studies bilateral	-	-	7.68	1,830.30
61130	X-ray of the left shoulder	-	-	3.48	829.35
61135	X-ray of the right shoulder	-	-	3.48	829.35
61140	X-ray of the left shoulder plus subacromial impingement views	-	-	5.92	1,410.85
61145	X-ray of the right shoulder plus subacromial impingement views	-	-	5.92	1,410.85
61150	X-ray of the left subacromial impingement views only	-	-	3.24	772.16

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
61155	X-ray of the right subacromial impingement views only	-	-	3.24	772.16
61160	X-ray arthrography shoulder joint including introduction of contrast	-	-	15.83	3,772.61
61170	X-ray guidance and introduction of contrast into shoulder joint only	-	-	7.41	1,765.95
61200	Ultrasound of the left shoulder joint	-	-	6.50	1,549.08
61210	Ultrasound of the right shoulder joint	-	-	6.50	1,549.08
61300	CT of the left shoulder joint – uncontrasted	-	-	24.36	5,805.48
61305	CT of the right shoulder joint – uncontrasted	-	-	24.36	5,805.48
61310	CT of the left shoulder – complete with 3D recon	-	-	37.66	8,975.13
61315	CT of the right shoulder – complete with 3D recon	-	-	37.66	8,975.13
61320	CT of the left shoulder joint - pre and post contrast	-	-	48.63	11,589.50
61325	CT of the right shoulder joint - pre and post contrast	-	-	48.63	11,589.50
61400	MR of the left shoulder	-	-	64.64	15,405.00
61405	MR of the right shoulder	-	-	64.64	15,405.00
61410	MR of the left shoulder pre and post contrast	-	-	101.04	24,079.85
61415	MR of the right shoulder pre and post contrast	-	-	101.04	24,079.85
	Humerus	-	-		
62100	X-ray of the left humerus	-	-	2.94	700.66
62105	X-ray of the right humerus	-	-	2.94	700.66
62300	CT of the left upper arm	-	-	24.36	5,805.48
62305	CT of the right upper arm	-	-	24.36	5,805.48
62310	CT of the left upper arm contrasted	-	-	39.97	9,525.65
62315	CT of the right upper arm contrasted	-	-	39.97	9,525.65
62320	CT of the left upper arm pre and post contrast	-	-	48.58	11,577.59
62325	CT of the right upper arm pre and post contrast	-	-	48.58	11,577.59
62400	MR of the left upper arm	-	-	64.20	15,300.14
62405	MR of the right upper arm	-	-	64.20	15,300.14
62410	MR of the left upper arm pre and post contrast	-	-	102.04	24,318.17
62415	MR of the right upper arm pre and post contrast	-	-	102.04	24,318.17
62900	Nuclear medicine study – Bone limited/regional static	21.50	5,123.88		
62905	Nuclear medicine study – Bone limited static plus flow	27.53	6,560.95		
62910	Nuclear medicine study – Bone tomography regional	13.41	3,195.87		
	Elbow	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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	748.32
63105	X-ray of the right elbow	-	-	3.14	748.32
63110	X-ray of the left elbow with stress	-	-	4.34	1,034.31
63115	X-ray of the right elbow with stress	-	-	4.34	1,034.31
63120	X-ray arthrography elbow joint including introduction of contrast	-	-	15.89	3,786.90
63130	X-ray guidance and introduction of contrast into elbow joint only	-	-	7.41	1,765.95
63200	Ultrasound of the left elbow joint	-	-	6.50	1,549.08
63205	Ultrasound of the right elbow joint	-	-	6.50	1,549.08
63300	CT of the left elbow	-	-	24.36	5,805.48
63305	CT of the right elbow	-	-	24.36	5,805.48
63310	CT of the left elbow – complete with 3D recon	-	-	37.66	8,975.13
63315	CT of the right elbow – complete with 3D recon	-	-	37.66	8,975.13
63320	CT of the left elbow contrasted	-	-	39.97	9,525.65
63325	CT of the right elbow contrasted	-	-	39.97	9,525.65
63330	CT of the left elbow pre and post contrast	-	-	48.63	11,589.50
63335	CT of the right elbow pre and post contrast	-	-	48.63	11,589.50
63400	MR of the left elbow	-	-	64.64	15,405.00
63405	MR of the right elbow	-	-	64.64	15,405.00
63410	MR of the left elbow pre and post contrast	-	-	101.04	24,079.85
63415	MR of the right elbow pre and post contrast	-	-	101.04	24,079.85
63905	Nuclear medicine study – Bone limited/regional static	21.50	5,123.88		
63910	Nuclear medicine study – Bone limited static plus flow	27.53	6,560.95		
63915	Nuclear medicine study – Bone tomography regional	13.41	3,195.87		
	Forearm	-	-		
64100	X-ray of the left forearm	-	-	2.94	700.66
64105	X-ray of the right forearm	-	-	2.94	700.66
64110	X-ray peripheral bone densitometry	-	-	1.96	467.11
64300	CT of the left forearm	-	-	24.36	5,805.48
64305	CT of the right forearm	-	-	24.36	5,805.48
64310	CT of the left forearm contrasted	-	-	39.97	9,525.65
64315	CT of the right forearm contrasted	-	-	39.97	9,525.65
64320	CT of the left forearm pre and post contrast	-	-	48.58	11,577.59

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
64325	CT of the right forearm pre and post contrast	-	-	48.58	11,577.59
64400	MR of the left forearm	-	-	64.20	15,300.14
64405	MR of the right forearm	-	-	64.20	15,300.14
64410	MR of the left forearm pre and post contrast	-	-	98.04	23,364.89
64415	MR of the right forearm pre and post contrast	-	-	98.04	23,364.89
64900	Nuclear medicine study – Bone limited/regional static	21.50	5,123.88		
64905	Nuclear medicine study – Bone limited static plus flow	27.53	6,560.95		
64910	Nuclear medicine study – Bone tomography regional	13.41	3,195.87		
	Hand and Wrist	-	-		
	Code 65120 (finger) may not be combined with 65100 or 65105 (hands). Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done. Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added). 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	734.03
65105	X-ray of the right hand	-	-	3.08	734.03
65110	X-ray of the left hand – bone age	-	-	3.08	734.03
65120	X-ray of a finger	-	-	2.67	636.31
65130	X-ray of the left wrist	-	-	3.18	757.86
65135	X-ray of the right wrist	-	-	3.18	757.86
65140	X-ray of the left scaphoid	-	-	3.30	786.46
65145	X-ray of the right scaphoid	-	-	3.30	786.46
65150	X-ray of the left wrist, scaphoid and stress views	-	-	7.56	1,801.70
65155	X-ray of the right wrist, scaphoid and stress views	-	-	7.56	1,801.70
65160	X-ray arthrography wrist joint including introduction of contrast	-	-	15.93	3,796.44
65170	X-ray guidance and introduction of contrast into wrist joint only	-	-	7.41	1,765.95
65200	Ultrasound of the left wrist	-	-	6.50	1,549.08
65210	Ultrasound of the right wrist	-	-	6.50	1,549.08
65300	CT of the left wrist and hand	-	-	24.36	5,805.48
65305	CT of the right wrist and hand	-	-	24.36	5,805.48
65310	CT of the left wrist and hand - complete with 3D recon	-	-	37.66	8,975.13
65315	CT of the right wrist and hand - complete with 3D recon	-	-	37.66	8,975.13
65320	CT of the left wrist and hand contrasted	-	-	39.97	9,525.65

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
65325	CT of the right wrist and hand contrasted	-	-	39.97	9,525.65
65330	CT of the left wrist and hand pre and post contrast	-	-	48.63	11,589.50
65335	CT of the right wrist and hand pre and post contrast	-	-	48.63	11,589.50
65400	MR of the left wrist and hand	-	-	64.64	15,405.00
65405	MR of the right wrist and hand	-	-	64.64	15,405.00
65410	MR of the left wrist and hand pre and post contrast	-	-	101.04	24,079.85
65415	MR of the right wrist and hand pre and post contrast	-	-	101.04	24,079.85
65900	Nuclear Medicine study – bone limited/regional static	21.50	5,123.88	-	-
65905	Nuclear Medicine study – bone limited static plus flow	27.53	6,560.95	-	-
65910	Nuclear Medicine study – bone tomography regional	13.41	3,195.87	-	-
	Soft Tissue			-	-
69900	Nuclear medicine study – Tumour localisation planar, static	20.74	4,942.76	-	-
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies	35.17	8,381.71	-	-
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT	34.15	8,138.63	-	-
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	47.56	11,334.50	-	-
69920	Nuclear medicine study – Infection localisation planar, static	18.04	4,299.29	-	-
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies	31.45	7,495.16	-	-
69930	Nuclear medicine study – Infection localisation planar, static and SPECT	31.45	7,495.16	-	-
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	44.86	10,691.04	-	-
69940	Nuclear medicine study – Regional lymph node mapping dynamic	6.02	1,434.69	-	-
69945	Nuclear medicine study – Regional lymph node mapping, static, planar	24.10	5,743.51	-	-
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	37.51	8,939.38	-	-
69955	Nuclear medicine study – Regional lymph node mapping SPECT	13.41	3,195.87	-	-
69960	Nuclear medicine study – Lymph node localisation with gamma probe	13.41	3,195.87	-	-
	Lower Limbs	-	-		
	General	-	-		

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	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 e.g. 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	1,077.21
70110	X-ray lower limbs - any region-tomography	-	-	4.30	1,024.78
70120	X-ray of the lower limbs full length study	-	-	6.46	1,539.55
70200	Ultrasound lower limb – soft tissue - any region	-	-	7.38	1,758.80
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler	-	-	13.64	3,250.68
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler	-	-	13.64	3,250.68
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis	-	-	13.64	3,250.68
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	4,685.37
70300	CT of the lower limbs limited study	-	-	9.50	2,264.04
70310	CT angiography of the lower limb	-	-	79.43	18,929.76
70320	CT angiography abdominal aorta and outflow lower limbs	-	-	98.34	23,436.39
70400	MR of the lower limbs limited study	-	-	46.40	11,058.05
70410	MR angiography of the lower limb	-	-	76.66	18,269.61
70420	MR angiography of the abdominal aorta and lower limbs	-	-	118.86	28,326.72
70500	Angiography of pelvic and lower limb arteries unilateral	-	-	40.59	9,673.41
70505	Angiography of pelvic and lower limb arteries bilateral	-	-	75.92	18,093.25
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral	-	-	61.23	14,592.33
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral	-	-	85.66	20,414.49

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
70520	Angiography translumbar aorta with full peripheral study	-	-	45.68	10,886.46
70530	Venography, antegrade of lower limb veins, unilateral	-	-	25.46	6,067.63
70535	Venography, antegrade of lower limb veins, bilateral	-	-	49.43	11,780.16
70540	Venography, retrograde of lower limb veins, unilateral	-	-	31.17	7,428.43
70545	Venography, retrograde of lower limb veins, bilateral	-	-	56.79	13,534.19
70560	Lymphangiography, lower limb, unilateral	-	-	51.04	12,163.85
70565	Lymphangiography, lower limb, bilateral	-	-	83.97	20,011.73
70900	Nuclear medicine study – Venogram lower limb	37.12	8,846.44		
	Femur	-	-		
71100	X-ray of the left femur	-	-	2.94	700.66
71105	X-ray of the right femur	-	-	2.94	700.66
71300	CT of the left femur	-	-	24.52	5,843.61
71305	CT of the right femur	-	-	24.52	5,843.61
71310	CT of the left upper leg contrasted	-	-	41.83	9,968.93
71315	CT of the right upper leg contrasted	-	-	41.83	9,968.93
71320	CT of the left upper leg pre and post contrast	-	-	49.71	11,846.89
71325	CT of the right upper leg pre and post contrast	-	-	49.71	11,846.89
71400	MR of the left upper leg	-	-	64.80	15,443.14
71405	MR of the right upper leg	-	-	64.80	15,443.14
71410	MR of the left upper leg pre and post contrast	-	-	102.04	24,318.17
71415	MR of the right upper leg pre and post contrast	-	-	102.04	24,318.17
71900	Nuclear Medicine study – Bone limited/regional static	21.50	5,123.88		
71905	Nuclear Medicine study – Bone limited static plus flow	27.53	6,560.95		
71910	Nuclear Medicine study – Bone tomography regional	13.41	3,195.87		
	Knee	-	-		
	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	660.15
72105	X-ray of the right knee one or two views	-	-	2.77	660.15
72110	X-ray of the left knee, more than two views	-	-	3.32	791.22

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
72115	X-ray of the right knee, more than two views	-	-	3.32	791.22
72120	X-ray of the left knee including patella	-	-	4.62	1,101.04
72125	X-ray of the right knee including patella	-	-	4.62	1,101.04
72130	X-ray of the left knee with stress views	-	-	5.82	1,387.02
72135	X-ray of the right knee with stress views	-	-	5.82	1,387.02
72140	X-ray of left patella	-	-	2.77	660.15
72145	X-ray of right patella	-	-	2.77	660.15
72150	X-ray both knees standing – single view	-	-	2.80	667.30
72160	X-ray arthrography knee joint including introduction of contrast	-	-	15.81	3,767.84
72170	X-ray guidance and introduction of contrast into knee joint only	-	-	7.41	1,765.95
72200	Ultrasound of the left knee joint	-	-	6.50	1,549.08
72205	Ultrasound of the right knee joint	-	-	6.50	1,549.08
72300	CT of the left knee	-	-	24.52	5,843.61
72305	CT of the right knee	-	-	24.52	5,843.61
72310	CT of the left knee complete study with 3D reconstructions	-	-	35.93	8,562.84
72315	CT of the right knee complete study with 3D reconstructions	-	-	35.93	8,562.84
72320	CT of the left knee contrasted	-	-	41.83	9,968.93
72325	CT of the right knee contrasted	-	-	41.83	9,968.93
72330	CT of the left knee pre and post contrast	-	-	49.76	11,858.80
72335	CT of the right knee pre and post contrast	-	-	49.76	11,858.80
72400	MR of the left knee	-	-	64.10	15,276.31
72405	MR of the right knee	-	-	64.10	15,276.31
72410	MR of the left knee pre and post contrast	-	-	100.84	24,032.19
72415	MR of the right knee pre and post contrast	-	-	100.84	24,032.19
72900	Nuclear Medicine study – Bone limited/regional static	21.50	5,123.88		
72905	Nuclear Medicine study – Bone limited static plus flow	27.53	6,560.95		
72910	Nuclear Medicine study – Bone tomography regional	13.41	3,195.87		
	Lower Leg	-	-		
73100	X-ray of the left lower leg	-	-	2.94	700.66
73105	X-ray of the right lower leg	-	-	2.94	700.66
73300	CT of the left lower leg	-	-	24.52	5,843.61
73305	CT of the right lower leg	-	-	24.52	5,843.61
73310	CT of the left lower leg contrasted	-	-	41.83	9,968.93
73315	CT of the right lower leg contrasted	-	-	41.83	9,968.93
73320	CT of the left lower leg pre and post contrast	-	-	49.71	11,846.89
73325	CT of the right lower leg pre and post contrast	-	-	49.71	11,846.89
73400	MR of the left lower leg	-	-	64.20	15,300.14
73405	MR of the right lower leg	-	-	64.20	15,300.14

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
73410	MR of the left lower leg pre and post contrast	-	-	102.04	24,318.17
73415	MR of the right lower leg pre and post contrast	-	-	102.04	24,318.17
73900	Nuclear Medicine study – bone limited/regional static	21.50	5,123.88		
73905	Nuclear Medicine study – bone limited static plus flow	27.53	6,560.95		
73910	Nuclear Medicine study – bone tomography regional	13.41	3,195.87		
	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 74405 (MR) are not supported except in exceptional circumstances with motivation.	-	-		
74100	X-ray of the left ankle	-	-	3.32	791.22
74105	X-ray of the right ankle	-	-	3.32	791.22
74110	X-ray of the left ankle with stress views	-	-	4.52	1,077.21
74115	X-ray of the right ankle with stress views	-	-	4.52	1,077.21
74120	X-ray of the left foot	-	-	2.80	667.30
74125	X-ray of the right foot	-	-	2.80	667.30
74130	X-ray of the left calcaneus	-	-	2.74	653.00
74135	X-ray of the right calcaneus	-	-	2.74	653.00
74140	X-ray of both feet – standing – single view	-	-	2.80	667.30
74145	X-ray of a toe	-	-	2.67	636.31
74150	X-ray of the sesamoid bones one or both sides	-	-	2.80	667.30
74160	X-ray arthrography ankle joint including introduction of contrast	-	-	15.91	3,791.67
74170	X-ray guidance and introduction of contrast into ankle joint	-	-	7.41	1,765.95
74210	Ultrasound of the left ankle	-	-	6.50	1,549.08
74215	Ultrasound of the right ankle	-	-	6.50	1,549.08
74220	Ultrasound of the left foot	-	-	6.50	1,549.08
74225	Ultrasound of the right foot	-	-	6.50	1,549.08
74290	Ultrasound bone densitometry	-	-	2.04	486.17
74300	CT of the left ankle/foot	-	-	24.52	5,843.61

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
74305	CT of the right ankle/foot	-	-	24.52	5,843.61
74310	CT of the left ankle/foot – complete with 3D recon	-	-	37.81	9,010.88
74315	CT of the right ankle/foot – complete with 3D recon	-	-	37.81	9,010.88
74320	CT of the left ankle/foot contrasted	-	-	41.83	9,968.93
74325	CT of the right ankle/foot contrasted	-	-	41.83	9,968.93
74330	CT of the left ankle/foot pre and post contrast	-	-	49.71	11,846.89
74335	CT of the right ankle/foot pre and post contrast	-	-	49.71	11,846.89
74400	MR of the left ankle	-	-	64.10	15,276.31
74405	MR of the right ankle	-	-	64.10	15,276.31
74410	MR of the left ankle pre and post contrast	-	-	100.64	23,984.52
74415	MR of the right ankle pre and post contrast	-	-	100.64	23,984.52
74420	MR of the left foot	-	-	64.20	15,300.14
74425	MR of the right foot	-	-	64.20	15,300.14
74430	MR of the left foot pre and post contrast	-	-	102.04	24,318.17
74435	MR of the right foot pre and post contrast	-	-	102.04	24,318.17
74900	Nuclear Medicine study – Bone limited/regional static	21.50	5,123.88		
74905	Nuclear Medicine study – Bone limited static plus flow	27.53	6,560.95		
74910	Nuclear Medicine study – Bone tomography regional	13.41	3,195.87		
	Soft Tissue				
79900	Nuclear Medicine study – Tumour localisation planar, static	20.74	4,942.76	-	-
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	35.17	8,381.71	-	-
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	34.15	8,138.63	-	-
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	47.56	11,334.50	-	-
79920	Nuclear Medicine study – Infection localisation planar, static	18.43	4,392.24	-	-
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	31.84	7,588.11	-	-
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	31.84	7,588.11	-	-
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	45.25	10,783.98	-	-
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	6.02	1,434.69	-	-
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	24.10	5,743.51	-	-
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	37.51	8,939.38	-	-
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	13.41	3,195.87	-	-
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	13.41	3,195.87	-	-

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
	Intervention				
	General				
	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	2,233.06
80605	Fine needle aspiration biopsy, any region	-	-	4.22	1,005.71
80610	Cutting needle, trochar biopsy, any region Clinical Motivation Required	-	-	6.36	1,515.72
80620	Tumour/cyst ablation chemical	-	-	25.37	6,046.18
80630	Tumour ablation radio frequency, per lesion	-	-	21.21	5,054.77
80640	Insertion of CVP line in radiology suite	-	-	8.99	2,142.50
80645	Peripheral central venous line insertion	-	-	12.12	2,888.44
80650	Infiltration of a peripheral joint, any region	-	-	6.40	1,525.25
	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	51,124.41
81605	Intracranial arteriovenous shunt occlusion	-	-	254.82	60,728.70
81610	Dural sinus arteriovenous shunt occlusion	-	-	264.33	62,995.13
81615	Extracranial arteriovenous shunt occlusion	-	-	157.28	37,482.97
81620	Extracranial arterial embolisation (head and neck) Clinical Motivation Required	-	-	163.12	38,874.76
81625	Carotico-cavernous fistula occlusion	-	-	192.29	45,826.55
81630	Intracranial angioplasty for stenosis, vasospasm	-	-	126.92	30,247.57
81632	Intracranial stent placement (including PTA)	-	-	133.72	31,868.15

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
81635	Temporary balloon occlusion test	-	-	83.42	19,880.65
	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	42,463.86
81645	Intracranial aneurysm occlusion with balloon remodelling	-	-	216.35	51,560.53
81650	Intracranial aneurysm occlusion with stent assistance Clinical Motivation Required	-	-	230.45	54,920.84
81655	Intracranial thrombolysis, catheter directed	-	-	58.94	14,046.58
	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	1,825.53
81665	Neurolysis, head and neck, per level	-	-	20.14	4,799.76
81670	Nerve block, head and neck, radio frequency, per level	-	-	19.04	4,537.61
81680	Nerve block, coeliac plexus or other regions, per level	-	-	9.28	2,211.61
	Thorax	-	-		
82600	Chest drain insertion	-	-	8.82	2,101.98
82605	Trachial, bronchial stent insertion	-	-	30.36	7,235.40
	Gastrointestinal	-	-		
83600	Oesophageal stent insertion	-	-	31.22	7,440.35
83605	GIT balloon dilation	-	-	24.36	5,805.48
83610	GIT stent insertion (non-oesophageal)	-	-	32.02	7,631.01
83615	Percutaneous gastrostomy, jejunostomy	-	-	25.36	6,043.80
	Hepatobiliary	-	-		
84600	Percutaneous biliary drainage, external	-	-	33.98	8,098.11
84605	Percutaneous external/internal biliary drainage	-	-	37.21	8,867.89
84610	Permanent biliary stent insertion	-	-	51.22	12,206.75
84615	Drainage tube replacement	-	-	20.22	4,818.83
84620	Percutaneous bile duct stone or foreign object removal	-	-	49.98	11,911.23
84625	Percutaneous gall bladder drainage	-	-	29.58	7,049.51
84630	Percutaneous gallstone removal, including drainage	-	-	69.25	16,503.66
84635	Transjugular liver biopsy	-	-	24.93	5,941.32
84640	Transjugular intrahepatic Portosystemic shunt	-	-	119.47	28,472.09
84645	Transhepatic Portogram including venous sampling, pressure studies	-	-	81.89	19,516.02
84650	Transhepatic Portogram with embolisation of varices	-	-	100.81	24,025.04

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
84655	Percutaneous hepatic tumour ablation	-	-	15.68	3,736.86
84660	Percutaneous hepatic abscess, cyst drainage	-	-	13.20	3,145.82
84665	Hepatic chemoembolisation	-	-	59.44	14,165.74
84670	Hepatic arterial infusion catheter placement	-	-	60.30	14,370.70
	Urogenital	-	-		
85600	Percutaneous nephrostomy, external drainage	-	-	29.97	7,142.45
85605	Percutaneous double J stent insertion including access	-	-	40.82	9,728.22
85610	Percutaneous renal stone, foreign body removal including access	-	-	66.79	15,917.39
85615	Percutaneous nephrostomy tract establishment	-	-	29.27	6,975.63
85620	Change of nephrostomy tube	-	-	15.90	3,789.29
85625	Percutaneous cystostomy	-	-	16.52	3,937.05
85630	Urethral balloon dilatation	-	-	14.24	3,393.68
85635	Urethral stent insertion	-	-	31.22	7,440.35
85640	Renal cyst ablation	-	-	11.92	2,840.77
85645	Renal abscess, cyst drainage	-	-	15.16	3,612.93
	Spinal	-	-		
86600	Spinal vascular malformation embolisation	-	-	275.16	65,576.13
86605	Vertebroplasty per level	-	-	22.30	5,314.54
86610	Facet joint block per level, uni- or bilateral	-	-	9.54	2,273.57
	Code 86610 may only be billed once per level, and not per left and right side per level	-	-		
86615	Spinal nerve block per level, uni- or bilateral	-	-	8.16	1,944.69
86620	Epidural block	-	-	9.42	2,244.97
86625	Chemonucleolysis, including discogram	-	-	18.32	4,366.02
86630	Spinal nerve ablation per level	-	-	11.60	2,764.51
	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 than 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	13,479.38

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
87601	Percutaneous transluminal angioplasty: iliac	-	-	55.76	13,288.72
87602	Percutaneous transluminal angioplasty: femoropopliteal	-	-	60.16	14,337.33
87603	Percutaneous transluminal angioplasty: subpopliteal	-	-	73.34	17,478.39
87604	Percutaneous transluminal angioplasty: brachiocephalic	-	-	67.12	15,996.04
87605	Percutaneous transluminal angioplasty: subclavian, axillary	-	-	60.16	14,337.33
87606	Percutaneous transluminal angioplasty: extracranial carotid	-	-	71.62	17,068.48
87607	Percutaneous transluminal angioplasty: extracranial vertebral	-	-	73.30	17,468.86
87608	Percutaneous transluminal angioplasty: renal	-	-	87.69	20,898.28
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	-	-	87.69	20,898.28
87620	Aorta stent-graft placement	-	-	120.75	28,777.14
87621	Stent insertion (including PTA): aorta, IVC	-	-	73.87	17,604.70
87622	Stent insertion (including PTA): iliac	-	-	76.37	18,200.50
87623	Stent insertion (including PTA): femoropopliteal	-	-	77.97	18,581.81
87624	Stent insertion (including PTA): subpopliteal	-	-	84.55	20,149.96
87625	Stent insertion (including PTA): brachiocephalic	-	-	98.47	23,467.37
87626	Stent insertion (including PTA): subclavian, axillary	-	-	86.69	20,659.96
87627	Stent insertion (including PTA): extracranial carotid	-	-	106.99	25,497.86
87628	Stent insertion (including PTA): extracranial vertebral	-	-	100.55	23,963.08
87629	Stent insertion (including PTA): renal	-	-	98.59	23,495.97
87630	Stent insertion (including PTA): coeliac, mesenteric	-	-	98.59	23,495.97
87631	Stent-graft placement: iliac	-	-	76.37	18,200.50
87632	Stent-graft placement: femoropopliteal	-	-	77.97	18,581.81
87633	Stent-graft placement: brachiocephalic	-	-	98.47	23,467.37
87634	Stent-graft placement: subclavian, axillary	-	-	82.77	19,725.75
87635	Stent-graft placement: extracranial carotid	-	-	120.43	28,700.88
87636	Stent-graft placement: extracranial vertebral	-	-	114.73	27,342.45
87637	Stent-graft placement: renal	-	-	98.59	23,495.97
87638	Stent-graft placement: coeliac, mesenteric	-	-	98.59	23,495.97
87650	Thrombolysis in angiography suite, per 24 hours	-	-	45.82	10,919.82
	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional codes 10520, 20500, 20510, 20520, 20530, 20540, 32500, 32530, 44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87638.	-	-		
87651	Aspiration, rheolytic thrombectomy	-	-	77.67	18,510.31
87652	Atherectomy, per vessel	-	-	91.89	21,899.22

		025 - Nuclear Medicine		038 - Radiology	
		U	R	U	R
87653	Percutaneous tunnelled / subcutaneous arterial or venous central or other line insertion	-	-	28.15	6,708.71
87654	Thrombolysis follow-up	-	-	23.57	5,617.20
87655	Percutaneous sclerotherapy, vascular malformation	-	-	21.10	5,028.55
87660	Embolisation, mesenteric	-	-	100.43	23,934.48
87661	Embolisation, renal	-	-	99.36	23,679.48
87662	Embolisation, bronchial, intercostal	-	-	108.34	25,819.59
87663	Embolisation, pulmonary arteriovenous shunt Clinical Motivation Required	-	-	103.22	24,599.39
87664	Embolisation, abdominal, other vessels	-	-	101.44	24,175.18
87665	Embolisation, thoracic, other vessels	-	-	97.60	23,260.03
87666	Embolisation, upper limb	-	-	90.92	21,668.05
87667	Embolisation, lower limb	-	-	92.14	21,958.80
87668	Embolisation, pelvis, non-uterine	-	-	117.12	27,912.04
87669	Embolisation, uterus	-	-	113.88	27,139.88
87670	Embolisation, spermatic, ovaria veins	-	-	85.82	20,452.62
87680	Inferior vena cava filter placement	-	-	61.84	14,737.71
87681	Intravascular foreign body removal	-	-	85.03	20,264.35
87682	Revision of access port (tunnelled or implantable)	-	-	14.12	3,365.08
87683	Removal of access port (tunnelled or implantable)	-	-	11.12	2,650.12
87690	Superior petrosal venous sampling	-	-	73.01	17,399.74
87691	Pancreatic stimulation test	-	-	89.79	21,398.75
87692	Transportal venous sampling	-	-	76.95	18,338.72
87693	Adrenal venous sampling	-	-	55.01	13,109.98
87694	Parathyroid venous sampling	-	-	86.66	20,652.81
87695	Renal venous sampling	-	-	55.01	13,109.98

		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	R4.84 per km for each kilometre travelled in own car: 19 km total = 19 x R4.84 = R91.96 (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	628.92		
5007	General Practitioner: 12,00 clinical procedure units per hour or part thereof			12	419.28
5009	After hours: Specialist: 27,00 clinical procedure units per hour or part thereof	27	943.38		
5011	After hours: General Practitioners: 18,00 clinical procedure units per hour or part thereof			18	628.92
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				

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