Tariff Codes

1 of 3 2017

gems
Government Employees Medical Scheme

Please click on the relevant headings below to see a full list of the **GEMS Tariff codes for 2017**

ACUPUNCTURE & CHINESE MEDICINE

GEMS TARIFF FOR SERVICES BY ACUPUNCTURE & CHINESE MEDICINE PRACTITIONERS WITH EFFECT FROM 1 JANUARY 2017						Acupuncture & Chinese Medicine Code: 41000
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**Flag**	**2017 values**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
	RULES					
01	All accounts must be presented with the following information clearly stated: • name of the practitioner • qualifications of the practitioner • BHF practice number • postal address and telephone number • date on which the service(s) were provided • applicable item codes • the nature of the treatment • the surname and initials of the member • the first name of the patient • the name of the medical scheme • the membership number of the patient • the name and practice number of the referring practitioner					
02	When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately.					
03	Not more than two separate techniques may be charged for at each session.					
04	The maximum number of acupuncture treatments per course to be charged for is limited to ten. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient.					

GEMS TARIFF FOR SERVICES BY ACUPUNCTURE & CHINESE MEDICINE PRACTITIONERS WITH EFFECT FROM 1 JANUARY 2017						Acupuncture & Chinese Medicine Code: 41000
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**Flag**	**2017 values**
	ITEMS					
1.	**Consultations**					
	Consultation encompasses consultation, history taking, patient examination and assessment, side room diagnostic tests, counselling and/or diagnosis.					
1100	Consultation (up to 15 mins)	580	10	1		R 149,10
1101	Consultation (16-30 mins)	580	22,5	1		R 335,40
1102	Consultation (31-45 mins)	580	37,5	1		R 559,10
1103	Consultation (46-60 mins)	580	52,5	1		R 782,80
1110	Consultation, each additional full 15 mins beyond 60 mins	580	15	1		R 223,70
2.	**Treatments**					
3100	First treatment (needles, plus maximum of two speciality therapy techniques)	580	39,524	1		R 589,30
3200	Follow-up treatment (needles, plus maximum of two speciality therapy techniques)	580	36,145	1		R 538,90
3.	**Speciality therapy techniques**					
4010	Moxibustion	580	22,77	1		R 339,50
4020	Cupping	580	19,493	1		R 290,60
4030	Dermal needle therapy (plum-blossom or seven-star)	580	18,184	1		R 271,00
4040	Auricular therapy (micro acupuncture)	580	32,146	1		R 479,20
4050	Scalp acupuncture	580	27,308	1		R 407,30
4060	Shilao (diet therapy)	580	23,712	1		R 353,70
4070	Tui-Na (massage/pressure)	580	34,226	1		R 510,20

BIOKINETICS

GEMS TARIFF FOR SERVICES BY BIOKINETICS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Biokinetics Tariff Code: 37700	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**Flag**	**2017 values**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
	GENERAL RULES					
002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation.					
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include the full range of diagnostic and evaluation procedures within the scope of practice of the biokineticist, including for example: anthropometric/body composition assessments, ergological testing evaluations and perceptual motor evaluation.					
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. This limitation shall be inclusive of a maximum of one group treatment procedure (code 12), where applicable. Treatment procedures include the full range of rehabilitative or preventive treatment or care procedures within the scope of practice of the biokineticist, including for example: hydrotherapy, callisthenics exercises and programme prescription for individuals with CHD.					
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Further continuance of treatment should only be considered if recommended by the medical practitioner(s) and others involved in the rehabilitation of the patient.					

GEMS TARIFF FOR SERVICES BY BIOKINETICS WITH EFFECT FROM 1 JANUARY 2017						Practice Type: Biokinetics Tariff Code: 37700
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**Flag**	**2017 values**
010	Every biokineticist must acquaint himself with the provisions of the Medical Schemes Act, 1998, and the regulations promulgated under the Act in connection with the rendering of accounts. Every account shall contain the following particulars: • the name and practice code number of the referring practitioner • the name of the member • the name of the patient • the name of the medical scheme • the membership number of the member • the date on which the service was rendered • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered					
011	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.					
1	**Consultations/patient education/counselling**					
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the “By arrangement with the scheme” or “Patient own account” category).	340	0	0		
901	Initial consultation including: a problem focused history, a short problem focused examination, and straightforward biokinetic decision making but excluding evaluation. To be charged only once per course of treatment (inclusive of lung function tests).	340	16,7	1		R 112,80
903	Subsequent consultation for the same condition (global fee covering a problem focused interval history and re-examination, and straightforward biokinetic decision making but excluding physical re-assessment). To be charged only once per course of treatment.	340	11,7	1		R 79,20
905	Consultation at hospital (global fee including a problem focused history, a problem focused examination, and biokinetic decision making excluding evaluation and physical re-assessment of a patient). To be charged only once per course of treatment.	340	16,7	1		R 112,80
922	Patient education (based upon the evaluation outcomes)	340	16,3	1		R 110,20
936	Health promotion and lifestyle modifications	340	0	0		
2	**Evaluation/diagnostic procedures**					
908	Simple evaluation at the first visit only (to be fully documented)	340	10	1		R 67,70
909	Complex evaluation at the first visit only (to be fully documented)	340	16,7	1		R 112,80
912	Anthropometric/body composition assessment	340	10	1		R 67,70

GEMS TARIFF FOR SERVICES BY BIOKINETICS WITH EFFECT FROM 1 JANUARY 2017						Practice Type: Biokinetics Tariff Code: 37700
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**Flag**	**2017 values**
913	Ergological testing evaluation of body segment, limb or joint	340	28,5	1		R 192,80
914	Neurological patients: Ergological evaluation	340	16,7	1		R 112,80
915	Postural analysis and/or analysis of activities of daily living, gait and specific motor acts	340	16,7	1		R 112,80
916	Perceptual motor evaluation (perception and gross motor function)	340	16,7	1		R 112,80
917	Physical work capacity (treadmill or bicycle ergometer/other electronic equipment) and musculoskeletal assessment (strength, endurance, range of motion, posture)	340	28,5	1		R 192,80
918	Physical work capacity with full ECG	340	28,5	1		R 192,80
920	Isotonic, isometric or EMG testing by means of specialised electronic equipment	340	28,5	1		R 192,80
921	Isokinetic testing by means of specialised electronic equipment	340	28,5	1		R 192,80
3	**Therapeutic procedures (physical rehabilitation)**					
	Maximum of 3 modalities, per diagnosis, may be charged per visit					
923	Proprioception, balance and motor co-ordination exercise therapy session with or without equipment	340	16,3	1		R 110,20
925	Hydrotherapy where the condition of the patient is such that it requires the undivided attention of the biokineticist	340	16,3	1		R 110,20
926	Exercise on isokinetic apparatus/isotonic/isometric resistance equipment	340	16,3	1		R 110,20
927	Posture, gait and activities of daily living (ADL), with/without equipment use	340	16,3	1		R 110,20
928	A rehabilitative exercise prescription	340	16,3	1		R 110,20
929	Callisthenics exercises	340	16,3	1		R 110,20
930	Group session with high-risk patients, per patient (maximum 10 patients)	340	8,8	1		R 59,50
931	Passive and active range of motion exercise therapy	340	16,3	1		R 110,20
933	Programme prescription for an individual with CHD health risks including hyperlipedemia, metabolic disorders, low-back pain/lumbago etc.					
934	Group exercise sessions, per patient	340	8,8	1		R 59,50

CHIROPRACTIC

GEMS TARIFF FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2017					Chiropractor Code: 40400
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.				
	GENERAL RULES				
001	All accounts must be presented with the following information clearly stated: • name of chiropractor • qualifcations of the chiropractor • BHF practice number • postal address and telephone number • date on which service(s) were provided • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered • the surname and initials of the member • the first name of the patient • the name of the scheme • the membership number of the member • a statement of whether the account is in accordance with the National Reference Price List • the name and practice number of the referring practitioner, if applicable				
002	The consultation code may be charged only once at the same consultation or visit. Consultation includes history taking, guidance, education, health promotion and/or consultation.				
003	A maximum of three diagnostic procedures may be charged at the same consultation or visit. Diagnostic procedures include physical examination, neurological examination, orthopaedic examination, ergonomical analysis, postural analysis and radiological examination.				
004	A maximum of three treatment procedures may be charged at the same consultation or visit for any single diagnosis. Treatment procedures include, inter alia: spinal or extra-spinal manipulation, acupuncture, cold applications, non-heating modalities, deep heating radiation, soft tissue manipulation, superficial heating therapy and therapeutic exercises (other than in relation to preparation or fitting of appliances).				
005	After a series of 12 treatments in respect of one patient for the same condition, the practitioner concerned shall report to the scheme as soon as possible if further treatment is necessary. Payment for treatment in excess of the stipulated number may be granted by the scheme after receipt of a letter from the practitioner concerned, motivating the need for such treatment.				

GEMS TARIFF FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2017					Chiropractor Code: 40400
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
006	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.				
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).				
301	Consultation	180	25,000	1,0	R 171,90
	Only a single item from this section may be charged per patient encounter				R 0,00
	Radiation Control Council Certificate number to be on account if X-Rays charged				R 0,00
311	Single diagnostic procedure	180	25,000	1,0	R 171,90
312	Two diagnostic procedures	180	37,500	1,0	R 257,70
313	Three diagnostic procedures	180	50,000	1,0	R 343,70
	Only a single item from this section may be charged per patient encounter				R 0,00
321	Single instance of immobilisation or therapeutic exercises	180	10,000	1,0	R 68,80
322	Two instances of immobilisation or therapeutic exercises	180	15,000	1,0	R 103,10
	Only a single item from this section may be charged per patient encounter				R 0,00
331	Single treatment procedure	180	10,000	1,0	R 68,80
332	Two treatment procedures	180	15,000	1,0	R 103,10
333	Three treatment procedures	180	20,000	1,0	R 137,40
334	Four treatment procedures	180	25,000	1,0	R 171,90
335	Five treatment procedures	180	30,000	1,0	R 206,10
336	Six treatment procedures	180	35,000	1,0	R 240,50

GEMS TARIFF FOR SERVICES BY CHIROPRACTORS EFFECTIVE FROM 1 JANUARY 2017					Chiropractor Code: 40400
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus: – 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands – a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				R 0,00
100	Medication/material: Charge for medication or material, identified by the appropriate NAPPI code	180	-	0,0	R 0,00
110	X-Ray films	180	-	0,0	R 0,00

CLINICAL TECHNOLOGY

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Clinical Technology Code: 37500
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
	In calculating the GEMS Tariff , the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.				
	GENERAL RULES				
001	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.				
	MODIFIERS				
0001	Fee prorated according to number of treatment days: fee = ([number of treatment days]/30) X (item fee).				
	ITEMS				
	Surgical support				
010	Ablations	190	219,700	1,0	R 2 815,50
011	Preparation of extra-corporeal equipment for surgical procedures	190	196,700	1,0	R 2 520,70
012	Operation of heart laser during myocardial revascularisation	190	219,700	1,0	R 2 815,50
013	Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time	190	20,300	1,0	R 260,10
014	Radiofrequency catheter ablations	190	219,700	1,0	R 2 815,50
	Not to be charged with Item 012				
015	Preparation and operation of pre-operative, intra-operative or post-operative physiological monitoring per patient, per admission	190	19,400	1,0	R 248,60
	May only submit once in theatre and once in catheterisation laboratory				
017	Standby with extra-corporeal equipment for surgery within hospital	190	58,800	1,0	R 753,60
	Cannot be used with 011				
019	Standby within the hospital for coronary angioplasty	190	19,400	1,0	R 248,60
021	Preparation and operation of intra-aortic balloon pump in theatre, intensive care unit and catheterisation laboratory	190	58,800	1,0	R 753,60
085	Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time	190	10,000	1,0	R 128,10
023	Global fee for preparation and operation and removal of cardio assist device (LVAD, RVAD, BVAD) in theatre and intensive care unit	190	196,700	1,0	R 2 520,70

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Clinical Technology Code: 37500
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
027	Preparation and operation of a pre- and post-operative blood salvage device	190	19,400	1,0	R 248,60
029	Preparation and operation of an autotransfusion cell washing system	190	77,100	1,0	R 988,20
031	Determination and monitoring of haemodynamic/pulmonary parameters, metabolism, arterial/venous pressure flow studies in high care/ICU (per patient per multiple procedures per day)	190	61,700	1,0	R 790,70
033	Assistance with bronchoscopy procedures, placement of arterial/venous catheters, ultrasound examinations or photography	190	14,600	1,0	R 187,20
034	Lymph compression treatment	190	22,500	1,0	R 288,20
116	Preparation and operation of an artificial heart (Berlin-Heart)	190	219,700	1,0	R 2 815,50
118	Daily monitoring of artificial heart, per hour	190	33,400	1,0	R 428,00
157	Standby with extra corporeal equipment (maximum 4 hours per event)	190	26,300	1,0	R 337,10
	Pulmonology				
	Items 035 to 061 apply only to outpatient department and normal wards, not high care or intensive care, except item 050 which applies to intensive care only.				
035	Nebulisation (per one procedure)	190	12,300	1,0	R 157,60
037	Measurement of lung volumes and capacities by means of closed circuit (He) or (N2) washout or body plethysmography	190	24,200	1,0	R 310,10
039	Flow-volume determinations	190	30,600	1,0	R 392,00
041	Flow-volume (Pre-post B-D)	190	50,800	1,0	R 651,00
043	Airways resistance and conductance measurements using plethysmograph or similar apparatus	190	24,200	1,0	R 310,10
045	Gas distribution measurements	190	24,200	1,0	R 310,10
047	Diffusion determinations	190	24,200	1,0	R 310,10
049	Exercise testing (EIA)	190	17,100	1,0	R 219,10
050	ECMO change-out and re-establishment	190	46,300	1,0	R 593,40
051	Exercise testing with recording of: VT, VO2, HR, RR, ECG and Oximetry	190	24,200	1,0	R 310,10
053	Allergy tests	190	11,400	1,0	R 146,20
055	If RAST included add (per allergen)	190	11,400	1,0	R 146,20
057	Bronchial provocation testing	190	40,800	1,0	R 522,90
059	Compliance measurements	190	24,200	1,0	R 310,10
061	Maximum inspiratory (MIP) and/or expiratory (MEP) pressures and/or Vital Capacity and/or PEFR	190	6,000	1,0	R 76,90
	Cardiology				
062	Assist in preparations and operations of Rotablator procedures	190	29,900	1,0	R 383,30
063	Cardiac catheterisation for the first hour	190	40,300	1,0	R 516,50

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Clinical Technology Code: 37500
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
064	Intravascular Ultrasound (IVUS)	190	25,700	1,0	R 329,50
065	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	190	10,000	1,0	R 128,10
	This fee can only be charged once, irrespective of how many times this procedure is repeated. The technologist cannot charge for this procedure if a representative of a company or any other person is operating the IVUS machine.				
068	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	190	10,000	1,0	R 128,10
066	Cardiac Cath Right Heart Studies	190	56,000	1,0	R 717,60
067	Cardiac electro physiology and related procedures for first four hours	190	67,900	1,0	R 870,20
069	Temporary and single pacemaker procedures	190	40,300	1,0	R 516,50
070	Permanent and dual pacemaker procedures or implantation and testing of ICD devices	190	46,300	1,0	R 593,40
	Not to be charged in conjunction with Items 063 or 065				
071	Each additional 30 minutes or part thereof provided that such part comprises 50% or more of the time	190	10,000	1,0	R 128,10
072	Multisite Pacing (Bi-ventricular pacing)	190	46,300	1,0	R 593,40
073	Dilatation procedures and stents	190	55,400	1,0	R 710,00
074	Wavemap – measurement of Fractional Flow Reserve to assess the functional severity of coronary artery stenoses	190	10,000	1,0	R 128,10
075	Pacemaker checking and/or reprogramming	190	14,000	1,0	R 179,40
077	24-hour Holter ambulatory monitoring	190	55,400	1,0	R 710,00
079	Cardiac exercise stress testing	190	29,100	1,0	R 373,00
081	Recording of twelve lead ECG	190	7,700	1,0	R 98,60
087	M Mode echocardiogram	190	16,600	1,0	R 212,80
089	2D echocardiogram	190	29,400	1,0	R 376,70
091	Doppler flow	190	32,300	1,0	R 413,80
093	Colour imaging	190	32,300	1,0	R 413,80
095	ECG signal averaging (Hi-Res)	190	53,700	1,0	R 688,20
097	Ambulatory bloodpressure monitoring	190	18,600	1,0	R 238,20
099	Vector cardiogram	190	55,400	1,0	R 710,00
111	Transoesophageal echocardiogram	190	43,100	1,0	R 552,40
	Neurology				
	Preparation, recording and analyses/technical report of:				
178	Short latency brainstem auditory evoked potentials, neurological examination, bilateral	190	74,100	1,0	R 949,70
179	Auditory evoked potentials, full audiological examination, bilateral	190	74,100	1,0	R 949,70

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Clinical Technology Code: 37500
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
180	Pattern-reversal visual evoked potentials: full evaluation of visual pathways, unilateral	190	37,110	1,0	R 475,50
181	Somatosensory evoked potentials, unilateral, upper limb	190	37,110	1,0	R 475,50
115	Additional two nerves (used as adjunct with nerve conduction studies, including F-waves, H-reflexes or additional nerves required for diagnosis)	190	14,900	1,0	R 190,90
117	Electroretinography (ERG) – unilateral or Electro-oculography (EOG)	190	43,100	1,0	R 552,40
183	Electronystagmography for spontaneous and positional nystagmus (3253)	190	24,150	1,0	R 309,40
184	Caloric test done with electronystagmography (3255)	190	67,570	1,0	R 865,90
119	Sleep EEG	190	31,400	1,0	R 402,50
185	Overnight polysomnography	190	264,830	1,0	R 3 393,90
186	Obstructive sleep apnea screening	190	137,170	1,0	R 1 757,90
187	Long-term EEG monitoring with a minimum of eight hours (but less than 16 hours) recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	190	137,890	1,0	R 1 767,20
188	Long-term EEG monitoring with 16 to 24 hours recording time, including preparation (collodion adhesive technique with at least 21 electrodes) and interpretation	190	264,830	1,0	R 3 393,90
125	Multiple sleep latency test (MSLT)	190	111,100	1,0	R 1 423,80
127	Overnight CPAP titration	190	104,200	1,0	R 1 335,40
132	Mobile EEG setup in ICU (to be added to Item 133 if appropriate)	190	17,420	1,0	R 223,30
133	EEG with special activation	190	49,400	1,0	R 633,00
135	Electromyography: Needle examination per muscle/conduction velocity (motor/sensory) each, to a maximum of five	190	14,900	1,0	R 190,90
137	Intra-operative evoked potentials for the first hour	190	55,400	1,0	R 710,00
139	Each additional hour or part thereof provided that such part comprises 50% or more of the time	190	37,100	1,0	R 475,40
141	Intra-operative EEG (carotid endarterectomy)	190	26,300	1,0	R 337,10
143	Transcranial or Carotid Doppler (bilateral)	190	39,400	1,0	R 504,90
	Dialysis				
145	Preparation of extra-corporeal equipment: Haemoperfusion (HP), Haemofiltration (HF), Haemoconcentration (HC), continuous renal replacement therapy (CRRT), Aphaeresis, auto transfusion and cell recovery (AT)	190	46,300	1,0	R 593,40
146	Chronic haemodialysis (acetate dialysate)	190	149,400	1,0	R 1 914,60
148	Chronic haemodialysis (bicarbonate dialysate)	190	159,600	1,0	R 2 045,40

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017				Practice Type: Clinical Technology Code: 37500	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
	In the case of Items 146 and 148, routine outpatient dialysis includes dialyser, bloodlines, acetate dialysate, priming set, sodium heparin anticoagulant, saline infusion, dressing pack, fistula needles/catheter dressing, syringes and needles, cleaning materials, equipment set-up, up to five hours treatment time, equipment rental.				
147	Peritoneal dialysis, per day	190	16,800	1,0	R 215,40
	The global fees for Continuous Ambulatory Peritoneal Dialysis (CAPD) (Item 176) and Automated Peritoneal Dialysis (APD) (Item 177) include: consumables, cost of machine and machine disposables, professional fee, initial training, in-centre follow-up visits and home visits. However, they exclude Tenckhoff catheter and insertion thereof and disposables required for a transfer set change (usually six monthly). These fees are chargeable for each 30 day cycle in which CAPD or APD is provided. If CAPD or APD is provided for less than 30 days in any one cycle (for example due to complications or death of the patient): a. If the period of treatment is 26 days or more in that cycle, the full fee applies b. If the period of treatment is up to 25 days in that cycle, the fee should be prorated according to the number of actual treatment days. Modifier 0001 should be quoted, and number of treatment days specified				
176	Global fee for Continuous Ambulatory Peritoneal Dialysis (CAPD), per 30 day period	190	1700,000	1,0	R 21 785,70
177	Global fee for Automated Peritoneal Dialysis (APD), per 30 day period	190	2360,000	1,0	R 30 243,60
149	Treatment procedure per one hour (excluding acute haemodialysis, chronic haemodialysis and CRRT)	190	33,400	1,0	R 428,00
150	Acute haemodialysis	190	317,200	1,0	R 4 064,90
	Emergency dialysis treatment in hospital includes: dialyser, bloodlines, acetate/bicarbonate dialysate, priming set, equipment set-up, up to five hours treatment time, equipment rental				
151	Treatment procedures for CRRT up to six hours or part thereof provided that such part comprises 50% or more of the time	190	24,800	1,0	R 317,70
152	Treatment procedure for CRRT up to 12 hours or part thereof provided that such part comprises more than six hours of the time	190	49,700	1,0	R 636,80
154	Treatment procedure for CRRT up to 18 hours or part thereof provided that such part comprises more than 12 hours of the time	190	74,500	1,0	R 954,80
156	Treatment procedure for CRRT up to 24 hours or part thereof provided that such part comprises more than 18 hours of the time	190	99,300	1,0	R 1 272,40
153	Patient training in centre for dialysis, CPAP training and problem-solving, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	190	16,600	1,0	R 212,80
155	Patient training or follow-up at patient's home, for dialysis, home ventilators and nebulisers, per 30 minutes (to maximum of 24 hours)	190	29,100	1,0	R 373,00
	Reproductive health				
	As schemes will not necessarily grant benefits in respect of some items below, they fall into the "By arrangement with the scheme" category.				

GEMS TARIFF FOR SERVICES BY CLINICAL TECHNOLOGISTS WITH EFFECT FROM 1 JANUARY 2017					Practice Type: Clinical Technology Code: 37500
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**
159	Post-vasectomy semen analysis	190	10,000	1,0	R 128,10
161	Complete semen analysis	190	31,700	1,0	R 406,10
163	Semen wash for A I	190	30,300	1,0	R 388,40
165	IVF, GIFT, PROST with semen and serum preparation including ovum and embryo handling and transfer	190	368,700	1,0	R 4 724,90
	Cannot be used with Items 161, 163, 167 and 169				
167	Ovum and embryo freezing	190	131,300	1,0	R 1 682,70
169	Semen freezing	190	30,300	1,0	R 388,40
	Miscellaneous				
171	Travelling per km in excess of 16km (in own car)	190	0,675	1,0	R 8,61
173	Equipment hire (by arrangement with scheme)	190	-	0,0	
175	Medication/material	190	-	0,0	
	The amount charged in respect of medicines and scheduled substances shall not exceed the limits prescribed in the Regulations Relating to a Transparent Pricing System for Medicines and Scheduled Substances, dated 30 April 2004, made in terms of the Medicines and Related Substances Act, 1965 (Act No 101 of 1965). In relation to all other materials, items are to be charged (exclusive of VAT) at net acquisition price plus: – 26% of the net acquisition price where the net acquisition price of that material is less than one hundred rands. – a maximum of twenty six rands where the net acquisition price of that material is greater than or equal to one hundred rands.				

CONTRACTED ANAESTHESIOLOGIST REO OPTION

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10 cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.			R 0,00	
	RULES GOVERNING THE STRUCTURE			R 0,00	
A.	**Consultation definitions** a. New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. b. Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. c. Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.			R 0,00	
B.	**Normal hours and after hours** After-hour services are paid at the same rate as benefits for normal-hour services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and Items 0146 or 0147 (which should be added to the appropriate consultative services code selected from Items 0190-0192, 0173-0175, 0161-0164, 0166-0169).			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
C.	**Comparable services** A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When Item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include: 1. An adequate definition or description of the nature, extent and need for the procedure/service or "medical necessity". 2. In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report. 3. Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case. 4. A description of the complexity of the symptoms and concurrent problems must be supplied. 5. Final diagnosis supported by the appropriate ICD-10 code(s). 6. Mention any pertinent physical findings (size, location and number of lesions if applicable) 7. Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session. 8. Mention any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period. 9. Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure.			R 0,00	
D.	**Cancellation of appointments** Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be.			R 0,00	
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital.			R 0,00	
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
G.	**Post-operative care** a. Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). b. If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. c. When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. d. Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions.			R 0,00	
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days.			R 0,00	
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits .			R 0,00	
K.	**Practice of specialists** In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists.			R 0,00	
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged.			R 0,00	
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion.			R 0,00	
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention.			R 0,00	
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
P.	**Travelling fees** a. Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. b. If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. c. A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. d. Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). e. Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). f. For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances			R 0,00	
Q.	**Intensive care/high care** Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221. but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and x-rays. g. Intravenous treatment (Items 0206 and 0207), except intravenous infusion in patients under the age of three years (Item 0205) that does not form part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management.			R 0,00	
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. item 1211: Cardio-respiratory resuscitation).			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
S.	**Ventilation** Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies. b. Testing and connecting the machine. c. Putting patient on machine: setting machine, synchronising patient with machine. d. Instruction to nursing staff. e. All subsequent visits for 24 hours.			R 0,00	
T.	Ventilation (Items 1212 to 1214) does not form art of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring.			R 0,00	
U.	**Obstetric procedures** a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to item 2614: Global obstetric care. ii. If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to item 2614: Global obstetric care.			R 0,00	
V.	a. Electro-convulsive treatment: Visits at a hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.			R 0,00	
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used.			R 0,00	
Z.	No fee is subject to more than one reduction.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
AA.	Procedures to exclude cost of isotope.			R 0,00	
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes.			R 0,00	
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp.			R 0,00	
EE.	**Ultrasound examinations** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist.			R 0,00	
FF.	a. When a cystoscopy precedes a related operation, Modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, Modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to item 1949: Cystoscopy, when performed together with any of items 1951 to 1973.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.			R 0,00	
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").			R 0,00	
XX.	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to a hospital or day clinic,			R 0,00	
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 a hospital or day clinic (could be within the confines of a hospital).			R 0,00	
	MODIFIERS GOVERNING THE STRUCTURE			R 0,00	
0002	Written report on X-rays: The lowest-level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest-level initial hospital visit code, as appropriate, are not to be used for routine reporting of X-rays taken elsewhere.			R 0,00	
0004	**Procedures performed in own procedure rooms** a. Procedures performed in a doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). b. See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which Modifier 0004 should not be applied. c. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0005	**Multiple therapeutic procedures/operations under the same anaesthetic** a. Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedure b. In the case of multiple fractures and/or dislocations the above values shall prevail. c. When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic. procedures performed, are performed under the same general anaesthetic, Modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d. Please note: When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) Modifier 0005 is not applicable as the fee is already a reduced fee. e. "+" means that this item is used in addition to another definitive procedure and is therefore not subject to reduction a=ccording to Modifier 0005 (see also Modifier 0082).			R 0,00	
0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote Modifier 0006 with the particular items which they use.			R 0,00	
0007	a. Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – 15,00 clinical procedure units irrespective of the number of items of equipment provided. b. Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital – 15,00 clinical procedure units irrespective of the number of items of equipment provided. c. Not funded for all disciplines when using tariff code 5103.			R 0,00	
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedure units.			R 0,00	
0010	**Local anaesthetic** a. A fee for a local anaesthetic administered by the operator may only be charged for 1. an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single item); or 2. where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. b. The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per Modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. c. Not applicable to radiological procedures (such as angiography and myelography). d. No fee may be levied for topical application of local anaesthetic. e. Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.			R 0,00	
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment).			R 0,00	
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.			R 0,00	
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.			R 0,00	
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item).			R 0,00	
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.			R 0,00	
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2 500 g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.			R 0,00	
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable.			R 0,00	
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.			R 0,00	
0048	Where, in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).			R 0,00	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures, including debridement.			R 0,00	
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable) .			R 0,00	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.			R 0,00	
0053	Fracture requiring percutaneous internal fixation (insertion and removal of fixatives [wires] in respect of fingers and toes included): Specialists and general practitioners add 32,00 clinical procedure units.			R 0,00	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.			R 0,00	
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers).			R 0,00	
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.			R 0,00	
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.			R 0,00	
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts.			R 0,00	
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere.			R 0,00	
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee.			R 0,00	
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (for other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhere in the Tariff).			R 0,00	
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.			R 0,00	
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope.			R 0,00	
0072	Non-invasive peripheral vascular tests: The number of tests in a single case is restricted to two (2) per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.			R 0,00	
0073	When item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists (‘33’): fee for procedure + 100%.			R 0,00	
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee (“+” codes excluded) will apply where endoscopic procedures are performed with own equipment.			R 0,00	
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the Tariff.			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. Only applicable if services are provided by a specialist in physical medicine.			R 0,00	
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure.			R 0,00	
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (Items 2957, 2974 or 2975).			R 0,00	
0080	Multiple examinations: Full fee			R 0,00	
0081	Repeat examinations: No reduction			R 0,00	
0082	“+” means that this item is complementary to a preceding item and is therefore not subject to reduction			R 0,00	
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.			R 0,00	
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. (This information is obtainable from the Radiological Society of SA.)			R 0,00	
0085	‘Left Side’ modifier be added to when items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined.			R 0,00	
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations.			R 0,00	
0090	Radiologist’s fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only.)			R 0,00	
0091	Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to a hospital or day clinic (refer to Rule XX).			R 0,00	
0092	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to a hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY).			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0095	Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, Modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, 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.			R 0,00	
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope			R 0,00	
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.			R 0,00	
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units.			R 0,00	
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units.			R 0,00	
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: Plus 30%			R 0,00	
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.			R 0,00	
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.			R 0,00	
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee.			R 0,00	
6103	Post-contrast study: Bone tumour – 100% of the fee.			R 0,00	
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable			R 0,00	
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items.			R 0,00	
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.			R 0,00	

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6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability			R 0,00	
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”			R 0,00	
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain study.			R 0,00	
6110	MRI spectroscopy: 50% of fee			R 0,00	
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for Items 3536-3550 will be allowed (specify time of procedure on account).			R 0,00	
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).			R 0,00	
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).			R 0,00	
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non-radiologist performing the procedure.			R 0,00	
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.			R 0,00	
I.	**Consultative services (refer to Psychiatrists Consultative Service guide)**			R 0,00	
I.a	General Practitioner visits			R 0,00	
I.b	Specialists tiered consultation structure			R 0,00	
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only			R 0,00	
0161	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with problem-focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist refer to Items 0166-0169)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0162	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169)			R 0,00	
0163	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).			R 0,00	
0164	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist refer to Items 0166-0169).			R 0,00	
0166	Psychiatry (22): First hospital consultation/visit with problem-focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes			R 0,00	
0167	Psychiatry (22): First 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 and 35 minutes			R 0,00	
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes			R 0,00	
0169	Psychiatry (22): First hospital consultation/visit 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			R 0,00	
I.c	General practitioner and specialist services (refer to the Medical Practitioner Consultative Service guide)			R 0,00	
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health-care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Items 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.			R 0,00	
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 Items 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
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.			R 0,00	
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.			R 0,00	
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health-care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.			R 0,00	
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.			R 0,00	
0109	Hospital follow-up visit to patient in ward or nursing facility: Refer to General Rule G.a. for post-operative care. May only be charged once per day – not to be used with Items 0111, 0145, 0146, 0147 or ICU Items 1204-1214.			R 0,00	
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists. May only be charged once per day. Not to be used with Item 0109 or ICU Items 1204-1214. For a healthy neonate please use item 0109 for a hospital follow-up visit.			R 0,00	
0129	Prolonged face-to-face attendance to a patient: Add to either Item 0192, Item 0175, Item 0164 or Item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes.			R 0,00	
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): Add only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164 or Items 0166-0169, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.			R 0,00	
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: Add only to the consultation/visit items 0190-0192, Items 0161-0164 or Items 0151-0153, as appropriate (refer to General Rule B). Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.			R 0,00	
0147	For an emergency consultation/visit away from the doctor's home or rooms, all hours: Add only to the consultation/visit Iitems 0190-0192, Items 0173-0175, Items 0161-0164, Items 0166-0169 or Items 0151-0153, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
I.e	Pre-anaesthetic assessment			R 0,00	
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes.			R 0,00	
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes.			R 0,00	
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes.			R 0,00	
I.f	Prenatal visits and newborn attendance			R 0,00	
0107	Newborn attendance: Exclusive attendance to baby at caesarean section, normal delivery or visit in the ward (once per patient). Items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to Item 0107.			R 0,00	
	Item 0107 can be used once only for given confinement.			R 0,00	
0113	Newborn attendance: Emergency attendance to newborn at all hours (once per patient). Items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to Item 0113.			R 0,00	
I.g	Consultative services: Miscellaneous			R 0,00	
0130	Telephone consultation (all hours)			R 0,00	
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (need not be face-to-face contact) “Consultation” via SMS or electronic media included.			R 0,00	
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent.			R 0,00	
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent.			R 0,00	
II.	**Medicine, material, supplies and use of own equipment**			R 0,00	
II.a	Medicine codes			R 0,00	
II.a.1	Dispensing of medicine by licensed dispensing medical practitioners			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0197	Licenced dispensing medical practitioners: Dispensing cost As per legislated tariff. Add to each NAPPI code to provide for the dispensing cost.			R 0,00	
II.a.2	Once-off administration of medicine used during a consultation			R 0,00	
0198	Once-off administration of medicinesThis item provides for medicines used at a consultation, viz once-off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS legislated tariff for dispensing fees. (Where applicable, VAT should be added to the dispensing fee only and not to the SEP, since the SEP is VAT inclusive.) (According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation.) The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the medicine used. Please note: Refer to item 0201 for cost of material used in treatment.			R 0,00	
II.a.3	Cost of chemotherapy drugs			R 0,00	
0212	Cost of chemotherapy drugs: This item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.			R 0,00	
II.b	Material codes			R 0,00	
II.b.1	Prosthesis and/or internal fixation			R 0,00	
II.b.2	Material used during a consultation			R 0,00	
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above.) The appropriate Surgical and Material Nappi code(s), selected from those codes commencing with 4, 5 or 6, where applicable, for the material used, must be provided. Please note: Refer to Item 0198 for once-off administration of medicine.			R 0,00	
0194	Procurement cost for human donor material – no mark-up allowed.			R 0,00	
II.c	Setting of sterile tray			R 0,00	
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to item 0201, as appropriate			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
II.d	Own equipment used in treatment			R 0,00	
5930	Surgical laser apparatus: Hire fee for own equipment.			R 0,00	
5932	Candella laser apparatus: Hire fee for own equipment (rates by arrangement with the scheme concerned).			R 0,00	
III.	**Procedures**			R 0,00	
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use Item 6999.			R 0,00	
	GENERAL MODIFIERS GOVERNING THIS SECTION			R 0,00	
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.			R 0,00	
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.			R 0,00	
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.			R 0,00	
	MODIFIERS GOVERNING SECTION 1			R 0,00	
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative service units using modifier 0017 to reflect the amount (not chargeable together with a consultation item).			R 0,00	
1	**General**			R 0,00	
1.1	Injections, infusions and inhalation sedation treatment			R 0,00	
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states – first quarter-hour or part thereof			R 0,00	
0204	Inhalation sedation: Per additional quarter-hour or part thereof			R 0,00	
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in), patients under three years – cut-down and/or insertion of cannula chargeable once per 24 hours			R 0,00	
0206	Intravenous treatment: Intravenous infusions (push-in), patients over three years – insertion of cannula – chargeable once per 24 hours			R 0,00	
0207	Intravenous treatment: Intravenous infusions (cut-down) (patients over three years) – cut-down and insertion of cannula chargeable once per 24 hours			R 0,00	
0208	Venesection: Therapeutic venesection (not to be used when blood is drawn for the purpose of laboratory investigations)			R 0,00	
0209	Umbilical artery cannulation at birth			R 0,00	
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)			R 0,00	
0211	Exchange transfusion: First and subsequent (including after-care)			R 0,00	
	Note: How to charge for intravenous infusions Practitioners are entitled to charge according to the appropriate item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultation (not applicable ti Item 0205).			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1.2	Chemotherapy treatment (not in chemotherapy facilities)			R 0,00	
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.			R 0,00	
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.			R 0,00	
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.			R 0,00	
1.3	Oncology related services in non-oncology facilties			R 0,00	
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included.			R 0,00	
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included.			R 0,00	
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included.			R 0,00	
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately).			R 0,00	
	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS			R 0,00	
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.			R 0,00	
0021	Determination of anaesthetic fees: Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the “Anaesthetic Performed” column) plus the time units (calculated according to the formula in modifier 0023) and the appropriate modifers (see modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by modifiers 5441 to 5448.			R 0,00	

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0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/ anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time – the remuneration for anaesthetic time shall be per 15-minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15-minute period or part thereof, provided that should the duration of the anaesthetic be longer than one hour the number of units shall, after one hour, be 3,00 anaesthetic units per 15 minute period or part thereof.			R 0,00	
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.			R 0,00	
0025	**Calculation of anaesthetic time** Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/ anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.			R 0,00	
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units.			R 0,00	
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute			R 0,00	
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic.			R 0,00	
0030	Indicator for use of low flow anaesthetic technique 1-2 litres/minute: Fresh gas flow of 1 to 2 litres/minute.			R 0,00	
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to or during actual theatre or operating time.			R 0,00	
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.			R 0,00	

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0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist and modifier 0036: Anaesthetic administered by general practitioners.			R 0,00	
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.			R 0,00	
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).			R 0,00	
0036	**Anaesthetic administered by general practitioners** The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time [refer to modifier 0023] plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.			R 0,00	
0037	Body hypothermia: Utilisation of total body hypothermia – add 3,00 anaesthetic units	30	3	R 304,90	
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage			R 0,00	
0039	Control of blood pressure: Deliberate control of blood pressure – all cases up to one hour – add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof			R 0,00	
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units			R 0,00	
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation – add 3,00 anaesthetic units	30	3	R 304,90	
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation – add 3,00 anaesthetic units	30	3	R 304,90	
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added	30	3	R 304,90	

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0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to modifier 0043: Cases under one year of age	30	3	R 304,90	
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable			R 0,00	
	Modifiers 5441 to 5448 Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. The letter “M” is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items.			R 0,00	
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in modifiers 5442 to 5448	30	1	R 101,50	
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units	30	2	R 203,40	
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units	30	3	R 304,90	
5444	Shaft of femur: Add four (4,00) anaesthetic units	30	4	R 406,90	
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units.	30	5	R 508,50	
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units	30	8	R 813,40	
	Post-operative alleviation of pain			R 0,00	
0045	**Post-operative alleviation of pain** a. When a regional or nerve block procedure is performed, the appropriate procedure item to patient in a ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique. b. When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in a ward or nursing facility. c. None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drugs).			R 0,00	
2	**Integumentary system**			R 0,00	
2.1	Allergy			R 0,00	
0217	Allergy: Patch tests – first patch			R 0,00	

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0218	Allergy: Skin-prick tests – skin-prick testing: insect venom, latex and drugs			R 0,00	
0219	Allergy: Patch tests – each additional patch			R 0,00	
0220	Allergy: Skin-prick tests – immediate hypersensitivity testing (Type I reaction): per antigen – inhalant and food allergens			R 0,00	
0221	Allergy: Skin-prick tests – delayed hypersensitivity testing (Type IV reaction): per antigen			R 0,00	
2.2	Skin (general)			R 0,00	
0222	Intralesional injection into areas of pathology e.g. Keloid, single			R 0,00	
0223	Intralesional injection into areas of pathology e.g. Keloids, multiple			R 0,00	
0225	Epilation: Per session			R 0,00	
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of comedones and/or steaming, abrasive cleaning of skin and UVR per session.	30	4	R 406,90	T
0228	PUVA treatment: Maximum of 21 treatments			R 0,00	
0229	PUVA: Follow-up or maintenance therapy once a week			R 0,00	
0230	UVR treatment			R 0,00	
0231	UVR follow-up – for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp.			R 0,00	
0232	Biopsy of superficial soft tissue: Back or flank		5	R 508,50	
0233	Biopsy without suturing: First lesion	30	3	R 304,90	T
0234	Biopsy without suturing: Subsequent lesions (each)	30	3	R 304,90	T
0235	Biopsy without suturing: Maximum for multiple additional lesions	30	3	R 304,90	T
0236	Biopsy of superficial soft tissue: Shoulder area		3	R 304,90	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	30	3	R 304,90	T
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		3	R 304,90	
0239	Biopsy of superficial soft tissue: Forearm and/or wrist		3	R 304,90	

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0240	Biopsy of superficial soft tissue: Leg or ankle area		3	R 304,90	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	30	3	R 304,90	T
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	30	3	R 304,90	T
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	30	3	R 304,90	T
0244	Repair of nail bed	30	3	R 304,90	T
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	30	3	R 304,90	T
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	30	3	R 304,90	T
0247	Biopsy of superficial soft tissue: Pelvis and hip area		3	R 304,90	
0248	Biopsy of superficial soft tissue: Thigh or knee area		3	R 304,90	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	30	3	R 304,90	T
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	30	3	R 304,90	T
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	30	3	R 304,90	T
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus.	30	3	R 304,90	T
0259	Removal of foreign body – superficial to deep fascia (except hands)	30	3	R 304,90	T
0261	Removal of foreign body – deep to deep fascia (except hands)	30	3	R 304,90	T
0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax, less than 3 cm		5	R 508,50	
0263	Excision tumour of subcutaneous soft tissue: Shoulder area, less than 3 cm		3	R 304,90	
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area, less than 3 cm		3	R 304,90	
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area, less than 3 cm		3	R 304,90	
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger, less than 1.5 cm		3	R 304,90	
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area, less than 3 cm		3	R 304,90	

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0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area, less than 3 cm		3	R 304,90	
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area, less than 3 cm		3	R 304,90	
0270	Excision tumour of subcutaneous soft tissue: Foot or toe, less than 1.5 cm		3	R 304,90	
0271	Kurtin planing for acne scarring: Whole face	30	4	R 406,90	T
0273	Kurtin planing for acne scarring: Extensive	30	4	R 406,90	T
0274	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour-coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue). First stage, up to five tissue blocks.		5	R 508,50	
0275	Kurtin planing for acne scarring: Limited	30	4	R 406,90	T
0276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour-coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue). Each additional stage after the first stage, up to five tissue blocks.		5	R 508,50	
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	30	4	R 406,90	T
0278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour-coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue). Each additional block after the first five tissue blocks, any stage.		5	R 508,50	
0279	Surgical treatment for axillary hyperhidrosis	30	4	R 406,90	T
0280	Laser treatment for small skin lesions: First lesion	30	3	R 304,90	T
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	30	3	R 304,90	T
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	30	3	R 304,90	T
0283	Laser treatment for large skin lesions: Limited area	30	4	R 406,90	T
0284	Laser treatment for large skin lesions: Extensive area	30	4	R 406,90	T
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	30	4	R 406,90	T
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp			R 0,00	
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device			R 0,00	

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2.3	Major plastic repair			R 0,00	
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	30	4	R 406,90	T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	30	4	R 406,90	T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	30	4	R 406,90	T
0292	Distant flaps: First stage	30	4	R 406,90	T
0293	Contour grafts (excluding cost of material)	30	4	R 406,90	T
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	30	6	R 610,20	T
0295	Local skin flaps (large, complicated)	30	4	R 406,90	T
0296	Other procedures of major technical nature	30	4	R 406,90	T
0297	Subsequent major procedures for repair of same lesion	30	4	R 406,90	T
0298	Lower abdominal dermo-lipectomy	30	5	R 508,50	T
0299	Major abdominal lipectomy with repositioning of umbilicus	30	5	R 508,50	T
2.4	Lacerations, scars, tumours, cysts and other skin lesions			R 0,00	
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia); including normal after-care	30	3	R 304,90	T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	30	3	R 304,90	T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	30	4	R 406,90	T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	30	4	R 406,90	T
0304	Major debridement of wound, sloughectomy or secondary suture	30	3	R 304,90	T
0305	Needle biopsy – soft tissue	30	3	R 304,90	T
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	30	3	R 304,90	T
0308	Each additional small procedure done at the same time	30	3	R 304,90	T
0310	Radical excision of nailbed	30	3	R 304,90	T
0311	Excision of large benign tumour (more than 5 cm)	30	3	R 304,90	T
0313	Extensive resection for malignant soft tissue tumour including muscle.	30	4	R 406,90	T

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0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	30	4	R 406,90	T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	30	3	R 304,90	T
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		3	R 304,90	
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis – add for every additional 20 square cm or part thereof		3	R 304,90	
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		5	R 508,50	
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue – add for every additional 20 square cm or part thereof		5	R 508,50	
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		6	R 610,20	
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia – add for every additional 20 square cm or part thereof		6	R 610,20	
4880	Biopsy soft tissue: Neck or thorax		5	R 508,50	
4881	Biopsy of soft tissue: Deep – back or flank		5	R 508,50	
4882	Biopsy of soft tissue: Deep – shoulder area		5	R 508,50	
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular) – upper arm or elbow area		3	R 304,90	
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular) – forearm and/or wrist		3	R 304,90	
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular) – thigh or knee area		4	R 406,90	
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular) – leg or ankle area		3	R 304,90	
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular) – pelvis and hip area		4	R 406,90	
2.5	Breasts			R 0,00	
0316	Fine needle aspiration for soft tissue (all areas)			R 0,00	
0317	Aspiration of cyst or tumour	30	3	R 304,90	T
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	30	3	R 304,90	T
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	30	3	R 304,90	T
0323	Subareolar cone excision of ducts of wedge excision of breast	30	3	R 304,90	T
0324	Wedge excision of breast and axillary dissection	30	5	R 508,50	T

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0325	Total mastectomy	30	5	R 508,50	T
0327	Total mastectomy with axillary gland biopsy	30	5	R 508,50	T
0329	Total mastectomy with axillary gland dissection	30	5	R 508,50	T
0330	Nipple and areola reconstruction	30	4	R 406,90	T
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	30	4	R 406,90	T
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	30	4	R 406,90	T
0334	Removal of breast implant by means of capsulectomy: Per breast	30	4	R 406,90	T
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	30	4	R 406,90	T
0337	Reduction: Mammoplasty for pathological hypertrophy – unilateral	30	5	R 508,50	T
0339	Reduction: Mammoplasty for pathological hypertrophy – bilateral	30	5	R 508,50	T
0341	Gynaecomastia: Unilateral	30	3	R 304,90	T
0343	Gynaecomastia: Bilateral	30	3	R 304,90	T
2.6	Burns			R 0,00	
0351	Major Burns: Resuscitation (including supervision and intravenous therapy – first 48 hours)	30	5	R 508,50	T
0353	Tangential excision and grafting: Small	30	5	R 508,50	T
0354	Tangential excision and grafting: Large	30	5	R 508,50	T
2.7	Hands (skin)			R 0,00	
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	30	4	R 406,90	T
0357	Small skin graft in acute hand injury	30	3	R 304,90	T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	30	3	R 304,90	T
0361	Z-plasty	30	3	R 304,90	T
0363	Local flap and skin graft	30	3	R 304,90	T
0365	Cross finger flap (all stages)	30	3	R 304,90	T
0367	Palmar flap (all stages)	30	3	R 304,90	T

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0369	Distant flap: First stage	30	3	R 304,90	T
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	30	3	R 304,90	T
0373	Transfer neurovascular island flap	30	3	R 304,90	T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	30	3	R 304,90	T
0375	Dupuytren's contracture: Fasciotomy	30	3	R 304,90	T
0376	Dupuytren's contracture: Fasciectomy	30	3	R 304,90	T
2.8	Acupuncture			R 0,00	
	Please note: General Rule M is not applicable to section 2.8 of this price list.			R 0,00	
0377	Standard acupuncture			R 0,00	
0378	Laser acupuncture using more than six points			R 0,00	
0379	Electro-acupuncture			R 0,00	
0380	Scalp acupuncture			R 0,00	
0381	Micro-acupuncture (ear, hand)			R 0,00	
	RULES GOVERNING THE SECTION ON ACUPUNCTURE			R 0,00	
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp.			R 0,00	
3	**Musculo-skeletal system**			R 0,00	
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS.			R 0,00	
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.			R 0,00	

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0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).			R 0,00	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including, debridement.			R 0,00	
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either Modifier 0049: Cases of compound fractures, or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either Modifier 0049: Cases of compound fractures or Modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable).			R 0,00	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.			R 0,00	
0052	Except where otherwise specified, fracture (traumatic or surgical, ie. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixtion/and or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as long bone or pelvis fracture/osteotomy (refer to modifier 0051) for specialist and general practitioners for HAND or FOOT fracture/osteotomy: Add			R 0,00	
0053	Fracture requiring percutaneous internal fixation (insertion and removal of fixatives [wires] in respect of fingers and toes included): Specialists and general practitioners add 32,00 clinical procedure units.			R 0,00	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.			R 0,00	
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.			R 0,00	
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Per fee for total joint replacement + 100%			R 0,00	
3.1	Bones			R 0,00	
3.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047)			R 0,00	
0383	Fracture (reduction under general anaesthetic): Scapula	30	3	R 304,90	TM
0384	Fracture: Scapula – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0386	Fracture: Clavicle – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	

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0387	Fracture (reduction under general anaesthetic): Clavicle	30	3	R 304,90	TM
0388	Percutaneous pinning of supracondylar fracture: Elbow – stand-alone procedure	30	3	R 304,90	TM
0389	Fracture (reduction under general anaesthetic): Humerus	30	3	R 304,90	TM
0390	Fracture: Humerus – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0391	Fracture (reduction under general anaesthetic): Radius and/or ulna	30	3	R 304,90	TM
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	30	3	R 304,90	TM
0401	Fracture: Carpal bone – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0402	Fracture (reduction under general anaesthetic): Carpal bone	30	3	R 304,90	TM
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	30	3	R 304,90	TM
0404	Fracture: Bennett fracture/dislocation – open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)		3	R 304,90	
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal – simple	30	3	R 304,90	TM
0406	Fracture: Metacarpal bone – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0409	Fracture (reduction under general anaesthetic): Finger phalanx – distal, simple	30	3	R 304,90	TM
0410	Fracture: Finger phalanx, distal, simple – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0411	Fracture (reduction under general anaesthetic): Finger phalanx – distal, compound	30	3	R 304,90	TM
0413	Fracture (reduction under general anaesthetic): Proximal or middle – simple	30	3	R 304,90	T
0414	Fracture: Finger phalanx, proximal or middle – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0415	Fracture (reduction under general anaesthetic): Proximal or middle – compound	30	3	R 304,90	TM
0417	Fracture (reduction under general anaesthetic): Pelvis fracture – closed	30	3	R 304,90	T
0419	Fracture (reduction under general anaesthetic): Pelvis – operative reduction and fixation	30	3	R 304,90	TM
0420	Fracture: Acetabulum: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0421	Fracture (reduction under general anaesthetic): Femur – neck or shaft	30	3	R 304,90	TM
0422	Fracture: Femur neck or shaft – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0425	Fracture (reduction under general anaesthetic): Patella	30	3	R 304,90	TM
0426	Fracture: Patella – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	30	3	R 304,90	TM
0430	Fracture: Tibia, with or without fibula – open reduction and internal fixation (modifiers 0051, 0052 not applicable		3	R 304,90	
0433	Fracture (reduction under general anaesthetic): Fibula shaft	30	3	R 304,90	TM
0434	Fracture: Fibula shaft – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	30	3	R 304,90	TM
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	30	3	R 304,90	TM
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	30	3	R 304,90	TM
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	30	3	R 304,90	TM
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	30	3	R 304,90	TM
0441	Fracture (reduction under general anaesthetic): Metatarsal	30	3	R 304,90	TM
0442	Fracture: Metatarsal bones – open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0443	Fracture (reduction under general anaesthetic): Toe phalanx – distal, simple	30	3	R 304,90	T
0444	Fracture: Toe phalanx, distal – open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0445	Fracture (reduction under general anaesthetic): Toe phalanx – compound	30	3	R 304,90	TM
0446	Fracture: Tarsal bones (excluding talus and calcaneus): Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0447	Fracture (reduction under general anaesthetic): Other – simple	30	3	R 304,90	T
0448	Fracture: Calcaneus (reduction under general anaesthetic)		3	R 304,90	
0449	Fracture (reduction under general anaesthetic): Other – compound	30	3	R 304,90	TM
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribsclosed	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Copen reduction and fixation of multiple fractured ribs for flail chest	30	3	R 304,90	TM
0455	Fracture (reduction under general anaesthetic): Spine: with or without paralysis – cervical	30	3	R 304,90	TM
0461	Fracture (reduction under general anaesthetic): Compression fracture – cervical	30	3	R 304,90	TM
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes – cervical	30	3	R 304,90	TM
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes – rest	30	3	R 304,90	TM
3.1.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047) – operations for fractures			R 0,00	
0465	Fractures involving large joints (includes the item for the relative bone) (this item may not be used as a modifier)	30	3	R 304,90	TM
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone; open reduction and internal fixation (modifiers 0051, 0052 not applicable)		3	R 304,90	
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) (modifier 0005 not applicable)	30	3	R 304,90	T
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, fibia, humerus, radius and ulna	30	3	R 304,90	TM
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	30	3	R 304,90	TM
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		10	R 1 016,80	
0481	Radical resection of bone tumour: Fibula		4	R 406,90	
0482	Radical resection of bone tumour: Femur or knee		5	R 508,50	
0483	Radical resection of malignant bone tumour: Scapula		6	R 610,20	
0484	Radical resection of bone tumour: Clavicle		6	R 610,20	
0485	Radical resection of bone tumour: Metatarsal		4	R 406,90	
3.1.2	Bony operations			R 0,00	
3.1.2.1	Bony operations: Bone grafting			R 0,00	
0497	Resection of bone or tumour with or without grafting (benign)	30	3	R 304,90	TM
0498	Resection of bone or tumour with or without grafting (malignant) – does not include digits	30	3	R 304,90	TM
0499	Grafts to cysts: Large bones	30	3	R 304,90	TM
0501	Grafts to cysts: Small bones	30	3	R 304,90	TM

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0503	Grafts to cysts: Cartilage graft	30	3	R 304,90	TM
0505	Grafts to cysts: Inter-metacarpal bone graft	30	3	R 304,90	TM
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	30	3	R 304,90	TM
3.1.2.2	Bony operations: Acute or chronic osteomyelitis			R 0,00	
0509	Acute or chronic osteomyelitis: Conservative treatment			R 0,00	
0511	Acute or chronic osteomyelitis: Operation – tariff which would be applicable for compound fracture of the bone involved, including six weeks' post-operative care			R 0,00	
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage, including six weeks' after-care	30	3	R 304,90	TM
3.1.2.3	Bony operations: Osteotomy			R 0,00	
0514	Osteotomy: Sternum – repair of pectus excavatum	30	3	R 304,90	TM
0515	Osteotomy: Sternum – repair of pectus carinatum	30	3	R 304,90	TM
0516	Osteotomy: Pelvic	30	3	R 304,90	TM
0521	Osteotomy: Femoral – proximal	30	3	R 304,90	TM
0527	Osteotomy: Knee region	30	3	R 304,90	TM
0528	Osteotomy: Os Calcis (Dwyer operation)	30	3	R 304,90	TM
0530	Osteotomy: Metacarpal and phalanx – corrective for malunion or rotation	30	3	R 304,90	TM
0531	Rotational osteotomy of tibia and fibula – stand-alone procedure	30	3	R 304,90	TM
0532	Osteotomy: Rotation osteotomy of the radius, ulna or humerus	30	3	R 304,90	TM
0533	Osteotomy: Single metatarsal	30	3	R 304,90	TM
0534	Osteotomy: Multiple metatarsal osteotomies	30	3	R 304,90	TM
3.1.2.4	Bony operations: Exostosis			R 0,00	
0535	Exostosis: Excision – readily accessible sites	30	3	R 304,90	TM
0537	Exostosis: Excision – less accessible sites	30	3	R 304,90	TM
3.1.2.5	Bony operations: Biopsy			R 0,00	
0539	Needle biopsy: Spine (no after-care) – modifier 0005 not applicable	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0541	Needle biopsy: Other sites (no after-care) – modifier 0005 not applicable	30	4	R 406,90	T
0543	Biopsy: Open (modifier 0005 not applicable) – readily accessible site			R 0,00	
0545	Biopsy: Open (modifier 0005 not applicable) – less accessible site			R 0,00	
3.2	Joints			R 0,00	
3.2.1	Joints: Dislocations			R 0,00	
0547	Joint: Dislocation – clavicle either end	30	3	R 304,90	TM
0549	Joint: Dislocation – shoulder	30	3	R 304,90	TM
0551	Joint: Dislocationvelbow	30	3	R 304,90	TM
0552	Joint: Dislocation – wrist	30	3	R 304,90	TM
0553	Joint: Dislocation – perilunar trans-scaphoid fracture dislocation	30	3	R 304,90	TM
0555	Joint: Dislocation – lunate	30	3	R 304,90	TM
0556	Joint: Dislocation – carpo-metacarpo dislocation	30	3	R 304,90	TM
0557	Joint: Dislocation – metacarpo-phalangeal or interphalangeal (hand)	30	3	R 304,90	TM
0559	Joint: Dislocation – hip	30	3	R 304,90	TM
0561	Joint: Dislocation – knee	30	3	R 304,90	TM
0563	Joint: Dislocation – patella	30	3	R 304,90	TM
0565	Joint: Dislocation – ankle	30	3	R 304,90	TM
0567	Joint: Dislocation – sub-Talar dislocation	30	3	R 304,90	TM
0569	Joint: Dislocation – intertarsal or tarsometatarsal or mid-tarsal	30	3	R 304,90	TM
0571	Joint: Dislocation – meta-tarsophalangeal or interphalangeal joints (foot)	30	3	R 304,90	TM
0573	Joint: Dislocation – spine with or without paralysis			R 0,00	
3.2.2	Joints: Operations for dislocations			R 0,00	
0578	Operations for dislocations: Recurrent dislocation of shoulder	30	3	R 304,90	TM
0579	Operations for dislocations: Recurrent dislocation of all other joints	30	3	R 304,90	TM

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3.2.3	Joints: Capsular operations			R 0,00	
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	30	3	R 304,90	TM
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	30	3	R 304,90	TM
0585	Capsulectomy digital joint	30	3	R 304,90	TM
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	30	3	R 304,90	TM
0587	Release of digital joint contracture	30	3	R 304,90	TM
3.2.4	Joints: Synovectomy			R 0,00	
0589	Synovectomy: Digital joint	30	3	R 304,90	TM
0592	Synovectomy: Large joint	30	3	R 304,90	TM
0593	Tendon synovectomy	30	3	R 304,90	TM
3.2.5	Joints: Arthrodesis			R 0,00	
0597	Arthrodesis: Shoulder	30	3	R 304,90	TM
0598	Arthrodesis: Elbow	30	3	R 304,90	TM
0599	Arthrodesis: Wrist	30	3	R 304,90	TM
0600	Arthrodesis: Digital joint	30	3	R 304,90	TM
0601	Arthrodesis: Hip	30	3	R 304,90	TM
0602	Arthrodesis: Knee	30	3	R 304,90	TM
0603	Arthrodesis: Ankle	30	3	R 304,90	TM
0604	Arthrodesis: Sub-talar	30	3	R 304,90	TM
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	30	3	R 304,90	TM
0607	Arthrodesis: Mid-tarsal wedge resection	30	3	R 304,90	TM
3.2.6	Joints: Arthroplasty			R 0,00	
0614	Arthroplasty: Debridement large joints	30	3	R 304,90	TM
0615	Arthroplasty: Excision medial or lateral end of clavicle	30	3	R 304,90	TM

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0617	Shoulder: Acromioplasty	30	3	R 304,90	TM
0619	Shoulder: Partial replacement	30	5	R 508,50	TM
0620	Shoulder: Total replacement	30	5	R 508,50	TM
0621	Elbow: Excision head of radius	30	3	R 304,90	TM
0622	Elbow: Excision	30	3	R 304,90	TM
0623	Elbow: Partial replacement	30	3	R 304,90	TM
0624	Elbow: Total replacement	30	3	R 304,90	TM
0625	Wrist: Excision distal end of ulna	30	3	R 304,90	TM
0626	Wrist: Excision single bone	30	3	R 304,90	TM
0627	Wrist: Excision proximal row	30	3	R 304,90	TM
0631	Wrist: Total replacement	30	3	R 304,90	TM
0635	Digital Joint: Total replacement	30	3	R 304,90	TM
0637	Hip: Total replacement	30	3	R 304,90	TM
0641	Hip: Prosthetic replacement of femoral head	30	3	R 304,90	TM
0643	Hip: Girdlestone	30	3	R 304,90	TM
0645	Knee: Partial replacement	30	3	R 304,90	TM
0646	Knee: Total replacement	30	3	R 304,90	TM
0649	Ankle: Total replacement	30	3	R 304,90	TM
0650	Ankle: Astragalectomy	30	3	R 304,90	TM
3.2.7	Joints: Miscellaneous (joints)			R 0,00	
0661	Aspiration of joint or intra-articular injection (not including after-care) – modifier 0005 not applicable	30	3	R 304,90	T
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) – modifier 0005 not applicable, first joint	30	3	R 304,90	T
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) – modifier 0005 not applicable, additional (each)	30	3	R 304,90	T

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0667	Arthroscopy (excluding after-care) (modifiers 0005 and 0013 not applicable)	30	3	R 304,90	T
0669	Manipulating knee or shoulder joint under general anaesthetic (not including after-care) – modifier 0005 not applicable	30	3	R 304,90	T
0669A	Manipulating hip joint under general anaesthetic (not including after-care) – modifier 0005 not applicable	30	4	R 406,90	T
	Only the consultation fee should be charged when manipulation of a large joint is performed without general anaesthetic,			R 0,00	
0673	Meniscectomy or operation for other internal derangement of knee	30	3	R 304,90	TM
3.2.8	Joints: Joint ligament reconstruction or suture			R 0,00	
0675	Joint ligament reconstruction or suture: Ankle – collateral	30	3	R 304,90	TM
0677	Joint ligament reconstruction or suture: Knee – collateral	30	3	R 304,90	TM
0678	Joint ligament reconstruction or suture: Knee – cruciate	30	3	R 304,90	TM
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	30	3	R 304,90	TM
0680	Joint ligament reconstruction or suture: Digital joint ligament	30	3	R 304,90	TM
3.3	Amputations			R 0,00	
3.3.1	Amputations: Specific amputations			R 0,00	
0681	Amputation humerus: Includes primary closure		4	R 406,90	
0682	Amputation: Fore-quarter amputation	30	9	R 915,00	TM
0683	Amputation: Through shoulder	30	5	R 508,50	TM
0684	Amputation: Forearm		3	R 304,90	
0685	Amputation: Upper arm or forearm	30	3	R 304,90	TM
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		4	R 406,90	
0687	Partial amputation of the hand: One ray	30	3	R 304,90	TM
0688	Amputation: Foot, midtarsal (Chopart type)		3	R 304,90	
0691	Amputation: Whole or part of finger	30	3	R 304,90	TM
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		3	R 304,90	

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0693	Hindquarter amputation	30	6	R 610,20	TM
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		3	R 304,90	
0695	Amputation: Through hip joint region	30	6	R 610,20	TM
0696	Re-amputation: Thigh, through femur, any level		3	R 304,90	
0697	Amputation: Through thigh	30	6	R 610,20	TM
0698	Re-amputation: Leg, through tibia and fibula		3	R 304,90	
0699	Amputation: Below knee, through knee or Syme	30	5	R 508,50	TM
0700	Scar revision/secondary closure: Amputated shoulder		3	R 304,90	
0701	Amputation: Trans-metatarsal or trans-tarsal	30	3	R 304,90	TM
0702	Scar revision/secondary closure: Amputated humerus		3	R 304,90	
0703	Amputation: Foot – one ray	30	3	R 304,90	TM
0704	Scar revision/secondary closure: Amputated forearm		3	R 304,90	
0705	Amputation: Toe	30	3	R 304,90	TM
3.3.2	Amputations: Post-amputation reconstruction			R 0,00	
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	30	3	R 304,90	TM
0707	Post-amputation reconstruction: Krukenberg reconstruction	30	3	R 304,90	TM
0708	Re-amputation: Humerus		6	R 610,20	
0710	Re-amputation: Through forearm		3	R 304,90	
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	30	3	R 304,90	TM
0712	Post-amputation reconstruction: Toe to thumb transfer	30	3	R 304,90	TM
3.4	Muscles, tendons and fasciae			R 0,00	
3.4.1	Muscles, tendons and fasciae: Investigations			R 0,00	
0713	Electromyography	30	3	R 304,90	T

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0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with Item 2730)	30	3	R 304,90	T
0715	Strength duration curve per session	30	3	R 304,90	T
0717	Electrical examination of single nerve or muscle	30	3	R 304,90	T
0718	Oxidative study for mitochondrial function			R 0,00	
0721	Voltage integration during isometric contraction	30	3	R 304,90	T
0723	Tonometry with edrophonium	30	3	R 304,90	T
0725	Isometric tension studies with edrophonium	30	3	R 304,90	T
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	30	3	R 304,90	T
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	30	3	R 304,90	T
0729	Tendon reflex time	30	3	R 304,90	T
0730	Limb brain somatosensory studies (per limb)			R 0,00	
0731	Vision and audio-sensory studies			R 0,00	
0733	Motor nerve conduction studies (single nerve)			R 0,00	
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	30	3	R 304,90	T
0737	Biopsy for motor nerve terminals and end plates	30	3	R 304,90	T
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	30	8	R 813,40	T
0740	Muscle fatigue studies	30	3	R 304,90	T
0741	Muscle biopsy	30	8	R 813,40	T
0742	Global fee for all muscle studies, including histochemical studies			R 0,00	
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase			R 0,00	
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase			R 0,00	
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase			R 0,00	
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase			R 0,00	
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase			R 0,00	
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase			R 0,00	
4715	Biochemical estimations on muscle biopsy specimens: Enolase			R 0,00	
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase			R 0,00	
4719	Biochemical estimations on muscle biopsy specimens: Aldolase			R 0,00	
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase			R 0,00	
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase			R 0,00	
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase			R 0,00	
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase			R 0,00	
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study			R 0,00	
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)			R 0,00	
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)			R 0,00	
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies			R 0,00	
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)			R 0,00	
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation			R 0,00	
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia			R 0,00	
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy			R 0,00	
3.4.2	Muscles, tendons and fasciae: Decompression operations			R 0,00	
0743	Major compartmental decompression	30	3	R 304,90	T
0744	Decompression operation: Fasciotomy only	30	3	R 304,90	T
5550	Decompression faciotomy: Buttock compartments – unilateral		5	R 508,50	
5551	Decompression fasciotomy: Leg – anterior and/or lateral and posterior compartment(s); EXCLUDES debridement of nonviable muscle and/or nerve		3	R 304,90	
5552	Decompression fasciotomy: Leg – anterior and/or lateral and posterior compartment(s); INCLUDES debridement of nonviable muscle and/or nerve		3	R 304,90	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5553	Decompression fasciotomy: Leg – anterior and/or lateral compartment(s) only; EXCLUDES debridement of nonviable muscle and/or nerve		3	R 304,90	
5554	Decompression fasciotomy: Leg – anterior and/or lateral compartment(s) only; INCLUDES debridement of nonviable muscle and/or nerv		3	R 304,90	
5555	Decompression fasciotomy: Leg – posterior compartment only; EXCLUDES debridement of nonviable muscle and/or nerve		3	R 304,90	
5556	Decompression fasciotomy: Leg – posterior compartment only; INCLUDES debridement of nonviable muscle and/or nerve		3	R 304,90	
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		4	R 406,90	
5558	Decompression fasciotomy: Fasciotomy – foot and/or toe		3	R 304,90	
5559	Decompression fasciotomy: Forearm and/or wrist – flexor and extensor compartment; EXCLUDES debridement of nonviable muscle or nerve		3	R 304,90	
5560	Decompression fasciotomy: Forearm and/or wrist – flexor and extensor compartment; INCLUDES debridement of nonviable muscle or nerve		3	R 304,90	
5561	Decompression fasciotomy: Forearm and/or wrist – flexor or extensor compartment; EXCLUDES debridement of nonviable muscle or nerve		3	R 304,90	
5562	Decompression fasciotomy: Forearm and/or wrist – flexor or extensor compartment; INCLUDES debridement of nonviable muscle or nerve		3	R 304,90	
5563	Decompression faciotomy: Fingers and/or hand		3	R 304,90	
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair			R 0,00	
0745	Muscle and tendon repair: Biceps humeri	30	3	R 304,90	T
0746	Muscle and tendon repair: Removal of calcification in rotator cuff	30	3	R 304,90	TM
0747	Muscle and tendon repair: Rotator cuff	30	4	R 406,90	T
0748	Muscle and tendon repair: Debridement rotator cuff	30	4	R 406,90	T
0749	Muscle and tendon repair: Scapulopexy – stand-alone procedure	30	4	R 406,90	T
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	30	3	R 304,90	T
0757	Muscle and tendon repair: Achilles tendon repair	30	4	R 406,90	T
0759	Muscle and tendon repair: Other single tendon	30	3	R 304,90	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0760	Hand: Flexor tendon suture – primary, zone 1 (each) – modifier 0005 applicable		3	R 304,90	
0761	Hand: Flexor tendon repair – primary, zone 2 (no mans land), each – modifier 0005 applicable		3	R 304,90	
0762	Hand: Flexor tendon suture – primary, zone 3 and 4 (wrist and forearm), each – modifier 0005 applicable		3	R 304,90	
0763	Muscle and tendon repair: Tendon or ligament injection	30	3	R 304,90	T
0764	Hand: Flexor tendon repair – secondary, zone 1		3	R 304,90	
0765	Hand: Flexor tendon repair – secondary, zone 2 (no man's land)		3	R 304,90	
0766	Hand: Flexor tendon repair – secondary, zone 3 and 4 (wrist and forearm)		3	R 304,90	
0767	Hand: Flexor tendon suture – primary (per tendon)	30	3	R 304,90	T
0768	Repair: Intrinsic muscles of hand (each) – modifier 0005 applicable)		3	R 304,90	
0769	Hand: Flexor tendon suture: Secondary (per tendon)	30	3	R 304,90	T
0771	Extensor tendon suture: Primary (per tendon)	30	3	R 304,90	T
0773	Extensor tendon suture: Secondary (per tendon)	30	3	R 304,90	T
0774	Repair of Boutonniere deformity or Mallet finger with graft	30	3	R 304,90	T
3.4.4	Muscles, tendons and fasciae: Tendon graft			R 0,00	
0775	Free tendon graft	30	3	R 304,90	T
0776	Reconstruction of pulley for flexor tendon	30	3	R 304,90	T
0777	Tendon graft: Finger – flexor	30	3	R 304,90	T
0779	Tendon graft: Finger – extensor	30	3	R 304,90	T
0780	Two stage flexor tendon graft using silastic rod	30	3	R 304,90	T
3.4.5	Muscles, tendons and fasciae: Tendolysis			R 0,00	
0781	Tendon freeing operation, except where specified elsewhere	30	3	R 304,90	T
0782	Carpal tunnel syndrome	30	3	R 304,90	T
0783	Tenolysis: De Quervain	30	3	R 304,90	T
0784	Trigger finger	30	3	R 304,90	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0785	Flexor tendon freeing operation following free tendon graft or suture	30	3	R 304,90	T
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	30	3	R 304,90	T
0788	Intrinsic tendon release per finger	30	3	R 304,90	T
0789	Central tendon tenotomy for Boutonniere deformity	30	3	R 304,90	T
3.4.6	Muscles, tendons and fasciae: Tenodesis			R 0,00	
0790	Tenodesis: Digital joint	30	3	R 304,90	T
3.4.7	Muscles, tendons and fasciae: Muscle tendon and facia transfer			R 0,00	
0791	Single tendon transfer	30	3	R 304,90	T
0792	Multiple tendon transfer	30	3	R 304,90	T
0793	Hamstring to quadriceps transfer	30	3	R 304,90	T
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	30	5	R 508,50	T
0795	Tendon transfer at elbow	30	3	R 304,90	T
0802	Radial club hand repair – stand-alone procedure	30	3	R 304,90	T
0803	Hand tendons: Single tendon transfer (first)	30	3	R 304,90	T
0809	Hand tendons: Substitution for intrinsic paralysis of hand	30	3	R 304,90	T
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	30	3	R 304,90	T
3.4.8	Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening			R 0,00	
0812	Percutaneous tenotomy: All sites	30	3	R 304,90	T
0813	Torticollis	30	5	R 508,50	T
0815	Scalenotomy	30	5	R 508,50	T
0817	Scalenotomy with excision of first rib	30	3	R 304,90	TM
0821	Tennis elbow	30	3	R 304,90	T
0822	Open release elbow (Mitals) – stand-alone procedure	30	3	R 304,90	TM
0823	Excision or slide for Volkmann's Contracture	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0825	Hip: Open muscle release	30	7	R 711,60	T
0829	Knee: Quadriceps plasty	30	3	R 304,90	T
0831	Knee: Open tenotomy	30	3	R 304,90	T
0835	Calf	30	4	R 406,90	T
0837	Open elongation tendon Achilles	30	4	R 406,90	T
0838	Percutaneous “Hoke” elongation tendon Achilles	30	4	R 406,90	T
0845	Foot: Plantar fasciotomy	30	3	R 304,90	T
0846	Foot: Postero-medial release for club foot	30	3	R 304,90	T
3.5	Bursae and ganglia			R 0,00	
0847	Excision: Semimembranosus	30	4	R 406,90	T
0849	Excision: Prepatellar	30	3	R 304,90	T
0851	Excision: Olecranon	30	3	R 304,90	T
0853	Excision: Small bursa or ganglion	30	3	R 304,90	T
0855	Excision: Compound palmar ganglion or synovectomy	30	3	R 304,90	T
0857	Bursae and ganglia: Aspiration or injection (no after-care) – modifier 0005 not applicable	30	3	R 304,90	T
3.6	Musculo-skeletal system: Miscellaneous			R 0,00	
3.6.1	Musculo-skeletal system: Miscellaneous – leg equalisation and congenital hips and feet			R 0,00	
0859	Leg equalisation and congenital hips and feet: Leg shortening	30	3	R 304,90	TM
0861	Leg equalisation and congenital hips and feet: Leg lengthening	30	3	R 304,90	TM
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	30	3	R 304,90	TM
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast – one hip	30	3	R 304,90	TM
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast – both hips	30	3	R 304,90	TM
0868	Open reduction of congenital dislocation of the hip	30	3	R 304,90	TM
0869	Subsequent plasters			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0873	Congenital club foot: Manipulation and plaster – one foot	30	3	R 304,90	T
0874	Ponseti technique assistant (medical practitioner)			R 0,00	
3.6.2	Musculo-skeletal system: Miscellaneous – removal of internal fixatives of prosthesis			R 0,00	
0883	Removal of internal fixatives or prosthesis: Readily accessible	30	3	R 304,90	
0884	Removal of internal fixatives: Less accessible	30	3	R 304,90	
0885	Removal of prosthesis for infection soon after operation	30	6	R 610,20	
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): Add to the item for total joint replacement of the specific joint	30	6	R 610,20	TM
3.7	Plasters (exclusive of after-care)			R 0,00	
0887	Limb cast (excluding after-care) – modifier 0005 not applicable	30	3	R 304,90	T
0888	Application of short limb cast (forearm, lower leg), excluding after-care (first cast included in procedure)		3	R 304,90	
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	30	4	R 406,90	T
0891	Turnbuckle cast for scoliosis (excluding after-care)	30	5	R 508,50	T
0892	Application of cast: Revision (walker, window, bivalve) – excluding after-care		5	R 508,50	
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	30	5	R 508,50	T
0894	Application of cast: Club foot (excluding after-care) – first cast included in procedure		5	R 508,50	
3.8	Musculo-skeletal system: Special areas			R 0,00	
3.8.1	Special areas: Foot and ankle			R 0,00	
0895	Club foot: Revision club foot release – stand-alone procedure	30	3	R 304,90	TM
0896	Club foot: Posterior release only – stand-alone procedure	30	3	R 304,90	TM
0900	Excision tarsal coalition – stand-alone procedure	30	3	R 304,90	TM
0901	Tenotomy: Single tendon	30	3	R 304,90	TM
0903	Hammer toe: One toe	30	3	R 304,90	TM
0905	Filleting of toe or Ruiz-Mora procedure	30	3	R 304,90	TM
0906	Arthrodesis Hallux	30	3	R 304,90	TM

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0907	Silver bunionectomy or similar for Hallux Valgus	30	3	R 304,90	TM
	Not to be charged with Item 0911			R 0,00	
0909	Excision arthroplasty	30	3	R 304,90	TM
0910	Cheilectomy or metatarsophangeal implant Hallux	30	3	R 304,90	TM
0911	Metatarsal osteotomy or Lapidus or similar or Chevron – stand-alone procedure	30	3	R 304,90	TM
	Not to be charged with Item 0907			R 0,00	
5730	Hallux Valgus double osteotomy etc.	30	3	R 304,90	TM
5731	Distal soft tissue procedure for Hallux Valgus	30	3	R 304,90	TM
5732	Aitkin procedure or similar	30	3	R 304,90	T
5734	Removal of bony prominence from foot e.g. bunionette (Bunionette not applicable to COID)	30	3	R 304,90	TM
5735	Repair angular deformity of toe (lesser toes)	30	3	R 304,90	TM
5736	Sesamoidectomy	30	3	R 304,90	TM
5737	Repair major foot tendons e.g. Tib Post	30	3	R 304,90	TM
5738	Repair of dislocating peroneal tendons	30	3	R 304,90	T
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar – one foot	30	3	R 304,90	TM
5740	Steindler strip – plantar fascia	30	3	R 304,90	T
5741	Kelikian syndactilly (one web space)	30	3	R 304,90	T
5742	Tendon transfer foot	30	3	R 304,90	T
5743	Capsulotomy metatarsophalangeal joints: Foot	30	3	R 304,90	T
3.8.2	Big toe (refer to section 3.8.1 for procedures on big toe)			R 0,00	
3.8.3	Special areas: Reimplantations			R 0,00	
0912	Replantation of amputated upper limb proximal to wrist joint	30	3	R 304,90	TM
0913	Replantation of thumb	30	3	R 304,90	TM
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	30	3	R 304,90	TM

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0915	Replantation operation through the palm	30	3	R 304,90	TM
3.8.4	Special areas: Hands (Note: Skin – see integumentary system)			R 0,00	
0919	Tumours: Epidermoid cysts	30	3	R 304,90	TM
0920	Tumours: Ganglion or fibroma	30	3	R 304,90	TM
0921	Tumours: Nodular synovitis (giant cell tumour of tendon sheath)	30	3	R 304,90	TM
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	30	3	R 304,90	TM
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	30	3	R 304,90	TM
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) – minimum	30	3	R 304,90	TM
	Item 0924: The number of units chargeable under this item ranges from 37.00 to 110.00 for Specialists and General Practitioners.			R 0,00	
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	30	3	R 304,90	TM
3.8.5	Special areas: Spine			R 0,00	
	Please note the following with regard to section 3.8.5: Spine a. Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together: 1. Bone graft procedures and instrumentation are to be charged in ddition to arthrodesis. 2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumntation may e charged for in addition. b. Modifier 0005 (multiple procedures/operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. osteotomy, laminectomy			R 0,00	
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	30	3	R 304,90	TM
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	30	3	R 304,90	TM
0929	Manipulation of spine under general anaesthetic (no after-care) (modifier 0005 not applicable)	30	5	R 508,50	TM
0930	Posterior osteotomy of spine: One vertebral segment	30	3	R 304,90	TM
0931	Posterior spinal fusion: One level	30	3	R 304,90	TM
0932	Posterior osteotomy of spine: Each additional vertebral segment	30	3	R 304,90	TM
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	30	3	R 304,90	TM

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	30	3	R 304,90	TM
0938	Anterior fusion base of skull to C2	30	4	R 406,90	TM
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	30	3	R 304,90	TM
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	30	3	R 304,90	TM
0941	Anterior interbody fusion: One level	30	3	R 304,90	TM
0942	Anterior interbody fusion: Each additional level	30	3	R 304,90	TM
0944	Posterior fusion: Occiput to C2	30	4	R 406,90	TM
0946	Posterior spinal fusion: Each additional level	30	3	R 304,90	TM
0948	Posterior interbody lumbar fusion: One level	30	3	R 304,90	TM
0950	Posterior interbody lumbar fusion: Each additional interspace	30	3	R 304,90	TM
0959	Excision of coccy	30	3	R 304,90	TM
0961	Costo-transversectomy	30	3	R 304,90	TM
0963	Antero-lateral decompression of spinal cord or anterior debridement	30	3	R 304,90	T
	MODIFIER			R 0,00	
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.			R 0,00	
3.8.6	Special areas: Spinal deformities			R 0,00	
	Please note: Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).			R 0,00	
0952	Posterior fusion for spinal deformity: Up to six levels	30	3	R 304,90	TM
0954	Posterior fusion for spinal deformity: Seven to 12 levels	30	3	R 304,90	TM
0955	Posterior fusion for spinal deformity: 13 or more levels	30	3	R 304,90	TM
0956	Anterior fusion for spinal deformity: Two or three levels	30	3	R 304,90	TM
0957	Anterior fusion for spinal deformity: Four to seven levels	30	3	R 304,90	TM
0958	Anterior fusion for spinal deformity: Eight or more levels	30	3	R 304,90	TM

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
	MODIFIER			R 0,00	
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months – 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere			R 0,00	
3.8.7	Special areas: All spinal problems			R 0,00	
0943	Laminectomy with decompression of nerve roots and disc removal: One level	30	3	R 304,90	TM
0960	Posterior non-segmental instrumentation	30	5	R 508,50	TM
0962	Posterior segmental instrumentation: Two to six vertebrae	30	5	R 508,50	TM
0964	Posterior segmental instrumentation: Seven to 12 vertebrae	30	5	R 508,50	TM
0966	Posterior segmental instrumentation: 13 or more vertebrae	30	5	R 508,50	TM
0968	Anterior instrumentation: Two to three vertebrae	30	5	R 508,50	TM
0969	Skull or skull-femoral traction including two weeks after-care			R 0,00	
0970	Anterior instrumentation: Four to seven vertebrae	30	5	R 508,50	TM
0971	Halo-splint and POP jacket including two weeks after-care			R 0,00	
0972	Anterior instrumentation: Eight or more vertebrae	30	5	R 508,50	TM
0974	Additional pelvic fixation of instrumentation other than sacrum	30	5	R 508,50	TM
5750	Reinsertion of instrumentation	30	6	R 610,20	TM
5751	Removal of posterior non-segmental instrumentation	30	6	R 610,20	TM
5752	Removal of posterior segmental instrumentation	30	6	R 610,20	TM
5753	Removal of anterior instrumentation	30	6	R 610,20	TM
5755	Laminectomy for spinal stenosis (excludes diskectomy, foraminotomy and spondylolisthesis): One or two levels	30	3	R 304,90	TM
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	30	3	R 304,90	TM
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	30	3	R 304,90	TM
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	30	3	R 304,90	TM
5759	Laminectomy for decompression diskectomy, etc. revision operation	30	4	R 406,90	TM
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	30	3	R 304,90	TM

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	30	3	R 304,90	TM
5763	Anterior disc removal and spinal decompression cervical: One level	30	3	R 304,90	TM
5764	Anterior disc removal and spinal decompression cervical: Each additional level	30	3	R 304,90	TM
5765	Vertebral corpectomy for spinal decompression: One level	30	3	R 304,90	TM
5766	Vertebral corpectomy for spinal decompression: Each additional level	30	3	R 304,90	TM
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)			R 0,00	
3.9	Facial bone procedures			R 0,00	
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9.			R 0,00	
0987	Repair of orbital floor (blowout fracture)	30	4	R 406,90	TM
0988	Genioplasty	30	4	R 406,90	TM
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	30	4	R 406,90	TM
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	30	4	R 406,90	TM
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	30	4	R 406,90	TM
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	30	4	R 406,90	TM
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	30	4	R 406,90	TM
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	30	4	R 406,90	TM
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	30	4	R 406,90	TM
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement			R 0,00	
0997	Mandible: Fractured nose and zygoma – open reduction and fixation	30	3	R 304,90	TM
0998	Excision mandible bone, e.g. osteomyelitis, abscess		5	R 508,30	TM
0999	Mandible: Fractured nose and zygoma – closed reduction by inter-maxillary fixation	30	3	R 304,90	TM
1000	Excision facial bone, e.g. osteomyelitis, abscess		5	R 508,30	TM
1001	Temporo-mandibular joint: Reconstruction for dysfunction	30	4	R 406,90	TM
1002	Harvesting: Bone for contouring of benign bony growths (e.g. fibrous dysplasia)		5	R 508,30	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1003	Manipulation: Immobilisation and follow-up of fractured nose	30	3	R 304,90	TM
1005	Nasal fracture without manipulation			R 0,00	
1007	Mandibulectomy	30	5	R 508,50	TM
1008	Excision: Torus mandibularis		5	R 508,30	TM
1009	Maxillectomy	30	4	R 406,90	TM
1010	Excision: Torus palatinus		5	R 508,30	
1011	Bone graft to mandible	30	4	R 406,90	TM
1012	Adjustment of occlusion by ramisection	30	4	R 406,90	TM
1013	Fracture of arch of zygoma without displacement			R 0,00	
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	30	3	R 304,90	TM
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	30	3	R 304,90	TM
4	**Respiratory system**			R 0,00	
4.1	Nose and sinuses			R 0,00	
1018	Flexible nasopharyngolaryngoscope examination			R 0,00	
1019	ENT endoscopy in rooms with rigid endoscope			R 0,00	
1020	Repair of perforated septum: Any method	30	4	R 406,90	T
1022	Functional reconstruction of nasal septum	30	4	R 406,90	T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	30	4	R 406,90	T
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	30	4	R 406,90	T
1027	Dacrocystorhinostomy	30	5	R 508,50	T
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	30	4	R 406,90	T
1030	Endoscopic turbinectomy: Laser or microdebrider	30	5	R 508,50	T
1031	Removal of single nasal polyp at rooms (at initial consultation only)			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1033	Removal of multiple polyps in hospital under general anaesthetic	30	4	R 406,90	T
1034	Autogenous nasal bone transplant: Bone removal included	30	4	R 406,90	T
1035	Functional endoscopic sinus surgery: Unilateral	30	4	R 406,90	T
1036	Functional endoscopic sinus surgery: Bilateral	30	4	R 406,90	T
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic			R 0,00	
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	30	4	R 406,90	T
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	30	6	R 610,20	T
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	30	6	R 610,20	T
1045	Ligation anterior ethmoidal artery	30	6	R 610,20	T
1047	Caldwell-Luc operation: Unilateral	30	4	R 406,90	T
1048	Endonasal frontal sinus drainage, with or without removal of tissue (modifier 0069 applies)		5	R 508,30	T
1049	Ligation internal maxillary artery	30	6	R 610,20	T
1050	Vidian neurectomy (transantral or transnasal)	30	4	R 406,90	T
1051	Removal nasopharyngeal fibroma	30	6	R 610,20	T
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	30	4	R 406,90	T
1053	Frontal sinus drainage, trephine operation	30	4	R 406,90	T
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)			R 0,00	
1055	External frontal ethmoidectomy	30	4	R 406,90	T
1056	Anterior cranial fossa, craniofacial approach, extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration		3	R 304,90	
1057	External ethmoidectomy and/or sphenoidectomy	30	4	R 406,90	T
1058	Sublabial transseptal sphenoidotomy	30	4	R 406,90	T
1059	Frontal osteomyelitis	30	4	R 406,90	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1060	Obliteration of frontal sinus	30	4	R 406,90	T
1061	Lateral rhinotomy	30	4	R 406,90	T
1062	Excision nasolabial cyst	30	4	R 406,90	T
1063	Removal of foreign bodies from nose: At rooms			R 0,00	
1065	Removal of foreign bodies from nose: Under general anaesthetic	30	4	R 406,90	T
1067	Proof puncture at rooms: Unilateral	30	4	R 406,90	T
1069	Proof puncture, uni- or bilateral under general anaesthetic	30	4	R 406,90	T
1071	Proetz treatment (consultation fee only to be charged for first treatment)			R 0,00	
1077	Septum abscess: At rooms, including after-care			R 0,00	
1079	Septum abscess: Under general anaesthetic	30	4	R 406,90	T
1081	Oro-antral fistula (without Caldwell-Luc)	30	4	R 406,90	T
1083	Choanal atresia: Intranasal approach	30	5	R 508,50	T
1084	Choanal atresia: Transpalatal approach	30	7	R 711,60	T
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	30	5	R 508,50	T
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	30	5	R 508,50	T
1089	Forehead rhinoplasty (all stages): Total	30	5	R 508,50	T
1091	Forehead rhinoplasty (all stages): Partial	30	5	R 508,50	T
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	30	5	R 508,50	T
1095	Full nasal reconstruction for secondary cleft lip deformity	30	5	R 508,50	T
1097	Partial nasal reconstruction for cleft lip deformity	30	5	R 508,50	T
1099	Columella reconstruction or lengthening	30	5	R 508,50	T
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision		3	R 304,90	
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision		3	R 304,90	
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision		3	R 304,90	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision		3	R 304,90	
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision		3	R 304,90	
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision		3	R 304,90	
	MODIFIERS GOVERNING NASAL OPERATIONS			R 0,00	
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083			R 0,00	
4.2	Throat			R 0,00	
1101	Tonsillectomy (dissection of the tonsils)	30	4	R 406,90	T
1102	Laser tonsillectomy	30	6	R 610,20	T
1105	Removal of adenoids	30	4	R 406,90	T
1106	Laser-assisted functional reconstruction of palate uvula: At rooms (+ Item 5930 for hire of laser)	30	5	R 508,50	T
1107	Opening of quinsy: At rooms	30	6	R 610,20	T
1108	Laser-assisted functional reconstruction of palate uvula: At rooms (+ Item 5930 for hire of laser) – follow-up operation performed by the same surgeon	30	5	R 508,50	T
1109	Opening of quinsy: Under general anaesthetic	30	6	R 610,20	T
1110	Ludwig's Angina: Drainage	30	9	R 915,00	T
1111	Post-tonsillectomy or adenoidectomy haemorrhage	30	6	R 610,20	T
1112	Pharyngeal pouch operation	30	5	R 508,50	T
1113	Retropharyngeal abscess: Internal approach	30	6	R 610,20	T
1115	Retropharyngeal abscess: External approach	30	6	R 610,20	T
1116	Functional reconstruction of palate and uvula	30	5	R 508,50	T
4.3	Larynx			R 0,00	
1117	Laryngeal intubation			R 0,00	
1118	Laryngeal stroboscopy with video capture	30	6	R 610,20	T
1119	Laryngectomy without block dissection of the neck	30	7	R 711,60	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1122	Laryngeal function studies		3	R 304,90	
1123	Botulinus toxin injection for adductor disphonia (+ Item 0198 + Item 0201 + Item 0202)			R 0,00	
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	30	6	R 610,20	T
1126	Post laryngectomy for voice restoration	30	9	R 915,00	T
1127	Tracheotomy	30	9	R 915,00	T
1128	Endolaryngeal operations	30	8	R 813,40	T
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	30	8	R 813,40	T
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	30	6	R 610,20	T
1131	Direct laryngoscopy plus foreign body removal	30	6	R 610,20	T
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal		3	R 304,90	
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy		3	R 304,90	
4918	Laryngoplasty: Open reduction of fracture		3	R 304,90	
4919	Laryngoplasty: Cricoid split		3	R 304,90	
4922	Tracheostoma: Revision, without flap rotation, simple		3	R 304,90	
4923	Tracheostoma: Revision, with flap rotation, complex		3	R 304,90	
4926	Tracheostomy: Fenestration with skin flaps		3	R 304,90	
4927	Tracheostomy: Revision of scar		3	R 304,90	
4928	Tracheostomy/fistula: Closure, without plastic repair		3	R 304,90	
4929	Tracheostomy/fistula: Closure, with plastic repair		3	R 304,90	
4932	Tracheobronchoscopy: Through established tracheostomy incision		3	R 304,90	
4933	Tracheoplasty: Cervical		3	R 304,90	
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage		3	R 304,90	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
	MODIFIERS			R 0,00	
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed. For other operations requiring the use of an operation microscope, the fee includes the use of the microscope, except where otherwise specified elsewhere in the tariff.			R 0,00	
4.4	Bronchial procedures			R 0,00	
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy.			R 0,00	
1132	Bronchoscopy: Diagnostic bronchoscopy	30	6	R 610,20	T
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	30	8	R 813,40	T
1134	Bronchoscopy: Bronchoscopy with laser	30	8	R 813,40	T
1136	Nebulisation (in rooms)	20	12	R 194,40	ç
1137	Bronchial lavage	30	8	R 813,40	T
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	30	12	R 1 220,30	T
4.5	Pleura			R 0,00	
1139	Pleural needle biopsy (no after-care) – modifier 0005 not applicable	30	3	R 304,90	T
1141	Insertion of intercostal catheter (under water drainage)	30	6	R 610,20	T
1142	Intra-pleural block	20	36	R 583,20	ç
1143	Paracentesis chest: Diagnostic	30	3	R 304,90	T
1145	Paracentesis chest: Therapeutic	30	3	R 304,90	T
1147	Pneumothorax: Induction (diagnostic)			R 0,00	
1149	Pleurectomy	30	11	R 1 118,40	T
1151	Decortication of lung	30	11	R 1 118,40	T
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	30	3	R 304,90	T
4.6	Pulmonary procedures			R 0,00	
4.6.1	Pulmonary procedures: Surgical			R 0,00	
1155	Needle biopsy lung (no after-care) – modifier 0005 not applicable	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1157	Pneumonectomy	30	11	R 1 118,40	T
1159	Pulmonary lobectomy	30	11	R 1 118,40	T
1161	Segmental lobectomy	30	11	R 1 118,40	T
1163	Excision tracheal stenosis: Cervical	30	8	R 813,40	T
1164	Excision tracheal stenosis: Intra thoracic	30	12	R 1 220,30	T
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	30	12	R 1 220,30	T
1168	Thoracoplasty: Complete	30	11	R 1 118,40	T
1169	Thoracoplasty: Limited (osteoplastic)	30	11	R 1 118,40	T
1171	Drainage empyema (including six weeks after treatment)	30	11	R 1 118,40	T
1173	Drainage of lung abscess (including six weeks after treatment)	30	11	R 1 118,40	T
1175	Thoracotomy (limited): For lung or pleural biopsy	30	11	R 1 118,40	T
1177	Major: Diagnostic, as for inoperable carcinoma	30	11	R 1 118,40	T
1179	Thoracoscopy	30	11	R 1 118,40	T
1181	Lung transplant: Unilateral	30	15	R 1 525,10	T
1182	Harvesting donor lung: Unilateral	30	5	R 508,50	T
1183	Excision or plication of emphysematous cyst: Unilateral	30	11	R 1 118,40	T
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	30	11	R 1 118,40	T
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	30	11	R 1 118,40	T
4.6.2	Pulmonary function tests			R 0,00	
	When these procedures are performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units			R 0,00	
1186	Flow volume test: Inspiration/expiration	20	30	R 485,90	ç
1187	Exhaled nitric oxide determination		0	R 0,00	
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation – thereafter Item 1186 applies)	20	50	R 810,20	ç

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1189	Forced expirogram only	20	10	R 161,80	ç
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry			R 0,00	
1191	N2 single breath distribution	20	10	R 161,80	ç
1192	Peak expiratory flow only	20	5	R 81,00	ç
1193	Functional residual capacity or residual volume: Helium method, nitrogen open-circuit method, or other method			R 0,00	
1195	Thoracic gas volume			R 0,00	
1196	Determination of resistance to airflow, oscillary or plethysmographic methods			R 0,00	
1197	Compliance and resistance, using oesophageal balloon	20	24	R 389,00	ç
1198	Prolonged post-exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry			R 0,00	
1199	Pulmonary stress testing: For determination of VO2 max			R 0,00	
1200	Carbon monoxide diffusing capacity, any method			R 0,00	
1201	Maximum inspiratory/expiratory pressure	20	5	R 81,00	ç
4.7	Intensive care			R 0,00	
	RULES GOVERNING THIS SECTION			R 0,00	
Q.	Intensive care/high care: Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221. but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and X-rays. g. Intravenous treatment (Items 0206 and 0207) except intravenous infusion in patients under the age of three years (Item 0205) that does not form part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management).			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. Item 1211: Cardio-respiratory resuscitation).			R 0,00	
S.	Ventilation: Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies. b. Testing and connecting the machine. c. Putting patient on machine: setting machine, synchronising patient with machine. d. Instruction to nursing staff. e. All subsequent visits for 24 hours..			R 0,00	
T.	Ventilation (Items 1212 to 1214) does not form part of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring.			R 0,00	
4.7.1	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – neonatal procedures			R 0,00	
1202	Insertion of central venous catheter via peripheral vein in neonates	20	40	R 648,00	ç
4.7.2	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – tariff items for intensive care			R 0,00	
1204	Intensive care: Category 1 (High Care) – cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.); per day	20	30	R 485,90	ç
	i. Only one practitioner may charge Category 1: Intensive monitoring of patient in high care unit. ii. Item 1204 may not be charged by the surgeon who performed a surgical procedure. Intensive monitoring is regarded as normal post-operative care, which is included in the global fee attached to that surgical procedure. iii. Practitioners involved in treating a patient in a high care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.			R 0,00	
1205	Intensive care: Category 2 (ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.). Ventilation may or may not be part of the active system support). First day.	20	100	R 1 620,20	ç
1206	Intensive care: Category 2 (ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.). Ventilation may or may not be part of the active system support). Subsequent days, per day.	20	50	R 810,20	ç
1207	Intensive care: Category 2(ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc.). Ventilation may or may not be part of the active system support). After two weeks, per day.	20	30	R 485,90	ç

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
	Please note: i. The principal practitioner may charge Items 1205-1207; other participating practitioners must charge the consultation Item, e.g. Item 0109. ii. Only one practitioner may charge Category 2: Intensive monitoring of patient in intensive care unit. iii. Should a patient during the post-operative care period require active system support, the person who is responsible for the active systems support, may use Items 1205-1207 (as appropriate). iv. It would be acceptable for the surgeon who performed a surgical procedure of which the after-care is included, to charge fees according to the appropriate hospital follow-up visit (Item 0109). v. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.			R 0,00	
1208	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention; first day (primary practitioner)	20	137	R 2 219,60	ç
1209	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention; first day (per involved practitioner)	20	58	R 939,60	ç
1210	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention; subsequent days (per involved practitioner)	20	50	R 810,20	ç
	Please note: i. Items 1208-1210 are used if more than one practitioner is involved in active system support on a Category 2 patient in the intensive care unit. ii. Items 1208-1210 are used for Category 3 patients with multiple organ failure. iii. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.			R 0,00	
4.7.3	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general; procedures			R 0,00	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.			R 0,00	
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) – 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.			R 0,00	
1212	Ventilation: First day	20	75	R 1 215,20	ç
1213	Ventilation: Subsequent days, per day	20	50	R 810,20	ç
1214	Ventilation: After two weeks, per day	20	25	R 405,00	ç

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1215	Insertion of arterial pressure cannula	20	25	R 405,00	ç
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	20	50	R 810,20	ç
1217	Insertion of central venous line via peripheral vein	20	10	R 161,80	ç
1218	Insertion of central venous line via subclavian or jugular veins	20	25	R 405,00	ç
1219	Hyperalimentation (daily tariff)	20	15	R 243,10	ç
1220	Patient-controlled analgesic pump: Hire fee per 24 hours (cassette to be charged for according to Item 0201 per patient)	20	30	R 485,90	ç
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charge the appropriate hospital follow-up consultation/visit code)	20	30	R 485,90	ç
4.8	Hyperbaric Oxygen Therapy			R 0,00	
	Internationally recognised scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic) b. Decompression sickness (‘the bends’) c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis i. Bone and soft tissue radiation necrosis j. Compromised skin grafts and flaps k. Acute thermal burns l. Acute bloodloss anaemia (transfusion is contra-indicated – e.g. Jehovah’s Witnesses or haemolytic anaemia) m. Cerebral abscesses				
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post-treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 mins) – PROFESSIONAL COMPONENT			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4820	Low pressure table (1,5-1,8 ATA x 45-60 mins): TECHNICAL COMPONENT			R 0,00	
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 mins) – PROFESSIONAL COMPONENT			R 0,00	
4821	Routine HBO table (2-2,5 ATA x 90-120 mins): TECHNICAL COMPONENT			R 0,00	
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 mins) – PROFESSIONAL COMPONENT			R 0,00	
4822	Emergency HBO table (2,5-3 ATA x 90-120 mins): TECHNICAL COMPONENT			R 0,00	
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 mins) – PROFESSIONAL COMPONENT			R 0,00	
4825	USN TT5 (2,8 ATA x 135 mins): TECHNICAL COMPONENT			R 0,00	
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 mins) – PROFESSIONAL COMPONENT			R 0,00	
4826	USN TT6 (2,8 ATA x 285 mins): TECHNICAL COMPONENT			R 0,00	
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 mins) – PROFESSIONAL COMPONENT			R 0,00	
4827	USN TT6ext (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT			R 0,00	
4828	USN 6A (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT			R 0,00	
4829	USN Cx 30 (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT			R 0,00	
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour; minimum 40,00 clinical procedure units; maximum 320,00 clinical procedure units			R 0,00	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.			R 0,00	
5	**Mediastinal procedures**			R 0,00	
1222	Mediastinal tumours	30	11	R 1 118,40	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1223	Mediastinoscopy	30	5	R 508,50	T
1224	Mediastinotomy	30	11	R 1 118,40	T
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	30	11	R 1 118,40	T
1226	Removal of single rib with a lesion	30	11	R 1 118,40	T
6	**Cardiovascular system**			R 0,00	
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP			R 0,00	
6.1	Cardiovascular system: General			R 0,00	
1227	Prolonged neonatal resuscitation	20	20	R 324,00	ç
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG.			R 0,00	
1228	General Practitioner's fee for the taking of an ECG only: Without effort – ½ (item 1232)			R 0,00	
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort – ½ (Item 1233)			R 0,00	
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added.			R 0,00	
1230	Physician's fee for interpreting an ECG: Without effort			R 0,00	
1231	Physician's fee for interpreting an ECG: With and without effort			R 0,00	
	A specialist physician is entitled to the fees specified in Item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation.			R 0,00	
1232	Electrocardiogram: Without effort			R 0,00	
1233	Electrocardiogram: With and without effort			R 0,00	
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus			R 0,00	
1235	Multi-stage treadmill test			R 0,00	
1236	Electrocardiogram without effort: Under 4 years old			R 0,00	
1237	24-hour ambulatory blood pressure: Hire fee			R 0,00	

CONTRACTED ANAESTHESIOLOGIST REO OPTION

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1238	24-hour ambulatory ECG monitoring (holter): Hire fee			R 0,00	
1239	24-hour ambulatory ECG monitoring (holter): Interpretation			R 0,00	
1240	Signal averaged electrocardiogram			R 0,00	
1241	X-ray Screening: Chest			R 0,00	
1242	X-ray screening: Prosthetic valves			R 0,00	
1243	Two-week event triggered ambulatory ECG monitoring: Hire fee			R 0,00	
1244	Two-week event triggered ambulatory ECG monitoring: Interpretation			R 0,00	
1245	Angiography cerebral: First two series	30	4	R 406,90	T
1246	Angiography peripheral: Per limb	30	4	R 406,90	T
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	30	6	R 610,20	T
1248	Paracentesis of pericardium	30	9	R 915,00	T
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing			R 0,00	
	MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER			R 0,00	
0073	When Item 1288 (Cardiac catheterisation for congenital heart disease: All ages above one year old) or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33') – fee for procedure + 100%			R 0,00	
6.2	Invasive cardiology			R 0,00	
6.2.1	Invasive cardiology: Cardiac catheterisation			R 0,00	
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	30	9	R 915,00	T
1250	Endomyocardial biopsy	30	9	R 915,00	T
1251	Transeptal puncture	30	9	R 915,00	T
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	30	9	R 915,00	T
1253	Right heart catheterisation (with or without biopsy)	30	9	R 915,00	T

CONTRACTED ANAESTHESIOLOGIST REO OPTION

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	30	9	R 915,00	T
1255	Tilt test			R 0,00	
6.2.2	Invasive cardiology: Electrophysiological study			R 0,00	
1256	Ventricular stimulation study	30	9	R 915,00	T
1257	Full electrophysiological study	30	9	R 915,00	T
6.2.3	Invasive cardiology: Pacemakers			R 0,00	
1258	Pacemaker: Permanent – single chamber	30	9	R 915,00	T
1259	Pacemaker: Permanent –- dual chamber	30	9	R 915,00	T
1260	AV nodal ablation	30	9	R 915,00	T
1261	Accessory pathway ablation	30	9	R 915,00	T
1262	Electrophysiological mapping			R 0,00	
1263	Insertion transvenous implantable defibrillator	30	15	R 1 525,10	T
1264	Test for implantable transvenous defibrillator	30	15	R 1 525,10	T
1265	Renewal of pacemaker unit only, team fee	30	9	R 915,00	T
1266	Resiting pacemaker generator			R 0,00	
1267	Repositioning of catheter electrode	30	9	R 915,00	T
1268	Threshold testing: Own equipment			R 0,00	
1269	Threshold testing: Hospital equipment			R 0,00	
1270	Programming of atrio-ventricular sequential pacemaker			R 0,00	
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	30	9	R 915,00	T
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts			R 0,00	
1275	Termination of arrhythmia – programmed stipulation and lead insertion of temporary pacer	30	9	R 915,00	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6.2.4	Invasive cardiology: Percutaneous translumical angioplasty			R 0,00	
1276	Percutaneous transluminal angioplasty: First cardiologist – single lesion	30	13	R 1 321,70	T
1277	Percutaneous transluminal angioplasty: Second cardiologist – single lesion	30	13	R 1 321,70	T
1278	Percutaneous transluminal angioplasty: First cardiologist – second lesion	30	13	R 1 321,70	T
1279	Percutaneous transluminal angioplasty: Second cardiologist – second lesion	30	13	R 1 321,70	T
1280	Percutaneous transluminal angioplasty: First cardiologist – third or subsequent lesions (each)	30	13	R 1 321,70	T
1281	Percutaneous transluminal angioplasty: Second cardiologist – third or subsequent lesions (each)	30	13	R 1 321,70	T
1282	Use of balloon procedures including: First cardiologist – atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty	30	15	R 1 525,10	T
1283	Use of balloon procedure as in Item 1282: Second cardiologist	30	15	R 1 525,10	T
1284	Atherectomy: Single lesion – first cardiologist			R 0,00	
1285	Atherectomy: Single lesion – second cardiologist			R 0,00	
1286	Insertion of intravascular stent: First cardiologist			R 0,00	
1287	Insertion of intravascular stent: Second cardiologist			R 0,00	
	The insertion of a stent(s) (Item 1286 and 1267) may only be charged once per vessel regardless of the number of stents inserted in this vessel.			R 0,00	
1290	Use of balloon procedures including: First paediatric cardiologist (33): Atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty, closure atrial septal defect, closure of patient ductus arteriosus	30	15	R 1 525,10	T
1291	Use of balloon procedure as in Item 1290: Second paediatric cardiologist (33)	30	15	R 1 525,10	T
1292	Multi-slice computed tomography coronary angiography: Own equipment			R 0,00	
5961	Balloon angioplasty pulmonary mitral valve or tricuspid valve		10	R 1 016,80	
5962	Balloon angioplasty aortic valve (congenital aortic stenosis)		10	R 1 016,80	
5963	Balloon angioplasty, pulmonary artery branches: First vessel		10	R 1 016,80	
5964	Balloon angioplasty, pulmonary artery branches: Subsequent vessels (per vessel)		10	R 1 016,80	
5965	Balloon angioplasty aorta for congenital lesion/coarctation		10	R 1 016,80	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl MAPCA) or venous system (IVC, SVC, systemic vein): First vessel		5	R 508,50	
5967	Balloon angioplasty, collateral vessel (incl. MAPCA): Subsequent vessels (per vessel)		5	R 508,50	
5968	Balloon angioplasty venous system (IVC, SVC, systemic vein)		5	R 508,50	
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		5	R 508,50	
5970	Cutting balloon angioplasty, cardiovascular structure: Subsequent vessels (per vessel)		5	R 508,50	
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation			R 0,00	
1288	Cardiac catheterisation for congenital heart disease: All ages above one year old	30	12	R 1 220,30	T
1289	Paediatric cardiac catheterisation: Infants below the age of one year	30	12	R 1 220,30	T
6.3	Cardiac surgery			R 0,00	
1294	Patent ductus arteriosus	30	13	R 1 321,70	T
1295	Pericardiectomy for constrictive pericarditis	30	15	R 1 525,10	T
1296	Fractional flow reserve (FFR): First vessel (add-on code)			R 0,00	
1297	Coarctation of aorta	30	15	R 1 525,10	T
1298	Fractional flow reserve (FFR): Each additional vessel (add-on code)			R 0,00	
1299	Systemo-pulmonary anastomosis	30	15	R 1 525,10	T
1300	Renal denervation (RDN), per artery (modifier 0005 applicable)			R 0,00	
1301	Mitral valvotomy: Closed heart technique	30	15	R 1 525,10	T
1302	Heart transplant	30	15	R 1 525,10	T
1303	Harvesting donor heart	30	5	R 508,50	T
1305	Operative implantation of cardiac pacemaker by thoracotomy	30	15	R 1 525,10	T
1307	Re-exploration after cardiac surgery	30	15	R 1 525,10	T
1308	Heart and lung transplant	30	15	R 1 525,10	T
1309	Harvesting donor heart and lungs	30	5	R 508,50	T
1311	Pericardial drainage	30	13	R 1 321,70	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6.3.1	Cardiac surgery: Open heart surgery			R 0,00	
1312	Evaluation of coronary angiogram by cardiothoracic surgeon			R 0,00	
1320	Repeat open heart surgery (additional fee above procedure fee)	30	15	R 1 525,10	T
1321	Stand-by fee for coronary angioplasty	20	30	R 485,90	ç
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour			R 0,00	
6.3.1.1	Cardiac surgery: Open heart surgery: Congenital conditions			R 0,00	
1323	Atrial septal defect: Osteum secundum	30	15	R 1 525,10	T
1325	Atrial septal defect: Sinus venosus or osteum primum	30	15	R 1 525,10	T
1327	Atrial septal defect: Ventricular septal defect	30	15	R 1 525,10	T
1329	Atrial septal defect: Fallot's tetralogy	30	15	R 1 525,10	T
1330	Atrial septal defect: Pulmonary stenosis	30	15	R 1 525,10	T
1331	Transposition of large vessels (venous repair)	30	15	R 1 525,10	T
1332	Transposition of great arteries (arterial repair)	30	15	R 1 525,10	T
1333	Ebstein's Anomaly	30	15	R 1 525,10	T
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	30	20	R 2 033,40	T
1335	Total anomalous venous drainage	30	15	R 1 525,10	T
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	30	20	R 2 033,40	T
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	30	15	R 1 525,10	T
1338	Fontan type repair	30	15	R 1 525,10	T
6.3.1.2	Cardiac surgery: Open heart surgery – acquired conditions			R 0,00	
1339	Mitral valve replacement	30	15	R 1 525,10	T
1340	Mitral valvuloplasty	30	15	R 1 525,10	T
1341	Aortic valve replacement	30	15	R 1 525,10	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1342	Tricuspid annulo plasty	30	15	R 1 525,10	T
1343	Double valve replacement	30	15	R 1 525,10	T
1344	Acute dissecting aneurysm repair	30	15	R 1 525,10	T
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	30	15	R 1 525,10	T
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins – unilateral (Modifier 0005 not applicable)			R 0,00	
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins – bilateral (Modifier 0005 not applicable)			R 0,00	
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilizing saphenous veins	30	15	R 1 525,10	T
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant – any artery	30	15	R 1 525,10	T
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant – any artery	30	15	R 1 525,10	T
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	30	15	R 1 525,10	T
1352	Cardiac aneurysm	30	15	R 1 525,10	T
1353	Ascending/descending thoracic aortic aneurysm repair	30	15	R 1 525,10	T
1354	Arrhythmia surgery	30	15	R 1 525,10	T
1355	Cardiac tumour	30	15	R 1 525,10	T
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	30	15	R 1 525,10	T
1358	Harvesting of radial artery			R 0,00	
6.4	Peripheral vascular system			R 0,00	
	MODIFIER GOVERNING THIS SECTION			R 0,00	
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.			R 0,00	
6.4.1	Peripheral vascular system: Investigations			R 0,00	
1357	Skin temperature test: Response to reflex heating			R 0,00	
1359	Skin temperature test: Response to reflex cooling			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1360	Closure: Left atrial appendage (LAA)		15	R 1 525,10	
1361	Cold sensitivity test			R 0,00	
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		15	R 1 525,10	
1363	Oscillometry test			R 0,00	
1365	Sweating test			R 0,00	
1366	Transcutaneous oximetry: Transcutaneous oximetry – single site			R 0,00	
1367	Doppler blood tests			R 0,00	
5369	Doppler arterial pressures			R 0,00	
5371	Doppler arterial pressures with exercise			R 0,00	
5373	Doppler segmental pressures and wave forms			R 0,00	
5375	Venous doppler examination (both limbs)			R 0,00	
5377	Venous plethysmography			R 0,00	
5379	Supra-orbital doppler test			R 0,00	
5381	Carotid non-invasive complex tests			R 0,00	
6.4.2	Peripheral vascular system: Arterio-venous abnormalities			R 0,00	
1369	Fistula or aneurysm (as for grafting of various arteries)			R 0,00	
6.4.3	Arteries			R 0,00	
6.4.3.1	Peripheral vascular system: Arteries –aorta-iliac and major branches			R 0,00	
1372	Abdominal aorta and iliac artery: Unruptured	30	15	R 1 525,10	T
1373	Abdominal aorta and iliac artery: Ruptured	30	15	R 1 525,10	T
1375	Grafting and/or thrombo-endarterectomy for thrombosis	30	15	R 1 525,10	T
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	30	15	R 1 525,10	T
6.4.3.2	Peripheral vascular system: Arteries –iliac artery			R 0,00	
1379	Prosthetic grafting and/or thrombo-endarterectomy	30	13	R 1 321,70	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6.4.3.3	Peripheral vascular system: Arteries – peripheral			R 0,00	
1385	Prosthetic grafting	30	5	R 508,50	T
1387	Grafting vein: Vein grafting proximal to knee joint	30	5	R 508,50	T
1388	Grafting vein: Distal to knee joint	30	5	R 508,50	T
1389	Grafting vein: Endarterectomy when not part of another specified procedure	30	5	R 508,50	T
1390	Grafting vein: Carotid endarterectomy	30	15	R 1 525,10	T
1393	Embolectomy: Peripheral embolectomy transfemoral	30	5	R 508,50	T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma	30	5	R 508,50	T
1396	Suture major blood vessel (artery or vein) – trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure.	30	15	R 1 525,10	T
1397	Profundoplasty	30	5	R 508,50	T
1399	Distal tibial (ankle region)	30	5	R 508,50	T
1401	Femoro-femoral	30	5	R 508,50	T
1402	Carotid-subclavian	30	8	R 813,40	T
1403	Axillo-femoral: Bifemoral + 50%	30	8	R 813,40	T
6.4.4	Peripheral vascular system: Veins			R 0,00	
1407	Ligation of saphenous vein	30	3	R 304,90	T
1408	Placement of Hickman catheter or similar	30	4	R 406,90	T
1410	Litigation of inferior vena cava: Abdominal	30	8	R 813,40	T
1412	Umbrella operation on inferior vena cava: Abdominal	30	8	R 813,40	T
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – unilateral	30	3	R 304,90	T
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – bilateral	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1417	Extensive sub-fascial ligation of perforating veins	30	3	R 304,90	T
1419	Lesser varicose vein procedures	30	3	R 304,90	T
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)			R 0,00	
1425	Thrombectomy: Inferior vena cava (trans-abdominal)	30	11	R 1 118,40	T
1427	Thrombectomy: Illio-femoral	30	6	R 610,20	T
6.4.5	Peripheral vascular system: Portal hypertension			R 0,00	
1429	Porto-caval shunt	30	11	R 1 118,40	T
6.5	Cardiac rehabilitation			R 0,00	
1431	Cardiac rehabilitation: Phase II – exercise rehabilitation; per patient per 60-minute session with a maximum of five patients per group			R 0,00	
1432	Cardiac rehabilitation: Phase III – exercise rehabilitation; per patient per 60-minute session with a maximum of 10 patients per group			R 0,00	
	Please note : a. A practitioner is only allowed to instruct one group at a time. b. Benefits are limited to three times per week for a period of 60 minutes with a maximum of three months.			R 0,00	
7	**Lympho reticular system**			R 0,00	
7.1	Spleen			R 0,00	
1435	Splenectomy (in all cases)	30	9	R 915,00	T
1436	Splenorrhaphy	30	9	R 915,00	T
1437	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic donor lymphocyte infusions – PROFESSIONAL COMPONENT			R 0,00	
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic – PROFESSIONAL COMPONENT			R 0,00	
7.2	Lymph nodes and lymphatic channels			R 0,00	
1439	Excision of lymph node for biopsy: Neck or axilla	30	4	R 406,90	T
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous – PROFESSIONAL COMPONENT			R 0,00	

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1441	Excision of lymph node for biopsy: Groin	30	3	R 304,90	T
1442	Lymphadenectomy: Modified radical neck dissection, cervical		3	R 304,90	
1443	Simple excision of lymph nodes for tuberculosis	30	3	R 304,90	T
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic – PROFESSIONAL COMPONENT			R 0,00	
1445	Radical excision of lymph nodes of neck: Total – unilateral	30	5	R 508,50	T
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous – PROFESSIONAL COMPONENT			R 0,00	
1447	Radical excision of lymph nodes of neck: Total – suprahyoid unilateral	30	5	R 508,50	T
1448	Bone marrow harvesting for transplant – PROFESSIONAL COMPONENT			R 0,00	
1449	Radical excision of lymph nodes of axilla	30	4	R 406,90	T
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	30	5	R 508,50	T
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	30	4	R 406,90	T
1453	Radical excision of lymph nodes of groin: Inguinal	30	4	R 406,90	T
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) (specify time used)	30	5	R 508,50	T
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	30	6	R 610,20	T
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	30	5	R 508,50	T
1457	Bone marrow biopsy: By trephine	30	3	R 304,90	T
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula			R 0,00	
1459	Staging laparotomy for lymphoma (including splenectomy	30	7	R 711,60	T
1460	Sentinel lymph node(s): Intra-operative indentification, INCLUDES injection of non-radioactive dye, when performed			R 0,00	

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8	**Digestive system**			R 0,00	
	MODIFIERS GOVERNING THIS SECTION			R 0,00	
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee (“+” codes excluded) will apply where endoscopic procedures are performed with own equipment.			R 0,00	
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff.			R 0,00	
8.1	Oral cavity			R 0,00	
1461	All dental procedures	30	4	R 406,90	T
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	30	4	R 406,90	T
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	30	4	R 406,90	T
1467	Drainage of intra-oral abscess	30	4	R 406,90	T
1469	Local excision of mucosal lesion of oral cavity	30	4	R 406,90	T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	30	7	R 711,60	T
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	30	7	R 711,60	T
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	30	6	R 610,20	T
1477	Cleft palate: Secondary repair	30	6	R 610,20	T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	30	6	R 610,20	T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	30	6	R 610,20	T
1480	Repair of oronasal fistula (large) e.g. distant flap	30	6	R 610,20	T
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	30	5	R 508,50	T
1482	Repair of oronasal fistula (large): Second stage	30	5	R 508,50	T
1483	Alveolar periosteal or other flaps for arch closure	30	4	R 406,90	T
1486	Closure of anterior nasal floor	30	5	R 508,50	T

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8.2	Lips			R 0,00	
1484	Cleft lip repair: Lip adhesion (cleft lip)	30	5	R 508,50	T
1485	Local excision of benign lesion of lip	30	4	R 406,90	T
1487	Resection for lip malignancy	30	4	R 406,90	T
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	30	5	R 508,50	T
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction) – one of two stages	30	5	R 508,50	T
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction) – one stage	30	5	R 508,50	T
1492	Cleft lip repair: Bilateral cleft lip repair – second stage	30	5	R 508,50	T
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	30	5	R 508,50	T
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	30	5	R 508,50	T
1495	Abbé or Estlander type flap (all stages included)	30	5	R 508,50	T
1497	Vermilionectomy	30	4	R 406,90	T
1499	Lip reconstruction following an injury: Direct repair	30	4	R 406,90	T
1501	Lip reconstruction following an injury or tumour removal: Flap repair	30	4	R 406,90	T
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	30	4	R 406,90	T
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see Item 0297)	30	4	R 406,90	T
8.3	Tongue			R 0,00	
1505	Partial glossectomy	30	6	R 610,20	T
1507	Local excision of lesion of tongue	30	4	R 406,90	T
8.4	Palate, uvula and salivary glands			R 0,00	
1509	Wide excision of lesion of palate	30	5	R 508,50	T
1511	Radical resection of palate (including skin graft)	30	7	R 711,60	T
1513	Excision of ranula	30	5	R 508,50	T
1515	Excision of sublingual salivary gland	30	4	R 406,90	T

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1517	Excision of submandibular salivary gland	30	4	R 406,90	T
1519	Excision of submandibular salivary gland with suprahyoid dissection	30	5	R 508,50	T
1521	Excision of submandibular salivary gland: With radical neck dissection	30	6	R 610,20	T
1523	Local resection of parotid tumour	30	5	R 508,50	T
1525	Partial parotidectomy	30	5	R 508,50	T
1526	Total parotidectomy with preservation of facial nerve	30	5	R 508,50	T
1527	Total parotidectomy	30	5	R 508,50	T
1529	Parotidectomy: Extracapsular	30	5	R 508,50	T
1531	Drainage of parotid abscess	30	4	R 406,90	T
1533	Closure of salivary fistula	30	4	R 406,90	T
1535	Dilatation of salivary duct	30	4	R 406,90	T
1537	Operative removal of salivary calculus	30	4	R 406,90	T
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated		3	R 304,90	
1539	Salivary duct: Meatotomy	30	4	R 406,90	T
1541	Branchial cyst and/or fistula: Excision	30	5	R 508,50	T
1543	Excision of cystic hygroma	30	5	R 508,50	T
1544	Ludwig's Angina: Drainage	30	9	R 915,00	T
8.5	Oesophagus			R 0,00	
1545	Oesophagoscopy with rigid instrument: First and subsequent	30	4	R 406,90	T
1549	Oesophagoscopy with dilatation of stricture	30	4	R 406,90	T
1550	Oesophagoscopy with removal of foreign body	30	4	R 406,90	T
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	30	4	R 406,90	T
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	30	4	R 406,90	T
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	30	15	R 1 525,10	T
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic		7	R 711,60	
1557	Oesophageal dilatation	30	4	R 406,90	T
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		7	R 711,60	
1559	Oesophagectomy: Two stage	30	11	R 1 118,40	T
1560	Oesophagectomy: Three stage	30	11	R 1 118,40	T
1561	Thoraco-abdominal oesophagogastrectomy	30	11	R 1 118,40	T
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	30	11	R 1 118,40	T
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		7	R 711,60	
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	30	11	R 1 118,40	T
1566	Private fee: Gastroplasty	30	8	R 813,40	T
1567	Bochdalek hernia repair in newborn	30	14	R 1 423,40	T
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	30	11	R 1 118,40	T
1569	Heller's operation	30	14	R 1 423,40	T
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure)		7	R 711,60	
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		15	R 1 525,10	
1575	Insertion of indwelling oesophageal tube by laparotomy	30	6	R 610,20	T
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): Add to major procedure (modifier 0005 does not apply)		7	R 711,60	
1578	Oesophageal motility (4 channel + pneumograph)	30	4	R 406,90	T
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	30	11	R 1 118,40	T
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	30	4	R 406,90	T
1581	Removal of benign oesophageal tumours	30	11	R 1 118,40	T
1582	Oesophageal motility (4 or 6 channel + pneumograph – ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1583	Excision of intrathoracic oesophageal diverticulum	30	11	R 1 118,40	T
1584	24 hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe – 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)			R 0,00	
1585	24 hour oesophageal pH studies: Interpretation			R 0,00	
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		7	R 711,60	
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		7	R 711,60	
5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		15	R 1 525,10	
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		15	R 1 525,10	
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		15	R 1 525,10	
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		15	R 1 525,10	
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		7	R 711,60	
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		7	R 711,60	
8.6	Stomach			R 0,00	
1587	Upper gastro-intestinal endoscopy: Hospital equipment	30	4	R 406,90	T
1588	Plus polypectomy: Add to gastro-intestinal endoscopy (Item 1587)	30	4	R 406,90	T
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (Item 1587) or colonoscopy (Item 1653)	30	6	R 610,20	T
1591	Plus removal of foreign bodies (stomach): Add to gastro-intestinal endoscopy (Item 1587)	30	4	R 406,90	T
1593	Augmented histamine test: Gastric intubation with X-ray screening			R 0,00	
1597	Gastrostomy or gastrotomy	30	6	R 610,20	T

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1598	Gastrotomy with suture repair of bleeding ulcer	30	6	R 610,20	T
1599	Pyloromyotomy (Rammstedt)	30	6	R 610,20	T
1601	Local excision of ulcer or benign neoplasm	30	6	R 610,20	T
1603	Vagotomy: Abdominal	30	6	R 610,20	T
1604	Vagotomy: Thoracic	30	11	R 1 118,40	T
1605	Truncal or selective with drainage procedures	30	6	R 610,20	T
1607	Vagotomy and antrectomy	30	6	R 610,20	T
1609	Highly selective vagotomy	30	6	R 610,20	T
1611	Pyloroplasty	30	6	R 610,20	T
1613	Gastroenterostomy	30	6	R 610,20	T
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	30	7	R 711,60	T
1617	Partial gastrectomy	30	7	R 711,60	T
1619	Total gastrectomy	30	7	R 711,60	T
1621	Revision of gastrectomy or gastro-enterostomy	30	7	R 711,60	T
1625	Gastro-esophageal operation for portal hypertension (Tanner)	30	11	R 1 118,40	T
8.7	Duodenum			R 0,00	
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	30	6	R 610,20	T
1627	Duodenal intubation (under X-ray screening)			R 0,00	
1629	Duodenal intubation with biliary drainage after gall bladder stimulation			R 0,00	
1631	Duodenal intubation: Under three years of age			R 0,00	
8.8	Intestines			R 0,00	
1632	H2 breath test (intestines)			R 0,00	
1633	Complete test using lactose or lactulose			R 0,00	
1634	Enterotomy or Enterostomy	30	6	R 610,20	T

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1635	Intestinal obstruction of the newborn	30	7	R 711,60	T
1636	Oral food challenge test			R 0,00	
1637	Operation for relief of intestinal obstruction	30	7	R 711,60	T
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering		3	R 304,90	
1639	Resection of small bowel with enterostomy or anastomosis	30	6	R 610,20	T
1640	Resection of small bowel for congenital atresia, proximal segment, with tapering		3	R 304,90	
1641	Entero-enterostomy or entero-colostomy for bypass	30	6	R 610,20	T
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (Item 0201 applicable for video capsule – disposable single patient use). Please note: All patients should have had a normal gastroscopy and colonoscopy)			R 0,00	
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report			R 0,00	
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	30	6	R 610,20	T
1647	Closure of intestinal fistula	30	6	R 610,20	T
1649	Excision of Meckel's diverticulum	30	6	R 610,20	T
1651	Excision of lesion of mesentery	30	4	R 406,90	T
1652	Laparotomy for mesenteric thrombosis	30	8	R 813,40	T
1653	Total colonoscopy: With hospital equipment (including biopsy)	30	4	R 406,90	T
1654	Plus removal of polyps: Add to colonoscopy (Item 1653)	30	4	R 406,90	T
1656	Left-sided colonoscopy	30	4	R 406,90	T
1657	Right or left hemicolectomy or segmental colectomy	30	6	R 610,20	T
1658	Reconstruction of colon after Hartman's procedure	30	6	R 610,20	T
1659	Surgeon present assisting with air enema for reduction of intussuception (Paediatric surgeons add Modifier 0016)			R 0,00	
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) – paediatric surgeons add modifier 0016		4	R 406,90	

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1661	Colotomy: Including removal of tumour or foreign body	30	6	R 610,20	T
1663	Total colectomy	30	6	R 610,20	T
1665	Colostomy or ileostomy isolated procedure	30	6	R 610,20	T
1666	Continent ileostomy pouch (all types)	30	6	R 610,20	T
1667	Colostomy: Closure	30	5	R 508,50	T
1668	Revision of ileostomy pouch	30	6	R 610,20	T
1669	Total proctocolectomy and ileostomy	30	7	R 711,60	T
1670	Proctocolectomy, ileostomy and ileostomy pouch	30	7	R 711,60	T
1671	Colomyotomy (Reilly operation)	30	6	R 610,20	T
8.9	Appendix			R 0,00	
1673	Drainage of appendix abscess	30	5	R 508,50	T
1675	Appendicectomy	30	4	R 406,90	T
8.10	Rectum and anus			R 0,00	
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment.	30	3	R 304,90	T
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	30	3	R 304,90	T
1678	Plus polypectomy: Add to sigmoidoscopy (Item 1676)	30	3	R 304,90	T
1679	Sigmoidoscopy with removal of polyps, first and subsequent	30	3	R 304,90	T
1681	Proctoscopy with removal of polyps: First time	30	3	R 304,90	T
1683	Proctoscopy with removal of polyps: Subsequent times	30	3	R 304,90	T
1685	Endoscopic fulguration of tumour	30	4	R 406,90	T
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	30	6	R 610,20	T
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	30	8	R 813,40	T
1689	Perineal resection of rectum	30	5	R 508,50	T

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	Please note: Items 1691 and 1692 – abdominal and/or perineal assistant's fee to be charged additionally.			R 0,00	
1691	Abdomino-perineal resection of rectum: Abdominal surgeon	30	7	R 711,60	T
1692	Abdomino-perineal resection of rectum: Perineal surgeon			R 0,00	
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	30	4	R 406,90	T
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	30	7	R 711,60	T
1697	Repair of prolapsed rectum: Abdominal – roscoe Graham Moskovitz	30	6	R 610,20	T
1699	Repair of prolapsed rectum: Abdominal – ivalon sponge	30	6	R 610,20	T
1701	Repair of prolapsed rectum: Abdominal – perineal	30	4	R 406,90	T
1703	Repair of prolapsed rectum: Abdominal – thierisch suture	30	4	R 406,90	T
1705	Incision and drainage of peri-anal abscess	30	3	R 304,90	T
1707	Drainage of submucous abscess	30	3	R 304,90	T
1709	Drainage of ischio-rectal abscess	30	3	R 304,90	T
1711	Excision of pelvi-rectal fistula	30	5	R 508,50	T
1713	Excision of fistula-in-ano	30	3	R 304,90	T
1715	Operation for fissure-in-ano	30	3	R 304,90	T
1716	Rectal Tumour: Destruction (any method):Transanal Approach		5	R 508,50	
1717	Rectal tumour: Excision, transanal approach, EXCLUDING muscularis propria (partial thickness)		5	R 508,50	
1718	Rectal tumour: Excision, transanal approach, INCLUDING muscularis propria (full thickness)		5	R 508,50	
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	30	3	R 304,90	T
1721	Sclerosing injection for haemorrhoids: Per injection			R 0,00	
1723	Haemorrhoidectomy	30	3	R 304,90	T
1725	Drainage of external thrombosed pile	30	3	R 304,90	T
1727	Multiple procedures (haemorrhoids, fissure, etc.)	30	3	R 304,90	T
1728	Biopsy of ano-rectal wall, for congenital megacolon	30	5	R 508,50	T

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1729	Excision of anal skin tags	30	3	R 304,90	T
1731	Operation for low imperforate anus	30	6	R 610,20	T
1733	Anoplasty: Y-V-plasty	30	3	R 304,90	T
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)		3	R 304,90	
1735	Anal sphincteroplasty for incontinence	30	3	R 304,90	T
1737	Dilation of ano-rectal stricture	30	3	R 304,90	T
1739	Closure of recto-vesical fistula	30	5	R 508,50	T
1741	Closure of recto-urethral fistula	30	5	R 508,50	T
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor			R 0,00	
8.11	Liver			R 0,00	
1743	Needle biopsy of liver	30	3	R 304,90	T
1745	Biopsy of liver by laparotomy	30	4	R 406,90	T
1747	Drainage of liver abscess or cyst	30	7	R 711,60	T
1748	Body composition measured by bio-electrical impedance			R 0,00	
1749	Hemi-hepatectomy: Right	30	9	R 915,00	T
1751	Hemi-hepatectomy: Left	30	9	R 915,00	T
1752	Extended right or left hepatectomy	30	9	R 915,00	T
1753	Partial or segmental hepatectomy	30	9	R 915,00	T
1754	Hepatico-jejunostomy	30	9	R 915,00	T
1755	Liver transplant	30	15	R 1 525,10	T
1756	Harvesting donor hepatectomy	30	5	R 508,50	T
1757	Suture of liver wound or injury	30	9	R 915,00	T
8.12	Biliary tract			R 0,00	
1759	Cholecystostomy	30	6	R 610,20	T

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1761	Cholecystectomy	30	6	R 610,20	T
1762	Cholecystectomy and operative cholangiogram	30	6	R 610,20	T
1763	With exploration of common bile duct	30	6	R 610,20	T
1765	Exploration of common bile duct: Secondary operation	30	6	R 610,20	T
1767	Reconstruction of common bile duct	30	6	R 610,20	T
1768	Resection bile duct tumour with reconstruction	30	6	R 610,20	T
1769	Cholecysto-enterostomy or gastrostomy	30	6	R 610,20	T
1772	Endoscopic placement of a nasobiliary drainage tube: Add to ERCP (Item 1778)	30	6	R 610,20	T
1773	Transduodenal sphincteroplasty	30	6	R 610,20	T
1774	Balloon dilatation of common bile duct strictures	30	6	R 610,20	T
1775	Excision choledochal cyst with reconstruction	30	6	R 610,20	T
1777	Porto-enterostomy for biliary atresia	30	11	R 1 118,40	T
8.13	Pancreas			R 0,00	
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	30	4	R 406,90	T
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. Add to ERCP (Item 1778)	30	4	R 406,90	T
1780	Gastric and duodenal intubation			R 0,00	
1781	Procedure (excluding laboratory tests)			R 0,00	
1782	Endoscopic Sphincterotomy: Add to ERCP (Item 1778)	30	4	R 406,90	T
1783	Drainage of pancreatic abscess	30	6	R 610,20	T
1784	Debridement pancreatic necrosis	30	6	R 610,20	T
1785	Internal drainage of pancreatic cyst	30	6	R 610,20	T
1770	Endoscopic placement of biliduodenal endoprosthesis: Add to ERCP (Item 1778)	30	6	R 610,20	T
1786	Internal drainage of pancreatic cyst with Roux-Y	30	6	R 610,20	T
1787	Operative pancreatogram: Add			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1788	Biopsy of pancreas	30	6	R 610,20	T
1789	Pancreatico-duodenectomy	30	8	R 813,40	T
1791	Local, partial or subtotal pancreatectomy	30	8	R 813,40	T
1793	Distal pancreatectomy with internal drainage	30	8	R 813,40	T
8.14	Peritoneal cavity			R 0,00	
1797	Pneumo-peritoneum: First	30	4	R 406,90	T
1799	Pneumo-peritoneum: Repeat	30	4	R 406,90	T
1800	Peritoneal lavage			R 0,00	
1801	Diagnostic paracentesis: Abdomen			R 0,00	
1803	Therapeutic paracentesis: Abdomen			R 0,00	
1807	Add to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	30	5	R 508,50	T
1808	Omentectomy (separate procedures)		6	R 610,20	
1809	Laparotomy	30	4	R 406,90	T
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	30	7	R 711,60	T
1811	Suture of burst abdomen	30	7	R 711,60	T
1812	Laparotomy for control of surgical haemorrhage	30	9	R 915,00	T
1813	Drainage of sub-phrenic abscess	30	7	R 711,60	T
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	30	5	R 508,50	T
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	30	4	R 406,90	T
9	**Herniae**			R 0,00	
1819	Inguinal or femoral hernia: Adult	30	4	R 406,90	T
1821	Inguinal or femoral hernia: Child under 14 years	30	4	R 406,90	T
1823	Inguinal hernia: Infant under one year	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1825	Recurrent inguinal or femoral hernia	30	4	R 406,90	T
1827	Strangulated hernia or femoral hernia	30	7	R 711,60	T
1829	Epigastric hernia	30	4	R 406,90	T
1831	Umbilical hernia: Adult	30	4	R 406,90	T
1833	Umbilical hernia: Child under 14 years	30	4	R 406,90	T
1835	Incisional hernia	30	4	R 406,90	T
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair. List separately in addition to item for the incisional or ventral hernia repair	30	4	R 406,90	T
1837	Repair of omphalocele in new-born (one or more procedures)	30	7	R 711,60	T
10	**Urinary system**			R 0,00	
	RULES GOVERNING THE SECTION URINARY SYSTEM			R 0,00	
FF.	a. When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to Item 1949: Cystoscopy, when performed together with any of Items 1951 to 1973.			R 0,00	
10.1	Kidney			R 0,00	
1839	Renal biopsy: Per kidney, open	30	5	R 508,50	T
1841	Renal biopsy: Needle	30	3	R 304,90	T
1843	Peritoneal dialysis: First day			R 0,00	
1845	Peritoneal dialysis: Every subsequent day			R 0,00	
1847	Haemodialysis: Per hour or part thereof			R 0,00	
1849	Haemodialysis: Maximum – eight hours			R 0,00	
1851	Haemodialysis: Thereafter per week			R 0,00	
1852	Continuous haemodiafiltration per day in intensive or high care unit			R 0,00	
1853	Nephrectomy: Primary nephrectomy	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1855	Nephrectomy: Secondary nephrectomy	30	5	R 508,50	T
1857	Radical with regional lymph adenectomy for tumour	30	6	R 610,20	T
1859	Nephrectomy: Partial	30	5	R 508,50	T
1861	Symphysiotomy for horse-shoe kidney	30	6	R 610,20	T
1863	Nephro-ureterectomy	30	5	R 508,50	T
1865	Nephrotomy with drainage nephrostomy	30	6	R 610,20	T
1868	Nephrolithotomy, for congenital kidney abnormality, complicated		3	R 304,90	
1869	Nephrolithotomy	30	5	R 508,50	T
1870	Nephrolithotomy: Multiple calculi – repeat open operation + 25%	30	5	R 508,50	T
1871	Staghorn stone: Surgical	30	6	R 610,20	T
1873	Suture renal laceration (renorraphy)	30	6	R 610,20	T
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	30	3	R 304,90	T
1877	Operation for renal cyst: Marsupialisation or excision	30	5	R 508,50	T
1878	Ablation of one or more renal tumour(s): Cryotherapy, percutaneous, unilateral		3	R 304,90	
1879	Closure renal fistula	30	5	R 508,50	T
1881	Pyeloplasty	30	5	R 508,50	T
1882	Pyeloplasty, complicated; with or without plastic procedure on ureter; nephropexy; nephrostomy; pyelostomy; ureteral splinting. (Secondary procedure for congenital kidney abnormality or solitary kidney)		3	R 304,90	
1883	Pyelostomy	30	5	R 508,50	T
1885	Pyelolithotomy	30	5	R 508,50	T
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	30	5	R 508,50	T
1889	Nephrectomy for Allograft: Living or dead	30	5	R 508,50	T
1891	Perinephric abscess or renal abscess: Drainage	30	7	R 711,60	T
1893	Aberrant renal vessels: Repositioning with pyeloplasty	30	5	R 508,50	T
1894	Auto transplantation of kidney	30	10	R 1 016,80	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1895	Allo transplantation of kidney	30	10	R 1 016,80	T
10.2	Ureter			R 0,00	
1897	Ureterorraphy: Suture of ureter	30	5	R 508,50	T
1898	Ureterorraphy: Lumbar approach	30	5	R 508,50	T
1899	Ureteroplasty	30	5	R 508,50	T
1901	Ureterolysis	30	5	R 508,50	T
1902	Ureterolysis: Lumbar approach	30	5	R 508,50	T
1903	Ureterectomy only	30	5	R 508,50	T
1905	Ureterolithotomy	30	5	R 508,50	T
1907	Cutaneous ureterostomy: Unilateral	30	5	R 508,50	T
1909	Cutaneous ureterostomy: Bilateral	30	5	R 508,50	T
1911	Uretero-enterostomy: Unilateral	30	5	R 508,50	T
1913	Uretero-enterostomy: Bilateral	30	5	R 508,50	T
1915	Uretero-ureterostomy	30	5	R 508,50	T
1917	Transuretero-ureterostomy	30	5	R 508,50	T
1919	Closure of ureteric fistula	30	5	R 508,50	T
1921	Immediate deligation of ureter	30	5	R 508,50	T
1923	Ureterolysis for retrocaval ureter with anastomosis	30	5	R 508,50	T
1924	Ureterocalicostomy		3	R 304,90	
1925	Uretero-pyelostomy	30	5	R 508,50	T
1927	Uretero-neo-cystostomy: Unilateral	30	5	R 508,50	T
1929	Uretero-neo-cystostomy: Bilateral	30	5	R 508,50	T
1931	Uretero-neo-cystostomy: With Boariplasty	30	5	R 508,50	T
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1935	Uretero-ileal conduit	30	5	R 508,50	T
1937	Replacement of ureter by bowel segment: Unilateral	30	5	R 508,50	T
1939	Replacement of ureter by bowel segment: Bilateral	30	5	R 508,50	T
1941	Ureterostomy-in-situ: Unilateral	30	5	R 508,50	T
1943	Ureterostomy-in-situ: Bilateral	30	5	R 508,50	T
10.3	Bladder			R 0,00	
1952	J J Stent catheter	30	3	R 304,90	T
1953	With hydrodilatation of the bladder for interstitial cystitis	30	3	R 304,90	T
1954	Uretroscopy	30	3	R 304,90	T
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	30	3	R 304,90	T
1957	With dilatation of the ureter or ureters	30	3	R 304,90	T
1959	With manipulation of ureteral calculus	30	3	R 304,90	T
1961	With removal of foreign body or calculus from urethra or bladder	30	3	R 304,90	T
1963	With fulguration or treatment of minor lesions, with or without biopsy	30	3	R 304,90	T
1964	And control of haemorrhage and blood clot evacuation	30	3	R 304,90	T
1965	And catheterisation of the ejaculatory duct	30	3	R 304,90	T
1967	With ureteric meatotomy: Unilateral or bilateral	30	3	R 304,90	T
1969	And cold biopsy	30	3	R 304,90	T
1971	With cryosurgery for bladder or prostatic disease	30	3	R 304,90	T
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	30	3	R 304,90	T
1975	Ultraviolet cystoscopy for bladder tumour	30	3	R 304,90	T
1976	Optic urethrotomy	30	3	R 304,90	T
1977	Transurethral resection of ejaculatory duct	30	3	R 304,90	T
1979	Internal urethrotomy: Female	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
1981	Internal urethrotomy: Male	30	3	R 304,90	T
1983	Transurethral resection of bladder tumour	30	5	R 508,50	T
1984	Transurethral resection of bladder tumours: Large multiple tumours	30	5	R 508,50	T
1985	Transurethral resection of bladder neck: Female or child	30	5	R 508,50	T
1986	Transurethral resection of bladder neck: Male	30	5	R 508,50	T
1987	Litholapaxy	30	5	R 508,50	T
1989	Cystometrogram	30	3	R 304,90	T
1991	Flometric bladder, studies with videocystograph	30	3	R 304,90	T
1992	Without videocystograph	30	3	R 304,90	T
1993	Voiding cysto-urethrogram	30	3	R 304,90	T
1994	Rigiscan examination			R 0,00	
1995	Percutaneous aspiration of bladder	30	3	R 304,90	T
1996	Bladder catheterisation: Male (not at operation)	30	3	R 304,90	T
1997	Bladder catheterisation: Female (not at operation)			R 0,00	
1999	Percutaneous cystostomy	30	3	R 304,90	T
1945	Instillation of radio-opaque material for cystography or urethrocystography	30	3	R 304,90	T
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	30	3	R 304,90	T
1949	Cystoscopy: Hospital equipment	30	3	R 304,90	T
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	30	3	R 304,90	T
2001	Total cystectomy: After previous urinary diversion	30	8	R 813,40	T
2003	Total cystectomy: With conduit construction and ureteric anastomosis	30	8	R 813,40	T
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	30	8	R 813,40	T
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	30	8	R 813,40	T
2007	Partial cystectomy	30	6	R 610,20	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	30	8	R 813,40	T
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	30	8	R 813,40	T
2010	Reversion of temporary conduit	30	8	R 813,40	T
2011	Partial cystectomy with uretero-neo-cystostomy	30	6	R 610,20	T
2012	Reversion of conduit with major urinary tract reconstruction	30	8	R 813,40	T
2013	Diverticulectomy (independent procedure): Multiple or single	30	5	R 508,50	T
2014	Closure of cystostomy (stand alone procedure)		3	R 304,90	
2015	Suprapubic cystostomy	30	5	R 508,50	T
2016	Abdomino-neo-urethrostomy	30	5	R 508,50	T
2017	Open loop fulguration or excision of bladder tumour	30	5	R 508,50	T
2019	Operation for vesico-vaginal or urethra-vaginal fistula	30	5	R 508,50	T
2020	Repair of vesico vaginal fistula: Abdominal approach	30	5	R 508,50	T
2021	Vesico-plication (Hamilton Stewart)	30	5	R 508,50	T
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	30	5	R 508,50	T
2025	Vesico-urethropexy with rectus sling	30	5	R 508,50	T
2027	Open operation for ureterocele: Unilateral	30	5	R 508,50	T
2029	Open operation for ureterocele: Bilateral	30	5	R 508,50	T
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	30	8	R 813,40	T
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	30	8	R 813,40	T
2035	Cutaneous vesicostomy	30	5	R 508,50	T
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	30	5	R 508,50	T
2039	Operation for ruptured bladder	30	6	R 610,20	T
2042	Enterocystoplasty plus bowel anastomosis	30	5	R 508,50	T
2043	Cysto-lithotomy	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2045	Excision of patent-urachus or urachal cyst	30	5	R 508,50	T
2047	Drainage of perivesical or prevesical abscess	30	5	R 508,50	T
2049	Evacuation of clots from bladder: Other than post-operative	30	3	R 304,90	T
2050	Evacuation of clots from bladder: Post-operative	30	4	R 406,90	T
2051	Simple bladder lavage: Including catheterisation	30	3	R 304,90	T
2053	Bladder neck plasty: Male	30	5	R 508,50	T
2057	Bladder neck plasty: Female	30	5	R 508,50	T
10.4	Urethra			R 0,00	
2059	Open biopsy of urethra: Male	30	3	R 304,90	T
2061	Open biopsy of urethra: Female	30	3	R 304,90	T
2063	Dilatation of urethra stricture: By passage sound, initial (male)	30	3	R 304,90	T
2065	Dilatation of urethra stricture: By passage sound, subsequent (male)	30	3	R 304,90	T
2067	Dilatation of urethra stricture: By passage sound, by passage of filiform and follower (male)	30	3	R 304,90	T
2069	Dilatation of female urethra	30	3	R 304,90	T
2071	Urethrorraphy: Suture of urethral wound or injury	30	4	R 406,90	T
2073	External urethrotomy: Pendulous urethra (anterior)	30	3	R 304,90	T
2075	Urethraplasty: Pendulous urethra, first stage	30	4	R 406,90	T
2077	Urethraplasty: Pendulous urethra, second stage	30	4	R 406,90	T
2079	Reconstruction of female urethra	30	4	R 406,90	T
2081	Reconstruction or repair of male anterior urethra (one stage)	30	4	R 406,90	T
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	30	6	R 610,20	T
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	30	6	R 610,20	T
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	30	6	R 610,20	T
2087	Urethral diverticulectomy: Male or female	30	4	R 406,90	T

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2088	Peri-urethral teflon injection: Male or female – fee as for cystoscopy (Item 1949) plus 42,00 clinical procedure units			R 0,00	
2089	Marsupialisation of urethral diverticula: Male or female	30	4	R 406,90	T
2091	Total urethrectomy: Female	30	5	R 508,50	T
2093	Total urethrectomy: Male	30	5	R 508,50	T
2095	Drainage of simple localised perineal urinary extravasation	30	5	R 508,50	T
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	30	5	R 508,50	T
2099	Fulguration for urethral caruncle or polyp	30	3	R 304,90	T
2101	Excision of urethral caruncle	30	3	R 304,90	T
2103	Simple urethral meatotomy	30	3	R 304,90	T
2105	Incision of deep peri-urethral abscess: Female	30	3	R 304,90	T
2107	Incision of deep peri-urethral abscess: Male	30	3	R 304,90	T
2108	Sling operation for male urinary incontinence (fascia or synthetic)		3	R 304,90	
2109	Badenoch pull-through for intractable stricture or incontinence	30	5	R 508,50	T
2110	Removal/revision: Sling for male urinary incontinence (fascia or synthetic)		3	R 304,90	
2111	External sphincterotomy	30	5	R 508,50	T
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff		3	R 304,90	
2113	Drainage of Skene gland abscess or cyst	30	3	R 304,90	T
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff		3	R 304,90	
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	30	5	R 508,50	T
2116	Urethral meatoplasty	30	3	R 304,90	T
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	30	3	R 304,90	T
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff		3	R 304,90	
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff		3	R 304,90	
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridment of infected tissue		3	R 304,90	

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2121	Closure of urethrovaginal fistula: Including diversionary procedures	30	5	R 508,50	T
11	**Male genital system**			R 0,00	
11.1	Penis			R 0,00	
2123	Biopsy of penis (independent procedure)	30	3	R 304,90	T
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see Item 2317)	30	3	R 304,90	T
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	30	3	R 304,90	T
2129	Electrodesiccation: Limited number	30	3	R 304,90	T
2131	Electrodesiccation: Multiple extensive	30	3	R 304,90	T
2132	Ligation of abnormal venous drainage	30	3	R 304,90	T
2133	Circumcision: Clamp procedure	30	3	R 304,90	T
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	30	3	R 304,90	T
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	30	3	R 304,90	T
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	30	3	R 304,90	T
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	30	3	R 304,90	T
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	30	3	R 304,90	T
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	30	3	R 304,90	T
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	30	3	R 304,90	T
2153	Reconstructive operation for epispadias with incontinence	30	3	R 304,90	T
2154	Induction of artificial erection	30	3	R 304,90	T
2155	Hypospadias: Urethral reconstruction	30	3	R 304,90	T
2157	Hypospadias: Subsequent procedures for repair of urethra – total	30	3	R 304,90	T
2159	Hypospadias: Urethraplasty – complete, one stage for hypospadias	30	3	R 304,90	T
2161	Total amputation of penis: Without gland dissection	30	4	R 406,90	T
2163	Total amputation of penis: With gland-dissection	30	6	R 610,20	T

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2165	Partial amputation of penis: With gland-dissection	30	6	R 610,20	T
2167	Partial amputation of penis: Without gland-dissection	30	4	R 406,90	T
2169	Injection procedure for Peyronie's disease	30	3	R 304,90	T
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	30	3	R 304,90	T
2173	Priapism operation: Shunt procedure, any type	30	4	R 406,90	T
2174	Priapism operation: Stab shunt	30	4	R 406,90	T
11.2	Testis and epididymis			R 0,00	
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure.			R 0,00	
2175	Testis biopsy: Needle (independent procedure)	30	3	R 304,90	T
2177	Testis biopsy: Incisional – independent procedure, unilateral	30	3	R 304,90	T
2179	Testis biopsy: Incisional – independent procedure, bilateral	30	3	R 304,90	T
2181	Epididymis biopsy: Needle	30	3	R 304,90	T
2183	Puncture aspiration hydrocele with or without injection of medication	30	3	R 304,90	T
2185	Operation for maldescended testicle: Including herniotomy	30	4	R 406,90	T
2187	Operation for torsion appendix testis	30	4	R 406,90	T
2189	Operation for torsion testis with fixation of contralateral testis	30	4	R 406,90	T
2191	Orchidectomy (total or subcapsular): Unilateral	30	3	R 304,90	T
2193	Orchidectomy (total or subcapsular): Bilateral	30	3	R 304,90	T
2195	Radical operation for malignant testis: Excluding gland dissection	30	6	R 610,20	T
2197	Operation for hydrocele or spermatocele	30	4	R 406,90	T
2199	Varicocelectomy	30	4	R 406,90	T
2201	Abdominal ligation of spermatic vein for varicocele	30	4	R 406,90	T
2203	Epididymectomy: Unilateral	30	3	R 304,90	T
2205	Epididymectomy: Bilateral	30	3	R 304,90	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	30	3	R 304,90	T
2209	Vasotomy: Unilateral or bilateral	30	3	R 304,90	T
2210	Vasogram, seminal vesiculogram: Unilateral	30	3	R 304,90	T
2211	Vasogram, seminal vesiculogram: Bilateral	30	3	R 304,90	T
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	30	4	R 406,90	T
2213	Suture or repair of testicular injury	30	4	R 406,90	T
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	30	4	R 406,90	T
2217	Excision of local lesion of testis or epididymis	30	4	R 406,90	T
2219	Vaso-vasostomy: Unilateral	30	3	R 304,90	T
2221	Vaso-vasostomy: Bilateral	30	3	R 304,90	T
2223	Epididymo-vasostomy: Unilateral	30	3	R 304,90	T
2225	Epididymo-vasostomy: Bilateral	30	3	R 304,90	T
2227	Incision and drainage of scrotal wall abscess	30	3	R 304,90	T
2229	Excision of Mullerian duct cyst	30	4	R 406,90	T
2231	Excision of lesion of spermatic cord	30	3	R 304,90	T
2233	Seminal Vesiculectomy	30	5	R 508,50	T
11.3	Prostate			R 0,00	
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	30	3	R 304,90	T
2237	Biopsy prostate: Incisional, any approach	30	4	R 406,90	T
2239	Transurethral drainage of prostatic abscess	30	4	R 406,90	T
2241	Perineal drainage of prostatic abscess	30	4	R 406,90	T
2243	Trans-urethral cryo-surgical removal of prostate	30	6	R 610,20	T
2245	Trans-urethral resection of prostate	30	6	R 610,20	T
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	30	6	R 610,20	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2249	Trans-urethral resection of post-operative bladder neck contracture	30	5	R 508,50	T
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing		8	R 813,40	
2251	Prostatectomy: Perineal, sub-total	30	6	R 610,20	T
2253	Prostatectomy: Perineal, radical	30	8	R 813,40	T
2254	Pelvic lymph adenectomy	30	8	R 813,40	T
2255	Supra-pelvic, transversical	30	6	R 610,20	T
2257	Retropubic: Sub-total	30	6	R 610,20	T
2259	Retropubic: Radical	30	8	R 813,40	T
2260	Prostate brachytherapy	30	8	R 813,40	T
12	**Female genital system**			R 0,00	
12.1	Vulva and introitus			R 0,00	
2271	Removal of tag or polyp	30	3	R 304,90	T
2272	Removal of small superficial benign lesions	30	3	R 304,90	T
2273	Biopsy with suture in theatre (excluding after-care)	30	3	R 304,90	T
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	30	3	R 304,90	T
2275	Reduction labial hypertrophy	30	4	R 406,90	T
2277	Removal of extensive benign vulva tumour	30	4	R 406,90	T
2279	Secondary perineal repair: Repair second degree tear	30	6	R 610,20	T
2280	Secondary perineal repair: Repair third degree tear	30	6	R 610,20	T
2281	Excision of inclusion cyst	30	4	R 406,90	T
2283	Hymenectomy	30	4	R 406,90	T
2285	Drainage haematocolpos	30	4	R 406,90	T
2287	Clitoris repair for injury: Including skin graft, if required	30	4	R 406,90	T
2288	Clitoral reduction	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2289	Denervation or alcohol infiltration vulva (Woodruff)	30	4	R 406,90	T
2291	Vulva: Undercutting skin (ball)	30	4	R 406,90	T
2293	Vulva and introitus: Drainage of abscess	30	3	R 304,90	T
2295	Bartholin gland: Bartholin abscess marsupialisation	30	3	R 304,90	T
2297	Bartholin gland: Bartholin gland excision	30	3	R 304,90	T
2299	Bartholin gland: Bartholin radical excision for malignant lesion	30	6	R 610,20	T
2301	Operation for enlarging introitus: Fenton plasty	30	4	R 406,90	T
2303	Operation for enlarging introitus: Bilateral Z-plastic	30	4	R 406,90	T
2305	Vulvectomy: Partial	30	4	R 406,90	T
2307	Vulvectomy	30	6	R 610,20	T
2309	Radical vulvectomy with bilateral lymphdenectomy	30	6	R 610,20	T
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	30	6	R 610,20	T
12.2	Vaginal procedures and operations			R 0,00	
2312	Artificial insemination			R 0,00	
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) – Stand alone procedure	30	3	R 304,90	T
2314	Intra uterine insemination			R 0,00	
2315	Simms Hühner test plus wet smear			R 0,00	
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	30	3	R 304,90	T
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – limited	30	3	R 304,90	T
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	30	3	R 304,90	T
2319	Excision of cysts or tumours	30	3	R 304,90	T
2321	Drainage of vaginal abscess	30	3	R 304,90	T
2322	Pudendal nerve block			R 0,00	
2323	Reconstruction of vagina after atresia	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2324	Revision of prosthetic vaginal graft: Vaginal approach (removal included)		5	R 508,30	T
2325	Construction of artificial vagina: Labial fusion	30	4	R 406,90	T
2326	Revision of prosthetic vaginal graft: Abdominal approach (removal included)		3	R 304,90	
2327	Construction of artificial vagina: Macindoe type	30	5	R 508,50	T
2329	Construction of vagina: Bowel pull-through operation – two surgeons, each	30	6	R 610,20	T
2330	Fitting/insertion of pessary or other intravaginal support device		3	R 304,90	
2331	Vaginal septum removal	30	4	R 406,90	T
2333	Vaginal prolapse: Abdominal approach – sacrocolpopexy with use of mesh	30	6	R 610,20	T
2334	Vaginal prolapse: Abdominal approach – use of rectus sheath or tape	30	6	R 610,20	T
2335	Vaginal prolapse: Vaginal approach – sacrospinous fixations	30	6	R 610,20	T
2336	Vaginal prolapse: Vaginal approach – use of mesh or tape	30	6	R 610,20	T
2339	Colpotomy: Diagnostic (excluding after-care)	30	4	R 406,90	T
2341	Colpotomy: Therapeutic, with or without sterilisation	30	4	R 406,90	T
2343	Vaginal hysterectomy: Without repair	30	6	R 610,20	T
2345	Vaginal hysterectomy: With repair	30	6	R 610,20	T
2355	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy		5	R 508,30	T
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	30	6	R 610,20	T
2359	Colporrhaphy: Anteroposterior, with enterocele repair		3	R 304,90	
2361	Vaginal hysterectomy and repair for total prolapse	30	6	R 610,20	T
2363	Fothergill or Manchester repair operation	30	5	R 508,50	T
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	30	5	R 508,50	T
2366	Posterior repair alone	30	5	R 508,50	T
2367	Other operations for prolapse: Anterior repair – with or without posterior repair	30	5	R 508,50	T
2368	Uterovesical fistula	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2369	Repair of Vesico- or urethro-vaginal fistula	30	5	R 508,50	T
2370	Repair of VVF – Obstetric or radiation	30	5	R 508,50	T
2371	Closure of uretero-vaginal fistula	30	5	R 508,50	T
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	30	5	R 508,50	T
2373	Closure of recto-vaginal fistula	30	5	R 508,50	T
2374	Closure of recto-vaginal fistula: Obstetric or radiation	30	5	R 508,50	T
2375	Colpocleisis	30	4	R 406,90	T
2377	Le Fort operation	30	4	R 406,90	T
2379	Schauta operation	30	8	R 813,40	T
2381	Vaginectomy	30	8	R 813,40	T
2383	Synchronous combined hysterocolpectomy: One or two surgeons – total fee	30	8	R 813,40	T
2385	Vaginal laceration or trauma: Repair	30	4	R 406,90	T
2386	Repair: Paravaginal defect repair (including repair of cystocele, if performed), abdominal approach		3	R 304,90	
2387	Repair: Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach		3	R 304,90	
12.3	Cervix			R 0,00	
2389	Paracervical (pelvis) nerve block (for neck refer to Item 3294)			R 0,00	
2391	Cervix: Canal reconstruction	30	3	R 304,90	T
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room			R 0,00	
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	30	3	R 304,90	T
2396	Laser or harmonic scalpel treatment of the cervix	30	3	R 304,90	T
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	30	3	R 304,90	T
2399	Punch biopsy (excluding after-care)	30	3	R 304,90	T
2400	Biopsy during pregnancy (excluding after-care)	30	3	R 304,90	T
2403	Wedge biopsy: Cervix (excluding after-care)	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2404	Biopsy: Wedge during pregnancy – cervix (excluding after-care)	30	3	R 304,90	T
2405	Cone biopsy: Cervix (excluding after-care)	30	3	R 304,90	T
2407	Amputation: Cervix	30	3	R 304,90	T
2409	Cervix encirclage: McDonald stitch	30	3	R 304,90	T
2411	Cervix encirclage: Shirodkar suture	30	3	R 304,90	T
2413	Cervix encirclage: Lash	30	3	R 304,90	T
2415	Cervix encirclage: Removal Items 2409 and 2411 – without anaesthetic			R 0,00	
2416	Cervix: Removal Items 2409 and 2411 – with anaesthetic in theatre	30	3	R 304,90	T
2417	Repair of tears: Emmet repair of tears	30	3	R 304,90	T
2418	Repair of tears: Sturmdorff repair of tears	30	3	R 304,90	T
2421	Extirpation of cervical stump: Vaginal	30	5	R 508,50	T
2423	Extirpation of cervical stump: Abdominal	30	5	R 508,50	T
2425	Removal of cervical polyps (excluding after-care)	30	3	R 304,90	T
2427	Removal of cervical myomata	30	3	R 304,90	T
2429	Colposcopy (excluding after-care)	30	3	R 304,90	T
12.4	Uterus			R 0,00	
2432	Hysteroscopic bilateral tubal occlusion with permanent implants (includes hysteroscopy)		3	R 304,90	
2433	Embryo transfer	30	4	R 406,90	T
2434	Endometrial biopsy (excluding after-care)	30	3	R 304,90	T
2435	Hysterosalpingogram (excluding after-care)	30	3	R 304,90	T
2436	Hysteroscopy (excluding after-care)	30	3	R 304,90	T
2437	Hysteroscopy and D&C (excluding after-care)	30	3	R 304,90	T
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	30	3	R 304,90	T
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2440	Hysteroscopy and polypectomy (excluding after-care)	30	3	R 304,90	T
2441	Hysteroscopy and myomectomy (excluding after-care)	30	3	R 304,90	T
2442	Insertion of intra uterine contraceptive device (IUCD) (excluding after-care)	30	3	R 304,90	T
2443	Dilatation and curettage (D&C) (excluding after-care)	30	3	R 304,90	T
2444	Fractional dilatation and curettage (D&C) (excluding after-care)	30	3	R 304,90	T
2445	Evacuation of uterus: Incomplete abortion: Before 12 weeks gestation	30	4	R 406,90	T
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	30	4	R 406,90	T
2448	Termination of pregnancy before 12 weeks	30	4	R 406,90	T
2449	Evacuation: Missed abortion: Before 12 weeks gestation	30	4	R 406,90	T
2451	Evacuation: Missed abortion: After 12 weeks gestation	30	4	R 406,90	T
2452	Termination of pregnancy after 12 weeks – administration of intra/extra amniotic prostaglandin	30	4	R 406,90	T
2453	Evacuation hydatidiform mole	30	5	R 508,50	T
2455	Evacuation uterus post-partum	30	6	R 610,20	T
2461	Ventrosuspension	30	4	R 406,90	T
2463	Uteroplasty: Strassman	30	6	R 610,20	T
2465	Uteroplasty: Tompkins	30	6	R 610,20	T
2467	Myomectomy	30	6	R 610,20	T
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	30	6	R 610,20	T
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy – uncomplicated	30	6	R 610,20	T
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	30	6	R 610,20	T
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	30	8	R 813,40	T
2477	Abdominal hysterotomy with or without sterilisation	30	6	R 610,20	T
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	30	6	R 610,20	T
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	30	6	R 610,20	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2480	Laparoscopy by second gynaecologist during endometrial ablation (Item 2479)			R 0,00	
12.5	Fallopian tubes			R 0,00	
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee			R 0,00	
2481	Insufflation fallopian tubes (excluding after-care)	30	3	R 304,90	T
2483	Salpingolysis	30	4	R 406,90	T
2485	Salpingostomy	30	4	R 406,90	T
2487	Tuboplasty tubal anastomosis or re-implantation	30	4	R 406,90	T
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	30	6	R 610,20	T
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	30	6	R 610,20	T
2491	Ectopic pregnancy after 12 weeks	30	6	R 610,20	T
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	30	5	R 508,50	T
	Note: Use Item 1807 for open procedures performed with a laparoscope instead of Item 2493. Item 1807 may only be added once, and may not be charged together with Item 2493 for more than one procedure performed laparoscopically			R 0,00	
2493	Diagnostic laparoscopy (excluding after-care)	30	5	R 508,50	T
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	30	5	R 508,50	T
2497	Laparoscopy: Plus sterilisation	30	5	R 508,50	T
2499	Laparoscopy: Plus biopsy (excluding after-care)	30	5	R 508,50	T
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	30	5	R 508,50	T
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	30	5	R 508,50	T
2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	30	5	R 508,50	T
2503	Laparoscopy: Plus ovarian drilling	30	5	R 508,50	T
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	30	5	R 508,50	T
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	30	5	R 508,50	T
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
12.6	Ovaries			R 0,00	
2525	Wedge resection of ovaries, unilateral or bilateral	30	4	R 406,90	T
2527	Removal of ovarian tumour or cyst	30	4	R 406,90	T
2529	Oophorectomy: Uni- or bilateral	30	4	R 406,90	T
2531	Ovarian carcinoma debulking and omentectomy	30	6	R 610,20	T
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	30	6	R 610,20	T
12.7	Miscellaneous procedures			R 0,00	
2535	Exenteration: Anterior Exenteration	30	8	R 813,40	T
2537	Exenteration: Posterior Exenteration	30	8	R 813,40	T
2539	Exenteration: Total	30	8	R 813,40	T
2541	Presacral neurectomy	30	5	R 508,50	T
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)		3	R 304,90	
2543	Moschowitz operation	30	5	R 508,50	T
2544	Laparoscopic vaginal suspension for stress incontinence (Item 1807 may not be used together with this item)	30	5	R 508,50	T
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	30	5	R 508,50	T
2546	Operations for stress incontinence: Urethro-vesicopexy – abdominal approach	30	6	R 610,20	T
2547	Operations for stress incontinence: Burch colposuspension	30	5	R 508,50	T
2548	Operation for stress incontinence: Use of tape	30	5	R 508,50	T
2550	Operations for stress incontinence: Urethro-vesicopexy – combined abdominal and vaginal approach	30	5	R 508,50	T
2551	Laparotomy	30	4	R 406,90	T
2552	Removal benign retroperitoneal tumour	30	6	R 610,20	T
2553	Radical removal of malignant retroperitoneal tumour	30	8	R 813,40	T
2554	Drainage of pelvic abscess per abdomen	30	6	R 610,20	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2556	Drainage of pelvic abscess per vagina (refer to Item 2341)	30	5	R 508,50	T
2558	Drainage intra-abdominal abscess: Delayed closure	30	6	R 610,20	T
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	30	6	R 610,20	T
2561	Surgery for severe endometriosis (AFS stage 4 – retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	30	6	R 610,20	T
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	30	6	R 610,20	T
2565	Implantation hormone pellets (excluding after-care)			R 0,00	
2570	Ligation of internal iliac vessels (when not part of another procedure)	30	8	R 813,40	T
13	**Obstetric procedures**			R 0,00	
	RULES GOVERNING THIS SECTION			R 0,00	
U.	**Obstetric procedures** a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to Item 2614: Global obstetric care. ii. If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to Item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to Item 2614: Global obstetric care.			R 0,00	
13.1	Pre-natal care and procedures			R 0,00	
2603	External cephalic version (excluding after-care)			R 0,00	
2605	Amniocentesis (excluding after-care)			R 0,00	
2607	Amnioscopy (excluding after-care)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2609	Intra-uterine transfusion of foetus or cordocentesis			R 0,00	
2610	Tococardiography – pre-natal and intrapartum (including stress and non-stress test: Own machine (excluding after-care)			R 0,00	
2611	Chorion villus sampling (excluding after-care)			R 0,00	
13.2	Confinements			R 0,00	
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit)	30	6	R 610,20	T
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit).	30	6	R 610,20	T
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)			R 0,00	
	Global obstetric care includes • All inductions of labour (medical or surgical) • Intrapartum paracervical and pudential blocks Intrapartum amnioscopy • Foetal blood sampling • Application of scalp leads • Symphysiotomy • Manual removal of placenta • Repair cervical tears • Drainage of vulval haematoma • Repair second degree tear • Repair episiotomy • Resuscitation of newborn by obstetrician • Tracheal intubation • Missed confinement			R 0,00	
	Global obstetric care excludes • Prenatal consultation • Prenatal procedures (Items 2603 – 2611) • Emergency hysterectomy for obstetrical reasons • Abdominal operation for repair of ruptured gravid uterus • Intensive care for obstetrical emergencies • Tubal ligation performed as a post-partum procedure • Post-partum complications occurring after discharge from the hospital				

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
13.3	Operative procedures (excluding antenatal care)			R 0,00	
2653	Caesarean-hysterectomy	30	9	R 915,00	T
2657	Post-partum hysterectomy	30	8	R 813,40	T
2669	Abdominal operation for ruptured gravid uterus: Repair	30	9	R 915,00	T
14	**Nervous system**			R 0,00	
14.1	Diagnostic procedures			R 0,00	
2680	Haemodynamic and autonomic nervous system testing with task Force system – PROFESSIONAL COMPONENTS			R 0,00	
2681	Visual evoked potentials (VEP): Unilateral			R 0,00	
2682	Visual evoked potentials (VEP): Bilateral			R 0,00	
2683	Electro-retinography (Ganzfeld method): Unilateral			R 0,00	
2684	Electro-retinography (Ganzfeld method): Bilateral			R 0,00	
2685	Electro-oculography: Unilateral			R 0,00	
2686	Electro-oculography: Bilateral			R 0,00	
2687	VEP stable condition (photic drive): Unilateral			R 0,00	
2689	VEP stable condition (photic drive): Bilateral			R 0,00	
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP			R 0,00	
	Note: See Items 2691 to 2702 under section 17.5.1: Audiometry			R 0,00	
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex			R 0,00	
2704	Neurostimulation, percutaneous: Sacral nerve			R 0,00	
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment			R 0,00	
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming			R 0,00	
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation			R 0,00	
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2709	Full spinogram including bilateral median and posterior-tibial studies			R 0,00	
2710	Morphia saturation testing in rooms (consultation x 2 plus Item 0206: Intravenous infusion) – excluding injection material			R 0,00	
2711	Electro-encephalography: Taking of record			R 0,00	
2712	Electro-encephalography: Interpretation			R 0,00	
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications			R 0,00	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.			R 0,00	
2714	Cisternal puncture and/or intrathecal injections			R 0,00	
2715	Eight hour ambulatory EEG monitoring (Holter): Hire			R 0,00	
2716	Eight hour ambulatory EEG monitoring (Holter): Interpretation			R 0,00	
2717	Electromyography: First			R 0,00	
2718	Electromyography: Subsequent			R 0,00	
2719	Overnight polysomnogram and sleep staging: Hire			R 0,00	
2720	Overnight polysomnogram and sleep staging: Interpretation			R 0,00	
2721	Daytime polysomnogram: Hire			R 0,00	
2722	Daytime polysomnogram: Interpretation			R 0,00	
2723	Multiple sleep latency test: Interpretation			R 0,00	
2724	Overnight continuous positive airways pressure (CPAP) titration			R 0,00	
2725	Angiography carotis: Unilateral	30	4	R 406,90	T
2726	Angiography carotis: Bilateral	30	4	R 406,90	T
2727	Vertebral artery: Direct needling	30	4	R 406,90	T
2728	Unattended overnight home-based polysomnogram: Interpretation			R 0,00	
2729	Vertebral catheterisation	30	4	R 406,90	T
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist (‘20’) – not to be used with Item 0714			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	30	4	R 406,90	T
2732	Overnight home-based polysomnogram: Interpretation			R 0,00	
2733	Cortical stimulation			R 0,00	
2734	Sodium Amytal Testing (WADA test)	30	13	R 1 321,70	T
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician			R 0,00	
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen			R 0,00	
2739	Ventricular needling without burring: Tapping only	30	4	R 406,90	T
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	30	4	R 406,90	T
2743	Subdural tapping: First sitting	30	4	R 406,90	T
2745	Subdural tapping: Subsequent	30	4	R 406,90	T
6001	Sleep electro-encephalography: Infants that fit into a perambulator – taking of record			R 0,00	
6002	Sleep electro-encephalography: Infants that fit into a perambulator – interpretation			R 0,00	
6003	Sleep electro-encephalography: Adults and children over infant age – taking of record			R 0,00	
6004	Sleep electro-encephalography: Adults and children over infant age – iInterpretation			R 0,00	
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised 16 or more channel EEG, which may include video recording (e.g. for pre-operative localisation) – each full 24 hour period			R 0,00	
6011	Interpretation of item 6010: Electro-encephalogram monitoring. To be charged once only for each full 24 hour period of monitoring			R 0,00	
14.2	Introduction of burr holes for			R 0,00	
2746	Biopsy: Temporal artery			R 0,00	
2747	Ventriculography	30	8	R 813,40	T
2749	Catheterisation for ventriculography and/or drainage	30	8	R 813,40	T
2751	Biopsy of brain tumour	30	8	R 813,40	T
2753	Subdural haematoma or hygroma	30	8	R 813,40	T
2755	Subdural empyema	30	8	R 813,40	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2757	Brain abscess	30	8	R 813,40	T
14.3	Nerve procedures			R 0,00	
2759	Nerve biopsy: Peripheral	30	4	R 406,90	T
2763	Nerve biopsy: Cranial nerves: Extra-cranial	30	4	R 406,90	T
2765	Nerve biopsy: Nerve conduction studies (see Items 0733 and 3285)	30	4	R 406,90	T
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + Item 0201 + Item 0202)			R 0,00	
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ Item 0198 + Item 0201 + Item 0202)			R 0,00	
6007	Botulinus toxin injections: For adductor disphonia (+ Item 0198 + 0201 + Item 0202)			R 0,00	
6008	Botulinus toxin injections: In extra-ocular muscles (+ Item 0198 + Item 0201 + Item 0202)			R 0,00	
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ Item 0198 + Item 0201 + Item 0202)			R 0,00	
14.3.1	Nerve procedures: Nerve repair or suture			R 0,00	
2767	Suture brachial plexus (see also Items 2837 and 2839)	30	6	R 610,20	T
2769	Suture: Large nerve: Primary	30	5	R 508,50	T
2771	Suture: Large nerve: Secondary	30	5	R 508,50	T
2773	Digital nerve: Primary	30	3	R 304,90	T
2775	Digital nerve: Secondary	30	3	R 304,90	T
2777	Nerve graft: Simple	30	4	R 406,90	T
2779	Fascicular: First fasciculus	30	4	R 406,90	T
2781	Fascicular: Each additional fasciculus	30	4	R 406,90	T
2782	Nerve pedicle transfer: First stage (not to be used together with Item 2783)		4	R 406,70	T
2783	Fascicular: Nerve flap – to include all stages	30	4	R 406,90	T
2784	Nerve pedicle transfer: Second stage (not to be used together with Item 2783)		4	R 406,70	T
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	30	6	R 610,20	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2787	Fascicular: Grafting of facial nerve	30	5	R 508,50	T
14.3.2	Nerve procedures: Neurectomy			R 0,00	
2789	Trigeminal ganglion: Injection of alcohol	30	4	R 406,90	T
2791	Trigeminal ganglion: Injection of cortisone	30	3	R 304,90	T
2793	Trigeminal ganglion: Coagulation through high frequency	30	3	R 304,90	T
2799	Procedures for pain relief: Intrathecal injections for pain	30	4	R 406,90	T
2800	Procedures for pain relief: Plexus nerve block	20	36	R 583,20	ç
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) – refer to modifier 0021 for epidural anaesthetic			R 0,00	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.			R 0,00	
2802	Procedures for pain relief: Peripheral nerve block	20	25	R 405,00	ç
2803	Alcohol injection in peripheral nerves for pain: Unilateral	30	3	R 304,90	T
2804	Inserting an indwelling nerve catheter (includes removal of catheter) – not for bolus technique	20	10	R 161,80	ç
2805	Alcohol injection in peripheral nerves for pain: Bilateral	30	3	R 304,90	T
2809	Peripheral nerve section for pain	30	3	R 304,90	T
2811	Pudendal neurectomy: Bilateral	30	3	R 304,90	T
2813	Obturator or Stoffels	30	3	R 304,90	T
2815	Interdigital	30	3	R 304,90	T
2825	Excision: Neuroma – peripheral	30	3	R 304,90	T
14.3.3	Nerve procedures: Other nerve procedures			R 0,00	
2827	Transposition of ulnar nerve	30	3	R 304,90	T
2829	Neurolysis: Minor	30	3	R 304,90	T
2831	Neurolysis: Major	30	3	R 304,90	T
2833	Neurolysis: Digital	30	3	R 304,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2834	Neuroplasty: Sciatic nerve		3	R 304,90	T
2835	Scalenotomy	30	6	R 610,20	T
2837	Neuroplasty: Brachial Plexus	30	5	R 508,30	T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	30	6	R 610,20	T
2841	Carpal tunnel	30	3	R 304,90	T
2843	Lumbar sympathectomy: Unilateral	30	4	R 406,90	T
2845	Lumbar sympathectomy: Bilateral	30	6	R 610,20	T
2846	Cervical sympathectomy: Trans-thoracic approach (use Item 2847 or item 2848 as appropriate)	30	11	R 1 118,40	T
2847	Cervical sympathectomy: Unilateral	30	4	R 406,90	T
2848	Cervical sympathectomy: Bilateral	30	6	R 610,20	T
2849	Sympathetic block: Other levels – unilateral	30	3	R 304,90	T
2851	Sympathetic block: Other levels – bilateral	30	3	R 304,90	T
2853	Sympathetic block: Other levels – diagnostic/therapeutic nerve block (unassociated with surgery). Either intercostal, or brachial, or peripheral, or stellate ganglion	30	4	R 406,90	T
14.4	Skull procedures			R 0,00	
2855	Removal of skull tumour: With or without plastic repair, small	30	5	R 508,50	T
2857	Removal of skull tumour: With or without plastic repair, major	30	8	R 813,40	T
2859	Repair of depressed fracture of skull: Without brain laceration, major	30	8	R 813,40	T
2860	Repair of depressed fracture of skull: Without brain laceration, small	30	8	R 813,40	T
2861	Repair of depressed fracture of skull: With brain lacerations, small	30	8	R 813,40	T
2862	Repair of depressed fracture of skull: With brain lacerations, major	30	8	R 813,40	T
2863	Cranioplasty	30	8	R 813,40	T
2864	Encephalocele (excluding frontal)	30	8	R 813,40	T
2865	Craniostenosis: Few suturae	30	9	R 915,00	T
2867	Craniostenosis: Multiple suturae	30	9	R 915,00	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
14.5	Shunt procedures			R 0,00	
2869	Ventriculo-cisternostomy	30	8	R 813,40	T
2871	Ventriculo-caval shunt	30	11	R 1 118,40	T
2873	Ventriculo-peritoneal shunt	30	8	R 813,40	T
2875	Theco-peritoneal C.S.F. shunt	30	8	R 813,40	T
14.6	Aneurysm repair			R 0,00	
2876	Repair of aneurysms or arteriovenous anomalies (intracranial)	30	15	R 1 525,10	T
2877	Extracranial to intracranial vascular	30	15	R 1 525,10	T
2878	Posterior fossa arteriovenous anomalies	30	15	R 1 525,10	T
14.7	Craniectomy or craniotomy			R 0,00	
2879	Glosso pharyngeal nerve	30	6	R 610,20	T
2881	Eighth nerve: Intracranial	30	8	R 813,40	T
2883	Eighth nerve: Extracranial	30	4	R 406,90	T
2884	Sub-temporal section of the trigeminal nerve	30	9	R 915,00	T
2885	Trigeminal tractotomy	30	9	R 915,00	T
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	30	9	R 915,00	T
2887	Vestibular nerve	30	9	R 915,00	T
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	30	11	R 1 118,40	T
2891	Posterior fossa tumour removal: Glioma, secondary deposits	30	11	R 1 118,40	T
2893	Posterior fossa tumour removal: Abscess	30	11	R 1 118,40	T
2895	Excision of tumour of glomus jugulare: Intracranial	30	11	R 1 118,40	T
2897	Excision of tumour of glomus jugulare: Extracranial	30	9	R 915,00	T
2898	Excision of tumour of glomus jugulare: Hemispherectomy	30	15	R 1 525,10	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
14.7.1	Posterior fossa surgery: Supratentorial procedures			R 0,00	
2899	Craniectomy for extra-dural haematoma or empyema	30	11	R 1 118,40	T
14.8	Craniotomy for			R 0,00	
2900	Extra-dural orbital decompression or excision of orbital tumour	30	11	R 1 118,40	T
2901	Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	30	11	R 1 118,40	T
2903	Abscess, glioma	30	11	R 1 118,40	T
2904	Haematoma, foreign body: Cerebral or cerebellar	30	11	R 1 118,40	T
2905	Focal epilepsy: Excision of cortical scar	30	11	R 1 118,40	T
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	30	11	R 1 118,40	T
2907	Temporal lobectomy	30	11	R 1 118,40	T
2908	Torkildsen anastomosis	30	11	R 1 118,40	T
2909	CSF-leaks	30	11	R 1 118,40	T
2910	Removal of arteriovenous malformation	30	11	R 1 118,40	T
14.8.1	Stereotaxis, stereotactic radiosurgery (cranial), neurostimulators (intracranial)			R 0,00	
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	30	4	R 406,90	T
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	30	4	R 406,90	T
2915	Transnasal hypophysectomy	30	11	R 1 118,40	T
2916	Transfrontal hypophysectomy	30	11	R 1 118,40	T
2917	Transnasal hypophyseal implants	30	11	R 1 118,40	T
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)			R 0,00	
14.9	Spinal operations			R 0,00	
	See section 3.8.7 for laminectomy procedures			R 0,00	
2923	Chordotomy: Unilateral	30	3	R 304,90	TM
2925	Chordotomy: Open	30	3	R 304,90	TM

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2927	Rhizotomy: Extradural, but intraspinal	30	3	R 304,90	TM
2928	Rhizotomy: Intradural	30	3	R 304,90	TM
2929	Removal of spinal cord tumour: Intramedullar – posterior approach	30	8	R 813,40	T
2930	Removal of spinal cord tumour: Intramedullar – anterio-lateral approach	30	8	R 813,40	T
2931	Removal of spinal cord tumour: Extramedullary, but intradural – posterior approach	30	3	R 304,90	TM
2932	Removal of spinal cord tumour: Extramedullary, but intradural – anterio-lateral approach	30	8	R 813,40	T
2933	Removal of spinal cord tumour: Extramedullary, but intradural: Intraspinal, but extradural – posterior approach	30	7	R 711,60	T
2935	Removal of spinal cord tumour: Extramedullary, but intradural – transcutaneous chordotomy	30	3	R 304,90	T
2937	Repair of meningocele, involving nerve tissue	30	9	R 915,00	T
2938	Simple	30	9	R 915,00	T
2939	Excision of arterial vascular malformations and cysts of the spinal cord	30	9	R 915,00	T
2940	Lumbar osteophyte removal	30	3	R 304,90	TM
2941	Cervical or thoracic osteophyte removal	30	3	R 304,90	TM
14.10	Arterial ligations			R 0,00	
2951	Carotis: Trauma	30	8	R 813,40	T
2953	Carotis: For aneurysm (AV anomaly)	30	8	R 813,40	T
2955	Removal of carotid body tumour (without vascular reconstruction)	30	8	R 813,40	T
14.11	Medical psychotherapy			R 0,00	
2957	Individual psychotherapy (specify type): Including play therapy for children: Per short session (20 minutes)			R 0,00	
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session			R 0,00	
2963	Pairs, marriage or sex therapy: Per 20-minute session			R 0,00	
2968	Group therapy: Adults (specify number) – tariff per person per 80-minute session. Children (specify number): Tariff per person per 80-minute session			R 0,00	
2974	Individual psychotherapy (specify type): Including play therapy for children – per intermediate session (40 minutes)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2975	Individual psychotherapy (specify type): Including play therapy for children – per extended session (60 minutes or longer)			R 0,00	
2976	Intermediate treatment where either Items 2962 or 2963 are used: Per 40-minute session			R 0,00	
2977	Extended treatment where either Items 2962 or 2963 are used: Per 60-minute session			R 0,00	
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY			R 0,00	
V.	a. Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.			R 0,00	
0079	When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (Items 2957, 2974 or 2975).			R 0,00	
99	Stat basis tests: For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos: Stat test requesting may only be done by the referring practitioner and not by the pathologist. • Stat test requesting may only be done by the referring practitioner and not by the pathologist. • Specimens must be collected on a stat basis where applicable. • Test must be performed on a stat basis. • Documentation (or a copy thereof) relating to the request of the referring practitioner must be • retained. • This modifier will only apply during normal working hours and will never be used in combination with Item 4547: After-hours servic			R 0,00	
14.12	Physical treatment methods			R 0,00	
2970	Electro-convulsive treatment (ECT): Each time (see rule V.a.)	30	3	R 304,90	T
14.13	Psychiatric examination methods			R 0,00	
2972	Narco-analysis (maximum of three sessions per treatment): Per 60-minute session			R 0,00	
2973	Psychometry (specify examination): Per session (maximum of three sessions per examination)			R 0,00	
15	**Endocrine system**			R 0,00	
15.1	Thyroid			R 0,00	
2983	Lobectomy: Partial	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
2985	Lobectomy: Total	30	5	R 508,50	T
2987	Thyroidectomy: Subtotal	30	5	R 508,50	T
2989	Thyroidectomy: Total	30	5	R 508,50	T
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		6	R 610,20	
2991	Thyroglossal cyst or fistula excision	30	5	R 508,50	T
15.2	Parathyroid			R 0,00	
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		12	R 1 220,30	
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	30	5	R 508,50	T
15.3	Adrenals			R 0,00	
2994	Parathyroid: Autotransplantation of parathyriod: Add to major procedure (modifier 0005 does not apply)		6	R 610,20	
2995	Adrenalectomy: Unilateral	30	9	R 915,00	T
2997	Bilateral exploration of adrenal glands: Including removal	30	11	R 1 118,40	T
15.4	Hypophysis			R 0,00	
2999	Transethmoidal hypophysectomy	30	11	R 1 118,40	T
3000	Transnasal hypophysectomy (see also Item 2915)	30	11	R 1 118,40	T
15.5	Endocrine system: General			R 0,00	
3001	Implantation of pellets (excluding cost of material) (excluding after-care)			R 0,00	
16	**Eye**			R 0,00	
16.1	Eye: Procedures performed in rooms			R 0,00	
	a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions. b. Material used is excluded. c. The fee for photography is not related to the number of photographs taken.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
16.1.1	Eye investigations			R 0,00	
3002	Gonioscopy			R 0,00	
3003	Fundus contact lens or 90 D lens examination (not to be charged with Item 3004 or Item 3012)			R 0,00	
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with Item 3003 and/or Item 3012)			R 0,00	
3006	Keratometry			R 0,00	
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			R 0,00	
3012	Pre-surgical retinal examination before retinal surgery			R 0,00	
3013	Ocular motility assessment: Comprehensive examination			R 0,00	
3014	Tonometry per test with maximum of two tests for provocative tonometry (one or both eyes)			R 0,00	
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations			R 0,00	
16.1.2	Special eye investigations			R 0,00	
3005	Endothelial cell count			R 0,00	
3007	Potential acuity measurement			R 0,00	
3008	Contrast sensitivity test			R 0,00	
3010	Orthoptics consultation			R 0,00	
3011	Orthoptic subsequent sessions			R 0,00	
3015	Charting of visual field with manual perimeter			R 0,00	
3016	Retinal threshold test without storage facilities			R 0,00	
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs			R 0,00	
3018	Retinal threshold trend evaluation (additional to Item 3017)			R 0,00	
3019	Ocular muscle function with Hess screen or perimeter			R 0,00	
3020	Special eye investigations: Pachymetry – only when own instrument is used, per eye. Only in addition to corneal surgery			R 0,00	
3022	Digital fluorescein video angiography	30	9	R 915,00	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3023	Digital indocyanine video angiography	30	9	R 915,00	T
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to Items 3022, 3023, 3031, 3039			R 0,00	
3025	Electronic tonography			R 0,00	
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum			R 0,00	
3027	Fundus photography			R 0,00	
3028	Optical Coherent Tomography (OCT) of optic nerve or macula: Per eye			R 0,00	
3029	Anterior segment microphotography			R 0,00	
3031	Fluorescein Angiography: One or both eyes (not to be used with Item 3022)			R 0,00	
3032	Eyelid and orbit photography			R 0,00	
3033	Interpretation of Items 3022, 3023 and 3031 referred by other clinicians			R 0,00	
3034	Determination of lens implant power per eye			R 0,00	
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			R 0,00	
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)			R 0,00	
16.2	Retina			R 0,00	
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	30	6	R 610,20	T
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	30	6	R 610,20	T
3041	Pan retinal photocoagulation (per eye): Done in one sitting	30	6	R 610,20	T
3044	Removal of encircling band and/or buckling material	30	6	R 610,20	T
16.3	Cataract			R 0,00	
3045	Cataract: Intra-capsular	30	7	R 711,60	T
3047	Cataract: Extra-capsular (including capsulotomy)	30	7	R 711,60	T
3049	Insertion of lenticulus in addition to Item 3045 or Item 3047 (cost of lens excluded) – modifier 0005 not applicable	30	7	R 711,60	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3050	Repositioning of intra ocular lens	30	7	R 711,60	T
3051	Needling or capsulotomy	30	4	R 406,90	T
3052	Laser capsulotomy	30	4	R 406,90	T
3057	Removal of lenticulus	30	7	R 711,60	T
3058	Exchange of intra ocular lens	30	7	R 711,60	T
3059	Insertion of lenticulus when Item 3045 or Item 3047 was not executed (cost of lens excluded)	30	7	R 711,60	T
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) – for use by ophthalmologists only			R 0,00	
16.4	Glaucoma			R 0,00	
3061	Drainage operation	30	6	R 610,20	T
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to Item 3061)	30	6	R 610,20	T
3063	Cyclocryotherapy or cyclodiathermy	30	6	R 610,20	T
3064	Laser trabeculoplasty	30	6	R 610,20	T
3065	Removal of blood from anterior chamber	30	4	R 406,90	T
3067	Goniotomy	30	7	R 711,60	T
16.5	Intra-ocular foreign body			R 0,00	
3071	Intra-ocular foreign body: Anterior to Iris	30	4	R 406,90	T
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	30	6	R 610,20	T
16.6	Strabismus			R 0,00	
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to Item 0202)			R 0,00	
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	30	5	R 508,50	T
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	30	5	R 508,50	T
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	30	5	R 508,50	T
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
16.7	Globe			R 0,00	
3079	Transcleral biopsy	30	4	R 406,90	T
3080	Examination of eyes under general anaesthetic where no surgery is done	30	4	R 406,90	T
3081	Treatment of minor perforating injury	30	6	R 610,20	T
3083	Treatment of major perforating injury	30	6	R 610,20	T
3085	Enucleation or Evisceration	30	5	R 508,50	T
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	30	5	R 508,50	T
3088	Hydroxyapetite insertion (additional to Item 3087)	30	5	R 508,50	T
3089	Subconjunctival injection if not done at time of operation	30	5	R 508,50	T
3090	Intra vitreal injection drug	30	4	R 406,90	T
3091	Retrobulbar injection (if not done at time of operation)	30	4	R 406,90	T
3092	External laser treatment for superficial lesions			R 0,00	
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	30	6	R 610,20	T
3094	Implantation of intra vitreal drug delivery system	30	4	R 406,90	T
3095	Biopsy of vitreous body or anterior chamber contents	30	6	R 610,20	T
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	30	7	R 711,60	T
3097	Anterior vitrectomy	30	6	R 610,20	T
3098	Removal of silicon from globe	30	6	R 610,20	T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	30	6	R 610,20	T
3100	Lensectomy done at time of posterior vitrectomy	30	7	R 711,60	T
16.8	Orbit			R 0,00	
3101	Drainage of orbital abscess	30	5	R 508,50	T
3103	Orbit: Removal of tumour	30	5	R 508,50	T
3104	Removal orbital prosthesis	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3105	Orbit: Exenteration	30	5	R 508,50	T
3107	Orbitotomy requiring bone flap	30	5	R 508,50	T
3108	Eye socket reconstruction	30	5	R 508,50	T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	30	5	R 508,50	T
3110	Second stage hydroxyapetite implantation	30	5	R 508,50	T
16.9	Cornea			R 0,00	
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)			R 0,00	
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens as for corneal erosion, ulcer, abrasion or corneal wound.			R 0,00	
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one year			R 0,00	
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery – EQUIPMENT component only			R 0,00	
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			R 0,00	
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	30	6	R 610,20	T
3117	Removal of foreign body: On the basis of fee per consultation	30	4	R 406,90	T
3118	Curettage of cornea after removal of foreign body (after-care excluded)			R 0,00	
3119	Tattooing	30	4	R 406,90	T
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) – for machine hire fee for LTK: Use Item 3201	30	6	R 610,20	T
3121	Corneal graft (Lamellar or full thickness)	30	6	R 610,20	T
3122	Epikeratophakia			R 0,00	
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	30	6	R 610,20	T
3124	Removal of corneal stitches under microscope (maximum of two procedures). Additional fee for sterile tray (see Item 0202)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3125	Keratectomy	30	6	R 610,20	T
3126	Additional to Item 3120 for the use of own microkeratome used with a excimer laser			R 0,00	
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	30	4	R 406,90	T
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	30	6	R 610,20	T
3129	Additional to Item 3128 for the use of own diamond knives			R 0,00	
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	30	4	R 406,90	T
3131	Cornea: Paracentesis	30	4	R 406,90	T
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	30	6	R 610,20	T
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used – stand alone procedure	30	4	R 406,90	T
3136	Conjunctival flap or graft (not for use with pterigium surgery)	30	6	R 610,20	T
3138	Removal corneal epithelium and chelating agent for band keratopathy	30	4	R 406,90	T
4980	Corneal transplant: Endothelial		3	R 304,90	
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)		0	R 0,00	
4985	Corneal cross linking		3	R 304,90	
4986	Cross linking equipment hire		0	R 0,00	
16.10	Ducts			R 0,00	
3133	Probing and/or syringing, per duct	30	4	R 406,90	T
3135	Insert polythene tubes	30	4	R 406,90	T
3137	Excision of lacrimal sac: Unilateral	30	4	R 406,90	T
3139	Dacrocystorhinostomy (Single) with or without polythene tube	30	5	R 508,50	T
3141	Sealing Punctum surgical or by cautery: Per eye	30	4	R 406,90	T
3142	Sealing Punctum with plugs: Per eye	30	4	R 406,90	T
3143	Three-snip operation	30	4	R 406,90	T
3145	Repair of caniculus: Primary procedure	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3147	Repair of caniculus: Secondary procedure	30	4	R 406,90	T
16.11	Iris			R 0,00	
3149	Iridectomy or iridotomy by open operation as isolated procedure	30	4	R 406,90	T
3151	Excision of iris tumour	30	6	R 610,20	T
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	30	4	R 406,90	T
3155	Iridocyclectomy for tumour	30	6	R 610,20	T
3157	Division of anterior synechiae as isolated procedure	30	4	R 406,90	T
3158	Repair iris as in dialysis: Anterior chamber reconstruction	30	4	R 406,90	T
16.12	Lids			R 0,00	
3161	Tarsorrhaphy	30	4	R 406,90	T
3163	Excision of superficial lid tumour	30	4	R 406,90	T
3165	Repair of skin laceration lid: Simple	30	4	R 406,90	T
3167	Diathermy to wart on lid margin	30	4	R 406,90	T
3169	Electrolysis of any number of eyelashes: Per eye			R 0,00	
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see Item 0202)	30	4	R 406,90	T
3173	Epicanthal folds	30	4	R 406,90	T
3174	Botulinus toxin injection for blepharospasm (+ Item 0198 + Item 0201 + Item 0202)			R 0,00	
3175	Botulinus toxin injection in extra-ocular muscles (+ Item 0198 + Item 0201+ Item 0202)			R 0,00	
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	30	4	R 406,90	T
16.12.1	Lids: Entropion or ectropion by			R 0,00	
3177	Entropion or ectropion by cautery	30	4	R 406,90	T
3179	Entropion or ectropion by suture	30	4	R 406,90	T
3181	Entropion or ectropion by open operation	30	4	R 406,90	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3183	Entropion or ectropion by Free skin, mucosal grafting or flap	30	4	R 406,90	T
16.12.2	Lids: Reconstruction of eyelid			R 0,00	
3185	Staged procedure for partial or total loss of eyelid: First stage	30	4	R 406,90	T
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	30	4	R 406,90	T
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	30	4	R 406,90	T
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	30	4	R 406,90	T
3172	Blepharoplasty lower eyelid plus fat pad	30	4	R 406,90	T
16.12.3	Lids: Ptosis			R 0,00	
3193	Repair by superior rectus, levator or frontalis muscle operation	30	4	R 406,90	T
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	30	4	R 406,90	T
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	30	4	R 406,90	T
16.13	Conjunctiva			R 0,00	
3199	Repair of conjunctiva by grafting	30	4	R 406,90	T
3200	Repair of lacerated conjunctiva	30	4	R 406,90	T
16.14	Eye: General			R 0,00	
	Own equipment used in treatment: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.			R 0,00	
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting			R 0,00	
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of the indicated amount per minute may be charged			R 0,00	
3196	Diamond knife: Use of own diamond knife during intraocular surgery			R 0,00	
3198	Excimer laser: Hire fee (per eye)			R 0,00	
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting. Not to be used with IOL Master			R 0,00	
3202	Phako emulsification apparatus: Hire fee			R 0,00	
3203	Vitrectomy apparatus: Hire fee			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3208	Biopsy: External auditory canal		3	R 304,90	
17	**Ear**			R 0,00	
	Fitting/orientation/checking of a hearing aid: report this service using the appropriate consultation code			R 0,00	
	Repair/modification of hearing aid: rRport this service using Item 0201 and supply invoice			R 0,00	
17.1	External ear (Pinna)			R 0,00	
	Fitting/orientation/checking of a hearing aid: Report this service using the appropriate consultation code			R 0,00	
	Repair/modification of hearing aid: Report this service using 0201 and supply invoice			R 0,00	
3267	Major congenital deformity reconstruction of external ear: Unilateral	30	5	R 508,50	T
3269	Major congenital deformity reconstruction of external ear: Bilateral	30	5	R 508,50	T
3270	Excision of superficial pre-auricular fistula	30	4	R 406,90	T
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear			R 0,00	
3272	Excision of complicated pre-auricular fistula	30	4	R 406,90	T
5170	Drainage: Haematoma or abscess of external ear		3	R 304,90	
5173	Biopsy: External ear		3	R 304,90	
5175	Excision: External ear, partial, simple repair		3	R 304,90	
5176	Excision: External ear, complete		3	R 304,90	
17.2	External ear canal			R 0,00	
3204	External ear canal: Removal of foreign body, at rooms			R 0,00	
3205	External ear canal: Removal of foreign body, under general anaesthetic	30	4	R 406,90	T
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	30	4	R 406,90	T
3217	Meatus atresia: Congenital	30	4	R 406,90	T
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) – not to be used combined with Item 3206			R 0,00	
3219	Meatus atresia: Removal of osteoma from meatus: Solitary	30	4	R 406,90	T

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3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) – not to be used combined with Item 3206		3	R 304,90	
3221	Meatus atresia: Removal of osteoma from meatus: Multiple	30	4	R 406,90	T
17.3	Middle ear			R 0,00	
3206	Microscopic examination of tympanic membrane including microsuction			R 0,00	
3207	Myringotomy: Unilateral	30	4	R 406,90	T
3209	Myringotomy: Bilateral	30	4	R 406,90	T
3211	Unilateral myringotomy with insertion of ventilation tube	30	4	R 406,90	T
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	30	4	R 406,90	T
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	30	4	R 406,90	T
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	30	5	R 508,50	T
3237	Exploratory tympanotomy	30	5	R 508,50	T
3242	Fenestration: Revision		3	R 304,90	
3243	Myringoplasty	30	5	R 508,50	T
3245	Functional reconstruction of tympanic membrane	30	5	R 508,50	T
3249	Stapedotomy and stapedectomy	30	5	R 508,50	T
3257	Cortical mastoidectomy	30	5	R 508,50	T
3259	Radical mastoidectomy (excluding minor procedures)	30	5	R 508,50	T
3261	Muscle grafting to mastoid cavity without tympanoplasty	30	5	R 508,50	T
3263	Autogenous bone graft to mastoid cavity	30	5	R 508,50	T
3264	Tympanomastoidectomy	30	5	R 508,50	T
3265	Reconstruction of posterior canal wall, following radical mastoid	30	5	R 508,50	T
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	30	5	R 508,50	T

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17.4	Facial nerve			R 0,00	
17.4.1	Facial nerve: Facial nerve tests			R 0,00	
3223	Percutaneous stimulation of the facial nerve	30	4	R 406,90	T
3224	Electroneurography (ENOG)	30	4	R 406,90	T
17.4.2	Facial nerve: Facial nerve surgery			R 0,00	
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	30	5	R 508,50	T
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including Item 3227)	30	5	R 508,50	T
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	30	5	R 508,50	T
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	30	6	R 610,20	T
17.5	Inner ear			R 0,00	
17.5.1	Inner ear: Audiometry			R 0,00	
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral			R 0,00	
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral			R 0,00	
2693	AEP: Audiological examination – unilateral at a minimum of four decibels			R 0,00	
2694	AEP: Audiological examination – bilateral at a minimum of four decibels			R 0,00	
2695	Audiology 40Hz response: Unilateral			R 0,00	
2696	Audiology 40Hz response: Bilateral			R 0,00	
2697	Mid- and long latency auditory evoked potentials: Unilateral			R 0,00	
2698	Mid- and long latency auditory evoked potentials: Bilateral			R 0,00	
2699	Electro-cochleography: Unilateral			R 0,00	
2700	Electro-cochleography: Bilateral			R 0,00	
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	30	4	R 406,90	T
3248	Otoacoustic emission performed as a screening test			R 0,00	
3250	Otoacoustic emission (high risk patients only)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3273	Pure tone audiometry (air conduction)			R 0,00	
3274	Pure tone audiometry (bone conduction with masking)			R 0,00	
3275	Impedance audiometry (tympanometry)			R 0,00	
3276	Impedance audiometry (stapedial reflex) – no charge for volume, compliance etc.			R 0,00	
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score			R 0,00	
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)			R 0,00	
17.5.2	Inner ear: Balance tests			R 0,00	
3251	Minimal caloric test (excluding consultation fee)			R 0,00	
3252	Bithermal Halpike caloric test (excluding consultation fee)			R 0,00	
3253	Electro-nystagmography for spontaneous and positional nystagmus			R 0,00	
3254	Video nystagmoscopy (monocular)			R 0,00	
3255	Caloric test done with electronystamography			R 0,00	
3256	Video nystagmoscopy (binocular)			R 0,00	
3258	Otolith repositioning manoeuvre	30	4	R 406,90	T
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems			R 0,00	
17.5.3	Middle and inner ear surgery			R 0,00	
3233	Labyrinthectomy via the middle ear or mastoid	30	5	R 508,50	T
3240	Endolymphatic sac surgery	30	4	R 406,90	T
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	30	5	R 508,50	T
3246	Cochlear implant surgery	30	5	R 508,50	T
5196	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy		3	R 304,90	
5197	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy		3	R 304,90	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5199	Revision: Stapedectomy or stapedotomy		3	R 304,90	
17.6	Microsurgery of the skull base			R 0,00	
17.6.1	Microsurgery of the skull base: Middel fossa approach (i.e transtemporal or supralabyrinthine)			R 0,00	
3229	Facial nerve: Exploration of the labyrinthine segment	30	5	R 508,50	T
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	30	11	R 1 118,40	T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	30	11	R 1 118,40	T
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	30	11	R 1 118,40	T
5224	Removal of acoustic neuroma via the middle fossa approach	30	11	R 1 118,40	T
17.6.2	Microsurgery of the skull base: Translabyrinthe approach			R 0,00	
3239	Acoustic neuroma removal translabyrinthine	30	5	R 508,50	T
5227	Cochleo-vestibular neurectomy	30	11	R 1 118,40	T
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)	30	11	R 1 118,40	T
17.6.3	Microsurgery of the skull base: Transotic approach to the cerebellopontime angle			R 0,00	
5232	Removal of acoustic neuroma or cyst of the internal auditory canal	30	11	R 1 118,40	T
17.6.4	Microsurgery of the skull base: Intratemporal fossa approach type A			R 0,00	
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours	30	11	R 1 118,40	T
17.6.5	Microsurgery of the skull base: Intratemporal fossa approach type B			R 0,00	
5238	Removal of tumour of the petrous apex	30	11	R 1 118,40	T
5239	Removal of tumour of the clivus	30	11	R 1 118,40	T
17.6.6	Microsurgery of the skull base: Intrafemoral approach type C			R 0,00	
5242	Removal of nasopharyngeal angiofibroma or carcinoma	30	8	R 813,40	T
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	30	11	R 1 118,40	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
17.6.7	Microsurgery of the skull base: Subtotal petrosectomy			R 0,00	
5246	Subtotal petrosectomy for removal of temporal bone tumour	30	11	R 1 118,40	T
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	30	11	R 1 118,40	T
17.6.8	Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa			R 0,00	
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland	30	11	R 1 118,40	T
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	30	8	R 813,40	T
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	30	8	R 813,40	T
18	**Physical treatment**			R 0,00	
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)			R 0,00	
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)			R 0,00	
3281	Ultrasonic therapy			R 0,00	
3282	Shortwave diathermy			R 0,00	
3284	Sensory nerve conduction studies			R 0,00	
3285	Motor nerve conduction studies			R 0,00	
3287	Spinal joint and ligament injection			R 0,00	
3288	Epidural injection			R 0,00	
3289	Multiple injections: First joint			R 0,00	
3290	Multiple injections: Each additional joint			R 0,00	
3291	Tendon or ligament injection			R 0,00	
3292	Aspiration of joint or inter-articular injection			R 0,00	
3293	Aspiration or injection of bursa or ganglion			R 0,00	
3294	Paracervical (neck) nerve block (for pelvis refer to Item 2389)			R 0,00	
3295	Paravertebral root block: Unilateral			R 0,00	
3296	Paravertebral root block: Bilateral			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3297	Manipulation of spine performed by a specialist in physical medicine			R 0,00	
3298	Spinal traction			R 0,00	
3299	Manipulation of large joints: Under general anaesthesia	30	3	R 304,90	T
3299a	Manipulation of large joints: Under general anaesthesia	30	4	R 406,90	T
3300	Manipulation of large joints: Without anaesthetic			R 0,00	
3301	Muscle fatigue studies			R 0,00	
3302	Strength duration curve per session			R 0,00	
3303	Electromyography			R 0,00	
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment. For subsequent treatments by a general practitioner, for the same condition within four months after initial treatment: A fee for the treatment only, is applicable: See general rules L and M			R 0,00	
	SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT			R 0,00	
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine)			R 0,00	
5431	Physical status modifier: Normal health patient, ASA 1 – add 0.00 anaesthetic units			R 0,00	
5432	Physical status modifier: A patient with mild systemic disease, ASA 2 – add 0,00 anaesthetic units			R 0,00	
5436	Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes ASA 6 – add 0,00 anaesthetic units			R 0,00	
19	**Radiology**			R 0,00	
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values			R 0,00	
	RULES GOVERNING THE SECTION RADIOLOGY			R 0,00	
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
Z.	No fee is subject to more than one reduction			R 0,00	
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years			R 0,00	
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").			R 0,00	
	MODIFIERS GOVERNING THE SECTION			R 0,00	
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere			R 0,00	
0080	Multiple examinations: Full Fee			R 0,00	
0081	Repeat examinations: No reduction			R 0,00	
0082	"+" means that this item is complementary to a preceding item and is therefore not subject to reduction			R 0,00	
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used			R 0,00	
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. This information is obtainable from the Radiological Society of SA.			R 0,00	
19.1	Skeleton			R 0,00	
19.1.1	Skeleton: Limbs			R 0,00	
3305	Finger, toe			R 0,00	
3309	Smith-Petersen or equivalent control, in theatre			R 0,00	
3311	Stress studies, e.g., joint			R 0,00	
3313	Full length study, both legs			R 0,00	
3315	Skeletal survey under five years			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3317	Skeletal survey over 5 years			R 0,00	
3319	Arthrography per joint			R 0,00	
3320	Introduction of contrast medium or air: Add			R 0,00	
6500	Hand			R 0,00	
6501	Wrist (specify region)			R 0,00	
6503	Scaphoid			R 0,00	
6504	Radius and ulna			R 0,00	
6505	Elbow			R 0,00	
6506	Humerus			R 0,00	
6507	Shoulder			R 0,00	
6508	Acromio-Clavicula joint			R 0,00	
6509	Clavicle			R 0,00	
6510	Scapula			R 0,00	
6511	Foot			R 0,00	
6512	Ankle			R 0,00	
6513	Calcaneus			R 0,00	
6514	Tibia and fibula			R 0,00	
6515	Knee			R 0,00	
6516	Patella			R 0,00	
6517	Femur			R 0,00	
6518	Hip			R 0,00	
6519	Sesamoid Bone			R 0,00	
19.1.2	Skeleton: Spinal column			R 0,00	
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3325	Stress studies			R 0,00	
3329	Scoliosis studies			R 0,00	
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of view is required)			R 0,00	
3333	Myelography: Lumbar	30	4	R 406,90	T
3334	Myelography: Thoracic	30	4	R 406,90	T
3335	Myelography: Cervical	30	4	R 406,90	T
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)	30	4	R 406,90	T
3344	Introduction of contrast medium			R 0,00	
3345	Discography	30	4	R 406,90	T
3347	Introduction of contrast medium per disc level: Add			R 0,00	
19.1.3	Skeleton: Skull			R 0,00	
3349	Skull studies			R 0,00	
3351	Paranasal sinuses			R 0,00	
3353	Facial bones and/or orbits			R 0,00	
3355	Mandible			R 0,00	
3357	Nasal bone			R 0,00	
3359	Mastoid: Bilateral			R 0,00	
3361	Teeth: One quadrant			R 0,00	
3363	Teeth: Two quadrants			R 0,00	
3365	Teeth: Full mouth			R 0,00	
3366	Teeth: Rotation tomography of the teeth and jaws			R 0,00	
3367	Teeth: Tempero-mandibular joints, per side			R 0,00	
3369	Teeth: Tomography: Per side			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3371	Localisation of foreign body in the eye			R 0,00	
3381	Ventriculography	30	4	R 406,90	T
3385	Post-nasal studies: Lateral neck			R 0,00	
3387	Maxillo-facial cephalometry			R 0,00	
3389	Dacrocystography	30	4	R 406,90	T
3391	For introduction of contrast medium: Add			R 0,00	
19.2	Alimentary tract			R 0,00	
3393	Bowel washout: Add			R 0,00	
3395	Sialography (plus 80% for each additional gland)	30	4	R 406,90	T
3397	Introduction of contrast medium (plus 80% for each additional gland: add)			R 0,00	
3399	Pharynx and oesophagus			R 0,00	
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through			R 0,00	
3405	Double contrast: Add			R 0,00	
3406	Small bowel meal (control film of abdomen included except when part of Item 3408)			R 0,00	
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)			R 0,00	
3409	Barium enema (control film of abdomen included)			R 0,00	
3411	Air contrast study: Add			R 0,00	
3415	Biliary Tract: ERCP own equipment – choledogram and/or pancreatography screening included	30	4	R 406,90	T
3416	Pancreas: ERCP hospital equipment– choledogram and/or pancreatography screening included	30	4	R 406,90	T
	Note: For Items 3415 and 3416 – endoscopy (see Item 1778)			R 0,00	
3417	Gastric/oesophageal/duodenal intubation control			R 0,00	
3419	Gastric/oesophageal intubation insertion of tube: Add			R 0,00	
3421	Duodenal intubation – insertion of tube: Add			R 0,00	
3423	Hypotonic duodenography (Item 3403 and Item 3405 included)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
19.3	Biliary tract			R 0,00	
3425	Oral cholecystography			R 0,00	
3427	Cholangiography: Intravenous			R 0,00	
3431	Operative cholangiography: First series – add Item 3607 only when the radiologist attends personally in theatre			R 0,00	
3433	Post operative: T-tube			R 0,00	
3435	Introduction of contrast medium: Add			R 0,00	
3437	Trans hepatic, percutaneous			R 0,00	
3439	Introduction of contrast medium: Add			R 0,00	
3441	Tomography of biliary tract: Add			R 0,00	
19.4	Chest			R 0,00	
3443	Larynx (Tomography included)			R 0,00	
3445	Chest (Item 3601 included)			R 0,00	
3447	Chest and cardiac studies (Item 3601)			R 0,00	
3449	Ribs			R 0,00	
3451	Sternum or sterno-clavicular joints			R 0,00	
3453	Bronchography: Unilateral	30	8	R 813,40	T
3455	Bronchography: Bilateral	30	8	R 813,40	T
3457	Introduction of contrast medium included			R 0,00	
3461	Pleurography	30	3	R 304,90	T
3463	For introduction of contrast medium: Add			R 0,00	
3465	Laryngography			R 0,00	
3467	For introduction of contrast medium: Add			R 0,00	
3468	Thoracic inlet			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
19.5	Abdomen			R 0,00	
3477	Control films of the Abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)			R 0,00	
3479	Acute abdomen or equivalent studies			R 0,00	
19.6	Urinary tract			R 0,00	
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) (item 0206 not applicable)			R 0,00	
3493	Waterload test: Add			R 0,00	
3497	Cystography only or urethrography only (retrograde)			R 0,00	
3499	Cysto-urethrography: Retrograde			R 0,00	
3503	Cysto-urethrography: Introduction of contrast medium			R 0,00	
3505	Retrograde-prograde pyelography	30	3	R 304,90	T
3511	Aspiration renal cyst			R 0,00	
3513	Tomography of renal tract: Add			R 0,00	
19.7	Gynaecology and obstetrics			R 0,00	
3515	Pregnancy			R 0,00	
3517	Pelvimetry			R 0,00	
3519	Hystero-salpingography	30	3	R 304,90	T
3521	Introduction of contrast medium: Add			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
19.8	Vascular studies			R 0,00	
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (Items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii. All fluoroscopy (Item 3601 does not apply). iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)				
	MODIFIER GOVERNING VASCULAR STUDIES			R 0,00	
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier 0080: Multiple examinations			R 0,00	
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account)			R 0,00	
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)			R 0,00	
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)			R 0,00	
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure			R 0,00	
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
19.8.1	Vascular studies: Film Series			R 0,00	
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.			R 0,00	
3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment			R 0,00	
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment			R 0,00	
3538	Analogue monoplane table with DSA attachment			R 0,00	
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment			R 0,00	
3545	Venography: Per limb			R 0,00	
3548	Analogue monoplane screening table			R 0,00	
3550	Digital monoplane screening table			R 0,00	
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)			R 0,00	
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	30	4	R 406,90	T
3558	Translumbar aortic puncture, with full study	30	5	R 508,50	T
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram	30	4	R 406,90	T
3560	Selective second order catheterisation, arterial or venous, with angiogram/venogram	30	4	R 406,90	T
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram	30	4	R 406,90	T
3564	Direct femoral arterial or venous or jugular venous puncture			R 0,00	
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)	30	5	R 508,50	T
3569	Intravascular pressure studies, arterial or venous, once off per case			R 0,00	
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	30	5	R 508,50	T
3572	Transcatheter selective blood sampling, arterial or venous			R 0,00	
3574	Spinal angiogram (global fee) including all selective catheterisations	30	5	R 508,50	T
19.8.2	Vascular studies: Introduction of contrast medium			R 0,00	
3563	Direct intravenous for limb			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3575	Cut-downs for venography: Add			R 0,00	
19.9	Tomography and cinematography			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values.			R 0,00	
3577	Tomography (conventional except where otherwise specified): ADD 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations.			R 0,00	
3579	Tomography (multi-dimensional in motion): Add 150%			R 0,00	
3581	Cinematography: For first series – add 100%			R 0,00	
3583	Cinematography: For each series after the first – add 80% of the primary fee			R 0,00	
19.9.1	Tomography and cinematography: Computed tomography			R 0,00	
3592	Where a fully digital C-arm portable X-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour			R 0,00	
3597	Contrast media: General Rule Y applies (Please note: Item 0201 is not applicable for contrast media)			R 0,00	
3598	Electron beam computed tomography (EBCT) for assessment of coronary artery calcification (complete fee – no additions)			R 0,00	
3599	Electron beam computed tomography (EBCT) of the heart. Total fee for contract examination excluding cost of contrast medium. Not to be used for coronary artery calcium assessment or scoring – see Item 3598.			R 0,00	
6400	Plus spiral CT			R 0,00	
6401	Plus 3D reconstruction			R 0,00	
6402	Plus high resolution study			R 0,00	
6403	CT limb uncontrasted	30	5	R 508,50	T
6404	CT limb with contrast only	30	5	R 508,50	T
6405	CT limb pre- AND post contrast	30	5	R 508,50	T
6406	CT joint uncontrasted	30	5	R 508,50	T
6407	CT joint with contrast only	30	5	R 508,50	T
6408	CT joint pre AND post contrast	30	5	R 508,50	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6409	CT brain uncontrasted (including posterior fossa)	30	5	R 508,50	T
6410	CT brain with contrast only (including posterior fossa)	30	5	R 508,50	T
6411	CT brain pre AND post contrast (including posterior fossa)	30	5	R 508,50	T
6412	CT orbits complete study, axial OR coronal, uncontrasted	30	5	R 508,50	T
6413	CT orbits complete study, axial AND coronal, uncontrasted	30	5	R 508,50	T
6414	CT orbits complete study, axial OR coronal pre AND post contrast	30	5	R 508,50	T
6415	CT orbits complete study, axial AND coronal pre AND post contrast	30	5	R 508,50	T
6416	CT paranasal sinuses limited study axial OR coronal	30	5	R 508,50	T
6417	CT paranasal sinuses limited study axial AND coronal	30	5	R 508,50	T
6418	CT paranasal sinuses complete study, axial OR coronal, uncontrasted	30	5	R 508,50	T
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	30	5	R 508,50	T
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	30	5	R 508,50	T
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	30	5	R 508,50	T
6422	CT pituitary fossa, uncontrasted	30	5	R 508,50	T
6423	CT pituitary fossa, pre AND post contrast	30	5	R 508,50	T
6424	CT internal auditory meati, uncontrasted	30	5	R 508,50	T
6425	CT internal audiory meati, pre AND post contrast	30	5	R 508,50	T
6426	CT mastoids	30	5	R 508,50	T
6427	CT ear structures, limited study	30	5	R 508,50	T
6428	CT middle AND inner ear, complete study including reconstructions	30	5	R 508,50	T
6429	CT facial bones	30	5	R 508,50	T
6430	CT neck soft tissue, uncontrasted	30	5	R 508,50	T
6431	CT neck soft tissue with contrast only	30	5	R 508,50	T
6432	CT neck pre AND post contrast	30	5	R 508,50	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6433	CT cervical spine uncontrasted	30	5	R 508,50	T
6434	CT cervical spine pre AND post contrast	30	5	R 508,50	T
6435	CT cervical spine post myelogram	30	5	R 508,50	T
6436	CT dorsal spine uncontrasted	30	5	R 508,50	T
6437	CT dorsal spine pre AND post contrast	30	5	R 508,50	T
6438	CT dorsal spine post myelogram	30	5	R 508,50	T
6439	CT lumbar spine uncontrasted	30	5	R 508,50	T
6440	CT lumbar spine pre AND post contrast	30	5	R 508,50	T
6441	CT lumbar spine post myelogram	30	5	R 508,50	T
6442	CT pelvimetry (topogram only)	30	5	R 508,50	T
6443	CT chest uncontrasted	30	5	R 508,50	T
6444	CT chest with contrast	30	5	R 508,50	T
6445	CT chest pre AND post contrast	30	5	R 508,50	T
6446	CT chest high resolution lungs, limited study	30	5	R 508,50	T
6447	CT high resolution lungs, complete study	30	5	R 508,50	T
6448	CT abdomen uncontrasted	30	5	R 508,50	T
6449	CT abdomen with contrast	30	5	R 508,50	T
6450	CT abdomen pre AND post contrast	30	5	R 508,50	T
6451	CT abdomen triphasic study	30	5	R 508,50	T
6452	CT pelvis uncontrasted	30	5	R 508,50	T
6453	CT pelvis with contrast	30	5	R 508,50	T
6454	CT pelvis pre AND post contrast	30	5	R 508,50	T
6455	CT abdomen AND pelvis uncontrasted	30	5	R 508,50	T
6456	CT abdomen AND pelvis with contrast	30	5	R 508,50	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6457	CT abdomen AND pelvis pre AND post contrast	30	5	R 508,50	T
6458	CT chest, abdomen AND pelvis with contrast	30	5	R 508,50	T
6459	CT base of skull to symphysis pubis with contrast	30	5	R 508,50	T
6460	CT for dental implants maxilla OR mandible		5	R 508,50	
6461	CT for dental implants maxilla AND mandible		5	R 508,50	
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)	30	5	R 508,50	T
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	30	5	R 508,50	T
6464	CT limited study, any region. Region to be identified on the account	30	5	R 508,50	T
6465	CT guidance for aspiration, biopsy or drainage	30	11	R 1 118,40	T
6466	CT guidance for aspiration at time of CT diagnostic study			R 0,00	
6467	CT stereotactic localisation for biopsy	30	11	R 1 118,40	T
6468	CT for radiotherapy planning (not to be used as an add-on)			R 0,00	
6469	Quantitative CT for bone mineral density			R 0,00	
6470	Triphasic study of the liver with CT abdomen and pelvis pre and post contrast	30	5	R 508,50	T
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast	30	5	R 508,50	T
6472	Computer-aided diagnosis for mammography			R 0,00	
19.10	Radiology: Miscellaneous			R 0,00	
3594	Mammogram of surgically removed breast biopsy specimen			R 0,00	
3600	Peripheral bone densitometry utilizing ionizing radiation			R 0,00	
3601	Fluoroscopy: Per half hour: Add (not applicable for Items 3445 and 3447)			R 0,00	
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour – add			R 0,00	
3603	Sinography			R 0,00	
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This item may not be used together with an item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, Item 3629 is used			R 0,00	
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour			R 0,00	
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except Item 3309): Per half hour: Plus fee or examination performed. Only to be used by radiological technical staff.			R 0,00	
3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position	30	3	R 304,90	T
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done			R 0,00	
3611	Foreign body localisation: Introduction of sterile needle markers: Add			R 0,00	
3613	Setting of sterile trays			R 0,00	
5029	Mammotome – stereotaxis: Hand held			R 0,00	
5034	Fine needle aspiration or biopsy or core biopsy of mamma	30	6	R 610,20	T
19.10.2	Radiology: Miscellaneous – mammography			R 0,00	
19.11	Ultrasound investigations			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values			R 0,00	
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.			R 0,00	
3596	Intravascular ultrasound per case, arterial or venous, for intervention			R 0,00	
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	30	5	R 508,50	T
3612	Ultrasonic bone densitometry			R 0,00	
3614	Transvaginal aspiration of ova			R 0,00	
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment			R 0,00	
3616	Contrast media: General Rule Y applies			R 0,00	
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)			R 0,00	
3619	Intravascular ultrasound imaging assesses the atheroschlerotic process to guide the placement of an intracoronary stent. This item may be applied once per vessel (left anterior descending territory, circumflex territory and/or right coronary territory) in which a stent or multiple stents are deployed	30	9	R 915,00	T
3620	Cardiac examination plus Doppler colour mapping			R 0,00	
3621	Cardiac examination (MMode)			R 0,00	
3622	Cardiac examination: 2 Dimensional			R 0,00	
3623	Cardiac examination + effort			R 0,00	
3624	Cardiac examinations + contrast			R 0,00	
3625	Cardiac examinations + doppler			R 0,00	
3626	Cardiac examination + phonocardiography			R 0,00	
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)			R 0,00	
3628	Renal tract			R 0,00	
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.			R 0,00	
3631	Ophthalmic examination			R 0,00	
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with item 3034			R 0,00	
3633	Neonatal head scan			R 0,00	
3634	Peripheral vascular study, B mode only			R 0,00	
3635	+ Doppler			R 0,00	
3636	Trans-oesophageal echocardiography including passing the device			R 0,00	
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114)			R 0,00	
5026	Ultrasound guided amniocentesis	30	6	R 610,20	T
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5101	Pleural space ultrasound			R 0,00	
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint			R 0,00	
5103	Ultrasound soft tissue, any region		7,59	R 772,10	
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy			R 0,00	
5107	Ultrasound after 24 weeks – motivation required			R 0,00	
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)			R 0,00	
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy			R 0,00	
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with Items 5110, 5112, 5113 or 5114)			R 0,00	
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			R 0,00	
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis			R 0,00	
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally			R 0,00	
5115	Intra-operative ultrasound study	30	3	R 304,90	T
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure			R 0,00	
5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery – LAD (left anterior desending), Circumflex or Right coronary artery. May be used a maximum of twice per angiographic procedure.			R 0,00	
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS			R 0,00	
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (static realtime): Fee for part examined plus 30% of the units			R 0,00	
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units			R 0,00	
5104	Ultrasound in pregnancy, multiple gestation, after 20 weeks: Plus 30%			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
	GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY			R 0,00	
EE.	**Ultrasound examinations** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist			R 0,00	
19.12	Portable unit examinations			R 0,00	
3639	Where portable X-ray unit is used in the hospital or theatre: Add			R 0,00	
3640	Theatre investigations with fixed installation			R 0,00	
19.13	Diagnostic procedures requiring the use of radio-isotopes			R 0,00	
AA.	Procedures to exclude cost of isotope			R 0,00	
3641	Tracer test			R 0,00	
3642	Repeat of further tracer tests for same investigation: Half of above fee			R 0,00	
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee			R 0,00	
3644	Tracer test of complete body or brain tumour location			R 0,00	
3645	Other organ scanning with use of relevant radio isotopes			R 0,00	
3646	Thyroid scanning			R 0,00	
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera			R 0,00	
19.14	Interventional radiological procedures			R 0,00	
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (Items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii. All fluoroscopy (Item 3601 does not apply). iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)				
	Note: In regard to multiple examinations see modifier 0080			R 0,00	
5002	Percutaneous transluminal angioplasty: Aortic/IVC	30	13	R 1 321,70	T
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel	30	13	R 1 321,70	T
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial	30	13	R 1 321,70	T
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial	30	13	R 1 321,70	T
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic	30	13	R 1 321,70	T
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral – stand alone procedure	30	13	R 1 321,70	T
5014	Atherectomy (per vessel)			R 0,00	
5016	Aspiration thrombectomy (per vessel)			R 0,00	
5017	Endoscopic ultrasound: Colon			R 0,00	
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy			R 0,00	
5021	Proctosigmoidoscopy with endoscopic ultrasound examination			R 0,00	
5022	Embolisation non-intracranial, per vessel	30	9	R 915,00	T
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy			R 0,00	
5024	Endoscopic ultrasound: Oesophagus			R 0,00	
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy			R 0,00	
5030	Percutaneous nephrostomy for further procedure or drainage	30	6	R 610,20	T
5031	Antegrade ureteric stent insertion	30	6	R 610,20	T
5033	Percutaneous cystostomy in radiology suite			R 0,00	
5035	Urethral balloon dilatation in radiology suite			R 0,00	
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality			R 0,00	
5037	Urethral stenting in radiology suite			R 0,00	
5038	Intracranial/spinal AVM embolisation (per session)	30	13	R 1 321,70	T
5039	Intracranial thrombolysis (on-table) per session	30	13	R 1 321,70	T
5040	Intracranial aneurysm occlusion	30	13	R 1 321,70	T
5041	Balloon occlusion/Wada test	30	9	R 915,00	T
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation	30	13	R 1 321,70	T
5043	Intracranial angioplasty	30	13	R 1 321,70	T
5044	Transhepatic portogram	30	9	R 915,00	T
5045	Hepatic arterial infusion catheter insertion	30	6	R 610,20	T
5046	Percutaneous biliary drainage (external)	30	9	R 915,00	T
5047	Combined internal/external biliary drainage	30	9	R 915,00	T
5048	Biliary stent insertion	30	9	R 915,00	T
5049	Percutaneous gall bladder drainage	30	9	R 915,00	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5050	Percutaneous or renal gall bladder stone removal	30	5	R 508,50	T
5058	Stent insertion: Aortic/IVC – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5060	Stent insertion: Iliac/subclavian/AV fistula – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5064	Stent insertion: Sub-popliteal – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5066	Stent insertion: Renal/visceral/brachiocephalic – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5068	Stent insertion: Extracranial carotid/vertebral – including percutaneous transluminal angioplasty (PTA) – stand alone procedure	30	13	R 1 321,70	
5070	Stent insertion: Aorto-iliac stent graft – including percutaneous transluminal angioplasty (PTA)	30	13	R 1 321,70	T
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite	30	5	R 508,50	T
5074	IVC filter insertion jugular or femoral route	30	9	R 915,00	T
5076	Intravascular foreign body removal, arterial or venous, any route	30	9	R 915,00	T
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)	30	5	R 508,50	T
5080	Transjugular intrahepatic porto-systemic shunt	30	13	R 1 321,70	T
5082	Transjugular liver biopsy	30	9	R 915,00	T
5084	Endoluminal fallopian tube recanalisation	30	6	R 610,20	T
5086	Renal cyst aspiration/ablation			R 0,00	
5088	Oesophageal stent insertion in radiology suite	30	6	R 610,20	T
5090	Tracheal stent insertion	30	6	R 610,20	T
5091	GIT balloon dilatation under fluoroscopy	30	6	R 610,20	T
5092	Other GIT stent insertion	30	6	R 610,20	T
5093	Percutaneous gastrostomy in radiology suite			R 0,00	
5094	Cutting needle biopsy with image guidance			R 0,00	
5095	Chest drain insertion in radiology suite			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5096	Percutaneous cyst or tumour ablation (non aspiration)			R 0,00	
5097	Vertebroplasty – Introduction of stabilising material under screening or CT control – per level	30	13	R 1 321,70	T
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate			R 0,00	
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy			R 0,00	
5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation – PROFESSIONAL COMPONENT			R 0,00	
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal – PROFESSIONAL COMPONENT			R 0,00	
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		6	R 610,20	
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)		6	R 610,20	
5974	Stent placement,branch pulmonary artery: First vessel		6	R 610,20	
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)		6	R 610,20	
5976	Stent placement coarctation of the aorta		6	R 610,20	
5980	Stent patent ductus arteriosus and interatrial communication		6	R 610,20	
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		6	R 610,20	
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		10	R 1 016,80	
5986	VSD closure, percutaneous, device placement		10	R 1 016,80	
5987	PFO closure with device		10	R 1 016,80	
5989	PDA closure-coil or ductal device		6	R 610,20	
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		6	R 610,20	
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		6	R 610,20	
5992	Closure interatrial communication (Fontan fenestration etc)		10	R 1 016,80	
5995	Rapid right ventricular pacing for percutaneous procedure		10	R 1 016,80	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5996	Removal of embolised device/materials		6	R 610,20	
5998	Biopsy: Endomyocardial		7	R 711,60	
6000	Actigraphy: Patient monitored for a minimum of 72 hours (includes equipment fee and interpretation)			R 0,00	
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES			R 0,00	
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or X-ray procedures. Only to be charged if radiologist is hands-on, and not for interpretation of images only.			R 0,00	
19.15	Magnetic Resonance Imaging (MRI)			R 0,00	
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes			R 0,00	
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region			R 0,00	
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charged at 50% of the fee.			R 0,00	
6103	Post-contrast study: Bone tumour – 100% of the fee			R 0,00	
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable.			R 0,00	
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items			R 0,00	
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.			R 0,00	
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.			R 0,00	
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a "flow sensitive series".			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.			R 0,00	
6110	MRI spectroscopy: 50% of fee			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.			R 0,00	
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.			R 0,00	
6200	Magnetic Resonance Imaging: Per anatomical region, brain	30	5	R 508,50	T
6201	Magnetic Resonance Imaging: Per anatomical region, orbitae	30	5	R 508,50	T
6202	Magnetic Resonance Imaging: Per anatomical region, paranasal sinuses	30	5	R 508,50	T
6203	Magnetic Resonance Imaging: Per anatomical region – soft tissue, face/skull	30	5	R 508,50	T
6204	Magnetic Resonance Imaging: Per anatomical region, skull basis/cranio-cervical joint	30	5	R 508,50	T
6205	Magnetic Resonance Imaging: Per anatomical region, middle and internal ears	30	5	R 508,50	T
6206	Magnetic Resonance Imaging: Per anatomical region – soft tissue, neck	30	5	R 508,50	T
6207	Magnetic Resonance Imaging: Per anatomical region, thyroid/para-thyroid	30	5	R 508,50	T
6208	Magnetic Resonance Imaging: Per anatomical region, hypophysis (see modifiers 6104 and 6105 for limited examinations)	30	5	R 508,50	T
6209	Magnetic Resonance Imaging: Per anatomical region, bone tumour (see modifier 6103)	30	5	R 508,50	T
6210	Magnetic Resonance Imaging: Per anatomical region, cervical vertebrae	30	5	R 508,50	T
6211	Magnetic Resonance Imaging: Per anatomical region, thoracic vertebrae	30	5	R 508,50	T
6212	Magnetic Resonance Imaging: Per anatomical region, lumbar vertebrae	30	5	R 508,50	T
6213	Magnetic Resonance Imaging: Per anatomical region, sacrum	30	5	R 508,50	T
6214	Magnetic Resonance Imaging: Per anatomical region, pelvis	30	5	R 508,50	T
6215	Magnetic Resonance Imaging: Per anatomical region, pelvic organs	30	5	R 508,50	T
6216	Magnetic Resonance Imaging: Per anatomical region, abdomen	30	5	R 508,50	T
6217	Magnetic Resonance Imaging: Per anatomical region, thorax wall	30	5	R 508,50	T

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6218	Magnetic Resonance Imaging: Per anatomical region, mediastinum	30	5	R 508,50	T
6219	Magnetic Resonance Imaging: Per anatomical region – soft tissue, back	30	5	R 508,50	T
6220	Magnetic Resonance Imaging: Per anatomical region, left shoulder	30	5	R 508,50	T
6221	Magnetic Resonance Imaging: Per anatomical region, right shoulder	30	5	R 508,50	T
6222	Magnetic Resonance Imaging: Per anatomical region, both hips	30	5	R 508,50	T
6223	Magnetic Resonance Imaging: Per anatomical region, left hip	30	5	R 508,50	T
6224	Magnetic Resonance Imaging: Per anatomical region, right hip	30	5	R 508,50	T
6225	Magnetic Resonance Imaging: Per anatomical region, left upper-arm	30	5	R 508,50	T
6226	Magnetic Resonance Imaging: Per anatomical region, right upper-arm	30	5	R 508,50	T
6227	Magnetic Resonance Imaging: Per anatomical region, left elbow	30	5	R 508,50	T
6228	Magnetic Resonance Imaging: Per anatomical region, right elbow	30	5	R 508,50	T
6229	Magnetic Resonance Imaging: Per anatomical region, left forearm	30	5	R 508,50	T
6230	Magnetic Resonance Imaging: Per anatomical region, right forearm	30	5	R 508,50	T
6231	Magnetic Resonance Imaging: Per anatomical region, left wrist and hand	30	5	R 508,50	T
6232	Magnetic Resonance Imaging: Per anatomical region, right wrist and hand	30	5	R 508,50	T
6233	Magnetic Resonance Imaging: Per anatomical region, left upper-leg	30	5	R 508,50	T
6234	Magnetic Resonance Imaging: Per anatomical region, right upper-leg	30	5	R 508,50	T
6235	Magnetic Resonance Imaging: Per anatomical region, left knee	30	5	R 508,50	T
6236	Magnetic Resonance Imaging: Per anatomical region, right knee	30	5	R 508,50	T
6237	Magnetic Resonance Imaging: Per anatomical region, left lower-leg	30	5	R 508,50	T
6238	Magnetic Resonance Imaging: Per anatomical region, right lower-leg	30	5	R 508,50	T
6239	Magnetic Resonance Imaging: Per anatomical region, left ankle	30	5	R 508,50	T
6240	Magnetic Resonance Imaging: Per anatomical region, right ankle	30	5	R 508,50	T
6241	Magnetic Resonance Imaging: Per anatomical region, left foot	30	5	R 508,50	T

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
6242	Magnetic Resonance Imaging: Per anatomical region, right foot	30	5	R 508,50	T
6250	Magnetic Resonance angiography (see modifiers 6106 to 6108): Brain	30	5	R 508,50	T
6251	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, neck	30	5	R 508,50	T
6252	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, chest	30	5	R 508,50	T
6253	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, abdomen	30	5	R 508,50	T
6254	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, legs	30	5	R 508,50	T
6255	Magnetic Resonance angiography (see modifiers 6106 to 6108): Heart	30	5	R 508,50	T
6260	Contrast medium: Current price according the regular price list published by the Radiology Society of SA.			R 0,00	
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations.	30	5	R 508,50	T
20	**Radiation oncology**			R 0,00	
	GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST a. Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services. b. The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.				
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values			R 0,00	
20.1	Kilovolt therapy			R 0,00	
20.2	Radium therapy			R 0,00	
20.3	Isotope therapy			R 0,00	
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope			R 0,00	
20.4	Megavolt therapy			R 0,00	
20.5	Beta-ray therapy with strontium-90-applicator			R 0,00	
20.6	Planning of therapy			R 0,00	
20.7	Technical aids			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5141	Radiation materials (see modifier 0095)			R 0,00	
20.8	Oncological surgical procedures			R 0,00	
20.9	Special procedures			R 0,00	
20.10	Chemotherapy			R 0,00	
	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.			R 0,00	
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities.			R 0,00	
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).			R 0,00	
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.			R 0,00	
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.			R 0,00	
	Non-infusional chemotherapy: Consultations are charged separately.			R 0,00	
	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.			R 0,00	
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)			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
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.			R 0,00	
5795	Infusional chemotherapy facility fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with item 5793) – only one of the parties are to charge this fee.			R 0,00	
	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).			R 0,00	
20.11	Radiation therapy planning			R 0,00	
20.11.1	Manual radiotherapy planning procedures			R 0,00	
5801	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT			R 0,00	
5601	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest -TECHNICAL COMPONENT			R 0,00	
5802	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT			R 0,00	
5602	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT			R 0,00	
5803	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT			R 0,00	
5603	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
20.11.2	Conventional radiotherapy planning procedures			R 0,00	
5808	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT			R 0,00	
5608	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT			R 0,00	
5809	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT			R 0,00	
5609	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT			R 0,00	
5810	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT			R 0,00	
5610	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT			R 0,00	
20.11.3	Three dimensional radiotherapy planning procedures			R 0,00	
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)			R 0,00	
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)			R 0,00	
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)			R 0,00	
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)			R 0,00	
5822	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)			R 0,00	
5622	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)			R 0,00	
20.11.4	Intensity modulated radiotherapy planning procedures			R 0,00	
5823	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5623	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)			R 0,00	
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)			R 0,00	
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)			R 0,00	
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)			R 0,00	
5626	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)			R 0,00	
20.11.5	Kilovolt radiation treatment			R 0,00	
5834	Kilovolt radiation treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof – PROFESSIONAL COMPONENT			R 0,00	
5634	Kilovolt radiation treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof – TECHNICAL COMPONENT			R 0,00	
20.11.6	Short course radiation treatment			R 0,00	
5835	Short course radiation treatment: Short course treatment, Single Volume of Interest – PROFESSIONAL COMPONENT			R 0,00	
5635	Short course radiation treatment: Short course treatment, Single Volume of Interest – TECHNICAL COMPONENT			R 0,00	
5836	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT			R 0,00	
5636	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT			R 0,00	
5837	Short course radiation treatment: Short course Treatment, Special Technique – PROFESSIONAL COMPONENT			R 0,00	
5637	Short course radiation treatment: Short course Treatment, Special Technique – TECHNICAL COMPONENT			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
20.11.7	Weekly radiation treatment sessions			R 0,00	
20.11.7.1	Weekly radiation treatment sessions – conventional techniques			R 0,00	
5839	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Single Volume of Interest – PROFESSIONAL COMPONENT			R 0,00	
5639	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Single Volume of Interest – TECHNICAL COMPONENT			R 0,00	
5840	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT			R 0,00	
5640	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT			R 0,00	
5841	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Special Technique – PROFESSIONAL COMPONENT			R 0,00	
5641	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Special Technique – TECHNICAL COMPONENT			R 0,00	
20.11.7.2	Weekly radiation treatment sessions – advanced techniques			R 0,00	
5849	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – PROFESSIONAL COMPONENT			R 0,00	
5649	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – TECHNICAL COMPONENT			R 0,00	
5850	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – PROFESSIONAL COMPONENT			R 0,00	
5650	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – TECHNICAL COMPONENT			R 0,00	
5851	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – PROFESSIONAL COMPONENT			R 0,00	
5651	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – TECHNICAL COMPONENT			R 0,00	
5854	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – PROFESSIONAL COMPONENT			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
5654	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – TECHNICAL COMPONENT			R 0,00	
5855	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – PROFESSIONAL COMPONENT			R 0,00	
5655	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – TECHNICAL COMPONENT			R 0,00	
20.11.8	Stereotactic radiation			R 0,00	
5860	Stereotactic radiation: Stereotactic Radiation, Single or up to four Fractions, Global Fee – PROFESSIONAL COMPONENT			R 0,00	
5660	Stereotactic radiation: Stereotactic Radiation, Single Fraction, Global Fee – TECHNICAL COMPONENT			R 0,00	
5861	Stereotactic radiation: Stereotactic Radiation, five or more Fractions, Full course, Global Fee – PROFESSIONAL COMPONENT			R 0,00	
5661	Stereotactic radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee – TECHNICAL COMPONENT			R 0,00	
20.12	Brachytherapy			R 0,00	
20.12.1	Isotope/Applicator Therapy			R 0,00	
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.			R 0,00	
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.			R 0,00	
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.			R 0,00	
20.12.2	Brachytherapy implants			R 0,00	
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.			R 0,00	
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.			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
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.			R 0,00	
20.12.3	Brachytherapy treatment			R 0,00	
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.			R 0,00	
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			R 0,00	
5893	Global Fee for remote afterloading – includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included – TECHNICAL COMPONENT			R 0,00	
20.12.4	Brachytherapy imaging			R 0,00	
5895	Brachytherapy imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than items 5883 or 5885			R 0,00	
21	**Clinical pathology**			R 0,00	
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values. Note: For fees for Histology and Cytology refer to items 4561-4593 under Section 22: Anatomical Pathology				
21.1	Haematology			R 0,00	
3705	Alkali resistant haemoglobin			R 0,00	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)			R 0,00	
3710	Antibody titration			R 0,00	
3712	Antibody identification			R 0,00	
3713	Bleeding time (does not include the cost of the simplate device)			R 0,00	
3714	Blood volume, dye method			R 0,00	
3715	Buffy layer examination			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3716	Mean cell volume			R 0,00	
3717	Bone marrow cytological examination only			R 0,00	
3719	Bone marrow: Aspiration			R 0,00	
3720	Bone marrow trephine biopsy			R 0,00	
3721	Bone marrow aspiration and trephine biopsy (excluding histology)			R 0,00	
3722	Capillary fragility: Hess			R 0,00	
3723	Circulating anticoagulants			R 0,00	
3724	Coagulation factor inhibitor assay			R 0,00	
3726	Activated protein C resistance			R 0,00	
3727	Coagulation time			R 0,00	
3728	Anti-factor Xa Activity			R 0,00	
3729	Cold agglutinins			R 0,00	
3730	Protein S: Functional			R 0,00	
3731	Compatibility for blood transfusion			R 0,00	
3732	Cryoglobulin			R 0,00	
3734	Protein C (chromogenic)			R 0,00	
3735	Anti-thrombin III (chromogenic)			R 0,00	
3736	Plasminogen (chromogenic)			R 0,00	
3737	Lupus Russel Viper method			R 0,00	
3738	Lupus Kaolin Exner method			R 0,00	
3739	Erythrocyte count			R 0,00	
3740	Factors V and VII: Qualitative			R 0,00	
3741	Coagulation factor assay: Functional			R 0,00	
3743	Erythrocyte sedimentation rate			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3744	Fibrin stabilising factor (urea test)			R 0,00	
3746	Fibrin monomers			R 0,00	
3748	Plasminogen activator inhibitor (PAI-I)			R 0,00	
3750	Tissue plasminogen Activator (tPA)			R 0,00	
3753	Osmotic fragility (before and after incubation)			R 0,00	
3754	ABO Reverse Group			R 0,00	
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)			R 0,00	
3756	Full cross match			R 0,00	
3757	Coagulation factors: Quantitative			R 0,00	
3758	Factor VIII related antigen			R 0,00	
3759	Coagulation factor correction study			R 0,00	
3761	Factor XIII related antigen			R 0,00	
3762	Haemoglobin estimation			R 0,00	
3763	Contact activated product assay			R 0,00	
3764	Grouping: A B and O antigens			R 0,00	
3765	Grouping: Rh antigen			R 0,00	
3766	PIVKA			R 0,00	
3767	Euglobulin Lysis time			R 0,00	
3768	Haemoglobin A2 (column chromatography)			R 0,00	
3769	Haemoglobin electrophoresis			R 0,00	
3770	Haemoglobin-S (solubility test)			R 0,00	
3772	Haptoglobin: Quantitative			R 0,00	
3773	Ham’s acidified serum test			R 0,00	
3775	Heinz bodies			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3776	Haemosiderin in urinary sediment			R 0,00	
3783	Leucocyte differential count			R 0,00	
3785	Leucocytes: Total count			R 0,00	
3786	QBC malaria concentration and fluorescent staining			R 0,00	
3787	LE-cells			R 0,00	
3789	Neutrophil alkaline phosphatase			R 0,00	
3791	Packed cell volume: Haematocrit			R 0,00	
3792	Plasmodium falciparum: Monoclonal immunological identification			R 0,00	
3793	Plasma haemoglobin			R 0,00	
3794	Platelet sensitivities			R 0,00	
3795	Platelet aggregation per aggregant			R 0,00	
3797	Platelet count			R 0,00	
3799	Platelet adhesiveness			R 0,00	
3801	Prothrombin consumption			R 0,00	
3803	Prothrombin determination (two stages)			R 0,00	
3805	Prothrombin index			R 0,00	
3806	Therapeutic drug level: Dosage			R 0,00	
3809	Reticulocyte count			R 0,00	
3810	Schumm's test			R 0,00	
3811	Sickling test			R 0,00	
3814	Sucrose lysis test for PNH			R 0,00	
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)			R 0,00	
3820	Thrombo – Elastogram			R 0,00	
3825	Fibrinogen titre			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3829	Glucose 6-phosphate-dehydrogenase: Qualitative			R 0,00	
3830	Glucose 6-phosphate-dehydrogenase: Quantitative			R 0,00	
3832	Red cell pyruvate kinase: Quantitative			R 0,00	
3834	Red cell Rhesus phenotype			R 0,00	
3835	Haemoglobin F in blood smear			R 0,00	
3837	Partial thromboplastin time			R 0,00	
3841	Thrombin time (screen)			R 0,00	
3843	Thrombin time (serial)			R 0,00	
3847	Haemoglobin H			R 0,00	
3851	Fibrin degeneration products (diffusion plate)			R 0,00	
3853	Fibrin degeneration products (latex slide)			R 0,00	
3854	XDP (Dimer test or equivalent latex slide test)			R 0,00	
3855	Haemagglutination inhibition			R 0,00	
3856	D-Dimer (quantitative)			R 0,00	
3857	Ristocetin Cofactor			R 0,00	
3858	Heparin removal			R 0,00	
21.2	Microscopic and miscellaneous tests			R 0,00	
3863	Autogenous vaccine			R 0,00	
3864	Entomological examination			R 0,00	
3865	Parasites in blood smear			R 0,00	
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)			R 0,00	
3868	Fungus identification			R 0,00	
3869	Faeces (including parasites)			R 0,00	
3873	Transmission electron microscopy			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3874	Scanning electron microscopy			R 0,00	
3875	Inclusion bodies			R 0,00	
3878	Crystal identification polarized light microscopy			R 0,00	
3879	Campylobacter in stool: Fastidious culture			R 0,00	
3880	Antigen detection with polyclonal antibodies			R 0,00	
3881	Mycobacteria			R 0,00	
3882	Antigen detection with monoclonal antibodies			R 0,00	
3883	Concentration techniques for parasites			R 0,00	
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana			R 0,00	
3885	Cytochemical stain			R 0,00	
21.3	Bacteriology			R 0,00	
3887	Antibiotic susceptibility test: Per organism			R 0,00	
3888	Adhesive tape preparation			R 0,00	
3889	Clostridium difficile toxin: Monoclonal immunological			R 0,00	
3890	Antibiotic assay of tissues and fluids			R 0,00	
3891	Blood culture: Aerobic			R 0,00	
3892	Blood culture: Anaerobic			R 0,00	
3893	Bacteriological culture: Miscellaneous			R 0,00	
3894	Radiometric blood culture			R 0,00	
3895	Bacteriological culture: Fastidious organisms			R 0,00	
3896	In vivo culture: Bacteria			R 0,00	
3897	In vivo culture: Virus			R 0,00	
3899	Bacterial exotoxin production (in vivo assay)			R 0,00	
3901	Fungal culture			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3902	Clostridium difficile (cytotoxicity neutralisation)			R 0,00	
3903	Antibiotic level: Biological fluids			R 0,00	
3904	Rotavirus latex slide test			R 0,00	
3905	Identification of virus or rickettsia			R 0,00	
3906	Identification: Chlamydia			R 0,00	
3908	Anaerobe culture: Comprehensive			R 0,00	
3909	Anaerobe culture: Limited procedure			R 0,00	
3911	Beta-lactamase assay			R 0,00	
3914	Sterility control test: Biological method			R 0,00	
3915	Mycobacterium culture			R 0,00	
3916	Radiometric tuberculosis culture			R 0,00	
3918	Mycoplasma culture: Comprehensive			R 0,00	
3919	Identification of mycobacterium			R 0,00	
3920	Mycobacterium: Antibiotic sensitivity			R 0,00	
3921	Antibiotic synergistic study			R 0,00	
3922	Viable cell count			R 0,00	
3923	Biochemical identification of bacterium: Abridged			R 0,00	
3924	Biochemical identification of bacterium: Extended			R 0,00	
3925	Serological identification of bacterium: Abridged			R 0,00	
3926	Serological identification of bacterium: Extended			R 0,00	
3927	Grouping for streptococci			R 0,00	
3928	Antimicrobic substances			R 0,00	
3929	Radiometric mycobacterium identification			R 0,00	
3930	Radiometric mycobacterium antibiotic sensitivity			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3931	Helicobacter: Monoclonal immunological			R 0,00	
4650	Antibiotic MIC per organism per antibiotic			R 0,00	
4651	Non-radiometric automated blood cultures			R 0,00	
4652	Rapid automated bacterial identification per organism			R 0,00	
4653	Rapid automated antibiotic susceptibility per organism			R 0,00	
4654	Rapid automated MIC per organism per antibiotic			R 0,00	
4655	Mycobacteria: MIC determination – E Test			R 0,00	
4656	Mycobacteria: Identification HPLC			R 0,00	
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain			R 0,00	
21.4	Serology			R 0,00	
3958	Anti Gad/Ia2 Ab			R 0,00	
3959	Rose Waaler agglutination test			R 0,00	
3960	Gonococcal, listeria or echinococcus agglutination			R 0,00	
3961	Slide agglutination test			R 0,00	
3963	Serum complement level: Each component			R 0,00	
3965	Anti Ia2 Antibodies			R 0,00	
3966	Anti Gad Antibodies			R 0,00	
3967	Auto-antibody: Sensitized erythrocytes			R 0,00	
3968	Herpes virus typing: Monoclonal immunological			R 0,00	
3969	Western blot technique			R 0,00	
3932	Antibodies to human immunodeficiency virus (HIV): ELISA			R 0,00	
3933	IgE: Total: EMIT or ELISA			R 0,00	
3934	Auto antibodies by labelled antibodies			R 0,00	
3935	Sperm antibodies			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3936	Virus neutralisation test: First antibody			R 0,00	
3937	Virus neutralisation test: Each additional antibody			R 0,00	
3938	Precipitation test per antigen			R 0,00	
3939	Agglutination test per antigen			R 0,00	
3940	Haemagglutination test: Per antigen			R 0,00	
3941	Modified Coombs' test for brucellosis			R 0,00	
3942	Hepatitis Rapid Viral Ab			R 0,00	
3943	Antibody titer to bacterial exotoxin			R 0,00	
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag			R 0,00	
3945	Complement fixation test			R 0,00	
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag			R 0,00	
3947	C-reactive protein			R 0,00	
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag			R 0,00	
3949	Qualitative Kahn, VDRL or other flocculation			R 0,00	
3950	Neutrophil phagocytosis			R 0,00	
3951	Quantitative Kahn, VDRL or other flocculation			R 0,00	
3952	Neutrophil chemotaxis			R 0,00	
3953	Tube agglutination test			R 0,00	
3955	Paul Bunnell: Presumptive			R 0,00	
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)			R 0,00	
3971	Immuno-diffusion test: Per antigen			R 0,00	
3972	Respiratory syncytial virus (ELISA technique)			R 0,00	
3973	Immuno electrophoresis: Per immune serum			R 0,00	
3974	Polymerase chain reaction			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)			R 0,00	
3978	Lymphocyte transformation			R 0,00	
3980	Bilharzia Ag Serum/Urine			R 0,00	
3982	Histone Ab			R 0,00	
4600	Anti-CCP			R 0,00	
4601	Panel typing: Antibody detection – Class I			R 0,00	
4602	Panel typing: Antibody detection – Class II			R 0,00	
4603	HLA test for specific locus/antigen – serology			R 0,00	
4604	HLA typing: Class I – serology			R 0,00	
4605	HLA typing: Class II – serology			R 0,00	
4606	HLA typing: Class I & II – serology			R 0,00	
4607	Cross matching T-cells (per tray)			R 0,00	
4608	Cross matching B-cells			R 0,00	
4609	Cross matching T- & B-cells			R 0,00	
4610	Helicobacter: Pylori antigen test			R 0,00	
4611	Erythropoietin			R 0,00	
4612	HTLV I/II			R 0,00	
4613	Anti-Gm1 Antibody Assay			R 0,00	
4614	HIV Ab – Rapid Test			R 0,00	
21.5	Skin tests			R 0,00	
	For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section			R 0,00	
21.6	Biochemical tests: Blood			R 0,00	
3991	Abnormal pigments: Qualitative			R 0,00	
3993	Abnormal pigments: Quantitative			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
3995	Acid phosphate			R 0,00	
3998	Amino acids Quantitative (Post derivatisation HPLC)			R 0,00	
3999	Albumin			R 0,00	
4000	Alcohol			R 0,00	
4001	Alkaline phosphatase			R 0,00	
4002	Alkaline phosphatase-iso-enzymes			R 0,00	
4003	Ammonia: Enzymatic			R 0,00	
4004	Ammonia: Monitor			R 0,00	
4005	Alpha-1-antitrypsin: Total			R 0,00	
4006	Amylase			R 0,00	
4007	Arsenic in blood, hair or nails			R 0,00	
4008	Bilirubin – Reflectance			R 0,00	
4009	Bilirubin: Total			R 0,00	
4010	Bilirubin: Conjugated			R 0,00	
4011	Breath Hydrogen Test			R 0,00	
4012	CSF Nicotinic Acid			R 0,00	
4013	CSF Glutamine			R 0,00	
4014	Cadmium: Atomic absorption			R 0,00	
4016	Calcium: Ionised			R 0,00	
4017	Calcium: Spectrophotometric			R 0,00	
4018	Calcium: Atomic absorption			R 0,00	
4019	Carotene			R 0,00	
4020	Carnitine (total or free) in biological fluid: Each			R 0,00	
4021	Carnitine (total or free) in muscle: Each			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4022	Acyl Carnitine			R 0,00	
4023	Chloride			R 0,00	
4025	Chol/HDL/LDL/Trig			R 0,00	
4026	LDL cholesterol (chemical determination)			R 0,00	
4027	Cholesterol total			R 0,00	
4028	HDL cholesterol			R 0,00	
4029	Cholinesterase: Serum or erythrocyte – each			R 0,00	
4030	Cholinesterase phenotype (Dibucaine or fluoride each)			R 0,00	
4031	Total CO2			R 0,00	
4032	Creatinine			R 0,00	
4033	CSF-Immunoglobulin G			R 0,00	
4034	C1-Esterase Inhibitor			R 0,00	
4035	CSF-Albumin			R 0,00	
4036	CSF-IgG Index			R 0,00	
4038	Glutamic acid			R 0,00	
4040	Homocysteine (random)			R 0,00	
4041	Homocysteine (after Methionine load)			R 0,00	
4042	D-Xylose absorption test: Two hours			R 0,00	
4045	Fibrinogen: Quantitative			R 0,00	
4049	Glucose tolerance test (two specimens)			R 0,00	
4050	Glucose strip-test with photometric reading			R 0,00	
4051	Galactose			R 0,00	
4052	Glucose tolerance test (three specimens)			R 0,00	
4053	Glucose tolerance test (four specimens)			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4057	Glucose: Quantitative			R 0,00	
4061	Glucose tolerance test (five specimens)			R 0,00	
4062	Galactose-1-phosphate uridyl transferase			R 0,00	
4063	Fructosamine			R 0,00	
4064	HbA1C			R 0,00	
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda			R 0,00	
4067	Lithium: Flame ionisation			R 0,00	
4068	Lithium: Atomic absorption			R 0,00	
4071	Iron			R 0,00	
4073	Iron-binding capacity			R 0,00	
4076	Blood gases: Astrup/pO2 and ancillary tests – can only be charged to a maximum of 6 times per patient per day			R 0,00	
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb			R 0,00	
4079	Ketones in plasma: Qualitative			R 0,00	
4081	Drug level-biological fluid: Quantitative			R 0,00	
4082	Tacrolimus assay			R 0,00	
4083	Lysosomal enzyme assay			R 0,00	
4084	Thymidine kinase			R 0,00	
4085	Lipase			R 0,00	
4086	Lactate			R 0,00	
4091	Lipoprotein electrophoresis			R 0,00	
4092	Orosmucoid			R 0,00	
4093	Osmolality: Serum or urine			R 0,00	
4094	Magnesium: Spectrophotometric			R 0,00	
4095	Magnesium: Atomic absorption			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4096	Mercury: Atomic absorption			R 0,00	
4098	Copper: Atomic absorption			R 0,00	
4105	Protein electrophoresis			R 0,00	
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class			R 0,00	
4109	Phosphate			R 0,00	
4113	Potassium			R 0,00	
4114	Sodium			R 0,00	
4117	Protein: Total			R 0,00	
4121	pH, pCO2 or pO2: Each			R 0,00	
4123	Pyruvic acid			R 0,00	
4125	Salicylates			R 0,00	
4127	Caeruloplasmin			R 0,00	
4128	Phenylalanine: Quantitative			R 0,00	
4130	Aspartate aminotransferase (AST)			R 0,00	
4131	Alanine aminotransferase (ALT)			R 0,00	
4132	Creatine kinase (CK)			R 0,00	
4133	Lactate dehidrogenase (LD)			R 0,00	
4134	Gamma glutamyl transferase (GGT)			R 0,00	
4135	Aldolase			R 0,00	
4136	Angiotensin converting enzyme (ACE)			R 0,00	
4137	Lactate dehydrogenase isoenzyme			R 0,00	
4138	CK-MB: Immunoinhibition/precipitation			R 0,00	
4139	Adenosine deaminase			R 0,00	
4143	Serum/plasma enzymes			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4144	Transferrin			R 0,00	
4146	Lead: Atomic absorption			R 0,00	
4147	Triglyceride			R 0,00	
4148	Tay – Sachs Study			R 0,00	
4149	Red cell magnesium			R 0,00	
4151	Urea			R 0,00	
4152	CK-MB: Mass determination – quantitative (automated)			R 0,00	
4153	CK-MB: Mass determination – quantitative (not automated)			R 0,00	
4154	Myoglobin quantitative: Monoclonal immunological			R 0,00	
4155	Uric acid			R 0,00	
4156	Vitamin D3			R 0,00	
4157	Vitamin A-saturation test			R 0,00	
4158	Vitamin E (tocopherol)			R 0,00	
4159	Vitamin A			R 0,00	
4161	Troponin isoforms: Each			R 0,00	
4163	Apoprotein AI: Turbidometric method			R 0,00	
4165	Apoprotein AII: Turbidometric method			R 0,00	
4167	Apoprotein B: Turbidometric method			R 0,00	
4170	Lipoprotein a. (Lpa.) assay			R 0,00	
4171	Sodium + potassium + chloride + CO2 + urea			R 0,00	
4172	ELISA/EMIT technique			R 0,00	
4173	Sirolimus Assay			R 0,00	
4181	Quantitative protein estimation: Mancini method			R 0,00	
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4183	Quantitative protein estimation: Labelled antibody			R 0,00	
4184	C-reactive protein (ultra sensitive)			R 0,00	
4185	Lactose			R 0,00	
4186	Vitamin B6			R 0,00	
4187	Zinc: Atomic absorption			R 0,00	
21.7	Biochemical tests: Urine			R 0,00	
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)			R 0,00	
4189	Abnormal pigments			R 0,00	
4193	Alkapton test: Homogentisic acid			R 0,00	
4194	Amino acids: Quantitative (Post derivatisation HPLC)			R 0,00	
4195	Amino laevulinic acid			R 0,00	
4197	Amylase			R 0,00	
4198	Arsenic			R 0,00	
4199	Ascorbic acid			R 0,00	
4201	Bence-Jones protein			R 0,00	
4204	Calcium: Atomic absorption			R 0,00	
4205	Calcium: Spectrophotometric			R 0,00	
4209	Lead: Atomic absorption			R 0,00	
4210	Urine collagen telopeptides			R 0,00	
4211	Bile pigments: Qualitative			R 0,00	
4213	Protein: Quantitative			R 0,00	
4216	Mucopolysaccharides: Qualitative			R 0,00	
4217	Oxalate			R 0,00	
4218	Glucose: Quantitative			R 0,00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4219	Steroids: Chromatography (each)			R 0,00	
4221	Creatinine			R 0,00	
4223	Creatinine clearance			R 0,00	
4227	Electrophoresis: Qualitative			R 0,00	
4228	Fetal Lung Maturity			R 0,00	
4230	Urine/Fluid – Specific Gravity			R 0,00	
4231	Metabolites HPLC (High Pressure Liquid Chromatography)			R 0,00	
4232	Metabolites (Gaschromatography/Mass spectrophotometry)			R 0,00	
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)			R 0,00	
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)			R 0,00	
4237	5-Hydroxy-indole-acetic acid: Screen test			R 0,00	
4238	5HIAA (Hplc)			R 0,00	
4247	Ketones: Excluding dip-stick method			R 0,00	
4248	Reducing substances			R 0,00	
4251	Metanephrines: Column chromatography			R 0,00	
4252	Metanephrine (Hplc)			R 0,00	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)			R 0,00	
4254	Nitrosonaphtol test for tyrosine			R 0,00	
4255	Orotic Acid – Urine			R 0,00	
4256	Very long Chain Fatty Acids			R 0,00	
4261	Micro Albumin: Quantitative			R 0,00	
4262	Micro Albumin: Qualitative			R 0,00	
4263	pH: Excluding dip-stick method			R 0,00	
4265	Thin layer chromatography: One way			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4266	Thin layer chromatography: Two way			R 0,00	
4268	Organic acids: Quantitative: GCMS			R 0,00	
4269	Phenylpyruvic acid: Ferric chloride			R 0,00	
4270	Chromium Total Urine			R 0,00	
4271	Phosphate excretion index			R 0,00	
4272	Porphobilinogen qualitative screen: Urine			R 0,00	
4273	Porphobilinogen/ALA: Quantitative each			R 0,00	
4283	Magnesium: Spectrophotometric			R 0,00	
4284	Magnesium: Atomic absorption			R 0,00	
4285	Identification of carbohydrate			R 0,00	
4287	Identification of drug: Qualitative			R 0,00	
4288	Identification of drug: Quantitative			R 0,00	
4293	Urea clearance			R 0,00	
4297	Copper: Spectrophotometric			R 0,00	
4298	Copper: Atomic absorption			R 0,00	
4301	Chloride			R 0,00	
4309	Urobilinogen: Quantitative			R 0,00	
4313	Phosphates			R 0,00	
4315	Potassium			R 0,00	
4316	Sodium			R 0,00	
4319	Urea			R 0,00	
4321	Uric acid			R 0,00	
4323	Total protein and protein electrophoresis			R 0,00	
4325	VMA: Quantitative			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4326	Catecholamines (HPLC)			R 0,00	
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda			R 0,00	
4328	Immunoglobulin D			R 0,00	
4335	Cystine: Quantitative			R 0,00	
4336	Dinitrophenol hydrazine test: Ketoacids			R 0,00	
21.8	Biochemical tests: Faeces			R 0,00	
4339	Chloride			R 0,00	
4343	Fat: Qualitative			R 0,00	
4345	Fat: Quantitative			R 0,00	
4347	Ph			R 0,00	
4351	Occult blood: Chemical test			R 0,00	
4352	Occult blood: Monoclonal antibodies			R 0,00	
4357	Potassium			R 0,00	
4358	Sodium			R 0,00	
4359	Secretory IgA			R 0,00	
4362	Elastase quantitative ELISA			R 0,00	
4363	Stercobilinogen: Quantitative			R 0,00	
21.9	Biochemical tests: Miscellaneous			R 0,00	
4366	Porphyrin screen qualitative: Urine, stool, red blood cells – each			R 0,00	
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells – each			R 0,00	
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells – each			R 0,00	
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells – each			R 0,00	
4370	Drug level in biological fluid: Monoclonal immunological			R 0,00	
4371	Amylase in exudate			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4372	Fluoride in biological fluids and water			R 0,00	
4374	Trace metals in biological fluid: Atomic absorption			R 0,00	
4375	Calcium in fluid: Spectrophotometric			R 0,00	
4376	Calcium in fluid: Atomic absorption			R 0,00	
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)			R 0,00	
4378	Urea breath test			R 0,00	
4380	Lecithin in amniotic fluid: L/S ratio			R 0,00	
4381	Lamellar body count in amniotic fluid			R 0,00	
4390	Foam test: Amniotic fluid			R 0,00	
4391	Renal calculus: Chemistry			R 0,00	
4392	Renal calculus: Crystallography			R 0,00	
4395	Sweat: Sodium			R 0,00	
4396	Sweat: Potassium			R 0,00	
4397	Sweat: Chloride			R 0,00	
4399	Sweat collection by iontophoresis (excluding collection material)			R 0,00	
4400	Tryptophane loading test			R 0,00	
21.10	Cerebrospinal fluid			R 0,00	
4401	Cell count			R 0,00	
4407	Cell count, protein, glucose and chloride			R 0,00	
4409	Chloride			R 0,00	
4416	Sodium			R 0,00	
4417	Protein: Qualitative			R 0,00	
4419	Protein: Quantitative			R 0,00	
4421	Glucose			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4423	Urea			R 0,00	
4425	Protein electrophoresis			R 0,00	
21.11	RNA/DNA based tests and andrology			R 0,00	
21.11.1	RNA/DNA based tests and andrology: RNA/DNA based tests			R 0,00	
4424	HLA test for specific allele DNA-PCR			R 0,00	
4426	HLA typing low resolution Class I DNA-PCR per locus			R 0,00	
4427	HLA typing low resolution Class II DNA-PCR per locus			R 0,00	
4428	HLA typing high resolution Class I or II DNA-PCR per locus			R 0,00	
4429	Quantitative PCR (DNA/RNA)			R 0,00	
4430	Recombinant DNA technique			R 0,00	
4431	Ribosomal RNA targeting for bacteriological identification			R 0,00	
4432	Ribosomal RNA amplification for bacteriological identification			R 0,00	
4433	Bacteriological DNA identification (LCR)			R 0,00	
4434	Bacteriological DNA identification (PCR)			R 0,00	
4439	Quantitative PCR – viral load (not HIV) – hepatitis C, hepatitis B, CMV, etc.			R 0,00	
21.11.2	RNA/DNA based tests and andrology: Andrology			R 0,00	
4435	Mixed antiglobulin reaction: Semen			R 0,00	
4436	Friberg test: Semen			R 0,00	
4437	Kremer test: Semen			R 0,00	
4440	Semen analysis: Cell count			R 0,00	
4441	Semen analysis: Cytology			R 0,00	
4442	Semen analysis: Viability + motility – six hours			R 0,00	
4443	Semen analysis: Supravital stain			R 0,00	
4445	Seminal fluid: Alpha glucosidase			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4446	Seminal fluid fructose			R 0,00	
4447	Seminal fluid: Acid phosphatase			R 0,00	
21.12	Immunology			R 0,00	
4448	HCG: Latex agglutination – qualitative (side room)			R 0,00	
4449	HCG: Latex agglutination – semi-quantitative (side room)			R 0,00	
4450	HCG: Monoclonal immunological – qualitative			R 0,00	
4451	HCG: Monoclonal immunological – quantitative			R 0,00	
4452	Bone Specific Alk Phosphatase			R 0,00	
4455	Anti IgE receptor antibody test (10 samples and dilution)			R 0,00	
4456	Eosinophil cationic protein			R 0,00	
4457	Mast cell tryptase			R 0,00	
4458	Micro-albuminuria: Radio-isotope method			R 0,00	
4459	Acetyl choline receptor antibody			R 0,00	
4460	CA-199 tumour marker			R 0,00	
4461	Nuclear Matrix Protein 22			R 0,00	
4462	CA-125 tumour marker			R 0,00	
4463	C6 complement functional essay			R 0,00	
4466	Beta-2-microglobulin			R 0,00	
4467	Chromograqnin A			R 0,00	
4468	CA-549			R 0,00	
4469	Tumour markers: Monoclonal immunological (each)			R 0,00	
4470	CA-195 tumour marker			R 0,00	
4471	Carcino-embryonic antigen			R 0,00	
4473	TSH Receptor Ab			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4474	Cast per allergen			R 0,00	
4475	CA-724			R 0,00	
4477	Neuron specific enolase			R 0,00	
4478	Osteocalcin			R 0,00	
4479	Vitamin B12-absorption: Shilling test			R 0,00	
4480	Serotonin			R 0,00	
4482	Free thyroxine (FT4)			R 0,00	
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)			R 0,00	
4485	Insulin			R 0,00	
4486	C-Peptide			R 0,00	
4487	Calcitonin			R 0,00	
4488	B-Type Natriuretic Peptide			R 0,00	
4490	Releasing hormone response			R 0,00	
4491	Vitamin B12			R 0,00	
4492	Vitamin D3: Calcitroil (RIA)			R 0,00	
4493	Drug concentration: Quantitative			R 0,00	
4494	Free hormone assay			R 0,00	
4495	Growth hormone			R 0,00	
4496	Hormone concentration: Quantitative			R 0,00	
4497	Carbohydrate deficient transferrin			R 0,00	
4499	Cortisol			R 0,00	
4500	DHEA sulphate			R 0,00	
4501	Testosterone			R 0,00	
4502	Free testosterone			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4503	Oestradiol			R 0,00	
4505	Oestriol			R 0,00	
4506	Multiple antigen specific IgE screening test for Atopy			R 0,00	
4507	Thyrotropin (TSH)			R 0,00	
4508	Combined antigen specific IgE			R 0,00	
4509	Free tri-iodothyronine (FT3)			R 0,00	
4511	Renin activity			R 0,00	
4512	Parathormone			R 0,00	
4513	IgE: Total			R 0,00	
4514	Antigen specific IgE			R 0,00	
4515	Aldosterone			R 0,00	
4516	Follitropin (FSH)			R 0,00	
4517	Lutropin (LH)			R 0,00	
4518	Soluble transferrin receptor			R 0,00	
4519	Prostate specific antigen			R 0,00	
4520	17 Hydroxy progesterone			R 0,00	
4521	Progesterone			R 0,00	
4522	Alpha-feto protein			R 0,00	
4523	ACTH			R 0,00	
4524	Free PSA			R 0,00	
4526	Sex hormone binding globulin			R 0,00	
4527	Gastrin			R 0,00	
4528	Ferritin			R 0,00	
4529	Anti-DNA antibodies			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
4530	Antiplatelet antibodies			R 0,00	
4531	Hepatitis: Per antigen or antibody			R 0,00	
4532	Transcobalamine			R 0,00	
4533	Folic acid			R 0,00	
4534	Prostatic acid phosphatase			R 0,00	
4536	Erythrocyte folate			R 0,00	
4537	Prolactin			R 0,00	
4538	Procalcitonin: Semi-quantitative			R 0,00	
4539	Procalcitonin: Quantitative			R 0,00	
4540	HCG: Quantitative as used for Down's screen			R 0,00	
4546	First trimester Downs screen			R 0,00	
4552	Second Trimester Down's screen			R 0,00	
4553	Thyroglubulin			R 0,00	
4554	SCC marker			R 0,00	
21.13	Clinical pathology: Miscellaneous			R 0,00	
4544	Attendance in theatre			R 0,00	
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays – Refer to General Rule B.			R 0,00	
4551	Unlisted pathology service: Fees for items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the fee for a comparable service in the coding structure. New items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note General Rule C and item 6999 are not applicable to pathology services (sections 21, 22 and 23).			R 0,00	
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be charged separately.			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
22	**Anatomical pathology**			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values			R 0,00	
22.1	Exfoliative cytology			R 0,00	
4561	Sputum, all body fluids and tumour aspirates: First unit			R 0,00	
4563	Sputum, all body fluids and tumour aspirates: Each additional unit			R 0,00	
4564	Performance of fine-needle aspiration for cytology			R 0,00	
4565	Examination of fine needle aspiration in theatre			R 0,00	
4566	Vaginal or cervical smears, each			R 0,00	
22.2	Histology			R 0,00	
4567	Histology per sample			R 0,00	
4571	Histology per additional block, each			R 0,00	
4575	Histology and frozen section in laboratory			R 0,00	
4577	Histology and frozen section in theatre			R 0,00	
4578	Second and subsequent frozen sections, each			R 0,00	
4579	Attendance in theatre – no frozen section performed			R 0,00	
4582	Serial step sections (including Item 4567)			R 0,00	
4584	Serial step sections per additional block, each			R 0,00	
4587	Histology consultation			R 0,00	
4589	Special stains			R 0,00	
4591	Immunofluorescence studies			R 0,00	
4592	Immunoperoxidase studies			R 0,00	
4593	Electron microscopy			R 0,00	
4595	Foetal autopsy excluding histology			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
23	**Human genetics**			R 0,00	
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values			R 0,00	
23.1	Cytogenitc			R 0,00	
4750	Cell culture: Lymphocytes, cord blood			R 0,00	
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures			R 0,00	
4752	Cell culture: Chorionic villi			R 0,00	
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique			R 0,00	
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique			R 0,00	
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques			R 0,00	
4760	FISH procedure, including cell culture			R 0,00	
4761	FISH analysis per probe system			R 0,00	
23.2	DNA-testing			R 0,00	
4763	Blood: DNA extraction			R 0,00	
4764	Blood: Genotype per person – southern blotting			R 0,00	
4765	Blood: Genotype per person – PCR			R 0,00	
4766	HIV Drug Resistance Testing			R 0,00	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue – DNA extraction			R 0,00	
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue – genotype per person, southern blotting			R 0,00	
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue – genotype per person, PCR			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED ANAESTHESIOLOGISTS REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017				Practice type: Anaesthesiology Discipline 10	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**
IV.	**Travelling expenses**			R 0,00	
P.	**Travelling fees** a. Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. b. If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. c. A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. d. Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). e. Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). f. For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.			R 0,00	
5003	The indicated amount for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16= 3 X Indicated amount		1	R 16,10	
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof			R 0,00	
5007	Normal hours: General practitioner – 18,00 clinical procedure units per hour or part thereof			R 0,00	
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them			R 0,00	
V.	**LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED**			R 0,00	
	Modifier 0004 is not applicable to the following sections: • All anaesthetic services • Section 19: Radiology • Section 21: Clinical Pathology (except for items 3719, 3720 and 3721 where modifier 0004 may be applied) • Section 22: Anatomical Pathology • Section 23: Human Genetic Please note: This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures.				

CONTRACTED DENTAL PRACTITIONERS

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.						
	The schedule includes procedures and services for use by oral health care providers for purposes of keeping accurate patient records, reporting procedures on patients, and processing oral health care related insurance claims. The procedures are those performed by general dental practitioners, oral pathologists, prosthodontists, periodontists, orthodontists, maxillo-facial and oral surgeons and dental therapists. The procedures codes listed in the schedule have, for the convenience in using the schedule, been divided into categories of services, based on the branches of clinical dental practice. The procedures are grouped under the category of service with which the procedures are most frequently identified and should not be interpreted as excluding certain categories of oral health care providers from performing such procedures. Individual procedure codes consist of a procedure code, procedure description (nomenclature), and when necessary, a descriptor, that provides further definition and/or guidelines to clarify the intended use of the procedure code.						
I.	**Introduction**						
A.	**ADMINISTRATIVE AND INVOICING RULES**						
001	Invoices						
	a. A practitioner shall render a monthly invoice for every procedure which has been completed irrespective of whether the total treatment plan has been concluded.						

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	b. An invoice shall contain the following particulars: i. the surname and initials of the member ii. the first name of the patient iii. the name of the scheme iv. the membership number of the member v. the practice number vi. the date on which every service was rendered; vii. the code number, description and fee/benefit of the procedure or service viii. the name of the dentist rendering the service x. the appropriate ICD-10 code(s) for the procedures performed						
	Note: Photocopies of original invoices shall be certified by way of a rubber stamp or the signature of the dentist.						
002	Cost of direct materials: The expenses incurred for direct materials identified in the Schedule may be billed in addition to the procedure code. These expenses are limited to the net acquisition cost of the materials and a handling fee. The price of the materials should be VAT inclusive. Use modifier 8025 for handling fee.						

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
003	Dental laboratory services: Manual submission of invoices. Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by reporting code 8099 – dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code. The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician (or a copy thereof) shall accompany the invoice of the dentist and a copy (or the original) shall be filed by the dentist for record purposes. Electronic submission of invoices: Fees charged by dental technicians for laboratory services (PLUS L) shall be indicated on the dentist's invoice by submitting code 8099 – dental laboratory service with the appropriate laboratory fee on the line following the relevant dental procedure code on the date on which the dental procedure was rendered. The laboratory fee shall be submitted for payment on the date on which the procedure code is submitted for payment, and the appropriate dental laboratory service codes shall be reported on the lines following code 8099.						
	The technician's invoice shall be certified by the dentist (or a person appointed by the dentist) for correctness by means of a signature. The original invoice of the dental technician shall be filed by the dentist for record purposes.						
005	Procedure accompanied by unusual circumstances: In exceptional cases where the proposed fee/benefit is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the patient/medical scheme may be billed. Use modifier 8011 with a narrative description. Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances a lower fee may be billed. The service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.						

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
B.	**GENERAL CODING RULES**						
006	The schedule does not prescribe the scope of practice of a particular category of oral health care provider; neither does it confine the performing of procedures or services to a registered speciality. Fees listed within a column of a particular category of oral health care provider are customary fees, should the procedure or service be rendered by that provider category. Specialists are, however, encouraged to confine their practice to the speciality or related specialities in which they are registered. Specialist may charge fees for procedures or services which usually pertain to some other speciality, if such procedures or services are also recognised in their speciality, and if it is carried out only for their bona fide patients. Such fees shall not be higher than those charged by general practitioners for the same procedures or services (HPCSA, Rule 25). Fees for procedures or services not listed within the column of dental therapists that do fall within the field of dental therapy in terms of their scope of practice are regarded as being “by arrangement” until such fees are listed.						
007	Procedures not listed in the Dental Schedule: When a procedure is performed that is not listed in the schedule, an appropriate procedure code, listed in the NHRPL for medical practitioners may be reported.						
	Unlisted procedures: Any procedure that is neither described in the schedule, nor in the medical schedule, should be reported using code 9099 – unlisted dental procedure or service. The fee for an unlisted dental procedure or service should be based on the fee of a comparable procedure. Code 9099 codes should not be used to report procedures where the fee is determined “by arrangement” with the patient and/or medical scheme.						

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
C.	**SERVICES RULES**						
008	Oral evaluations and completion of treatment plans: Oral examinations include an examination, diagnosis and treatment planning (when treatment is required). No further fees/ benefits shall be levied for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. The completion of a treatment plan effected from an oral examination and/or comprehensive examination should be indicated by reporting code 8120 – treatment plan completed. Oral diagnosis defined: The determination by the dentist of the oral health condition of an individual patient achieved through the evaluation of data gathered by means of history taking, direct examination, patient conference, and such clinical aids and tests as may be necessary in the judgement of the dentist. Treatment plan defined: The treatment plan is the sequential guide for the patient's care as determined by the dentist's diagnosis and is used by the dentists for the restoration and/or maintenance of optimal oral health.						
009	Surgery guidelines: 1. Follow-up care for therapeutic surgical procedures: The fee/ benefit for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not him/herself complete the post-operative care, he/she shall arrange for post-operative care without additional charges. A fee/benefit for post-operative treatment of a prolonged or specialised nature may be charged as agreed upon between the practitioner and the scheme.						

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	2. Multiple procedures (maxillo-facial and oral surgery): The fee/ benefit for more than one operation or procedure performed through the same incision shall be determined as the fee for the major operation plus fee/benefit for the subsidiary operation to the indicated maximum for each such subsidiary operation or procedure (modifier 8005). The fee/benefit for more than one operation or procedure performed under the same anaesthetic but through another incision shall be determined on the fee/ benefit for the major operation plus 75% for the second procedure/operation (modifier 8009) and 50% for the third and subsequent procedures/operations (modifier 8006). This rule shall not apply where two or more unrelated operations are performed by practitioners in different specialities, in which case each practitioner shall be entitled to the full fee/benefit of the operation. If, within four months, a second operation for the same condition or injury is performed, the fee/benefit for the second operation shall be 50% of that of the first operation (modifier 8006).						
	3. Assistant surgeon (maxillo-facial and periodontal surgery): The fee payable to a specialist assistant is determined as 1/3 of the fee of the practitioner performing the procedure (modifier 8001). The fee payable to a general dental practitioner assistant is determined as 15% of the fee of the practitioner performing the procedure (modifier 8007). The patient must be informed beforehand that another dentist/ specialist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the patient.						
	4. Surgical team (maxillo-facial and oral surgery): The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (modifier 8008).						

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010	Orthodontic guidelines: The documentation and first invoice to the patient/medical scheme regarding orthodontic services will include the following information: a. the treatment plan and type of treatment (treatment code number) b. a diagnostic code (ICD-10) c. an orthodontic payment plan indicating the following: i. the total fee that will be levied for the treatment ii. the total months of orthodontic treatment (retention period excluded) iii. the initial fee payable by the patient (approximately 20% of the total fee) iv. the monthly payments of the balance of the fee						
	2. The fee for orthodontic treatment does not include a clinical oral evaluation and necessary diagnostic services. The fee for corrective therapy (i.e. codes 8861 to 8888) is an inclusive fee and no additional fees may be levied for intra-operative oral evaluations and preventive services. A pre-orthodontic treatment visit, an orthodontic retention, and an oral evaluation on completion of the treatment plan (retention phase included) are excluded and should be reported in addition to corrective orthodontic treatment as separate procedures (Code 8803 x3). Intra/post orthodontic treatment records consisting of radiographs/diagnostic images (limited to a cephalometric film and five oral/facial images) and diagnostic casts may be levied when a corrective orthodontic treatment plan is completed (retention phase included).						
	3. The fee for 'Fixed appliance therapy' (codes 8861 and 8865 to 8888), as determined by the individual practitioner, will be levied on a monthly manner over the treatment period (retention phase excluded).						

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	4. When partial fixed appliance or preliminary orthodontic treatment (codes 8858, 8861, 8865 or 8866) is followed by full fixed appliance orthodontic treatment (codes 8873 to 8888) provided by the same orthodontist, the fees levied for the partial fixed appliance therapy or preliminary treatment will be deducted from the fee quoted for the full fixed appliance orthodontic treatment.						
	5. The total fee for multiple phases of full fixed appliance orthodontic treatment provided by the same orthodontist may not exceed the most recent fee (determined on commencement date of the final stage of full fixed appliance treatment) for the appropriate full fixed orthodontic procedure.						
	6. When the patient transfers to another practitioner during treatment, or treatment is terminated for any reason, the original treating practitioner must report the number of treatment months remaining and determine the balance of the fee by applying the following formula: Total payment (for treatment only) minus 20% of the total fee (for banding when applicable) multiplied by the percentage of treatment remaining. For example, if the practitioner was paid R 10,000.00 for a 24-month treatment plan and 18 months of treatment were completed the balance would be R 2,000.00 (or R 10,000.00 - R 2,000.00 x 6/24). The length of the treatment plan from the original request for authorisation will be used to determine the number of treatment months remaining. The practitioner continuing treatment will provide the information stipulated in paragraph 1 above. Report code 8891 (orthodontic transfer) with the fee that will be levied for continuation of the treatment in addition to the appropriate orthodontic treatment code. The fee for continuous treatment is subject to prior authorisation by the patient's medical scheme.						

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	7. When an established orthodontic patient requires re-treatment, the information stipulated in paragraph 1 above and the cause(s) for re-treatment will be provided. Report code 8892 (orthodontic re-treatment) with the fee that will be levied for re-treatment in addition to the appropriate orthodontic treatment code. Orthodontic re-treatment is subject to prior authorisation by the patient's medical scheme.						
011	Dento-legal fees: Practitioners are entitled to remuneration if they are present at court at the request of an advocate or attorney. Use code 8111 (dental testimony) to report dento-legal work. The code is listed in the adjunctive general services sections in the code lists.						
D.	**MODIFIERS**						
012	Modifiers: Modifiers should be used with procedures identified throughout the NHRPL. Modifiers provide the means by which the reporting practitioner can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed it its definition or code. The sensible application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of the report that: a. a service or procedure was performed by more than one practitioner b. a service or procedure has been increased or reduced. c. only part of a service was performed d. an adjunctive service was performed e. a service or procedure was provided more than once f. the fee/benefit was altered due to a financial agreement						
8001	Assistant surgeon – specialist (1/3 of the appropriate benefit)						

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8005	Maximum multiple procedures (same incision) – MFO surgeon						
8006	Multiple surgical procedures – third and subsequent procedures (50% of the appropriate benefit)						
8007	Assistant surgeon – general dental practitioner (15% of the appropriate benefit)						
8008	Emergency surgery – after hours (PLUS 25% of the appropriate benefit)						
8009	Multiple surgical procedures – second procedure (75% of the appropriate benefit)						
8010	Open reduction (PLUS 75% of the appropriate benefit)						
8011	Procedure accompanied by unusual circumstances (benefit PLUS X% as determined by the practitioner and agreed upon by patient/ medical scheme)						
8012	Reduced services (benefit MINUS X% as determined by the practitioner)						
8013	Multiple modifiers						
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)						
8025	Handling fee – direct materials (26% of material cost to a maximum of R26.00)						

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E.	**EXPLANATIONS**						
	Tooth identification and designation of areas of the oral cavity						
	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.						
	Treatment categories: Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows: • Basic dentistry – designated as (B) in the treatment category column • Advanced dentistry – designated as (A) in the treatment category column • Surgery – designated as (S) in the treatment category column						
	Abbreviations used in Dental Coding **DM** Direct Material Column **+D** Add fee/benefit for denture **+L** Add laboratory fee **+M** Add material fee **MP** Mouth Part Column **M** Maxilla/Mandible						

CONTRACTED DENTAL PRACTITIONERS

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
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	Q Quadrant **S** Sextant **T** Tooth **TC** Treatment Category Column **A** Advanced dentistry **B** Basic dentistry **S** Surgery						
	Practice type codes: 25400 General Dental Practitioner 26200 Specialist Maxillo Facial and Oral Surgeon 26400 Specialist Orthodontist 29200 Specialist in Oral Medicine and Periodontics 29400 Specialist Prosthodontist 29800 Specialist Oral Pathologist 39500 Dental Therapist						

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F.	**GUIDELINES TO MEDICAL SCHEMES**						
	Age of a child The determination of a child or adult status of the patient should be based on the clinical development of the patient's dentition. Where administrative constraints preclude the use of clinical development so that the chronological age must be used to determine the child or adult status, the patient is defined as an adult beginning at age 12 with the exclusion of treatment for orthodontics or sealants. **Frequency of benefits** The South African Dental Association recommends to medical schemes, where considered necessary and appropriate, that contract limitations on the frequency of providing care for certain services be stated as "twice a calendar year" rather than once in every six months. **Radiographs and records** Radiographs should be taken only for clinical reasons as determined by the treating dentist. Postoperative radiographs should only be required as part of dental treatment. When a dentist determined it is appropriate to comply with a third-party payer's request for radiographs, a duplicate set should be submitted and the originals retained by the dentist. Any additional costs incurred by the dentists in copying radiographs and clinical records for claims determination should be reimbursed by the third-party payer or the patient.						

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	New vs. established patient A new patient is one who has not received any professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. An established patient (patient of record) is one who has received professional services from the dentist or another dentist of the same speciality who belongs to the same group practice, within the past three years. In the instance where a dentist is on call for or covering for another dentist, the patient's encounter will be classified as it would have been by the dentist who is not available.						

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II.	**Dental procedures and services**						
A.	Diagnostic services						
	The branch of dentistry used to identify and prevent dental disorders and disease. Includes all services/procedures available to the dentist for evaluating existing conditions and determining any further dental care that may be required. **Clinical oral examinations** The purpose of oral examinations is to observe and record pertinent information, past and present, necessary to arrive at a diagnosis and treatment plan (when treatment is indicated). A treatment plan is a list of procedures or services the dentist proposes to perform on a dental patient based on the results of the examination and diagnosis. Often more than one treatment plan is presented. Oral examinations may require the integration of information that is acquired through additional diagnostic procedures, which should be reported separately. The oral examination, diagnosis, and treatment planning are the responsibility of the dentist. The collection and recording of some data and components of the oral examination may however be delegated. Oral examinations and consultations include the issuing of prescriptions where medication is required.						
	General dental practitioner						
8101	Oral examination	R 202,20					
8102	Comprehensive oral examination	R 326,40					
8104	Limited oral examination	R 97,90					
8189	Re-examination – existing condition	R 97,90					
8176	Periodontal screening	R 170,30					

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8190	Consultation – second opinion or advice	R 202,20					
	Maxillo facial surgeon						
8901	Consultation – MFOS		R 257,60				
8902	Consultation – MFOS (detailed)		R 674,30				
*8840	Treatment planning for orthognathic surgery – ALL	R 581,80	R 872,70	R 872,70			
	Orthodontist						
8801	Consultation – orthodontist			R 257,60			
8803	Consultation – orthodontis (subsequent, retention and post treatment)			R 150,00			
8837	Diagnosis and treatment planning – orthodontist			R 119,60			
	Periodontist/oral medicine						
	Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.						
8701	Consultation – periodontist				R 257,60		
8703	Consultation – periodontist (detailed)				R 674,30		
8705	Re-examination – periodontist				R 201,60		
8707	Periodontal screening – periodontist				R 201,60		
8781	Consultation – oral medicine (simple)				R 201,60		
8782	Consultation – oral medicine (complex)				R 354,60		
8783	Consultation – oral medicine (subsequent)				R 150,00		
	Prosthodontist						
8501	Consultation – prosthodontis					R 257,60	
8507	Comprehensive consultation – prosthodontist					R 413,60	
8506	Detailed consultation – prosthodontist					R 674,30	

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	Oral pathologist					R 0,00	
9201	Consultation – oral pathologist					R 0,00	R 258,50
9205	Consultation – oral pathologist (subsequent)					R 0,00	R 150,50
	Radiographs/diagnostic imaging					R 0,00	
	Diagnostic radiographs/diagnostic images include interpretation. Radiographs/diagnostic images should only be taken for clinical reasons as determined by the dentist and practitioners should comply with the Regulations concerning safe radiological practice and take the necessary precaution to minimise radiation of patients. Radiographs/diagnostic images are part of the patient's clinical record, should be of diagnostic quality, properly identified and dated. The dentist should retain the original images and only copies should be used to fulfil requests made by patients or third party funders. Diagnostic radiographs/diagnostic images preceding endodontic treatment, periodontal treatment, the surgical extraction of teeth or roots and fixed prostheses are fundamental to ethical clinical practice.				R 0,00		
8107	Intraoral radiograph – periapical	R 81,80	R 81,80	R 81,80	R 81,80	R 81,80	
8108	Intraoral radiographs – complete series	R 633,50	R 633,50	R 633,50	R 633,50	R 633,50	
8112	Intraoral radiograph – bitewing	R 81,80	R 81,80	R 81,80	R 81,80	R 81,80	
8113	Intraoral radiograph – occlusal	R 140,80	R 140,80	R 140,80	R 140,80	R 140,80	
8114	Extraoral radiograph – hand-wrist	R 327,10	R 327,10	R 327,10	R 327,10	R 327,10	
8115	Extraoral radiograph – panoramic	R 327,10	R 327,10	R 327,10	R 327,10	R 327,10	
8116	Extraoral radiograph – cephalometric	R 327,10	R 327,10	R 327,10	R 327,10	R 327,10	
8118	Extraoral radiograph – skull/facial bone	R 327,10	R 327,10	R 327,10	R 327,10	R 327,10	
8121	Oral and/or facial image (digital/conventional)	R 88,00	R 88,00	R 88,00	R 88,00	R 88,00	

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	Other diagnostic procedures					R 0,00	
8117	Diagnostic models	R 88,00	R 88,00	R 88,00	R 88,00	R 88,00	
8119	Diagnostic models mounted	R 221,20	R 221,20	R 221,20	R 221,20	R 221,20	
*8122	Microbiological studies					R 0,00	
*8123	Caries susceptibility tests (by arrangement)	R 91,60				R 0,00	
8124	Pulp tests	R 24,20				R 0,00	
8503	Occlusion analysis mounted	R 275,40				R 413,60	
8505	Pantographic recording	R 399,90				R 600,10	
*8508	Electrognathographic recording	R 428,20				R 642,30	
*8509	Electrognathographic recording with computer analysis	R 711,00				R 1066,70	
8811	Tracing and analysis of extra-oral film	R 38,00	R 38,00	R 38,00	R 38,00	R 38,00	
8839	Diagnostic setup (orthodontics)	R 168,90		R 253,30		R 0,00	
B.	Preventive services					R 0,00	
	Services/procedures intended to eliminate or reduce the need for future dental treatment					R 0,00	
	Dental prophylaxis					R 0,00	
8155	Polishing – complete dentition	R 124,10			R 171,20	R 124,10	
8159	Prophylaxis – complete dentition	R 244,00			R 344,10	R 244,00	
*8160	Removal of gross calculus					R 0,00	
8179	Polishing – complete dentition (periodontally compromised patient)	R 142,50				R 0,00	
8180	Prophylaxis – complete dentition (periodontally compromised patient)	R 265,00				R 0,00	

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	Topical fluoride teatment					R 0,00	
	Topical fluoride treatment procedures involve the professionally application of topical fluoride within the dental office. Excludes fluoride application as part of prophylaxis paste, fluoride rinses or “swish”. For application of desensitising medicaments, see codes 8166 and 8167 in the supplementary section.				R 0,00		
8161	Topical application of fluoride – child	R 124,10			R 124,10	R 124,10	
8162	Topical application of fluoride – adult	R 124,10			R 124,10	R 124,10	
	Space maintenance (passive appliances)					R 0,00	
	Passive appliances are designed to prevent tooth movement					R 0,00	
8173	Space maintainer – fixed, per abutment	R 230,50				R 0,00	
8175	Space maintainer – removable	R 297,20				R 0,00	
	Other preventive procedures					R 0,00	
*8149	Nutritional counselling					R 0,00	
*8150	Tobacco counselling					R 0,00	
*8151	Oral hygiene instruction	R 124,10			R 248,60	R 248,60	
*8153	Oral hygiene instruction – each additional visit	R 90,90			R 119,60	R 119,60	
8163	Dental sealant	R 81,80				R 81,80	
8169	Occlusal guard	R 477,10				R 0,00	
8171	Mouth guard	R 144,50				R 0,00	
8177	Oral hygiene instruction (periodontally compromised patient)	R 188,10				R 0,00	
8178	Oral hygiene instruction – each additional visit (periodontally compromised patient)	R 101,40				R 0,00	

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C.	Restorative services					R 0,00	
	The branch of dentistry that deals with the reconstruction of the hard tissues of a tooth or group of teeth, injured or destroyed by trauma or disease. Restorative services/procedures intend to restore the function of a natural tooth. Anterior teeth include incisors and canines. Posterior teeth include premolars and molars. The number of tooth surfaces restored, i.e. mesial, occlusal (or incisal), distal, lingual, or vestibular (buccal or labial), is used to determine the appropriate procedure code. A one surface restoration for example, involves only one of the surfaces, while a two-surface restoration extends to two of the five surfaces. With a four-or-more-surfaces anterior restoration involving four tooth surfaces and the incisal angle is involved Limitations on amalgam and resin-based composite restorations 1. The reporting of two separate restorations of the same material (e.g., a MO and DO amalgam restoration) on the same tooth is appropriate. Some medical schemes however, have a clause in its dental plan(s) that restricts coverage of the same tooth surface, such as an occlusal, twice on the same day and may require the reporting of a MOD restoration instead of a separate MO and DO restoration. 2. The current NHRPL rates include direct pulp capping (code 8301) and rubber dam application (code 8304).				R 0,00		
	Amalgam restorations					R 0,00	
	All adhesives, liners, bases and polishing are included as part of the restoration. If pins are used, they should be reported separately See codes 8345, 8347 and 8348 for post and/or pin retention.				R 0,00		
8341	Amalgam – one surface	R 247,10				R 0,00	
8342	Amalgam – two surfaces	R 304,30				R 0,00	
8343	Amalgam – three surfaces	R 371,20				R 0,00	

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8344	Amalgam – four or more surfaces	R 413,60				R 0,00	
	Resin-based composite restorations					R 0,00	
	Resin restorations refer to a broad category of materials including but not limited to composites. Report these codes when glass ionomers/compomers are used as restorations. The procedures include acid etching, adhesives (including resin bonding agents) and curing part of the restoration. Resin restorations utilise the direct technique. For the indirect technique, see "Resin inlays/onlays". If pins are used, they should be reported in addition to these codes – see codes 8345, 8347 and 8348 for post and/or pin retention.				R 0,00		
8350	Resin crown – anterior primary tooth (direct)	R 538,90				R 0,00	
8351	Resin – one surface, anterior	R 271,00				R 0,00	
8352	Resin – two surfaces, anterior	R 341,10				R 0,00	
8353	Resin – three surfaces, anterior	R 407,40				R 0,00	
8354	Resin – four or more surfaces, anterior	R 454,50				R 0,00	
8367	Resin – one surface, posterior	R 293,90				R 0,00	
8368	Resin – two surfaces, posterior	R 363,60				R 0,00	
8369	Resin – three surfaces, posterior	R 439,50				R 0,00	
8370	Resin – four or more surfaces, posterior	R 472,70				R 0,00	
	Gold foil restorations – deleted from GEMS Tariff 2011					R 0,00	
*8561	Gold foil class I or IV – deleted from GEMS Tariff 2011					R 1078,70	
*8563	Gold foil class V – deleted from GEMS Tariff 2011					R 1262,00	
*8565	Gold foil class III – deleted from GEMS Tariff 2011					R 1587,80	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Inlay/onlay restorations					R 0,00	
	Temporary and/or intermediate inlays/onlays, the removal thereof and cementing of the permanent restoration are included as part of the restoration. The cusp tip must be overlaid to be considered an onlay.					R 0,00	
	Metal inlays/onlays					R 0,00	
	Use these codes for single metal inlay/onlay restorations. See the Fixed Prosthodontic Service section for metal inlay/only bridge retainers. Metal components include structures manufactured by means of conventional casting and/or electroforming. The benefits provided by some medical schemes for metal inlays on anterior teeth (incisors and canines) may be subject to pre-authorisation.				R 0,00		
8361	Inlay – metal, one surface	R 377,40				R 743,80	
8362	Inlay/onlay – metal, two surfaces	R 551,50				R 1078,70	
8363	Inlay/onlay – metal, three surfaces	R 919,60				R 1672,80	
8364	Inlay/onlay – metal, four or more surfaces	R 1112,20				R 1672,80	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Porcelain/ceramic inlays/onlays					R 0,00	
	Use these codes for single porcelain/ceramic inlay/onlay restorations. See the Fixed Prosthodontic Service section for porcelain/ceramic inlay/only bridge retainers. Porcelain/ceramic inlays/onlays include all indirect ceramic, porcelain and polymer-reinforced porcelain type inlays/onlays. To be confirmed: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.				R 0,00		
8371	Inlay – porcelain, one surface	R 454,50				R 898,60	
8372	Inlay/onlay – porcelain, two surfaces	R 671,10				R 1294,00	
8373	Inlay/onlay – porcelain, three surfaces	R 1106,10				R 2010,50	
8374	Inlay/onlay – porcelain, four or more surfaces	R 1339,60				R 2010,50	
8560	Cost of ceramic block					R 0,00	
8570	Fabrication of computer generated ceramic restoration					R 0,00	
	Resin-based inlays/onlays					R 0,00	
	Resin based inlays/onlays usually utilise the indirect technique. Fees for the application of a rubber dam (8304) may be levied in addition to these codes.When the direct technique is used, laboratory costs do not apply. An additional fee may be levied by reporting modifier 8023 in addition to these codes.				R 0,00		
8381	Inlay – resin, one surface	R 454,50				R 898,60	
8382	Inlay/onlay – resin, two surfaces	R 671,10				R 1294,00	
8383	Inlay/onlay – resin, three surfaces	R 1106,10				R 2010,50	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
8384	Inlay/onlay – resin, four or more surfaces	R 1339,60				R 2010,50	
	Crowns – single restorations					R 0,00	
	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the Implant Services section for crowns on osseo-integrated implants. Porcelain/ceramic crowns include all ceramic, porcelain and porcelain fused to metal crowns. Resin crowns and resin metal crowns include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming. Temporary and/or intermediate crowns, the removal thereof (provisional crowns included) and cementing of the permanent restorations are included as part of the restorations. To be confirmed: When computer generated (CAD-CAM) ceramic restorations are fabricated by the dental practitioner, laboratory costs do not apply. Report codes 8570 (fabrication of computer generated ceramic restoration) and 8560 for the cost of the ceramic block in addition to the restoration.				R 0,00		
8401	Crown – full cast metal	R 1418,20				R 2087,90	
8403	Crown – 3/4 cast metal	R 1418,20				R 2087,90	
8404	Crown – 3/4 porcelain/ceramic	R 1339,40				R 2010,50	
8405	Crown – resin laboratory	R 1339,40				R 2010,50	
8407	Crown – resin with metal	R 1418,20				R 2087,90	
8409	Crown – porcelain/ceramic	R 1418,20				R 2087,90	
8411	Crown – porcelain with metal	R 1418,20				R 2087,90	
8410	Provisional crown	R 275,40			R 275,40	R 413,60	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Veneers					R 0,00	
8355	Veneer – resin (chair-side)	R 430,30				R 430,30	
8552	Veneer – porcelain (laboratory)	R 952,40				R 1428,70	
8554	Veneer – resin (laboratory)	R 952,40				R 1428,70	
	Temporary restorations					R 0,00	
8137	Emergency crown (chair-side)	R 425,80				R 425,80	
8357	Prefabricated metal crown	R 253,30				R 253,30	
8375	Prefabricated resin crown	R 253,30				R 253,30	
	Other restorative procedures					R 0,00	
	Pin retention and cores					R 0,00	
8345	Prefabricated post retention, per post (in addition to restoration)	R 244,00				R 0,00	
8347	Pin retention – first pin (in addition to restoration)	R 122,70				R 0,00	
8348	Pin retention – each additional pin (in addition to restoration)	R 113,60				R 0,00	
8366	Pin retention as part of cast restoration (any number of pins)	R 183,40				R 248,60	
8376	Core build-up with prefabricated posts	R 675,50				R 675,50	
8379	Cost of prefabricated posts					R 0,00	
8391	Cast core with single post	R 285,00				R 0,00	
8392	Cast post (each additional)	R 169,60				R 0,00	
8397	Cast core with pins (any number of pins)	R 454,50				R 590,90	
8398	Core build-up with or without pins	R 551,50				R 551,50	
8581	Cast core with single post					R 421,10	
8582	Cast core with double post					R 600,10	
8583	Cast core with triple post					R 743,80	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Unclassified restorative procedures					R 0,00	
8133	Recement inlay, onlay, crown or veneer	R 124,10				R 157,40	
8135	Remove inlay, onlay or crown	R 247,10				R 247,10	
8138	Remove retention post (prefabricated or cast)	R 161,90				R 0,00	
*8146	Resin bonding for restorations					R 0,00	
8157	Re-burnishing and polishing of restorations - complete dentition	R 124,10				R 0,00	
8349	Carve restoration to accommodate existing removable prosthesis	R 50,00				R 0,00	
8413	Repair crown (permanent or provisional)	R 275,40				R 275,40	
8414	Additional fee for provision of crown within an existing clasp or rest	R 81,80				R 0,00	
D.	Endodontic services					R 0,00	
	Services/procedures intended to treat diseases of the dental pulp and their sequelae.					R 0,00	
	Pulp capping					R 0,00	
	These codes should not be used as a base or liner under a restoration. Certain funders (medical aids) may restrict the placement of the final restoration during the same visit.					R 0,00	
8301	Pulp cap – direct	R 165,30				R 0,00	
8303	Pulp cap – indirect	R 165,30				R 0,00	
	Pulpotomy					R 0,00	
8307	Pulp amputation (pulpotomy)	R 161,90				R 0,00	
8132	Pulp removal (pulpectomy)	R 202,90				R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Endodontic therapy					R 0,00	
	Includes endodontic therapy on primary teeth. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Limitation: Intra-operative radiographs/diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report code 8304 (application of a rubber dam) in addition to these codes				R 0,00		
	Preparatoty visits					R 0,00	
8332	Root canal preparatory visit – single canal tooth	R 124,10				R 0,00	
8333	Root canal preparatory visit – multi canal tooth	R 174,00				R 0,00	
	Obtuation of canals					R 0,00	
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).					R 0,00	
8335	Root canal obturation – anteriors and premolars, first canal	R 563,60				R 0,00	
8328	Root canal obturation – anteriors and premolars, each additional canal	R 230,50				R 0,00	
8336	Root canal obturation – posteriors, first canal	R 775,60				R 0,00	
8337	Root canal obturation – posteriors, each additional canal	R 230,50				R 0,00	
	Complete therapy					R 0,00	
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).					R 0,00	

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8338	Root canal therapy – anteriors and premolars, first canal	R 862,30				R 0,00	
8329	Root canal therapy – anteriors and premolars, each additional canal	R 287,80				R 0,00	
8339	Root canal therapy – posteriors, first canal	R 1184,70				R 0,00	
8340	Root canal therapy – posteriors, each additional canal	R 287,80				R 0,00	
8631	Root canal therapy, first canal					R 1463,60	
8633	Root canal therapy, each additional canal					R 368,10	
	Endodontic retreatment					R 0,00	
8334	Re-preparation of previously obturated root canal	R 183,40				R 221,20	
	Apexification/recalcification procedures					R 0,00	
8635	Apexification/recalcification – per visit	R 165,30				R 244,00	
	Periradicular procedures					R 0,00	
9015	Apicectomy – anteriors (including retrograde filling)	R 612,30	R 812,00		R 812,00	R 812,00	
9016	Apicectomy – posteriors (including retrograde filling)	R 1079,70	R 1619,90		R 1619,90	R 1619,90	
	Other endodontic procedures					R 0,00	
8330	Removal of root canal obstruction	R 161,90				R 0,00	
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	R 110,70				R 0,00	
8640	Removal of fractured post or instrument from root canal					R 430,30	
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)	R 541,50			R 812,00	R 812,00	
E.	Periodontic services					R 0,00	
	The branch of dentistry used to treat and prevent disease affecting the gingivae, ligaments and bone that supports the teeth.					R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Surgical services					R 0,00	
	Surgical services includes usual postoperative care					R 0,00	
8741	Gingivectomy/gingivoplasty – four or more teeth per quadrant	R 648,50			R 889,50	R 0,00	
8743	Gingivectomy or gingivoplasty – one to three teeth per quadrant	R 518,10			R 706,10	R 0,00	
8749	Flap procedure, root planing and one to three surgical services – per quadrant	R 1346,30			R 2019,80	R 0,00	
8751	Flap procedure, root planing and one to three surgical services – per sextant	R 1115,00			R 1672,80	R 0,00	
8753	Flap procedure, root planing and four or more surgical services – per quadrant	R 1668,80			R 2503,00	R 0,00	
8755	Flap procedure, root planing and four or more surgical services – per sextant	R 1352,30			R 2028,90	R 0,00	
8756	Clinical crown lengthening (isolated procedure)	R 820,10			R 1230,30	R 0,00	
8759	Pedicle flapped graft (isolated procedure)	R 616,40			R 924,30	R 0,00	
*8761	Masticatory mucosal autograft – one to four teeth (isolated procedure)	R 669,60	R 1004,60		R 1004,60	R 0,00	
*8762	Masticatory mucosal autograft – four or more teeth (isolated procedure)	R 1005,90	R 1509,10		R 1509,10	R 0,00	
8763	Wedge resection (isolated procedure)	R 394,10			R 590,90	R 0,00	
*8766	Bone regeneration/repair procedure as part of a flap operation	R 322,20			R 483,30	R 0,00	
*8767	Bone regeneration/repair procedure at a single site	R 835,50	R 1253,10		R 1253,10	R 0,00	
*8769	Membrane removal (used for guided tissue regeneration)	R 394,10	R 590,90		R 590,90	R 0,00	
*8770	Cost of bone regenerative/repair material					R 0,00	
*8772	Submucosal connective tissue autograft (isolated procedure)	R 676,70	R 1015,10		R 1015,10	R 0,00	
8995	Gingivectomy per jaw	R 960,50	R 1440,80			R 0,00	

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	Non-surgical periodontal services					R 0,00	
8723	Provisional splinting – extracoronal (wire), per sextant	R 230,50			R 345,50	R 345,50	
8725	Provisional splinting – extracoronal (wire plus resin), per sextant	R 334,50			R 501,40	R 501,40	
8727	Provisional splinting – intracoronal, per tooth	R 105,00			R 157,40	R 157,40	
8737	Root planing – four or more teeth, per quadrant	R 497,00			R 674,30	R 0,00	
8739	Root planing – one to three teeth, per quadrant	R 395,40			R 537,90	R 0,00	
8773	Cost of intrapocket chemotherapeutic agent					R 0,00	
	Other periodontal services					R 0,00	
8768	Unlisted periodontal procedure	R 394,10			R 590,90	R 0,00	
8787	Unlisted oral medicine procedure	R 141,10			R 212,10	R 0,00	
F.	Removable prosthodontics					R 0,00	
	The branch of prosthodontics concerned with the replacement of teeth by artificial substitutes that is readily removable. Removable prosthodontic services include routine post-operative care.				R 0,00		
	Complete dentures					R 0,00	
8231	Complete dentures – maxillary and mandibular	R 2003,00				R 4181,80	
8232	Complete denture – maxillary or mandibular	R 1234,80				R 2925,70	
8244	Immediate denture – maxillary	R 1234,80				R 1852,40	
8245	Immediate denture – mandibular	R 1234,80				R 1852,40	
8643	Complete dentures – maxillary and mandibular (with complications)					R 5427,00	
8645	Complete dentures – maxillary and mandibular (with major complications)					R 6675,70	
8649	Complete denture – maxillary or mandibular (with complications)					R 3339,20	

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8651	Complete denture – maxillary or mandibular (with major complications)					R 3756,00	
	Partial dentures					R 0,00	
8233	Partial denture – resin base, one tooth	R 574,10				R 0,00	
8234	Partial denture – resin base, two teeth	R 574,10				R 0,00	
8235	Partial denture – resin base, three teeth	R 859,20				R 0,00	
8236	Partial denture – resin base, four teeth	R 859,20				R 0,00	
8237	Partial denture – resin base, five teeth	R 859,20				R 0,00	
8238	Partial denture – resin base, six teeth	R 1139,70				R 0,00	
8239	Partial denture – resin base, seven teeth	R 1139,70				R 0,00	
8240	Partial denture – resin base, eight teeth	R 1139,70				R 0,00	
8241	Partial denture – resin base, nine or more teeth	R 1139,70				R 0,00	
8281	Partial denture – cast metal framework only	R 1339,60				R 0,00	
8671	Partial denture – cast metal framework with resin denture base					R 3339,20	
	Adjustments to dentures					R 0,00	
8275	Adjust complete or partial denture	R 90,90				R 90,90	
8662	Adjust complete or partial dentures (remounting)	R 321,40				R 482,00	
	Repairs to dentures					R 0,00	
	Professional fees should not be levied for the repair of dentures/ intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.					R 0,00	
8269	Repair denture or other intra-oral appliance	R 157,40				R 169,60	
8270	Add clasp to existing partial denture	R 113,60				R 0,00	
8271	Add tooth to existing partial denture	R 113,60				R 0,00	

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8273	Impression to repair or modify a denture or other intra-oral appliance	R 90,90				R 90,90	
	Denture rebase procedures					R 0,00	
	Rebase – the partial or complete removal and replacement of the denture base					R 0,00	
8259	Rebase complete or partial denture (laboratory)	R 468,10				R 675,50	
8261	Remodel complete or partial denture	R 751,60				R 0,00	
	Denture reline procedures					R 0,00	
	Reline – the addition of material to the fitting surface of a denture base					R 0,00	
8263	Reline complete or partial denture (chair-side)	R 297,20				R 371,20	
8267	Reline complete or partial denture (laboratory)	R 683,60				R 683,60	
	Interim dentures					R 0,00	
	Also known as provisional, temporary, or transitional dentures. Provisional dentures are used for a limited period of time for reasons of aesthetics, function or occlusal support, after which it is replaced by a more definitive prosthesis.					R 0,00	
8658	Interim complete denture	R 1234,80				R 1852,30	
8659	Interim partial denture	R 987,70				R 1481,90	
8661	Diagnostic dentures (including tissue conditioning)					R 3339,20	
	Other removable prosthetic procedures					R 0,00	
*8251	Clasp or rest – cast gold	R 113,60				R 0,00	
*8253	Clasp or rest – wrought gold	R 113,60				R 0,00	
8255	Clasp or rest – stainless steel	R 119,60				R 0,00	
8257	Bar – lingual or palatal	R 140,80				R 0,00	

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8265	Tissues conditioning per arch (including soft self-cure reline)	R 194,10				R 248,60	
*8277	Inlay in denture					R 0,00	
8597	Locks and milled rests	R 113,20				R 169,60	
8599	Precision attachment (removable denture)	R 275,40				R 413,60	
8652	Overdenture – complete	R 2226,20				R 3339,20	
8653	Overdenture – partial	R 1780,90				R 2671,50	
8657	Replacement of precision attachment	R 157,40				R 169,60	
8663	Metal base to complete denture	R 670,60				R 1005,90	
8664	Remount crown or bridge for prosthetics	R 321,40				R 503,40	
8667	Soft base to denture (heat cured)	R 670,60				R 1005,90	
8672	Altered cast technique (in addition to partial denture)	R 86,00				R 128,80	
8674	Additive partial denture	R 1010,10				R 1515,30	
G.	Maxillo-facial prosthetics					R 0,00	
	The branch of prosthodontics concerned with the restoration of stomatognathic and associated facial structures that have been affected by disease, injury, surgery or congenital defect. Where “+D” appears the practitioner will charge the relevant fee/ benefit for the denture in the Where “+D” appears the practitioner will charge the relevant fee/benefit for the denture in the Schedule plus the fee/benefit indicated.				R 0,00		
	Maxilliary prosthesis					R 0,00	
9101	Obturator prosthesis, surgical – modified denture	R 165,80				R 248,60	
9102	Obturator prosthesis, surgical – continuous base	R 449,40				R 674,30	
9103	Obturator prosthesis, surgical – split base	R 669,60				R 1004,60	

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9104	Obturator prosthesis, interim – on existing denture	R 1010,10				R 1515,30	
9105	Obturator prosthesis, interim – on new denture	R 3119,40				R 4678,80	
9106	Obturator prosthesis, definitive – open/hollow box	R 1010,10				R 1515,30	
9107	Obturator prosthesis, definitive – silicone glove	R 1950,60				R 2925,70	
	Mandibular resection prostheses					R 0,00	
9108	Mandibular resection prosthesis w/ guide flange	R 2395,90				R 3594,00	
9109	Mandibular resection prosthesis w/o guide flange	R 2226,20				R 3339,20	
9110	Mandibular resection prosthesis, palatal augmentation	R 449,40				R 674,30	
	Glossal resection prostheses					R 0,00	
9111	Glossal resection prosthesis – simple	R 937,20				R 1406,30	
9112	Glossal resection prosthesis – complex	R 1Ê404,20				R 2106,00	
	Radiotherapy appliances					R 0,00	
9113	Radiation carrier – simple	R 1010,10				R 1515,30	
9114	Radiation carrier – complex	R 2787,80				R 4181,80	
9115	Radiation shield – simple	R 1010,10				R 1515,30	
9116	Radiation shield – complex	R 2787,80				R 4181,80	
9117	Radiation cone locator	R 1010,10				R 1515,30	
	Chemotherapy appliances					R 0,00	
9118	Chemotherapeutic agent carrier	R 1010,10				R 1515,30	
	Cleft palate prostheses					R 0,00	
8855	Consultation – cleft palate therapy (house or hospital)	R 230,50		R 345,50		R 345,50	
8856	Consultation – cleft palate (subsequent)	R 113,20		R 169,60		R 169,60	
8857	Consultation – cleft palate (maximum)	R 786,80		R 1180,30		R 1180,30	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Neonatal prostheses					R 0,00	
9119	Feeding aid prosthesis, neonatal	R 894,00		R 1341,20		R 1341,20	
9120	Orthopaedic appliance, active presurgical – minor	R 894,00		R 1341,20		R 1341,20	
9121	Orthopaedic appliance, active presurgical – moderate	R 1323,10		R 1984,70		R 1984,70	
9122	Orthopaedic appliance, active presurgical – severe	R 2226,20		R 3339,20		R 3339,20	
9123	Orthopaedic appliance, active presurgical – modification	R 113,20		R 169,60		R 169,60	
	Intermediate/definitive prostheses					R 0,00	
9125	Speech aid/obturator prosthesis – palatal alteration	R 450,50				R 675,50	
9126	Speech aid/obturator prosthesis – velar alteration	R 1010,10				R 1515,30	
9127	Speech aid/obturator prosthesis – pharyngeal alteration	R 2226,20				R 3339,20	
9128	Speech aid/obturator prosthesis – modification	R 113,20				R 169,60	
9129	Speech aid/obturator prosthesis – surgical	R 894,00				R 1341,20	
	Speech appliances					R 0,00	
9130	Speech aid appliance – palatal lift	R 449,40				R 674,30	
9131	Speech aid appliance – palatal stimulating	R 1010,10				R 1515,30	
9132	Speech aid appliance – bulb	R 2226,20				R 3339,20	
9133	Speech aid appliance – modification	R 113,20				R 169,60	
9134	Unspecified speech aid appliance					R 0,00	
	Extra-oral appliances					R 0,00	
9135	Auricular prosthesis – simple	R 2787,80				R 4181,80	
9136	Auricular prosthesis – complex	R 3637,50				R 5427,00	
9137	Nasal prosthesis – simple	R 2787,80				R 4181,80	
9138	Nasal prosthesis – complex	R 3637,50				R 5427,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
9139	Ocular prosthesis – interim	R 1010,10				R 1515,30	
9140	Ocular prosthesis – modified stock appliance	R 2506,10				R 3759,20	
9141	Ocular prosthesis – custom appliance	R 3637,50				R 5427,00	
9142	Orbital prosthesis – simple	R 2506,10				R 3759,20	
9143	Orbital prosthesis – complex	R 3637,50				R 5427,00	
9144	Facial prosthesis, combination – small					R 0,00	
9145	Facial prosthesis, combination – medium					R 0,00	
9146	Facial prosthesis, combination – large					R 0,00	
9147	Facial prosthesis, combination – complex					R 0,00	
9148	Unspecified body prosthesis – simple	R 2506,10				R 3759,20	
9149	Unspecified body prosthesis – complex	R 3637,50				R 5427,00	
9150	Facial prosthesis, surgical – simple	R 1950,60				R 2925,70	
9151	Facial prosthesis, surgical – complex	R 2506,10				R 3759,20	
9152	Extraoral appliance – additional prosthesis					R 0,00	
9153	Extraoral appliance – replacement prosthesis					R 0,00	
9155	Cranial prosthesis	R 1010,10				R 1515,30	
	Custom implants					R 0,00	
9156	Cranial implant prosthesis, custom made	R 1219,40				R 1828,70	
9157	Facial implant prosthesis, custom made – simple	R 609,10				R 913,40	
9158	Facial implant prosthesis, custom made – complex	R 1219,40				R 1828,70	
9159	Ocular implant prosthesis, custom made	R 609,10				R 913,40	
9160	Body implant prosthesis, custom made	R 2711,10				R 4066,70	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Surgical appliances					R 0,00	
9161	Surgical splint – simple	R 275,40				R 413,60	
9162	Surgical splint – complex	R 1010,10				R 1515,30	
9163	Surgical template – simple	R 275,40				R 413,60	
9164	Surgical template – complex	R 1010,10				R 1515,30	
9165	Surgical conformer – simple	R 275,40				R 413,60	
9166	Surgical conformer – complex	R 1010,10				R 1515,30	
	Trismus appliances					R 0,00	
9167	Trismus appliance (simple)	R 113,20				R 169,60	
9168	Trismus appliance (complex)	R 1010,10				R 1515,30	
9169	Orthoses appliance	R 2226,20				R 3339,20	
9170	Facial palsy appliance	R 669,60				R 1004,60	
9171	Commissure splint	R 275,40				R 413,60	
9172	Oral retractor, dynamic – per arm	R 275,40				R 413,60	
9173	Hand splint					R 0,00	
9174	Unspecified burn appliance					R 0,00	
	Attendance in theatre					R 0,00	
9175	Theatre attendance (MaxFac prosthod)/hour	R 372,50				R 559,20	
H.	Implant services					R 0,00	
	Services/procedures concerned with the surgical insertion of materials and devices into, onto and about the jaws and oral cavity for purposes of oral maxillofacial or oral occlusal rehabilitation or cosmetic corrections.					R 0,00	

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	Surgical implant procedures					R 0,00	
	The codes in this subsection are intended to report surgical procedures for the placement of implants to be used as prosthetic abutments. The surgical phase includes all procedures concerned with placing the implant into or onto the bone and preparation for the prosthetic phase.					R 0,00	
*9180	Surgical placement of sub-periosteal implant – preparatory stage	R 1634,40	R 2451,90			R 0,00	
*9181	Surgical placement of sub-periosteal implant – placement stage	R 1634,40	R 2451,90			R 0,00	
*9182	Surgical placement of endosteal implant plate	R 818,10	R 1227,30		R 1227,30	R 0,00	
*9183	Surgical placement of endosteal implant – first per jaw	R 1151,40	R 1565,20		R 1565,20	R 0,00	
*9184	Surgical placement of endosteal implant – second per jaw	R 862,30	R 1174,20		R 1174,20	R 0,00	
*9185	Surgical placement of endosteal implant – third and subsequent per jaw	R 577,20	R 786,50		R 786,50	R 0,00	
*9190	Surgical placement of abutment – first per jaw	R 427,20	R 578,40		R 578,40	R 578,40	
*9191	Surgical placement of abutment – second per jaw	R 321,20	R 435,00		R 435,00	R 435,00	
*9192	Surgical placement of abutment – third and subsequent per jaw	R 215,10	R 292,60		R 292,60	R 292,60	
	Implant supported prosthetics					R 0,00	
	Services/procedures concerned with the construction and placement of fixed or removable prosthesis on any implant device. Prosthetic devices which are not listed in this subsection should be reported using existing fixed or removable prosthetic codes.					R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Abutments and bars					R 0,00	
	These codes are intended to report the placement of final restorations and should not be used to report the placement of temporary/provisional components e.g. healing abutments/collars, temporary abutments, caps, cylinders, etc. Abutments as part of one-piece endosteal implants (incorporating both the implant and integral fixed abutment) are considered being part of the implant body and should not be reported in addition to the surgical placement of the implant. See codes 9187 to 9189 located in the "Other implant services" section to submit the cost of implant components.					R 0,00	
*8584	Connector bar – implant supported	R 2226,20				R 3339,20	
*8578	Prefabricated abutment	R 230,50				R 345,50	
*8579	Custom abutment	R 1050,40				R 1575,80	
	Removable dentures					R 0,00	
*8533	Implant supported removable complete overdenture	R 2226,20				R 3339,20	
*8534	Implant supported removable partial overdenture	R 1780,90				R 2671,50	
	Fixed-detachable dentures					R 0,00	
8654	Implant supported fixed-detachable complete overdenture	R 2504,10				R 3756,00	
*8655	Implant supported fixed-detachable partial overdenture	R 2003,10				R 2573,80	
*8660	Additional fee to implant supported fixed-detachable denture – per implant	R 345,50				R 345,50	
	Crowns – single restorations					R 0,00	
*8536	Crown, implant/abutment supported – porcelain/ceramic	R 1840,90				R 2434,80	
*8537	Crown, implant/abutment supported – porcelain with metal	R 1840,90				R 2434,80	
*8538	Crown, implant/abutment supported – cast metal	R 1840,90				R 2434,80	
*8592	Crown, implant/abutment supported					R 2434,80	

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	Bridge retainers – crowns					R 0,00	
*8546	Crown retainer, implant/abutment supported – porcelain/ceramic	R 1840,90				R 2434,80	
*8547	Crown retainer, implant/abutment supported – porcelain with metal	R 1840,90				R 2434,80	
*8548	Crown retainer, implant/abutment supported – cast metal	R 1840,90				R 2434,80	
	Other implant services					R 0,00	
*8590	Implant maintenance procedures – per implant	R 102,00				R 153,00	
*8594	Repair of implant supported prosthesis	R 113,20				R 169,60	
*8595	Repair of implant abutment	R 113,20				R 169,60	
*8600	Cost of implant components					R 0,00	
*9187	Cost of endosteal implant body					R 0,00	
*9188	Cost of prefabricated abutment					R 0,00	
*9189	Cost of other implant compnts					R 0,00	
*9198	Surgical removal of implant	R 532,20	R 798,50		R 798,50	R 0,00	

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I.	Fixed prosthodontics					R 0,00	
	The branch of prosthodontics concerned with the replacement or restoration of teeth by artificial substitutes that are not readily removable. A prosthetic retainer (e.g. crown/inlay/onlay retainer) in this section is defined as a part of a bridge that attaches a pontic to the abutment tooth. A pontic is that part of a bridge which replaces a missing tooth or teeth. Each retainer and each pontic constitutes a unit in a bridge. Porcelain/ceramic retainers and pontics presently include all ceramic, porcelain and porcelain fused to metal retainers and pontics. Resin retainers and pontics and resin metal retainers and pontics include all reinforced heat and/or pressure-cured resin materials. Metal components include structures manufactured by means of conventional casting and/or electroforming.				R 0,00		
	Pontics					R 0,00	
	Comment: Codes 8415, 8416, 8417and 8418 include ovate pontic designs. The nomenclatures of the pontics have been revised to coincide with the nomenclature used for crowns, which improves accurate record keeping. A similar approach has been followed for crowns and inlays/onlays utilised as bridge retainers.					R 0,00	
8415	Pontic – porcelain/ceramic	R 1157,50				R 0,00	
8416	Pontic – cast metal	R 919,60				R 0,00	
8417	Pontic – resin with metal	R 1157,50				R 0,00	
8418	Pontic – porcelain fused to metal	R 1157,50				R 0,00	
8419	Provisional pontic	R 275,40				R 413,60	
8611	Pontic – sanitary					R 1262,00	

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8613	Pontic – posterior					R 1544,10	
8615	Pontic – anterior/premolar					R 1668,30	
	Bridge retainers – inlays/onlays					R 0,00	
	An inlay/onlay retainer for a bridge that gains retention, support and stability from a tooth. The cusp tip must be overlayed to be considered an onlay. See inlay/onlay restorations in the Restorative Services Section for inlay/onlay retainers.				R 0,00		
8432	Inlay/onlay retainer – metal, two surfaces	R 551,50				R 1078,70	
8433	Inlay/onlay retainer – metal, three surfaces	R 919,60				R 1672,80	
8434	Inlay/onlay retainer – metal, four or more surfaces	R 1112,20				R 1672,80	
8436	Inlay/onlay retainer – porcelain, two surfaces	R 671,10				R 1294,00	
8437	Inlay/onlay retainer – porcelain, three surfaces	R 1106,10				R 2010,50	
8438	Inlay/onlay retainer – porcelain, four or more surfaces	R 1339,60				R 2010,50	
8617	Retainer cast metal (Maryland type retainer)	R 551,50				R 1078,70	
	Bridge retainers – crowns					R 0,00	
	A crown retainer for a bridge that gains retention, support and stability from a tooth.					R 0,00	
8441	Crown retainer – full cast metal	R 1418,20				R 2087,90	
8442	Crown retainer – 3/4 cast metal	R 1418,20				R 2087,90	
8443	Crown retainer – porcelain/ceramic	R 1418,20				R 2087,90	
8444	Crown retainer – 3/4 porcelain/ceramic	R 1418,20				R 2087,90	
8445	Crown retainer – porcelain with metal	R 1418,20				R 2087,90	
8446	Crown retainer – resin with metal	R 1418,20				R 2087,90	

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8447	Provisional crown retainer	R 275,40				R 413,60	
	Other fixed prosthodontic procedures					R 0,00	
	See “other restorative services” for procedures related to fixed prosthesis not listed in this sub-section.					R 0,00	
8514	Recement bridge	R 124,10				R 157,40	
8516	Remove bridge	R 247,10				R 247,10	
8518	Repair bridge	R 275,40				R 275,40	
8585	Connector bar	R 2226,20				R 3339,20	
8586	Stress breaker	R 830,30				R 1245,40	
8587	Coping metal	R 185,00				R 345,50	
J.	Oral and maxillo-facial surgery					R 0,00	
	The branch of dentistry using surgery to treat disorders/diseases of the mouth. Surgical procedures include routine postoperative care.					R 0,00	
	Extractions					R 0,00	
8201	Extraction – tooth or exposed tooth roots (first per quadrant)	R 124,10	R 186,20			R 0,00	
8202	Extraction – each additional tooth or exposed tooth roots	R 50,00	R 75,10			R 0,00	
	Surgical extractions					R 0,00	
	Report code 8220 when sutures are provided by the practitioner.					R 0,00	
8213	Surgical removal of residual roots, first tooth – per tooth	R 536,40				R 0,00	
8214	Surgical removal of residual roots, second and subsequent teeth’s roots	R 413,60				R 0,00	
8937	Surgical removal of tooth	R 536,40	R 724,10			R 0,00	
8941	Surgical removal of impacted tooth – first tooth	R 889,50	R 1Ê169,80			R 0,00	
8943	Surgical removal of impacted tooth – second tooth	R 477,10	R 630,20			R 0,00	

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8945	Surgical removal of impacted tooth – third and subsequent teeth	R 271,00	R 357,70			R 0,00	
8953	Surgical removal of residual roots, first tooth – per tooth		R 724,10			R 0,00	
	Other surgical procedures					R 0,00	
8517	Reimplantation of avulsed tooth (include stabilisation)	R 287,00				R 430,30	
8909	Oral antral fistula closure	R 1257,60	R 1886,50			R 0,00	
8911	Caldwell-Luc procedure	R 492,10	R 738,00			R 0,00	
8917	Biopsy of oral tissue – soft	R 313,60	R 418,30		R 418,30	R 0,00	
8919	Biopsy of bone – needle	R 482,70	R 724,10			R 0,00	
8921	Biopsy – extra-oral bone/soft tissue	R 789,90	R 1184,70			R 0,00	
8961	Tooth transplantation	R 1079,70	R 1619,90			R 0,00	
8965	Peripheral neurectomy	R 1079,70	R 1619,90			R 0,00	
8966	Repair of oronasal fistula (local flaps)	R 1502,10	R 2253,20			R 0,00	
8981	Surgical exposure of impacted or unerupted teeth to aid eruption	R 991,00	R 1350,00		R 1350,00	R 0,00	
8983	Corticotomy – first tooth	R 717,00	R 1075,70			R 0,00	
8984	Corticotomy – each additional tooth	R 363,60	R 545,40			R 0,00	
	Alveoloplasty					R 0,00	
8957	Alveolotomy or alveolectomy (including extractions)	R 658,70	R 987,90			R 0,00	
*9003	Reposition mental foramen and nerve – per side	R 1500,00	R 2250,30			R 0,00	
*9004	Lateralization of inferior dental nerve	R 2417,00	R 3625,90			R 0,00	
	Vestibuloplasty					R 0,00	
	Any of a series of surgical procedures designed to increase relative alveolar ridge height.					R 0,00	
8997	Sulcoplasty/vestibuloplasty	R 2475,80	R 3713,90		R 3713,90	R 0,00	

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	Surgical excision of soft tissue lesions	R 0,00	R 0,00			R 0,00	
8971	Excision of tumour of the soft tissue	R 482,70	R 724,10	R 0,00	R 724,10	R 0,00	
	Surgical excision of intra-osseous lesions					R 0,00	
8967	Surgical removal of jaw cyst – intra-oral approach	R 1500,00	R 2250,30			R 0,00	
8969	Surgical removal of jaw cyst – extra-oral approach	R 2402,90	R 3604,50			R 0,00	
8973	Surgical excision of tumours of the jaw	R 2402,90	R 3604,50			R 0,00	
9290	Maxillectomy – Alveolus only, Level I					R 0,00	
9292	Maxillectomy – Alveolus and sinus or nasal floor, Level II					R 0,00	
9294	Maxillectomy – Alveolus, sinus, nasal floor and zygoma excluding orbital rim Level III					R 0,00	
9296	Maxillectomy – Alveolus, sinus, nasal floor and zygoma including orbital rim Level IV					R 0,00	
9298	Maxillectomy – Alveolus, sinus, nasal floor, zygoma, orbital rim and pterygoid plates Level V					R 0,00	
9300	Hemiresection of jaw including condyle and coronoid process					R 0,00	
	Excision of bone tissue					R 0,00	
8975	Hemiresection of jaw excluding condyl	R 2524,30	R 3786,50			R 0,00	
8987	Reduction of mylohyoid ridges – per side	R 1079,70	R 1619,90			R 0,00	
8989	Removal torus mandibularis	R 1079,70	R 1619,90			R 0,00	
8991	Removal of torus palatinus	R 1079,70	R 1619,90			R 0,00	
8993	Surgical reduction of osseous tuberosity – per side	R 482,70	R 724,10			R 0,00	
	Surgical incision					R 0,00	
8731	Incision and drainage of abscess – intra-oral	R 198,00			R 297,20	R 0,00	
8908	Surgical removal of roots from maxillary antrum	R 1640,40	R 2460,70			R 0,00	

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9011	Incision and drainage of abscess – intra-oral (pyogenic)	R 307,20	R 460,50			R 0,00	
9013	Incision and drainage of abscess – extra-oral (pyogenic)	R 419,90	R 630,20			R 0,00	
9017	Decortication, saucerisation and sequestrectomy	R 2223,20	R 3334,70			R 0,00	
9019	Sequestrectomy – intra oral per sextant and or ramus	R 482,70	R 724,10			R 0,00	
	Treatment of fractures					R 0,00	
	Alveolus fractures					R 0,00	
9024	Dento-alveolar fracture – per sextant	R 541,50	R 812,00			R 0,00	
	Mandibular fractures					R 0,00	
9025	Mandible fracture – closed reduction	R 1199,20	R 1798,50			R 0,00	
9027	Mandible fracture – compound, with eyelet wiring	R 1684,10	R 2525,70			R 0,00	
9029	Mandible fracture – splints	R 1864,60	R 2796,80			R 0,00	
9031	Mandible fracture – open reduction	R 2763,70	R 4145,50			R 0,00	
	Maxilliary fractures					R 0,00	
9035	Maxilla fracture – Le Fort I or Guerin	R 1686,90	R 2530,40			R 0,00	
9037	Maxilla fracture – Le Fort II or middle third face	R 2763,70	R 4145,50			R 0,00	
9039	Maxilla fracture – Le Fort III or craniofacial disjunction	R 3963,90	R 5945,60			R 0,00	
	Zygoma/orbital/antral fractures					R 0,00	
9041	Zygomatic arch fracture – closed reduction	R 1199,20	R 1798,50			R 0,00	
9043	Zygomatic arch fracture – open reduction	R 2402,90	R 3604,50			R 0,00	
9045	Zygomatic arch fracture – open reduction (requiring osteosynthesis and/or grafting)	R 3600,00	R 5400,00			R 0,00	

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9046	Placement of Zygomaticus fixture, per fixture	R 2378,10	R 3566,90			R 0,00	
	Nasal fractures					R 0,00	
9280	Open reduction and fixation of nasal fractures					R 0,00	
9282	Manipulation and immobilisation of nasal fracture					R 0,00	
	Temporomandibular joint					R 0,00	
	Procedures which are an integral part of a primary procedure should not be reported separately.					R 0,00	
8172	Cost of orthotic appliance					R 0,00	
8850	Treatment of MPDS – first visit	R 189,90		R 285,00		R 285,00	
8851	Treatment of MPDS – subsequent visit	R 100,00		R 150,00		R 150,00	
8852	Occlusal orthotic appliance	R 477,10	R 628,80	R 628,80	R 628,80	R 628,80	
9053	Coronoidectomy (intra-oral approach)	R 1499,10	R 2248,50			R 0,00	
9074	TMJ arthroscopy diagnostic	R 1192,90	R 1789,50			R 0,00	
9075	Condylectomy, coronoidectomy or both	R 2997,00	R 4495,50			R 0,00	
9076	TMJ artrocentesis	R 658,70	R 987,90			R 0,00	
9077	TMJ intra-articular injection	R 179,80	R 269,90			R 0,00	
9079	Trigger point injection	R 140,30	R 210,60			R 0,00	
9081	Condylectomy (Ward/Kostecka)	R 1199,20	R 1798,50			R 0,00	
9083	TMJ srthroplasty	R 2997,00	R 4495,50			R 0,00	
9085	Reduction of TMJ disloc w/o anaesthetic	R 238,20	R 357,70			R 0,00	
9087	Reduction of TMJ disloc w/ anaesthetic	R 482,70	R 724,10			R 0,00	
9089	Reduction of TMJ disloc w/ anaesthetic and immobobilisation	R 1199,20	R 1798,50			R 0,00	
9091	Reduction of TMJ dislocation – open reduction	R 2997,00	R 4495,50			R 0,00	

GEMS TARIFF FOR SERVICES BY CONTRACTED DENTAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017		General dental practioner 2017 value	Maxillo facial and oral surgery 2017 value	Orthodontics 2017 value	Oral medicine and periodontics 2017 value	Prosthodontist 2017 value	Oral pathology 2017 value
Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
9092	Joint reconstruction	R 8001,10	R 12001,60			R 0,00	
	Repair of traumatic wounds					R 0,00	
8192	Suture – minor	R 612,30				R 0,00	
	Complicated suturing					R 0,00	
	Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.					R 0,00	
9021	Suture – reconstruction, minor (excludes closure of surgical incisions)	R 612,30	R 812,00			R 0,00	
9023	Suture – reconstruction, major (excludes closure of surgical incisions)	R 1139,70	R 1709,20			R 0,00	
	Other repair procedures					R 0,00	
8958	Emergency tracheotomy	R 553,40	R 830,20			R 0,00	
8959	Pharyngostomy	R 553,40	R 830,20			R 0,00	
*8962	Harvest iliac crest graft	R 398,30	R 489,20			R 0,00	
*8963	Harvest rib graft	R 456,60	R 685,00			R 0,00	
*8964	Harvest cranium graft	R 357,70	R 536,40			R 0,00	
8977	Surgical repair of maxilla or mandible – major	R 2522,40	R 3783,30			R 0,00	
*8979	Harvesting of autogenous grafts (intra-oral)	R 208,00	R 312,10		R 312,10	R 0,00	
8985	Frenulectomy/frenulotomy	R 658,70	R 987,90		R 987,90	R 0,00	
*9005	Alveolar ridge augmentation – total (by bone graft)	R 2524,30	R 3786,50		R 3786,50	R 0,00	
*9007	Alveolar ridge augmentation – total (by alloplastic material)	R 1589,10	R 2383,30			R 0,00	
*9008	Alveolar ridge augmentation – one to two tooth sites	R 491,20	R 898,60		R 898,60	R 0,00	
*9009	Alveolar ridge augmentation – three across three or more tooth sites	R 1091,80	R 1637,80		R 1637,80	R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
*9010	Sinus lift procedure	R 1640,40	R 2460,70		R 2460,70	R 0,00	
*9032	Reduction of masseter muscle and bone – extra-oral approach					R 0,00	
*9033	Reduction of masseter muscle and bone – intra-oral approach					R 0,00	
9048	Surgical removal of internal fixation devices, per site	R 461,60	R 692,50			R 0,00	
	Functional correction of malocclusion					R 0,00	
	For Codes 9047 to 9072 the full fee may be charged.					R 0,00	
*9047	Osteotomy – open with stabilisation	R 5038,30	R 7557,90			R 0,00	
*9049	Osteotomy – mandible body, anterior segmental	R 4199,10	R 6298,60			R 0,00	
*9050	Osteotomy – total subapical	R 7680,80	R 11521,20			R 0,00	
*9051	Genioplasty	R 2402,90	R 3604,50			R 0,00	
*9052	Midfacial exposure	R 3804,20	R 5706,00			R 0,00	
*9055	Osteotomy – segmented, posterior	R 4199,10	R 6298,60			R 0,00	
*9057	Osteotomy – segmented, anterior	R 4199,10	R 6298,60			R 0,00	
*9059	Reconstruct maxilla – Le Fort I osteotomy, one piece	R 7901,10	R 11851,60			R 0,00	
*9060	Reconstruct maxilla – Le Fort I osteotomy w/ repositioning and graft	R 8869,90	R 13304,60			R 0,00	
*9061	Palatal osteotomy	R 2763,70	R 4145,50			R 0,00	
*9062	Reconstruct maxilla – Le Fort I osteotomy, multiple segments	R 10086,00	R 15128,80			R 0,00	
9063	Reconstruct maxilla – Le Fort 2 osteotomy (facial and post-traumatic deformities)	R 10091,20	R 15136,40			R 0,00	
9065	Reconstruct maxilla – Le Fort 3 osteotomy (severe congenital deformities)	R 15123,20	R 22684,80			R 0,00	
*9066	Surgical expansion – maxilliary or mandibular	R 2402,90	R 3604,50			R 0,00	
9069	Glossectomy – partial	R 1799,80	R 2699,80			R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
*9071	Geniohyoidotomy	R 1079,70	R 1619,90			R 0,00	
9072	Close secondary oro-nasal fistula w/ bone grafting (complete procedure)	R 7901,10	R 11851,60			R 0,00	
	Salivary glands					R 0,00	
9093	Removal of salivary stone (sialolithotomy)	R 541,50	R 812,00			R 0,00	
9095	Excision of sublinglual salivary gland	R 1334,30	R 2001,50			R 0,00	
9096	Excision of salivary gland – extra oral approach	R 1976,80	R 2965,20			R 0,00	
	Pedicle flaps					R 0,00	
	Report codes 9284, 9286 and 9288 for flaps taken for repair of post – cancer/trauma/tumour surgery. These are not vestibuloplasty procedures. The use of the codes are not subject to modifier use.					R 0,00	
9284	Musculofascial flap					R 0,00	
9286	Musculocranial flap					R 0,00	
9288	Buccal fat pad (major repair)					R 0,00	
	Repair of frontal bones					R 0,00	
	The use of codes 9274, 9275 and 9278 imply the bicoronal/ hemicoronal approach.					R 0,00	
9274	Repair anterior table, frontal sinus and/or supraorbital rim					R 0,00	
9276	Repair anterior and posterior wall w/ obturation and/or cranialisation of frontal sinus					R 0,00	
9278	Repair medial canthal ligament (canthopexy), per side					R 0,00	
	Cleft lip and palate					R 0,00	
9220	Repair cleft hard palate – unilateral	R 4413,40	R 6619,70			R 0,00	
9222	Repair cleft hard palate – bilateral (one procedure)	R 5602,10	R 8402,90			R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
9224	Repair cleft hard palate – bilateral (two procedures)	R 8347,70	R 12520,00			R 0,00	
9226	Repair cleft soft palate – w/o muscle reconstruction	R 3697,90	R 5547,00			R 0,00	
9228	Repair cleft soft palate – w/ muscle reconstruction	R 5369,70	R 8054,60			R 0,00	
9230	Repair submucosal cleft and/or bifid uvula – w/ muscle reconstruction	R 3998,00	R 5997,20			R 0,00	
9232	Velopharyngeal reconstruction – uncomplicated	R 4114,10	R 6171,20			R 0,00	
9234	Velopharyngeal reconstruction – complicated	R 4399,20	R 6598,60			R 0,00	
9238	Repair oronasal fistula (one procedure)	R 2516,40	R 3774,30			R 0,00	
9240	Repair oronasal fistula (two procedures)	R 4389,80	R 6584,80			R 0,00	
9246	Secondary periosteal flaps	R 2193,90	R 3291,00			R 0,00	
9248	Lipadhesion	R 820,10	R 1230,30			R 0,00	
9250	Repair cleft lip – unilateral w/o muscle reconstruction	R 1444,50	R 2166,70			R 0,00	
9252	Repair cleft lip – unilateral w/ muscle reconstruction	R 1958,40	R 2937,80			R 0,00	
9254	Repair cleft lip – bilateral w/o muscle reconstruction	R 2017,20	R 3025,90			R 0,00	
9256	Repair cleft lip – bilateral w/ muscle reconstruction	R 3116,20	R 4674,40			R 0,00	
9258	Repair anterior nasal floor	R 786,80	R 1180,30			R 0,00	
9260	Revision of secondary cleft lip deformity – partial	R 786,80	R 1180,30			R 0,00	
9262	Revision of secondary cleft lip deformity – total w/ muscle reconstruction	R 1777,80	R 2666,60			R 0,00	
9264	Abbe-flap – two stages	R 2013,30	R 3019,90			R 0,00	
9266	Reconstruct columella	R 1190,00	R 1784,70			R 0,00	
9268	Reconstruct nose due to cleft deformity – partial	R 1512,00	R 2268,30			R 0,00	
9270	Reconstruct nose due to cleft deformity – complete	R 2390,00	R 3584,90			R 0,00	
9272	Paranasal augmentation for nasal base deviation	R 1190,00	R 1784,70			R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
K.	Orthodontic services					R 0,00	
	The branch of dentistry used to correct malocclusions of the mouth and restore it to proper alignment and function. Includes all services/procedures concerned with the supervision, guidnance and correction of the growing and mature dentofacial structures.					R 0,00	
	Removable appliance therapy					R 0,00	
	Removable indicates patient can remove including appliances for limited orthodontic treatment (e.g. partial treatment to open spaces or upright of a tooth) and minor orthodontic treatment to control harmful habits (e.g. thumb sucking and tongue trusting).					R 0,00	
8862	Ortho Tx – removable appliance	R 1393,00		R 2089,40		R 0,00	
8863	Ortho Tx – each additional removable appliance	R 700,10		R 1050,00		R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Functional appliance therapy					R 0,00	
	A removable functional appliance is an appliance with no fixed dental component which is designed to harness the forces generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane. Orthodontic treatment by means of a functional appliance is usually followed by comprehensive orthodontic treatment utilising fixed orthodontic appliances. When both phases of orthodontic treatment is provided by the same practitioner, the fees levied for treatment by means of the functional appliance, will be deducted from the fee quoted for comprehensive orthodontic treatment. When the preliminary/interceptive phase(s) of orthodontic treatment is followed by comprehensive orthodontic treatment and both phases of orthodontic treatment is provided by the same practitioner, the fees levied for preliminary/interceptive orthodontic treatment will be deducted from the fee quoted for comprehensive orthodontic treatment.				R 0,00		
8858	Ortho Tx – functional appliance	R 2509,10		R 3763,70		R 0,00	
	Fixed appliance therapy					R 0,00	
	Fixed appliance therapy – partial The intention of this phase in treatment is to intercept and modify the development of skeletal, dental and functional components of developing malocclusion usually in the mixed dentition.				R 0,00	R 0,00	
8861	Ortho Tx – partial fixed appliance, minor	R 1668,80		R 2503,00		R 0,00	
8865	Ortho Tx – partial fixed appliance, one arch	R 4451,40		R 6677,20		R 0,00	
8866	Ortho Tx – partial fixed appliance, both arches	R 6122,00		R 9183,30		R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Fixed appliance therapy – comprehensive: single arch					R 0,00	
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within an arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.					R 0,00	
8867	Ortho Tx – fixed appliance, one arch	R 4785,10		R 7177,20		R 0,00	
8868	Ortho Tx – fixed appliance: one arch, moderate	R 5902,10		R 8853,10		R 0,00	
8869	Ortho Tx – fixed appliance: one arch, severe	R 6903,20		R 10354,60		R 0,00	
	Fixed appliance therapy – comprehensive: both arches					R 0,00	
	This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within both arches and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase.					R 0,00	
8873	Ortho Tx – fixed appliance: both arches, Class 1 mild	R 8756,60		R 13135,00		R 0,00	
8875	Ortho Tx – fixed appliance: both arches, Class 1 moderate	R 10749,80		R 16124,20		R 0,00	
8877	Ortho Tx – fixed appliance: both arches, Class 1 severe	R 12531,40		R 18797,10		R 0,00	
8879	Ortho Tx – fixed appliance: both arches, Class 1 severe w/ complications	R 14083,00		R 21124,20		R 0,00	
8881	Ortho Tx – fixed appliance: both arches, Class 2/3 mild	R 12531,40		R 18797,10		R 0,00	
8883	Ortho Tx – fixed appliance: both arches, Class 2/3 moderate	R 14083,00		R 21124,20		R 0,00	
8885	Ortho Tx – fixed appliance: both arches, Class 2/3 severe	R 15809,30		R 23713,80		R 0,00	
8887	Ortho Tx – fixed appliance: both arches, Class 2/3 severe w/ complications	R 17812,20		R 26718,30		R 0,00	

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Tariff Code	**Description of Tariff Code**	**25400**	**26200**	**26400**	**29200**	**29400**	**29800**
	Lingual orthodontics – comprehensive: single arch					R 0,00	
	This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires.					R 0,00	
8841	Ortho Tx – fixed lingual appliance, one arch	R 8993,30		R 13489,60		R 0,00	
8842	Ortho Tx – fixed lingual appliance: one arch, moderate	R 10568,70		R 15853,20		R 0,00	
8843	Ortho Tx – fixed lingual appliance: one arch, severe	R 12041,40		R 18062,00		R 0,00	
	Lingual orthodontics – comprehensive, both arches					R 0,00	
8874	Ortho Tx – fixed lingual appliance: both arches, Class 1 mild	R 17155,70		R 25733,60		R 0,00	
8876	Ortho Tx – fixed lingual appliance: both arches, Class 1 moderate	R 20086,00		R 30129,10		R 0,00	
8878	Ortho Tx – fixed lingual appliance: both arches, Class 1 severe	R 22795,10		R 34192,60		R 0,00	
8880	Ortho Tx – fixed lingual appliance: both arches, Class 1 severe w/ complications	R 25293,10		R 37939,50		R 0,00	
8882	Ortho Tx – fixed lingual appliance: both arches, Class 2/3 mild	R 20939,40		R 31409,20		R 0,00	
8884	Ortho Tx – fixed lingual appliance: both arches, Class 2/3 moderate	R 23424,50		R 35136,40		R 0,00	
8886	Ortho Tx – fixed lingual appliance: both arches, Class 2/3 severe	R 26088,90		R 39133,50		R 0,00	
8888	Ortho Tx – fixed lingual appliance: both arches, Class 2/3 severe w/ complications	R 29029,60		R 43544,00		R 0,00	
	Other orthodontic services					R 0,00	
8846	Repair orthodontic appliance – removable	R 113,80		R 171,20		R 0,00	
8847	Replace orthodontic appliance – removable	R 394,10		R 590,90		R 0,00	
8848	Repair orthodontic appliance – fixed	R 168,90		R 253,30		R 0,00	
8849	Retainer (orthodontic)	R 394,10		R 590,90		R 0,00	
8890	Monthly instalment ortho Tx					R 0,00	

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8891	Orthodontic transfer					R 0,00	
*8892	Orthodontic re-treatment					R 0,00	
L.	Supplementary services					R 0,00	
	The branch of dentistry for unclassified treatment including palliative care and anaesthesia.					R 0,00	
	Anaesthesia					R 0,00	
8499	General anaesthetic					R 0,00	
8141	Inhalation sedation – first 15 minutes or part thereof	R 90,90				R 0,00	
8143	Inhalation sedation – each additional 15 minutes	R 46,90				R 0,00	
8144	Intravenous sedation	R 54,60				R 0,00	
8145	Local anaesthetic – per visit	R 79,00				R 0,00	
8147	Monitoring equipment for intravenous sedation	R 194,10				R 0,00	
	Professional visits					R 0,00	
8129	Office/hospital visit – after regularly scheduled hours	R 304,30				R 0,00	
8140	House/extended care facility/hospital call	R 201,60	R 0,00		R 201,60	R 0,00	
8903	House/hospital/nursing home consultation – MFOS		R 225,60			R 0,00	
8904	House/hospital/nursing home consultation (subsequent) – MFOS		R 150,00			R 0,00	
8905	After regularly hours consultation – MFOS		R 330,50			R 0,00	
8907	House/hospital/nursing home consultation (maximum per week) – MFOS		R 375,60			R 0,00	
9203	House/hospital/nursing home consultation – oral pathologist					R 0,00	R 226,50
9207	After hours visit – oral pathologist					R 0,00	R 331,70

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	Drugs, medicaments and materials					R 0,00	
8109	Infection control/barrier techniques	R 18,30				R 0,00	
8110	Sterilised instrumentation	R 46,90				R 0,00	
8183	Therapeutic drug injection	R 54,60				R 0,00	
8220	Cost of suture material					R 0,00	
8304	Rubber dam per arch	R 97,00				R 0,00	
8306	Cost of MTA					R 0,00	
*8310	Supply of bleaching materials					R 0,00	
	Administrative and laboratory services					R 0,00	
*8099	Dental laboratory service					R 0,00	
*8106	Special report	R 207,70	R 207,70	R 207,70	R 207,70	R 207,70	
*8111	Dental testimony					R 0,00	
*8120	Treatment plan completed					R 0,00	
*8139	Appointment not kept/30mins					R 0,00	
	Miscellaneous services					R 0,00	
	Palliative treatment					R 0,00	
8131	Emergency dental treatment	R 124,10				R 253,30	
8166	Application of desensitising resin, per tooth	R 81,80				R 0,00	
8167	Application of desensitising medicament, per visit	R 95,40				R 0,00	
8165	Sedative filling	R 124,10				R 0,00	
	Post-surgical complications					R 0,00	
8931	Treatment of post-extraction haemorrhage	R 90,90	R 545,40			R 0,00	
8933	Treatment of haemorrhage (blood dyscracias)	R 1257,60	R 1886,50			R 0,00	

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8935	Treatment of septic socket	R 90,90	R 142,50			R 0,00	
	Bleaching					R 0,00	
*8308	External bleaching, per arch					R 0,00	
*8309	Home bleaching – instructions and applicator					R 0,00	
*8311	Home bleaching – subsequent visit					R 0,00	
8325	Internal bleaching – per tooth	R 293,90				R 441,00	
8327	Internal bleaching – each additional visit	R 140,80				R 211,50	
	Unclassified treatment					R 0,00	
*8158	Enamel microabrasion	R 113,60				R 0,00	
*8168	Behavior management					R 0,00	
8551	Occlusal adjustment – major	R 785,70		R 1178,70		R 1178,70	
*8553	Occlusal adjustment – minor	R 274,20		R 375,60	R 375,60	R 375,60	
*9099	Unlisted dental procedure or service (by report)					R 0,00	
	MODIFIERS					R 0,00	
8001	Assistant surgeon – specialist (1/3 of the appropriate benefit)					R 0,00	
8005	Maximum multiple procedures (same incision) – MFO surgeon						
8006	Multiple surgical procedures – third and subsequent procedures (50% of the appropriate benefit)					R 0,00	
8007	Assistant surgeon – general dental practitioner (15% of the appropriate benefit)					R 0,00	
8008	Emergency surgery – after hours (PLUS 25% of the appropriate benefit)					R 0,00	
8009	Multiple surgical procedures – second procedure (75% of the appropriate benefit)					R 0,00	
8010	Open reduction (PLUS 75% of the appropriate benefit)					R 0,00	

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8011	Procedure accompanied by unusual circumstances (benefit PLUS x% as determined by the practitioner and agreed upon by patient/ medical scheme)					R 0,00	
8012	Reduced services (benefit MINUS x% as determined by the practitioner)					R 0,00	
8013	Multiple modifiers					R 0,00	
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)					R 0,00	
8025	Handling fee – direct materials (26% of material cost to a maximum of R26.00)					R 0,00	

CONTRACTED DENTAL THERAPY

GEMS TARIFF FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Therapy Code: 39500	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10 cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
	GENERAL RULES					
001	Item 001 refers to a full mouth examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.					
002	(a) Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been.....missing text (b) Every account shall contain the following particulars: i. the surname and initials of the member ii. the first name of the patient iii. the name of the scheme iv. the membership number of the member v. the practice number vi. date on which every service was rendered vii. where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist viii. a statement of whether the account is in accordance with the National Reference Price List ix. the name of the dental therapist rendering the service must be shown on the account x. the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered					
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.					
	ITEMS					
8139	Appointment not kept/30mins	210	-	1,0		
8109	Infection control/barrier techniques	210	1,730	1,0	R 18,10	
8110	Sterilised instrumentation	210	4,460	1,0	R 46,70	
8120	Treatment plan completed	210	-	1,0		

	Diagnostic services					
8101	Oral examination	210	10,000	1,0	R 104,70	
8102	Comprehensive oral examination	210	16,147	1,0	R 169,20	
8104	Limited oral examination	210	7,791	1,0	R 81,60	
8189	Re-examination – existing condition	210	7,791	1,0	R 81,60	
8129	Office/hospital visit – after regularly scheduled hours	210	24,000	1,0	R 251,50	
8140	House/extended care facility/hospital call	210	15,875	1,0	R 166,40	
8190	Consultation – second opinion or advice	210	-	1,0		
	Radiographs/diagnostic imaging					
8107	Intraoral radiograph – periapical	210	7,500	1,0	R 78,60	
8108	Intraoral radiographs – complete series	210	60,187	1,0	R 630,50	
8112	Intraoral radiograph – bitewing	210	7,500	1,0	R 78,60	
8113	Intraoral radiograph – occlusal	210	12,894	1,0	R 135,10	
8114	Extraoral radiograph – hand-wrist	210	-	1,0		
8115	Extraoral radiograph – panoramic	210	30,000	1,0	R 314,40	
8116	Extraoral radiograph – cephalometric	210	30,000	1,0	R 314,40	
8118	Extraoral radiograph – skull/facial bone	210	-	1,0		
8121	Oral and/or facial image (digital/conventional)	210	8,044	1,0	R 84,30	
	Preventive services					
	Note: Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where Item 8159 is applied, Item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under nine years of age.					
8151	Oral hygiene instruction	210	7,850	1,0	R 82,40	
8153	Oral hygiene instruction – each additional visit	210	5,746	1,0	R 60,20	
8155	Polishing – complete dentition	210	9,603	1,0	R 100,60	
8159	Prophylaxis – complete dentition	210	17,491	1,0	R 183,30	
8161	Topical application of fluoride – child	210	9,603	1,0	R 100,60	
8162	Topical application of fluoride – adult	210	9,603	1,0	R 100,60	
8163	Dental sealant	210	7,109	1,0	R 74,60	
	Note: 8163 chargeable once only in respect of a tooth per annum. 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.					

	Extractions during a single visit					
8201	Extraction – tooth or exposed tooth roots (first per quadrant)	210	11,200	1,0	R 117,30	
8202	Extraction – each additional tooth or exposed tooth roots	210	4,324	1,0	R 45,30	
8145	Local anaesthetic – per visit	210	1,700	1,0	R 17,90	
8220	Cost of suture material	210	-	1,0		
8931	Treatment of post-extraction haemorrhage	210	7,304	1,0	R 76,50	
8935	Treatment of septic socket	210	7,304	1,0	R 76,50	
9011	Incision and drainage of abscess – intra-oral (pyogenic)	210	13,790	1,0	R 144,50	
8303	Pulp cap – indirect	210	14,200	1,0	R 148,90	
	Amalgam restorations (including polishing)					
8341	Amalgam – one surface	210	20,491	1,0	R 214,70	
8342	Amalgam – two surfaces	210	25,263	1,0	R 264,70	
8343	Amalgam – three surfaces	210	30,795	1,0	R 322,80	
8344	Amalgam – four or more surfaces	210	34,301	1,0	R 359,30	
	Only one of the above items may be charged per tooth within a year.					
	Resin restorations (using resin bonding technique)					
8351	Resin – one surface, anterior	210	24,795	1,0	R 259,80	
8352	Resin – two surfaces, anterior	210	31,165	1,0	R 326,50	
8367	Resin – one surface, posterior	210	26,880	1,0	R 281,50	
8369	Resin – three surfaces, posterior	210	40,164	1,0	R 420,70	
8370	Resin – four or more surfaces, posterior	210	43,202	1,0	R 452,70	
8368	Resin – two surfaces, posterior	210	33,249	1,0	R 348,40	
8353	Resin – three surfaces, anterior	210	37,242	1,0	R 390,10	
8354	Resin – four or more surfaces, anterior	210	41,566	1,0	R 435,60	
8350	Resin crown – anterior primary tooth (direct)	210	44,683	1,0	R 468,30	
	Note: Only one of the above codes may be charged per tooth within a year.					
	Palliative treatment					
8131	Emergency dental treatment	210	10,000	1,0	R 104,70	
8165	Sedative filling	210	10,000	1,0	R 104,70	
8166	Application of desensitising resin, per tooth	210	6,603	1,0	R 69,20	
8167	Application of desensitising medicament, per visit	210	7,694	1,0	R 80,70	

CONTRACTED EMERGENCY MEDICAL SERVICES

GEMS TARIFF FOR SERVICES RENDERED BY EMERGENCY MEDICAL SERVICES EFFECTIVE FROM 1 JANUARY 2017				
Contracted Network				
	Code	**Description**	**Interhospital Transfer (IHT) 2017 value**	**Primary Response 2017 value**
All services for Emergency Medical Services are subject to pre-authorisation. Please contact the GEMS Emergency Medical Evacuation Dispatch Centre on 0800 444 367.				
Basic life support	100	Up to 45 minutes	R 1 268,69	R 1 456,77
	102	Up to 60 minutes	R 1 690,10	R 1 940,64
	103	Every 15 minutes after	R 422,90	R 485,66
	111	>100 km transfer with patient	R 21,04	R 24,25
	112	>100 km transfer without patient	R 7,44	R 8,69
	104	Call out fee (under 100 km travel to scene)	R 496,13	
	113	Non-patient carrying rate per km up to a maximum of R 1 800	R 7,44	
Intermediate life support	125	Up to 45 minutes	R 1 712,82	R 1966,89
	127	Every 15 minutes after	R 571,04	655,63
	129	>100 km transfer with patient	R 28,48	32,68
	130	>100 km transfer without patient	R 7,44	8,69
	126	Call out fee (under 100 km travel to scene)	R 744,19	
	128	Non-patient carrying rate per km up to a maximum of R 1 800	R 7,44	
Advanced life support/MICU	131	Up to 60 minutes	R 3 012,07	R 3 458,95
	133	Every 15 minutes after	R 753,02	R 864,64
	141	>100 km transfer with patient	R 37,51	R 43,09
	142	>100 km transfer without patient	R 7,44	R 8,69
	151	Resuscitation fee	R 3 362,93	R 3 862,01
	153	Doctor per hour		
	134	Call out fee (under 100 km travel to scene)		
	143	Non-patient carrying rate per km up to a maximum of R 1 800	R 7,44	

Additional tariffs added for 2016 after Scheme and EMS agreement: Aeromedical Transfers*				
Aeromedical transfers	500	Basic call cost (start up)		
Flying time	531	30 minutes		
	533	45 minutes		
	535	60 minutes		
	537	75 minutes		
	539	90 minutes		
	541	105 minutes		
	543	120 minutes		
Staff and consumables	581	30 minutes		
	583	45-75 minutes		
	585	90-105 minutes		
	587	120 minutes		
Aircraft Type D	591	Hourly rate plus 20%		
Winching	595	Winching, per lift		
Staff costs per hour	621	Doctor		
	623	ICU sister		
	625	Paramedic		
Equipment cost	631	Per patient, per hour		

Aircraft cost (per km)	653	Lear 24F		
	655	Lear 35		
	657	Falcon 10		
	659	King Air 200		
	663	Cessna 402		
	665	Beechcraft Baron		
	667	CitationII		
	669	Pilatus PC12		
		Lear 55		
		King Air 300		
		King Air C90		
		Falcon FA20		
		Cessna 520		
		Hawker 125		
		Hawker 400		
		Embraer E 90		
		Conquest II-425		
HEMS cost (per hour)		Bell 222	R 37 340,37	R 37 340,37
		Bell Long Ranger L4	R 28 649,25	R 28 649,25
		Bell Jet Ranger	R 28 649,25	R 28 649,25
		Eurocopter EC 130	R 37 340,37	R 37 340,37
		AgustaWestland AW119	R 37 340,37	R 37 340,37

CONTRACTED MEDICAL PRACTITIONERS CONSULTATIVE SERVICES

GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED MEDICAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017	
Tariff Code	**Description of Tariff Code**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10 cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.
I.c.1.	New and established patient consultation/visit
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit refer to Item 0173-0175 or Item 0109). Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit refer to Item 0173-0175 or Item 0109). Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit refer to Item 0173-0175 or Item 0109). Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.
0193	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). Typically the doctor spends between 46 and 60 minutes with the patient and/or family.
I.c.2.	Hospital consultation/visit
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure).
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure).
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure).
0109	Hospital follow-up visit to patient in ward or nursing facility – refer to general rule G. a. for post-operative care. May only be charged once per day. Not to be used with Items 0111, 0145, 0146, 0147 or ICU Items 1204-1214.
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists. May only be charged once per day. Not to be used with Items 0109 or ICU Items 1204-1214.For a healthy neonate please use Item 0109 for a hospital follow-up visit.
I.c.3.	Hospital discharge day management
0176	Hospital discharge day management, 30 minutes or less

GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED MEDICAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017	
Tariff Code	**Description of Tariff Code**
I.c.4.	Add-on consultative services
0129	Prolonged face-to-face attendance to a patient: ADD to either Item 0192, Item 0175, Item 0164 or Item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes.
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164 or Items 0166-0169, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.
0146	For an unscheduled emergency consultation/visit at the doctor's home or rooms, all hours: ADD only to the consultation/visit Items 0190-0192, Items 0161-0164 or Items 0151-0153, as appropriate (refer to general rule B). Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.
0147	For an emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164, Items 0166-0169 or Items 0151-0153, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.
I.c.5.	Observation care
7050	Initial observation care, per day. Evaluation and management of a patient requires the following three key components a. detailed or comprehensive history b. detailed or comprehensive examination c. straightforward or low complexity medical decision making Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or needs. Usually, the problem(s) requiring admission to observation status are of high severity.
7051	Initial observation care, per day. Evaluation and management of a patient requires the following three components a. comprehensive history b. comprehensive examination c. medical decision making of moderate complexity Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or needs. Usually, the problem(s) requiring admission to observation status are of high severity.
7052	Initial observation care, per day. Evaluation and management of a patient requires the following three components a. comprehensive history b. comprehensive examination c. medical decision making of high complexity Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or needs. Usually, the problem(s) requiring admission to observation status are of high severity.

GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED MEDICAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017	
Tariff Code	**Description of Tariff Code**
I.c.6.	Emergency department
7060	Emergency department visit for the evaluation and management of a patient, which requires these three key components a. expanded problem focused history b. expanded problem focused examination c. straightforward medical decision making Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
7061	Emergency department visit for the evaluation and management of a patient, which requires these three key components a. expanded problem focused history b. expanded problem focused examination c. medical decision making of low complexity Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low or moderate severity.
7062	Emergency department visit for the evaluation and management of a patient, which requires these three key components a. expanded problem focused history b. expanded problem focused examination c. medical decision making of moderate complexity Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
7063	Emergency department visit for the evaluation and management of a patient, which requires these three key components a. a detailed history b. a detailed examination c. medical decision making of moderate complexity Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the medical practitioner but do not pose an immediate significant threat to life or physiologic function.
I.e	Pre-anaesthetic assessment
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes.
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes.
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderately complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes.

GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED MEDICAL PRACTITIONERS EFFECTIVE FROM 1 JANUARY 2017	
Tariff Code	**Description of Tariff Code**
I.f	Prenatal visits and new-born attendance
0107	Newborn attendance: Exclusive attendance to baby at caesarean section, normal delivery or visit in the ward (once per patient). Items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to Item 0107. Item 0107 can be used once only for given confinement.
0113	Newborn attendance: Emergency attendance to newborn at all hours (once per patient). Items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to Item 0113.
I.g	Consultative services: Miscellaneous
0130	Telephone consultation (all hours)
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient – needs not be face-to-face contact. “Consultation” via SMS or electronic media included.
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent.
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent.

CONTRACTED MEDICAL PRACTITIONERS CONSULTATIVE SERVICES

Prac Type		0190	0191	0192	0193	0173	0174	0175	0176
11400	General medical practice	R 343,00	R 343,00	R 343,00	R 343,00	R 343,00	R 343,00	R 343,00	R 475,70
13200	Paediatrics	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00
11600	Obstetrics and gynaecology	R 459,20	R 459,20	R 459,20	R 459,20	R 459,20	R 459,20	R 459,20	R 636,70
11000	Anaesthesiology	R 419,50	R 419,50	R 419,50	R 419,50	R 419,50	R 419,50	R 419,50	R 581,60
11700	Pulmonology	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 919,40
11800	Medicine (specialist physician)	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 919,40
11900	Gastroenterology	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 919,40
12000	Neurology	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 919,40
12100	Cardiology	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 919,40
13100	Rheumatology	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 663,00	R 900,40
Prac Type		0177	0109	0111	0129	0145	0146	0147	0151
11400	General medical practice	R 475,70	R 306,10	R 0,00	R 306,10	R 122,50	R 163,30	R 285,70	R 366,00
13200	Paediatrics	R 663,00	R 392,30	R 573,90	R 392,30	R 157,10	R 209,20	R 366,20	R 0,00
11600	Obstetrics and gynaecology	R 636,70	R 392,30	R 0,00	R 392,30	R 157,10	R 209,20	R 366,20	R 0,00
11000	Anaesthesiology	R 581,60	R 392,30	R 0,00	R 392,30	R 0,00	R 209,40	R 366,20	R 454,00
11700	Pulmonology	R 919,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00
11800	Medicine (specialist physician)	R 919,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00
11900	Gastroenterology	R 919,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00
12000	Neurology	R 919,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00
12100	Cardiology	R 919,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00
13100	Rheumatology	R 900,40	R 392,30	R 0,00	R 392,30	R 157,00	R 209,40	R 366,20	R 0,00

CONTRACTED MEDICAL PRACTITIONERS CONSULTATIVE SERVICES

Prac Type		0152	0153	0107	0113	0130	0132	0133	0199
11400	General medical practice	R 366,00	R 366,00	R 673,40	R 918,30	R 244,90	R 102,10	R 183,50	R 437,50
13200	Paediatrics	R 0,00	R 0,00	R 863,10	R 1177,10	R 459,20	R 130,70	R 235,30	R 523,10
11600	Obstetrics and gynaecology	R 0,00	R 0,00	R 863,10	R 0,00	R 306,00	R 130,70	R 235,30	R 523,10
11000	Anaesthesiology	R 454,00	R 454,00	R 0,00	R 0,00	R 0,00	R 0,00	R 235,30	R 0,00
11700	Pulmonology	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
11800	Medicine (specialist physician)	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
11900	Gastroenterology	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
12000	Neurology	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
12100	Cardiology	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
13100	Rheumatology	R 0,00	R 0,00	R 0,00	R 0,00	R 459,10	R 130,90	R 235,30	R 493,50
Prac Type		7050	7051	7052	7060	7061	7062	7063	7064
11400	General medical practice	R 528,20	R 528,20	R 528,20	R 135,00	R 135,00	R 135,00	R 135,00	R 135,00
13200	Paediatrics	R 648,30	R 648,30	R 648,30	R 209,30	R 209,30	R 209,30	R 209,30	R 209,30
11600	Obstetrics and gynaecology	R 566,60	R 566,60	R 566,60	R 144,90	R 144,90	R 144,90	R 144,90	R 144,90
11000	Anaesthesiology	R 528,60	R 528,60	R 528,60	R 170,60	R 170,60	R 170,60	R 170,60	R 170,60
11700	Pulmonology	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60
11800	Medicine (specialist physician)	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60
11900	Gastroenterology	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60
12000	Neurology	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60
12100	Cardiology	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60
13100	Rheumatology	R 835,40	R 835,40	R 835,40	R 269,60	R 269,60	R 269,60	R 269,60	R 269,60

CONTRACTED MEDICAL PRACTITIONERS

GEMS TARIFF FOR SERVICES BY CONTRACTED MEDICAL PRACTITIONERS, EFFECTIVE FROM 1 JANUARY 2017			Practice Type: Paediatricians Code: 13200				Practice Type: Obstetrics and gynaecology Code: 11600				Practice Type: General medical practice Code: 11400			
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**2017 value**	**Flag**	**CF**	**Units**	**2017 value**	**Flag**	**CF**	**Units**	**2017 value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new Item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.												

	RULES GOVERNING THE STRUCTURE												
A.	**Consultations – definitions** a. New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. b. Subsequent visits: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. c. Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.												
B.	Normal hours and after hours: After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and Items 0146 or 0147 (which should be added to the appropriate consultative services code selected from Items 0190-0192, 0173-0175, 0161-0164, 0166-0169).												

C.	**Comparable services** A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), Item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/ service which will be based on the fee for a comparable service in the coding structure. When Item 6999 is used to indicate that an unlisted service was rendered, the use of the Item must be supported by a special report. This report must include: 1. An adequate definition or description of the nature, extent and need for the procedure/ service or “medical necessity”; 2. In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/ service, time and effort, special/dedicated equipment needed to provide this service, must be included in the report; 3. Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; 4. A description of the complexity of the symptoms and concurrent problems must be supplied; 5. Final diagnosis supported by the appropriate ICD-10 code(s); 6. Pertinent physical findings (size, location and number of lesions if applicable);												

C.	7. Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; 8. Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and 9. Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/ service after which time an application has to be made for the addition of a specific code for this procedure.												
D.	**Cancellation of appointments** Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be.												
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital												
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself												

G.	**Post-operative care** a. Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). b. If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. c. When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. d. Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions.												
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days												
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.												

K.	Practice of specialists: In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists.												
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged												
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion												
N.	“Per consultation”: No additional fee may be charged for a service for which the fee is indicated as “per consultation”. Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention												
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme												

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

Q.	**Intensive care/high care** Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221. but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and X-rays. g. Intravenous treatment (Items 0206 and 0207), except intravenous infusion in patients under the age of three years (Item 0205) that does not form a part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management).												
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. Item 1211: Cardio-respiratory resuscitation)												

S.	Ventilation: Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies. b. Testing and connecting the machine. c. Putting patient on machine: setting machine, synchronising patient with machine. d. Instruction to nursing staff. e. All subsequent visits for 24 hours.												
T.	Ventilation (Items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring.												

U.	**Obstetric procedures** a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than six hours, the general practitioner shall charge 50,00 clinical procedure units according to Item 2614: Global obstetric care. ii. If the patient has been in labour for more than six hours, the general practitioner shall charge 80,00 clinical procedure units according to Item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to Item 2614: Global obstetric care.												

V.	a. Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods												
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used												
Z.	No fee is subject to more than one reduction												
AA.	Procedures to exclude cost of isotope												
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes												
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp.												

EE.	**Ultrasound examinations** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist.												

FF.	a. When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to Item 1949: Cystoscopy, when performed together with any of Items 1951 to 1973.												
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years												
RR.	"The radiology section in this price list is not for use by registered specialist radiology practices (Pr No ""038"") or nuclear medicine practices (Pr No ""025""), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No ""038"") and nuclear medicine practices (Pr No ""025"")."												
XX.	Diagnostic services rendered to hospital inpatients: Quote modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic.												

YY.	Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital).												
	MODIFIERS GOVERNING THE STRUCTURE												
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned Item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere.												
0004	Procedures performed in own procedure rooms: Procedures performed in doctors' own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA's DBT) for a list of procedures, which are often done in rooms to which modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors' own procedure rooms.												

0005	**Multiple therapeutic procedures/ operations under the same anaesthetic** a) Unless otherwise identified in the tariff when multiple therapeutic procedures/ operations add significant time and/or complexity, and when each procedure/ operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/ operation, 75% for the second procedure/ operation, 50% for the third procedure/ operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b) In the case of multiple fractures and/or dislocations the above values shall prevail. c) When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d) Please note: When more than one small procedure is performed and the tariff makes provision for Items for “”subsequent”” or “”maximum for multiple additional procedures”” (see Section 2. Integumentary System) modifier 0005 is not applicable as the fee is already a reduced fee. e) “+” 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)												

0006	Visiting specialists performing procedures: Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote modifier 0006 with the particular Items which they use.												
0007	a) Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – 15,00 clinical procedure units irrespective of the number of Items of equipment provided. b) Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital – 15,00 clinical procedure units irrespective of the number of Items of equipment provided.	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon.												
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units.												

0010	**Local anaesthesic** a. A fee for a local anaesthetic administered by the operator may only be charged for i. an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single Item) or; ii. where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. b. The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. c. Not applicable to radiological procedures (such as angiography and myelography. d. No fee may be levied for topical application of local anaesthetic. e. Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.												
0011	Emergency procedures: Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/ or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. (A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment).												

0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.												
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.												
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.												
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item).	10	7,500	R 196,40		10	7,500	R 196,40		10	7,500	R 153,10	

0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure +50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.												
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.												
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable.												
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.												
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	

0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either modifier 0049: Cases of compound fractures, or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either modifier 0049: Cases of compound fractures or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable).	20	115,500	R 1 871,30		20	115,500	R 1 871,30		20	115,500	R 1 459,90	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0052	Except where otherwise specified, fracture (traumatic or surgical, ie. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixtion/and or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as long bone or pelvis fracture/osteotomy (refer to modifier 0051) for specialist and general practitioners for HAND or FOOT fracture/osteotomy: Add		81,100	R 1 313,60			81,100	R 1 313,60			81,100	R 1 024,70	
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units.	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	

0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to Modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.												
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Units as for the procedure(s) + 100% of the units as for the total revision procedure (the units for modifier 0058 equals 100% of the procedure(s) performed plus appropriate modifiers).												
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.												
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.												
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts.												
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere.												
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee.												

0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (for other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the tariff).												
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.												
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope.	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.												
0073	When Item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%.												
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.												
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the Items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	

0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. Only applicable if services are provided by a specialist in physical medicine.												
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure.												
0079	When a first 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).												
0080	Multiple examinations: Full Fee												
0081	Repeat examinations: No reduction												
0082	“+” means that this Item is complementary to a preceding Item and is therefore not subject to reduction.												
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.												
0084	Film costs: In the case of radiological Items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. This information is obtainable from the Radiological Society of SA.												

0085	Left Side' modifier to be added to when Items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined.												
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of modifier 0080: Multiple examinations.												
0090	Radiologist’s fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or X-ray procedures. Only to be charged if radiologist is hands-on, and not for interpretation of images only.												
0091	Diagnostic services rendered to hospital inpatients: Quote modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX).												
0092	Diagnostic services rendered to outpatients: Quote modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY).												

0095	**Radiation materials** Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, 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												
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope.												
0097	Pathology tests performed by non-pathologists: Where Items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.												
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units.												
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units.	60	6,000	R 92,60		60	6,000	R 92,60		60	6,000	R 72,20	
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: plus 30%.												
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.												

6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.												
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee.												
6103	Post-contrast study: Bone tumour – 100% of the fee												
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable.												
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable Items.												
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.												
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.												

6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”.												
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.												
6110	MRI spectroscopy: 50% of fee												
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for Items 3536-3550 will be allowed (specify time of procedure on account).												
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).												
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).												
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.												
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.												

I.	**Consultative Services (refer to Psychiatrists Consultative Service guide)**												
I.a	General practitioner visits												
I.b	Specialists tiered consultation structure												
I.b.1	New and established patients: Consultations/ visits by psychiatrists (22) only												
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.												
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.												
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.												

0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.												
0166	Psychiatry (22): First hospital consultation/ visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes.												
0167	Psychiatry (22): First 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 and 35 minutes.												
0168	Psychiatry (22): First hospital consultation/ visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes.												
0169	Psychiatry (22): First hospital consultation/ visit 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.												

I.c	General practitioner and specialist services (refer to the Medical Practitioner Consultative Service guide)												
0190	New and established patient: Consultation/ visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit – refer to Item 0173-0175 or Item 0109). Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.												
0191	New and established patient: Consultation/ visit of new or established patient of a moderately above average duration and/ or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Item 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure .												
0192	New and established patient: Consultation/ visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Item 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.												

0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.												
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/ or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.												
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.												
0109	Hospital follow-up visit to patient in ward or nursing facility – refer to general rule G a. for post-operative care). May only be charged once per day – not to be used with Items 0111, 0145, 0146, 0147 or ICU Items 1204-1214.												
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists. May only be charged once per day. Not to be used with Items 0109 or ICU Items 1204-1214. For a healthy neonate please use Item 0109 for a hospital follow-up visit.												

0129	Prolonged face-to-face attendance to a patient: Add to either Item 0192, Item 0175, Item 0164 or Item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes.												
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): Add only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164 or Items 0166-0169, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.												
0146	For an unscheduled emergency consultation/ visit at the doctors' home or rooms, all hours: Add only to the consultation/visit Items 0190-0192, Items 0161-0164 or Items 0151-0153, as appropriate (refer to general rule B). Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.												
0147	For an emergency consultation/visit away from the doctor's home or rooms, all hours: Add only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164, Items 0166-0169 or Items 0151-0153, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.												
I.e	Pre-anaesthetic assessment.												
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes.												

0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes.												
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes.												
I.f	Prenatal visits and newborn attendance												
0107	Newborn attendance: Exclusive attendance to baby at caesarean section, normal delivery or visit in the ward (once per patient). Items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to Item 0107.												
	Item 0107 can be used once only for given confinement.												
0113	Newborn attendance: Emergency attendance to newborn at all hours (once per patient). Items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to Item 0113.												
I.g	Consultative services: Miscellaneous												
0130	Telephone consultation (all hours)												
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact). “Consultation” via SMS or electronic media included.												
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent.												

0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent.												
II.	**Medicine, material, supplies and use of own equipment**												
II.a	Medicine codes												
II.a.1	Dispensing of medicine by licensed dispensing medical practitioners												
0197	Licenced dispensing medical practitioners: Dispensing cost – as per legislated tariff. Add to each NAPPI code to provide for the dispensing cost.												
II.a.2	Once-off administration of medicine used during a consultation												

0198	**Once-off administration of medicines** This Item provides for medicines used at a consultation, viz, once off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS legislated tariff for dispensing fees. Where applicable, VAT should be added to the dispensing fee only and not to the SEP, since the SEP is VAT inclusive. According to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiring preparation for a once-off administration to a patient during a consultation. The appropriate Ethical Medicine NAPPI code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not areference code), should be added applicable to the medicine used. Please note: Refer to Item 0201 for cost of material used in treatment."												
II.a.3	Cost of chemotherapy drugs												
0212	Cost of chemotherapy drugs: This Item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). Where applicable, VAT should be added to the above. The appropriate Ethical Medicine NAPPI code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.												

II.b	Material codes												
II.b.1	Prosthesis and/or internal fixation												
II.b.2	Material used during a consultation												
0201	Cost of material in treatment: This Item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). Where applicable, VAT should be added to the above. The appropriate Surgical and Material NAPPI code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to Item 0198 for once off administration of medicine.												
II.c	Setting of sterile tray												
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to Item 0201, as appropriate.	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
II.d	Own equipment used in treatment												
5930	Surgical laser apparatus: Hire fee for own equipment.	20	109,000	R 1 766,00		20	109,000	R 1 766,00		20	109,000	R 1 377,80	
5932	Candella laser apparatus: Hire fee for own equipment (Rates by arrangement with the scheme concerned).												
III.	**Procedures**												
6999	Unlisted procedure/service: A procedure/ service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use Item 6999.												
	GENERAL MODIFIERS GOVERNING THIS SECTION												

0011	**Emergency procedures** Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.												
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.												
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.												

	MODIFIERS GOVERNING SECTION 1												
0015	Intravenous infusions: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.												
0017	Injections administered by practitioners: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation item).	10	7,500	R 196,40		10	7,500	R 196,40		10	7,500	R 153,10	
1	**General**												
1.1	Injections, infusions and inhalation sedation treatment												
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states – first quarter-hour or part thereof	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
0204	Inhalation sedation: Per additional quarter-hour or part thereof	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in) – patients under three years: Cut-down and/or insertion of cannula – chargeable once per 24 hours	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	

0206	Intravenous treatment: Intravenous infusions (push-in) – patients over three years: Insertion of cannula – chargeable once per 24 hours	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
0207	Intravenous treatment: Intravenous infusions (cut-down) – patients over three years: Cut-down and insertion of cannula – chargeable once per 24 hours	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
0208	Venesection: Therapeutic venesection. Not to be used when blood is drawn for the purpose of laboratory investigations.	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
0209	Umbilical artery cannulation at birth	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	20	3,250	R 52,70		20	3,250	R 52,70		20	3,250	R 41,10	
0211	Exchange transfusion: First and subsequent (including after-care)	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
	Note: How to charge for intravenous infusions Practitioners are entitled to charge according to the appropriate Item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to Item 0205).												
1.2	Chemotherapy treatment (not in chemotherapy facilities)												
0213	Treatment with cytostatic agents Administering of chemotherapy: Intramuscular or subcutaneous, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	

0214	Intravenous treatment with cytostatic agents Administering of chemotherapy: Intravenous bolus technique, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
0215	Intravenous treatment with cytostatic agents Administering of chemotherapy: Intravenous infusion technique, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
1.3	Oncology related services in non-oncology facilties												
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic. The cost of materials is not included.	20	394,860	R 6 396,90	Z	20	394,860	R 6 396,90	Z	20	315,890	R 3 992,70	Z
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy. The cost of materials is not included.	20	262,410	R 4 251,10	Z	20	262,410	R 4 251,10	Z	20	209,930	R 2 653,40	Z
5782	Isotope Therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure. The cost of materials is not included.	20	77,810	R 1 260,60	Z	20	77,810	R 1 260,60	Z	20	77,810	R 983,50	Z
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately).	20	42,650	R 691,00	Z	20	42,650	R 691,00	Z	20	42,650	R 539,10	Z

	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS												
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.												
0021	**Determination of anaesthetic fees** Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the "Anaesthetic Performed" column) plus the time units (calculated according to the formula in modifier 0023) and the appropriate modifers (see modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by modifiers 5441 to 5448.												

0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/ anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by “T”) will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one hour the number of units shall, after one hour, be 3,00 anaesthetic units per 15 minute period or part thereof.												
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/ anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit Item should be charged.												

0025	**Calculation of anaesthetic time** Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.												
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units.												
0028	Indicator for use of low flow anaesthetic technique less than 1 litre/minute: Fresh gas flow of less than 1 litre/minute.												
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic.												
0030	Indicator for use of low flow anaesthetic technique 1-2 litres/minute: Fresh gas flow of 1 to 2 litres/minute.												

0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.												
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.												
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.												
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.												
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).												

0036	**Anaesthetic administered by general practitioners** The units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time – refer to modifier 0023 – plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/ anaesthetist.												
0037	Body hypothermia: Utilisation of total body hypothermia – add 3,00 anaesthetic units												
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage.												
0039	Control of blood pressure: Deliberate control of the blood pressure – all cases up to one hour, add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof.												
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units.												

0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation – add 3,00 anaesthetic units												
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation – add 3,00 anaesthetic units												
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added												
0044	Neonates (i.e up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to modifier 0043: Cases under one year of age.												
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable.												
	Modifiers 5441 to 5448 Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. The letter “M” is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items.												
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in modifiers 5442 to 5448.												
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units												
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units												

5444	Shaft of femur: Add four (4,00) anaesthetic units												
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units												
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units.												
	Post-operative alleviation of pain												
0045	a. When a regional or nerve block procedure is performed, the appropriate procedure Item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique b. When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. c. None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug)												
2	**Integumentary system**												
2.1	Allergy												
0217	Allergy: Patch tests, first patch	20	4,000	R 64,80		20	4,000	R 64,80		20	4,000	R 50,60	
0218	Allergy: Skin-prick tests – skin-prick testing: Insect venom, latex and drugs	20	2,800	R 45,50		20	2,800	R 45,50		20	2,800	R 35,50	
0219	Allergy: Patch tests, each additional patch	20	2,000	R 32,60		20	2,000	R 32,60		20	2,000	R 25,40	
0220	Allergy: Skin-prick tests – immediate hypersensitivity testing (Type I reaction). Per antigen: Inhalant and food allergens	20	1,900	R 30,80		20	1,900	R 30,80		20	1,900	R 23,90	

0221	Allergy: Skin-prick tests – delayed hypersensitivity testing (Type IV reaction), per antigen	20	2,800	R 45,50		20	2,800	R 45,50		20	2,800	R 35,50	
2.2	**Skin (general)**												
0222	Intralesional injection into areas of pathology e.g. Keloid, single	20	4,000	R 64,80		20	4,000	R 64,80		20	4,000	R 50,60	
0223	Intralesional injection into areas of pathology e.g. Keloids, multiple	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
0225	Epilation: Per session	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session.	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
0228	PUVA Treatment: Maximum of 21 treatments	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0229	PUVA: Follow-up or maintenance therapy once a week	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0230	UVR-Treatment	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0231	UVR-Follow-up – for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp.	20	5,500	R 89,10		20	5,500	R 89,10		20	5,500	R 69,70	
232	Biopsy of superficial soft tissue: Back or flank		47,400	R 767,80			47,400	R 767,80			47,400	R 598,80	
0233	Biopsy without suturing: First lesion	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
0234	Biopsy without suturing: Subsequent lesions (each)	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
0235	Biopsy without suturing: Maximum for multiple additional lesions	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
236	Biopsy of superficial soft tissue: Shoulder area		49,100	R 795,30			49,100	R 795,30			49,100	R 620,30	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
238	Biopsy of superficial soft tissue: Upper arm or elbow area		49,100	R 795,30			49,100	R 795,30			49,100	R 620,30	

239	Biopsy of superficial soft tissue: Forearm and/ or wrist		48,500	R 785,50			48,500	R 785,50			48,500	R 612,80	
240	Biopsy of superficial soft tissue: Leg or ankle area		48,300	R 782,40			48,300	R 782,40			48,300	R 610,30	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First Lesion	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
0244	Repair of nail bed	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
247	Biopsy of superficial soft tissue: Pelvis and hip area		58,300	R 944,30			58,300	R 944,30			58,300	R 736,60	
248	Biopsy of superficial soft tissue: Thigh or knee area		52,300	R 847,10			52,300	R 847,10			52,300	R 660,80	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	

0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	20	87,000	R 1 409,40		20	87,000	R 1 409,40		20	87,000	R 1 099,70	
0259	Removal of foreign body superficial to deep fascia (except hands)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0261	Removal of foreign body deep to deep fascia (except hands)	20	31,000	R 502,30		20	31,000	R 502,30		20	31,000	R 391,90	
262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax; less than 3 cm		90,100	R 1 459,40			90,100	R 1 459,40			90,100	R 1 138,40	
263	Excision tumour of subcutaneous soft tissue: Shoulder area; less than 3 cm		84,200	R 1 363,80			84,200	R 1 363,80			84,200	R 1 063,90	
264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area; less than 3 cm		94,500	R 1 530,70			94,500	R 1 530,70			94,500	R 1 194,00	
265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area; less than 3 cm		94,700	R 1 533,90			94,700	R 1 533,90			94,700	R 1 196,50	
266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger, less than 1.5 cm		99,300	R 1 608,40			99,300	R 1 608,40			99,300	R 1 254,60	
267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area, less than 3 cm		111,600	R 1 807,70			111,600	R 1 807,70			111,600	R 1 409,90	
268	Excision tumour of subcutaneous soft tissue: Thigh or knee area, less than 3 cm		92,100	R 1 491,80			92,100	R 1 491,80			92,100	R 1 163,70	
269	Excision tumour of subcutaneous soft tissue: Leg or ankle area, less than 3 cm		92,600	R 1 499,80			92,600	R 1 499,80			92,600	R 1 170,00	
270	Excision tumour of subcutaneous soft tissue: Foot or toe, less than 1.5 cm		78,300	R 1 268,20			78,300	R 1 268,20			78,300	R 989,30	
0271	Kurtin planing for acne scarring: Whole face	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0273	Kurtin planing for acne scarring: Extensive	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	

274	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue) – first stage, up to five tissue blocks		113,900	R 1 845,00			113,900	R 1 845,00			113,900	R 1 439,10	
0275	Kurtin planing for acne scarring: Limited	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue) – each additional stage after the first stage, up to five tissue blocks.		60,500	R 979,90			60,500	R 979,90			60,500	R 764,50	
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	20	103,000	R 1 668,60		20	103,000	R 1 668,60		20	103,000	R 1 301,70	
278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue) – each additional block after the first five tissue blocks, any stage		15,900	R 257,60			15,900	R 257,60			15,900	R 201,00	
0279	Surgical treatment for axillary hyperhidrosis	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0280	Laser treatment for small skin lesions: First lesion	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	20	56,000	R 907,40		20	56,000	R 907,40		20	56,000	R 707,80	
0283	Laser treatment for large skin lesions: Limited area	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

0284	Laser treatment for large skin lesions: Extensive area	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	20	56,630	R 917,40	Z	20	56,630	R 917,40	Z	20	56,630	R 715,80	Z
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	20	43,440	R 703,70	Z	20	43,440	R 703,70	Z	20	43,440	R 549,20	Z
2.3	Major plastic repair												
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	20	234,000	R 3 790,80		20	234,000	R 3 790,80		20	187,200	R 2 366,20	
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	20	410,000	R 6 642,20		20	410,000	R 6 642,20		20	328,000	R 4 145,70	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	20	800,000	R 12 960,70		20	800,000	R 12 960,70		20	640,000	R 8 089,10	
0292	Distant flaps: First stage	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0293	Contour grafts (excluding cost of material)	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	20	1200,000	R 19 440,80		20	1200,000	R 19 440,80		20	960,000	R 12 134,00	
0295	Local skin flaps (large, complicated)	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0296	Other procedures of major technical nature	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0297	Subsequent major procedures for repair of same lesion	20	104,000	R 1 684,80		20	104,000	R 1 684,80		20	104,000	R 1 314,50	
0298	Lower abdominal dermo-lipectomy	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
0299	Major abdominal lipectomy with repositioning of umbilicus	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	

2.4	Lacerations, scars, tumours, cysts and other skin lesions												
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0304	Major debridement of wound, sloughectomy or secondary suture	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
0305	Needle biopsy – soft tissue	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
0308	Each additional small procedure done at the same time	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0310	Radical excision of nailbed	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	
0311	Excision of large benign tumour (more than 5 cm)	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
0313	Extensive resection for malignant soft tissue tumour including muscle	20	283,900	R 4 599,40		20	283,900	R 4 599,40		20	227,120	R 2 870,60	
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	20	104,000	R 1 684,80		20	104,000	R 1 684,80		20	104,000	R 1 314,50	
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		13,900	R 225,20			13,900	R 225,20			13,900	R 175,70	

4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; add for every additional 20 square cm or part thereof		5,300	R 85,90			5,300	R 85,90			5,300	R 66,90	
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		36,000	R 583,10			36,000	R 583,10			36,000	R 454,90	
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; add for every additional 20 square cm or part thereof		11,200	R 181,30			11,200	R 181,30			11,200	R 141,40	
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		62,500	R 1 012,40			62,500	R 1 012,40			62,500	R 789,70	
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; add for every additional 20 square cm or part thereof		19,500	R 315,80			19,500	R 315,80			19,500	R 246,30	
4880	Biopsy soft tissue: Neck or thorax		46,400	R 751,60			46,400	R 751,60			46,400	R 586,30	
4881	Biopsy of soft tissue: Deep, back or flank		100,400	R 1 626,20			100,400	R 1 626,20			100,400	R 1 268,50	
4882	Biopsy of soft tissue: Deep, shoulder area		117,600	R 1 904,80			117,600	R 1 904,80			117,600	R 1 485,90	
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular): Upper arm or elbow area		117,600	R 1 904,80			117,600	R 1 904,80			117,600	R 1 485,90	
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular), forearm and/or wrist		106,600	R 1 726,70			106,600	R 1 726,70			106,600	R 1 346,80	
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular), thigh or knee area		112,900	R 1 828,70			112,900	R 1 828,70			112,900	R 1 426,40	
4886	Biopsy of soft tissue: Deep (subfascial or intramuscular), leg or ankle area		119,500	R 1 935,70			119,500	R 1 935,70			119,500	R 1 509,80	
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular), pelvis and hip area		197,700	R 3 202,20			197,700	R 3 202,20			197,700	R 2 497,80	
2.5	Breasts												
0316	Fine needle aspiration for soft tissue (all areas)	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
0317	Aspiration of cyst or tumour	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	

0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	20	94,200	R 1 526,00		20	94,200	R 1 526,00		20	94,200	R 1 190,50	
0323	Subareolar cone excision of ducts of wedge excision of breast	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
0324	Wedge excision of breast and axillary dissection	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
0325	Total mastectomy	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
0327	Total mastectomy with axillary gland biopsy	20	185,000	R 2 997,10		20	185,000	R 2 997,10		20	148,000	R 1 870,70	
0329	Total mastectomy with axillary gland dissection	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	
0330	Nipple and areola reconstruction	20	95,000	R 1 539,10		20	95,000	R 1 539,10		20	95,000	R 1 200,80	
0331	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Unilateral	20	234,000	R 3 790,80		20	234,000	R 3 790,80		20	187,200	R 2 366,20	
0333	Subcutaneous mastectomy for disease of breast; including reconstruction but excluding cost of prosthesis: Bilateral	20	410,000	R 6 642,20		20	410,000	R 6 642,20		20	328,000	R 4 145,70	
0334	Removal of breast implant by means of capsulectomy: Per breast	20	234,000	R 3 790,80		20	234,000	R 3 790,80		20	187,200	R 2 366,20	
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
0337	Reduction: Mammoplasty for pathological hypertrophy: Unilateral	20	234,000	R 3 790,80		20	234,000	R 3 790,80		20	187,200	R 2 366,20	
0339	Reduction: Mammoplasty for pathological hypertrophy: Bilateral	20	410,000	R 6 642,20		20	410,000	R 6 642,20		20	328,000	R 4 145,70	
0341	Gynaecomastia: Unilateral	20	92,000	R 1 490,60		20	92,000	R 1 490,60		20	92,000	R 1 162,90	
0343	Gynaecomastia: Bilateral	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2.6	Burns												
0351	Major Burns: Resuscitation (including supervision and intravenous therapy – first 48 hours)	20	276,000	R 4 471,30		20	276,000	R 4 471,30		20	220,800	R 2 790,90	

0353	Tangential excision and grafting: Small	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
0354	Tangential excision and grafting: Large	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2.7	Hands (skin)												
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	20	147,400	R 2 387,90		20	147,400	R 2 387,90		20	120,000	R 1 516,60	
0357	Small skin graft in acute hand injury	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
0359	Release of extensive skin contracture and/ or excision of scar tissue with major skin graft resurfacing	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0361	Z-plasty	20	220,100	R 3 565,80		20	220,100	R 3 565,80		20	176,080	R 2 225,50	
0363	Local flap and skin graft	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
0365	Cross finger flap (all stages)	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0367	Palmar flap (all stages)	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0369	Distant flap: First stage	20	158,000	R 2 559,70		20	158,000	R 2 559,70		20	126,400	R 1 597,60	
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0373	Transfer neurovascular island flap	20	230,500	R 3 734,20		20	230,500	R 3 734,20		20	184,400	R 2 330,70	
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	20	242,400	R 3 927,00		20	242,400	R 3 927,00		20	193,920	R 2 451,00	
0375	Dupuytren's contracture: Fasciotomy	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0376	Dupuytren's contracture: Fasciectomy	20	218,000	R 3 531,70		20	218,000	R 3 531,70		20	174,400	R 2 204,30	
2.8	Acupuncture												
	Please note: General Rule M not applicable to section 2.8 of this price list												
0377	Standard acupuncture	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
0378	Laser acupuncture using more than six points	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0379	Electro-acupuncture	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0380	Scalp acupuncture	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	

0381	Micro-acupuncture (ear, hand)	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
	RULES GOVERNING THE SECTION ACUPUNCTURE												
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp												
3	**Musculo-skeletal system**												
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS												
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.												
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	

0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either modifier 0049: Cases of compound fractures, or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either modifier 0049: Cases of compound fractures or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable)	20	115,500	R 1 871,30		20	115,500	R 1 871,30		20	115,500	R 1 459,90	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units.	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.												

0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Per fee for total joint replacement + 100%												
3.1	Bones												
3.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047)												
0383	Fracture (reduction under general anaesthetic): Scapula	20	-									R 1 418,10	v
0384	Fracture: Scapula, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		284,20	R 4 603,30			284,20	R 4 603,30			227,36	R 2 872,60	
0386	Fracture: Clavicle, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		209,400	R 3 391,70			209,400	R 3 391,70			67,520	R 853,10	
0387	Fracture (reduction under general anaesthetic): Clavicle	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0388	Percutaneous pinning of supracondylar fracture: Elbow – stand alone procedure	20	175,700	R 2 846,30		20	175,700	R 2 846,30		20	140,560	R 1 776,70	
0389	Fracture (reduction under general anaesthetic): Humerus	20	111,600	R 1 808,00		20	111,600	R 1 808,00		20	111,600	R 1 410,60	
0390	Fracture: Humerus, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		255,300	R 4 135,20			255,300	R 4 135,20			204,240	R 2 580,50	
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
0401	Fracture: Carpal bone, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		208,700	R 3 380,50			208,700	R 3 380,50			166,960	R 2 109,50	
0402	Fracture (reduction under general anaesthetic): Carpal bone	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	

0404	Fracture: Bennett fracture/dislocation, open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)		179,800	R 2 912,30			179,800	R 2 912,30			143,840	R 1 817,30	
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal, simple	20	118,300	R 1 916,40		20	118,300	R 1 916,40		20	118,300	R 1 495,10	
0406	Fracture: Metacarpal bone, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		163,600	R 2 650,00			163,600	R 2 650,00			130,880	R 1 653,60	
0409	Fracture (reduction under general anaesthetic): Finger phalanx – distal, simple	20	-									R 972,40	ß
0410	Fracture: Finger phalanx, distal, simple – open reduction and internal fixation (modifiers 0051, 0052 not applicable		141,100	R 2 285,30			141,100	R 2 285,30			120,000	R 1 516,20	
0411	Fracture (reduction under general anaesthetic): Finger phalanx – distal, compound	20	52,000	R 842,30		20	52,000	R 842,30		20	52,000	R 657,20	
0413	Fracture (reduction under general anaesthetic): Proximal or middle, simple	20	48,000	R 777,60		20	48,000	R 777,60		20	48,000	R 606,70	
0414	Fracture: Finger phalanx, proximal or middle – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		169,900	R 2 751,90			169,900	R 2 751,90			135,920	R 1 717,40	
0415	Fracture (reduction under general anaesthetic): Proximal or middle – compound	20	102,000	R 1 652,40		20	102,000	R 1 652,40		20	102,000	R 1 289,20	
0417	Fracture (reduction under general anaesthetic): Pelvis fracture, closed	20	-									R 1 515,40	ß
0419	Fracture (reduction under general anaesthetic): Pelvis, operative reduction and fixation	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0420	Fracture: Acetabulum – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		560,000	R 9 070,60			560,000	R 9 070,60			448,000	R 5 660,20	
0421	Fracture (reduction under general anaesthetic): Femur, neck or shaft	20	237,000	R 3 839,40		20	237,000	R 3 839,40		20	189,600	R 2 396,30	

0422	Fracture: Femur neck or shaft – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		392,300	R 6 354,30			392,300	R 6 354,30			313,840	R 3 965,20	
0425	Fracture (reduction under general anaesthetic): Patella	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0426	Fracture: Patella – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		219,500	R 3 555,30			219,500	R 3 555,30			175,600	R 2 218,80	
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0430	Fracture: Tibia, with or without fibula – open reduction and internal fixation (modifiers 0051, 0052 not applicable		293,200	R 4 749,20			293,200	R 4 749,20			234,560	R 2 963,50	
0433	Fracture (reduction under general anaesthetic): Fibula shaft	20	-									R 1 419,50	ß
0434	Fracture: Fibula shaft – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207,000	R 3 352,90			207,000	R 3 352,90			165,680	R 2 093,30	
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
0436	Fracture: Ankle malleolus: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207,100	R 3 354,40			207,100	R 3 354,40			165,680	R 2 093,30	
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	20	198,700	R 3 219,10		20	198,700	R 3 219,10		20	158,960	R 2 009,30	
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	20	403,500	R 6 537,00		20	403,500	R 6 537,00		20	322,500	R 4 076,30	
0441	Fracture (reduction under general anaesthetic): Metatarsal	20	41,800	R 677,10		20	41,800	R 677,10		20	41,800	R 528,30	

0442	Fracture: Metatarsal bones – open reduction with internal fixation (modifiers 0051, 0052 not applicable)		154,700	R 2 505,60			154,700	R 2 505,60			123,760	R 1 563,70	
0443	Fracture (reduction under general anaesthetic): Toe phalanx – distal simple	20	-										ß
0444	Fracture: Toe phalanx, distal – open reduction with internal fixation (modifiers 0051, 0052 not applicable)		144,500	R 2 340,70			144,500	R 2 340,70			120,000	R 1 516,20	
0445	Fracture (reduction under general anaesthetic): Toe phalanx, compound	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0446	Fracture: Tarsal bones (excluding talus and calcaneus) – open reduction with internal fixation (modifiers 0051, 0052 not applicable)		178,200	R 2 886,50			178,200	R 2 886,50			142,560	R 1 801,10	
0447	Fracture (reduction under general anaesthetic): Other, simple	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
0448	Fracture: Calcaneus (reduction under general anaesthetic)		103,300	R 1 673,20			103,300	R 1 673,20			103,300	R 1 305,20	
0449	Fracture (reduction under general anaesthetic): Other, compound	20	52,000	R 842,30		20	52,000	R 842,30		20	52,000	R 657,20	
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs, closed	20	-										ß
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs: Open reduction and fixation of multiple fractured ribs for flail chest	20	230,000	R 3 726,10		20	230,000	R 3 726,10		20	184,000	R 2 325,60	
0455	Fracture (reduction under general anaesthetic): Spine, with or without paralysis – cervical	20	-										ß
0461	Fracture (reduction under general anaesthetic): Compression fracture – cervical	20	-										v
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes – cervical	20	-										v
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes –rest	20	-										v

3.1.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047: Operations for fractures)												
0465	Fractures involving large joints (includes the Item for the relative bone) – this item may not be used as a modifier	20	288,000	R 4 665,60		20	288,000	R 4 665,60		20	230,400	R 2 912,10	
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		210,900	R 3 416,10			210,900	R 3 416,10			168,720	R 2 131,60	
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) – modifier 0005 not applicable	20	43,000	R 696,90		20	43,000	R 696,90		20	43,000	R 543,70	
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, tibia, humerus, radius and ulna	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	20	154,000	R 2 495,00		20	154,000	R 2 495,00		20	123,200	R 1 557,20	
480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		415,000	R 6 722,00			415,000	R 6 722,00			332,000	R 4 194,60	
481	Radical resection of bone tumour: Fibula		240,100	R 3 889,10			240,100	R 3 889,10			192,080	R 2 426,90	
482	Radical resection of bone tumour: Femur or knee		371,800	R 6 022,20			371,800	R 6 022,20			297,440	R 3 758,10	
483	Radical resection of malignant bone tumour: Scapula		237,700	R 3 850,10			237,700	R 3 850,10			190,160	R 2 402,60	
484	Radical resection of bone tumour: Clavicle		413,800	R 6 702,60			413,800	R 6 702,60			331,040	R 4 182,60	
485	Radical resection of bone tumour: Metatarsal		185,000	R 2 996,50			185,000	R 2 996,50			148,000	R 1 869,90	
3.1.2.1	Bony operations: Bone grafting												
0497	Resection of bone or tumour with or without grafting (benign)	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	
0498	Resection of bone or tumour with or without grafting (malignant) – does not include digits	20	340,000	R 5 508,20		20	340,000	R 5 508,20		20	272,000	R 3 438,00	
0499	Grafts to cysts: Large bones	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	

0501	Grafts to cysts: Small bones	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0503	Grafts to cysts: Cartilage graft	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0505	Grafts to cysts: Inter-metacarpal bone graft	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
3.1.2.2	Bony operations: Acute or chronic osteomyelitis												
0509	Acute or chronic osteomyelitis: Conservative treatment	20	-										v
0511	Acute or chronic osteomyelitis: Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care												
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage – including six weeks after-care	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
3.1.2.3	Bony operations: Osteotomy												
0514	Osteotomy: Sternum: Repair of pectus excavatum	20	330,000	R 5 346,30		20	330,000	R 5 346,30		20	264,000	R 3 336,90	
0515	Osteotomy: Sternum: Repair of pectus carinatum	20	330,000	R 5 346,30		20	330,000	R 5 346,30		20	264,000	R 3 336,90	
0516	Osteotomy: Pelvic	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0521	Osteotomy: Femoral – proximal	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0527	Osteotomy: Knee region	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0528	Osteotomy: Os Calcis (Dwyer operation)	20	115,000	R 1 863,10		20	115,000	R 1 863,10		20	115,000	R 1 453,60	
0530	Osteotomy: Metacarpal and phalanx – corrective for malunion or rotation	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
0531	Rotational osteotomy of tibia and fibula – stand alone procedure	20	278,900	R 4 518,40		20	278,900	R 4 518,40		20	223,120	R 2 820,10	
0532	Osteotomy: Rotation osteotomy of the radius, ulna or humerus	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0533	Osteotomy: Single metatarsal	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	

0534	Osteotomy: Multiple metatarsal osteotomies	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
3.1.2.4	Bony operations: Exostosis												
0535	Exostosis: Excision – readily accessible sites	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
0537	Exostosis: Excision – less accessible sites	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
3.1.2.5	Bony operations: Biopsy												
0539	Needle Biopsy: Spine (no after-care) – modifier 0005 not applicable	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
0541	Needle Biopsy: Other sites (no after-care) – modifier 0005 not applicable	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0543	Biopsy: Open (modifier 0005 not applicable) – readily accessible site	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0545	Biopsy: Open (modifier 0005 not applicable) – less accessible site	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
3.2	Joints												
3.2.1	Joints: Dislocations												
0547	Joint: Dislocation, clavicle either end	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	
0551	Joint: Dislocation, elbow	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0552	Joint: Dislocation, wrist	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0553	Joint: Dislocation, perilunar trans-scaphoid fracture dislocation	20	130,000	R 2 106,00		20	130,000	R 2 106,00		20	120,000	R 1 516,60	
0555	Joint: Dislocation, lunate	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0556	Joint: Dislocation, carpo-metacarpo dislocation	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0557	Joint: Dislocation, metacarpo-phalangeal or interphalangeal (hand)	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
0559	Joint: Dislocation, hip	20	109,000	R 1 766,00		20	109,000	R 1 766,00		20	109,000	R 1 377,80	
0561	Joint: Dislocation, knee	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0563	Joint: Dislocation, patella	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0565	Joint: Dislocation, ankle	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
0567	Joint: Dislocation, sub-talar dislocation	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	

0569	Joint: Dislocation – intertarsal or tarsometatarsal or mid-tarsal	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0571	Joint: Dislocation – meta-tarsophalangeal or interphalangeal joints (foot)	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0573	Joint: Dislocation – spine with or without paralysis	20	-										v
3.2.2	Joints: Operations for dislocations												
0578	Operations for dislocations: Recurrent dislocation of shoulder	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
0579	Operations for dislocations: Recurrent dislocation of all other joints	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
3.2.3	Joints: Capsular operations												
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0585	Capsulectomy digital joint	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
0587	Release of digital joint contracture	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
3.2.4	Joints: Synovectomy												
0589	Synovectomy: Digital joint	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0592	Synovectomy: Large joint	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0593	Tendon synovectomy	20	203,700	R 3 300,00		20	203,700	R 3 300,00		20	162,960	R 2 059,90	
3.2.5	Joints: Arthrodesis												
0597	Arthrodesis: Shoulder	20	224,000	R 3 629,00		20	224,000	R 3 629,00		20	179,200	R 2 265,00	
0598	Arthrodesis: Elbow	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
0599	Arthrodesis: Wrist	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
0600	Arthrodesis: Digital joint	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	

0601	Arthrodesis: Hip	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0602	Arthrodesis: Knee	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
0603	Arthrodesis: Ankle	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
0604	Arthrodesis: Sub-talar	20	130,000	R 2 106,00		20	130,000	R 2 106,00		20	120,000	R 1 516,60	
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
0607	Arthrodesis: Mid-tarsal wedge resection	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
3.2.6	Joints: Arthroplasty												
0614	Arthroplasty: Debridement large joints	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0615	Arthroplasty: Excision medial or lateral end of clavicle	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
0617	Shoulder: Acromioplasty	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0619	Shoulder: Partial replacement	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
0620	Shoulder: Total replacement	20	416,000	R 6 739,40		20	416,000	R 6 739,40		20	332,800	R 4 206,50	
0621	Elbow: Excision head of radius	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0622	Elbow: Excision	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0623	Elbow: Partial replacement	20	188,000	R 3 045,70		20	188,000	R 3 045,70		20	150,400	R 1 900,90	
0624	Elbow: Total replacement	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	
0625	Wrist: Excision distal end of ulna	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0626	Wrist: Excision single bone	20	110,000	R 1 782,10		20	110,000	R 1 782,10		20	110,000	R 1 390,30	
0627	Wrist: Excision proximal row	20	166,000	R 2 689,50		20	166,000	R 2 689,50		20	132,800	R 1 678,60	
0631	Wrist: Total replacement	20	249,000	R 4 033,90		20	249,000	R 4 033,90		20	199,200	R 2 517,90	
0635	Digital joint: Total replacement	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0637	Hip: Total replacement	20	416,000	R 6 739,40		20	416,000	R 6 739,40		20	332,800	R 4 206,50	
0641	Hip: Prosthetic replacement of femoral head	20	288,000	R 4 665,60		20	288,000	R 4 665,60		20	230,400	R 2 912,10	
0643	Hip: Girdlestone	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0645	Knee: Partial replacement	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
0646	Knee: Total replacement	20	416,000	R 6 739,40		20	416,000	R 6 739,40		20	332,800	R 4 206,50	

0649	Ankle: Total replacement	20	290,400	R 4 704,70		20	290,400	R 4 704,70		20	232,320	R 2 936,30	
0650	Ankle: Astragalectomy	20	154,000	R 2 495,00		20	154,000	R 2 495,00		20	123,200	R 1 557,20	
3.2.7	Joints: Miscellaneous (joints)												
0661	Aspiration of joint or intra-articular injection (not including after-care) – modifier 0005 not applicable	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
0663	Multiple intra-articular injections for rheumatoid arthritis, excluding after-care (modifier 0005 not applicable): First joint	20	7,500	R 121,50		20	7,500	R 121,50		20	7,500	R 94,80	
0665	Multiple intra-articular injections for rheumatoid arthritis, excluding after-care (modifier 0005 not applicable): Additional (each)	20	4,000	R 64,80		20	4,000	R 64,80		20	4,000	R 50,60	
0667	Arthroscopy, excluding after-care (modifiers 0005 and 0013 not applicable)	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
0669	Manipulation knee or shoulder joint under general anaesthetic, not including after-care (modifier 0005 not applicable)	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0669A	Manipulation hip joint under general anaesthetic, not including after-care (modifier 0005 not applicable)	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
	Only the consultation fee should be charged when manipulation of a large joint is performed without general anaesthetic												
0673	Meniscectomy or operation for other internal derangement of knee	20	109,000	R 1 766,00		20	109,000	R 1 766,00		20	109,000	R 1 377,80	
3.2.8	Joints: Joint ligament reconstruction or suture												
0675	Joint ligament reconstruction or suture: Ankle, collateral	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0677	Joint ligament reconstruction or suture: Knee, collateral	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0678	Joint ligament reconstruction or suture: Knee, cruciate	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	

0680	Joint ligament reconstruction or suture: Digital joint ligament	20	165,000	R 2 673,00		20	165,000	R 2 673,00		20	132,000	R 1 668,50	
3.3	Amputations												
3.3.1	Amputations: Specific Amputations												
681	Amputation Humerus: Includes primary closure		211,600	R 3 427,40			211,600	R 3 427,40			169,280	R 2 138,90	
0682	Amputation: Fore-quarter amputation	20	294,000	R 4 763,00		20	294,000	R 4 763,00		20	235,200	R 2 972,70	
0683	Amputation: Through shoulder	20	148,000	R 2 397,70		20	148,000	R 2 397,70		20	120,000	R 1 516,60	
684	Amputation: Forearm		213,500	R 3 458,10			213,500	R 3 458,10			170,480	R 2 154,00	
0685	Amputation: Upper arm or fore-arm	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
686	Amputation: Ankle (e.g. Syme, Pirogoff type)		204,100	R 3 305,80			204,100	R 3 305,80			163,280	R 2 062,90	
0687	Partial amputation of the hand: One ray	20	102,000	R 1 652,40		20	102,000	R 1 652,40		20	102,000	R 1 289,20	
688	Amputation: Foot, midtarsal (Chopart type)		165,700	R 2 683,90			165,700	R 2 683,90			132,000	R 1 667,70	
0691	Amputation: Whole or part of finger	20	116,800	R 1 892,30		20	116,800	R 1 892,30		20	116,800	R 1 476,30	
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		150,700	R 2 440,90			150,700	R 2 440,90			120,560	R 1 523,10	
0693	Hindquarter amputation	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		173,900	R 2 816,70			173,900	R 2 816,70			139,120	R 1 757,70	
0695	Amputation: Through hip joint region	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0696	Re-amputation: Thigh, through femur, any level		217,300	R 3 519,70			217,300	R 3 519,70			173,840	R 2 196,30	
0697	Amputation: Through thigh	20	205,000	R 3 321,00		20	205,000	R 3 321,00		20	164,000	R 2 072,80	
0698	Re-amputation: Leg, through tibia and fibula		198,200	R 3 210,40			198,200	R 3 210,40			158,560	R 2 003,40	
0699	Amputation: Below knee, through knee or Syme	20	194,000	R 3 143,30		20	194,000	R 3 143,30		20	155,200	R 1 961,60	
700	Scar revision/secondary closure: Amputated shoulder		128,100	R 2 074,90			128,100	R 2 074,90			120,000	R 1 516,20	
0701	Amputation: Trans-metatarsal or trans-tarsal	20	142,000	R 2 300,40		20	142,000	R 2 300,40		20	120,000	R 1 516,60	

702	Scar revision/secondary closure: Amputated humerus		163,100	R 2 641,80			163,100	R 2 641,80			130,480	R 1 648,60	
0703	Amputation: Foot – one ray	20	97,000	R 1 571,60		20	97,000	R 1 571,60		20	97,000	R 1 226,20	
704	Scar revision/secondary closure: Amputated forearm		184,100	R 2 981,90			184,100	R 2 981,90			147,280	R 1 860,80	
0705	Amputation: Toe	20	66,000	R 1 069,20		20	66,000	R 1 069,20		20	66,000	R 834,10	
708	Re-amputation: Humerus		223,100	R 3 613,70			223,100	R 3 613,70			178,480	R 2 255,00	
710	Re-amputation: Through forearm		206,000	R 3 336,70			206,000	R 3 336,70			164,800	R 2 082,20	
3.3.2	Amputations: Post-amputation reconstruction												
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
0707	Post-amputation reconstruction: Krukenberg reconstruction	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	
0712	Post-amputation reconstruction: Toe to thumb transfer	20	800,000	R 12 960,70		20	800,000	R 12 960,70		20	640,000	R 8 089,10	
3.4	Muscles, tendons and fasciae												
3.4.1	Muscles, tendons and fasciae: Investigations												
0713	Electromyography	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with Item 2730)	20	57,000	R 923,40		20	57,000	R 923,40		20	57,000	R 720,40	
0715	Strength duration curve per session	20	10,500	R 170,00		20	10,500	R 170,00		20	10,500	R 132,70	
0717	Electrical examination of single nerve or muscle	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
0718	Oxidative study for mitochondrial function	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0721	Voltage integration during isometric contraction	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
0723	Tonometry with edrophonium	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	

0725	Isometric tension studies with edrophonium	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0729	Tendon reflex time	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
0730	Limb brain somatosensory studies (per limb)	20	49,000	R 793,80		20	49,000	R 793,80		20	49,000	R 619,20	
0731	Vision and audio-sensory studies	20	49,000	R 793,80		20	49,000	R 793,80		20	49,000	R 619,20	
0733	Motor nerve conduction studies (single nerve)	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	20	31,000	R 502,30		20	31,000	R 502,30		20	31,000	R 391,90	
0737	Biopsy for motor nerve terminals and end plates	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	20	34,000	R 550,80		20	34,000	R 550,80		20	34,000	R 429,70	
0740	Muscle fatigue studies	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0741	Muscle biopsy	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
0742	Global fee for all muscle studies, including histochemical studies	20	262,000	R 4 244,50		20	262,000	R 4 244,50					
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	20	20,250	R 328,00		20	20,250	R 328,00					
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	20	33,300	R 539,50		20	33,300	R 539,50					
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	20	5,700	R 92,40		20	5,700	R 92,40					
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	20	1,600	R 25,90		20	1,600	R 25,90					
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	20	9,900	R 160,30		20	9,900	R 160,30					
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	20	13,700	R 222,00		20	13,700	R 222,00					

4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	20	25,900	R 419,60		20	25,900	R 419,60					
4715	Biochemical estimations on muscle biopsy specimens: Enolase	20	32,700	R 529,60		20	32,700	R 529,60					
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	20	37,700	R 610,90		20	37,700	R 610,90					
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	20	15,750	R 255,30		20	15,750	R 255,30					
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	20	11,060	R 179,20		20	11,060	R 179,20					
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	20	34,700	R 562,30		20	34,700	R 562,30					
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	20	40,300	R 652,80		20	40,300	R 652,80					
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase	20	28,800	R 466,60		20	28,800	R 466,60					
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	20	43,000	R 696,90		20	43,000	R 696,90					
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	20	14,000	R 226,70		20	14,000	R 226,70					
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	20	20,000	R 324,00		20	20,000	R 324,00					
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	20	71,000	R 1 150,30		20	71,000	R 1 150,30					
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	20	69,000	R 1 117,80		20	69,000	R 1 117,80					
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation	20	82,000	R 1 328,70		20	82,000	R 1 328,70					
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	20	143,000	R 2 316,70		20	143,000	R 2 316,70					
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	20	75,000	R 1 215,10		20	75,000	R 1 215,10					

3.4.2	Muscles, tendons and fasciae: Decompression operations												
0743	Major compartmental decompression	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
0744	Decompression operation: Fasciotomy only	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
5550	Decompression Faciotomy: Buttock compartments, unilateral		243,000	R 3 936,00			243,000	R 3 936,00			243,000	R 3 070,20	
5551	Decompression fasciotomy: Leg – anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		151,900	R 2 460,40			151,900	R 2 460,40			151,900	R 1 919,20	
5552	Decompression fasciotomy: Leg –anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		253,100	R 4 099,60			253,100	R 4 099,60			253,100	R 3 197,90	
5553	Decompression fasciotomy: Leg – anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve		123,700	R 2 003,70			123,700	R 2 003,70			123,700	R 1 562,90	
5554	Decompression fasciotomy: Leg – anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/or nerve		162,100	R 2 625,60			162,100	R 2 625,60			162,100	R 2 048,10	
5555	Decompression fasciotomy: Leg – posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		130,800	R 2 118,70			130,800	R 2 118,70			130,800	R 1 652,50	
5556	Decompression fasciotomy: Leg – posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		171,500	R 2 777,90			171,500	R 2 777,90			171,500	R 2 166,80	
5557	Decompression fasciotomy: Fasciotomy/ tenotomy, iliotibial		137,300	R 2 224,00			137,300	R 2 224,00			137,300	R 1 734,60	
5558	Decompression fasciotomy: Fasciotomy – foot and/or toe		86,600	R 1 402,70			86,600	R 1 402,70			86,600	R 1 094,10	
5559	Decompression fasciotomy: Forearm and/ or wrist – flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		226,300	R 3 665,40			226,300	R 3 665,40			226,300	R 2 859,30	

5560	Decompression fasciotomy: Forearm and/ or wrist – flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		354,500	R 5 742,00			354,500	R 5 742,00			354,500	R 4 479,00	
5561	Decompression fasciotomy: Forearm and/ or wrist – flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		166,800	R 2 701,70			166,800	R 2 701,70			166,800	R 2 107,50	
5562	Decompression fasciotomy: Forearm and/ or wrist – flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		321,100	R 5 201,00			321,100	R 5 201,00			321,100	R 4 056,90	
5563	Decompression Faciotomy: Fingers and/or hand		165,600	R 2 682,20			165,600	R 2 682,20			165,600	R 2 092,30	
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair												
0745	Muscle and tendon repair: Biceps humeri	20	109,000	R 1 766,00		20	109,000	R 1 766,00		20	109,000	R 1 377,80	
0746	Muscle and tendon repair: Removal of calcification in Rotator cuff	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0747	Muscle and tendon repair: Rotator cuff	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
0748	Muscle and tendon repair: Debridement rotator cuff	20	139,700	R 2 263,50		20	139,700	R 2 263,50		20	120,000	R 1 516,60	
0749	Muscle and tendon repair: Scapulopexy – stand alone procedure	20	271,900	R 4 405,20		20	271,900	R 4 405,20		20	217,520	R 2 749,40	
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0757	Muscle and tendon repair: Achilles tendon repair	20	197,600	R 3 201,20		20	197,600	R 3 201,20		20	158,080	R 1 998,00	
0759	Muscle and tendon repair: Other single tendon	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) – modifier 0005 applicable		220,300	R 3 568,30			220,300	R 3 568,30			176,240	R 2 226,70	
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land) (each) – modifier 0005 applicable		249,600	R 4 043,00			249,600	R 4 043,00			199,680	R 2 522,90	

0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 – wrist and forearm, each (modifier 0005 applicable		191,300	R 3 098,60			191,300	R 3 098,60			153,040	R 1 933,60	
0763	Muscle and tendon repair: Tendon or ligament injection	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
0764	Hand: Flexor tendon repair – secondary, zone 1		243,900	R 3 950,60			243,900	R 3 950,60			195,100	R 2 465,10	
0765	Hand: Flexor tendon repair – secondary, zone 2 (no mans land)		249,600	R 4 043,00			249,600	R 4 043,00			199,680	R 2 522,90	
0766	Hand: Flexor tendon repair – secondary, zone 3 and 4 (wrist and forearm)		190,600	R 3 087,20			190,600	R 3 087,20			152,480	R 1 926,50	
0767	Hand: Flexor tendon suture – primary (per tendon)	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0768	Repair: Intrinsic muscles of hand, each (modifier 0005 applicable)		125,300	R 2 029,50			125,300	R 2 029,50			100,240	R 1 266,50	
0769	Hand: Flexor tendon suture – secondary (per tendon)	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0771	Extensor tendon suture: Primary (per tendon)	20	129,700	R 2 101,30		20	129,700	R 2 101,30		20	120,000	R 1 516,60	
0773	Extensor tendon suture: Secondary (per tendon)	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
0774	Repair of Boutonniere deformity or Mallet finger with graft	20	183,700	R 2 976,00		20	183,700	R 2 976,00		20	146,960	R 1 857,60	
3.4.4	Muscles, tendons and fasciae: Tendon graft												
0775	Free tendon graft	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0776	Reconstruction of pulley for flexor tendon	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
0777	Tendon graft: Finger – flexor	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0779	Tendon graft: Finger – extensor	20	122,000	R 1 976,40		20	122,000	R 1 976,40		20	120,000	R 1 516,60	
0780	Two stage flexor tendon graft using silastic rod	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
3.4.5	Muscles, tendons and fasciae: Tendolysis												
0781	Tendon freeing operation, except where specified elsewhere	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	

0782	Carpal tunnel syndrome	20	98,700	R 1 599,20		20	98,700	R 1 599,20		20	98,700	R 1 247,60	
0783	Tenolysis: De Quervain	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	
0784	Trigger finger	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	
0785	Flexor tendon freeing operation following free tendon graft or suture	20	186,800	R 3 026,50		20	186,800	R 3 026,50		20	149,440	R 1 888,80	
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	20	180,900	R 2 930,80		20	180,900	R 2 930,80		20	144,720	R 1 829,10	
0788	Intrinsic tendon release per finger	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0789	Central tendon tenotomy for Boutonniere deformity	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
3.4.6	Muscles, tendons and fasciae: Tenodesis												
0790	Tenodesis: Digital joint	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
3.4.7	Muscles, tendons and fasciae: Muscle tendon and facia transfer												
0791	Single tendon transfer	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0792	Multiple tendon transfer	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0793	Hamstring to quadriceps transfer	20	141,000	R 2 284,30		20	141,000	R 2 284,30		20	120,000	R 1 516,60	
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
0795	Tendon transfer at elbow	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
0802	Radial club hand repair – stand alone procedure	20	360,300	R 5 837,10		20	360,300	R 5 837,10		20	288,240	R 3 643,40	
0803	Hand tendons: Single tendon transfer (first)	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0809	Hand tendons: Substitution for intrinsic paralysis of hand	20	224,000	R 3 629,00		20	224,000	R 3 629,00		20	179,200	R 2 265,00	
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	20	220,600	R 3 574,00		20	220,600	R 3 574,00		20	176,480	R 2 230,70	
3.4.8	Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening												
0812	Percutaneous Tenotomy: All sites	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	

0813	Torticollis	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0815	Scalenotomy	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
0817	Scalenotomy with excision of first rib	20	190,000	R 3 078,10		20	190,000	R 3 078,10		20	152,000	R 1 921,20	
0821	Tennis elbow	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0822	Open release elbow (Mitals) – stand alone procedure	20	278,200	R 4 507,00		20	278,200	R 4 507,00		20	222,560	R 2 813,00	
0823	Excision or slide for Volkmann's Contracture	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
0825	Hip: Open muscle release	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
0829	Knee: Quadriceps plasty	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0831	Knee: Open tenotomy	20	141,000	R 2 284,30		20	141,000	R 2 284,30		20	120,000	R 1 516,60	
0835	Calf	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0837	Open elongation tendon Achilles	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0838	Percutaneous "Hoke" elongation tendo Achilles	20	79,300	R 1 284,70		20	79,300	R 1 284,70		20	79,300	R 1 002,20	
0845	Foot: Plantar fasciotomy	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
0846	Foot: Postero-medial release for club-foot	20	192,000	R 3 110,60		20	192,000	R 3 110,60		20	153,600	R 1 941,50	
3.5	Bursae and ganglia												
0847	Excision: Semimembranosus	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
0849	Excision: Prepatellar	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
0851	Excision: Olecranon	20	81,800	R 1 325,20		20	81,800	R 1 325,20		20	81,800	R 1 033,80	
0853	Excision: Small bursa or ganglion	20	80,900	R 1 310,50		20	80,900	R 1 310,50		20	80,900	R 1 022,50	
0855	Excision: Compound palmar ganglion or synovectomy	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	128,000	R 1 617,80	
0857	Bursae and ganglia: Aspiration or injection (no after-care) – modifier 0005 not applicable	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
3.6	Musculo-skeletal system: Miscellaneous												
3.6.1	Musculo-skeletal system: Miscellaneous – leg equalisation and congenital hips and feet												
0859	Leg equalisation and congenital hips and feet: Leg shortening	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	

0861	Leg equalisation and congenital hips and feet: Leg lengthening	20	416,000	R 6 739,40		20	416,000	R 6 739,40		20	332,800	R 4 206,50	
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast – one hip	20	109,000	R 1 766,00		20	109,000	R 1 766,00		20	109,000	R 1 377,80	
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast – both hips	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0868	Open reduction of congenital dislocation of the hip	20	186,000	R 3 013,30		20	186,000	R 3 013,30		20	148,800	R 1 880,80	
0869	Subsequent plasters	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0873	Congenital club foot: Manipulation and plaster – one foot	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
0874	Ponseti technique assistant (medical practitioner)	20	13,000	R 210,40	Z	20	13,000	R 210,40	Z	20	13,000	R 164,20	Z
3.6.2	Musculo-skeletal system: Miscellaneous – removal of internal fixatives of prosthesis												
0883	Removal of internal fixatives or prosthesis: Readily accessible	20	36,600	R 592,90		20	36,600	R 592,90		20	36,600	R 462,60	
0884	Removal of internal fixatives: Less accessible	20	75,500	R 1 223,30		20	75,500	R 1 223,30		20	75,500	R 954,50	
0885	Removal of prosthesis for infection soon after operation	20	128,000	R 2 073,90		20	128,000	R 2 073,90		20	120,000	R 1 516,60	
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): Add to the Item for total joint replacement of the specific joint	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
3.7	Plasters (exclusive of after-care)												
0887	Limb cast (excluding after-care) – modifier 0005 not applicable	20	13,000	R 210,40	ò	20	13,000	R 210,40	ò	20	13,000	R 164,20	ò
0888	Application of short limb cast: forearm, lower leg (excluding after-care) – first cast included in procedure		18,400	R 298,00			18,400	R 298,00			18,400	R 232,50	

0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0891	Turnbuckle cast for scoliosis (excluding after-care)	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
0892	Application of cast: Revision (walker, window, bivalve) – excluding after-care		18,900	R 306,20			18,900	R 306,20			18,900	R 238,90	
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	20	19,000	R 308,00		20	19,000	R 308,00		20	19,000	R 240,20	
0894	Application of cast: Clubfoot (excluding after-care) – first cast included in procedure		34,000	R 550,70			34,000	R 550,70			34,000	R 429,50	
3.8	Musculo-skeletal system: Special areas												
3.8.1	Special areas: Foot and ankle												
0895	Club foot: Revision club foot release – stand alone procedure	20	302,700	R 4 904,00		20	302,700	R 4 904,00		20	242,160	R 3 060,90	
0896	Club foot: Posterior release only – stand alone procedure	20	159,300	R 2 580,60		20	159,300	R 2 580,60		20	127,440	R 1 610,70	
0900	Excision tarsal coalition – stand alone procedure	20	141,500	R 2 292,50		20	141,500	R 2 292,50		20	120,000	R 1 516,60	
0901	Tenotomy: Single tendon	20	63,300	R 1 025,50		20	63,300	R 1 025,50		20	63,300	R 800,10	
0903	Hammer toe: One toe	20	99,500	R 1 612,10		20	99,500	R 1 612,10		20	99,500	R 1 257,70	
0905	Filleting of toe or Ruiz-Mora procedure	20	99,500	R 1 612,10		20	99,500	R 1 612,10		20	99,500	R 1 257,70	
0906	Arthrodesis Hallux	20	148,000	R 2 397,70		20	148,000	R 2 397,70		20	120,000	R 1 516,60	
0907	Silver bunionectomy or similar for Hallux Valgus	20	126,200	R 2 044,60		20	126,200	R 2 044,60		20	120,000	R 1 516,60	
	Not to be charged with Item 0911												
0909	Excision arthroplasty	20	145,200	R 2 352,20		20	145,200	R 2 352,20		20	120,000	R 1 516,60	
0910	Cheilectomy or metatarsophangeal implant Hallux	20	183,000	R 2 964,80		20	183,000	R 2 964,80		20	146,400	R 1 850,50	
0911	Metatarsal osteotomy or Lapidus or similar or Chevron – stand alone procedure	20	189,200	R 3 065,10		20	189,200	R 3 065,10		20	151,360	R 1 913,20	
	Not to be charged with Item 0907												

5730	Hallux Valgus double osteotomy etc.	20	182,600	R 2 958,40		20	182,600	R 2 958,40		20	146,080	R 1 846,50	
5731	Distal soft tissue procedure for Hallux Valgus	20	173,600	R 2 812,30		20	173,600	R 2 812,30		20	138,880	R 1 755,40	
5732	Aitkin procedure or similar	20	166,800	R 2 702,40		20	166,800	R 2 702,40		20	133,440	R 1 686,60	
5734	Removal bony prominence foot e.g. bunionette (Bunionette not applicable to COID)	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
5735	Repair angular deformity toe (lesser toes)	20	97,200	R 1 574,80		20	97,200	R 1 574,80		20	97,200	R 1 228,70	
5736	Sesamoidectomy	20	97,800	R 1 584,30		20	97,800	R 1 584,30		20	97,800	R 1 236,20	
5737	Repair major foot tendons e.g. Tib Post	20	147,300	R 2 386,40		20	147,300	R 2 386,40		20	120,000	R 1 516,60	
5738	Repair of dislocating peroneal tendons	20	173,200	R 2 806,00		20	173,200	R 2 806,00		20	138,560	R 1 751,50	
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar – one foot	20	202,300	R 3 277,50		20	202,300	R 3 277,50		20	161,840	R 2 045,60	
5740	Steindler strip – plantar fascia	20	97,200	R 1 574,80		20	97,200	R 1 574,80		20	97,200	R 1 228,70	
5741	Kelikian syndactilly (one web space)	20	97,200	R 1 574,80		20	97,200	R 1 574,80		20	97,200	R 1 228,70	
5742	Tendon transfer foot	20	172,000	R 2 786,70		20	172,000	R 2 786,70		20	137,600	R 1 739,30	
5743	Capsulotomy metatarsophalangeal joints: Foot	20	86,800	R 1 406,30		20	86,800	R 1 406,30		20	86,800	R 1 097,10	
3.8.2	Big toe (refer to section 3.8.1 for procedures on big toe)												
3.8.3	Special areas: Reimplantations												
0912	Replantation of amputated upper limb proximal to wrist joint	20	730,000	R 11 826,30		20	730,000	R 11 826,30		20	584,000	R 7 381,50	
0913	Replantation of thumb	20	670,000	R 10 854,60		20	670,000	R 10 854,60		20	536,000	R 6 774,90	
0914	Replantation of a single digit (to be motivated), for multiple digits (modifier 0005 applicable)	20	580,000	R 9 396,50		20	580,000	R 9 396,50		20	464,000	R 5 864,70	
0915	Replantation operation through the palm	20	1270,000	R 20 574,90		20	1270,000	R 20 574,90		20	1016,000	R 12 841,90	
3.8.4	Special areas: Hands (Note: Skin: See Integumentary System)												
0919	Tumours: Epidermoid cysts	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
0920	Tumours: Ganglion or fibroma	20	77,500	R 1 255,50		20	77,500	R 1 255,50		20	77,500	R 979,50	

0921	Tumours: Nodular synovitis (giant cell tumour of tendon sheath)	20	86,000	R 1 393,10		20	86,000	R 1 393,10		20	86,000	R 1 087,00	
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	20	19,000	R 308,00		20	19,000	R 308,00		20	19,000	R 240,20	
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) – minimum	20	37,000	R 599,40		20	37,000	R 599,40		20	37,000	R 467,70	
	Item 0924: The number of units chargeable under this Item ranges from 37.00 to 110.00 for specialists and general practitioners.												
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
3.8.5	Special areas: Spine												
	Please note the following with regard to section 3.8.5: Spine a. Modifier 0005 (multiple procedures/ operations under the same anaesthetic) is not applicable if the following procedures are performed together: 1. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis. 2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition. b. Modifier 0005 (multiple procedures/ operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. Osteotomy, laminectomy.												
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	20	207,000	R 3 353,70		20	207,000	R 3 353,70		20	165,600	R 2 093,20	
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	

0929	Manipulation of spine under general anaesthetic (no after-care) – modifier 0005 not applicable	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
0930	Posterior osteotomy of spine: One vertebral segment	20	339,000	R 5 492,10		20	339,000	R 5 492,10		20	271,200	R 3 427,80	
0931	Posterior spinal fusion: One level	20	385,000	R 6 237,20		20	385,000	R 6 237,20		20	308,000	R 3 892,90	
0932	Posterior osteotomy of spine: Each additional vertebral segment	20	103,000	R 1 668,60		20	103,000	R 1 668,60		20	103,000	R 1 301,70	
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	20	315,000	R 5 103,10		20	315,000	R 5 103,10		20	252,000	R 3 185,20	
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	20	103,000	R 1 668,60		20	103,000	R 1 668,60		20	103,000	R 1 301,70	
0938	Anterior fusion base of skull to C2	20	449,000	R 7 274,20		20	449,000	R 7 274,20		20	359,200	R 4 540,20	
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
0941	Anterior interbody fusion: One level	20	360,000	R 5 832,30		20	360,000	R 5 832,30		20	288,000	R 3 640,00	
0942	Anterior interbody fusion: Each additional level	20	102,000	R 1 652,40		20	102,000	R 1 652,40		20	102,000	R 1 289,20	
0944	Posterior fusion: Occiput to C2	20	390,000	R 6 318,20		20	390,000	R 6 318,20		20	312,000	R 3 943,50	
0946	Posterior spinal fusion: Each additional level	20	111,000	R 1 798,30		20	111,000	R 1 798,30		20	111,000	R 1 403,10	
0948	Posterior interbody lumbar fusion: One level	20	364,000	R 5 897,00		20	364,000	R 5 897,00		20	291,200	R 3 680,60	
0950	Posterior interbody lumbar fusion: Each additional interspace	20	95,000	R 1 539,10		20	95,000	R 1 539,10		20	95,000	R 1 200,80	
0959	Excision of coccyx	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
0961	Costo-transversectomy	20	198,000	R 3 207,60		20	198,000	R 3 207,60		20	158,400	R 2 002,20	
0963	Antero-lateral decompression of spinal cord or anterior debridement	20	326,000	R 5 281,50		20	326,000	R 5 281,50		20	260,800	R 3 296,50	

	MODIFIER												
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed												
3.8.6	Special areas: Spinal deformities												
	Please note: Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).												
0952	Posterior fusion for spinal deformity: Up to six levels	20	359,000	R 5 816,20		20	359,000	R 5 816,20		20	287,200	R 3 630,20	
0954	Posterior fusion for spinal deformity: Seven to 12 levels	20	547,000	R 8 861,80		20	547,000	R 8 861,80		20	437,600	R 5 531,10	
0955	Posterior fusion for spinal deformity: 13 or more levels	20	593,000	R 9 607,00		20	593,000	R 9 607,00		20	474,400	R 5 996,20	
0956	Anterior fusion for spinal deformity: Two or three levels	20	410,000	R 6 642,20		20	410,000	R 6 642,20		20	328,000	R 4 145,70	
0957	Anterior fusion for spinal deformity: Four to seven levels	20	444,000	R 7 193,10		20	444,000	R 7 193,10		20	355,200	R 4 489,50	
0958	Anterior fusion for spinal deformity: Eight or more levels	20	539,000	R 8 732,20		20	539,000	R 8 732,20		20	431,200	R 5 450,20	
	MODIFIER												
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere												
3.8.7	Special areas: All spinal problems												
0943	Laminectomy with decompression of nerve roots and disc removal: One level	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
0960	Posterior non-segmental instrumentation	20	167,000	R 2 705,60		20	167,000	R 2 705,60		20	133,600	R 1 688,60	

0962	Posterior segmental instrumentation: Two to six vertebrae	20	176,000	R 2 851,20		20	176,000	R 2 851,20		20	140,800	R 1 779,50	
0964	Posterior segmental instrumentation: Seven to 12 vertebrae	20	201,000	R 3 256,30		20	201,000	R 3 256,30		20	160,800	R 2 032,30	
0966	Posterior segmental instrumentation:13 or more vertebrae	20	245,000	R 3 969,30		20	245,000	R 3 969,30		20	196,000	R 2 477,30	
0968	Anterior instrumentation: Two to three vertebrae	20	159,000	R 2 575,80		20	159,000	R 2 575,80		20	127,200	R 1 607,80	
0969	Skull or skull-femoral traction including two weeks after-care	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
0970	Anterior instrumentation: Four to seven vertebrae	20	185,000	R 2 997,10		20	185,000	R 2 997,10		20	148,000	R 1 870,70	
0971	Halo-splint and POP jacket including two weeks after-care	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
0972	Anterior instrumentation: Eight or more vertebrae	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
0974	Additional pelvic fixation of instrumentation other than sacrum	20	108,000	R 1 749,50		20	108,000	R 1 749,50		20	108,000	R 1 364,90	
5750	Reinsertion of instrumentation	20	276,000	R 4 471,30		20	276,000	R 4 471,30		20	220,800	R 2 790,90	
5751	Removal of posterior non-segmental instrumentation	20	173,000	R 2 802,80		20	173,000	R 2 802,80		20	138,400	R 1 749,40	
5752	Removal of posterior segmental instrumentation	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
5753	Removal of anterior instrumentation	20	204,000	R 3 305,10		20	204,000	R 3 305,10		20	163,200	R 2 062,70	
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	20	295,000	R 4 779,20		20	295,000	R 4 779,20		20	236,000	R 2 982,90	
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	20	304,000	R 4 925,10		20	304,000	R 4 925,10		20	243,200	R 3 074,10	
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	20	321,000	R 5 200,70		20	321,000	R 5 200,70		20	256,800	R 3 246,00	
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	20	63,000	R 1 020,70		20	63,000	R 1 020,70		20	63,000	R 796,30	

5759	Laminectomy for decompression diskectomy, etc. revision operation	20	352,000	R 5 702,60		20	352,000	R 5 702,60		20	281,600	R 3 559,30	
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	20	301,000	R 4 876,50		20	301,000	R 4 876,50		20	240,800	R 3 043,60	
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	20	68,000	R 1 101,80		20	68,000	R 1 101,80		20	68,000	R 859,50	
5763	Anterior disc removal and spinal decompression cervical: One level	20	344,000	R 5 572,90		20	344,000	R 5 572,90		20	275,200	R 3 478,30	
5764	Anterior disc removal and spinal decompression cervical: Each additional level	20	81,000	R 1 312,30		20	81,000	R 1 312,30		20	81,000	R 1 023,80	
5765	Vertebral corpectomy for spinal decompression: One level	20	466,000	R 7 549,60		20	466,000	R 7 549,60		20	372,800	R 4 712,10	
5766	Vertebral corpectomy for spinal decompression: Each additional level	20	88,000	R 1 425,70		20	88,000	R 1 425,70		20	88,000	R 1 112,30	
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	20	71,000	R 1 150,30		20	71,000	R 1 150,30		20	71,000	R 897,40	
3.9	Facial bone procedures												
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9												
0987	Repair of orbital floor (blowout fracture)	20	184,600	R 2 990,60		20	184,600	R 2 990,60		20	147,680	R 1 866,70	
0988	Genioplasty	20	263,000	R 4 260,80		20	263,000	R 4 260,80		20	210,400	R 2 659,30	
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	20	202,200	R 3 275,80		20	202,200	R 3 275,80		20	161,760	R 2 044,60	
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	20	302,000	R 4 892,70		20	302,000	R 4 892,70		20	241,600	R 3 053,70	
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	20	433,000	R 7 015,10		20	433,000	R 7 015,10		20	346,400	R 4 378,40	
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	20	970,000	R 15 714,60		20	970,000	R 15 714,60		20	776,000	R 9 808,40	

0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	20	302,000	R 4 892,70		20	302,000	R 4 892,70		20	241,600	R 3 053,70	
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	20	1103,000	R 17 869,30		20	1103,000	R 17 869,30		20	882,400	R 11 153,20	
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	20	1654,000	R 26 795,70		20	1654,000	R 26 795,70		20	1323,200	R 16 724,60	
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement	20	-										F
0997	Mandible: Fractured nose and zygoma – open reduction and fixation	20	302,000	R 4 892,70		20	302,000	R 4 892,70		20	241,600	R 3 053,70	
0998	Excision mandible bone, e.g. osteomyelitis, abscess		219,300	R 0,00			219,300	R 0,00			175,440	R 2 708,50	
0999	Mandible: Fractured nose and zygoma – closed reduction by inter-maxillary fixation	20	184,000	R 2 980,80		20	184,000	R 2 980,80		20	147,200	R 1 860,60	
1000	Excision facial bone e.g., osteomyelitis, abscess		144,300	R 0,00			144,300	R 0,00			120,000	R 1 852,60	
1001	Temporo-mandibular joint: Reconstruction for dysfunction	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
1002	Harvesting: Bone for contouring of benign bony growths (e.g. fibrous dysplasia)		189,200	R 0,00			189,200	R 0,00			151,360	R 2 336,70	
1003	Manipulation: Immobilisation and follow-up of fractured nose	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1005	Nasal fracture without manipulation	20	-										F
1007	Mandibulectomy	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
1008	Excision: Torus Mandibularis		84,100	R 0,00			84,100	R 0,00			84,100	R 1 298,30	
1009	Maxillectomy	20	382,500	R 6 196,60		20	382,500	R 6 196,60		20	306,000	R 3 867,70	
1010	Excision: Torus Palatinus		83,300	R 0,00			83,300	R 0,00			83,300	R 1 286,00	
1011	Bone graft to mandible	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
1012	Adjustment of occlusion by ramisection	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	

1013	Fracture of arch of zygoma without displacement	20	-										F
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	20	131,000	R 2 122,50		20	131,000	R 2 122,50		20	120,000	R 1 516,60	
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	20	262,000	R 4 244,50		20	262,000	R 4 244,50		20	209,600	R 2 649,20	
4	**Respiratory system**												
4.1	Nose and sinuses												
1018	Flexible nasopharyngolaryngoscope examination	20	51,940	R 841,50		20	51,940	R 841,50		20	51,940	R 656,50	
1019	ENT endoscopy in rooms with rigid endoscope	20	12,000	R 194,40		20	12,000	R 194,40					
1020	Repair of perforated septum: Any method	20	141,900	R 2 298,90		20	141,900	R 2 298,90		20	120,000	R 1 516,60	
1022	Functional reconstruction of nasal septum	20	121,200	R 1 963,70		20	121,200	R 1 963,70		20	120,000	R 1 516,60	
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	20	64,600	R 1 046,60		20	64,600	R 1 046,60		20	64,600	R 816,50	
1027	Dacrocystorhinostomy	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	20	62,600	R 1 014,10		20	62,600	R 1 014,10		20	62,600	R 791,20	
1030	Endoscopic turbinectomy: Laser or microdebrider	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
1031	Removal of single nasal polyp at rooms (at initial consultation only)	20	25,400	R 411,50		20	25,400	R 411,50		20	25,400	R 321,00	
1033	Removal of multiple polyps in hospital under general anaesthetic	20	81,800	R 1 325,20		20	81,800	R 1 325,20		20	81,800	R 1 033,80	
1034	Autogenous nasal bone transplant: Bone removal included	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	

1035	Functional endoscopic sinus surgery: Unilateral	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1036	Functional endoscopic sinus surgery: Bilateral	20	245,000	R 3 969,30		20	245,000	R 3 969,30		20	196,000	R 2 477,30	
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
1045	Ligation anterior ethmoidal artery	20	135,400	R 2 193,60		20	135,400	R 2 193,60		20	120,000	R 1 516,60	
1047	Caldwell-Luc operation: Unilateral	20	137,300	R 2 224,30		20	137,300	R 2 224,30		20	120,000	R 1 516,60	
1048	Endonasal frontal sinus drainage, with or without removal of tissue (modifier 0069 applies)		152,200	R 0,00			152,200	R 0,00			121,760	R 1 879,70	
1049	Ligation internal maxillary artery	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
1050	Vidian neurectomy (transantral or transnasal)	20	113,000	R 1 830,70		20	113,000	R 1 830,70		20	113,000	R 1 428,30	
1051	Removal nasopharyngeal fibroma	20	285,000	R 4 617,40		20	285,000	R 4 617,40		20	228,000	R 2 882,00	
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1053	Frontal sinus drainage, trephine operation	20	93,100	R 1 508,20		20	93,100	R 1 508,20		20	93,100	R 1 176,70	
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	20	37,300	R 604,40		20	37,300	R 604,40					
1055	External frontal ethmoidectomy	20	190,700	R 3 089,50		20	190,700	R 3 089,50		20	152,560	R 1 928,10	
1056	Anterior cranial fossa, craniofacial approach, extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	20	433,300	R 7 019,70		20	433,300	R 7 019,70					

1057	External ethmoidectomy and/or sphenoidectomy	20	199,400	R 3 230,50		20	199,400	R 3 230,50		20	159,520	R 2 016,20	
1058	Sublabial transseptal sphenoidotomy	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
1059	Frontal osteomyelitis	20	194,000	R 3 143,30		20	194,000	R 3 143,30		20	155,200	R 1 961,60	
1060	Obliteration of frontal sinus	20	291,100	R 4 716,10		20	291,100	R 4 716,10		20	232,880	R 2 943,50	
1061	Lateral rhinotomy	20	164,000	R 2 656,80		20	164,000	R 2 656,80		20	131,200	R 1 658,30	
1062	Excision nasolabial cyst	20	186,100	R 3 014,90		20	186,100	R 3 014,90		20	148,880	R 1 881,70	
1063	Removal of foreign bodies from nose: At rooms	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1065	Removal of foreign body from nose: Under general anaesthetic	20	38,600	R 625,20		20	38,600	R 625,20		20	38,600	R 487,70	
1067	Proof puncture at rooms: Unilateral	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1069	Proof puncture, uni- or bilateral under general anaesthetic	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1071	Proetz treatment (consultation fee only to be charged for first treatment)	20	4,000	R 64,80		20	4,000	R 64,80		20	4,000	R 50,60	
1077	Septum abscess: At rooms, including after-care	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
1079	Septum abscess: Under general anaesthetic	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1081	Oro-antral fistula (without Caldwell-Luc)	20	111,800	R 1 811,10		20	111,800	R 1 811,10		20	111,800	R 1 413,10	
1083	Choanal atresia: Intranasal approach	20	113,000	R 1 830,70		20	113,000	R 1 830,70		20	113,000	R 1 428,30	
1084	Choanal atresia: Transpalatal approach	20	194,000	R 3 143,30		20	194,000	R 3 143,30		20	155,200	R 1 961,60	
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
1089	Forehead rhinoplasty (all stages): Total	20	552,000	R 8 942,70		20	552,000	R 8 942,70		20	441,600	R 5 581,70	
1091	Forehead rhinoplasty (all stages): Partial	20	414,000	R 6 707,20		20	414,000	R 6 707,20		20	331,200	R 4 186,10	

1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
1095	Full nasal reconstruction for secondary cleft lip deformity	20	357,900	R 5 798,30		20	357,900	R 5 798,30		20	286,320	R 3 618,90	
1097	Partial nasal reconstruction for cleft lip deformity	20	199,700	R 3 235,20		20	199,700	R 3 235,20		20	159,760	R 2 019,40	
1099	Columella reconstruction or lengthening	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision	20	220,100	R 3 565,50		20	220,100	R 3 565,50					
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision	20	232,900	R 3 772,90		20	232,900	R 3 772,90					
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision	20	181,600	R 2 942,10		20	181,600	R 2 942,10					
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision	20	120,000	R 1 944,10		20	120,000	R 1 944,10					
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision	20	196,600	R 3 184,40		20	196,600	R 3 184,40					
4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision	20	195,400	R 3 166,40		20	195,400	R 3 166,40					
	MODIFIERS GOVERNING NASAL OPERATIONS												
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083												
4.2	Throat												
1101	Tonsillectomy (dissection of the tonsils)	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
1102	Laser tonsillectomy	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
1105	Removal of adenoids	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ Item 5930 for hire of laser)	20	168,300	R 2 726,70		20	168,300	R 2 726,70		20	134,640	R 1 701,80	
1107	Opening of quinsy: At rooms	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	

1108	Laser assisted functional reconstruction of palate uvula: In the rooms (+ Item 5930 for hire of laser) – follow-up operation performed by the same surgeon	20	85,000	R 1 377,10		20	85,000	R 1 377,10		20	85,000	R 1 074,40	
1109	Opening of quinsy: Under general anaesthetic	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1110	Ludwig's Angina: Drainage	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
1111	Post tonsillectomy or adenoidectomy haemorrhage	20	46,000	R 745,30		20	46,000	R 745,30		20	46,000	R 581,50	
1112	Pharyngeal pouch operation	20	231,800	R 3 755,30		20	231,800	R 3 755,30		20	185,440	R 2 344,00	
1113	Retropharyngeal abscess: Internal approach	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1115	Retropharyngeal abscess: External approach	20	85,000	R 1 377,10		20	85,000	R 1 377,10		20	85,000	R 1 074,40	
1116	Functional reconstruction of palate and uvula	20	168,300	R 2 726,70		20	168,300	R 2 726,70		20	134,640	R 1 701,80	
4.3	Larynx												
1117	Laryngeal intubation	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1118	Laryngeal stroboscopy with video capture	20	39,000	R 631,90		20	39,000	R 631,90		20	39,000	R 493,10	
1119	Laryngectomy without block dissection of the neck	20	430,000	R 6 966,30		20	430,000	R 6 966,30		20	344,000	R 4 347,90	
1122	Laryngeal function studies	20	11,600	R 187,80		20	11,600	R 187,80					
1123	Botulinus toxin injection for adductor disphonia (+ Item 0198 + Item 0201 + Item 0202)	20	35,000	R 567,00		20	35,000	R 567,00					
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	20	81,100	R 1 313,90		20	81,100	R 1 313,90		20	81,100	R 1 025,00	
1126	Post laryngectomy for voice restoration	20	139,500	R 2 260,00		20	139,500	R 2 260,00		20	120,000	R 1 516,60	
1127	Tracheotomy	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
1128	Endolaryngeal operations	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	20	294,400	R 4 769,40		20	294,400	R 4 769,40		20	235,520	R 2 976,90	

1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	20	41,400	R 670,60		20	41,400	R 670,60		20	41,400	R 523,30	
1131	Direct laryngoscopy plus foreign body removal	20	64,600	R 1 046,60		20	64,600	R 1 046,60		20	64,600	R 816,50	
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal	20	220,500	R 3 572,00		20	220,500	R 3 572,00					
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy	20	342,100	R 5 541,90		20	342,100	R 5 541,90					
4918	Laryngoplasty: Open reduction of fracture	20	293,800	R 4 759,10		20	293,800	R 4 759,10					
4919	Laryngoplasty: Cricoid split	20	184,200	R 2 984,80		20	184,200	R 2 984,80					
4922	Tracheostoma: Revision, without flap rotation, simple	20	102,400	R 1 659,00		20	102,400	R 1 659,00					
4923	Tracheostoma: Revision, with flap rotation, complex	20	133,800	R 2 168,40		20	133,800	R 2 168,40					
4926	Tracheostomy: Fenestration with skin flaps	20	144,300	R 2 338,00		20	144,300	R 2 338,00					
4927	Tracheostomy: Revision of scar	20	105,500	R 1 709,30		20	105,500	R 1 709,30					
4928	Tracheostomy/fistula: Closure, without plastic repair	20	104,000	R 1 684,90		20	104,000	R 1 684,90					
4929	Tracheostomy/fistula: Closure, with plastic repair	20	120,000	R 1 944,10		20	120,000	R 1 944,10					
4932	Tracheobronchoscopy: Through established tracheostomy incision	20	37,700	R 610,90		20	37,700	R 610,90					
4933	Tracheoplasty: Cervical	20	208,100	R 3 371,10		20	208,100	R 3 371,10					
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage	20	263,200	R 4 264,10		20	263,200	R 4 264,10					
	MODIFIERS												
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (for other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the tariff).												

4.4	Bronchial procedures												
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy												
1132	Bronchoscopy: Diagnostic bronchoscopy	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1134	Bronchoscopy: Bronchoscopy with laser	20	75,000	R 1 215,10		20	75,000	R 1 215,10					
1136	Nebulisation (in rooms)	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
1137	Bronchial lavage												
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
4.5	Pleura												
1139	Pleural needle biopsy (no after-care) – modifier 0005 not applicable	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1141	Insertion of intercostal catheter (underwater drainage)	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1142	Intra-pleural block	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
1143	Paracentesis chest: Diagnostic	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
1145	Paracentesis chest: Therapeutic	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
1147	Pneumothorax: Induction (diagnostic)	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1149	Pleurectomy	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1151	Decortication of lung	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
4.6	Pulmonary procedures												
4.6.1	Pulmonary procedures: Surgical												
1155	Needle biopsy lung: (no after-care) – modifier 0005 not applicable	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
1157	Pneumonectomy	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	

1159	Pulmonary lobectomy	20	389,500	R 6 310,30		20	389,500	R 6 310,30		20	311,600	R 3 938,30	
1161	Segmental lobectomy	20	365,000	R 5 913,30		20	365,000	R 5 913,30		20	292,000	R 3 690,60	
1163	Excision tracheal stenosis: Cervical	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
1164	Excision tracheal stenosis: Intra thoracic	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
1168	Thoracoplasty: Complete	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1169	Thoracoplasty: Limited (osteoplastic)	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1171	Drainage empyema (including six weeks after treatment)	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
1173	Drainage of lung abscess (including six weeks after treatment)	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
1175	Thoracotomy (limited): For lung or pleural biopsy	20	115,000	R 1 863,10		20	115,000	R 1 863,10		20	115,000	R 1 453,60	
1177	Major: Diagnostic, as for inoperable carcinoma	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
1179	Thoracoscopy	20	89,000	R 1 442,00		20	89,000	R 1 442,00		20	89,000	R 1 125,10	
1181	Lung transplant: Unilateral	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
1182	Harvesting donor lung: Unilateral	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1183	Excision or plication of emphysematous cyst: Unilateral	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (Median sternotomy)	20	438,000	R 7 095,90		20	438,000	R 7 095,90		20	350,400	R 4 428,90	
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
4.6.2	Pulmonary function tests												
	When these procedures are performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.												
1186	Flow volume test: Inspiration/expiration	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

1187	Exhaled nitric oxide determination	20	4,900	R 79,40		20	4,900	R 79,40					
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation – thereafter Item 1186 applies)	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1189	Forced expirogram only	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	20	45,310	R 734,10		20	45,310	R 734,10					
1191	N2 single breath distribution	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1192	Peak expiratory flow only	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	20	37,760	R 611,70		20	37,760	R 611,70					
1195	Thoracic gas volume	20	37,930	R 614,50		20	37,930	R 614,50					
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	20	45,310	R 734,10		20	45,310	R 734,10					
1197	Compliance and resistance, using oesophageal balloon	20	24,000	R 388,90		20	24,000	R 388,90		20	24,000	R 303,50	
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry	20	55,890	R 905,40		20	55,890	R 905,40		20	55,890	R 706,40	
1199	Pulmonary stress testing: For determination of VO2 max	20	96,500	R 1 563,50		20	96,500	R 1 563,50		20	96,500	R 1 219,80	
1200	Carbon monoxide diffusing capacity, any method	20	38,060	R 616,70		20	38,060	R 616,70					
1201	Maximum inspiratory/expiratory pressure	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	

4.7	Intensive care												
	RULES GOVERNING THIS SECTION												
Q.	**Intensive care/high care:** Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221. but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and X-rays. g. Intravenous treatment (Items 0206 and 0207), except intravenous infusion in patients under the age of three years (Item 0205) that does not form a part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management).												
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. Item 1211: Cardio-respiratory resuscitation)												

S.	Ventilation: Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies. b. Testing and connecting the machine. c. Putting patient on machine: setting machine, synchronising patient with machine. d. Instruction to nursing staff. e. All subsequent visits for 24 hours.												
T.	Ventilation (Items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring												
4.7.1	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – neonatal procedures												
1202	Insertion of central venous catheter via peripheral vein in neonates	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
4.7.2	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – tariff items for intensive care												
1204	Intensive care – Category 1 (high care): Cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.), per day	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

	i. Only one practitioner may charge category 1: Intensive monitoring of patient in high care unit. ii. Item 1204 may not be charged by the surgeon who performed a surgical procedure. Intensive monitoring is regarded as normal postoperative care, which is included in the global fee attached to that surgical procedure. iii. Practitioners involved in treating a patient in a high care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.												
1205	Intensive care – Category 2 (ICU): Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support), first day	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1206	Intensive care – Category 2 (ICU): Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support) – subsequent days, per day	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1207	Intensive care – Category 2(ICU): Cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support) – after two weeks, per day	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

	Please note: i. The principal practitioner may charge Items 1205-1207, other participating practitioners must charge the consultation item, e.g. Item 0109. ii. Only one practitioner may charge category 2: Intensive monitoring of patient in intensive care unit. ii. Should a patient during the post-operative care period require active system support, the person who is responsible for the active systems support, may use Items 1205-1207 (as appropriate). iii. It would be acceptable for the surgeon who performed a surgical procedure of which the after-care is included, to charge fees according to the appropriate hospital follow-up visit (Item 0109). iv. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.												
1208	Intensive care – Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention, first day (primary practitioner)	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
1209	Intensive care – Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention, first day (per involved practitioner)	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
1210	Intensive care – Category 3 (ICU): Cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention, subsequent days (per involved practitioner)	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	

	Please note: i. Items 1208-1210 are used if more than one practitioner is involved in active system support on a category 2 patient in the intensive care unit. ii. Items 1208-1210 are used for category 3 patients with multiple organ failure. iv. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.												
4.7.3	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – procedures												
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.												
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) – 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.												
1212	Ventilation: First day	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
1213	Ventilation: Subsequent days, per day	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1214	Ventilation: After two weeks, per day	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1215	Insertion of arterial pressure cannula	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	

1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1217	Insertion of central venous line via peripheral vein	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1218	Insertion of central venous line via subclavian or jugular veins	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1219	Hyperalimentation (daily tariff)	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours. Cassette to be charged for according to Item 0201 per patient.	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
4.8	Hyperbaric Oxygen Therapy												
	Internationally recognised scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic). b. Decompression sickness (‘the bends’). c. Carbon monoxide poisoning. d. Gas gangrene. e. Crush injuries, compartment syndromes or acute traumatic ischaemias. f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union). g. Necrotising soft tissue infections (e.g. necrotising fasciitis). h. Refractory osteomyelitis. i. Bone and soft tissue radiation necrosis. j. Compromised skin grafts and flaps. k. Acute thermal burns. l. Acute bloodloss anaemia (transfusion is contraindicated – e.g. Jehovah’s Witnesses or haemolytic anaemia). m. Cerebral abscesses.												

4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 mins) – PROFESSIONAL COMPONENT	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
4820	Low pressure table (1,5-1,8 ATA x 45-60 mins): TECHNICAL COMPONENT	20	101,130	R 1 638,20	Z	20	101,130	R 1 638,20	Z	20	101,130	R 1 278,20	Z
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 mins) – PROFESSIONAL COMPONENT	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
4821	Routine HBO table (2-2,5 ATA x 90-120 mins): TECHNICAL COMPONENT	20	131,260	R 2 126,40	Z	20	131,260	R 2 126,40	Z	20	131,260	R 1 659,00	Z
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 mins) – PROFESSIONAL COMPONENT	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
4822	Emergency HBO table (2,5-3 ATA x 90-120 mins): TECHNICAL COMPONENT	20	131,260	R 2 126,40	Z	20	131,260	R 2 126,40	Z	20	131,260	R 1 659,00	Z
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 mins) – PROFESSIONAL COMPONENT	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
4825	USN TT5 (2,8 ATA x 135 mins): TECHNICAL COMPONENT	20	214,180	R 3 469,70	Z	20	214,180	R 3 469,70	Z	20	214,180	R 2 707,00	Z

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 mins) – PROFESSIONAL COMPONENT	20	190,000	R 3 078,10		20	190,000	R 3 078,10		20	190,000	R 2 401,50	
4826	USN TT6 (2,8 ATA x 285 mins): TECHNICAL COMPONENT	20	386,420	R 6 260,40	Z	20	386,420	R 6 260,40	Z	20	386,420	R 4 884,30	Z
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 mins) – PROFESSIONAL COMPONENT	20	327,000	R 5 297,70		20	327,000	R 5 297,70		20	327,000	R 4 133,10	
4827	USN TT6ext (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	680,850	R 11 030,30	Z	20	680,850	R 11 030,30	Z	20	680,850	R 8 605,70	Z
4828	USN 6A (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	678,280	R 10 988,70	Z	20	678,280	R 10 988,70	Z	20	678,280	R 8 573,10	Z
4829	USN Cx 30 (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	671,850	R 10 884,50	Z	20	671,850	R 10 884,50	Z	20	671,850	R 8 491,90	Z
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour: Minimum 40,00 clinical procedure units – maximum 320,00 clinical procedure units												
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.												
5	**Mediastinal procedures**												
1222	Mediastinal tumours	20	285,000	R 4 617,40		20	285,000	R 4 617,40		20	228,000	R 2 882,00	
1223	Mediastinoscopy	20	95,000	R 1 539,10		20	95,000	R 1 539,10		20	95,000	R 1 200,80	
1224	Mediastinotomy	20	115,000	R 1 863,10		20	115,000	R 1 863,10		20	115,000	R 1 453,60	

1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
1226	Removal of single rib with a lesion	20	282,000	R 4 568,80		20	282,000	R 4 568,80		20	225,600	R 2 851,50	
6	**Cardiovascular system**												
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP												
6.1	Cardiovascular system: General												
1227	Prolonged neonatal resuscitation	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG.												
1228	General practitioner's fee for the taking of an ECG only: Without effort: ½ (Item 1232)									20	4,500	R 56,90	
1229	General practitioner's fee for the taking of an ECG only: Without and with effort: ½ (Item 1233)									20	6,500	R 82,20	
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added.												
1230	Physician's fee for interpreting an ECG: Without effort	20	6,000	R 97,40		20	6,000	R 97,40					
1231	Physician's fee for interpreting an ECG: With and without effort	20	10,000	R 161,80		20	10,000	R 161,80					
	A specialist physician is entitled to the fees specified in Item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation.												
1232	Electrocardiogram: Without effort	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
1233	Electrocardiogram: With and without effort	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	

1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1235	Multi-stage treadmill test	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
1236	Electrocardiogram without effort: Under four years old	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
1237	24 hour ambulatory blood pressure: Hire fee	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1238	24 hour ambulatory ECG monitoring (holter): Hire fee	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
1239	24 hour ambulatory ECG monitoring (holter): Interpretation	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
1240	Signal averaged electrocardiogram	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1241	X-ray screening: Chest	20	4,000	R 64,80		20	4,000	R 64,80		20	4,000	R 50,60	
1242	X-ray screening: Prosthetic valves	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1243	Two week event triggered ambulatory ECG monitoring: Hire fee	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1245	Angiography cerebral: First two series	20	34,300	R 555,70		20	34,300	R 555,70		20	34,300	R 433,70	
1246	Angiography peripheral: Per limb	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
1248	Paracentesis of pericardium	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	

	MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER												
0073	When Item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%												
6.2	Invasive cardiology												
6.2.1	Invasive cardiology: Cardiac catheterisation												
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	20	140,000	R 2 267,90		20	140,000	R 2 267,90					
1250	Endomyocardial biopsy	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
1251	Transeptal puncture	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	20	140,000	R 2 267,90		20	140,000	R 2 267,90				R 0,00	
1253	Right heart catheterisation (with or without biopsy)	20	70,000	R 1 134,00		20	70,000	R 1 134,00				R 0,00	
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1255	Tilt test	20	31,300	R 507,00		20	31,300	R 507,00		20	31,300	R 395,50	
6.2.2	Invasive cardiology: Electrophysiological study												
1256	Ventricular stimulation study	20	160,000	R 2 592,10		20	160,000	R 2 592,10					
1257	Full electrophysiological study	20	300,000	R 4 860,10		20	300,000	R 4 860,10					
6.2.3	Invasive cardiology: Pacemakers												
1258	Pacemaker: Permanent – single chamber	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
1259	Pacemaker: Permanent – dual chamber	20	230,000	R 3 726,10		20	230,000	R 3 726,10		20	184,000	R 2 325,60	
1260	AV nodal ablation	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1261	Accessory pathway ablation	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	

1262	Electrophysiological mapping	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1263	Insertion transvenous implantable defibrillator	20	212,000	R 3 434,70		20	212,000	R 3 434,70		20	169,600	R 2 143,50	
1264	Test for implantable transvenous defibrillator	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1265	Renewal of pacemaker unit only, team fee	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
1266	Resiting pacemaker generator	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1267	Repositioning of catheter electrode	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1268	Threshold testing: Own equipment	20	15,000	R 243,00		20	15,000	R 243,00					
1269	Threshold testing: Hospital equipment	20	11,000	R 178,30		20	11,000	R 178,30					
1270	Programming of atrio-ventricular sequential pacemaker	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts	20	260,000	R 4 212,30		20	260,000	R 4 212,30		20	208,000	R 2 629,00	
1275	Termination of arrhythmia – programmed stipulation and lead insertion of temporary pacer	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
6.2.4	Invasive cardiology: Percutaneous translumical angioplasty												
1276	Percutaneous transluminal angioplasty: First cardiologist – single lesion	20	260,000	R 4 212,30		20	260,000	R 4 212,30		20	208,000	R 2 629,00	
1277	Percutaneous transluminal angioplasty: Second cardiologist – single lesion	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1278	Percutaneous transluminal angioplasty: First cardiologist – second lesion	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
1279	Percutaneous transluminal angioplasty: Second cardiologist – second lesion	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1280	Percutaneous transluminal angioplasty: First cardiologist – third or subsequent lesions (each)	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	

1281	Percutaneous transluminal angioplasty: Second cardiologist – third or subsequent lesions (each)	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty	20	260,000	R 4 212,30		20	260,000	R 4 212,30		20	208,000	R 2 629,00	
1283	Use of balloon procedure as in Item 1282: Second cardiologist	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1284	Atherectomy: Single lesion – first cardiologist	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1285	Atherectomy: Single lesion – second cardiologist	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
1286	Insertion of intravascular stent: First cardiologist	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1287	Insertion of intravascular stent: Second cardiologist	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
	The insertion of a stent(s) (Item 1286 and 1267) may only be charged once per vessel regardless of the number of stents inserted in this vessel.												
1290	Use of balloon procedures including: First paediatric cardiologist (33) – atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty, closure atrial septal defect, closure of patient ductus arteriosus	20	300,000	R 4 860,10		20	300,000	R 4 860,10					
1291	Use of balloon procedure as in Item 1290: Second paediatric cardiologist (33)	20	160,000	R 2 592,10		20	160,000	R 2 592,10					
1292	Multi-slice computed tomography coronary angiography: Own equipment	20	655,260	R 10 615,70		20	655,260	R 10 615,70		20	524,210	R 6 625,90	
5961	Balloon angioplasty pulmonary mitral valve or tricuspid valve		437,700	R 7 089,60			437,700	R 7 089,60					
5962	Balloon angioplasty aortic valve (congenital aortic stenosis)		424,100	R 6 869,30			424,100	R 6 869,30					
5963	Balloon angioplasty, pulmonary artery branches: First vessel		202,000	R 3 271,90			202,000	R 3 271,90					

5964	Balloon angioplasty, pulmonary artery branches: Subsequent vessels (per vessel)		101,600	R 1 645,70			101,600	R 1 645,70					
5965	Balloon angioplasty aorta for congenital lesion/coarctation		629,700	R 10 199,60			629,700	R 10 199,60					
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl MAPCA) or venous system (IVC, SVC, systemic vein): First vessel		451,400	R 7 311,60			451,400	R 7 311,60					
5967	Balloon angioplasty, collateral vessel (incl. MAPCA): Subsequent vessels (per vessel)		112,850	R 1 827,80			112,850	R 1 827,80					
5968	Balloon angioplasty venous system (IVC, SVC, systemic vein)		451,400	R 7 311,60			451,400	R 7 311,60					
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		451,400	R 7 311,60			451,400	R 7 311,60					
5970	Cutting balloon angioplasty, cardiovascular structure: Subsequent vessels (per vessel)		112,850	R 1 827,80			112,850	R 1 827,80					
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation												
1288	Cardiac catheterisation for congenital heart disease: All ages above one years old	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
1289	Paediatric cardiac catheterisation: Infants below the age of one year	20	263,000	R 4 260,80		20	263,000	R 4 260,80		20	210,400	R 2 659,30	
6.3	Cardiac surgery												
1294	Patent ductus arteriosus	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
1295	Pericardiectomy for constrictive pericarditis	20	400,000	R 6 480,30		20	400,000	R 6 480,30		20	320,000	R 4 044,60	
1296	Fractional flow reserve (FFR): First vessel (add-on code)		28,000	R 453,60			28,000	R 453,60			28,000	R 353,90	
1297	Coarctation of aorta	20	425,000	R 6 885,30		20	425,000	R 6 885,30		20	340,000	R 4 297,40	
1298	Fractional flow reserve (FFR): Each additional vessel (add-on code)		22,400	R 362,90			22,400	R 362,90			22,400	R 283,10	
1299	Systemo-pulmonary anastomosis	20	425,000	R 6 885,30		20	425,000	R 6 885,30		20	340,000	R 4 297,40	
1300	Renal denervation (RDN), per artery (modifier 0005 applicable)		223,00	R 3 612,00			223,00	R 3 612,00			178,40	R 2 254,00	
1301	Mitral valvotomy: Closed heart technique	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	

1302	Heart transplant	20	875,000	R 14 175,70		20	875,000	R 14 175,70		20	700,000	R 8 847,60	
1303	Harvesting donor heart	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
1305	Operative implantation of cardiac pacemaker by thoracotomy	20	220,000	R 3 564,10		20	220,000	R 3 564,10		20	176,000	R 2 224,40	
1307	Re-exploration after cardiac surgery	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
1308	Heart and lung transplant	20	1000,000	R 16 200,80		20	1000,000	R 16 200,80		20	800,000	R 10 111,80	
1309	Harvesting donor heart and lungs	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1311	Pericardial drainage	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
6.3.1	Cardiac surgery: Open heart surgery												
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	20	25,000	R 405,10		20	25,000	R 405,10					
1320	Repeat open heart surgery (additional fee above procedure fee)	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1321	Stand-by fee for coronary angioplasty	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc – per hour	20	20,000	R 324,00		20	20,000	R 324,00					
6.3.1.1	Cardiac surgery: Open heart surgery – congenital conditions												
1323	Atrial septal defect: Osteum secundum	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1325	Atrial septal defect: Sinus venosus or osteum primum	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1327	Atrial septal defect: Ventricular septal defect	20	603,800	R 9 782,00		20	603,800	R 9 782,00		20	483,040	R 6 105,40	
1329	Atrial septal defect: Fallot's tetralogy	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1330	Atrial septal defect: Pulmonary stenosis	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1331	Transposition of large vessels (venous repair)	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1332	Transposition of great arteries (arterial repair)	20	750,000	R 12 150,40		20	750,000	R 12 150,40		20	600,000	R 7 583,60	
1333	Ebstein's Anomaly	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	20	548,800	R 8 890,90		20	548,800	R 8 890,90		20	439,040	R 5 549,40	

1335	Total anomalous venous drainage	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	20	658,900	R 10 674,70		20	658,900	R 10 674,70		20	527,120	R 6 662,60	
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1338	Fontan type repair	20	750,000	R 12 150,40		20	750,000	R 12 150,40		20	600,000	R 7 583,60	
6.3.1.2	Cardiac surgery: Open heart surgery – acquired conditions												
1339	Mitral valve replacement	20	657,000	R 10 643,90		20	657,000	R 10 643,90		20	525,600	R 6 643,40	
1340	Mitral valvuloplasty	20	688,000	R 11 146,20		20	688,000	R 11 146,20		20	550,400	R 6 956,90	
1341	Aortic valve replacement	20	623,800	R 10 106,00		20	623,800	R 10 106,00		20	499,040	R 6 307,60	
1342	Tricuspid annulo plasty	20	188,000	R 3 045,70		20	188,000	R 3 045,70		20	150,400	R 1 900,90	
1343	Double valve replacement	20	968,900	R 15 696,80		20	968,900	R 15 696,80		20	775,120	R 9 797,10	
1344	Acute dissecting aneurysm repair	20	750,000	R 12 150,40		20	750,000	R 12 150,40		20	600,000	R 7 583,60	
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	20	1000,000	R 16 200,80		20	1000,000	R 16 200,80		20	800,000	R 10 111,80	
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins – unilateral (modifier 0005 not applicable)	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins – bilateral (modifier 0005 not applicable)	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilising saphenous veins	20	750,000	R 12 150,40		20	750,000	R 12 150,40		20	600,000	R 7 583,60	
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant –any artery	20	781,000	R 12 652,70		20	781,000	R 12 652,70		20	624,800	R 7 897,20	
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant – any artery	20	813,000	R 13 171,10		20	813,000	R 13 171,10		20	650,400	R 8 220,80	

1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	20	875,000	R 14 175,70		20	875,000	R 14 175,70		20	700,000	R 8 847,60	
1352	Cardiac aneurysm	20	563,000	R 9 121,00		20	563,000	R 9 121,00		20	450,400	R 5 692,90	
1353	Ascending/descending thoracic aortic aneurysm repair	20	625,000	R 10 125,50		20	625,000	R 10 125,50		20	500,000	R 6 319,70	
1354	Arrhythmia surgery	20	688,000	R 11 146,20		20	688,000	R 11 146,20		20	550,400	R 6 956,90	
1355	Cardiac tumour	20	625,000	R 10 125,50		20	625,000	R 10 125,50		20	500,000	R 6 319,70	
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	20	188,000	R 3 045,70		20	188,000	R 3 045,70		20	150,400	R 1 900,90	
1358	Harvesting of radial artery	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
6.4	Peripheral vascular system												
	MODIFIER GOVERNING THIS SECTION												
0072	Non invasive peripheral vascular tests: The number of tests in a single case is restricted to two per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.												
6.4.1	Peripheral vascular system: Investigations												
1357	Skin temperature test: Response to reflex heating	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1359	Skin temperature test: Response to reflex cooling	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1360	Closure: Left atrial appendage (LAA)		828,000	R 13 411,50			828,000	R 13 411,50			662,400	R 8 369,00	
1361	Cold sensitivity test	20	17,000	R 275,30		20	17,000	R 275,30		20	17,000	R 214,90	
1362	Trans-aortic valve implantation (TAVI)/ Transcatheter aortic valve replacement (TAVR)		397,500	R 6 438,60			397,500	R 6 438,60			318,000	R 4 017,80	
1363	Oscillometry test	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
1365	Sweating test	20	17,000	R 275,30		20	17,000	R 275,30		20	17,000	R 214,90	
1366	Transcutaneous oximetry: Transcutaneous oximetry – single site	20	26,300	R 426,10		20	26,300	R 426,10		20	26,300	R 332,40	
1367	Doppler blood tests	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
5369	Doppler arterial pressures	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	

5371	Doppler arterial pressures with exercise	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
5373	Doppler segmental pressures and wave forms	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
5375	Venous doppler examination (both limbs)	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
5377	Venous plethysmography	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
5379	Supra-orbital doppler test	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
5381	Carotid non-invasive complex tests	20	39,000	R 631,90		20	39,000	R 631,90		20	39,000	R 493,10	
6.4.2	Peripheral vascular system: Arterio-venous abnormalities												
1369	Fistula or aneurysm (as for grafting of various arteries)												
6.4.3	Arteries												
6.4.3.1	Peripheral vascular system: Arteries: Aorta-iliac and major branches												
1372	Abdominal aorta and iliac artery: Unruptured	20	540,000	R 8 748,20		20	540,000	R 8 748,20		20	432,000	R 5 460,30	
1373	Abdominal aorta and iliac artery: Ruptured	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
1375	Grafting and/or thrombo-endarterectomy for thrombosis	20	444,000	R 7 193,10		20	444,000	R 7 193,10		20	355,200	R 4 489,50	
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	20	594,000	R 9 623,30		20	594,000	R 9 623,30		20	475,200	R 6 006,20	
6.4.3.2	Peripheral vascular system: Arteries: Iliac artery												
1379	Prosthetic grafting and/or thrombo-endarterectomy	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
6.4.3.3	Peripheral vascular system: Arteries: Peripheral												
1385	Prosthetic grafting	20	255,000	R 4 131,20		20	255,000	R 4 131,20		20	204,000	R 2 578,60	
1387	Grafting vein: Vein grafting proximal to knee joint	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1388	Grafting vein: Distal to knee joint	20	444,000	R 7 193,10		20	444,000	R 7 193,10		20	355,200	R 4 489,50	

1389	Grafting vein: Endarterectomy when not part of another specified procedure	20	264,000	R 4 277,10		20	264,000	R 4 277,10		20	211,200	R 2 669,40	
1390	Grafting vein: Carotid endarterectomy	20	321,000	R 5 200,70		20	321,000	R 5 200,70		20	256,800	R 3 246,00	
1393	Embolectomy: Peripheral embolectomy transfemoral	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
1395	Miscellaneous arterial procedures: Arterial suture – trauma	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	100,000	R 1 264,00	
1396	Suture major blood vessel (artery or vein) – trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery). The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure.	20	264,000	R 4 277,10		20	264,000	R 4 277,10		20	211,200	R 2 669,40	
1397	Profundoplasty	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
1399	Distal tibial (ankle region)	20	456,000	R 7 387,50		20	456,000	R 7 387,50		20	364,800	R 4 610,90	
1401	Femoro-femoral	20	254,000	R 4 115,00		20	254,000	R 4 115,00		20	203,200	R 2 568,30	
1402	Carotid-subclavian	20	288,000	R 4 665,60		20	288,000	R 4 665,60		20	230,400	R 2 912,10	
1403	Axillo-femoral: Bifemoral + 50%	20	288,000	R 4 665,60		20	288,000	R 4 665,60		20	230,400	R 2 912,10	
6.4.4	Peripheral vascular system: Veins												
1407	Ligation of saphenous vein	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1408	Placement of Hickman catheter or similar	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
1410	Litigation of inferior vena cava: Abdominal	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
1412	Umbrella operation on inferior vena cava: Abdominal	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – unilateral	20	141,000	R 2 284,30		20	141,000	R 2 284,30		20	120,000	R 1 516,60	

1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – bilateral	20	247,000	R 4 001,60		20	247,000	R 4 001,60		20	197,600	R 2 497,40	
1417	Extensive sub-fascial ligation of perforating veins	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
1419	Lesser varicose vein procedures	20	31,000	R 502,30		20	31,000	R 502,30		20	31,000	R 391,90	
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
1425	Thrombectomy: Inferior vena cava (trans-abdominal)	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
1427	Thrombectomy: Illio-femoral	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
6.4.5	Peripheral vascular system: Portal hypertension												
1429	Porto-caval shunt	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
6.5	Cardiac rehabilitation												
1431	Cardiac rehabilitation: Phase II: Exercise rehabilitation – per patient per 60 minute-session with a maximum of five patients per group	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
1432	Cardiac rehabilitation: Phase III – exercise rehabilitation: Per patient per 60 minute-session with a maximum of 10 patients per group	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
	Please note: a. A practitioner is only allowed to instruct one group at a time. b. Benefits are limited to three times per week for a period of 60 minutes with a maximum of three months.												

7	**Lympho reticular system**												
7.1	Spleen												
1435	Splenectomy (in all cases)	20	221,300	R 3 585,20		20	221,300	R 3 585,20		20	177,040	R 2 237,80	
1436	Splenorrhaphy	20	231,800	R 3 755,30		20	231,800	R 3 755,30		20	185,440	R 2 344,00	
1437	Bone marrow or blood-derived peripheral stem cell transplantation: Allogeneic donor lymphocyte infusions – PROFESSIONAL COMPONENT		28,100	R 455,20			28,100	R 455,20			28,100	R 355,00	
1438	Bone marrow or blood-derived peripheral stem cell transplantation: Allogeneic – PROFESSIONAL COMPONENT		36,900	R 597,70			36,900	R 597,70			36,900	R 466,10	
7.2	Lymph nodes and lymphatic channels												
1439	Excision of lymph node for biopsy: Neck or axilla	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
1440	Bone marrow or blood-derived peripheral stem cell transplantation: Autologous – PROFESSIONAL COMPONENT		36,800	R 596,00			36,800	R 596,00			36,800	R 465,00	
1441	Excision of lymph node for biopsy: Groin	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
1442	Lymphadenectomy: Modified radical neck dissection, cervical	20	293,100	R 4 748,90		20	293,100	R 4 748,90					
1443	Simple excision of lymph nodes for tuberculosis	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: Allogeneic – PROFESSIONAL COMPONENT		23,500	R 380,60			23,500	R 380,60			23,500	R 296,90	
1445	Radical excision of lymph nodes of neck: Total – unilateral	20	315,000	R 5 103,10		20	315,000	R 5 103,10		20	252,000	R 3 185,20	
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: Autologous – PROFESSIONAL COMPONENT		23,800	R 385,60			23,800	R 385,60			23,800	R 300,70	
1447	Radical excision of lymph nodes of neck: Total – suprahyoid unilateral	20	235,000	R 3 807,10		20	235,000	R 3 807,10		20	188,000	R 2 376,30	

1448	Bone marrow harvesting for transplant – PROFESSIONAL COMPONENT		101,000	R 1 636,00			101,000	R 1 636,00			101,000	R 1 276,20	
1449	Radical excision of lymph nodes of axilla	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
1453	Radical excision of lymph nodes of groin: Inguinal	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment, per hour (specify time used)	20	39,000	R 631,90		20	39,000	R 631,90		20	39,000	R 493,10	
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
1457	Bone marrow biopsy: By trephine	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
1459	Staging laparotomy for lymphoma (including splenectomy)	20	245,000	R 3 969,30		20	245,000	R 3 969,30		20	196,000	R 2 477,30	
1460	Sentinel lymph node(s): Intra-operative indentification – INCLUDES injection of non-radioactive dye, when performed		40,400	R 654,40			40,400	R 654,40			40,400	R 510,40	
8	**Digestive system**												
	MODIFIERS GOVERNING THIS SECTION												
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.												

0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the Items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
8.1	Oral cavity												
1461	All dental procedures			R 0,00				R 0,00			4,000	R 406,90	T
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1465	Surgical biopsy of tongue or palate: Under local anaesthetic	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1467	Drainage of intra-oral abscess	20	31,000	R 502,30		20	31,000	R 502,30		20	31,000	R 391,90	
1469	Local excision of mucosal lesion of oral cavity	20	23,000	R 372,60		20	23,000	R 372,60		20	23,000	R 290,70	
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	20	549,000	R 8 894,10		20	549,000	R 8 894,10		20	439,200	R 5 551,20	
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	20	-										q
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
1477	Cleft palate: Secondary repair	20	174,200	R 2 822,20		20	174,200	R 2 822,20		20	139,360	R 1 761,50	
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	
1480	Repair of oronasal fistula (large) e.g. distant flap	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	

1482	Repair of oronasal fistula (large): Second stage	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
1483	Alveolar periosteal or other flaps for arch closure	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
1486	Closure of anterior nasal floor	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
8.2	Lips												
1484	Cleft lip repair: Lip adhesion (cleft lip)	20	95,000	R 1 539,10		20	95,000	R 1 539,10		20	95,000	R 1 200,80	
1485	Local excision of benign lesion of lip	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
1487	Resection for lip malignancy	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction) – one of two stages	20	251,600	R 4 076,30		20	251,600	R 4 076,30		20	201,280	R 2 544,00	
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction) – one stage	20	329,900	R 5 344,50		20	329,900	R 5 344,50		20	263,920	R 3 335,90	
1492	Cleft lip repair: Bilateral cleft lip repair – second stage	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	20	251,600	R 4 076,30		20	251,600	R 4 076,30		20	201,280	R 2 544,00	
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
1495	Abbé or Estlander type flap (all stages included)	20	273,100	R 4 424,50		20	273,100	R 4 424,50		20	218,480	R 2 761,50	
1497	Vermilionectomy	20	94,900	R 1 537,40		20	94,900	R 1 537,40		20	94,900	R 1 199,50	
1499	Lip reconstruction following an injury: Direct repair	20	105,600	R 1 710,90		20	105,600	R 1 710,90		20	105,600	R 1 334,90	
1501	Lip reconstruction following an injury or tumour removal: Flap repair	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	

1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see Item 0297)	20	104,000	R 1 684,80		20	104,000	R 1 684,80		20	104,000	R 1 314,50	
8.3	Tongue												
1505	Partial glossectomy	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
1507	Local excision of lesion of tongue	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
8.4	Palate, uvula and salivary glands												
1509	Wide excision of lesion of palate	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1511	Radical resection of palate (including skin graft)	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1513	Excision of ranula	20	85,600	R 1 386,80		20	85,600	R 1 386,80		20	85,600	R 1 082,00	
1515	Excision of sublingual salivary gland	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1517	Excision of submandibular salivary gland	20	146,000	R 2 365,30		20	146,000	R 2 365,30		20	120,000	R 1 516,60	
1519	Excision of submandibular salivary gland with suprahyoid dissection	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1521	Excision of submandibular salivary gland: With radical neck dissection	20	352,000	R 5 702,60		20	352,000	R 5 702,60		20	281,600	R 3 559,30	
1523	Local resection of parotid tumour	20	169,600	R 2 747,50		20	169,600	R 2 747,50		20	135,680	R 1 715,10	
1525	Partial parotidectomy	20	310,000	R 5 022,20		20	310,000	R 5 022,20		20	248,000	R 3 134,80	
1526	Total parotidectomy with preservation of facial nerve	20	358,500	R 5 808,10		20	358,500	R 5 808,10		20	286,800	R 3 625,00	
1527	Total parotidectomy	20	358,500	R 5 808,10		20	358,500	R 5 808,10		20	286,800	R 3 625,00	
1529	Parotidectomy: Extracapsular	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1531	Drainage of parotid abscess	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1533	Closure of salivary fistula	20	91,000	R 1 474,20		20	91,000	R 1 474,20		20	91,000	R 1 150,20	
1535	Dilatation of salivary duct	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1537	Operative removal of salivary calculus	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated	20	58,500	R 947,80		20	58,500	R 947,80					
1539	Salivary duct: Meatotomy	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	

1541	Branchial cyst and/or fistula: Excision	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1543	Excision of cystic hygroma	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1544	Ludwig's Angina: Drainage	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
8.5	Oesophagus												
1545	Oesophagoscopy with rigid instrument: First and subsequent	20	47,000	R 761,30		20	47,000	R 761,30		20	47,000	R 593,90	
1549	Oesophagoscopy with dilatation of stricture	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
1550	Oesophagoscopy with removal of foreign body	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	20	400,000	R 6 480,30		20	400,000	R 6 480,30		20	320,000	R 4 044,60	
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic		314,700	R 5 097,30			314,700	R 5 097,30			251,760	R 3 180,80	
1557	Oesophageal dilatation	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		389,800	R 6 313,80			389,800	R 6 313,80			311,840	R 3 939,90	
1559	Oesophagectomy: Two stage	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1560	Oesophagectomy: Three stage	20	550,000	R 8 910,50		20	550,000	R 8 910,50		20	440,000	R 5 561,30	
1561	Thoraco-abdominal oesophagogastrectomy	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
1563	Hiatus hernia and diaphragmatic hernia repair: With anti-reflux procedure	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		357,100	R 5 784,10			357,100	R 5 784,10			258,680	R 3 268,30	
1565	Hiatus hernia and diaphragmatic hernia repair: With Collis Nissen oesophageal lengthening procedure	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	

1566	Private fee: Gastroplasty	20	325,000	R 5 265,00		20	325,000	R 5 265,00		20	260,000	R 3 286,40	
1567	Bochdalek hernia repair in newborn	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
1569	Heller's operation	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure)		377,700	R 6 117,80			377,700	R 6 117,80			302,160	R 3 817,60	
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		313,100	R 5 071,50			313,100	R 5 071,50			250,480	R 3 164,70	
1575	Insertion of indwelling oesophageal tube by laparotomy	20	142,000	R 2 300,40		20	142,000	R 2 300,40		20	120,000	R 1 516,60	
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): Add to major procedure (modifier 0005 does not apply)		48,300	R 782,40			48,300	R 782,40			48,300	R 610,30	
1578	Oesophageal motility (4 channel + pneumograph)	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	20	400,000	R 6 480,30		20	400,000	R 6 480,30		20	320,000	R 4 044,60	
1580	Oesophageal motility (6 channel + pneumograph + pH pull-through)	20	110,000	R 1 782,10		20	110,000	R 1 782,10		20	110,000	R 1 390,30	
1581	Removal of benign oesophageal tumours	20	285,000	R 4 617,40		20	285,000	R 4 617,40		20	228,000	R 2 882,00	
1582	Oesophageal motility (4 or 6 channel + pneumograph – ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1583	Excision of intrathoracic oesophageal diverticulum	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1584	24 Hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe: 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	

1585	24 hour oesophageal pH studies: Interpretation	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		348,200	R 5 640,10			348,200	R 5 640,10			278,560	R 3 519,40	
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		378,100	R 6 124,20			378,100	R 6 124,20			302,480	R 3 821,80	
5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		382,200	R 6 190,70			382,200	R 6 190,70			305,760	R 3 863,20	
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		411,800	R 6 670,10			411,800	R 6 670,10			329,440	R 4 162,40	
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		451,200	R 7 308,20			451,200	R 7 308,20			360,960	R 4 560,50	
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		492,500	R 7 977,40			492,500	R 7 977,40			394,000	R 4 978,10	
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		463,600	R 7 509,20			463,600	R 7 509,20			370,880	R 4 685,90	
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		520,900	R 8 437,30			520,900	R 8 437,30			416,720	R 5 265,00	
8.6	Stomach												
1587	Upper gastro-intestinal endoscopy: Hospital equipment	20	48,750	R 789,90	Z	20	48,750	R 789,90	Z	20	48,750	R 616,20	Z

1588	Plus polypectomy: Add to gastro-intestinal endoscopy (Item 1587)	20	25,000	R 405,10	Z	20	25,000	R 405,10	Z	20	25,000	R 315,90	Z
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (Item 1587) or colonoscopy (Item 1653)	20	34,000	R 550,80		20	34,000	R 550,80		20	34,000	R 429,70	
1591	Plus removal of foreign bodies (stomach): Add to gastro-intestinal endoscopy (Item 1587)	20	25,000	R 405,10	Z	20	25,000	R 405,10	Z	20	25,000	R 315,90	Z
1593	Augmented histamine test: Gastric intubation with X-ray screening	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
1597	Gastrostomy or gastrotomy	20	147,500	R 2 389,70		20	147,500	R 2 389,70		20	120,000	R 1 516,60	
1598	Gastrotomy with suture repair of bleeding ulcer	20	251,200	R 4 069,60	Z	20	251,200	R 4 069,60	Z	20	200,960	R 2 540,10	Z
1599	Pyloromyotomy (Rammstedt)	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
1601	Local excision of ulcer or benign neoplasm	20	195,600	R 3 168,90		20	195,600	R 3 168,90		20	156,480	R 1 977,90	
1603	Vagotomy: Abdominal	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1604	Vagotomy: Thoracic	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1605	Truncal or selective with drainage procedures	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1607	Vagotomy and antrectomy	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
1609	Highly selective vagotomy	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
1611	Pyloroplasty	20	180,200	R 2 919,30		20	180,200	R 2 919,30		20	144,160	R 1 822,10	
1613	Gastroenterostomy	20	203,600	R 3 298,70		20	203,600	R 3 298,70		20	162,880	R 2 058,60	
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1617	Partial gastrectomy	20	328,300	R 5 318,70		20	328,300	R 5 318,70		20	262,640	R 3 319,70	
1619	Total gastrectomy	20	384,430	R 6 228,20		20	384,430	R 6 228,20		20	307,540	R 3 887,20	
1621	Revision of gastrectomy or gastro-enterostomy	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	

1625	Gastro-esophageal operation for portal hypertension (Tanner)	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
8.7	Duodenum												
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1627	Duodenal intubation (under X-ray screening)	20	8,000	R 129,70		20	8,000	R 129,70					
1629	Duodenal intubation with biliary drainage after gall bladder stimulation	20	21,000	R 340,30		20	21,000	R 340,30					
1631	Duodenal intubation: Under three years of age	20	15,000	R 243,00		20	15,000	R 243,00					
8.8	Intestines												
1632	H2 breath test (intestines)	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
1633	Complete test using lactose or lactulose	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
1634	Enterotomy or enterostomy	20	202,600	R 3 282,50		20	202,600	R 3 282,50		20	162,080	R 2 048,70	
1635	Intestinal obstruction of the newborn	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
1636	Oral food challenge test		14,100	R 228,40			14,100	R 228,40			14,100	R 178,10	
1637	Operation for relief of intestinal obstruction	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering	20	195,900	R 3 174,20		20	195,900	R 3 174,20					
1639	Resection of small bowel with enterostomy or anastomosis	20	244,900	R 3 967,50		20	244,900	R 3 967,50		20	195,920	R 2 476,40	
1640	Resection of small bowel for congenital atresia, proximal segment, with tapering	20	431,100	R 6 984,50		20	431,100	R 6 984,50					
1641	Entero-enterostomy or entero-colostomy for bypass	20	213,100	R 3 452,50		20	213,100	R 3 452,50		20	170,480	R 2 154,90	
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (Item 0201 applicable for video capsule – disposable single patient use). Please note: All patients should have had a normal gastroscopy and colonoscopy.	20	150,000	R 2 430,20	Z	20	150,000	R 2 430,20	Z	20	120,000	R 1 516,60	Z

1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	20	90,000	R 1 458,00	Z	20	90,000	R 1 458,00	Z	20	90,000	R 1 137,60	Z
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	20	185,200	R 3 000,40		20	185,200	R 3 000,40		20	148,160	R 1 872,70	
1647	Closure of intestinal fistula	20	258,000	R 4 179,80		20	258,000	R 4 179,80		20	206,400	R 2 608,60	
1649	Excision of Meckel's diverticulum	20	179,800	R 2 912,90		20	179,800	R 2 912,90		20	143,840	R 1 818,10	
1651	Excision of lesion of mesentery	20	171,600	R 2 780,00		20	171,600	R 2 780,00		20	137,280	R 1 735,20	
1652	Laparotomy for mesenteric thrombosis	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1653	Total colonoscopy: With hospital equipment (including biopsy)	20	90,000	R 1 458,00	Z	20	90,000	R 1 458,00	Z	20	90,000	R 1 137,60	Z
1654	Plus removal of polyps: Add to colonoscopy (Item 1653)	20	30,000	R 485,70	Z	20	30,000	R 485,70	Z	20	30,000	R 379,10	Z
1656	Left-sided colonoscopy	20	60,000	R 972,20	Z	20	60,000	R 972,20	Z	20	60,000	R 758,60	Z
1657	Right or left hemicolectomy or segmental colectomy	20	325,000	R 5 265,00		20	325,000	R 5 265,00		20	260,000	R 3 286,40	
1658	Reconstruction of colon after Hartman's procedure	20	359,400	R 5 822,60		20	359,400	R 5 822,60		20	287,520	R 3 634,20	
1659	Surgeon present assisting with air enema for reduction of intussuception (paediatric surgeons add modifier 0016)		60,60	R 981,50			60,60	R 981,50			60,60	R 765,70	
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (paediatric surgeons add modifier 0016)		20,50	R 332,00			20,50	R 332,00			20,50	R 259,00	
1661	Colotomy: Including removal of tumour or foreign body	20	205,700	R 3 332,50		20	205,700	R 3 332,50		20	164,560	R 2 079,90	
1663	Total colectomy	20	390,000	R 6 318,20		20	390,000	R 6 318,20		20	312,000	R 3 943,50	
1665	Colostomy or ileostomy isolated procedure	20	233,800	R 3 787,80		20	233,800	R 3 787,80		20	187,040	R 2 364,10	
1666	Continent ileostomy pouch (all types)	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1667	Colostomy: Closure	20	179,100	R 2 901,50		20	179,100	R 2 901,50		20	143,280	R 1 810,90	
1668	Revision of ileostomy pouch	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	

1669	Total proctocolectomy and ileostomy	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
1670	Proctocolectomy, ileostomy and ileostomy pouch	20	540,000	R 8 748,20		20	540,000	R 8 748,20		20	432,000	R 5 460,30	
1671	Colomyotomy (Reilly operation)	20	185,000	R 2 997,10		20	185,000	R 2 997,10		20	148,000	R 1 870,70	
8.9	Appendix												
1673	Drainage of appendix abscess	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1675	Appendicectomy	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
8.10	Rectum and anus												
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment	20	48,750	R 789,90	Z	20	48,750	R 789,90	Z	20	48,750	R 616,20	Z
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
1678	Plus polypectomy: Add to sigmoidoscopy (Item 1676)	20	25,000	R 405,10	Z	20	25,000	R 405,10	Z	20	25,000	R 315,90	Z
1679	Sigmoidoscopy with removal of polyps, first and subsequent	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1681	Proctoscopy with removal of polyps: First time	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
1683	Proctoscopy with removal of polyps: Subsequent times	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1685	Endoscopic fulguration of tumour	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	20	381,300	R 6 177,50		20	381,300	R 6 177,50		20	305,040	R 3 855,60	
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	20	445,000	R 7 209,40		20	445,000	R 7 209,40		20	356,000	R 4 499,70	
1689	Perineal resection of rectum	20	141,000	R 2 284,30		20	141,000	R 2 284,30		20	120,000	R 1 516,60	
	Please note: Items 1691 and 1692 – abdominal and/or perineal assistant's fee to be charged additionally.												
1691	Abdomino-perineal resection of rectum: Abdominal surgeon	20	409,300	R 6 631,20		20	409,300	R 6 631,20		20	327,440	R 4 138,70	

1692	Abdomino-perineal resection of rectum: Perineal surgeon	20	158,500	R 2 567,80		20	158,500	R 2 567,80		20	126,800	R 1 602,70	
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	20	400,000	R 6 480,30		20	400,000	R 6 480,30		20	320,000	R 4 044,60	
1697	Repair of prolapsed rectum: Abdominal – Roscoe Graham Moskovitz	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
1699	Repair of prolapsed rectum: Abdominal – Ivalon sponge	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1701	Repair of prolapsed rectum: Abdominal – Perineal	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
1703	Repair of prolapsed rectum: Abdominal – Thierisch suture	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1705	Incision and drainage of peri-anal abscess	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1707	Drainage of submucous abscess	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1709	Drainage of ischio-rectal abscess	20	87,000	R 1 409,40		20	87,000	R 1 409,40		20	87,000	R 1 099,70	
1711	Excision of pelvi-rectal fistula	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1713	Excision of fistula-in-ano	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
1715	Operation for fissure-in-ano	20	66,800	R 1 082,20		20	66,800	R 1 082,20		20	66,800	R 844,20	
1716	Rectal Tumour: Destruction (any method) – Transanal Approach		167,900	R 2 719,50			167,900	R 2 719,50			133,600	R 1 688,00	
1717	Rectal tumour: Excision, transanal approach, EXCLUDING muscularis propria (partial thickness)		96,400	R 1 561,50			96,400	R 1 561,50			96,400	R 1 218,00	
1718	Rectal Tumour: Excision, transanal approach, INCLUDING muscularis propria (full thickness)		143,600	R 2 326,00			143,600	R 2 326,00			114,880	R 1 451,50	
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1721	Sclerosing injection for haemorrhoids: Per injection	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	

1723	Haemorrhoidectomy	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1725	Drainage of external thrombosed pile	20	12,500	R 202,70		20	12,500	R 202,70		20	12,500	R 158,00	
1727	Multiple procedures (haemorrhoids, fissure, etc.)	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
1728	Biopsy of ano-rectal wall, for congenital megacolon	20	60,600	R 981,60	Z	20	60,600	R 981,60	Z	20	60,600	R 765,90	Z
1729	Excision of anal skin tags	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1731	Operation for low imperforate anus	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
1733	Anoplasty: Y-V-plasty	20	41,000	R 664,20		20	41,000	R 664,20		20	41,000	R 518,30	
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)	20	90,000	R 1 458,00		20	90,000	R 1 458,00					
1735	Anal sphincteroplasty for incontinence	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
1737	Dilation of ano-rectal stricture	20	12,500	R 202,70		20	12,500	R 202,70		20	12,500	R 158,00	
1739	Closure of recto-vesical fistula	20	241,000	R 3 904,50		20	241,000	R 3 904,50		20	192,800	R 2 436,80	
1741	Closure of recto-urethral fistula	20	241,000	R 3 904,50		20	241,000	R 3 904,50		20	192,800	R 2 436,80	
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
8.11	Liver												
1743	Needle biopsy of liver	20	30,300	R 490,90		20	30,300	R 490,90		20	30,300	R 382,90	
1745	Biopsy of liver by laparotomy	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
1747	Drainage of liver abscess or cyst	20	179,100	R 2 901,50		20	179,100	R 2 901,50		20	143,280	R 1 810,90	
1748	Body composition measured by bio-electrical impedance	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
1749	Hemi-hepatectomy: Right	20	564,000	R 9 137,10		20	564,000	R 9 137,10		20	451,200	R 5 703,00	
1751	Hemi-hepatectomy: Left	20	521,100	R 8 442,20		20	521,100	R 8 442,20		20	416,880	R 5 269,10	
1752	Extended right or left hepatectomy	20	570,900	R 9 248,70		20	570,900	R 9 248,70		20	456,720	R 5 772,70	
1753	Partial or segmental hepatectomy	20	378,000	R 6 123,80		20	378,000	R 6 123,80		20	302,400	R 3 822,30	

1754	Hepatico-jejunostomy	20	369,200	R 5 981,20		20	369,200	R 5 981,20		20	295,360	R 3 733,30	
1755	Liver transplant	20	1400,800	R 22 694,10		20	1400,800	R 22 694,10		20	1120,640	R 14 164,40	
1756	Harvesting donor hepatectomy	20	616,200	R 9 982,80		20	616,200	R 9 982,80		20	492,960	R 6 230,80	
1757	Suture of liver wound or injury	20	214,200	R 3 470,40		20	214,200	R 3 470,40		20	171,360	R 2 165,90	
8.12	Biliary tract												
1759	Cholecystostomy	20	171,600	R 2 780,00		20	171,600	R 2 780,00		20	137,280	R 1 735,20	
1761	Cholecystectomy	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
1762	Cholecystectomy and operative cholangiogram	20	255,000	R 4 131,20		20	255,000	R 4 131,20		20	204,000	R 2 578,60	
1763	With exploration of common bile duct	20	264,500	R 4 285,10		20	264,500	R 4 285,10		20	211,600	R 2 674,60	
1765	Exploration of common bile duct: Secondary operation	20	327,700	R 5 309,10		20	327,700	R 5 309,10		20	262,160	R 3 313,60	
1767	Reconstruction of common bile duct	20	371,700	R 6 021,90		20	371,700	R 6 021,90		20	297,360	R 3 758,60	
1768	Resection bile duct tumour with reconstruction	20	327,700	R 5 309,10		20	327,700	R 5 309,10		20	262,160	R 3 313,60	
1769	Cholecysto-enterostomy or gastrostomy	20	236,300	R 3 828,20		20	236,300	R 3 828,20		20	189,040	R 2 389,30	
1772	Endoscopic placement of a nasobiliary drainage tube: Add to ERCP (Item 1778)	20	25,600	R 414,60		20	25,600	R 414,60		20	25,600	R 323,50	
1773	Transduodenal sphincteroplasty	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
1774	Balloon dilatation of common bile duct strictures	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	100,000	R 1 264,00	
1775	Excision choledochal cyst with reconstruction	20	327,700	R 5 309,10		20	327,700	R 5 309,10		20	262,160	R 3 313,60	
1777	Porto-enterostomy for biliary atresia	20	400,000	R 6 480,30		20	400,000	R 6 480,30		20	320,000	R 4 044,60	
8.13	Pancreas												
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	20	105,900	R 1 715,70		20	105,900	R 1 715,70		20	105,900	R 1 338,60	
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct. Add to ERCP (Item 1778)	20	15,820	R 256,40		20	15,820	R 256,40		20	15,820	R 199,90	
1780	Gastric and duodenal intubation	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	

1781	Procedure (excluding laboratory tests)	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
1782	Endoscopic Sphincterotomy: Add to ERCP (Item 1778)	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1783	Drainage of pancreatic abscess	20	239,300	R 3 876,80		20	239,300	R 3 876,80		20	191,440	R 2 419,60	
1784	Debridement pancreatic necrosis	20	348,400	R 5 644,20		20	348,400	R 5 644,20		20	278,720	R 3 522,90	
1785	Internal drainage of pancreatic cyst	20	250,600	R 4 059,70		20	250,600	R 4 059,70		20	200,480	R 2 534,00	
1770	Endoscopic placement of biliduodenal endoprosthesis: Add to ERCP (Item 1778)	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1786	Internal drainage of pancreatic cyst with Roux-Y	20	306,800	R 4 970,40		20	306,800	R 4 970,40		20	245,440	R 3 102,10	
1787	Operative pancreatogram: Add	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1788	Biopsy of pancreas	20	177,700	R 2 879,00		20	177,700	R 2 879,00		20	142,160	R 1 796,90	
1789	Pancreatico-duodenectomy	20	704,800	R 11 418,10		20	704,800	R 11 418,10		20	563,840	R 7 126,70	
1791	Local, partial or subtotal pancreatectomy	20	351,300	R 5 691,30		20	351,300	R 5 691,30		20	281,040	R 3 552,30	
1793	Distal pancreatectomy with internal drainage	20	377,400	R 6 114,00		20	377,400	R 6 114,00		20	301,920	R 3 816,10	
8.14	Peritoneal cavity												
1797	Pneumo-peritoneum: First	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
1799	Pneumo-peritoneum: Repeat	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
1800	Peritoneal lavage	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
1801	Diagnostic paracentesis: Abdomen	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
1803	Therapeutic paracentesis: Abdomen	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
1807	Add to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027).	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
1808	Omentectomy (separate procedures)		189,200	R 3 064,50			189,200	R 3 064,50			151,360	R 1 912,30	
1809	Laparotomy	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
1811	Suture of burst abdomen	20	188,300	R 3 050,80		20	188,300	R 3 050,80		20	150,640	R 1 904,10	

1812	Laparotomy for control of surgical haemorrhage	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
1813	Drainage of sub-phrenic abscess	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	20	248,400	R 4 024,20		20	248,400	R 4 024,20		20	198,720	R 2 511,70	
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
9	**Herniae**												
1819	Inguinal or femoral hernia: Adult	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
1821	Inguinal or femoral hernia: Child under 14 years	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	
1823	Inguinal hernia: Infant under one year	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1825	Recurrent inguinal or femoral hernia	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
1827	Strangulated hernia or femoral hernia	20	238,000	R 3 855,80		20	238,000	R 3 855,80		20	190,400	R 2 406,70	
1829	Epigastric hernia	20	93,300	R 1 511,60		20	93,300	R 1 511,60		20	93,300	R 1 179,40	
1831	Umbilical hernia: Adult	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
1833	Umbilical hernia: Child under 14 years	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
1835	Incisional hernia	20	166,800	R 2 702,40		20	166,800	R 2 702,40		20	133,440	R 1 686,60	
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to Item for the incisional or ventral hernia repair)	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
1837	Repair of omphalocele in newborn (one or more procedures)	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	

10	**Urinary system**												
	RULES GOVERNING THE SECTION URINARY SYSTEM												
FF.	a. When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to Item 1949: Cystoscopy, when performed together with any of Items 1951 to 1973.												
10.1	Kidney												
1839	Renal biopsy: Per kidney, open	20	71,000	R 1 150,30		20	71,000	R 1 150,30		20	71,000	R 897,40	
1841	Renal biopsy: Needle	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
1843	Peritoneal dialysis: First day	20	33,000	R 534,80		20	33,000	R 534,80		20	33,000	R 417,10	
1845	Peritoneal dialysis: Every subsequent day	20	33,000	R 534,80		20	33,000	R 534,80		20	33,000	R 417,10	
1847	Haemodialysis: Per hour or part thereof	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
1849	Haemodialysis: Maximum, eight hours	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
1851	Haemodialysis: Thereafter per week	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
1852	Continuous haemodiafiltration per day in intensive or high care unit	20	33,000	R 534,80		20	33,000	R 534,80		20	33,000	R 417,10	
1853	Nephrectomy: Primary nephrectomy	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
1855	Nephrectomy: Secondary nephrectomy	20	267,000	R 4 325,70		20	267,000	R 4 325,70		20	213,600	R 2 699,80	
1857	Radical with regional lymph adenectomy for tumour	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
1859	Nephrectomy: Partial	20	267,000	R 4 325,70		20	267,000	R 4 325,70		20	213,600	R 2 699,80	
1861	Symphysiotomy for horse-shoe kidney	20	287,000	R 4 649,60		20	287,000	R 4 649,60		20	229,600	R 2 902,10	
1863	Nephro-ureterectomy	20	305,000	R 4 941,20		20	305,000	R 4 941,20		20	244,000	R 3 084,10	

1865	Nephrotomy with drainage nephrostomy	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1868	Nephrolithotomy, for congenital kidney abnormality, complicated	20	268,400	R 4 348,20		20	268,400	R 4 348,20					
1869	Nephrolithotomy	20	227,000	R 3 677,60		20	227,000	R 3 677,60		20	181,600	R 2 295,40	
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	20	284,000	R 4 600,90		20	284,000	R 4 600,90		20	227,200	R 2 871,80	
1871	Staghorn stone: Surgical	20	341,000	R 5 524,40		20	341,000	R 5 524,40		20	272,800	R 3 448,10	
1873	Suture renal laceration (renorraphy)	20	193,000	R 3 126,70		20	193,000	R 3 126,70		20	154,400	R 1 951,50	
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	20	34,000	R 550,80		20	34,000	R 550,80		20	34,000	R 429,70	
1877	Operation for renal cyst: Marsupialisation or excision	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1878	Ablation of one or more renal tumour(s): Cryotherapy, percutaneous, unilateral	20	106,000	R 1 717,40		20	106,000	R 1 717,40				R 0,00	
1879	Closure renal fistula	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1881	Pyeloplasty	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
1882	Pyeloplasty, complicated; with or without plastic procedure on ureter; nephropexy; nephrostomy; pyelostomy; ureteral splinting. (Secondary procedure for congenital kidney abnormality or solitary kidney)	20	327,700	R 5 308,80		20	327,700	R 5 308,80					
1883	Pyelostomy	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1885	Pyelolithotomy	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	20	223,000	R 3 612,70		20	223,000	R 3 612,70		20	178,400	R 2 255,00	
1889	Nephrectomy for Allograft: Living or dead	20	255,000	R 4 131,20		20	255,000	R 4 131,20		20	204,000	R 2 578,60	
1891	Perinephric abscess or renal abscess: Drainage	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
1893	Aberrant renal vessels: Repositioning with pyeloplasty	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
1894	Auto transplantation of kidney	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	

1895	Allo transplantation of kidney	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	
10.2	Ureter												
1897	Ureterorraphy: Suture of ureter	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
1898	Ureterorraphy: Lumbar approach	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1899	Ureteroplasty	20	181,000	R 2 932,20		20	181,000	R 2 932,20		20	144,800	R 1 830,30	
1901	Ureterolysis	20	118,000	R 1 911,60		20	118,000	R 1 911,60		20	118,000	R 1 491,50	
1902	Ureterolysis: Lumbar approach	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1903	Ureterectomy only	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
1905	Ureterolithotomy	20	265,800	R 4 306,10		20	265,800	R 4 306,10		20	212,640	R 2 687,50	
1907	Cutaneous ureterostomy: Unilateral	20	108,000	R 1 749,50		20	108,000	R 1 749,50		20	108,000	R 1 364,90	
1909	Cutaneous ureterostomy: Bilateral	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
1911	Uretero-enterostomy: Unilateral	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
1913	Uretero-enterostomy: Bilateral	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
1915	Uretero-ureterostomy	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
1917	Transuretero-ureterostomy	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
1919	Closure of ureteric fistula	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
1921	Immediate deligation of ureter	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
1923	Ureterolysis for retrocaval ureter with anastomosis	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
1924	Ureterocalicostomy	20	20,000	R 4 291,20		20	20,000	R 4 291,20					
1925	Uretero-pyelostomy	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
1927	Uretero-neo-cystostomy: Unilateral	20	316,100	R 5 121,00		20	316,100	R 5 121,00		20	252,880	R 3 196,30	
1929	Uretero-neo-cystostomy: Bilateral	20	474,150	R 7 681,70		20	474,150	R 7 681,70		20	379,320	R 4 794,30	
1931	Uretero-neo-cystostomy: With Boariplasty	20	351,800	R 5 699,40		20	351,800	R 5 699,40		20	281,440	R 3 557,30	
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
1935	Uretero-ileal conduit	20	388,000	R 6 285,80		20	388,000	R 6 285,80		20	310,400	R 3 923,40	

1937	Replacement of ureter by bowel segment: Unilateral	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
1939	Replacement of ureter by bowel segment: Bilateral	20	485,000	R 7 857,40		20	485,000	R 7 857,40		20	388,000	R 4 904,10	
1941	Ureterostomy-in-situ: Unilateral	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1943	Ureterostomy-in-situ: Bilateral	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
10.3	Bladder												
1952	J J Stent catheter	20	44,000	R 712,80		20	44,000	R 712,80		20	44,000	R 556,20	
1953	With hydrodilatation of the bladder for interstitial cystitis	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
1954	Uretroscopy	20	35,000	R 567,00		20	35,000	R 567,00					
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
1957	With dilatation of the ureter or ureters	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1959	With manipulation of ureteral calculus	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
1961	With removal of foreign body or calculus from urethra or bladder	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
1963	With fulguration or treatment of minor lesions, with or without biopsy	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1964	And control of haemorrhage and blood clot evacuation	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1965	And catheterisation of the ejaculatory duct	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1967	With ureteric meatotomy: Unilateral or bilateral	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1969	And cold biopsy	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
1971	With cryosurgery for bladder or prostatic disease	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	

1975	Ultraviolet cystoscopy for bladder tumour	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
1976	Optic urethrotomy	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1977	Transurethral resection of ejaculatory duct	20	60,700	R 983,30		20	60,700	R 983,30		20	60,700	R 767,10	
1979	Internal urethrotomy: Female	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
1981	Internal urethrotomy: Male	20	76,200	R 1 234,60		20	76,200	R 1 234,60		20	76,200	R 963,20	
1983	Transurethral resection of bladder tumour	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
1984	Transurethral resection of bladder tumours: Large multiple tumours	20	115,000	R 1 863,10		20	115,000	R 1 863,10		20	115,000	R 1 453,60	
1985	Transurethral resection of bladder neck: Female or child	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
1986	Transurethral resection of bladder neck: Male	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
1987	Litholapaxy	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
1989	Cystometrogram	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1991	Flometric bladder, studies with videocystograph	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
1992	Without videocystograph	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
1993	Voiding cysto-urethrogram	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
1994	Rigiscan examination	20	66,000	R 1 069,20		20	66,000	R 1 069,20		20	66,000	R 834,10	
1995	Percutaneous aspiration of bladder	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1996	Bladder catheterisation: Male (not at operation)	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
1997	Bladder catheterisation: Female (not at operation)	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
1999	Percutaneous cystostomy	20	24,000	R 388,90		20	24,000	R 388,90		20	24,000	R 303,50	
1945	Instillation of radio-opaque material for cystography or urethrocystography	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
1949	Cystoscopy: Hospital equipment	20	44,000	R 712,80		20	44,000	R 712,80		20	44,000	R 556,20	

1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
2001	Total cystectomy: After previous urinary diversion	20	294,000	R 4 763,00		20	294,000	R 4 763,00		20	235,200	R 2 972,70	
2003	Total cystectomy: With conduit construction and ureteric anastomosis	20	554,700	R 8 986,60		20	554,700	R 8 986,60		20	443,760	R 5 609,00	
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	20	650,000	R 10 530,70		20	650,000	R 10 530,70		20	520,000	R 6 572,50	
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2007	Partial cystectomy	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	20	462,000	R 7 484,60		20	462,000	R 7 484,60		20	369,600	R 4 671,60	
2010	Reversion of temporary conduit	20	360,000	R 5 832,30		20	360,000	R 5 832,30		20	288,000	R 3 640,00	
2011	Partial cystectomy with uretero-neo-cystostomy	20	202,000	R 3 272,40		20	202,000	R 3 272,40		20	161,600	R 2 042,70	
2012	Reversion of conduit with major urinary tract reconstruction	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
2013	Diverticulectomy (independent procedure): Multiple or single	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
2014	Closure of cystostomy (stand alone procedure)	20	120,000	R 1 944,10		20	120,000	R 1 944,10					
2015	Suprapubic cystostomy	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2016	Abdomino-neo-urethrostomy	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
2017	Open loop fulguration or excision of bladder tumour	20	101,000	R 1 636,10		20	101,000	R 1 636,10		20	101,000	R 1 276,50	
2019	Operation for vesico-vaginal or urethra-vaginal fistula	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
2020	Repair of vesico vaginal fistula: Abdominal approach	20	255,000	R 4 131,20		20	255,000	R 4 131,20		20	204,000	R 2 578,60	

2021	Vesico-plication (Hamilton Stewart)	20	118,000	R 1 911,60		20	118,000	R 1 911,60		20	118,000	R 1 491,50	
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	20	195,000	R 3 159,10		20	195,000	R 3 159,10		20	156,000	R 1 971,90	
2025	Vesico-urethropexy with rectus sling	20	229,400	R 3 716,40		20	229,400	R 3 716,40		20	183,520	R 2 319,70	
2027	Open operation for ureterocele: Unilateral	20	118,000	R 1 911,60		20	118,000	R 1 911,60		20	118,000	R 1 491,50	
2029	Open operation for ureterocele: Bilateral	20	207,000	R 3 353,70		20	207,000	R 3 353,70		20	165,600	R 2 093,20	
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	20	264,000	R 4 277,10		20	264,000	R 4 277,10		20	211,200	R 2 669,40	
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	20	53,000	R 858,60		20	53,000	R 858,60		20	53,000	R 669,90	
2035	Cutaneous vesicostomy	20	118,000	R 1 911,60		20	118,000	R 1 911,60		20	118,000	R 1 491,50	
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	20	126,000	R 2 041,40		20	126,000	R 2 041,40		20	120,000	R 1 516,60	
2039	Operation for ruptured bladder	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
2042	Enterocystoplasty plus bowel anastomosis	20	419,900	R 6 802,60		20	419,900	R 6 802,60		20	335,920	R 4 246,00	
2043	Cysto-lithotomy	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
2045	Excision of patent-urachus or urachal cyst	20	112,000	R 1 814,50		20	112,000	R 1 814,50		20	112,000	R 1 415,60	
2047	Drainage of perivesical or prevesical abscess	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
2049	Evacuation of clots from bladder: Other than post-operative	20	132,100	R 2 140,10		20	132,100	R 2 140,10		20	120,000	R 1 516,60	
2050	Evacuation of clots from bladder: Post-operative												
2051	Simple bladder lavage: Including catheterisation	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
2053	Bladder neck plasty: Male	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
2057	Bladder neck plasty: Female	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
10.4	Urethra												
2059	Open biopsy of urethra: Male	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2061	Open biopsy of urethra: Female	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	

2063	Dilatation of urethra stricture: By passage sound – initial (male)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2065	Dilatation of urethra stricture: By passage sound – subsequent (male)	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
2067	Dilatation of urethra stricture: By passage sound – by passage of filiform and follower (male)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2069	Dilatation of female urethra	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
2071	Urethrorraphy: Suture of urethral wound or injury	20	139,000	R 2 251,80		20	139,000	R 2 251,80		20	120,000	R 1 516,60	
2073	External urethrotomy: Pendulous urethra (anterior)	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2075	Urethraplasty: Pendulous urethra – first stage	20	71,000	R 1 150,30		20	71,000	R 1 150,30		20	71,000	R 897,40	
2077	Urethraplasty: Pendulous urethra: Second stage	20	145,000	R 2 349,10		20	145,000	R 2 349,10		20	120,000	R 1 516,60	
2079	Reconstruction of female urethra	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2081	Reconstruction or repair of male anterior urethra (one stage)	20	261,600	R 4 238,10		20	261,600	R 4 238,10		20	209,280	R 2 645,30	
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	20	294,000	R 4 763,00		20	294,000	R 4 763,00		20	235,200	R 2 972,70	
2087	Urethral diverticulectomy: Male or female	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2088	Peri-urethral teflon injection: Male or female – fee as for cystoscopy (Item 1949) plus 42,00 clinical procedure units	20	86,000	R 1 393,10		20	86,000	R 1 393,10		20	86,000	R 1 087,00	
2089	Marsupialisation of urethral diverticula: Male or female	20	115,100	R 1 864,70		20	115,100	R 1 864,70		20	115,100	R 1 454,80	
2091	Total urethrectomy: Female	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2093	Total urethrectomy: Male	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	

2095	Drainage of simple localised perineal urinary extravasation	20	128,800	R 2 086,70		20	128,800	R 2 086,70		20	120,000	R 1 516,60	
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	20	137,000	R 2 219,70		20	137,000	R 2 219,70		20	120,000	R 1 516,60	
2099	Fulguration for urethral caruncle or polyp	20	53,600	R 868,40		20	53,600	R 868,40		20	53,600	R 677,40	
2101	Excision of urethral caruncle	20	53,600	R 868,40		20	53,600	R 868,40		20	53,600	R 677,40	
2103	Simple urethral meatotomy	20	26,300	R 426,10		20	26,300	R 426,10		20	26,300	R 332,40	
2105	Incision of deep peri-urethral abscess: Female	20	123,100	R 1 994,30		20	123,100	R 1 994,30		20	120,000	R 1 516,60	
2107	Incision of deep peri-urethral abscess: Male	20	123,100	R 1 994,30		20	123,100	R 1 994,30		20	120,000	R 1 516,60	
2108	Sling operation for male urinary incontinence (fascia or synthetic)	20	169,000	R 2 737,20		20	169,000	R 2 737,20					
2109	Badenoch pull-through for intractable stricture or incontinence	20	181,000	R 2 932,20		20	181,000	R 2 932,20		20	144,800	R 1 830,30	
2110	Removal/revision: Sling for male urinary incontinence (fascia or synthetic)	20	120,000	R 1 944,10		20	120,000	R 1 944,10					
2111	External sphincterotomy	20	108,000	R 1 749,50		20	108,000	R 1 749,50		20	108,000	R 1 364,90	
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff	20	217,600	R 3 525,40		20	217,600	R 3 525,40					
2113	Drainage of Skene gland abscess or cyst	20	42,300	R 685,40		20	42,300	R 685,40		20	42,300	R 534,70	
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff	20	142,500	R 2 308,30		20	142,500	R 2 308,30					
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
2116	Urethral meatoplasty	20	101,500	R 1 644,20		20	101,500	R 1 644,20		20	101,500	R 1 282,90	
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	20	150,300	R 2 434,80		20	150,300	R 2 434,80		20	120,240	R 1 520,00	
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff	20	154,400	R 2 501,30		20	154,400	R 2 501,30					
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff	20	123,500	R 2 001,10		20	123,500	R 2 001,10					

2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridment of infected tissue	20	278,200	R 4 506,50		20	278,200	R 4 506,50					
2121	Closure of urethrovaginal fistula: Including diversionary procedures	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
11	**Male genital system**												
11.1	Penis												
2123	Biopsy of penis (independent procedure)	20	52,100	R 844,00		20	52,100	R 844,00		20	52,100	R 658,50	
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see Item 2317)	20	16,600	R 268,90		20	16,600	R 268,90		20	16,600	R 209,80	
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	20	41,600	R 674,00		20	41,600	R 674,00		20	41,600	R 525,80	
2129	Electrodesiccation: Limited number	20	20,800	R 337,10		20	20,800	R 337,10		20	20,800	R 263,00	
2131	Electrodesiccation: Multiple extensive	20	41,600	R 674,00		20	41,600	R 674,00		20	41,600	R 525,80	
2132	Ligation of abnormal venous drainage	20	106,100	R 1 718,60		20	106,100	R 1 718,60		20	106,100	R 1 341,00	
2133	Circumcision: Clamp procedure	20	42,300	R 685,40		20	42,300	R 685,40		20	42,300	R 534,70	
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	20	36,800	R 596,10		20	36,800	R 596,10		20	36,800	R 465,20	
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	20	101,000	R 1 636,10		20	101,000	R 1 636,10		20	101,000	R 1 276,50	
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	20	188,600	R 3 055,50		20	188,600	R 3 055,50		20	150,880	R 1 906,90	
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	20	224,600	R 3 638,70		20	224,600	R 3 638,70		20	179,680	R 2 270,90	
2147	Reconstructive operation of penis: For injury: Including fracture of penis and skin graft, if required	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	

2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
2153	Reconstructive operation for epispadias with incontinence	20	168,000	R 2 721,70		20	168,000	R 2 721,70		20	134,400	R 1 698,70	
2154	Induction of artificial erection	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
2155	Hypospadias: Urethral reconstruction	20	187,000	R 3 029,60		20	187,000	R 3 029,60		20	149,600	R 1 891,10	
2157	Hypospadias: Subsequent procedures for repair of urethra: Total	20	84,000	R 1 360,70		20	84,000	R 1 360,70		20	84,000	R 1 061,40	
2159	Hypospadias: Urethraplasty: Complete, one stage for hypospadias	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
2161	Total amputation of penis: Without gland dissection	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
2163	Total amputation of penis: With gland-dissection	20	336,000	R 5 443,50		20	336,000	R 5 443,50		20	268,800	R 3 397,50	
2165	Partial amputation of penis: With gland-dissection	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
2167	Partial amputation of penis: Without gland-dissection	20	84,000	R 1 360,70		20	84,000	R 1 360,70		20	84,000	R 1 061,40	
2169	Injection procedure for Peyronie's disease	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	20	42,000	R 680,40		20	42,000	R 680,40		20	42,000	R 530,90	
2173	Priapism operation: Shunt procedure – any type	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
2174	Priapism operation: Stab shunt	20	114,400	R 1 853,50		20	114,400	R 1 853,50		20	114,400	R 1 446,10	
11.2	Testis and epididymis												
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure												
2175	Testis biopsy: Needle (independent procedure)	20	18,500	R 299,70		20	18,500	R 299,70		20	18,500	R 233,70	
2177	Testis biopsy: Incisional: Independent procedure – unilateral	20	58,900	R 954,20		20	58,900	R 954,20		20	58,900	R 744,50	

2179	Testis biopsy: Incisional: Independent procedure: Bilateral	20	58,900	R 954,20		20	58,900	R 954,20		20	58,900	R 744,50	
2181	Epididymis biopsy: Needle	20	86,100	R 1 394,90		20	86,100	R 1 394,90		20	86,100	R 1 088,20	
2183	Puncture aspiration hydrocele with or without injection of medication	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
2185	Operation for maldescended testicle: Including herniotomy	20	135,000	R 2 187,20		20	135,000	R 2 187,20		20	120,000	R 1 516,60	
2187	Operation for torsion appendix testis	20	119,200	R 1 931,30		20	119,200	R 1 931,30		20	119,200	R 1 506,60	
2189	Operation for torsion testis with fixation of contralateral testis	20	119,200	R 1 931,30		20	119,200	R 1 931,30		20	119,200	R 1 506,60	
2191	Orchidectomy (total or subcapsular): Unilateral	20	98,000	R 1 587,70		20	98,000	R 1 587,70		20	98,000	R 1 238,70	
2193	Orchidectomy (total or subcapsular): Bilateral	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2195	Radical operation for malignant testis: Excluding gland dissection	20	155,300	R 2 515,80		20	155,300	R 2 515,80		20	124,240	R 1 570,40	
2197	Operation for hydrocele or spermatocele	20	99,800	R 1 616,70		20	99,800	R 1 616,70		20	99,800	R 1 261,40	
2199	Varicocelectomy	20	106,100	R 1 718,60		20	106,100	R 1 718,60		20	106,100	R 1 341,00	
2201	Abdominal ligation of spermatic vein for varicocele	20	112,800	R 1 827,50		20	112,800	R 1 827,50		20	112,800	R 1 425,80	
2203	Epididymectomy: Unilateral	20	114,400	R 1 853,50		20	114,400	R 1 853,50		20	114,400	R 1 446,10	
2205	Epididymectomy: Bilateral	20	158,200	R 2 563,10		20	158,200	R 2 563,10		20	126,560	R 1 599,70	
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	20	55,900	R 905,50		20	55,900	R 905,50		20	55,900	R 706,50	
2209	Vasotomy: Unilateral or bilateral	20	70,400	R 1 140,60		20	70,400	R 1 140,60		20	70,400	R 890,00	
2210	Vasogram, seminal vesiculogram: Unilateral	20	58,100	R 941,20		20	58,100	R 941,20		20	58,100	R 734,40	
2211	Vasogram, seminal vesiculogram: Bilateral	20	58,100	R 941,20		20	58,100	R 941,20		20	58,100	R 734,40	
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	20	91,200	R 1 477,50		20	91,200	R 1 477,50		20	91,200	R 1 152,60	
2213	Suture or repair of testicular injury	20	110,300	R 1 786,80		20	110,300	R 1 786,80		20	110,300	R 1 394,10	
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	20	90,000	R 1 458,00		20	90,000	R 1 458,00		20	90,000	R 1 137,60	

2217	Excision of local lesion of testis or epididymis	20	90,800	R 1 470,90		20	90,800	R 1 470,90		20	90,800	R 1 147,50	
2219	Vaso-vasostomy: Unilateral	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2221	Vaso-vasostomy: Bilateral	20	117,000	R 1 895,60		20	117,000	R 1 895,60		20	117,000	R 1 478,90	
2223	Epididymo-vasostomy: Unilateral	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2225	Epididymo-vasostomy: Bilateral	20	117,000	R 1 895,60		20	117,000	R 1 895,60		20	117,000	R 1 478,90	
2227	Incision and drainage of scrotal wall abscess	20	42,700	R 691,80		20	42,700	R 691,80		20	42,700	R 539,80	
2229	Excision of Mullerian duct cyst	20	189,000	R 3 062,00		20	189,000	R 3 062,00		20	151,200	R 1 911,20	
2231	Excision of lesion of spermatic cord	20	84,000	R 1 360,70		20	84,000	R 1 360,70		20	84,000	R 1 061,40	
2233	Seminal Vesiculectomy	20	220,000	R 3 564,10		20	220,000	R 3 564,10		20	176,000	R 2 224,40	
11.3	Prostate												
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	20	23,300	R 377,50		20	23,300	R 377,50		20	23,300	R 294,40	
2237	Biopsy prostate: Incisional, any approach	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
2239	Transurethral drainage of prostatic abscess	20	117,400	R 1 902,20		20	117,400	R 1 902,20		20	117,400	R 1 484,00	
2241	Perineal drainage of prostatic abscess	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
2243	Trans-urethral cryo-surgical removal of prostate	20	126,000	R 2 041,40		20	126,000	R 2 041,40		20	120,000	R 1 516,60	
2245	Trans-urethral resection of prostate	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	20	126,000	R 2 041,40		20	126,000	R 2 041,40		20	120,000	R 1 516,60	
2249	Trans-urethral resection of post-operative bladder neck contracture	20	126,000	R 2 041,40		20	126,000	R 2 041,40		20	120,000	R 1 516,60	
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing		501,800	R 8 127,80			501,800	R 8 127,80			401,440	R 5 072,00	
2251	Prostatectomy: Perineal – sub-total	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
2253	Prostatectomy: Perineal – radical	20	336,000	R 5 443,50		20	336,000	R 5 443,50		20	268,800	R 3 397,50	
2254	Pelvic lymph adenectomy	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
2255	Supra-pelvic, transversical	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	
2257	Retropubic: Sub-total	20	252,000	R 4 082,60		20	252,000	R 4 082,60		20	201,600	R 2 548,10	

2259	Retropubic: Radical	20	336,000	R 5 443,50		20	336,000	R 5 443,50		20	268,800	R 3 397,50	
2260	Prostate brachytherapy	20	230,000	R 3 726,10		20	230,000	R 3 726,10		20	184,000	R 2 325,60	
12	**Female genital system**												
12.1	Vulva and introitus												
2271	Removal of tag or polyp	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
2272	Removal of small superficial benign lesions	20	23,000	R 372,60		20	23,000	R 372,60		20	23,000	R 290,70	
2273	Biopsy with suture in theatre (excluding after-care)	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	20	71,000	R 1 150,30		20	71,000	R 1 150,30		20	71,000	R 897,40	
2275	Reduction labial hypertrophy	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2277	Removal of extensive benign vulva tumour	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2279	Secondary perineal repair: Repair second degree tear	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2280	Secondary perineal repair: Repair third degree tear	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
2281	Excision of inclusion cyst	20	43,000	R 696,90		20	43,000	R 696,90		20	43,000	R 543,70	
2283	Hymenectomy	20	43,000	R 696,90		20	43,000	R 696,90		20	43,000	R 543,70	
2285	Drainage haematocolpos	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2287	Clitoris repair for injury: Including skin graft, if required	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2288	Clitoral reduction	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
2289	Denervation or alcohol infiltration vulva (Woodruff)	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2291	Vulva: Undercutting skin (ball)	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
2293	Vulva and introitus: Drainage of abscess	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
2295	Bartholin gland: Bartholin abscess marsupialisation	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
2297	Bartholin gland: Bartholin gland excision	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	

2299	Bartholin gland: Bartholin radical excision for malignant lesion	20	357,000	R 5 783,50		20	357,000	R 5 783,50		20	285,600	R 3 609,90	
2301	Operation for enlarging introitus: Fenton plasty	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2303	Operation for enlarging introitus: Bilateral Z-plastic	20	88,000	R 1 425,70		20	88,000	R 1 425,70		20	88,000	R 1 112,30	
2305	Vulvectomy: Partial	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2307	Vulvectomy	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
2309	Radical vulvectomy with bilateral lymphdenectomy	20	357,000	R 5 783,50		20	357,000	R 5 783,50		20	285,600	R 3 609,90	
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	20	402,000	R 6 512,70		20	402,000	R 6 512,70		20	321,600	R 4 064,90	
12.2	Vaginal procedures and operations												
2312	Artificial insemination	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) – stand alone procedure	20	25,500	R 413,20		20	25,500	R 413,20		20	25,500	R 322,50	
2314	Intra uterine insemination	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2315	Simms Hühner test plus wet smear	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – limited	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	20	56,000	R 907,40		20	56,000	R 907,40		20	56,000	R 707,80	
2319	Excision of cysts or tumours	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2321	Drainage of vaginal abscess	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2322	Pudendal nerve block	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
2323	Reconstruction of vagina after atresia	20	107,000	R 1 733,40		20	107,000	R 1 733,40		20	107,000	R 1 352,30	

2324	Revision of prosthetic vaginal graft: Vaginal approach (removal included)	20	129,800	R 0,00		20	129,800	R 2 058,80			120,000	R 1 852,60	
2325	Construction of artificial vagina: Labial fusion	20	179,000	R 2 899,90		20	179,000	R 2 899,90		20	143,200	R 1 810,00	
2326	Revision of prosthetic vaginal graft: Abdominal approach (removal included)	20	199,100	R 3 225,90		20	199,100	R 3 225,90					
2327	Construction of artificial vagina: Macindoe type	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2329	Construction of vagina: Bowel pull-through operation: Two surgeons, each	20	241,000	R 3 904,50		20	241,000	R 3 904,50		20	192,800	R 2 436,80	
2330	Fitting/insertion of pessary or other intravaginal support device	20	11,998	R 194,40		20	11,998	R 194,40			3,000	R 238,00	
2331	Vaginal septum removal	20	107,000	R 1 733,40		20	107,000	R 1 733,40		20	107,000	R 1 352,30	
2333	Vaginal prolapse: Abdominal approach – sacrocolpopexy with use of mesh	20	243,300	R 3 941,80		20	243,300	R 3 941,80		20	194,640	R 2 460,20	
2334	Vaginal prolapse: Abdominal approach – use of rectus sheath or tape	20	243,300	R 3 941,80		20	243,300	R 3 941,80		20	194,640	R 2 460,20	
2335	Vaginal prolapse: Vaginal approach – sacrospinous fixations	20	166,900	R 2 703,90		20	166,900	R 2 703,90		20	133,520	R 1 687,60	
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	20	166,900	R 2 703,90		20	166,900	R 2 703,90		20	133,520	R 1 687,60	
2339	Colpotomy: Diagnostic (excluding after-care)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2341	Colpotomy: Therapeutic, with or without sterilisation	20	103,000	R 1 668,60		20	103,000	R 1 668,60		20	103,000	R 1 301,70	
2343	Vaginal hysterectomy: Without repair	20	210,500	R 3 410,40		20	210,500	R 3 410,40		20	168,400	R 2 128,60	
2345	Vaginal hysterectomy: With repair	20	231,700	R 3 753,60		20	231,700	R 3 753,60		20	185,360	R 2 342,80	
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
2355	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy		110,300	R 0,00			110,300	R 1 749,50			110,300	R 1 702,80	
2359	Colporrhaphy: Anteroposterior, with enterocele repair	20	163,900	R 2 655,80		20	163,900	R 2 655,80					
2361	Vaginal hysterectomy and repair for total prolapse	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	

2363	Fothergill or Manchester repair operation	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	20	232,000	R 3 758,60		20	232,000	R 3 758,60		20	185,600	R 2 346,00	
2366	Posterior repair alone	20	107,000	R 1 733,40		20	107,000	R 1 733,40		20	107,000	R 1 352,30	
2367	Other operations for prolapse: Anterior repair – with or without posterior repair	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2368	Uterovesical fistula	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
2369	Repair of Vesico- or urethro-vaginal fistula	20	179,000	R 2 899,90		20	179,000	R 2 899,90		20	143,200	R 1 810,00	
2370	Repair of VVF – obstetric or radiation	20	232,000	R 3 758,60		20	232,000	R 3 758,60		20	185,600	R 2 346,00	
2371	Closure of uretero-vaginal fistula	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
2373	Closure of recto-vaginal fistula	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
2374	Closure of recto-vaginal fistula: Obstetric or radiation	20	151,000	R 2 446,30		20	151,000	R 2 446,30		20	120,800	R 1 526,90	
2375	Colpocleisis	20	129,000	R 2 090,00		20	129,000	R 2 090,00		20	120,000	R 1 516,60	
2377	Le Fort operation	20	129,000	R 2 090,00		20	129,000	R 2 090,00		20	120,000	R 1 516,60	
2379	Schauta operation	20	357,000	R 5 783,50		20	357,000	R 5 783,50		20	285,600	R 3 609,90	
2381	Vaginectomy	20	268,000	R 4 341,80		20	268,000	R 4 341,80		20	214,400	R 2 710,10	
2383	Synchronous combined hysterocolpectomy: One or two surgeons – total fee	20	429,000	R 6 950,20		20	429,000	R 6 950,20		20	343,200	R 4 338,10	
2385	Vaginal laceration or trauma: Repair	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2386	Repair: Paravaginal defect repair (including repair of cystocele, if performed), abdominal approach	20	172,800	R 2 799,50		20	172,800	R 2 799,50					
2387	Repair: Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach	20	140,100	R 2 269,40		20	140,100	R 2 269,40					
12.3	Cervix												
2389	Paracervical (pelvis) nerve block (for neck refer to Item 3294)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	

2391	Cervix: Canal reconstruction	20	147,000	R 2 381,50		20	147,000	R 2 381,50		20	120,000	R 1 516,60	
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	20	22,000	R 356,50		20	22,000	R 356,50		20	22,000	R 278,00	
2396	Laser or harmonic scalpel treatment of the cervix	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	20	31,000	R 502,30		20	31,000	R 502,30		20	31,000	R 391,90	
2399	Punch biopsy (excluding after-care)	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
2400	Biopsy during pregnancy (excluding after-care)	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	
2403	Wedge biopsy: Cervix (excluding after-care)	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	20	24,000	R 388,90		20	24,000	R 388,90		20	24,000	R 303,50	
2405	Cone biopsy: Cervix (excluding after-care)	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2407	Amputation: Cervix	20	67,000	R 1 085,40		20	67,000	R 1 085,40		20	67,000	R 846,80	
2409	Cervix encirclage: McDonald stitch	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
2411	Cervix encirclage: Shirodkar suture	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
2413	Cervix encirclage: Lash	20	49,000	R 793,80		20	49,000	R 793,80		20	49,000	R 619,20	
2415	Cervix encirclage: Removal Items 2409 and 2411, without anaesthetic	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
2416	Cervix: Removal Items 2409 and 2411, with anaesthetic in theatre	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
2417	Repair of tears: Emmet repair of tears	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2418	Repair of tears: Sturmdorff repair of tears	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2421	Extirpation of cervical stump: Vaginal	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
2423	Extirpation of cervical stump: Abdominal	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
2425	Removal of cervical polyps (excluding after-care)	20	13,000	R 210,40		20	13,000	R 210,40		20	13,000	R 164,20	

2427	Removal of cervical myomata	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2429	Colposcopy (excluding after-care)	20	27,000	R 437,50		20	27,000	R 437,50		20	27,000	R 341,30	
12.4	Uterus												
2432	Hysteroscopic bilateral tubal occlusion with permanent implants (includes hysteroscopy)	20	120,000	R 1 944,10		20	120,000	R 1 944,10					
2433	Embryo transfer	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2434	Endometrial biopsy (excluding after-care)	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2435	Hysterosalpingogram (excluding after-care)	20	22,000	R 356,50		20	22,000	R 356,50		20	22,000	R 278,00	
2436	Hysteroscopy (excluding after-care)	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
2437	Hysteroscopy and D&C (excluding after-care)	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	20	63,000	R 1 020,70		20	63,000	R 1 020,70		20	63,000	R 796,30	
2440	Hysteroscopy and polypectomy (excluding after-care)	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
2441	Hysteroscopy and myomectomy (excluding after-care)	20	130,000	R 2 106,00		20	130,000	R 2 106,00		20	120,000	R 1 516,60	
2442	Insertion of intra uterine contraceptive device (IUCD) – excluding after-care	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2443	Dilatation and curettage (D&C) – excluding after-care	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
2444	Fractional dilatation and curettage (D&C) – excluding after-care	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2445	Evacuation of uterus: Incomplete abortion – before 12 weeks gestation	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2447	Evacuation of uterus, incomplete abortion: After 12 weeks gestation	20	71,000	R 1 150,30		20	71,000	R 1 150,30		20	71,000	R 897,40	
2448	Termination of pregnancy before 12 weeks	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2449	Evacuation: Missed abortion – before 12 weeks gestation	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	

2451	Evacuation: Missed abortion – after 12 weeks gestation	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
2452	Termination of pregnancy after 12 weeks – administration of intra/extra amniotic prostaglandin	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2453	Evacuation hydatidiform mole	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
2455	Evacuation uterus post-partum	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
2461	Ventrosuspension	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
2463	Uteroplasty: Strassman	20	143,000	R 2 316,70		20	143,000	R 2 316,70		20	120,000	R 1 516,60	
2465	Uteroplasty: Tompkins	20	143,000	R 2 316,70		20	143,000	R 2 316,70		20	120,000	R 1 516,60	
2467	Myomectomy	20	143,000	R 2 316,70		20	143,000	R 2 316,70		20	120,000	R 1 516,60	
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	20	254,100	R 4 116,70		20	254,100	R 4 116,70		20	203,280	R 2 569,50	
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy – uncomplicated	20	252,200	R 4 086,00		20	252,200	R 4 086,00		20	201,760	R 2 550,10	
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	20	355,000	R 5 751,40		20	355,000	R 5 751,40		20	284,000	R 3 589,50	
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	20	472,800	R 7 659,80		20	472,800	R 7 659,80		20	378,240	R 4 780,90	
2477	Abdominal hysterotomy with or without sterilisation	20	188,000	R 3 045,70		20	188,000	R 3 045,70		20	150,400	R 1 900,90	
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
2480	Laparoscopy by second gynaecologist during endometrial ablation (Item 2479)	20	120,000	R 1 944,00		20	120,000	R 1 944,00					

12.5	Fallopian tubes												
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee												
2481	Insufflation Fallopian tubes (excluding after-care)	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
2483	Salpingolysis	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
2485	Salpingostomy	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2487	Tuboplasty tubal anastomosis or re-implantation	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	20	125,000	R 2 025,00		20	125,000	R 2 025,00		20	120,000	R 1 516,60	
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2491	Ectopic pregnancy after 12 weeks	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	20	94,000	R 1 523,00		20	94,000	R 1 523,00		20	94,000	R 1 188,20	
	Note: Use Item 1807 for open procedures performed with a laparoscope instead of Item 2493. Item 1807 may only be added once, and may not be charged together with Item 2493 for more than one procedure performed laparoscopically												
2493	Diagnostic laparoscopy (excluding after-care)	20	94,400	R 1 529,20		20	94,400	R 1 529,20		20	94,400	R 1 193,10	
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2497	Laparoscopy: Plus sterilisation	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
2499	Laparoscopy: Plus biopsy (excluding after-care)	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	

2502	Laparoscopy: Plus aspiration of follicles (IVF) (excluding after-care)	20	52,000	R 842,30		20	52,000	R 842,30		20	52,000	R 657,20	
2503	Laparoscopy: Plus ovarian drilling	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) (GIFT)	20	107,000	R 1 733,40		20	107,000	R 1 733,40		20	107,000	R 1 352,30	
2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	20	52,000	R 842,30		20	52,000	R 842,30		20	52,000	R 657,20	
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	20	58,000	R 939,60		20	58,000	R 939,60		20	58,000	R 733,10	
12.6	Ovaries												
2525	Wedge resection of ovaries, unilateral or bilateral	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
2527	Removal of ovarian tumour or cyst	20	187,000	R 3 029,60		20	187,000	R 3 029,60		20	149,600	R 1 891,10	
2529	Oophorectomy: Uni- or bilateral	20	134,500	R 2 179,10		20	134,500	R 2 179,10		20	120,000	R 1 516,60	
2531	Ovarian carcinoma debulking and omentectomy	20	357,000	R 5 783,50		20	357,000	R 5 783,50		20	285,600	R 3 609,90	
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	20	469,000	R 7 598,20		20	469,000	R 7 598,20		20	375,200	R 4 742,40	
12.7	Miscellaneous procedures												
2535	Exenteration: Anterior Exenteration	20	402,000	R 6 512,70		20	402,000	R 6 512,70		20	321,600	R 4 064,90	
2537	Exenteration: Posterior Exenteration	20	402,000	R 6 512,70		20	402,000	R 6 512,70		20	321,600	R 4 064,90	
2539	Exenteration: Total	20	625,000	R 10 125,50		20	625,000	R 10 125,50		20	500,000	R 6 319,70	
2541	Presacral neurectomy	20	98,000	R 1 587,70		20	98,000	R 1 587,70		20	98,000	R 1 238,70	
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)	20	151,400	R 2 452,20		20	151,400	R 2 452,20					
2543	Moschowitz operation	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
2544	Laparoscopic vaginal suspension for stress incontinence (Item 1807 may not be used together with this Item)	20	193,100	R 3 128,40		20	193,100	R 3 128,40		20	154,480	R 1 952,50	

2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	20	195,000	R 3 159,10		20	195,000	R 3 159,10		20	156,000	R 1 971,90	
2546	Operations for stress incontinence: Urethro-vesicopexy – abdominal approach	20	149,000	R 2 413,80		20	149,000	R 2 413,80		20	120,000	R 1 516,60	
2547	Operations for stress incontinence: Burch colposuspension	20	161,000	R 2 608,20		20	161,000	R 2 608,20		20	128,800	R 1 628,00	
2548	Operation for stress incontinence: Use of tape	20	229,400	R 3 716,40		20	229,400	R 3 716,40		20	183,520	R 2 319,70	
2550	Operations for stress incontinence: Urethro-vesicopexy – combined abdominal and vaginal approach	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2551	Laparotomy	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2552	Removal benign retroperitoneal tumour	20	223,000	R 3 612,70		20	223,000	R 3 612,70		20	178,400	R 2 255,00	
2553	Radical removal of malignant retroperitoneal tumour	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
2554	Drainage of pelvic abscess per abdomen	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
2556	Drainage of pelvic abscess per vagina (refer to Item 2341)	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
2558	Drainage intra-abdominal abscess: Delayed closure	20	268,000	R 4 341,80		20	268,000	R 4 341,80		20	214,400	R 2 710,10	
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2561	Surgery for severe endometriosis (AFS stage 4 – retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
2565	Implantation hormone pellets (excluding after-care)	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
2570	Ligation of internal iliac vessels (when not part of another procedure)	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	

13	**Obstetric procedures**												
	RULES GOVERNING THIS SECTION												
	Obstetric procedures a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than six hours, the general practitioner shall charge 50,00 clinical procedure units according to Item 2614: Global obstetric care. ii. If the patient has been in labour for more than six hours, the general practitioner shall charge 80,00 clinical procedure units according to Item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to Item 2614: Global obstetric care.												
13.1	Pre-natal care and procedures												
2603	External cephalic version (excluding after-care)	20	22,000	R 356,50		20	22,000	R 356,50		20	22,000	R 278,00	

2605	Amniocentesis (excluding after-care)	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
2607	Amnioscopy (excluding after-care)	20	18,000	R 291,50		20	18,000	R 291,50		20	18,000	R 227,40	
2609	Intra-uterine transfusion of foetus or cordocentesis	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
2610	Tococardiography – pre-natal and intrapartum (including stress and non-stress test: Own machine) – excluding after-care	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
2611	Chorion villus sampling (excluding after-care)	20	54,000	R 874,80		20	54,000	R 874,80		20	54,000	R 682,50	
13.2	Confinements												
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit)	20	282,000	R 4 568,80		20	282,000	R 5 868,70		20	225,600	R 4 109,80	
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit).	20	267,000	R 4 325,70		20	267,000	R 5 868,70		20	213,600	R 4 109,80	
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	20	190,000	R 3 078,10		20	190,000	R 3 078,10		20	152,000	R 1 921,20	

	Global obstetric care includes: • All modes of delivery (including caesarean) • All inductions of labour (medical or surgical) • Intrapartum paracervical and pudential blocks • Intrapartum amnioscopy • Foetal blood sampling • Application of scalp leads • Symphysiotomy • Manual removal of placenta • Repair cervical tears • Correction of uterine inversion • Drainage of vulval haematoma • Repair third degree tear • Repair second degree tear • Repair episiotomy • Resuscitation of newborn by obstetrician • Tracheal intubation • Missed confinement												
	Global obstetric care excludes: • Prenatal consultations • Prenatal procedures (Items 2603 – 2611) • Emergency hysterectomy for obstetrical reasons • Abdominal operation for repair of ruptured gravid uterus • Intensive care for obstetrical emergencies • Tubal ligation performed as a post-partum procedure • Post-partum complications occurring after discharge from the hospital												
13.3	Operative procedures (excluding antenatal care)												
2653	Caesarean-hysterectomy	20	335,000	R 5 427,10		20	335,000	R 5 427,10		20	268,000	R 3 387,40	
2657	Post-partum hysterectomy	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
2669	Abdominal operation for ruptured gravid uterus: Repair	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	

14	**Nervous system**												
14.1	Diagnostic procedures												
2680	Haemodynamic and autonomic nervous system testing with task Force system- PROFESSIONAL COMPONENTS		29,000	R 469,70			29,000	R 469,70					
2681	Visual evoked potentials (VEP): Unilateral	20	50,000	R 810,00		20	50,000	R 810,00					
2682	Visual evoked potentials (VEP): Bilateral	20	88,000	R 1 425,70		20	88,000	R 1 425,70					
2683	Electro-retinography (Ganzfeld method): Unilateral	20	60,000	R 972,20		20	60,000	R 972,20					
2684	Electro-retinography (Ganzfeld method): Bilateral	20	105,000	R 1 701,00		20	105,000	R 1 701,00					
2685	Electro-oculography: Unilateral	20	30,000	R 485,70		20	30,000	R 485,70					
2686	Electro-oculography: Bilateral	20	53,000	R 858,60		20	53,000	R 858,60					
2687	VEP stable condition (photic drive): Unilateral	20	50,000	R 810,00		20	50,000	R 810,00					
2689	VEP stable condition (photic drive): Bilateral	20	88,000	R 1 425,70		20	88,000	R 1 425,70					
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	20	150,000	R 2 430,20		20	150,000	R 2 430,20					
	Note: See Items 2691 to 2702 under section 17.5.1: Audiometry												
2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex	20	48,000	R 777,60		20	48,000	R 777,60					
2704	Neurostimulation, percutaneous: Sacral nerve		120,800	R 1 956,70			120,800	R 1 956,70					
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	20	6,000	R 97,40		20	6,000	R 97,40		20	6,000	R 76,00	
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment. Includes programming		8,800	R 142,60			8,800	R 142,60					

2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/ or posterior tibial stimulation	20	220,000	R 3 564,10		20	220,000	R 3 564,10					
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	20	80,000	R 1 296,30		20	80,000	R 1 296,30					
2709	Full spinogram including bilateral median and posterior-tibial studies	20	140,000	R 2 267,90		20	140,000	R 2 267,90					
2710	Morphia saturation testing in rooms (consultation x 2 plus Item 0206: Intravenous infusion) – excluding injection material												
2711	Electro-encephalography: Taking of record	20	36,100	R 584,90		20	36,100	R 584,90		20	36,100	R 456,30	
2712	Electro-encephalography: Interpretation	20	24,000	R 388,90		20	24,000	R 388,90		20	24,000	R 303,50	
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications.	20	18,400	R 297,90		20	18,400	R 297,90		20	18,400	R 232,50	Z
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.												
2714	Cisternal puncture and/or intrathecal injections	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
2715	Eight hour ambulatory EEG monitoring (Holter): Hire	20	136,000	R 2 203,30		20	136,000	R 2 203,30					
2716	Eight hour ambulatory EEG monitoring (Holter): Interpretation	20	30,000	R 485,70		20	30,000	R 485,70					
2717	Electromyography: First	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
2718	Electromyography: Subsequent	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
2719	Overnight polysomnogram and sleep staging: Hire	20	125,000	R 2 025,00		20	125,000	R 2 025,00					
2720	Overnight polysomnogram and sleep staging: Interpretation	20	23,000	R 372,60		20	23,000	R 372,60					
2721	Daytime polysomnogram: Hire	20	125,000	R 2 025,00		20	125,000	R 2 025,00					

2722	Daytime polysomnogram: Interpretation	20	17,000	R 275,30		20	17,000	R 275,30					
2723	Multiple sleep latency test: Interpretation	20	125,000	R 2 025,00		20	125,000	R 2 025,00					
2724	Overnight continuous positive airways pressure (CPAP) titration	20	155,000	R 2 511,30		20	155,000	R 2 511,30		20	124,000	R 1 567,20	
2725	Angiography carotis: Unilateral	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
2726	Angiography carotis: Bilateral	20	44,000	R 712,80		20	44,000	R 712,80		20	44,000	R 556,20	
2727	Vertebral artery: Direct needling	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2728	Unattended overnight home-based polysomnogram: Interpretation		24,500	R 396,90			24,500	R 396,90					
2729	Vertebral catheterisation	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') (not to be used with Item 0714)	20	60,000	R 972,20	Z	20	60,000	R 972,20	Z				
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	20	14,500	R 234,90		20	14,500	R 234,90					
2732	Overnight home-based polysomnogram: Interpretation		24,500	R 396,90			24,500	R 396,90					
2733	Cortical Stimulation	20	58,900	R 954,20		20	58,900	R 954,20		20	58,900	R 744,50	
2734	Sodium Amytal Testing (WADA test)	20	88,700	R 1 437,00		20	88,700	R 1 437,00		20	88,700	R 1 121,20	
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	20	31,500	R 510,20		20	31,500	R 510,20		20			v
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
2739	Ventricular needling without burring: Tapping only	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	

2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	20	43,000	R 696,90		20	43,000	R 696,90		20	43,000	R 543,70	
2743	Subdural tapping: First sitting	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
2745	Subdural tapping: Subsequent	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
2746	Biopsy: Temporal artery		91,000	R 1 474,10			91,000	R 1 474,10			91,900	R 1 161,00	
6001	Sleep electro-encephalography: Infants that fit into a perambulator – taking of record	20	36,100	R 584,90		20	36,100	R 584,90		20	36,100	R 456,30	
6002	Sleep electro-encephalography: Infants that fit into a perambulator – interpretation	20	24,500	R 397,10		20	24,500	R 397,10		20	24,500	R 309,90	
6003	Sleep electro-encephalography: Adults and children over infant age – taking of record	20	36,100	R 584,90		20	36,100	R 584,90		20	36,100	R 456,30	
6004	Sleep electro-encephalography: Adults and children over infant age – interpretation	20	24,500	R 397,10		20	24,500	R 397,10		20	24,500	R 309,90	
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised 16 or more channel EEG, which may include video recording (e.g. for pre-operative localisation) – each full 24-hour period	20	294,600	R 4 772,80		20	294,600	R 4 772,80		20	235,680	R 2 978,90	
6011	Interpretation of Item 6010: Electro-encephalogram monitoring – to be charged once only for each full 24-hour period of monitoring	20	128,600	R 2 083,40		20	128,600	R 2 083,40		20	120,000	R 1 516,60	
14.2	Introduction of burr holes for												
2747	Ventriculography	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2749	Catheterisation for ventriculography and/or drainage	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2751	Biopsy of brain tumour	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2753	Subdural haematoma or hygroma	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2755	Subdural empyema	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2757	Brain abscess	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	

14.3	Nerve procedures												
2759	Nerve biopsy: Peripheral	20	37,000	R 599,40		20	37,000	R 599,40		20	37,000	R 467,70	
2763	Nerve biopsy: Cranial nerves – extra-cranial	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2765	Nerve biopsy: Nerve conduction studies (see Items 0733 and 3285)	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + Item 0201 + Item 0202)	20	25,000	R 405,10		20	25,000	R 405,10					
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ Item 0198 + Item 0201 + Item 0202)	20	30,000	R 485,70		20	30,000	R 485,70					
6007	Botulinus toxin injections: For adductor disphonia (+ Item 0198 + 0201 + Item 0202)	20	35,000	R 567,00		20	35,000	R 567,00					
6008	Botulinus toxin injections: In extra-ocular muscles (+ Item 0198 + Item 0201 + Item 0202)	20	35,000	R 567,00		20	35,000	R 567,00					
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ Item 0198 + Item 0201 + Item 0202)	20	50,000	R 810,00		20	50,000	R 810,00					
14.3.1	Nerve procedures: Nerve repair or suture												
2767	Suture brachial plexus (see also Items 2837 and 2839)	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
2769	Suture: Large nerve, primary	20	134,000	R 2 171,10		20	134,000	R 2 171,10		20	120,000	R 1 516,60	
2771	Suture: Large nerve, secondary	20	202,000	R 3 272,40		20	202,000	R 3 272,40		20	161,600	R 2 042,70	
2773	Digital nerve: Primary	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
2775	Digital nerve: Secondary	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
2777	Nerve graft: Simple	20	202,000	R 3 272,40		20	202,000	R 3 272,40		20	161,600	R 2 042,70	
2779	Fascicular: First fasciculus	20	202,000	R 3 272,40		20	202,000	R 3 272,40		20	161,600	R 2 042,70	
2781	Fascicular: Each additional fasciculus	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
2782	Nerve pedicle transfer: First stage (not to be used together with Item 2783)		309,100	R 0,00			309,100	R 0,00			247,280	R 3 817,60	
2783	Fascicular: Nerve flap – to include all stages	20	224,000	R 3 629,00		20	224,000	R 3 629,00		20	179,200	R 2 265,00	

2784	Nerve pedicle transfer: Second stage (not to be used together with Item 2783)		338,300	R 0,00			338,300	R 0,00			270,640	R 4 178,20	
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	20	124,000	R 2 008,80		20	124,000	R 2 008,80		20	120,000	R 1 516,60	
2787	Fascicular: Grafting of facial nerve	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
14.3.2	Nerve procedures: Neurectomy												
2789	Trigeminal ganglion: Injection of alcohol	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2791	Trigeminal ganglion: Injection of cortisone	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
2793	Trigeminal ganglion: Coagulation through high frequency	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
2799	Procedures for pain relief: Intrathecal injections for pain	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
2800	Procedures for pain relief: Plexus nerve block	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) – refer to modifier 0021 for epidural anaesthetic	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.												
2802	Procedures for pain relief: Peripheral nerve block	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
2803	Alcohol injection in peripheral nerves for pain: Unilateral	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2804	Inserting an indwelling nerve catheter (includes removal of catheter) – not for bolus technique	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
2805	Alcohol injection in peripheral nerves for pain: Bilateral	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
2809	Peripheral nerve section for pain	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
2811	Pudendal neurectomy: Bilateral	20	116,000	R 1 879,30		20	116,000	R 1 879,30		20	116,000	R 1 466,20	
2813	Obturator or Stoffels	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	

2815	Interdigital	20	82,300	R 1 333,20		20	82,300	R 1 333,20		20	82,300	R 1 040,30	
2825	Excision: Neuroma – peripheral	20	109,500	R 1 774,00		20	109,500	R 1 774,00		20	109,500	R 1 383,90	
14.3.3	Nerve procedures: Other nerve procedures												
2827	Transposition of ulnar nerve	20	100,000	R 1 620,20		20	100,000	R 1 620,20		20	100,000	R 1 264,00	
2829	Neurolysis: Minor	20	51,000	R 826,10		20	51,000	R 826,10		20	51,000	R 644,50	
2831	Neurolysis: Major	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
2833	Neurolysis: Digital	20	96,000	R 1 555,10		20	96,000	R 1 555,10		20	96,000	R 1 213,30	
2834	Neuroplasty: Sciatic nerve		168,800	R 0,00			168,800	R 0,00			135,04	R 2 084,80	
2835	Scalenotomy	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
2837	Neuroplasty: Brachial Plexus	20	223,000	R 0,00		20	223,000	R 0,00		20	178,400	R 2 754,30	
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	20	895,200	R 14 502,90		20	895,200	R 14 502,90		20	716,160	R 9 051,80	
2841	Carpal tunnel	20	64,000	R 1 036,90		20	64,000	R 1 036,90		20	64,000	R 809,00	
2843	Lumbar sympathectomy: Unilateral	20	153,000	R 2 478,70		20	153,000	R 2 478,70		20	122,400	R 1 547,20	
2845	Lumbar sympathectomy: Bilateral	20	268,000	R 4 341,80		20	268,000	R 4 341,80		20	214,400	R 2 710,10	
2846	Cervical sympathectomy: Trans-thoracic approach (use Item 2847 or Item 2848 as appropriate)												
2847	Cervical sympathectomy: Unilateral	20	153,000	R 2 478,70		20	153,000	R 2 478,70		20	122,400	R 1 547,20	
2848	Cervical sympathectomy: Bilateral	20	268,000	R 4 341,80		20	268,000	R 4 341,80		20	214,400	R 2 710,10	
2849	Sympathetic block: Other levels – unilateral	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
2851	Sympathetic block: Other levels – bilateral	20	35,000	R 567,00		20	35,000	R 567,00		20	35,000	R 442,40	
2853	Sympathetic block: Other levels – diagnostic/ Therapeutic nerve block (unassociated with surgery); either intercostal, or brachial, or peripheral, or stellate ganglion	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	

14.4	Skull procedures												
2855	Removal of skull tumour: With or without plastic repair, small	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
2857	Removal of skull tumour: With or without plastic repair, major	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2859	Repair of depressed fracture of skull: Without brain laceration, major	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2860	Repair of depressed fracture of skull: Without brain laceration, small	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
2861	Repair of depressed fracture of skull: With brain lacerations, small	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2862	Repair of depressed fracture of skull: With brain lacerations, major	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
2863	Cranioplasty	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
2864	Encephalocele (excluding frontal)	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2865	Craniostenosis: Few suturae	20	213,000	R 3 450,60		20	213,000	R 3 450,60		20	170,400	R 2 153,90	
2867	Craniostenosis: Multiple suturae	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
14.5	Shunt procedures												
2869	Ventriculo-cisternostomy	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
2871	Ventriculo-caval shunt	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
2873	Ventriculo-peritoneal shunt	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
2875	Theco-peritoneal C.S.F. shunt	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
14.6	Aneurysm repair												
2876	Repair of aneurysms or arteriovenous anomalies (Intracranial)	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2877	Extracranial to intracranial vascular	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2878	Posterior fossa arteriovenous anomalies	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
14.7	Craniectomy or craniotomy												
2879	Glosso pharyngeal nerve	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
2881	Eighth nerve: Intracranial	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	

2883	Eighth nerve: Extracranial	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
2884	Sub-temporal section of the trigeminal nerve	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
2885	Trigeminal tractotomy	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2887	Vestibular nerve	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2891	Posterior fossa tumour removal: Glioma, secondary deposits	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2893	Posterior fossa tumour removal: Abscess	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2895	Excision of tumour of glomus jugulare: Intracranial	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	
2897	Excision of tumour of glomus jugulare: Extracranial	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	
2898	Excision of tumour of glomus jugulare: Hemispherectomy	20	500,000	R 8 100,30		20	500,000	R 8 100,30		20	400,000	R 5 055,80	
14.7.1	Posterior fossa surgery: Supratentorial procedures												
2899	Craniectomy for extra-dural haematoma or empyema	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
14.8	Craniotomy for												
2900	Craniotomy for extra-dural orbital decompression or excision of orbital tumour	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2901	Craniotomy for Osteoplastic Flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2903	Craniotomy for abscess, Glioma	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	

2904	Craniotomy for Haematoma, foreign body: Cerebral or cerebellar	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2905	Craniotomy for Focal epilepsy: Excision of cortical scar	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
2907	Craniotomy for Temporal lobectomy	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2908	Craniotomy for Torkildsen anastomosis	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
2909	Craniotomy for CSF-leaks	20	450,000	R 7 290,40		20	450,000	R 7 290,40		20	360,000	R 4 550,30	
2910	Craniotomy for removal of arteriovenous malformation	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
14.8.1	Stereotaxis, stereotactic radiosurgery (cranial), neurostimulators (intracranial)												
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	20	196,000	R 3 175,20		20	196,000	R 3 175,20		20	156,800	R 1 981,90	
2915	Transnasal hypophysectomy	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
2916	Transfrontal hypophysectomy	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
2917	Transnasal hypophyseal implants	20	172,000	R 2 786,70		20	172,000	R 2 786,70		20	137,600	R 1 739,30	
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)	20	-										
14.9	Spinal operations												
	See section 3.8.7 for laminectomy procedures												
2923	Chordotomy: Unilateral	20	178,000	R 2 883,80		20	178,000	R 2 883,80		20	142,400	R 1 800,00	
2925	Chordotomy: Open	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
2927	Rhizotomy: Extradural, but intraspinal	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
2928	Rhizotomy: Intradural	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
2929	Removal of spinal cord tumour: Intramedullar – posterior approach	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	

2930	Removal of spinal cord tumour: Intramedullar – anterio-lateral approach	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2931	Removal of spinal cord tumour: Extramedullary, but intradural – posterior approach	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
2932	Removal of spinal cord tumour: Extramedullary, but intradural – anterio-lateral approach	20	350,000	R 5 670,40		20	350,000	R 5 670,40		20	280,000	R 3 539,10	
2933	Removal of spinal cord tumour: Extramedullary, but intradural – intraspinal, but extradural, posterior approach	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
2935	Removal of spinal cord tumour: Extramedullary, but intradural – Transcutaneous chordotomy	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
2937	Repair of meningocele, involving nerve tissue	20	250,000	R 4 050,20		20	250,000	R 4 050,20		20	200,000	R 2 527,90	
2938	Simple	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2939	Excision of arterial vascular malformations and cysts of the spinal cord	20	700,000	R 11 340,40		20	700,000	R 11 340,40		20	560,000	R 7 078,30	
2940	Lumbar osteophyte removal	20	187,000	R 3 029,60		20	187,000	R 3 029,60		20	149,600	R 1 891,10	
2941	Cervical or thoracic osteophyte removal	20	285,000	R 4 617,40		20	285,000	R 4 617,40		20	228,000	R 2 882,00	
14.10	Arterial ligations												
2951	Carotis: Trauma	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
2953	Carotis: For aneurysm (AV anomaly)	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
2955	Removal of carotid body tumour (without vascular reconstruction)	20	335,600	R 5 436,90		20	335,600	R 5 436,90		20	268,480	R 3 393,50	
14.11	Medical psychotherapy												
2957	Individual psychotherapy (specify type): Including play therapy for children – per short session (20 minutes)									20	16,000	R 202,20	
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session									20	16,000	R 202,20	
2963	Pairs, marriage or sex therapy: Per 20-minute session									20	16,000	R 202,20	

2968	Group therapy: Adults (specify number), tariff per person per 80-minute session. Children (specify number): Tariff per person per 80-minute session									20	8,000	R 101,10	
2974	Individual psychotherapy (specify type): Including play therapy for children, per intermediate session (40 minutes)									20	32,000	R 404,50	
2975	Individual psychotherapy (specify type): Including play therapy for children, per extended session (60 minutes or longer)									20	48,000	R 606,70	
2976	Intermediate treatment where either Items 2962 or 2963 are used: Per 40-minute session									20	32,000	R 404,50	
2977	Extended treatment where either Items 2962 or 2963 are used: Per 60-minute session									20	48,000	R 606,70	
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY												
V.	a. Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.												
0079	When a first 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).												

0099	Stat basis tests: For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos: • Stat test requesting may only be done by the referring practitioner and not by the pathologist. • Specimens must be collected on a stat basis where applicable. • Test must be performed on a stat basis. • Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained. • This modifier will only apply during normal working hours and will never be used in combination with Item 4547: After-hours service.												
14.12	Physical treatment methods												
2970	Electro-convulsive treatment (ECT): Each time (see rule V.a.)									20	17,000	R 214,90	
14.13	Psychiatric examination methods												
2972	Narco-analysis (maximum of three sessions per treatment): Per 60-minute session									20	16,000	R 202,20	
2973	Psychometry (specify examination): Per session (maximum of three sessions per examination)									20	16,000	R 202,20	
15	**Endocrine system**												
15.1	Thyroid												
2983	Lobectomy: Partial	20	198,100	R 3 209,40		20	198,100	R 3 209,40		20	158,480	R 2 003,20	
2985	Lobectomy: Total	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
2987	Thyroidectomy: Subtotal	20	266,000	R 4 309,40		20	266,000	R 4 309,40		20	212,800	R 2 689,50	
2989	Thyroidectomy: Total	20	279,000	R 4 519,90		20	279,000	R 4 519,90		20	223,200	R 2 821,20	
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions – cervical approach		335,300	R 5 431,00			335,300	R 5 431,00			268,240	R 3 389,20	

2991	Thyroglossal cyst or fistula excision	20	126,200	R 2 044,60		20	126,200	R 2 044,60		20	120,000	R 1 516,60	
15.2	Parathyroid												
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions – with mediastinal exploration, sternal slit or transthoracic approach		370,700	R 6 004,40			370,700	R 6 004,40			296,560	R 3 746,90	
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	
2994	Parathyroid: Autotransplantation of parathyriod – add to major procedure (modifier 0005 does not apply)		70,500	R 1 141,90			70,500	R 1 141,90			70,500	R 890,70	
15.3	Adrenals												
2995	Adrenalectomy: Unilateral	20	225,000	R 3 645,10		20	225,000	R 3 645,10		20	180,000	R 2 275,20	
2997	Bilateral exploration of adrenal glands: Including removal	20	394,000	R 6 383,20		20	394,000	R 6 383,20		20	315,200	R 3 984,00	
15.4	Hypophysis												
2999	Transethmoidal hypophysectomy	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
3000	Transnasal hypophysectomy (see also Item 2915)	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
15.5	Endocrine system: General												
3001	Implantation of pellets (excluding cost of material) – excluding after-care	20	3,000	R 48,60		20	3,000	R 48,60		20	3,000	R 37,90	
16	**Eye**												
16.1	Eye: Procedures performed in rooms												
	a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions b. Material used is excluded c. The fee for photography is not related to the number of photographs taken												

16.1.1	Eye investigations												
3002	Gonioscopy	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3003	Fundus contact lens or 90 D lens examination (not to be charged with Item 3004 or Item 3012)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with Item 3003 and/or Item 3012)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3006	Keratometry	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations	20	11,680	R 189,10		20	11,680	R 189,10					
3012	Pre-surgical retinal examination before retinal surgery	20	32,000	R 518,40		20	32,000	R 518,40		20	32,000	R 404,50	
3013	Ocular motility assessment: Comprehensive examination	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
3014	Tonometry per test with maximum of two tests for provocative tonometry (one or both eyes)	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
16.1.2	Special eye investigations												
3005	Endothelial cell count	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3007	Potential acuity measurement	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3008	Contrast sensitivity test	20	7,000	R 113,40		20	7,000	R 113,40		20	7,000	R 88,50	
3010	Orthoptics consultation	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3011	Orthoptic subsequent sessions	20	5,000	R 81,10		20	5,000	R 81,10		20	5,000	R 63,10	
3015	Charting of visual field with manual perimeter	20	28,000	R 453,80		20	28,000	R 453,80		20	28,000	R 354,10	
3016	Retinal threshold test without storage facilities	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	20	74,000	R 1 198,80		20	74,000	R 1 198,80		20	74,000	R 935,20	
3018	Retinal threshold trend evaluation (additional to Item 3017)	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
3019	Ocular muscle function with Hess screen or perimeter	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
3020	Special eye investigations: Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery	20	46,000	R 745,30		20	46,000	R 745,30		20	46,000	R 581,50	
3022	Digital fluorescein video angiography	20	68,000	R 1 101,80		20	68,000	R 1 101,80		20	68,000	R 859,50	
3023	Digital indocyanine video angiography	20	110,000	R 1 782,10		20	110,000	R 1 782,10		20	110,000	R 1 390,30	
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to Items 3022, 3023, 3031, 3039	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
3025	Electronic tonography	20	19,000	R 308,00		20	19,000	R 308,00		20	19,000	R 240,20	
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum	20	19,300	R 312,80		20	19,300	R 312,80		20	19,300	R 244,00	
3027	Fundus photography	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
3028	Optical Coherent Tomography (OCT) of Optic nerve or macula: Per eye	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
3029	Anterior segment microphotography	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
3031	Fluorescein Angiography: One or both eyes (not to be used with Item 3022)	20	45,000	R 729,20		20	45,000	R 729,20		20	45,000	R 568,90	
3032	Eyelid and orbit photography	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
3033	Interpretation of Items 3022, 3023 and 3031 referred by other clinicians	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
3034	Determination of lens implant power per eye	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged	20	22,000	R 356,50		20	22,000	R 356,50		20	22,000	R 278,00	

3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery – may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	20	36,000	R 583,30		20	36,000	R 583,30		20	36,000	R 455,20	
16.2	Retina												
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	20	306,900	R 4 972,20		20	306,900	R 4 972,20		20	245,520	R 3 103,40	
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3041	Pan retinal photocoagulation (per eye): Done in one sitting	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
3044	Removal of encircling band and/or buckling material	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
16.3	Cataract												
3045	Cataract: Intra-capsular	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
3047	Cataract: Extra-capsular (including capsulotomy)	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
3049	Insertion of lenticulus in addition to Item 3045 or Item 3047 (cost of lens excluded) (modifier 0005 not applicable)	20	57,000	R 923,40		20	57,000	R 923,40		20	57,000	R 720,40	
3050	Repositioning of intra ocular lens	20	171,100	R 2 771,80		20	171,100	R 2 771,80		20	136,880	R 1 730,10	
3051	Needling or capsulotomy	20	130,000	R 2 106,00		20	130,000	R 2 106,00		20	120,000	R 1 516,60	
3052	Laser capsulotomy	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3057	Removal of lenticulus	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
3058	Exchange of intra ocular lens	20	236,000	R 3 823,40		20	236,000	R 3 823,40		20	188,800	R 2 386,40	
3059	Insertion of lenticulus when Item 3045 or Item 3047 was not executed (cost of lens excluded)	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) – for use by ophthalmologists only	20	4,000	R 64,80		20	4,000	R 64,80					

16.4	Glaucoma												
3061	Drainage operation	20	247,600	R 4 011,40		20	247,600	R 4 011,40		20	198,080	R 2 503,60	
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to Item 3061)	20	60,000	R 972,20		20	60,000	R 972,20		20	60,000	R 758,60	
3063	Cyclocryotherapy or cyclodiathermy	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3064	Laser trabeculoplasty	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3065	Removal of blood from anterior chamber	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3067	Goniotomy	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
16.5	Intra-ocular foreign body												
3071	Intra-ocular foreign body: Anterior to Iris	20	127,000	R 2 057,40		20	127,000	R 2 057,40		20	120,000	R 1 516,60	
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
16.6	Strabismus												
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to Item 0202)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	20	175,600	R 2 844,80		20	175,600	R 2 844,80		20	140,480	R 1 775,60	
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	20	120,000	R 1 944,00		20	120,000	R 1 944,00		20	120,000	R 1 516,60	
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
16.7	Globe												
3079	Transcleral biopsy	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	

3080	Examination of eyes under general anaesthetic where no surgery is done	20	80,000	R 1 296,30		20	80,000	R 1 296,30		20	80,000	R 1 011,30	
3081	Treatment of minor perforating injury	20	161,600	R 2 618,20		20	161,600	R 2 618,20		20	129,280	R 1 634,00	
3083	Treatment of major perforating injury	20	267,500	R 4 333,60		20	267,500	R 4 333,60		20	214,000	R 2 704,80	
3085	Enucleation or evisceration	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	20	160,000	R 2 592,10		20	160,000	R 2 592,10		20	128,000	R 1 617,80	
3088	Hydroxyapetite insertion (additional to Item 3087)	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
3089	Subconjunctival injection if not done at time of operation	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3090	Intra vitreal injection drug	20	47,600	R 771,20		20	47,600	R 771,20		20	47,600	R 601,70	
3091	Retrobulbar injection (if not done at time of operation)	20	16,000	R 259,40		20	16,000	R 259,40		20	16,000	R 202,20	
3092	External laser treatment for superficial lesions	20	53,000	R 858,60		20	53,000	R 858,60		20	53,000	R 669,90	
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/ or cryotherapy and/or laser therapy and/or photocoagulation	20	209,000	R 3 386,00		20	209,000	R 3 386,00		20	167,200	R 2 113,20	
3094	Implantation of intra vitreal drug delivery system	20	247,600	R 4 011,40		20	247,600	R 4 011,40		20	198,080	R 2 503,60	
3095	Biopsy of vitreous body or anterior chamber contents	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	20	130,000	R 2 106,00		20	130,000	R 2 106,00		20	120,000	R 1 516,60	
3097	Anterior vitrectomy	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
3098	Removal of silicon from globe	20	280,000	R 4 536,30		20	280,000	R 4 536,30		20	224,000	R 2 831,30	
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	20	419,000	R 6 787,90		20	419,000	R 6 787,90		20	335,200	R 4 236,80	
3100	Lensectomy done at time of posterior vitrectomy	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	

16.8	Orbit												
3101	Drainage of orbital abscess	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3103	Orbit: Removal of tumour	20	240,000	R 3 888,00		20	240,000	R 3 888,00		20	192,000	R 2 426,90	
3104	Removal orbital prosthesis	20	212,700	R 3 446,10		20	212,700	R 3 446,10		20	170,160	R 2 150,70	
3105	Orbit: Exenteration	20	275,000	R 4 455,00		20	275,000	R 4 455,00		20	220,000	R 2 780,70	
3107	Orbitotomy requiring bone flap	20	393,000	R 6 367,00		20	393,000	R 6 367,00		20	314,400	R 3 973,90	
3108	Eye socket reconstruction	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	20	300,000	R 4 860,10		20	300,000	R 4 860,10		20	240,000	R 3 033,50	
3110	Second stage hydroxyapetite implantation	20	110,000	R 1 782,10		20	110,000	R 1 782,10		20	110,000	R 1 390,30	
16.9	Cornea												
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	20	-										
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens as for corneal erosion, ulcer, abrasion or corneal wound	20	12,200	R 197,80		20	12,200	R 197,80		20	12,200	R 154,40	
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one year	20	200,000	R 3 240,10		20	200,000	R 3 240,10		20	160,000	R 2 022,30	
3114	Wavefront analysis (Aberometry) for customized ablation of pathological corneas prior to LASIK surgery – EQUIPMENT component only	20	78,850	R 1 277,50		20	78,850	R 1 277,50					
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	20	166,000	R 2 689,50		20	166,000	R 2 689,50		20	132,800	R 1 678,60	
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty	20	135,200	R 2 190,30		20	135,200	R 2 190,30		20	120,000	R 1 516,60	

3117	Removal of foreign body: On the basis of fee per consultation	20	-										
3118	Curettage of cornea after removal of foreign body (after-care excluded)	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3119	Tattooing	20	26,000	R 421,30		20	26,000	R 421,30		20	26,000	R 328,70	
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK). For machine hire fee for LTK: Use Item 3201	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
3121	Corneal graft (Lamellar or full thickness)	20	289,000	R 4 682,10		20	289,000	R 4 682,10		20	231,200	R 2 922,40	
3122	Epikeratophakia	20	289,000	R 4 682,10		20	289,000	R 4 682,10		20	231,200	R 2 922,40	
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	20	254,000	R 4 115,00		20	254,000	R 4 115,00		20	203,200	R 2 568,30	
3124	Removal of corneal stitches under microscope (maximum of two procedures). Additional fee for sterile tray (see Item 0202)	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
3125	Keratectomy	20	127,000	R 2 057,40		20	127,000	R 2 057,40		20	120,000	R 1 516,60	
3126	Additional to Item 3120 for the use of own microkeratome used with a excimer laser	20	52,180	R 845,30		20	52,180	R 845,30		20	52,180	R 659,40	
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
3129	Additional to Item 3128 for the use of own diamond knives	20	40,000	R 648,10		20	40,000	R 648,10		20	40,000	R 505,60	
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	20	96,900	R 1 569,90		20	96,900	R 1 569,90		20	96,900	R 1 224,70	
3131	Cornea: Paracentesis	20	53,000	R 858,60		20	53,000	R 858,60		20	53,000	R 669,90	
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	20	150,000	R 2 430,20		20	150,000	R 2 430,20		20	120,000	R 1 516,60	
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used – stand alone procedure	20	116,300	R 1 883,90		20	116,300	R 1 883,90		20	116,300	R 1 469,90	

3136	Conjunctival flap or graft (not for use with pterigium surgery)	20	95,700	R 1 550,40		20	95,700	R 1 550,40		20	95,700	R 1 209,70	
3138	Removal corneal epithelium and chelating agent for band keratopathy	20	69,500	R 1 125,90		20	69,500	R 1 125,90		20	69,500	R 878,30	
4980	Corneal transplant: Endothelial	20	219,800	R 3 561,60		20	219,800	R 3 561,60					
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)	20	-										
4985	Corneal cross linking	20	150,000	R 2 430,10		20	150,000	R 2 430,10					
4986	Cross linking equipment hire	20	54,000	R 875,00		20	54,000	R 875,00					
16.10	Ducts												
3133	Probing and/or syringing, per duct	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3135	Insert polythene tubes	20	51,800	R 839,30		20	51,800	R 839,30		20	51,800	R 654,80	
3137	Excision of lacrimal sac: Unilateral	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
3139	Dacrocystorhinostomy (single) with or without polythene tube	20	210,000	R 3 402,20		20	210,000	R 3 402,20		20	168,000	R 2 123,40	
3141	Sealing Punctum surgical or by cautery: Per eye	20	24,900	R 403,40		20	24,900	R 403,40		20	24,900	R 314,70	
3142	Sealing Punctum with plugs: Per eye	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
3143	Three-snip operation	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3145	Repair of caniculus: Primary procedure	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
3147	Repair of caniculus: Secondary procedure	20	175,000	R 2 835,30		20	175,000	R 2 835,30		20	140,000	R 1 769,50	
16.11	Iris												
3149	Iridectomy or iridotomy by open operation as isolated procedure	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
3151	Excision of iris tumour	20	185,000	R 2 997,10		20	185,000	R 2 997,10		20	148,000	R 1 870,70	
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	20	105,000	R 1 701,00		20	105,000	R 1 701,00		20	105,000	R 1 327,10	
3155	Iridocyclectomy for tumour	20	266,000	R 4 309,40		20	266,000	R 4 309,40		20	212,800	R 2 689,50	
3157	Division of anterior synechiae as isolated procedure	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	

3158	Repair iris as in dialysis: Anterior chamber reconstruction	20	142,400	R 2 307,00		20	142,400	R 2 307,00		20	120,000	R 1 516,60	
16.12	Lids												
3161	Tarsorrhaphy	20	47,000	R 761,30		20	47,000	R 761,30		20	47,000	R 593,90	
3163	Excision of superficial lid tumour	20	47,000	R 761,30		20	47,000	R 761,30		20	47,000	R 593,90	
3165	Repair of skin laceration lid: Simple	20	27,300	R 442,30		20	27,300	R 442,30		20	27,300	R 344,90	
3167	Diathermy to wart on lid margin	20	12,000	R 194,40		20	12,000	R 194,40		20	12,000	R 151,50	
3169	Electrolysis of any number of eyelashes: Per eye	20	15,000	R 243,00		20	15,000	R 243,00		20	15,000	R 189,60	
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see Item 0202)	20	20,400	R 330,50		20	20,400	R 330,50		20	20,400	R 257,90	
3173	Epicanthal folds	20	128,700	R 2 085,00		20	128,700	R 2 085,00		20	120,000	R 1 516,60	
3174	Botulinus toxin injection for blepharospasm (+ Item 0198 + Item 0201 + Item 0202)	20	25,000	R 405,10		20	25,000	R 405,10					
3175	Botulinus toxin injection in extra-ocular muscles (+ Item 0198 + Item 0201+ Item 0202)	20	35,000	R 567,00		20	35,000	R 567,00					
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	20	187,000	R 3 029,60		20	187,000	R 3 029,60		20	149,600	R 1 891,10	
16.12.1	Lids: Entropion or ectropion by												
3177	Entropion or ectropion by cautery	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3179	Entropion or ectropion by suture	20	49,400	R 800,40		20	49,400	R 800,40		20	49,400	R 624,40	
3181	Entropion or ectropion by open operation	20	111,500	R 1 806,30		20	111,500	R 1 806,30		20	111,500	R 1 409,30	
3183	Entropion or ectropion by free skin, mucosal grafting or flap	20	122,600	R 1 986,30		20	122,600	R 1 986,30		20	122,600	R 1 549,60	
16.12.2	Lids: Reconstruction of eyelid												
3185	Staged procedure for partial or total loss of eyelid: First stage	20	259,000	R 4 195,90		20	259,000	R 4 195,90		20	207,200	R 2 618,90	
3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	20	206,000	R 3 337,40		20	206,000	R 3 337,40		20	164,800	R 2 083,00	

3189	Full thickness eyelid laceration for tumour or injury: Direct repair	20	136,500	R 2 211,50		20	136,500	R 2 211,50		20	120,000	R 1 516,60	
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	20	150,200	R 2 433,40		20	150,200	R 2 433,40		20	120,160	R 1 518,70	
3172	Blepharoplasty lower eyelid plus fat pad	20	125,800	R 2 038,10		20	125,800	R 2 038,10		20	120,000	R 1 516,60	
16.12.3	Lids: Ptosis												
3193	Repair by superior rectus, levator or frontalis muscle operation	20	190,000	R 3 078,10		20	190,000	R 3 078,10		20	152,000	R 1 921,20	
3195	Ptosis: By lesser procedure e.g. sling operation – unilateral	20	137,600	R 2 229,40		20	137,600	R 2 229,40		20	120,000	R 1 516,60	
3197	Ptosis: By lesser procedure e.g. sling operation – bilateral	20	166,000	R 2 689,50		20	166,000	R 2 689,50		20	132,800	R 1 678,60	
16.13	Conjunctiva												
3199	Repair of conjunctiva by grafting	20	132,000	R 2 138,40		20	132,000	R 2 138,40		20	120,000	R 1 516,60	
3200	Repair of lacerated conjunctiva	20	47,000	R 761,30		20	47,000	R 761,30		20	47,000	R 593,90	
16.14	Eye: General												
	Own equipment used in treatment: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.	20	170,000	R 2 754,30		20	170,000	R 2 754,30		20	136,000	R 1 719,00	
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting	20	109,000	R 1 766,00		20	109,000	R 1 766,00					
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of the indicated amount per minute may be charged.	20	2,250	R 36,40		20	2,250	R 36,40		20	2,250	R 28,50	
3196	Diamond knife: Use of own diamond knife during intraocular surgery	20	12,000	R 194,40		20	12,000	R 194,40					
3198	Excimer laser: Hire fee (per eye)	20	284,130	R 4 603,00		20	284,130	R 4 603,00					
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting. Not to be used with IOL Master	20	109,000	R 1 766,00		20	109,000	R 1 766,00					
3202	Phako emulsification apparatus: Hire fee	20	109,000	R 1 766,00		20	109,000	R 1 766,00					

3203	Vitrectomy apparatus: Hire fee	20	120,000	R 1 944,00		20	120,000	R 1 944,00					
3208	Biopsy: External auditory canal	20	15,497	R 251,10		20	15,497	R 251,10			3,000	R 238,00	
17	**Ear**												
	Fitting/orientation/checking of a hearing aid: report this service using the appropriate consultation code												
	Repair/modification of hearing aid: report this service using Item 0201 and supply invoice												
17.1	External ear (Pinna)												
	Fitting/orientation/checking of a hearing aid: report this service using the appropriate consultation code												
	Repair/modification of hearing aid: report this service using 0201 and supply invoice												
3267	Major congenital deformity reconstruction of external ear: Unilateral	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	
3269	Major congenital deformity reconstruction of external ear: Bilateral	20	242,000	R 3 920,50		20	242,000	R 3 920,50		20	193,600	R 2 446,90	
3270	Excision of superficial pre-auricular fistula	20	55,000	R 890,90		20	55,000	R 890,90		20	55,000	R 695,10	
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear	20	-										
3272	Excision of complicated pre-auricular fistula	20	140,000	R 2 267,90		20	140,000	R 2 267,90		20	120,000	R 1 516,60	
5170	Drainage: Haematoma or abscess of external ear	20	34,800	R 563,70		20	34,800	R 563,70			3,000	R 238,00	
5173	Biopsy: External ear	20	12,400	R 201,00		20	12,400	R 201,00			3,000	R 238,00	
5175	Excision: External ear, partial, simple repair	20	63,500	R 1 028,80		20	63,500	R 1 028,80			3,000	R 238,00	
5176	Excision: External ear, complete	20	66,800	R 1 082,20		20	66,800	R 1 082,20			3,000	R 238,00	
17.2	External ear canal												
3204	External ear canal: Removal of foreign body – at rooms	20	-										

3205	External ear canal: Removal of foreign body – under general anaesthetic	20	21,000	R 340,30		20	21,000	R 340,30		20	21,000	R 265,50	
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	20	164,000	R 2 656,80		20	164,000	R 2 656,80		20	131,200	R 1 658,30	
3217	Meatus atresia: Congenital	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) – not to be used combined with Item 3206	20	17,420	R 282,30		20	17,420	R 282,30		20	17,420	R 220,30	
3219	Meatus atresia: Removal of osteoma from meatus – solitary	20	77,000	R 1 247,60		20	77,000	R 1 247,60		20	77,000	R 973,20	
3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) – not to be used combined with Item 3206	20	23,100	R 374,90		20	23,100	R 374,90					
3221	Meatus atresia: Removal of osteoma from meatus – multiple	20	215,000	R 3 483,20		20	215,000	R 3 483,20		20	172,000	R 2 174,00	
17.3	Middle ear												
3206	Microscopic examination of tympanic membrane including microsuction	20	8,000	R 129,70		20	8,000	R 129,70		20	8,000	R 101,10	
3207	Myringotomy: Unilateral	20	28,000	R 453,80		20	28,000	R 453,80		20	28,000	R 354,10	
3209	Myringotomy: Bilateral	20	46,000	R 745,30		20	46,000	R 745,30		20	46,000	R 581,50	
3211	Unilateral myringotomy with insertion of ventilation tube	20	38,000	R 615,60		20	38,000	R 615,60		20	38,000	R 480,30	
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	20	57,000	R 923,40		20	57,000	R 923,40		20	57,000	R 720,40	
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	20	65,000	R 1 053,20		20	65,000	R 1 053,20		20	65,000	R 821,60	
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	20	255,000	R 4 131,20		20	255,000	R 4 131,20		20	204,000	R 2 578,60	
3237	Exploratory tympanotomy	20	158,900	R 2 574,20		20	158,900	R 2 574,20		20	127,120	R 1 606,80	
3242	Fenestration: Revision	20	20,000	R 2 561,00		20	20,000	R 2 561,00					
3243	Myringoplasty	20	138,000	R 2 235,90		20	138,000	R 2 235,90		20	120,000	R 1 516,60	

3245	Functional reconstruction of tympanic membrane	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
3249	Stapedotomy and stapedectomy	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
3257	Cortical mastoidectomy	20	188,500	R 3 053,90		20	188,500	R 3 053,90		20	150,800	R 1 906,10	
3259	Radical mastoidectomy (excluding minor procedures)	20	277,400	R 4 493,90		20	277,400	R 4 493,90		20	221,920	R 2 805,00	
3261	Muscle grafting to mastoid cavity without tympanoplasty	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
3263	Autogenous bone graft to mastoid cavity	20	180,000	R 2 916,20		20	180,000	R 2 916,20		20	144,000	R 1 820,10	
3264	Tympanomastoidectomy	20	375,000	R 6 075,30		20	375,000	R 6 075,30		20	300,000	R 3 792,00	
3265	Reconstruction of posterior canal wall, following radical mastoid	20	320,000	R 5 184,30		20	320,000	R 5 184,30		20	256,000	R 3 235,80	
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	20	30,000	R 485,70		20	30,000	R 485,70		20	30,000	R 379,10	
17.4	Facial nerve												
17.4.1	Facial nerve: Facial nerve tests												
3223	Percutaneous stimulation of the facial nerve	20	9,000	R 145,80		20	9,000	R 145,80		20	9,000	R 113,70	
3224	Electroneurography (ENOG)	20	75,000	R 1 215,10		20	75,000	R 1 215,10		20	75,000	R 947,90	
17.4.2	Facial nerve: Facial nerve surgery												
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	20	297,000	R 4 811,60		20	297,000	R 4 811,60		20	237,600	R 3 003,20	
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including Item 3227)	20	436,000	R 7 063,60		20	436,000	R 7 063,60		20	348,800	R 4 408,60	
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	20	436,000	R 7 063,60		20	436,000	R 7 063,60		20	348,800	R 4 408,60	
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	20	124,000	R 2 008,80		20	124,000	R 2 008,80		20	120,000	R 1 516,60	

17.5	Inner ear												
17.5.1	Inner ear: Audiometry												
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	20	50,000	R 810,00		20	50,000	R 810,00					
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	20	88,000	R 1 425,70		20	88,000	R 1 425,70					
2693	AEP: Audiological examination – unilateral at a minimum of four decibels	20	60,000	R 972,20		20	60,000	R 972,20					
2694	AEP: Audiological examination – bilateral at a minimum of four decibels	20	105,000	R 1 701,00		20	105,000	R 1 701,00					
2695	Audiology 40Hz response: Unilateral	20	30,000	R 485,70		20	30,000	R 485,70					
2696	Audiology 40Hz response: Bilateral	20	53,000	R 858,60		20	53,000	R 858,60					
2697	Mid- and long latency auditory evoked potentials: Unilateral	20	30,000	R 485,70		20	30,000	R 485,70					
2698	Mid- and long latency auditory evoked potentials: Bilateral	20	53,000	R 858,60		20	53,000	R 858,60					
2699	Electro-cochleography: Unilateral	20	50,000	R 810,00		20	50,000	R 810,00					
2700	Electro-cochleography: Bilateral	20	88,000	R 1 425,70		20	88,000	R 1 425,70					
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	20	140,000	R 2 267,90		20	140,000	R 2 267,90					
3248	Otoacoustic emission performed as a screening test	20	33,240	R 538,40	Z	20	33,240	R 538,40	Z	20	33,240	R 420,20	Z
3250	Otoacoustic emission (high-risk patients only)	20	66,480	R 1 077,00		20	66,480	R 1 077,00		20	66,480	R 840,20	
3273	Pure tone audiometry (air conduction)	20	6,500	R 105,30		20	6,500	R 105,30		20	6,500	R 82,20	
3274	Pure tone audiometry (bone conduction with masking)	20	6,500	R 105,30		20	6,500	R 105,30		20	6,500	R 82,20	
3275	Impedance audiometry (tympanometry)	20	6,500	R 105,30		20	6,500	R 105,30		20	6,500	R 82,20	
3276	Impedance audiometry (stapedial reflex) – no charge for volume, compliance etc.	20	6,500	R 105,30		20	6,500	R 105,30		20	6,500	R 82,20	

3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	20	6,500	R 105,30		20	6,500	R 105,30		20	6,500	R 82,20	
17.5.2	Inner ear: Balance tests												
3251	Minimal caloric test (excluding consultation fee)	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
3252	Bithermal Halpike caloric test (excluding consultation fee)	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
3253	Electro-nystagmography for spontaneous and positional nystagmus	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
3254	Video nystagmoscopy (monocular)	20	25,000	R 405,10		20	25,000	R 405,10		20	25,000	R 315,90	
3255	Caloric test done with electronystamography	20	70,000	R 1 134,00		20	70,000	R 1 134,00		20	70,000	R 884,70	
3256	Video nystagmoscopy (binocular)	20	50,000	R 810,00		20	50,000	R 810,00		20	50,000	R 632,00	
3258	Otolith repositioning manoeuvre	20	14,000	R 226,70		20	14,000	R 226,70		20	14,000	R 176,90	
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	20	71,480	R 1 158,00	Z	20	71,480	R 1 158,00	Z	20	71,480	R 903,50	Z
17.5.3	Middle and inner ear surgery												
3233	Labyrinthectomy via the middle ear or mastoid	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
3240	Endolymphatic sac surgery	20	277,000	R 4 487,70		20	277,000	R 4 487,70		20	221,600	R 2 801,00	
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	20	310,000	R 5 022,20		20	310,000	R 5 022,20		20	248,000	R 3 134,80	
3246	Cochlear implant surgery	20	340,500	R 5 516,40		20	340,500	R 5 516,40		20	272,400	R 3 443,00	
5196	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy	20	212,300	R 3 439,80		20	212,300	R 3 439,80					

5197	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy	20	269,000	R 4 357,40		20	269,000	R 4 357,40					
5199	Revision: Stapedectomy or stapedotomy	20	251,900	R 4 081,40		20	251,900	R 4 081,40					
17.6	Microsurgery of the skull base												
17.6.1	Microsurgery of the skull base: Middle fossa approach (i.e transtemporal or supralabyrinthine)												
3229	Facial nerve: Exploration of the labyrinthine segment	20	420,000	R 6 804,20		20	420,000	R 6 804,20		20	336,000	R 4 246,90	
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	20	510,000	R 8 262,30		20	510,000	R 8 262,30		20	408,000	R 5 156,90	
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	20	620,000	R 10 044,40		20	620,000	R 10 044,40		20	496,000	R 6 269,10	
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours, or similar procedures	20	530,000	R 8 586,30		20	530,000	R 8 586,30		20	424,000	R 5 359,20	
5224	Removal of acoustic neuroma via the middle fossa approach	20	660,000	R 10 692,50		20	660,000	R 10 692,50		20	528,000	R 6 673,60	
17.6.2	Microsurgery of the skull base: Translabyrinthe approach												
3239	Acoustic neuroma removal translabyrinthine	20	660,000	R 10 692,50		20	660,000	R 10 692,50		20	528,000	R 6 673,60	
5227	Cochleo-vestibular neurectomy	20	530,000	R 8 586,30		20	530,000	R 8 586,30		20	424,000	R 5 359,20	
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)	20	660,000	R 10 692,50		20	660,000	R 10 692,50		20	528,000	R 6 673,60	
17.6.3	Microsurgery of the skull base: Transotic approach to the cerebellopontime angle												
5232	Removal of acoustic neuroma or cyst of the internal auditory canal	20	660,000	R 10 692,50		20	660,000	R 10 692,50		20	528,000	R 6 673,60	

17.6.4	Microsurgery of the skull base: Intratemporal fossa approach type A												
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours	20	710,000	R 11 502,50		20	710,000	R 11 502,50		20	568,000	R 7 179,20	
17.6.5	Microsurgery of the skull base: Intratemporal fossa approach type B												
5238	Removal of tumour of the petrous apex	20	620,000	R 10 044,40		20	620,000	R 10 044,40		20	496,000	R 6 269,10	
5239	Removal of tumour of the clivus	20	620,000	R 10 044,40		20	620,000	R 10 044,40		20	496,000	R 6 269,10	
17.6.6	Microsurgery of the skull base: Intrafemoral approach type C												
5242	Removal of nasopharyngeal angiofibroma or carcinoma	20	520,000	R 8 424,40		20	520,000	R 8 424,40		20	416,000	R 5 258,20	
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	20	520,000	R 8 424,40		20	520,000	R 8 424,40		20	416,000	R 5 258,20	
17.6.7	Microsurgery of the skull base: Subtotal petrosectomy												
5246	Subtotal petrosectomy for removal of temporal bone tumour	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	20	480,000	R 7 776,30		20	480,000	R 7 776,30		20	384,000	R 4 853,50	
17.6.8	Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa												
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland	20	520,000	R 8 424,40		20	520,000	R 8 424,40		20	416,000	R 5 258,20	
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	20	600,000	R 9 720,40		20	600,000	R 9 720,40		20	480,000	R 6 066,90	
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	20	660,000	R 10 692,50		20	660,000	R 10 692,50		20	528,000	R 6 673,60	

18	Physical treatment												
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient).	20	0,750	R 12,00		20	0,750	R 12,00					
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment).	20	13,500	R 218,60		20	13,500	R 218,60					
3281	Ultrasonic therapy	20	10,000	R 161,80		20	10,000	R 161,80					
3282	Shortwave diathermy	20	10,000	R 161,80		20	10,000	R 161,80					
3284	Sensory nerve conduction studies	20	31,000	R 502,30		20	31,000	R 502,30					
3285	Motor nerve conduction studies	20	26,000	R 421,30		20	26,000	R 421,30					
3287	Spinal joint and ligament injection	20	20,000	R 324,00		20	20,000	R 324,00		20	20,000	R 252,80	
3288	Epidural injection	20	36,000	R 583,30		20	36,000	R 583,30					
3289	Multiple injections: First joint	20	7,500	R 121,50		20	7,500	R 121,50					
3290	Multiple injections: Each additional joint	20	4,500	R 72,90		20	4,500	R 72,90					
3291	Tendon or ligament injection	20	9,000	R 145,80		20	9,000	R 145,80					
3292	Aspiration of joint or inter-articular injection	20	9,000	R 145,80		20	9,000	R 145,80					
3293	Aspiration or injection of bursa or ganglion	20	9,000	R 145,80		20	9,000	R 145,80					
3294	Paracervical (neck) nerve block (for pelvis refer to Item 2389)	20	20,000	R 324,00		20	20,000	R 324,00					
3295	Paravertebral root block: Unilateral	20	20,000	R 324,00		20	20,000	R 324,00					
3296	Paravertebral root block: Bilateral	20	30,000	R 485,70		20	30,000	R 485,70					
3297	Manipulation of spine performed by a specialist in physical medicine	20	14,000	R 226,70		20	14,000	R 226,70					
3298	Spinal traction	20	6,000	R 97,40		20	6,000	R 97,40					
3299	Manipulation of large joints: Under general anaesthesia	20	14,000	R 226,70		20	14,000	R 226,70					
3299a	Manipulation of large joints: Under general anaesthesia	20	14,000	R 226,70		20	14,000	R 226,70					

3300	Manipulation of large joints: Without anaesthetic	20	-										
3301	Muscle fatigue studies	20	20,000	R 324,00		20	20,000	R 324,00					
3302	Strength duration curve per session	20	10,500	R 170,00		20	10,500	R 170,00					
3303	Electromyography	20	75,000	R 1 215,10		20	75,000	R 1 215,10					
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment. For subsequent treatments by a general practitioner, for the same condition within four months after initial treatment: A fee for the treatment only, is applicable. See general rules L and M.	20	10,000	R 161,80		20	10,000	R 161,80		20	10,000	R 126,30	
	SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT												
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. Only applicable if services are provided by a specialist in physical medicine.												
5431	Physical status modifier: Normal health patient, ASA 1 – add 0.00 anaesthetic units												
5432	Physical status modifier: A patient with mild systemic disease, ASA 2 – add 0,00 anaesthetic units												
5436	Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes ASA 6 – add 0,00 anaesthetic units												
19	**Radiology**												
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values.												
	RULES GOVERNING THE SECTION RADIOLOGY												

Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used.												
Z.	No fee is subject to more than one reduction.												
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.												
RR.	"The radiology section in this price list is not for use by registered specialist radiology practices (Pr No ""038"") or nuclear medicine practices (Pr No ""025""), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No ""038"") and nuclear medicine practices (Pr No ""025"")."												
	MODIFIERS GOVERNING THE SECTION												
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned Item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere.												
0080	Multiple examinations: Full Fee												
0081	Repeat examinations: No reduction												
0082	“+” means that this Item is complementary to a preceding Item and is therefore not subject to reduction.												

0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.												
0084	Film costs: In the case of radiological Items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. This information is obtainable from the Radiological Society of SA.												
19.1	Skeleton												
19.1.1	Skeleton: Limbs												
3305	Finger, toe									40	6,300	R 112,90	
3309	Smith-Petersen or equivalent control, in theatre									40	38,700	R 692,80	
3311	Stress studies, e.g, joint									40	7,700	R 137,80	
3313	Full length study, both legs									40	15,500	R 277,60	
3315	Skeletal survey under five years		19,900	R 456,80						40	19,900	R 356,40	
3317	Skeletal survey over five years									40	28,000	R 501,30	
3319	Arthrography per joint									40	15,400	R 275,70	
3320	Introduction of contrast medium or air: Add									40	13,800	R 247,20	
6500	Hand									40	7,700	R 137,80	
6501	Wrist (specify region)									40	7,700	R 137,80	
6503	Scaphoid									40	7,700	R 137,80	
6504	Radius and ulna									40	7,700	R 137,80	
6505	Elbow									40	7,700	R 137,80	
6506	Humerus									40	7,700	R 137,80	
6507	Shoulder									40	7,700	R 137,80	

6508	Acromio-Clavicula joint									40	7,700	R 137,80	
6509	Clavicle									40	7,700	R 137,80	
6510	Scapula									40	7,700	R 137,80	
6511	Foot									40	7,700	R 137,80	
6512	Ankle									40	7,700	R 137,80	
6513	Calcaneus									40	7,700	R 137,80	
6514	Tibia and fibula									40	7,700	R 137,80	
6515	Knee									40	7,700	R 137,80	
6516	Patella									40	7,700	R 137,80	
6517	Femur									40	7,700	R 137,80	
6518	Hip									40	7,700	R 137,80	
6519	Sesamoid bone									40	7,700	R 137,80	
19.1.2	Skeleton: Spinal column												
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic									40	11,000	R 197,10	
3325	Stress studies									40	11,000	R 197,10	
3329	Scoliosis studies									40	21,000	R 376,10	
3331	Pelvis (sacro-iliac or hip joints only to be added where an extra set of view is required)									40	11,000	R 197,10	
3333	Myelography: Lumbar									40	28,900	R 517,30	
3334	Myelography: Thoracic									40	22,200	R 397,40	
3335	Myelography: Cervical									40	35,500	R 635,70	
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)												
3344	Introduction of contrast medium									40	18,700	R 334,60	
3345	Discography									40	34,600	R 619,50	
3347	Introduction of contrast medium per disc level: Add									40	28,200	R 505,10	

19.1.3	Skeleton: Skull												
3349	Skull studies									40	15,700	R 281,20	
3351	Paranasal sinuses									40	11,000	R 197,10	
3353	Facial bones and/or orbits									40	12,600	R 225,60	
3355	Mandible									40	9,400	R 168,40	
3357	Nasal bone									40	7,800	R 139,70	
3359	Mastoid: Bilateral									40	18,000	R 322,50	
3361	Teeth: One quadrant									40	3,700	R 66,40	
3363	Teeth: Two quadrants									40	6,300	R 112,90	
3365	Teeth: Full mouth									40	11,000	R 197,10	
3366	Teeth: Rotation tomography of the teeth and jaws									40	13,300	R 238,10	
3367	Teeth: Tempero-mandibular joints, per side									40	11,000	R 197,10	
3369	Teeth: Tomography, per side									40	11,000	R 197,10	
3371	Localisation of foreign body in the eye									40	15,700	R 281,20	
3381	Ventriculography									40	27,300	R 488,90	
3385	Post-nasal studies: Lateral neck									40	6,300	R 112,90	
3387	Maxillo-facial cephalometry									40	8,800	R 157,60	
3389	Dacrocystography									40	11,000	R 197,10	
3391	For introduction of contrast medium: Add									40	11,000	R 197,10	
19.2	Alimentary tract												
3393	Bowel washout: Add									40	4,800	R 86,00	
3395	Sialography (plus 80% for each additional gland)									40	12,700	R 227,40	
3397	Introduction of contrast medium (plus 80% for each additional gland: Add)		11,000	R 252,30						40	11,000	R 197,10	
3399	Pharynx and oesophagus									40	12,700	R 227,40	

3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through									40	20,000	R 358,20	
3405	Double contrast: Add									40	7,300	R 130,80	
3406	Small bowel meal (control film of abdomen included except when part of Item 3408)									40	20,000	R 358,20	
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)									40	28,900	R 517,30	
3409	Barium enema (control film of abdomen included)									40	18,300	R 327,70	
3411	Air contrast study: Add									40	19,300	R 345,70	
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included									40	23,300	R 417,10	
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included									40	15,500	R 277,60	
	Note: For Items 3415 and 3416 – endoscopy (see Item 1778)												
3417	Gastric/oesophageal/duodenal intubation control									40	5,900	R 105,60	
3419	Gastric/oesophageal intubation insertion of tube: Add		5,600	R 128,40						40	5,600	R 100,30	
3421	Duodenal intubation: Insertion of tube: Add									40	11,000	R 197,10	
3423	Hypotonic duodenography (Item 3403 and Item 3405 included)									40	29,300	R 524,60	
19.3	Biliary tract												
3425	Oral cholecystography									40	15,700	R 281,20	
3427	Cholangiography: Intravenous									40	22,000	R 393,60	
3431	Operative cholangiography: First series – add Item 3607 only when the radiologist attends personally in theatre.									40	21,000	R 376,10	

3433	Post operative: T-tube									40	16,700	R 299,10	
3435	Introduction of contrast medium: Add									40	5,600	R 100,30	
3437	Trans hepatic, percutaneous									40	18,300	R 327,70	
3439	Introduction of contrast medium: Add									40	33,100	R 592,60	
3441	Tomography of biliary tract: Add									40	9,400	R 168,40	
19.4	Chest												
3443	Larynx (Tomography included)									40	12,500	R 223,80	
3445	Chest (Item 3601 included)									40	9,400	R 168,40	
3447	Chest and cardiac studies (Item 3601)									40	12,600	R 225,60	
3449	Ribs									40	12,300	R 220,30	
3451	Sternum or sterno-clavicular joints									40	12,600	R 225,60	
3453	Bronchography: Unilateral									40	12,600	R 225,60	
3455	Bronchography: Bilateral									40	22,100	R 395,50	
3457	Introduction of contrast medium included									40	35,700	R 639,10	
3461	Pleurography									40	12,600	R 225,60	
3463	For introduction of contrast medium: Add									40	2,800	R 50,30	
3465	Laryngography									40	11,000	R 197,10	
3467	For introduction of contrast medium: Add									40	10,000	R 179,10	
3468	Thoracic inlet									40	6,300	R 112,90	
19.5	Abdomen												
3477	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)									40	9,400	R 168,40	
3479	Acute abdomen or equivalent studies									40	15,700	R 281,20	

19.6	Urinary tract												
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram). Item 0206 not applicable.		25,100	R 576,10						40	25,100	R 449,30	
3493	Waterload test: Add									40	12,200	R 218,60	
3497	Cystography only or urethrography only (retrograde)									40	19,300	R 345,70	
3499	Cysto-urethrography: Retrograde									40	31,900	R 571,20	
3503	Cysto-urethrography: Introduction of contrast medium									40	3,700	R 66,40	
3505	Retrograde-prograde pyelography									40	18,300	R 327,70	
3511	Aspiration renal cyst									40	18,400	R 329,50	
3513	Tomography of renal tract: Add									40	9,400	R 168,40	
19.7	Gynaecology and obstetrics												
3515	Pregnancy						9,400	R 215,70		40	9,400	R 168,40	
3517	Pelvimetry						17,400	R 399,40		40	17,400	R 311,60	
3519	Hystero-salpingography									40	12,500	R 223,80	
3521	Introduction of contrast medium: Add									40	15,300	R 274,10	

19.8	Vascular studies												
	The following rules are applicable to Section 19.8 (Vascular Studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii. All fluoroscopy (Item 3601 does not apply). iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)												

	MODIFIER GOVERNING VASCULAR STUDIES												
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: Neither fee is therefore subject to increase in terms of modifier 0080: Multiple examinations.												
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for Items 3536-3550 will be allowed (specify time of procedure on account).												
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).												
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).												
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.												
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.												
19.8.1	Vascular studies: Film series												
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.												

3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.												
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.												
3538	Analogue monoplane table with DSA attachment												
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment												
3545	Venography: Per limb									40	16,500	R 295,60	
3548	Analogue monoplane screening table												
3550	Digital monoplane screening table												
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)									40	166,800	R 2 986,40	
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram		48,600	R 1 115,50						40	48,600	R 870,10	
3558	Translumbar aortic puncture, with full study									40	69,600	R 1 246,10	
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram		57,000	R 1 308,40						40	57,000	R 1 020,50	
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram									40	65,400	R 1 170,90	
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram									40	73,200	R 1 310,70	
3564	Direct femoral arterial or venous or jugular venous puncture									40	37,200	R 665,90	
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)									40	85,800	R 1 536,30	
3569	Intravascular pressure studies, arterial or venous, once off per case									40	19,800	R 354,60	

3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement).									40	130,800	R 2 342,00	
3572	Transcatheter selective blood sampling, arterial or venous									40	32,400	R 580,10	
3574	Spinal angiogram (global fee) including all selective catheterisations.									40	480,000	R 8 593,90	
19.8.2	Vascular studies: Introduction of contrast medium												
3563	Direct intravenous for limb									40	7,400	R 132,50	
3575	Cut-downs for venography: Add									40	11,000	R 197,10	
19.9	Tomography and cinematography												
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values.												
3577	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations.												
3579	Tomography (multi-dimensional in motion): Add 150%												
3581	Cinematography: For first series – add 100%												
3583	Cinematography: For each series after the first – add 80% of the primary fee												
19.9.1	Tomography and cinematography: Computed tomography												
3592	Where a fully digital C-arm portable X-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour.												
3597	Contrast media: General Rule Y applies (Please note: Item 0201 is not applicable for contrast media).												

3598	Electron beam computed tomography (EBCT) for assessment of coronary artery calcification (complete fee – no additions).												
3599	Electron beam computed tomography (EBCT) of the heart. Total fee for contract examination excluding cost of contrast medium (not to be used for coronary artery calcium assessment or scoring – see Item 3598).												
6400	Plus spiral CT												
6401	Plus 3D reconstruction												
6402	Plus high resolution study												
6403	CT limb uncontrasted												
6404	CT limb with contrast only												
6405	CT limb pre AND post contrast												
6406	CT joint uncontrasted												
6407	CT joint with contrast only												
6408	CT joint pre AND post contrast												
6409	CT brain uncontrasted (including posterior fossa)												
6410	CT brain with contrast only (including posterior fossa)												
6411	CT brain pre AND post contrast (including posterior fossa)												
6412	CT orbits complete study, axial OR coronal, uncontrasted												
6413	CT orbits complete study, axial AND coronal, uncontrasted												
6414	CT orbits complete study, axial OR coronal pre AND post contrast												
6415	CT orbits complete study, axial AND coronal pre AND post contrast												
6416	CT paranasal sinuses limited study axial OR coronal												

6417	CT paranasal sinuses limited study axial AND coronal												
6418	CT paranasal sinuses complete study, axial OR coronal, uncontrasted												
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted												
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast												
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast												
6422	CT pituitary fossa, uncontrasted												
6423	CT pituitary fossa, pre AND post contrast												
6424	CT internal auditory meati, uncontrasted												
6425	CT internal audiory meati, pre AND post contrast												
6426	CT mastoids												
6427	CT ear structures, limited study												
6428	CT middle AND inner ear, complete study including reconstructions												
6429	CT facial bones												
6430	CT neck soft tissue, uncontrasted												
6431	CT neck soft tissue with contrast only												
6432	CT neck pre AND post contrast												
6433	CT cervical spine uncontrasted												
6434	CT cervical spine pre AND post contrast												
6435	CT cervical spine post myelogram												
6436	CT dorsal spine uncontrasted												
6437	CT dorsal spine pre AND post contrast												
6438	CT dorsal spine post myelogram												
6439	CT lumbar spine uncontrasted												

6440	CT lumbar spine pre AND post contrast												
6441	CT lumbar spine post myelogram												
6442	CT pelvimetry (topogram only)												
6443	CT chest uncontrasted												
6444	CT chest with contrast												
6445	CT chest pre AND post contrast												
6446	CT chest high resolution lungs, limited study												
6447	CT high resolution lungs, complete study												
6448	CT abdomen uncontrasted												
6449	CT abdomen with contrast												
6450	CT abdomen pre AND post contrast												
6451	CT abdomen triphasic study												
6452	CT pelvis uncontrasted												
6453	CT pelvis with contrast												
6454	CT pelvis pre AND post contrast												
6455	CT abdomen AND pelvis uncontrasted												
6456	CT abdomen AND pelvis with contrast												
6457	CT abdomen AND pelvis pre AND post contrast												
6458	CT chest, abdomen AND pelvis with contrast												
6459	CT base of skull to symphysis pubis with contrast												
6460	CT for dental implants maxilla OR mandible												
6461	CT for dental implants maxilla AND mandible												
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)												

6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)												
6464	CT limited study, any region – region to be identified on the account												
6465	CT guidance for aspiration, biopsy or drainage												
6466	CT guidance for aspiration at time of CT diagnostic study												
6467	CT stereotactic localisation for biopsy												
6468	CT for radiotherapy planning (not to be used as an add-on)												
6469	Quantitative CT for bone mineral density												
6470	Triphasic study of the liver with CT abdomen and pelvis pre and post contrast												
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast												
6472	Computer aided diagnosis for mammography												
19.10	Radiology: Miscellaneous												
3594	Mammogram of surgically removed breast biopsy specimen												
3600	Peripheral bone densitometry utilising ionising radiation	40	13,000	R 298,50		40	13,000	R 298,50		40	13,000	R 233,00	
3601	Fluoroscopy: Per half hour – add (not applicable for Items 3445 and 3447)									40	7,700	R 137,80	
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour – add									40	10,700	R 191,50	
3603	Sinography									40	18,400	R 329,50	
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	40	77,000	R 1 767,00		40	77,000	R 1 767,00		40	77,000	R 1 378,50	

3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This Item may not be used together with an Item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, Item 3629 is used.						33,000	R 757,60		40	33,000	R 590,80	
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour.						21,000	R 482,20		40	21,000	R 376,10	
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.									40	5,600	R 100,30	
3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position.									40	40,000	R 716,20	
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done									40	-	R 0,00	
3611	Foreign body localisation: Introduction of sterile needle markers – add									40	11,000	R 197,10	
3613	Setting of sterile trays						3,300	R 75,80		40	3,300	R 59,10	
5029	Mammotome – stereotaxis: Hand held										59,000	R 1 046,70	
5034	Fine needle aspiration or biopsy or core biopsy of mamma						25,000	R 573,80		40	25,000	R 447,60	
19.10.2	Radiology: Miscellaneous – mammography												
19.11	Ultrasound investigations												
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values.												
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.												

3596	Intravascular ultrasound per case, arterial or venous, for intervention.	60	30,000	R 463,40		60	30,000	R 463,40		60	30,000	R 361,40	
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment).	60	110,000	R 1 698,50		60	110,000	R 1 698,50		60	110,000	R 1 325,10	
3612	Ultrasonic bone densitometry	60	19,000	R 293,50		60	19,000	R 293,50		60	19,000	R 229,00	
3614	Transvaginal aspiration of ova	60	110,000	R 1 698,50		60	110,000	R 1 698,50		60	110,000	R 1 325,10	
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment.	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3616	Contrast media: General Rule Y applies											R 0,00	
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment.	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy).	60	40,000	R 617,70		60	40,000	R 617,70		60	40,000	R 482,00	
3619	Intravascular ultrasound imaging assesses the atheroschlerotic process to guide the placement of an intracoronary stent. This Item may be applied once per vessel (left anterior descending territory, circumflex territory and/ or right coronary territory) in which a stent or multiple stents are deployed.	60	30,000	R 463,40		60	30,000	R 463,40		60	30,000	R 361,40	
3620	Cardiac examination plus Doppler colour mapping	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3621	Cardiac examination (MMode)	60	25,000	R 386,10		60	25,000	R 386,10		60	25,000	R 301,40	
3622	Cardiac examination: 2 Dimensional	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3623	Cardiac examination + effort	60	10,000	R 154,50		60	10,000	R 154,50		60	10,000	R 120,50	
3624	Cardiac examinations + contrast	60	10,000	R 154,50		60	10,000	R 154,50		60	10,000	R 120,50	
3625	Cardiac examinations + doppler	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3626	Cardiac examination + phonocardiography	60	10,000	R 154,50		60	10,000	R 154,50		60	10,000	R 120,50	

3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs).	60	60,000	R 926,50		60	60,000	R 926,50		60	60,000	R 722,80	
3628	Renal tract	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3631	Ophthalmic examination	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3632	Axial length measurement and calculation of intra ocular lens power. Per eye. Not to be used with Item 3034	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3633	Neonatal head scan	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
3634	Peripheral vascular study, B mode only	60	39,000	R 602,30		60	39,000	R 602,30		60	39,000	R 469,90	
3635	+ Doppler	60	39,000	R 602,30		60	39,000	R 602,30		60	39,000	R 469,90	
3636	Trans-oesophageal echocardiography including passing the device	60	100,000	R 1 544,20		60	100,000	R 1 544,20		60	100,000	R 1 204,80	
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to Items 3605, 5110, 5111, 5112, 5113 or 5114)	60	78,000	R 1 204,40		60	78,000	R 1 204,40		60	78,000	R 939,80	
5026	Ultrasound guided amniocentesis	60	39,000	R 602,30		60	39,000	R 602,30				R 0,00	
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5101	Pleural space ultrasound	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5103	Ultrasound soft tissue, any region	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy.	60	25,000	R 386,10		60	25,000	R 386,10		60	25,000	R 301,40	

5107	Ultrasound after 24 weeks – motivation required	60	25,000	R 386,10		60	25,000	R 386,10		60	25,000	R 301,40	
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy	60	128,000	R 1 976,40		60	128,000	R 1 976,40		60	120,000	R 1 445,60	
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with Items 5110, 5112, 5113 or 5114)	60	206,000	R 3 180,90		60	206,000	R 3 180,90		60	164,800	R 1 985,30	
5112	Peripheral arterial ultrasound vascular study: B mode, pulsed and colour Doppler; per limb – to include waveforms at minimum of three levels, pressure studies at two levels and full interpretation of results	60	117,000	R 1 806,70		60	117,000	R 1 806,70		60	117,000	R 1 409,50	
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler – to evaluate deep vein thrombosis	60	117,000	R 1 806,70		60	117,000	R 1 806,70		60	117,000	R 1 409,50	
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler – in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally	60	178,000	R 2 748,70		60	178,000	R 2 748,70		60	142,400	R 1 715,60	
5115	Intra-operative ultrasound study	60	50,000	R 772,00		60	50,000	R 772,00		60	50,000	R 602,40	
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure.	60	88,000	R 1 358,90		60	88,000	R 1 358,90		60	88,000	R 1 060,20	

5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery [LAD (left anterior desending), Circumflex or Right coronary artery]). May be used a maximum of twice per angiographic procedure.	60	44,000	R 679,50		60	44,000	R 679,50		60	44,000	R 530,00	
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS												
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (static realtime): Fee for part examined plus 30% of the units												
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units	60	6,000	R 92,60		60	6,000	R 92,60		60	6,000	R 72,20	
5104	Ultrasound in pregnancy, multiple gestation, after twenty weeks: Plus 30%												

	GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY												
	Ultrasound examinations The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist												

19.12	Portable unit examinations												
3639	Where portable X-ray unit is used in the hospital or theatre: Add		7,000	R 160,70			7,000	R 160,70		40	7,000	R 125,40	
3640	Theatre investigations with fixed installation									40	3,000	R 53,70	
19.13	Diagnostic procedures requiring the use of radio-isotopes												
AA.	Procedures to exclude cost of isotope												
3641	Tracer test	40	33,200	R 762,10		40	33,200	R 762,10		40	22,100	R 395,50	
3642	Repeat of further tracer tests for same investigation: Half of above fee	40	16,600	R 380,90		40	16,600	R 380,90		40	11,100	R 198,80	
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee												
3644	Tracer test of complete body or brain tumour location	40	82,200	R 1 886,50		40	82,200	R 1 886,50		40	54,800	R 981,10	
3645	Other organ scanning with use of relevant radio isotopes	40	82,200	R 1 886,50		40	82,200	R 1 886,50		40	54,800	R 981,10	
3646	Thyroid scanning	40	28,800	R 661,10		40	28,800	R 661,10		40	19,200	R 344,00	
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera												
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera												

19.14	Interventional radiological procedures												
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (Items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii. All fluoroscopy (Item 3601 does not apply). iv All minor consumables (defined as any Item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable Items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)												
	Note: In regard to multiple examinations see modifier 0080												
5002	Percutaneous transluminal angioplasty: Aortic/IVC									40	102,600	R 1 836,90	

5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel									40	102,600	R 1 836,90	
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial									40	102,600	R 1 836,90	
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial									40	139,200	R 2 492,30	
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic									40	139,200	R 2 492,30	
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral – stand alone procedure									40	172,200	R 3 083,00	
5014	Atherectomy (per vessel)									40	204,600	R 3 663,20	
5016	Aspiration thrombectomy (per vessel)									40	131,400	R 2 352,60	
5017	Endoscopic ultrasound: Colon		79,900	R 1 294,10			79,900	R 1 294,10			79,900	R 1 009,50	
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite									40	106,800	R 1 911,90	
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy		100,700	R 1 631,10			100,700	R 1 631,10			100,700	R 1 272,30	
5021	Proctosigmoidoscopy with endoscopic ultrasound examination		41,900	R 678,60			41,900	R 678,60			41,900	R 529,30	
5022	Embolisation non-intracranial, per vessel									40	106,800	R 1 911,90	
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy		64,100	R 1 038,20			64,100	R 1 038,20			64,100	R 809,90	
5024	Endoscopic ultrasound: Oesophagus		50,900	R 824,50			50,900	R 824,50			50,900	R 643,10	
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy		70,200	R 1 137,20			70,200	R 1 137,20			70,200	R 886,90	
5030	Percutaneous nephrostomy for further procedure or drainage									40	73,800	R 1 321,30	
5031	Antegrade ureteric stent insertion									40	69,600	R 1 246,10	
5033	Percutaneous cystostomy in radiology suite									40	30,000	R 537,30	

5035	Urethral balloon dilatation in radiology suite									40	22,800	R 408,20	
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality						34,200	R 785,00		40	34,200	R 612,30	
5037	Urethral stenting in radiology suite									40	102,600	R 1 836,90	
5038	Intracranial/spinal AVM embolisation (per session)									40	335,400	R 6 005,00	
5039	Intracranial thrombolysis (on-table) per session									40	139,200	R 2 492,30	
5040	Intracranial aneurysm occlusion									40	286,800	R 5 134,80	
5041	Balloon occlusion/Wada test									40	106,800	R 1 911,90	
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation									40	286,800	R 5 134,80	
5043	Intracranial angioplasty									40	204,600	R 3 663,20	
5044	Transhepatic portogram									40	139,200	R 2 492,30	
5045	Hepatic arterial infusion catheter insertion									40	156,000	R 2 793,00	
5046	Percutaneous biliary drainage (external)									40	102,600	R 1 836,90	
5047	Combined internal/external biliary drainage									40	102,600	R 1 836,90	
5048	Biliary stent insertion									40	139,200	R 2 492,30	
5049	Percutaneous gall bladder drainage									40	69,600	R 1 246,10	
5050	Percutaneous or renal gall bladder stone removal									40	172,200	R 3 083,00	
5058	Stent insertion: Aortic/IVC – including percutaneous transluminal angioplasty (PTA)									40	139,200	R 2 492,30	
5060	Stent insertion: Iliac/subclavian/AV fistula – including percutaneous transluminal angioplasty (PTA)									40	139,200	R 2 492,30	
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial – including percutaneous transluminal angioplasty (PTA)									40	139,200	R 2 492,30	
5064	Stent insertion: Sub-popliteal – including percutaneous transluminal angioplasty (PTA)									40	172,200	R 3 083,00	

5066	Stent insertion: Renal/visceral/brachiocephalic – including percutaneous transluminal angioplasty (PTA)									40	204,600	R 3 663,20	
5068	Stent insertion: Extracranial carotid/vertebral – including percutaneous transluminal angioplasty (PTA), stand alone procedure									40	204,600	R 3 663,20	
5070	Stent insertion: Aorto-iliac stent graft – including percutaneous transluminal angioplasty (PTA)									40	311,400	R 5 575,30	
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite		82,200	R 1 886,70						40	82,200	R 1 471,80	
5074	IVC filter insertion jugular or femoral route									40	156,000	R 2 793,00	
5076	Intravascular foreign body removal, arterial or venous, any route									40	204,600	R 3 663,20	
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)									40	70,200	R 1 256,90	
5080	Transjugular intrahepatic porto-systemic shunt									40	335,400	R 6 005,00	
5082	Transjugular liver biopsy									40	69,600	R 1 246,10	
5084	Endoluminal fallopian tube recanalisation						172,200	R 3 952,50		40	172,200	R 3 083,00	
5086	Renal cyst aspiration/ablation									40	22,800	R 408,20	
5088	Oesophageal stent insertion in radiology suite									40	102,600	R 1 836,90	
5090	Tracheal stent insertion									40	102,600	R 1 836,90	
5091	GIT balloon dilatation under fluoroscopy									40	66,600	R 1 192,40	
5092	Other GIT stent insertion									40	102,600	R 1 836,90	
5093	Percutaneous gastrostomy in radiology suite		85,800	R 1 969,30						40	85,800	R 1 536,30	
5094	Cutting needle biopsy with image guidance						22,800	R 523,40		40	22,800	R 408,20	
5095	Chest drain insertion in radiology suite		32,400	R 743,60						40	32,400	R 580,10	
5096	Percutaneous cyst or tumour ablation (non aspiration)						54,600	R 1 253,30		40	54,600	R 977,70	

5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation – PROFESSIONAL COMPONENT		61,900	R 1 002,60			61,900	R 1 002,60					
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal – PROFESSIONAL COMPONENT		84,000	R 1 360,60			84,000	R 1 360,60					
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		132,520	R 2 146,40			132,520	R 2 146,40					
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)		81,490	R 1 320,10			81,490	R 1 320,10					
5974	Stent placement, branch pulmonary artery: First vessel		132,520	R 2 146,40			132,520	R 2 146,40					
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)		76,980	R 1 246,80			76,980	R 1 246,80					
5976	Stent placement coarctation of the aorta		132,520	R 2 146,40			132,520	R 2 146,40					
5980	Stent patent ductus arteriosus and interatrial communication		132,520	R 2 146,40			132,520	R 2 146,40					
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		132,520	R 2 146,40			132,520	R 2 146,40					
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		310,800	R 5 034,20			310,800	R 5 034,20					
5986	VSD closure, percutaneous, device placement		412,400	R 6 679,90			412,400	R 6 679,90					
5987	PFO closure with device		310,800	R 5 034,20			310,800	R 5 034,20					
5989	PDA closure-coil or ductal device		276,500	R 4 478,60			276,500	R 4 478,60					
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		276,500	R 4 478,60			276,500	R 4 478,60					

5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		276,500	R 4 478,60			276,500	R 4 478,60					
5992	Closure interatrial communication (Fontan fenestration etc)		310,800	R 5 034,20			310,800	R 5 034,20					
5995	Rapid right ventricular pacing for percutaneous procedure		51,000	R 826,10			51,000	R 826,10					
5996	Removal of embolised device/materials		80,600	R 1 305,50			80,600	R 1 305,50					
5998	Biopsy: Endomyocardial		236,100	R 3 824,10			236,100	R 3 824,10					
6000	Actigraphy: Patient monitored for a minimum of 72 hours (includes equipment fee and interpretation)		47,300	R 766,10			47,300	R 766,10			47,300	R 597,60	
5097	Vertebroplasty – introduction of stabilising material under screening or CT control, per level											R 0,00	
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate		81,400	R 1 318,50			81,400	R 1 318,50			81,400	R 1 028,60	
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy		113,800	R 1 843,30			113,800	R 1 843,30			113,800	R 1 437,90	
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES												
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or X-ray procedures. Only to be charged if radiologist is hands-on, and not for interpretation of images only.												
19.15	Magnetic Resonance Imaging (MRI)												

6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes												
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region												
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee												
6103	Post-contrast study: Bone tumour – 100% of the fee												
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable												
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable Items												
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.												

6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.												
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”.												
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.												
6110	MRI spectroscopy: 50% of fee												
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.												
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.												
6200	Magnetic Resonance Imaging: Per anatomical region – brain									75	400,000	R 5 450,60	
6201	Magnetic Resonance Imaging: Per anatomical region – orbitae									75	400,000	R 5 450,60	
6202	Magnetic Resonance Imaging: Per anatomical region – paranasal sinuses									75	400,000	R 5 450,60	
6203	Magnetic Resonance Imaging: Per anatomical region – soft tissue, face/skull									75	400,000	R 5 450,60	
6204	Magnetic Resonance Imaging: Per anatomical region – skull basis/cranio-cervical joint									75	400,000	R 5 450,60	
6205	Magnetic Resonance Imaging: Per anatomical region – middle and internal ears									75	400,000	R 5 450,60	

6206	Magnetic Resonance Imaging: Per anatomical region – soft tissue, neck									75	400,000	R 5 450,60	
6207	Magnetic Resonance Imaging: Per anatomical region – thyroid/para-thyroid									75	400,000	R 5 450,60	
6208	Magnetic Resonance Imaging: Per anatomical region – hypophysis (see modifiers 6104 and 6105 for limited examinations)									75	400,000	R 5 450,60	
6209	Magnetic Resonance Imaging: Per anatomical region – bone tumour (see modifier 6103)									75	400,000	R 5 450,60	
6210	Magnetic Resonance Imaging: Per anatomical region – cervical vertebrae									75	400,000	R 5 450,60	
6211	Magnetic Resonance Imaging: Per anatomical region – thoracic vertebrae									75	400,000	R 5 450,60	
6212	Magnetic Resonance Imaging: Per anatomical region – lumbar vertebrae									75	400,000	R 5 450,60	
6213	Magnetic Resonance Imaging: Per anatomical region – sacrum									75	400,000	R 5 450,60	
6214	Magnetic Resonance Imaging: Per anatomical region – pelvis									75	400,000	R 5 450,60	
6215	Magnetic Resonance Imaging: Per anatomical region – pelvic organs									75	400,000	R 5 450,60	
6216	Magnetic Resonance Imaging: Per anatomical region – abdomen									75	400,000	R 5 450,60	
6217	Magnetic Resonance Imaging: Per anatomical region – thorax wall									75	400,000	R 5 450,60	
6218	Magnetic Resonance Imaging: Per anatomical region – mediastinum									75	400,000	R 5 450,60	
6219	Magnetic Resonance Imaging: Per anatomical region – soft tissue, back									75	400,000	R 5 450,60	
6220	Magnetic Resonance Imaging: Per anatomical region – left shoulder									75	400,000	R 5 450,60	
6221	Magnetic Resonance Imaging: Per anatomical region – right shoulder									75	400,000	R 5 450,60	

6222	Magnetic Resonance Imaging: Per anatomical region, both hips									75	400,000	R 5 450,60	
6223	Magnetic Resonance Imaging: Per anatomical region, left hip									75	400,000	R 5 450,60	
6224	Magnetic Resonance Imaging: Per anatomical region, right hip									75	400,000	R 5 450,60	
6225	Magnetic Resonance Imaging: Per anatomical region, left upper-arm									75	400,000	R 5 450,60	
6226	Magnetic Resonance Imaging: Per anatomical region, right upper-arm									75	400,000	R 5 450,60	
6227	Magnetic Resonance Imaging: Per anatomical region, left elbow									75	400,000	R 5 450,60	
6228	Magnetic Resonance Imaging: Per anatomical region, right elbow									75	400,000	R 5 450,60	
6229	Magnetic Resonance Imaging: Per anatomical region, left forearm									75	400,000	R 5 450,60	
6230	Magnetic Resonance Imaging: Per anatomical region, right forearm									75	400,000	R 5 450,60	
6231	Magnetic Resonance Imaging: Per anatomical region, left wrist and hand									75	400,000	R 5 450,60	
6232	Magnetic Resonance Imaging: Per anatomical region, right wrist and hand									75	400,000	R 5 450,60	
6233	Magnetic Resonance Imaging: Per anatomical region, left upper-leg									75	400,000	R 5 450,60	
6234	Magnetic Resonance Imaging: Per anatomical region, right upper-leg									75	400,000	R 5 450,60	
6235	Magnetic Resonance Imaging: Per anatomical region, left knee									75	400,000	R 5 450,60	
6236	Magnetic Resonance Imaging: Per anatomical region, right knee									75	400,000	R 5 450,60	
6237	Magnetic Resonance Imaging: Per anatomical region, left lower-leg									75	400,000	R 5 450,60	
6238	Magnetic Resonance Imaging: Per anatomical region, right lower-leg									75	400,000	R 5 450,60	

6239	Magnetic Resonance Imaging: Per anatomical region, left ankle									75	400,000	R 5 450,60	
6240	Magnetic Resonance Imaging: Per anatomical region, right ankle									75	400,000	R 5 450,60	
6241	Magnetic Resonance Imaging: Per anatomical region, left foot									75	400,000	R 5 450,60	
6242	Magnetic Resonance Imaging: Per anatomical region, right foot									75	400,000	R 5 450,60	
6250	Magnetic Resonance angiography (see modifiers 6106 to 6108), brain									75	400,000	R 5 450,60	
6251	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, neck									75	400,000	R 5 450,60	
6252	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, chest									75	400,000	R 5 450,60	
6253	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, abdomen									75	400,000	R 5 450,60	
6254	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, legs									75	400,000	R 5 450,60	
6255	Magnetic Resonance angiography (see modifiers 6106 to 6108): Heart									75	400,000	R 5 450,60	
6260	Contrast medium: Current price according the regular price list published by the Radiology Society of SA												
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations									75	70,000	R 953,80	

20	**Radiation oncology**												
	GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST a. Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services. b. The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.												
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes.												
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values.												
20.1	Kilovolt therapy												
20.2	Radium therapy												
20.3	Isotope therapy												
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope												
20.4	Megavolt therapy												
20.5	Beta-ray therapy with strontium-90-applicator												
20.6	Planning of therapy												
20.7	Technical aids												
5141	Radiation materials (see modifier 0095)												
20.8	Oncological surgical procedures												
20.9	Special procedures												
20.10	Chemotherapy												

	Where patients are not treated in chemotherapy facilities, Items 0213, 0214 and 0215 are used instead of Items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.												
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities.												
5790	Non-infusional chemotherapy: Global fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day – for exclusive use by doctors with appropriate oncology training (consultations to be charged separately). Not applicable to oral hormonal therapy.	20	42,950	R 695,70	Z	20	42,950	R 695,70	Z	20	42,950	R 542,60	Z
5791	Non-infusional chemotherapy facility fee: A facility where oncology medicines are procured or scripted for oral chemotherapy, intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO. To be used in conjunction with Item 5790 (not applicable to oral hormonal therapy). Only one of the parties are to charge this fee.	20	24,490	R 396,80	Z	20	24,490	R 396,80	Z	20	24,490	R 309,50	Z

5792	Non-infusional chemotherapy facility fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO. To be used in conjunction with Item 5790 (not applicable to oral hormonal therapy). Only one of the parties are to charge this fee	20	30,610	R 496,00	Z	20	30,610	R 496,00	Z	20	30,610	R 387,00	Z
	Non-infusional chemotherapy: Consultations are charged separately												
	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.												
5793	Infusional chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day – for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities (consultations to be charged separately).	20	159,470	R 2 583,40	Z	20	159,470	R 2 583,40	Z	20	127,580	R 1 612,60	Z

5794	Infusional chemotherapy facility fee: A facility where oncology medicines are procured, stored, admixed and administered, and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO. To be used in conjunction with Item 5793 – only one of the parties are to charge this fee.	20	90,030	R 1 458,70	Z	20	90,030	R 1 458,70	Z	20	90,030	R 1 137,90	Z
5795	Infusional chemotherapy facility fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO. To be used in conjunction with Item 5793 – only one of the parties are to charge this fee.	20	112,540	R 1 823,10	Z	20	112,540	R 1 823,10	Z	20	112,540	R 1 422,30	Z
	Item 5795 is chargeable in addition to Item 5793 by the oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to Item 5793 if own or rented facility is used).												

20.11	Radiation therapy planning												
20.11.1	Manual radiotherapy planning procedures												
5801	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT	50	42,560	R 838,00	Z	50	42,560	R 838,00	Z				
5601	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT	50	99,320	R 1 955,50	Z	50	99,320	R 1 955,50	Z				
5802	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	56,180	R 1 106,20	Z	50	56,180	R 1 106,20	Z				
5602	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	131,100	R 2 581,20	Z	50	131,100	R 2 581,20	Z				
5803	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT	50	76,620	R 1 508,60	Z	50	76,620	R 1 508,60	Z				
5603	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT	50	178,770	R 3 519,70	Z	50	178,770	R 3 519,70	Z				
20.11.2	Conventional radiotherapy planning procedures												
5808	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT	50	170,260	R 3 352,10	Z	50	170,260	R 3 352,10	Z				
5608	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT	50	397,270	R 7 821,70	Z	50	397,270	R 7 821,70	Z				
5809	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	238,360	R 4 692,80	Z	50	238,360	R 4 692,80	Z				

5609	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	556,180	R 10 950,60	Z	50	556,180	R 10 950,60	Z				
5810	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT	50	297,950	R 5 866,10	Z	50	297,950	R 5 866,10	Z				
5610	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT	50	695,220	R 13 688,10	Z	50	695,220	R 13 688,10	Z				
20.11.3	Three dimensional radiotherapy planning procedures												
5820	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	240,230	R 4 729,70	Z	50	240,230	R 4 729,70	Z				
5620	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	977,200	R 19 239,80	Z	50	977,200	R 19 239,80	Z				
5821	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	407,750	R 8 028,10	Z	50	407,750	R 8 028,10	Z				
5621	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1368,070	R 26 935,80	Z	50	1368,070	R 26 935,80	Z				
5822	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	554,330	R 10 914,10	Z	50	554,330	R 10 914,10	Z				

5622	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1710,090	R 33 669,40	Z	50	1710,090	R 33 669,40	Z				
20.11.4	Intensity modulated radiotherapy planning procedures												
5823	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	642,920	R 12 658,40	Z	50	642,920	R 12 658,40	Z				
5623	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1916,810	R 37 739,50	Z	50	1916,810	R 37 739,50	Z				
5825	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	232,180	R 4 571,40	Z	50	232,180	R 4 571,40	Z				
5625	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	958,400	R 18 869,80	Z	50	958,400	R 18 869,80	Z				
5826	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	753,350	R 14 832,60	Z	50	753,350	R 14 832,60	Z				

5626	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	2174,480	R 42 812,80	Z	50	2174,480	R 42 812,80	Z				
20.11.5	Kilovolt radiation treatment												
5834	Kilovolt radiation treatment: Weekly treatment, Kilovolt or similar, per week or part thereof – PROFESSIONAL COMPONENT	50	49,080	R 966,30	Z	50	49,080	R 966,30	Z				
5634	Kilovolt radiation treatment: Weekly treatment, Kilovolt or similar, per week or part thereof – TECHNICAL COMPONENT	50	114,520	R 2 255,00	Z	50	114,520	R 2 255,00	Z				
20.11.6	Short course radiation treatment												
5835	Short course radiation treatment: Short course treatment, Single Volume of Interest – PROFESSIONAL COMPONENT	50	105,740	R 2 081,90	Z	50	105,740	R 2 081,90	Z				
5635	Short course radiation treatment: Short course treatment, Single Volume of Interest – TECHNICAL COMPONENT	50	246,730	R 4 857,90	Z	50	246,730	R 4 857,90	Z				
5836	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	148,040	R 2 914,90	Z	50	148,040	R 2 914,90	Z				
5636	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	345,410	R 6 800,70	Z	50	345,410	R 6 800,70	Z				
5837	Short course radiation treatment: Short course treatment, Special Technique – PROFESSIONAL COMPONENT	50	190,330	R 3 747,20	Z	50	190,330	R 3 747,20	Z				
5637	Short Course Radiation Treatment: Short course Treatment, Special Technique – TECHNICAL COMPONENT	50	444,110	R 8 744,00	Z	50	444,110	R 8 744,00	Z				

20.11.7	Weekly radiation treatment sessions												
20.11.7.1	Weekly radiation treatment sessions – conventional techniques												
5839	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Single Volume of Interest – PROFESSIONAL COMPONENT	50	193,860	R 3 817,00	Z	50	193,860	R 3 817,00	Z				
5639	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Single Volume of Interest – TECHNICAL COMPONENT	50	452,330	R 8 905,70	Z	50	452,330	R 8 905,70	Z				
5840	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	246,730	R 4 857,90	Z	50	246,730	R 4 857,90	Z				
5640	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	575,690	R 11 334,50	Z	50	575,690	R 11 334,50	Z				
5841	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Special Technique – PROFESSIONAL COMPONENT	50	317,220	R 6 245,70	Z	50	317,220	R 6 245,70	Z				
5641	Weekly radiation treatment sessions – conventional techniques: Weekly Treatment, Special Technique – TECHNICAL COMPONENT	50	740,180	R 14 573,20	Z	50	740,180	R 14 573,20	Z				
20.11.7.2	Weekly radiation treatment sessions – advanced techniques												
5849	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – PROFESSIONAL COMPONENT	50	236,240	R 4 651,30	Z	50	236,240	R 4 651,30	Z				
5649	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – TECHNICAL COMPONENT	50	551,210	R 10 852,70	Z	50	551,210	R 10 852,70	Z				

5850	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	330,730	R 6 511,60	Z	50	330,730	R 6 511,60	Z				
5650	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	771,710	R 15 194,00	Z	50	771,710	R 15 194,00	Z				
5851	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – PROFESSIONAL COMPONENT	50	425,230	R 8 372,30	Z	50	425,230	R 8 372,30	Z				
5651	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – TECHNICAL COMPONENT	50	992,190	R 19 534,70	Z	50	992,190	R 19 534,70	Z				
5854	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – PROFESSIONAL COMPONENT	50	348,870	R 6 868,90	Z	50	348,870	R 6 868,90	Z				
5654	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – TECHNICAL COMPONENT	50	814,030	R 16 027,30	Z	50	814,030	R 16 027,30	Z				
5855	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – PROFESSIONAL COMPONENT	50	826,830	R 16 279,20	Z	50	826,830	R 16 279,20	Z				
5655	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – TECHNICAL COMPONENT	50	1929,260	R 37 984,70	Z	50	1929,260	R 37 984,70	Z				
20.11.8	Stereotactic radiation												
5860	Stereotactic radiation: Stereotactic Radiation, Single or up to four Fractions, Global Fee – PROFESSIONAL COMPONENT	50	3719,340	R 73 229,00	Z	50	3719,340	R 73 229,00	Z				

5660	Stereotactic radiation: Stereotactic Radiation, Single Fraction, Global Fee – TECHNICAL COMPONENT	50	8678,460	R 170 867,70	Z	50	8678,460	R 170 867,70	Z				
5861	Stereotactic radiation: Stereotactic Radiation, five or more Fractions, Full course, Global Fee – PROFESSIONAL COMPONENT	50	4277,240	R 84 213,30	Z	50	4277,240	R 84 213,30	Z				
5661	Stereotactic radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee – TECHNICAL COMPONENT	50	9980,230	R 196 497,60	Z	50	9980,230	R 196 497,60	Z				
20.12	Brachytherapy												
20.12.1	Isotope/Applicator Therapy												
5870	Isotope/Applicator Therapy: Isotopes – low complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included.	50	108,400	R 2 134,30	Z	50	108,400	R 2 134,30	Z				
5872	Isotope/Applicator Therapy: Isotopes – intermediate complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included.	50	216,800	R 4 268,80	Z	50	216,800	R 4 268,80	Z				
5873	Isotope/Applicator Therapy: Isotopes – high complexity, surface application of seed arrays requiring dosimetric assessment and/ or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included	50	601,160	R 11 836,10	Z	50	601,160	R 11 836,10	Z				
20.12.2	Brachytherapy Implants												
5882	Brachytherapy implants: Implants – low complexity, placement of a single guide tube for the administration of brachytherapy requiring <8 dwell points. The cost of materials are not included.	50	216,800	R 4 268,80	Z	50	216,800	R 4 268,80	Z				

5883	Brachytherapy implants: Implants – intermediate complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included.	50	786,800	R 15 491,00	Z	50	786,800	R 15 491,00	Z				
5885	Brachytherapy implants: Implants – high complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included	50	1049,070	R 20 654,70	Z	50	1049,070	R 20 654,70	Z				
20.12.3	Brachytherapy treatment												
5890	Brachytherapy treatment: Global fee for manual afterloading – includes storage, handling, calibration, planning (manual or computerised), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included	50	613,040	R 12 070,00	Z	50	613,040	R 12 070,00	Z				
5892	Brachytherapy treatment: Global fee for remote afterloading – includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included – PROFESSIONAL COMPONENT	50	415,960	R 8 189,70	Z	50	415,960	R 8 189,70	Z				
5893	Brachytherapy treatment: Global fee for remote afterloading – includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included – PROFESSIONAL COMPONENT	50	970,560	R 19 109,00	Z	50	970,560	R 19 109,00	Z				
20.12.4	Brachytherapy imaging												
5895	Brachytherapy imaging: Brachytherapy: Special imaging where needed and if used, unusual to be added to any code other than Items 5883 or 5885.	50	156,770	R 3 086,70	Z	50	156,770	R 3 086,70	Z				

21	**Clinical pathology**												
0097	Pathology tests performed by non-pathologists: Where Items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.												
	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values. Note: For fees for Histology and Cytology refer to Items 4561-4593 under Section 22: Anatomical Pathology.												
21.1	Haematology												
3705	Alkali resistant haemoglobin	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	80	3,650	R 68,30		80	3,650	R 68,30		80	2,450	R 35,80	
3710	Antibody titration	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
3712	Antibody identification	80	8,450	R 158,10		80	8,450	R 158,10		80	5,650	R 82,50	
3713	Bleeding time (does not include the cost of the simplate device)	80	6,940	R 130,00		80	6,940	R 130,00		80	4,630	R 67,80	
3714	Blood volume, dye method	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
3715	Buffy layer examination	80	19,900	R 372,80		80	19,900	R 372,80		80	13,270	R 193,80	
3716	Mean cell Volume	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3717	Bone marrow cytological examination only	80	19,900	R 372,80		80	19,900	R 372,80		80	13,270	R 193,80	
3719	Bone marrow: Aspiration	80	8,400	R 157,30		80	8,400	R 157,30		80	5,600	R 82,00	
3720	Bone marrow trephine biopsy	80	32,600	R 610,70		80	32,600	R 610,70		80	21,700	R 317,10	
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	80	36,800	R 689,30		80	36,800	R 689,30		80	24,500	R 357,90	
3722	Capillary fragility: Hess	80	2,020	R 37,80		80	2,020	R 37,80		80	1,350	R 19,70	
3723	Circulating anticoagulants	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	

3724	Coagulation factor inhibitor assay	80	57,560	R 1 077,90		80	57,560	R 1 077,90		80	38,370	R 560,70	
3726	Activated protein C resistance	80	26,000	R 487,00		80	26,000	R 487,00		80	17,300	R 252,80	
3727	Coagulation time	80	3,160	R 59,20		80	3,160	R 59,20		80	2,110	R 30,80	
3728	Anti-factor Xa Activity	80	53,600	R 1 003,70		80	53,600	R 1 003,70		80	35,730	R 522,20	
3729	Cold agglutinins	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3730	Protein S: Functional	80	37,500	R 702,30		80	37,500	R 702,30		80	25,000	R 365,40	
3731	Compatibility for blood transfusion	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3732	Cryoglobulin	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3734	Protein C (chromogenic)	80	30,290	R 567,30		80	30,290	R 567,30		80	20,190	R 294,90	
3735	Anti-thrombin III (chromogenic)	80	22,000	R 412,00		80	22,000	R 412,00		80	14,700	R 214,80	
3736	Plasminogen (chromogenic)	80	61,650	R 1 154,70		80	61,650	R 1 154,70		80	41,100	R 600,50	
3737	Lupus Russel Viper method	80	17,000	R 318,30		80	17,000	R 318,30		80	11,300	R 165,20	
3738	Lupus Kaolin Exner method	80	25,000	R 468,20		80	25,000	R 468,20		80	16,700	R 244,00	
3739	Erythrocyte count	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3740	Factors V and VII: Qualitative	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
3741	Coagulation factor assay: Functional	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
3743	Erythrocyte sedimentation rate	80	3,000	R 56,30		80	3,000	R 56,30		80	2,000	R 29,30	
3744	Fibrin stabilising factor (urea test)	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3746	Fibrin monomers	80	2,700	R 50,60		80	2,700	R 50,60		80	1,800	R 26,30	
3748	Plasminogen activator inhibitor (PAI-I)	80	65,950	R 1 235,10		80	65,950	R 1 235,10		80	43,970	R 642,50	
3750	Tissue plasminogen activator (tPA)	80	67,790	R 1 269,70		80	67,790	R 1 269,70		80	45,190	R 660,30	
3753	Osmotic fragility (before and after incubation)	80	18,000	R 337,30		80	18,000	R 337,30		80	12,000	R 175,40	
3754	ABO Reverse Group	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3755	Full blood count (including Items 3739, 3762, 3783, 3785, 3791)	80	10,500	R 196,70		80	10,500	R 196,70		80	7,000	R 102,30	
3756	Full cross match	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
3757	Coagulation factors: Quantitative	80	32,200	R 602,90		80	32,200	R 602,90		80	21,470	R 313,70	
3758	Factor VIII related antigen	80	60,460	R 1 132,40		80	60,460	R 1 132,40		80	40,310	R 588,80	

3759	Coagulation factor correction study	80	11,720	R 219,60		80	11,720	R 219,60		80	7,810	R 114,10	
3761	Factor XIII related antigen	80	61,110	R 1 144,40		80	61,110	R 1 144,40		80	40,740	R 595,40	
3762	Haemoglobin estimation	80	1,800	R 33,60		80	1,800	R 33,60		80	1,200	R 17,50	
3763	Contact activated product assay	80	16,200	R 303,30		80	16,200	R 303,30		80	10,800	R 157,70	
3764	Grouping: A B and O antigens	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3765	Grouping: Rh antigen	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3766	PIVKA	80	43,490	R 814,50		80	43,490	R 814,50		80	28,990	R 423,50	
3767	Euglobulin Lysis time	80	25,580	R 479,10		80	25,580	R 479,10		80	17,050	R 249,10	
3768	Haemoglobin A2 (column chromatography)	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
3769	Haemoglobin electrophoresis	80	26,820	R 502,30		80	26,820	R 502,30		80	17,880	R 261,30	
3770	Haemoglobin-S (solubility test)	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3772	Haptoglobin: Quantitative	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
3773	Ham's acidified serum test	80	8,000	R 149,90		80	8,000	R 149,90		80	5,330	R 77,90	
3775	Heinz bodies	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3776	Haemosiderin in urinary sediment	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3783	Leucocyte differential count	80	6,200	R 116,30		80	6,200	R 116,30		80	4,150	R 60,70	
3785	Leucocytes: Total count	80	1,800	R 33,60		80	1,800	R 33,60		80	1,200	R 17,50	
3786	QBC malaria concentration and fluorescent staining	80	25,000	R 468,20		80	25,000	R 468,20		80	16,700	R 244,00	
3787	LE-cells	80	8,300	R 155,50		80	8,300	R 155,50		80	5,550	R 81,10	
3789	Neutrophil alkaline phosphatase	80	28,000	R 524,40		80	28,000	R 524,40		80	18,700	R 273,30	
3791	Packed cell volume: Haematocrit	80	1,800	R 33,60		80	1,800	R 33,60		80	1,200	R 17,50	
3792	Plasmodium falciparum: Monoclonal immunological identification	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	
3793	Plasma haemoglobin	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
3794	Platelet sensitivities	80	18,640	R 349,10		80	18,640	R 349,10		80	12,430	R 181,50	
3795	Platelet aggregation per aggregant	80	12,140	R 227,40		80	12,140	R 227,40		80	8,090	R 118,20	
3797	Platelet count	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	

3799	Platelet adhesiveness	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3801	Prothrombin consumption	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3803	Prothrombin determination (two stages)	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3805	Prothrombin index	80	6,000	R 112,20		80	6,000	R 112,20		80	4,000	R 58,30	
3806	Therapeutic drug level: Dosage	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3809	Reticulocyte count	80	3,000	R 56,30		80	3,000	R 56,30		80	2,000	R 29,30	
3810	Schumm's test	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3811	Sickling test	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3814	Sucrose lysis test for PNH	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	80	21,100	R 395,20		80	21,100	R 395,20		80	14,070	R 205,60	
3820	Thrombo – Elastogram	80	26,000	R 487,00		80	26,000	R 487,00		80	17,330	R 253,20	
3825	Fibrinogen titre	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	80	8,000	R 149,90		80	8,000	R 149,90		80	5,330	R 77,90	
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	80	16,000	R 299,70		80	16,000	R 299,70		80	10,700	R 156,50	
3832	Red cell pyruvate kinase: Quantitative	80	16,000	R 299,70		80	16,000	R 299,70		80	10,700	R 156,50	
3834	Red cell Rhesus phenotype	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3835	Haemoglobin F in blood smear	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3837	Partial thromboplastin time	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3841	Thrombin time (screen)	80	7,160	R 134,00		80	7,160	R 134,00		80	4,770	R 69,80	
3843	Thrombin time (serial)	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
3847	Haemoglobin H	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3851	Fibrin degeneration products (diffusion plate)	80	10,350	R 193,90		80	10,350	R 193,90		80	6,900	R 100,70	
3853	Fibrin degeneration products (latex slide)	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3854	XDP (Dimer test or equivalent latex slide test)	80	8,500	R 159,30		80	8,500	R 159,30		80	5,670	R 82,70	
3855	Haemagglutination inhibition	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	

3856	D-Dimer (quantitative)	80	27,520	R 515,60		80	27,520	R 515,60		80	18,350	R 268,10	
3857	Ristocetin Cofactor	80	35,530	R 665,40		80	35,530	R 665,40		80	23,690	R 346,30	
3858	Heparin removal	80	28,880	R 541,00		80	28,880	R 541,00		80	19,250	R 281,40	
21.2	Microscopic and miscellaneous tests												
3863	Autogenous vaccine	80	12,600	R 235,90		80	12,600	R 235,90		80	8,400	R 122,70	
3864	Entomological examination	80	20,700	R 387,80		80	20,700	R 387,80		80	13,800	R 201,60	
3865	Parasites in blood smear	80	5,600	R 105,00		80	5,600	R 105,00		80	3,730	R 54,60	
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	80	4,900	R 92,00		80	4,900	R 92,00		80	3,300	R 48,30	
3868	Fungus identification	80	8,300	R 155,50		80	8,300	R 155,50		80	5,500	R 80,40	
3869	Faeces (including parasites)	80	4,900	R 92,00		80	4,900	R 92,00		80	3,270	R 47,80	
3873	Transmission electron microscopy	80	85,000	R 1 591,90		80	85,000	R 1 591,90		80	57,000	R 833,10	
3874	Scanning electron microscopy	80	100,000	R 1 872,80		80	100,000	R 1 872,80		80	67,000	R 978,90	
3875	Inclusion bodies	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3878	Crystal identification polarised light microscopy	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3879	Campylobacter in stool: Fastidious culture	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3880	Antigen detection with polyclonal antibodies	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3881	Mycobacteria	80	3,000	R 56,30		80	3,000	R 56,30		80	2,000	R 29,30	
3882	Antigen detection with monoclonal antibodies	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
3883	Concentration techniques for parasites	80	3,000	R 56,30		80	3,000	R 56,30		80	2,000	R 29,30	
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	80	6,300	R 118,00		80	6,300	R 118,00		80	4,200	R 61,20	
3885	Cytochemical stain	80	5,450	R 101,90		80	5,450	R 101,90		80	3,650	R 53,20	
21.3	Bacteriology												
3887	Antibiotic susceptibility test: Per organism	80	8,000	R 149,90		80	8,000	R 149,90		80	5,330	R 77,90	
3888	Adhesive tape preparation	80	2,700	R 50,60		80	2,700	R 50,60		80	1,800	R 26,30	
3889	Clostridium difficile toxin: Monoclonal immunological	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	

3890	Antibiotic assay of tissues and fluids	80	13,900	R 260,40		80	13,900	R 260,40		80	9,270	R 135,30	
3891	Blood culture: Aerobic	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3892	Blood culture: Anaerobic	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3893	Bacteriological culture: Miscellaneous	80	6,300	R 118,00		80	6,300	R 118,00		80	4,200	R 61,20	
3894	Radiometric blood culture	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
3895	Bacteriological culture: Fastidious organisms	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3896	In vivo culture: Bacteria	80	16,000	R 299,70		80	16,000	R 299,70		80	10,650	R 155,70	
3897	In vivo culture: Virus	80	16,000	R 299,70		80	16,000	R 299,70		80	10,650	R 155,70	
3899	Bacterial exotoxin production (in vivo assay)	80	20,700	R 387,80		80	20,700	R 387,80		80	13,800	R 201,60	
3901	Fungal culture	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3902	Clostridium difficile (cytotoxicity neutralisation)	80	30,000	R 561,90		80	30,000	R 561,90		80	20,000	R 292,10	
3903	Antibiotic level: Biological fluids	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
3904	Rotavirus latex slide test	80	5,620	R 105,30		80	5,620	R 105,30		80	3,750	R 54,90	
3905	Identification of virus or rickettsia	80	20,700	R 387,80		80	20,700	R 387,80		80	13,800	R 201,60	
3906	Identification: Chlamydia	80	16,000	R 299,70		80	16,000	R 299,70		80	10,650	R 155,70	
3908	Anaerobe culture: Comprehensive	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3909	Anaerobe culture: Limited procedure	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3911	Beta-lactamase assay	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3914	Sterility control test: Biological method	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3915	Mycobacterium culture	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3916	Radiometric tuberculosis culture	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
3918	Mycoplasma culture: Comprehensive	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3919	Identification of mycobacterium	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3920	Mycobacterium: Antibiotic sensitivity	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3921	Antibiotic synergistic study	80	20,700	R 387,80		80	20,700	R 387,80		80	13,800	R 201,60	
3922	Viable cell count	80	1,350	R 25,20		80	1,350	R 25,20		80	0,900	R 13,00	
3923	Biochemical identification of bacterium: Abridged	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	

3924	Biochemical identification of bacterium: Extended	80	12,500	R 234,20		80	12,500	R 234,20		80	8,330	R 121,60	
3925	Serological identification of bacterium: Abridged	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
3926	Serological identification of bacterium: Extended	80	10,200	R 191,00		80	10,200	R 191,00		80	6,800	R 99,30	
3927	Grouping for streptococci	80	7,300	R 136,70		80	7,300	R 136,70		80	4,850	R 70,70	
3928	Antimicrobic substances	80	3,800	R 71,20		80	3,800	R 71,20		80	2,500	R 36,40	
3929	Radiometric mycobacterium identification	80	14,000	R 262,20		80	14,000	R 262,20		80	9,300	R 135,80	
3930	Radiometric mycobacterium antibiotic sensitivity	80	25,000	R 468,20		80	25,000	R 468,20		80	16,700	R 244,00	
3931	Helicobacter: Monoclonal immunological	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4650	Antibiotic MIC per organism per antibiotic	80	8,000	R 149,90		80	8,000	R 149,90		80	5,330	R 77,90	
4651	Non-radiometric automated blood cultures	80	13,900	R 260,40		80	13,900	R 260,40		80	9,270	R 135,30	
4652	Rapid automated bacterial identification per organism	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
4653	Rapid automated antibiotic susceptibility per organism	80	17,000	R 318,30		80	17,000	R 318,30		80	11,330	R 165,60	
4654	Rapid automated MIC per organism per antibiotic	80	17,000	R 318,30		80	17,000	R 318,30		80	11,330	R 165,60	
4655	Mycobacteria: MIC determination – E Test	80	16,500	R 308,90	Z	80	16,500	R 308,90	Z	80	11,000	R 160,90	Z
4656	Mycobacteria: Identification HPLC	80	35,000	R 655,60	Z	80	35,000	R 655,60	Z	80	23,330	R 340,70	Z
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	80	9,900	R 185,30	Z	80	9,900	R 185,30	Z	80	6,600	R 96,40	Z
21.4	Serology												
3958	Anti Gad/Ia2 Ab	80	67,950	R 1 272,50		80	67,950	R 1 272,50		80	45,300	R 661,90	
3959	Rose Waaler agglutination test	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3960	Gonococcal, listeria or echinococcus agglutination	80	9,500	R 178,00		80	9,500	R 178,00		80	6,300	R 92,00	
3961	Slide agglutination test	80	2,630	R 49,20		80	2,630	R 49,20		80	1,750	R 25,60	

3963	Serum complement level: Each component	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
3965	Anti Ia2 Antibodies	80	36,000	R 674,10		80	36,000	R 674,10		80	24,000	R 350,70	
3966	Anti Gad Antibodies	80	36,000	R 674,10		80	36,000	R 674,10		80	24,000	R 350,70	
3967	Auto-antibody: Sensitised erythrocytes	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3968	Herpes virus typing: Monoclonal immunological	80	20,690	R 387,50		80	20,690	R 387,50		80	13,790	R 201,50	
3969	Western blot technique	80	74,000	R 1 386,10		80	74,000	R 1 386,10		80	49,000	R 716,10	
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	80	14,100	R 264,10		80	14,100	R 264,10		80	9,400	R 137,40	
3933	IgE: Total: EMIT or ELISA	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
3934	Auto antibodies by labelled antibodies	80	16,000	R 299,70		80	16,000	R 299,70		80	10,650	R 155,70	
3935	Sperm antibodies	80	16,000	R 299,70		80	16,000	R 299,70		80	10,650	R 155,70	
3936	Virus neutralisation test: First antibody	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
3937	Virus neutralisation test: Each additional antibody	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
3938	Precipitation test per antigen	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3939	Agglutination test per antigen	80	5,500	R 103,10		80	5,500	R 103,10		80	3,670	R 53,60	
3940	Haemagglutination test: Per antigen	80	9,900	R 185,30		80	9,900	R 185,30		80	6,600	R 96,40	
3941	Modified Coombs' test for brucellosis	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3942	Hepatitis Rapid Viral Ab	80	12,240	R 229,20		80	12,240	R 229,20		80	8,160	R 119,10	
3943	Antibody titer to bacterial exotoxin	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
3945	Complement fixation test	80	5,850	R 109,50		80	5,850	R 109,50		80	3,900	R 57,00	
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	80	14,050	R 263,10		80	14,050	R 263,10		80	9,370	R 136,90	
3947	C-reactive protein	80	10,840	R 202,90		80	10,840	R 202,90		80	7,227	R 105,60	
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	80	12,950	R 242,80		80	12,950	R 242,80		80	8,630	R 126,00	
3949	Qualitative Kahn, VDRL or other flocculation	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	

3950	Neutrophil phagocytosis	80	25,200	R 472,00		80	25,200	R 472,00		80	16,800	R 245,40	
3951	Quantitative Kahn, VDRL or other flocculation	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
3952	Neutrophil chemotaxis	80	67,950	R 1 272,50		80	67,950	R 1 272,50		80	45,300	R 661,90	
3953	Tube agglutination test	80	4,150	R 77,80		80	4,150	R 77,80		80	2,760	R 40,30	
3955	Paul Bunnell: Presumptive	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	80	8,500	R 159,30		80	8,500	R 159,30		80	5,670	R 82,70	
3971	Immuno-diffusion test: Per antigen	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
3972	Respiratory syncytial virus (ELISA technique)	80	35,000	R 655,60		80	35,000	R 655,60		80	23,000	R 336,00	
3973	Immuno electrophoresis: Per immune serum	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
3974	Polymerase chain reaction	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	80	12,000	R 224,60		80	12,000	R 224,60		80	8,000	R 117,00	
3978	Lymphocyte transformation	80	51,700	R 968,20		80	51,700	R 968,20		80	34,500	R 504,10	
3980	Bilharzia Ag Serum/Urine	80	14,500	R 271,70		80	14,500	R 271,70		80	9,670	R 141,40	
3982	Histone Ab	80	16,000	R 299,70		80	16,000	R 299,70		80	10,670	R 155,90	
4600	Anti-CCP	80	17,460	R 327,10	Z	80	17,460	R 327,10	Z	80	11,640	R 170,10	Z
4601	Panel typing: Antibody detection – Class I	80	36,000	R 674,10		80	36,000	R 674,10		80	24,000	R 350,70	
4602	Panel typing: Antibody detection – Class II	80	44,000	R 824,00		80	44,000	R 824,00		80	29,300	R 428,10	
4603	HLA test for specific locus/antigen – serology	80	27,000	R 505,80		80	27,000	R 505,80		80	18,000	R 263,10	
4604	HLA typing: Class I – serology	80	52,000	R 973,90		80	52,000	R 973,90		80	34,700	R 507,20	
4605	HLA typing: Class II – serology	80	52,000	R 973,90		80	52,000	R 973,90		80	34,700	R 507,20	
4606	HLA typing: Class I & II – serology	80	90,000	R 1 685,60		80	90,000	R 1 685,60		80	60,000	R 876,60	
4607	Cross matching T-cells (per tray)	80	18,000	R 337,30		80	18,000	R 337,30		80	12,000	R 175,40	
4608	Cross matching B-cells	80	38,000	R 711,60		80	38,000	R 711,60		80	25,300	R 369,70	
4609	Cross matching T- & B-cells	80	48,000	R 899,00		80	48,000	R 899,00		80	32,000	R 467,70	
4610	Helicobacter: Pylori antigen test	80	34,600	R 648,10		80	34,600	R 648,10		80	23,070	R 337,20	
4611	Erythropoietin	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	

4612	HTLV I/II	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4613	Anti-Gm1 Antibody Assay	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
4614	HIV Ab – Rapid Test	80	12,000	R 224,60		80	12,000	R 224,60		80	8,000	R 117,00	
21.5	Skin tests												
	For skin-prick allergy tests, please refer to Items 0218, 0220 and 0221 in Section 2: Integumentary Section												
21.6	Biochemical tests: Blood												
3991	Abnormal pigments: Qualitative	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
3993	Abnormal pigments: Quantitative	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	
3995	Acid phosphate	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
3998	Amino acids Quantitative (post derivatisation HPLC)	80	78,120	R 1 463,30		80	78,120	R 1 463,30		80	52,080	R 761,00	
3999	Albumin	80	4,800	R 89,90		80	4,800	R 89,90		80	3,200	R 46,70	
4000	Alcohol	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4001	Alkaline phosphatase	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4002	Alkaline phosphatase-iso-enzymes	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
4003	Ammonia: Enzymatic	80	7,710	R 144,50		80	7,710	R 144,50		80	5,140	R 75,00	
4004	Ammonia: Monitor	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4005	Alpha-1-antitrypsin: Total	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
4006	Amylase	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4007	Arsenic in blood, hair or nails	80	36,250	R 679,00		80	36,250	R 679,00		80	24,170	R 353,10	
4008	Bilirubin – reflectance	80	4,770	R 89,50		80	4,770	R 89,50		80	3,180	R 46,50	
4009	Bilirubin: Total	80	4,770	R 89,50		80	4,770	R 89,50		80	3,180	R 46,50	
4010	Bilirubin: Conjugated	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4011	Breath Hydrogen Test	80	21,560	R 403,70		80	21,560	R 403,70		80	14,370	R 209,90	
4012	CSF Nicotinic Acid	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4013	CSF Glutamine	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	

4014	Cadmium: Atomic absorption	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4016	Calcium: Ionised	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4017	Calcium: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4018	Calcium: Atomic absorption	80	7,250	R 135,90		80	7,250	R 135,90		80	4,830	R 70,50	
4019	Carotene	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4020	Carnitine (total or free) in biological fluid: Each	80	11,690	R 218,80		80	11,690	R 218,80		80	7,790	R 113,70	
4021	Carnitine (total or free) in muscle: Each	80	23,380	R 438,10		80	23,380	R 438,10		80	15,590	R 227,60	
4022	Acyl Carnitine	80	23,380	R 438,10		80	23,380	R 438,10		80	15,590	R 227,60	
4023	Chloride	80	2,590	R 48,60		80	2,590	R 48,60		80	1,730	R 25,40	
4025	Chol/HDL/LDL/Trig	80	27,070	R 506,90		80	27,070	R 506,90		80	18,050	R 263,80	
4026	LDL cholesterol (chemical determination)	80	6,900	R 129,20		80	6,900	R 129,20		80	4,600	R 67,30	
4027	Cholesterol total	80	5,340	R 100,00		80	5,340	R 100,00		80	3,560	R 52,10	
4028	HDL cholesterol	80	6,900	R 129,20		80	6,900	R 129,20		80	4,600	R 67,30	
4029	Cholinesterase: Serum or erythrocyte: Each	80	7,480	R 139,90		80	7,480	R 139,90		80	4,990	R 72,90	
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	
4031	Total CO2	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4032	Creatinine	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4033	CSF-Immunoglobulin G	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4034	C1-Esterase Inhibitor	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4035	CSF-Albumin	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4036	CSF-IgG Index	80	22,050	R 413,10		80	22,050	R 413,10		80	14,700	R 214,80	
4038	Glutamic acid	80	29,060	R 544,30		80	29,060	R 544,30		80	19,370	R 283,10	
4040	Homocysteine (random)	80	15,300	R 286,40		80	15,300	R 286,40		80	10,200	R 149,00	
4041	Homocysteine (after Methionine load)	80	18,100	R 339,00		80	18,100	R 339,00		80	12,060	R 176,30	
4042	D-Xylose absorption test: Two hours	80	13,150	R 246,20		80	13,150	R 246,20		80	8,750	R 127,70	
4045	Fibrinogen: Quantitative	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	

4049	Glucose tolerance test (two specimens)	80	8,970	R 167,90		80	8,970	R 167,90		80	5,980	R 87,40	
4050	Glucose strip-test with photometric reading	80	1,800	R 33,60		80	1,800	R 33,60		80	1,200	R 17,50	
4051	Galactose	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4052	Glucose tolerance test (three specimens)	80	13,170	R 246,80		80	13,170	R 246,80		80	8,780	R 128,30	
4053	Glucose tolerance test (four specimens)	80	17,370	R 325,10		80	17,370	R 325,10		80	11,580	R 169,20	
4057	Glucose: Quantitative	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4061	Glucose tolerance test (five specimens)	80	21,560	R 403,70		80	21,560	R 403,70		80	14,370	R 209,90	
4062	Galactose-1-phosphate uridyl transferase	80	16,000	R 299,70		80	16,000	R 299,70		80	10,700	R 156,50	
4063	Fructosamine	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
4064	HbA1C	80	14,250	R 266,80		80	14,250	R 266,80		80	9,500	R 138,80	
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46,880	R 878,00		80	46,880	R 878,00		80	31,250	R 456,50	
4067	Lithium: Flame ionisation	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4068	Lithium: Atomic absorption	80	7,480	R 139,90		80	7,480	R 139,90		80	4,990	R 72,90	
4071	Iron	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4073	Iron-binding capacity	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
4076	Blood gases: Astrup/pO2 and ancillary tests – can only be charged to a maximum of six times per patient per day	80	19,100	R 357,70		80	19,100	R 357,70		80	12,730	R 186,10	
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4079	Ketones in plasma: Qualitative	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4081	Drug level-biological fluid: Quantitative	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4082	Tacrolimus assay	80	20,100	R 376,50		80	20,100	R 376,50		80	13,400	R 195,70	
4083	Lysosomal enzyme assay	80	36,560	R 684,80		80	36,560	R 684,80		80	24,370	R 356,20	
4084	Thymidine kinase	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4085	Lipase	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4086	Lactate	80	16,000	R 299,70		80	16,000	R 299,70		80	10,670	R 155,90	
4091	Lipoprotein electrophoresis	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	

4092	Orosmucoid	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4093	Osmolality: Serum or urine	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4094	Magnesium: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4095	Magnesium: Atomic absorption	80	7,250	R 135,90		80	7,250	R 135,90		80	4,830	R 70,50	
4096	Mercury: Atomic absorption	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4098	Copper: Atomic absorption	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4105	Protein electrophoresis	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	80	20,000	R 374,40		80	20,000	R 374,40		80	13,200	R 192,90	
4109	Phosphate	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4113	Potassium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4114	Sodium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4117	Protein: Total	80	3,110	R 58,10		80	3,110	R 58,10		80	2,070	R 30,20	
4121	pH, pCO2 or pO2: Each	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4123	Pyruvic acid	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4125	Salicylates	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4127	Caeruloplasmin	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4128	Phenylalanine: Quantitative	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4130	Aspartate aminotransferase (AST)	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4131	Alanine aminotransferase (ALT)	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4132	Creatine kinase (CK)	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4133	Lactate dehidrogenase (LD)	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4134	Gamma glutamyl transferase (GGT)	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4135	Aldolase	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4136	Angiotensin converting enzyme (ACE)	80	9,000	R 168,70		80	9,000	R 168,70		80	6,000	R 87,70	
4137	Lactate dehydrogenase isoenzyme	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4138	CK-MB: Immunoinhibition/precipitation	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4139	Adenosine deaminase	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	

4143	Serum/plasma enzymes	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4144	Transferrin	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
4146	Lead: Atomic absorption	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
4147	Triglyceride	80	7,930	R 148,60		80	7,930	R 148,60		80	5,290	R 77,20	
4148	Tay – Sachs Study	80	36,560	R 684,80		80	36,560	R 684,80		80	24,370	R 356,20	
4149	Red cell magnesium	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
4151	Urea	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4152	CK-MB: Mass determination: Quantitative (automated)	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4153	CK-MB: Mass determination: Quantitative (not automated)	80	17,470	R 327,20		80	17,470	R 327,20		80	11,650	R 170,30	
4154	Myoglobin quantitative: Monoclonal immunological	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4155	Uric acid	80	3,780	R 70,80		80	3,780	R 70,80		80	2,520	R 36,90	
4156	Vitamin D3	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4157	Vitamin A-saturation test	80	15,300	R 286,40		80	15,300	R 286,40		80	10,200	R 149,00	
4158	Vitamin E (tocopherol)	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
4159	Vitamin A	80	6,300	R 118,00		80	6,300	R 118,00		80	4,200	R 61,20	
4161	Troponin isoforms: Each	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4163	Apoprotein AI: Turbidometric method	80	8,280	R 155,10		80	8,280	R 155,10		80	5,520	R 80,60	
4165	Apoprotein AII: Turbidometric method	80	8,280	R 155,10		80	8,280	R 155,10		80	5,520	R 80,60	
4167	Apoprotein B: Turbidometric method	80	8,280	R 155,10		80	8,280	R 155,10		80	5,520	R 80,60	
4170	Lipoprotein a.(Lp a.) assay	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4171	Sodium + potassium + chloride + CO2 + urea	80	15,840	R 296,60		80	15,840	R 296,60		80	10,560	R 154,50	
4172	ELISA/EMIT technique	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4173	Sirolimus Assay	80	78,000	R 1 460,90		80	78,000	R 1 460,90		80	52,000	R 759,70	
4181	Quantitative protein estimation: Mancini method	80	7,760	R 145,30		80	7,760	R 145,30		80	5,170	R 75,60	

4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	80	8,280	R 155,10		80	8,280	R 155,10		80	5,520	R 80,60	
4183	Quantitative protein estimation: Labelled antibody	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4184	C-reactive protein (ultra sensitive)	80	11,680	R 218,60		80	11,680	R 218,60		80	7,790	R 113,70	
4185	Lactose	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4186	Vitamin B6	80	15,300	R 286,40		80	15,300	R 286,40		80	10,200	R 149,00	
4187	Zinc: Atomic absorption	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
21.7	Biochemical tests: Urine												
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	80	1,500	R 28,00		80	1,500	R 28,00		80	1,000	R 14,50	
4189	Abnormal pigments	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4193	Alkapton test: Homogentisic acid	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4194	Amino acids: Quantitative (Post derivatisation HPLC)	80	78,120	R 1 463,30		80	78,120	R 1 463,30		80	52,080	R 761,00	
4195	Amino laevulinic acid	80	18,000	R 337,30		80	18,000	R 337,30		80	12,000	R 175,40	
4197	Amylase	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4198	Arsenic	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4199	Ascorbic acid	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4201	Bence-Jones protein	80	2,700	R 50,60		80	2,700	R 50,60		80	1,800	R 26,30	
4204	Calcium: Atomic absorption	80	7,250	R 135,90		80	7,250	R 135,90		80	4,830	R 70,50	
4205	Calcium: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4209	Lead: Atomic absorption	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
4210	Urine collagen telopeptides	80	36,500	R 683,70		80	36,500	R 683,70		80	24,330	R 355,60	
4211	Bile pigments: Qualitative	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4213	Protein: Quantitative	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4216	Mucopolysaccharides: Qualitative	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
4217	Oxalate	80	9,380	R 175,90		80	9,380	R 175,90		80	6,250	R 91,40	
4218	Glucose: Quantitative	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	

4219	Steroids: Chromatography (each)	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
4221	Creatinine	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4223	Creatinine clearance	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
4227	Electrophoresis: Qualitative	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4228	Fetal lung maturity	80	36,560	R 684,80		80	36,560	R 684,80		80	24,370	R 356,20	
4230	Urine/fluid – specific gravity	80	0,900	R 16,80		80	0,900	R 16,80		80	0,600	R 8,86	
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	80	37,500	R 702,30	Z	80	37,500	R 702,30	Z	80	25,000	R 365,40	Z
4232	Metabolites (gaschromatography/mass spectrophotometry)	80	46,800	R 876,50	Z	80	46,800	R 876,50	Z	80	31,200	R 455,80	Z
4233	Pharmacological/drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	80	37,500	R 702,30	Z	80	37,500	R 702,30	Z	80	25,000	R 365,40	Z
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	80	46,800	R 876,50	Z	80	46,800	R 876,50	Z	80	31,200	R 455,80	Z
4237	5-Hydroxy-indole-acetic acid: Screen test	80	2,700	R 50,60		80	2,700	R 50,60		80	1,800	R 26,30	
4238	5HIAA (Hplc)	80	78,120	R 1 463,30		80	78,120	R 1 463,30		80	52,080	R 761,00	
4247	Ketones: Excluding dip-stick method	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4248	Reducing substances	80	1,800	R 33,60		80	1,800	R 33,60		80	1,200	R 17,50	
4251	Metanephrines: Column chromatography	80	22,050	R 413,10		80	22,050	R 413,10		80	14,700	R 214,80	
4252	Metanephrine (Hplc)	80	78,120	R 1 463,30		80	78,120	R 1 463,30		80	52,080	R 761,00	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	80	27,000	R 505,80		80	27,000	R 505,80		80	18,000	R 263,10	
4254	Nitrosonaphtol test for tyrosine	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4255	Orotic acid – urine	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4256	Very long chain fatty acids	80	129,380	R 2 423,00		80	129,380	R 2 423,00		80	86,250	R 1 260,30	
4261	Micro Albumin: Quantitative	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4262	Micro Albumin: Qualitative	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4263	pH: Excluding dip-stick method	80	0,900	R 16,80		80	0,900	R 16,80		80	0,600	R 8,86	

4265	Thin layer chromatography: One way	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4266	Thin layer chromatography: Two way	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4268	Organic acids: Quantitative: GCMS	80	109,380	R 2 048,70		80	109,380	R 2 048,70		80	72,920	R 1 065,40	
4269	Phenylpyruvic acid: Ferric chloride	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4270	Chromium total urine	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4271	Phosphate excretion index	80	22,050	R 413,10		80	22,050	R 413,10		80	14,700	R 214,80	
4272	Porphobilinogen qualitative screen: Urine	80	5,000	R 93,60		80	5,000	R 93,60		80	3,330	R 48,60	
4273	Porphobilinogen/ALA: Quantitative each	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
4283	Magnesium: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4284	Magnesium: Atomic absorption	80	7,250	R 135,90		80	7,250	R 135,90		80	4,830	R 70,50	
4285	Identification of carbohydrate	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
4287	Identification of drug: Qualitative	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4288	Identification of drug: Quantitative	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4293	Urea clearance	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4297	Copper: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4298	Copper: Atomic absorption	80	18,120	R 339,50		80	18,120	R 339,50		80	12,080	R 176,50	
4301	Chloride	80	2,590	R 48,60		80	2,590	R 48,60		80	1,730	R 25,40	
4309	Urobilinogen: Quantitative	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
4313	Phosphates	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4315	Potassium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4316	Sodium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4319	Urea	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4321	Uric acid	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4323	Total protein and protein electrophoresis	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4325	VMA: Quantitative	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4326	Catecholamines (HPLC)	80	78,120	R 1 463,30		80	78,120	R 1 463,30		80	52,080	R 761,00	

4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46,880	R 878,00		80	46,880	R 878,00		80	31,250	R 456,50	
4328	Immunoglobulin D	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4335	Cystine: Quantitative	80	12,600	R 235,90		80	12,600	R 235,90		80	8,400	R 122,70	
4336	Dinitrophenol hydrazine test: Ketoacids	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
21.8	Biochemical tests: Faeces												
4339	Chloride	80	2,590	R 48,60		80	2,590	R 48,60		80	1,730	R 25,40	
4343	Fat: Qualitative	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
4345	Fat: Quantitative	80	22,050	R 413,10		80	22,050	R 413,10		80	14,700	R 214,80	
4347	Ph	80	0,900	R 16,80		80	0,900	R 16,80		80	0,600	R 8,86	
4351	Occult blood: Chemical test	80	2,250	R 42,20		80	2,250	R 42,20		80	1,500	R 21,80	
4352	Occult blood: Monoclonal antibodies	80	10,000	R 187,40		80	10,000	R 187,40		80	6,670	R 97,30	
4357	Potassium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4358	Sodium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4359	Secretory IgA	80	9,450	R 176,90		80	9,450	R 176,90		80	6,300	R 92,00	
4362	Elastase quantitative ELISA	80	47,000	R 880,20		80	47,000	R 880,20		80	31,330	R 457,70	
4363	Stercobilinogen: Quantitative	80	6,750	R 126,40		80	6,750	R 126,40		80	4,500	R 65,80	
21.9	Biochemical tests: Miscellaneous												
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	80	5,000	R 93,60		80	5,000	R 93,60		80	3,330	R 48,60	
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells – each	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells – each	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells – each	80	30,000	R 561,90		80	30,000	R 561,90		80	20,000	R 292,10	
4370	Drug level in biological fluid: Monoclonal immunological	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4371	Amylase in exudate	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
4372	Fluoride in biological fluids and water	80	15,620	R 292,60		80	15,620	R 292,60		80	10,410	R 152,30	

4374	Trace metals in biological fluid: Atomic absorption	80	18,130	R 339,60		80	18,130	R 339,60		80	12,090	R 176,60	
4375	Calcium in fluid: Spectrophotometric	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4376	Calcium in fluid: Atomic absorption	80	7,250	R 135,90		80	7,250	R 135,90		80	4,830	R 70,50	
4377	Gallstone analysis: Bilirubin, Ca, P, Oxalate, Cholesterol	80	21,880	R 409,80		80	21,880	R 409,80		80	14,590	R 213,20	
4378	Urea breath test	80	58,000	R 1 086,40		80	58,000	R 1 086,40		80	38,670	R 565,10	
4380	Lecithin in amniotic fluid: L/S ratio	80	27,000	R 505,80		80	27,000	R 505,80		80	18,000	R 263,10	
4381	Lamellar body count in amniotic fluid	80	10,000	R 187,40		80	10,000	R 187,40		80	6,700	R 98,10	
4390	Foam test: Amniotic fluid	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
4391	Renal calculus: Chemistry	80	5,400	R 101,10		80	5,400	R 101,10		80	3,600	R 52,60	
4392	Renal calculus: Crystallography	80	16,250	R 304,50		80	16,250	R 304,50		80	10,800	R 157,70	
4395	Sweat: Sodium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4396	Sweat: Potassium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4397	Sweat: Chloride	80	2,590	R 48,60		80	2,590	R 48,60		80	1,730	R 25,40	
4399	Sweat collection by iontophoresis (excluding collection material)	80	4,500	R 84,20		80	4,500	R 84,20		80	3,000	R 43,80	
4400	Tryptophane loading test	80	22,050	R 413,10		80	22,050	R 413,10		80	14,700	R 214,80	
21.10	Cerebrospinal fluid												
4401	Cell count	80	3,450	R 64,70		80	3,450	R 64,70		80	2,300	R 33,70	
4407	Cell count, protein, glucose and chloride	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
4409	Chloride	80	2,590	R 48,60		80	2,590	R 48,60		80	1,730	R 25,40	
4416	Sodium	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4417	Protein: Qualitative	80	0,900	R 16,80		80	0,900	R 16,80		80	0,600	R 8,86	
4419	Protein: Quantitative	80	3,110	R 58,10		80	3,110	R 58,10		80	2,070	R 30,20	
4421	Glucose	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4423	Urea	80	3,620	R 67,80		80	3,620	R 67,80		80	2,410	R 35,40	
4425	Protein electrophoresis	80	12,600	R 235,90		80	12,600	R 235,90		80	8,400	R 122,70	

21.11	RNA/DNA based tests and andrology												
21.11.1	RNA/DNA based tests and andrology: RNA/ DNA based tests												
4424	HLA test for specific allele DNA-PCR	80	36,000	R 674,10		80	36,000	R 674,10		80	24,000	R 350,70	
4426	HLA typing low resolution Class I DNA-PCR per locus	80	100,000	R 1 872,80		80	100,000	R 1 872,80		80	67,000	R 978,90	
4427	HLA typing low resolution Class II DNA-PCR per locus	80	74,000	R 1 386,10		80	74,000	R 1 386,10		80	49,300	R 720,40	
4428	HLA typing high resolution Class I or II DNA-PCR per locus	80	66,000	R 1 236,30		80	66,000	R 1 236,30		80	44,000	R 642,90	
4429	Quantitative PCR (DNA/RNA)	80	84,300	R 1 578,80		80	84,300	R 1 578,80		80	56,200	R 821,30	
4430	Recombinant DNA technique	80	25,000	R 468,20		80	25,000	R 468,20		80	16,670	R 243,70	
4431	Ribosomal RNA targeting for bacteriological identification	80	35,000	R 655,60		80	35,000	R 655,60		80	23,330	R 340,70	
4432	Ribosomal RNA amplification for bacteriological identification	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
4433	Bacteriological DNA identification (LCR)	80	25,000	R 468,20		80	25,000	R 468,20		80	16,670	R 243,70	
4434	Bacteriological DNA identification (PCR)	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
4439	Quantitative PCR – viral load (not HIV) – hepatitis C, hepatitis B, CMV, etc.	80	150,000	R 2 809,20	Z	80	150,000	R 2 809,20	Z	80	100,000	R 1 461,10	Z
21.11.2	RNA/DNA based tests and andrology: Andrology												
4435	Mixed antiglobulin reaction: Semen	80	6,600	R 123,50		80	6,600	R 123,50		80	4,400	R 64,40	
4436	Friberg test: Semen	80	14,500	R 271,70		80	14,500	R 271,70		80	9,670	R 141,40	
4437	Kremer test: Semen	80	3,600	R 67,50		80	3,600	R 67,50		80	2,400	R 35,10	
4440	Semen analysis: Cell count	80	7,650	R 143,30		80	7,650	R 143,30		80	5,100	R 74,60	
4441	Semen analysis: Cytology	80	7,200	R 134,70		80	7,200	R 134,70		80	4,800	R 70,10	
4442	Semen analysis: Viability + motility – six hours	80	6,000	R 112,20		80	6,000	R 112,20		80	4,000	R 58,30	
4443	Semen analysis: Supravital stain	80	5,440	R 101,70		80	5,440	R 101,70		80	3,630	R 53,00	
4445	Seminal fluid: Alpha glucosidase	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	

4446	Seminal fluid fructose	80	3,150	R 59,10		80	3,150	R 59,10		80	2,100	R 30,70	
4447	Seminal fluid: Acid phosphatase	80	5,180	R 97,00		80	5,180	R 97,00		80	3,450	R 50,50	
21.12	Immunology												
4448	HCG: Latex agglutination – qualitative (side room)	80	4,000	R 74,70		80	4,000	R 74,70		80	2,670	R 39,00	
4449	HCG: Latex agglutination – semi-quantitative (side room)	80	9,310	R 174,20		80	9,310	R 174,20		80	6,210	R 90,80	
4450	HCG: Monoclonal immunological– qualitative	80	10,000	R 187,40		80	10,000	R 187,40		80	6,670	R 97,30	
4451	HCG: Monoclonal immunological – quantitative	80	12,400	R 232,20		80	12,400	R 232,20		80	8,270	R 120,90	
4452	Bone Specific Alk Phosphatase	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4455	Anti IgE receptor antibody test (10 samples and dilution)	80	161,560	R 3 025,60		80	161,560	R 3 025,60		80	107,710	R 1 573,70	
4456	Eosinophil cationic protein	80	27,810	R 520,70		80	27,810	R 520,70		80	18,540	R 270,70	
4457	Mast cell tryptase	80	96,870	R 1 814,40		80	96,870	R 1 814,40		80	64,580	R 943,70	
4458	Micro-albuminuria: Radio-isotope method	80	12,420	R 232,50		80	12,420	R 232,50		80	8,300	R 121,30	
4459	Acetyl choline receptor antibody	80	158,120	R 2 961,30		80	158,120	R 2 961,30		80	105,410	R 1 540,20	
4460	CA-199 tumour marker	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4461	Nuclear Matrix Protein 22	80	35,000	R 655,60		80	35,000	R 655,60		80	23,330	R 340,70	
4462	CA-125 tumour marker	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4463	C6 complement functional essay	80	45,000	R 842,70		80	45,000	R 842,70		80	30,000	R 438,40	
4466	Beta-2-microglobulin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4467	Chromograqnin A	80	47,000	R 880,20		80	47,000	R 880,20		80	31,330	R 457,70	
4468	CA-549	80	20,000	R 374,40		80	20,000	R 374,40		80	13,300	R 194,30	
4469	Tumour markers: Monoclonal immunological (each)	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4470	CA-195 tumour marker	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4471	Carcino-embryonic antigen	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4473	TSH Receptor Ab	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	

4474	Cast per allergen	80	27,810	R 520,70		80	27,810	R 520,70		80	18,540	R 270,70	
4475	CA-724	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4477	Neuron specific enolase	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4478	Osteocalcin	80	31,400	R 588,10		80	31,400	R 588,10		80	20,930	R 305,80	
4479	Vitamin B12-absorption: Shilling test	80	11,700	R 218,90		80	11,700	R 218,90		80	7,800	R 113,90	
4480	Serotonin	80	18,750	R 351,10		80	18,750	R 351,10		80	12,500	R 182,70	
4482	Free thyroxine (FT4)	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	
4484	Thyrotropin (TSH) + free Thyroxine (FT4)	80	37,080	R 694,60		80	37,080	R 694,60		80	24,720	R 361,20	
4485	Insulin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4486	C-Peptide	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4487	Calcitonin	80	18,900	R 354,20		80	18,900	R 354,20		80	12,600	R 184,10	
4488	B-Type Natriuretic Peptide	80	47,040	R 881,00		80	47,040	R 881,00		80	31,360	R 458,10	
4490	Releasing hormone response	80	50,000	R 936,50		80	50,000	R 936,50		80	33,350	R 487,20	
4491	Vitamin B12	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4492	Vitamin D3: Calcitroil (RIA)	80	75,000	R 1 404,70		80	75,000	R 1 404,70		80	50,000	R 730,60	
4493	Drug concentration: Quantitative	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4494	Free hormone assay	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	
4495	Growth hormone	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4496	Hormone concentration: Quantitative	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4497	Carbohydrate deficient transferrin	80	29,060	R 544,30		80	29,060	R 544,30		80	19,370	R 283,10	
4499	Cortisol	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4500	DHEA sulphate	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4501	Testosterone	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4502	Free testosterone	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	
4503	Oestradiol	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4505	Oestriol	80	10,800	R 202,10		80	10,800	R 202,10		80	7,200	R 105,20	
4506	Multiple antigen specific IgE screening test for Atopy	80	37,260	R 697,70		80	37,260	R 697,70		80	24,800	R 362,30	

4507	Thyrotropin (TSH)	80	19,600	R 367,30		80	19,600	R 367,30		80	13,070	R 191,00	
4508	Combined antigen specific IgE	80	24,480	R 458,30		80	24,480	R 458,30		80	16,600	R 242,60	
4509	Free tri-iodothyronine (FT3)	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	
4511	Renin activity	80	18,900	R 354,20		80	18,900	R 354,20		80	12,600	R 184,10	
4512	Parathormone	80	17,080	R 319,80		80	17,080	R 319,80		80	11,390	R 166,40	
4513	IgE: Total	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4514	Antigen specific IgE	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4515	Aldosterone	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4516	Follitropin (FSH)	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4517	Lutropin (LH)	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4518	Soluble transferrin receptor	80	11,250	R 210,60		80	11,250	R 210,60		80	7,500	R 109,50	
4519	Prostate specific antigen	80	14,490	R 271,40		80	14,490	R 271,40		80	9,660	R 141,20	
4520	17 Hydroxy progesterone	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4521	Progesterone	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4522	Alpha-feto protein	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4523	ACTH	80	21,740	R 407,20		80	21,740	R 407,20		80	14,490	R 211,80	
4524	Free PSA	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4526	Sex hormone binding globulin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4527	Gastrin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4528	Ferritin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4529	Anti-DNA antibodies	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4530	Antiplatelet antibodies	80	15,300	R 286,40		80	15,300	R 286,40		80	10,200	R 149,00	
4531	Hepatitis: Per antigen or antibody	80	14,490	R 271,40		80	14,490	R 271,40		80	9,660	R 141,20	
4532	Transcobalamine	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4533	Folic acid	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4534	Prostatic acid phosphatase	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4536	Erythrocyte folate	80	17,480	R 327,30		80	17,480	R 327,30		80	11,650	R 170,30	

4537	Prolactin	80	12,420	R 232,50		80	12,420	R 232,50		80	8,280	R 121,00	
4538	Procalcitonin: Semi-quantitative	80	32,000	R 599,40		80	32,000	R 599,40		80	21,330	R 311,70	
4539	Procalcitonin: Quantitative	80	46,000	R 861,50		80	46,000	R 861,50		80	30,670	R 448,20	
4540	HCG: Quantitative as used for Down's screen	80	15,000	R 280,80		80	15,000	R 280,80		80	10,000	R 146,30	
4546	First trimester Down’s screen	80	53,500	R 1 001,90		80	53,500	R 1 001,90		80	35,670	R 521,10	
4552	Second trimester Down's screen	80	33,620	R 629,70		80	33,620	R 629,70		80	22,410	R 327,40	
4553	Thyroglubulin	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
4554	SCC marker	80	20,000	R 374,40		80	20,000	R 374,40		80	13,330	R 195,00	
21.13	Clinical pathology: Miscellaneous												
4544	Attendance in theatre	80	27,000	R 505,80		80	27,000	R 505,80					
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays – refer to General Rule B.												
4551	**Unlisted pathology service** Fees for Items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the fee for a comparable service in the coding structure. New Items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note General Rule C and Item 6999 are not applicable to pathology services (sections 21, 22 and 23).												
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be charged separately.												

22	**Anatomical pathology**												
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values.												
22.1	Exfoliative cytology												
4561	Sputum, all body fluids and tumour aspirates: First unit	90	13,400	R 289,40		90	13,400	R 289,40		90	8,900	R 150,20	
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	90	7,800	R 168,70		90	7,800	R 168,70		90	5,200	R 87,70	
4564	Performance of fine-needle aspiration for cytology	90	15,000	R 324,00		90	15,000	R 324,00					
4565	Examination of fine needle aspiration in theatre	90	90,000	R 1 943,60		90	90,000	R 1 943,60		90	60,000	R 1 010,90	
4566	Vaginal or cervical smears, each	90	11,000	R 237,60		90	11,000	R 237,60		90	7,000	R 117,90	
22.2	Histology												
4567	Histology per sample	95	20,000	R 408,90		95	20,000	R 408,90		95	13,300	R 212,10	
4571	Histology per additional block, each	95	11,600	R 237,30		95	11,600	R 237,30		95	7,700	R 122,90	
4575	Histology and frozen section in laboratory	95	22,700	R 464,00		95	22,700	R 464,00		95	15,100	R 240,90	
4577	Histology and frozen section in theatre	95	90,000	R 1 840,20		95	90,000	R 1 840,20		95	60,000	R 957,00	
4578	Second and subsequent frozen sections, each	95	20,000	R 408,90		95	20,000	R 408,90		95	13,400	R 213,80	
4579	Attendance in theatre – no frozen section performed	95	45,000	R 920,10		95	45,000	R 920,10		95	30,000	R 478,70	
4582	Serial step sections (including Item 4567)	95	23,300	R 476,40		95	23,300	R 476,40		95	15,600	R 248,90	
4584	Serial step sections per additional block, each	95	13,500	R 275,90		95	13,500	R 275,90		95	9,000	R 143,60	
4587	Histology consultation	95	10,100	R 206,60		95	10,100	R 206,60		95	6,700	R 106,90	
4589	Special stains	95	6,700	R 136,80		95	6,700	R 136,80		95	4,500	R 71,90	
4591	Immunofluorescence studies	95	20,700	R 423,20		95	20,700	R 423,20		95	13,800	R 220,20	
4592	Immunoperoxidase studies	95	40,000	R 818,00		95	40,000	R 818,00		95	26,670	R 425,30	
4593	Electron microscopy	95	94,000	R 1 921,90		95	94,000	R 1 921,90		95	63,000	R 1 005,10	

4595	Foetal autopsy excluding histology	95	73,000	R 1 492,50		95	73,000	R 1 492,50		95	48,670	R 776,40	
23	**Human genetics**												
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values.												
23.1	Cytogenitc												
4750	Cell culture: Lymphocytes, cord blood	100	15,000	R 287,80		100	15,000	R 287,80		100	15,000	R 224,50	
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	100	45,000	R 863,10		100	45,000	R 863,10		100	45,000	R 673,40	
4752	Cell culture: Chorionic villi	100	60,000	R 1 151,00		100	60,000	R 1 151,00		100	60,000	R 898,00	
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	100	135,000	R 2 589,30		100	135,000	R 2 589,30		100	135,000	R 2 020,20	
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	100	270,000	R 5 179,00		100	270,000	R 5 179,00		100	270,000	R 4 040,60	
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	100	70,000	R 1 342,70		100	70,000	R 1 342,70		100	70,000	R 1 047,60	
4760	FISH procedure, including cell culture	100	115,000	R 2 205,90		100	115,000	R 2 205,90		100	115,000	R 1 721,00	
4761	FISH analysis per probe system	100	35,000	R 671,30		100	35,000	R 671,30		100	35,000	R 523,70	
23.2	DNA-testing												
4763	Blood: DNA extraction	100	45,000	R 863,10		100	45,000	R 863,10		100	45,000	R 673,40	
4764	Blood: Genotype per person – southern blotting	100	89,000	R 1 707,40		100	89,000	R 1 707,40		100	89,000	R 1 332,00	
4765	Blood: Genotype per person – PCR	100	60,000	R 1 151,00		100	60,000	R 1 151,00		100	60,000	R 898,00	
4766	HIV Drug Resistance Testing	100	513,000	R 9 840,00		100	513,000	R 9 840,00		100	342,000	R 5 118,10	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	100	90,000	R 1 726,30		100	90,000	R 1 726,30		100	90,000	R 1 346,80	

4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue – genotype per person, southern blotting	100	188,000	R 3 605,90		100	188,000	R 3 605,90		100	188,000	R 2 813,40	
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue – genotype per person, PCR	100	120,000	R 2 301,80		100	120,000	R 2 301,80		100	120,000	R 1 795,90	
IV.	**Travelling expenses**												
P.	**Travelling fees** a. Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. b. If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. c. A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. d. Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). e. Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). f. For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.												

5003	The indicated amount for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16=3 X indicated amount	20	1,000	R 16,10		20	1,000	R 16,10		20	1,000	R 12,50	
5005	Normal hours: Specialist – 18,00 clinical procedure units per hour or part thereof	20	18,000	R 291,50		20	18,000	R 291,50					
5007	Normal hours: General practitioner –18,00 clinical procedure units per hour or part thereof									20	18,000	R 227,40	
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them												
V.	**LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED**												
	Modifier 0004 is not applicable to the following sections: • All anaesthetic services • Section 19: Radiology • Section 20: Radiation Oncology • Section 21: Clinical Pathology (except for Items 3719, 3720 and 3721 where modifier 0004 may be applied) • Section 22: Anatomical Pathology • Section 23: Human Genetic Please note: This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures.												

CONTRACTED ORAL HYGIENIST

GEMS TARIFF FILE FOR CONTRACTED ORAL HYGIENIST EFFECTIVE JANUARY 2017		Practice Type: Oral Hygienists Code: 113
Tariff Code	**Description of Tariff Code**	**2017 value**
	Reimbursement for the tariff codes for procedures performed within the scope of practice for oral hygienist will be subject to scheme rules, managed care rules and benefit limits.	
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10 cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.	
	Funding for these tariff codes is subject to the managed care protocols and billing rules, scheme rules and benefit limits.	
8099	Dental laboratory service	Not funded
8154	Oral examination	R 104.70
8164	Limited oral examination	R 81.60
8106	Special report	Not funded
8107	Intraoral radiograph – periapical	R 78.60
8108	Intraoral radiographs – complete series	R 630.50
8109	Infection control/barrier techniques	R 18.10
8110	Sterilised instrumentation	R 46.70
8111	Dental testimony	Not funded
8112	Intraoral radiograph – bitewing	Not funded
8113	Intraoral radiograph – occlusal	Not funded
8115	Extraoral radiograph – panoramic	R 314.40
8116	Extraoral radiograph – cephalometric	Not funded
8117	Diagnostic models	R 65.20
8119	Diagnostic models mounted	R 163.90
8120	Treatment plan completed	Not funded

CONTRACTED ORAL HYGIENIST

GEMS TARIFF FILE FOR CONTRACTED ORAL HYGIENIST EFFECTIVE JANUARY 2017		Practice Type: Oral Hygienists Code: 113
Tariff Code	**Description of Tariff Code**	**2017 value**
8121	Oral and/or facial image (digital/conventional)	R 84.30
8123	Caries susceptibility tests (by arrangement)	Not funded
8129	Office/hospital visit – after regularly scheduled hours	Not funded
8131	Emergency dental treatment	Not funded
8139	Appointment not kept/30mins	Not funded
8140	House/extended care facility/hospital call	R 166.40
8145	Local anaesthetic – per visit	Not funded
8149	Nutritional counselling	Not funded
8150	Tobacco counselling	Not funded
8151	Oral hygiene instruction (not to be billed together with 8153)	Not funded
8153	Oral hygiene instruction – each additional visit (not to be billed together with 8151)	Not funded
8155	Polishing – complete dentition	R 100.60
8157	Re-burnishing and polishing of restorations – complete dentition	R 92.00
8158	Enamel microabrasion	Not funded
8159	Prophylaxis – complete dentition	R 183.30
8160	Removal of gross calculus	Not funded
8161	Topical application of fluoride – child	R 100.60
8162	Topical application of fluoride – adult	R 100.60
8163	Dental sealant	R 74.60
8165	Sedative filling placement of temporary filling	R 104.70
8166	Application of desensitising resin, per tooth	R 69.20
8167	Application of desensitising medicament, per visit	R 80.70
8168	Behaviour management	Not funded
8169	Occlusal guard	Not funded

GEMS TARIFF FILE FOR CONTRACTED ORAL HYGIENIST EFFECTIVE JANUARY 2017		Practice Type: Oral Hygienists Code: 113
Tariff Code	**Description of Tariff Code**	**2017 value**
8171	Mouth guard	R 107.00
8173	Space maintainer – fixed, per abutment	Not funded
8175	Space maintainer – removable	Not funded
8176	Periodontal screening	Not funded
8177	Oral hygiene instruction (periodontally compromised patient)	R 139.40
8178	Oral hygiene instruction – each additional visit (periodontally compromised patient)	R 75.10
8179	Polishing – complete dentition (periodontally compromised patient)	R 105.50
8180	Prophylaxis – complete dentition (periodontally compromised patient)	R 196.40
8265	Tissues conditioning per arch (including soft self-cure reline)	R 143.90
8273	Impression to repair or modify a denture or other intra-oral appliance	Not funded
8304	Rubber dam per arch	R 71.90
8308	External bleaching – per arch	Not funded
8309	Home bleaching – instructions and applicator	Not funded
8310	Supply of bleaching materials	Not funded
8311	Home bleaching – subsequent visit	Not funded
8325	Internal bleaching – per tooth	Not funded
8327	Internal bleaching – each additional visit	Not funded
8367	Resin – one surface, posterior	Not funded
8551	Occlusal adjustment major	Not funded
8553	Occlusal adjustment minor	Not funded
8590	Implant maintenance procedures – per implant	Not funded
8725	Provisional splinting – extracoronal (wire plus resin), per sextant	R 247.80
8727	Provisional; splinting – intra coronal, per tooth	Not funded
8737	Root planing – four or more teeth per quadrant	R 368.10

GEMS TARIFF FILE FOR CONTRACTED ORAL HYGIENIST EFFECTIVE JANUARY 2017		Practice Type: Oral Hygienists Code: 113
Tariff Code	**Description of Tariff Code**	**2017 value**
8739	Root planing – one to three teeth per quadrant	R 293.00
8773	Cost of intrapocket chemotherapeutic agent	Not funded
8815	Tracing and analysis of extra-oral film	R 28.20
9099	Unlisted dental procedure or service (by report)	Not funded

CONTRACTED PHYSICIANS REO

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new Item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
	RULES GOVERNING THE STRUCTURE					
A.	**Consultations – definitions** a. New and established patients: A consultation/visit refers to a clinical situation where a medical practitioner personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive additional remuneration. b. Subsequent visits: Refers to a voluntarily scheduled visit performed within four months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. c. Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may be levied (unless otherwise indicated). Where no procedure or operation was carried out, fees may be charged for hospital visits according to the appropriate hospital or inpatient follow-up visit code.					
B.	**Normal hours and after hours** After-hours services are paid at the same rate as benefits for normal hours services. Bona fide emergency medical services rendered to a patient, at any time, may attract a fee as specified in modifier 0011 and Items 0146 or 0147 (which should be added to the appropriate consultative services code selected from Items 0190-0192, 0173-0175, 0161-0164, 0166-0169).					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
C.	**Comparable services** A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s)/service(s), Item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure/service which will be based on the fee for a comparable service in the coding structure. When Item 6999 is used to indicate that an unlisted service was rendered, the use of the Item must be supported by a special report. This report must include: 1. An adequate definition or description of the nature, extent and need for the procedure/service or “medical necessity”; 2. In which respect is this service unusual or different in technique, compared to available procedures/services listed in the coding structure? Information regarding the nature and extent of the procedure/service, time and effort, special/ dedicated equipment needed to provide this service, must be included in the report; 3. Is this procedure/service medically appropriate under the circumstances? Explain why another procedure/service listed in the coding structure will not be appropriate in this case; 4. A description of the complexity of the symptoms and concurrent problems must be supplied; 5. Final diagnosis supported by the appropriate ICD-10 code(s); 6. Pertinent physical findings (size, location and number of lesions if applicable); 7. Mention any other diagnostic or therapeutic procedure(s)/service(s) provided at the same session; 8. Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and 9. Description of the follow-up care needed. Please note: This comparable service code may not be used for a period longer than six months for a particular procedure/service after which time an application has to be made for the addition of a specific code for this procedure.					
D.	**Cancellation of appointments** Unless timely steps are taken to cancel an appointment for a consultation, the relevant consultation fee may be charged. In the case of a general practitioner “timely” shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor’s rooms as the case may be.					
E.	Pre-operative visits: The appropriate fee may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital.					
F.	Administering of injections and/or infusions: Where applicable, fees for administering injections and/or infusions may only be charged when done by the practitioner himself.					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY				Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31		
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
G.	**Post-operative care** a. Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding ONE month (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed). b. If the normal after-care is delegated to any other registered health professional and not completed by the surgeon, it shall be his/her own responsibility to arrange for this to be done without extra charge. c. When post-operative care/treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the scheme or the patient (in case of a private account) may be charged. d. Normal after-care refers to an uncomplicated post-operative period not requiring any further incisions.					
H.	Removal of lesions: Items involving removal of lesions include follow-up treatment for 10 days.					
J.	Disproportionately low fees: In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. The use of this rule is not intended merely to increase the Medical Schemes Benefits.					
K.	**Practice of specialists** In terms of the conditions in respect of the practice of specialists as published in Government Gazette No. 12958 of 11 January 1991, a specialist may treat any person who comes to him direct for consultation. A specialist who is consulted by a patient or who treats a patient, shall take all reasonable steps to ensure the collaboration of the patient's general practitioner. Medical practitioners referring cases to other medical practitioners shall indicate in the reference whether the patient is a member of a medical scheme or a dependant of such member. This also applies in respect of specimens sent to pathologists.					
L.	Procedures performed at time of visits: If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged.					
M.	Procedure planned to be performed later: In cases where, during a consultation/visit, a procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion.					
N.	"Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention.					
O.	Costly or prolonged medical services or procedures: In the case of costly or prolonged medical services or procedures, the medical practitioner shall first ascertain from the medical scheme for what amount the medical scheme will accept responsibility in respect of such treatment, should the practitioner wish any direct payment from the scheme.					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
P.	**Travelling fees** a. Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. b. If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. c. A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. d. Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). e. Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). f. For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.					
Q.	**Intensive care/high care** Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221, but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and X-rays. g. Intravenous treatment (Items 0206 and 0207), except intravenous infusion in patients under the age of three years (Item 0205) that does not form a part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management).					
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. Item 1211: Cardio-respiratory resuscitation).					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
S.	**Ventilation** Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies; b. Testing and connecting the machine; c. Putting patient on machine: setting machine, synchronising patient with machine; d. Instruction to nursing staff; and e. All subsequent visits for 24 hours.					
T.	Ventilation (Items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring.					
U.	**Obstetric procedures** a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than 6 hours, the general practitioner shall charge 50,00 clinical procedure units according to Item 2614: Global obstetric care. ii. If the patient has been in labour for more than 6 hours, the general practitioner shall charge 80,00 clinical procedure units according to Item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to Item 2614: Global obstetric care.					
V.	**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. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.					
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used.					
Z.	No fee is subject to more than one reduction.					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
AA.	Procedures to exclude cost of isotope.					
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes.					
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp.					
EE.	**Ultrasound examinations** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist.					
FF.	a. When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to Item 1949: Cystoscopy, when performed together with any of Items 1951 to 1973.					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY					Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.					
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No “038”) or nuclear medicine practices (Pr No “025”), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No “038”) and nuclear medicine practices (Pr No “025”).					
XX.	Diagnostic services rendered to hospital inpatients: Quote modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic.					
YY.	Diagnostic services rendered to outpatients: Quote modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital).					
	MODIFIERS GOVERNING THE STRUCTURE					
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned Item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere.					
0004	**Procedures performed in own procedure rooms** Procedures performed in doctors’ own procedure rooms instead of in a hospital theatre or unattached theatre unit: as per fee for procedure + 100% (the value of modifier 0004 equals 100% of the value of the procedure performed). See Section V (Section G in SAMA’s DBT) for a list of procedures, which are often done in rooms to which modifier 0004 should not be applied. Please note: Only the medical practitioner who owns the facility and the equipment may charge modifier 0004. Only one person may claim this modifier for procedures performed in doctors’ own procedure rooms.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0005	**Multiple therapeutic procedures/operations under the same anaesthetic** a. Unless otherwise identified in the tariff when multiple therapeutic procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, 75% for the second procedure/operation, 50% for the third procedure/operation, 25% for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures. b. In the case of multiple fractures and/or dislocations the above values shall prevail. c. When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedures performed, are performed under the same general anaesthetic, modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedure and provide diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other (therapeutic) procedures performed under the same anaesthetic. d. Please note: When more than one small procedure is performed and the tariff makes provision for Items for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) modifier 0005 is not applicable as the fee is already a reduced fee. e. "+" 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).					
0006	**Visiting specialists performing procedures** Where specialists visit smaller centres to perform procedures, fees for these particular procedures are exclusive of after-care. The referring practitioner will then be entitled to subsequent hospital visits for after-care. If the referring practitioner is not available, the specialist shall, on consultation with the patient, choose an appropriate locum tenens. Both the surgeon and the practitioner who handled the after-care, must in such instances quote modifier 0006 with the particular Items which they use.					
0007	a. Use of own monitoring equipment in the rooms: Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – 15,00 clinical procedure units irrespective of the number of items of equipment provided. b. Use of own equipment in hospital theatre or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital – 15,00 clinical procedure units irrespective of the number of items of equipment provided. c. Not funded for all disciplines when using tariff code 5103.	20	15.000		R 187.00	
0008	Specialist surgeon assistant: Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0009	Assistant: The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36,00 clinical procedure units. The minimum fee payable may not be less than 36,00 clinical procedures units.					
0010	**Local anaesthesic** a. A fee for a local anaesthetic administered by the operator may only be charged for; i. an operation or procedure having a value greater than 30,00 clinical procedure units (i.e. 31,00 or more clinical procedure units allocated to a single Item); or ii. where more than one operation or procedure is done at the same time with a combined value greater than 50,00 clinical procedure units. b. The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per modifier 0036: Anaesthetic administered by a general practitioner, shall be applicable in such a case. c. Not applicable to radiological procedures, such as angiography and myelography. d. No fee may be levied for topical application of local anaesthetic. e. Please note: Modifier 0010: Local anaesthetic administered by the operator, may not be added on the surgeon's account for procedures that were performed under general anaesthetic.					
0011	**Emergency procedures** Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.					
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.					
0014	Operations previously performed by other surgeons: Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0015	**Intravenous infusions** Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.					
0017	**Injections administered by practitioners** When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him-/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation Item).	10	7.500		R 196.50	
0018	Surgical modifier for persons with a BMI of 35> (calculated according to kg/m2): Fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.					
0019	Surgery on neonates (up to and including 28 days after birth) and low birth weight infants (less than 2500g) under general anaesthesia (excluding circumcision): per fee for procedure + 50% for surgeons and a 50% increase in anaesthetic time units for anaesthesiologists.					
0046	Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. Please note: This reduction does not include the assistant's fee where applicable. After one month, a full fee as for the initial treatment, is applicable.					
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis.					
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).	20	27.000		R 336.60	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement.	20	77.000		R 959.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either modifier 0049: Cases of compound fractures, or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either modifier 0049: Cases of compound fractures or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable).	20	115.500		R 1 439.40	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.	20	77.000		R 959.70	
0053	Fracture requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists and general practitioners add 32,00 clinical procedure units.	20	32.000		R 398.80	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.	20	77.000		R 959.70	
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.					
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Per fee for total joint replacement + 100%					
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.					
0063	Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.					
0064	Where the replantation is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts.					
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere.					
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee.					
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff).					
0069	When endoscopic instruments are used during intranasal surgery add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0070	Add 45,00 clinical procedure units to procedure(s) performed through a thorascope.	20	45.000		R 729.20	
0072	Non-invasive peripheral vascular tests: The number of tests in a single case is restricted to two per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.					
0073	When Item 1288 (cardiac catheterisation for congenital heart disease: All ages above one year old or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): fee for procedure + 100%					
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee ("+" codes excluded) will apply where endoscopic procedures are performed with own equipment.					
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the Items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	20	21.000		R 261.80	
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. Only applicable if services are provided by a specialist in physical medicine.					
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure.					
0079	When a first 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)					
0080	Multiple examinations: Full Fee					
0081	Repeat examinations: No reduction					
0082	"+" means that this item is complementary to a preceding item and is therefore not subject to reduction.					
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.					
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. This information is obtainable from the Radiological Society of SA.					
0085	Left Side' modifier to be added to when Items 6500 to 6519 are used when the left side is examined. Please note that the absence of this modifier indicates that the right side was examined.					

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0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of modifier 0080: Multiple examinations.					
0090	Radiologist’s fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or X-ray procedures. Only to be charged if radiologist is hands-on, and not for interpretation of images only.					
0091	Diagnostic services rendered to hospital inpatients: Quote modifier 0091 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX).					
0092	Diagnostic services rendered to outpatients: Quote modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY).					
0095	**Radiation materials** Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, 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.					
0096	Radio-isotope therapy patients who fail to keep their appointments – fee will include cost of isotope.					
0097	Pathology tests performed by non-pathologists: Where Items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.					
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (static realtime): Fee for part examined plus 30% of the units.					
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units	60	6.000		R 92.70	
5104	Ultrasound in pregnancy, multiple gestation, after 20 weeks: Plus 30%					
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.					
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charged at 50% of the fee.					
6103	Post-contrast study: Bone tumour, 100% of the fee					
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable.					
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items.					
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.					
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.					
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”.					
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.					
6110	MRI spectroscopy: 50% of fee					
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for Items 3536-3550 will be allowed (specify time of procedure on account).					
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).					
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).					
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.					
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
I.	**Consultative services (refer to Psychiatrists Consultative Service guide)**					
I.a	General practitioner visits					
I.b	Specialists tiered consultation structure					
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only					
0161	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.					
0162	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes. For hospital consultation/visit by psychiatrist – refer to Items 0166-0169.					
0163	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).					
0164	Psychiatry ('22'): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).					
0166	Psychiatry (22): First hospital consultation/visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes.					
0167	Psychiatry (22): First 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 and 35 minutes.					
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes.					
0169	Psychiatry (22): First hospital consultation/visit 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.					

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I.c	General practitioner and specialist services (refer to the Medical Practitioner Consultative Service guide)					
0190	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Item 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure .					
0191	New and established patient: Consultation/visit of new or established patient of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Item 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure .					
0192	New and established patient: Consultation/visit of new or established patient of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. For hospital consultation/visit – refer to Item 0173-0175 or Item 0109. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure .					
0173	First hospital consultation/visit of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.					
0174	First hospital consultation/visit of a moderately above average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.					
0175	First hospital consultation/visit of long duration and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient. Not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics – refer to new anaesthetic structure.					
0109	Hospital follow-up visit to patient in ward or nursing facility – refer to general rule G.a. for post-operative care. May only be charged once per day. Not to be used with Items 0111, 0145, 0146, 0147 or ICU Items 1204-1214.					
0111	Paediatric hospital follow-up visits (excluding neonates) by paediatricians or paediatric cardiologists – may only be charged once per day. Not to be used with Items 0109 or ICU Items 1204-1214. For a healthy neonate please use Item 0109 for a hospital follow-up visit.					

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0129	Prolonged face-to-face attendance to a patient: ADD to either Item 0192, Item 0175, Item 0164 or Item 0169 as appropriate, for each 15-minute period only if service extends 10 minutes or more into the next 15-minute period following on the first 60 minutes.					
0145	For consultation/visit away from the doctor's home or rooms (non-emergency): ADD only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164 or Items 0166-0169, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.					
0146	For an unscheduled emergency consultation/visit at the doctors' home or rooms, all hours: ADD only to the consultation/visit Items 0190-0192, Items 0161-0164 or Items 0151-0153, as appropriate (refer to general rule B). Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.					
0147	For an emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit Items 0190-0192, Items 0173-0175, Items 0161-0164, Items 0166-0169 or Items 0151-0153, as appropriate. Note: Only one of Items 0145, 0146 or 0147 may be charged and not combinations thereof.					
I.e	Pre-anaesthetic assessment					
0151	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes.					
0152	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes.					
0153	Pre-anaesthetic assessment: Pre-anaesthetic assessment of patient or other consultative service. Consultation with detailed history, complete examination and moderate complex decision making and counselling. Typically occupies the doctor face-to-face for between 30 and 45 minutes.					
I.f	Prenatal visits and new born attendance					
0107	Newborn attendance: Exclusive attendance to baby at caesarean section, normal delivery or visit in the ward (once per patient). Items 0109, 0111, 0113, 0145, 0146 and/or 0147 may not be added to Item 0107.					
	Item 0107 can be used once only for given confinement.					
0113	Newborn attendance: Emergency attendance to newborn at all hours (once per patient) (Items 0107, 0109, 0111, 0145, 0146 and/or 0147 may not be added to Item 0113).					
I.g	Consultative services: Miscellaneous					
0130	Telephone consultation (all hours)					

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0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (needs not be face-to-face contact). “Consultation” via SMS or electronic media included.					
0133	Writing of special motivations for procedures and treatment without the physical presence of a patient (includes report on the clinical condition of a patient) requested by or on behalf of a third party funder or its agent.					
0199	Completion of chronic medication forms by medical practitioners with or without the physical presence of the patient requested by or on behalf of a third party funder or its agent.					
II.	**Medicine, material, supplies and use of own equipment**					
II.a	Medicine codes					
II.a.1	Dispensing of medicine by licensed dispensing medical practitioners					
0197	Licenced dispensing medical practitioners – dispensing cost: As per legislated tariff. Add to each NAPPI code to provide for the dispensing cost.					
II.a.2	Once-off administration of medicine used during a consultation.					
0198	**Once-off administration of medicines** This item provides for medicines used at a consultation, viz, once-off administration of medicine, special medicine used in treatment, or emergency dispensing. Charge for medicine used according to the Single Exit Price (SEP) PLUS legislated tariff for dispensing fees. Where applicable, VAT should be added to the dispensing fee only and not to the SEP, since the SEP is VAT inclusive (according to Section 18(8) of the Medicines and Related Substances Act (Act 101 of 1965) compounding and dispensing does not refer to a medicine requiringpreparation for a once-off administration to a patient during a consultation). The appropriate Ethical Medicine NAPPI code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not areference code), should be added applicable to the medicine used. Please note: Refer to Item 0201 for cost of material used in treatment.					
II.a.3	Cost of chemotherapy drugs					
0212	Cost of chemotherapy drugs: This Item provides for a charge for chemotherapy drugs used in treatment. Charge for chemotherapy drugs used in treatment at cost price PLUS 16% (with a maximum of R16,00). (Where applicable, VAT should be added to the above). The appropriate Ethical Medicine Nappi code(s), selected from those codes commencing with 7, 8 or 9 (provided that it is not a reference code), should be added applicable to the chemotherapy drugs used.					
II.b	Material codes					
II.b.1	Prosthesis and/or internal fixation					

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II.b.2	Material used during a consultation					
0201	Cost of material in treatment: This item provides for a charge for material used in treatment. Charge for material at cost price PLUS 26% (up to a maximum of R26,00). Where applicable, VAT should be added to the above. The appropriate Surgical and Material NAPPI code(s), selected from those codes commencing with 4, 5, 6, where applicable, for the material used, must be provided. Please note: Refer to Item 0198 for once off administration of medicine.					
0194	Procurement cost for human donor material, no mark-up allowed.		-			
II.c	Setting of sterile tray					
0202	Setting of sterile tray: A fee of 10,00 clinical procedure units may be charged for the setting of a sterile tray where a sterile procedure is performed in the rooms. Cost of stitching material, if applicable, shall be charged for according to Item 0201, as appropriate.	20	10.000		R 124.40	
II.d	Own equipment used in treatment					
5930	Surgical laser apparatus: Hire fee for own equipment.	20	109.000		R 1 358.40	
5932	Candella laser apparatus: Hire fee for own equipment (rates by arrangement with the scheme concerned)					
III.	**Procedures**					
6999	Unlisted procedure/service: A procedure/service may be provided that is not listed in this edition of the coding structure. Refer to General Rule C for the criteria to use Item 6999.					
	GENERAL MODIFIERS GOVERNING THIS SECTION					
0011	**Emergency procedures** Any bona fide, justifiable emergency procedure (all hours) undertaken in an operating theatre and/or in another setting in lieu of an operating theatre, will attract an additional 12,00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply in respect of patients on scheduled lists. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.					
0013	Endoscopic examinations done at operations: Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.					

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0014	**Operations previously performed by other surgeons** Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall 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.					
	MODIFIERS GOVERNING SECTION 1					
0015	**Intravenous infusions** Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after the operation or confinement, no extra fees shall be charged as this is included in the global operative or maternity fees. Should the practitioner doing the operation or attending to the maternity case prefer to ask another practitioner to perform post-operative or post-confinement intravenous infusions, then the practitioner himself (and not the patient) shall be responsible for remunerating such practitioner for the infusions.					
0017	**Injections administered by practitioners** When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner him/herself to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for the same condition should be charged at 7.50 consultative services units using modifier 0017 to reflect the amount (not chargeable together with a consultation Item).	10	7.500		R 196.50	
1	**General**					
1.1	Injections, Infusions and inhalation sedation treatment					
0203	Inhalation sedation: Use of analgesic nitrous oxide for alcohol and other withdrawal states, first quarter-hour or part thereof.	20	6.000		R 97.30	
0204	Inhalation sedation: Per additional quarter-hour or part thereof.	20	3.000		R 48.60	
0205	Intravenous treatment: Intravenous infusions (cut-down or push-in, patients under three years): Cut-down and/or insertion of cannula – chargeable once per 24 hours	20	12.000		R 194.40	
0206	Intravenous treatment: Intravenous infusions (push-in, patients over three years): Insertion of cannula – chargeable once per 24 hours	20	6.000		R 97.30	
0207	Intravenous treatment: Intravenous infusions (cut-down, patients over three years): Cut-down and insertion of cannula – chargeable once per 24 hours	20	8.000		R 129.60	

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0208	Venesection: Therapeutic venesection (not to be used when blood is drawn for the purpose of laboratory investigations)	20	6.000		R 97.30	
0209	Umbilical artery cannulation at birth	20	18.000		R 291.60	
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)	20	3.250		R 52.70	
0211	Exchange transfusion: First and subsequent (including after-care)	20	80.000		R 1 296.20	
	Note: How to charge for intravenous infusions Practitioners are entitled to charge according to the appropriate Item whenever they personally insert the cannula (but may only charge for this service once every 24 hours). For managing the infusion as such, e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultations (not applicable to Item 0205).					
1.2	Chemotherapy treatment (not in chemotherapy facilities)					
0213	Treatment with cytostatic agents: Administering of chemotherapy: Intramuscular or subcutaneous, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.	20	5.000		R 62.30	
0214	Intravenous treatment with cytostatic agents: Administering of chemotherapy: Intravenous bolus technique, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.	20	9.000		R 112.20	
0215	Intravenous treatment with cytostatic agents: Administering of chemotherapy: Intravenous infusion technique, per injection. For use by providers who do not make use of recognised chemotherapy facilities and/or who are not primarily responsible for managing the chemotherapy treatment.	20	14.000		R 174.40	
1.3	Oncology related services in non-oncology facilties					
5780	Interstitial implants: Placing of guide tubes for interstitial implants under local or general anaesthetic – the cost of materials is not included	20	394.860	z	R 4 920.70	z
5781	Intracavitary applications: Placing of guide tubes under local or general anaesthetic for manual or remote afterloading brachytherapy – the cost of materials is not included	20	262.410	z	R 3 270.10	z
5782	Isotope therapy: Administration of low dose surface applicators, up to five applications. Typically an out patient procedure – the cost of materials is not included	20	77.810	z	R 969.80	z
5783	Infusional pharmacotherapy: Fee for the treatment of non cancerous conditions with bolus or infusional pharmacotherapy per treatment day (consultations to be charged separately)	20	42.650	z	R 531.50	z

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	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHETICS FOR ALL PROCEDURES AND OPERATIONS					
0020	Conscious sedation: Any case that is conducted outside of a hospital theatre shall be coded with the relevant procedure code. To identify these cases, the above modifier should be used to indicate to the medical scheme that there will be no hospital/theatre account.					
0021	**Determination of anaesthetic fees** Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units (allocated to each procedure that might be performed under anaesthetic as indicated in the “Anaesthetic Performed” column) plus the time units (calculated according to the formula in modifier 0023) and the appropriate modifers (see modifiers 0037-0044). In cases of operative procedures on the musculoskeletal system, open fractures and open reduction of fractures or dislocations add units as laid down by modifiers 5441 to 5448.					
0023	The basic anaesthetic units are laid down in the tariff and are reflected in the anaesthetic column. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by “T”) will be added to the listed basic anaesthetic units in all cases on the following basis: Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic, i.e. 2,00 anaesthetic units per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one hour the number of units shall, after one hour, be 3,00 anaesthetic units per 15 minute period or part thereof.					
0024	Pre-operative assessments not followed by procedures: If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, it will be regarded as a visit at hospital or nursing home and the appropriate hospital visit item should be charged.					
0025	**Calculation of anaesthetic time** Anaesthetic time is calculated from the time the anaesthesiologist/anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/ anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time. The anaesthesiologist/anaesthetist must show on his/her account the exact anaesthetic time, including the supervision time spent with the patient.					
0027	More than one procedure under the same anaesthetic: Where more than one operation is performed under the same anaesthetic, the basic anaesthetic units will be that of the major operation with the highest number of units.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0028	Indicator for use of low flow anaesthetic technique less than 1litre/minute: Fresh gas flow of less than 1 litre/minute					
0029	Assistant anaesthesiologists: When rendered necessary by the scope of the anaesthetic, an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic.					
0030	Indicator for use of low flow anaesthetic technique 1-2 litres/minute: Fresh gas flow of 1 to 2 litres/minute					
0031	Intravenous drips and transfusions: Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.					
0032	Patients in prone position: Anaesthesia administered to patients in the prone position shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.					
0033	Participating in general care of patients: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic, such services may be remunerated at full anaesthetic rate, subject to the provisos of modifier 0035: Anaesthetic administered by an anaesthesiologist/anaesthetist. and modifier 0036: Anaesthetic administered by general practitioners.					
0034	Head and neck procedures: All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4,00 basic anaesthetic units. When the basic anaesthetic units for the procedure is 3,00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure is 4,00 or more, no extra units should be added.					
0035	Anaesthetic administered by an anaesthesiologist/anaesthetist: No anaesthetic administered shall have a total value of less than 7,00 anaesthetic units (basic units, time units plus appropriate modifiers).					
0036	**Anaesthetic administered by general practitioners**: he units (basic units plus time plus the appropriate modifiers) used to calculate the fee for an anaesthetic administered by a general practitioner lasting one hour or less, shall be the same as that for an anaesthesiologist. For anaesthetic lasting more than one hour, the units used to calculate the fee for an anaesthetic administered by a general practitioner will be 4/5 (80%) of the total number of units (basic units plus time – refer to modifier 0023 – plus the appropriate modifiers) applicable to an anaesthesiologist. Please note that the 4/5 (80%) principle will be applied to all anaesthetics administered by general practitioners with the proviso that no anaesthetic with a total number of units higher than 11.00 will be reduced to less than 11,00 units in total. The monetary value of the unit is the same for both an anaesthesiologist/anaesthetist.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0037	Body hypothermia: Utilisation of total body hypothermia –add 3,00 anaesthetic units					
0038	Peri-operative blood salvage: Add 4,00 anaesthetic units for intra-operative blood salvage and 4,00 anaesthetic units for post-operative blood salvage					
0039	Control of blood pressure: Deliberate control of the blood pressure: All cases up to one hour – add 3,00 anaesthetic units, thereafter add 1,00 (one) additional anaesthetic unit per quarter hour or part thereof					
0040	Phaeochromocytoma: The basic anaesthetic units for procedures performed for phaeochromocytoma shall be 15,00 anaesthetic units					
0041	Hyperbaric pressurisation: Utilisation of hyperbaric pressurisation – add 3,00 anaesthetic units					
0042	Extracorporeal circulation: Utilisation of extracorporeal circulation – add 3,00 anaesthetic units					
0043	Patients under one year of age: For all cases where the patient is under one year of age – 3,00 anaesthetic units to be added					
0044	Neonates (i.e. up to and including 28 days after birth): 3,00 anaesthetic units to be added to the basic anaesthetic units for the particular procedure. This modifier is charged in addition to modifier 0043: Cases under one year of age					
0100	Intra-aortic balloon pump: Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75,00 clinical procedure units is applicable					
	Modifiers 5441 to 5448: Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. The letter “M” is annotated next to the number of units of the appropriate Items, for facilitating identification of the relevant items.					
5441	Add one (1,00) anaesthetic unit, except where the procedure refers to the bones named in modifiers 5442 to 5448					
5442	Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2,00) anaesthetic units					
5443	Maxillary and orbital bones: Add three (3,00) anaesthetic units					
5444	Shaft of femur: Add four (4,00) anaesthetic units					
5445	Spine (except coccyx), pelvis, hip, neck of femur: Add five (5,00) anaesthetic units					
5448	Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8,00) anaesthetic units					

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	Post-operative alleviation of pain					
0045	**Post-operative alleviation of pain** a. When a regional or nerve block procedure is performed, the appropriate procedure item to patient in ward or nursing facility, can be charged, provided that it is not the primary anaesthetic technique. b. When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain, it shall be charged according to the particular procedure for instituting therapy. Revisits shall be charged according to the appropriate hospital follow-up visit to patient in ward or nursing facility. c. None of the above is applicable for routine post-operative pain management i.e. intramuscular, intravenous or subcutaneous administration of opiates or NSAID (non-steroidal anti-inflammatory drug).					
2	**Integumentary system**					
2.1	Allergy					
0217	Allergy: Patch tests, first patch	20	4.000		R 65.00	
0218	Allergy: Skin-prick tests – skin-prick testing: Insect venom, latex and drugs	20	2.800		R 45.50	
0219	Allergy: Patch tests, each additional patch	20	2.000		R 32.40	
0220	Allergy: Skin-prick tests – immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens	20	1.900		R 30.80	
0221	Allergy: Skin-prick tests – delayed hypersensitivity testing (Type IV reaction): Per antigen	20	2.800		R 45.50	
2.2	Skin (general)					
0222	Intralesional injection into areas of pathology e.g. Keloid, single	20	4.000		R 50.00	
0223	Intralesional injection into areas of pathology e.g. Keloids, multiple	20	8.000		R 99.60	
0225	Epilation: Per session	20	8.000		R 99.60	
0227	Special treatment of severe acne cases, including draining of cysts, expressing of cleaning of Comedones and/or steaming, abrasive cleaning of skin and UVR per session	20	8.000		R 99.60	
0228	PUVA Treatment: Maximum of 21 treatments	20	20.000		R 249.30	
0229	PUVA: Follow-up or maintenance therapy once a week	20	20.000		R 249.30	
0230	UVR-Treatment	20	20.000		R 249.30	
0231	UVR-Follow-up – for use of ultraviolet lamp (applied personally by the dermatologist). No charge to be levied if a nurse or physiotherapist applies the ultraviolet lamp	20	5.500		R 68.60	

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0232	Biopsy of superficial soft tissue: Back or flank		47.400		R 767.70	
0233	Biopsy without suturing: First lesion	20	6.000		R 97.30	
0234	Biopsy without suturing: Subsequent lesions (each)	20	3.000		R 48.60	
0235	Biopsy without suturing: Maximum for multiple additional lesions	20	18.000		R 291.60	
0236	Biopsy of superficial soft tissue: Shoulder area		49.100		R 795.20	
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing	20	12.000		R 149.50	
0238	Biopsy of superficial soft tissue: Upper arm or elbow area		49.100		R 795.20	
0239	Biopsy of superficial soft tissue: Forearm and/or wrist		48.500		R 785.40	
0240	Biopsy of superficial soft tissue: Leg or ankle area		48.300		R 782.30	
0241	Treatment of benign skin lesion by chemo-cryotherapy: First lesion	20	6.000		R 74.90	
0242	Treatment of benign skin lesion by chemo-cryotherapy: Subsequent lesions (each)	20	3.000		R 37.40	
0243	Treatment of benign skin lesion by chemo-cryotherapy: Maximum for multiple additional lesions	20	42.000		R 523.40	
0244	Repair of nail bed	20	30.000		R 373.80	
0245	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: First lesion	20	14.000		R 174.40	
0246	Removal of benign lesion by curretting under local or general anaesthesia followed by diathermy and curretting or electrocautery: Subsequent lesions (each)	20	7.000		R 87.40	
0247	Biopsy of superficial soft tissue: Pelvis and hip area		58.300		R 726.30	
0248	Biopsy of superficial soft tissue: Thigh or knee area		52.300		R 651.60	
0251	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: First lesion	20	30.000		R 373.80	
0252	Removal of malignant lesions by curretting under local or general anaesthesia followed by electrocautery: Subsequent lesions (each)	20	15.000		R 187.00	
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail	20	20.000		R 249.30	
0257	Drainage of major hand or foot infection: Drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus	20	87.000		R 1 084.20	

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0259	Removal of foreign body superficial to deep fascia (except hands)	20	20.000		R 249.30	
0261	Removal of foreign body deep to deep fascia (except hands)	20	31.000		R 386.30	
0262	Excision tumour of subcutaneous soft tissue: Neck or anterior thorax, less than 3 cm		90.100		R 1 122.50	
0263	Excision tumour of subcutaneous soft tissue: Shoulder area, less than 3 cm		84.200		R 1 049.10	
0264	Excision tumour of subcutaneous soft tissue: Upper arm or elbow area, less than 3 cm		94.500		R 1 177.30	
0265	Excision tumour of subcutaneous soft tissue: Forearm and/or wrist area, less than 3 cm		94.700		R 1 179.80	
0266	Excision tumour or vascular malformation of subcutaneous soft tissue: Hand or finger, less than 1.5 cm		99.300		R 1 237.00	
0267	Excision tumour of subcutaneous soft tissue: Pelvis and hip area, less than 3 cm		111.600		R 1 390.40	
0268	Excision tumour of subcutaneous soft tissue: Thigh or knee area, less than 3 cm		92.100		R 1 147.30	
0269	Excision tumour of subcutaneous soft tissue: Leg or ankle area, less than 3 cm		92.600		R 1 153.50	
0270	Excision tumour of subcutaneous soft tissue: Foot or toe, less than 1.5 cm		78.300		R 975.50	
0271	Kurtin planing for acne scarring: Whole face	20	206.000		R 2 567.10	
0273	Kurtin planing for acne scarring: Extensive	20	70.000		R 872.40	
0274	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): First stage, up to five tissue blocks.		113.900		R 1 419.10	
0275	Kurtin planing for acne scarring: Limited	20	30.000		R 373.80	
0276	Mohs micrographic surgery: Including removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional stage after the first stage, up to five tissue blocks.		60.500		R 753.70	
0277	Kurtin planing for acne scarring: Subsequent planing of whole face within 12 months	20	103.000		R 1 283.50	
0278	Mohs micrographic surgery: Includes removal of all gross tumour, surgical excision of tissue specimens, mapping, colour coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (e.g. haematoxylin and eosin, toluidine blue): Each additional block after the first five tissue blocks, any stage.		15.900		R 198.10	
0279	Surgical treatment for axillary hyperhidrosis	20	64.000		R 797.70	

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0280	Laser treatment for small skin lesions: First lesion	20	14.000		R 174.40	
0281	Laser treatment for small skin lesions: Subsequent lesions (each)	20	7.000		R 87.40	
0282	Laser treatment for small skin lesions: Maximum for multiple additional lesions	20	56.000		R 697.90	
0283	Laser treatment for large skin lesions: Limited area	20	30.000		R 373.80	
0284	Laser treatment for large skin lesions: Extensive area	20	70.000		R 872.40	
0285	Laser treatment for large skin lesions: Whole face or other areas of equivalent size or larger	20	206.000		R 2 567.10	
0286	Photo-dynamic therapy for malignant skin lesions: Equipment fee for PDT lamp	20	56.630		R 705.70	
0287	Scanning of pigmented skin lesions: Equipment fee for Molemax or similar device	20	43.440		R 541.40	
2.3	Major plastic repair					
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts	20	234.000		R 2 916.00	
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap	20	410.000		R 5 109.40	
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis	20	800.000		R 9 969.80	
0292	Distant flaps: First stage	20	206.000		R 2 567.10	
0293	Contour grafts (excluding cost of material)	20	206.000		R 2 567.10	
0294	Vascularised bone graft with or without soft tissue with one or more sets of micro-vascular anastomoses	20	1200.000		R 14 954.40	
0295	Local skin flaps (large, complicated)	20	206.000		R 2 567.10	
0296	Other procedures of major technical nature	20	206.000		R 2 567.10	
0297	Subsequent major procedures for repair of same lesion	20	104.000		R 1 296.00	
0298	Lower abdominal dermo-lipectomy	20	170.000		R 2 118.70	
0299	Major abdominal lipectomy with repositioning of umbilicus	20	275.000		R 3 427.10	
2.4	Lacerations, scars, tumours, cysts and other skin lesions					
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia), including normal after-care	20	14.000		R 174.40	
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	20	7.000		R 87.40	
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage	20	64.000		R 797.70	

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0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage	20	128.000		R 1 595.20	
0304	Major debridement of wound, sloughectomy or secondary suture	20	50.000		R 623.20	
0305	Needle biopsy – soft tissue	20	25.000		R 311.50	
0307	Excision and repair by direct suture – excision nail fold or other minor procedures of similar magnitude	20	27.000		R 336.60	
0308	Each additional small procedure done at the same time	20	14.000		R 174.40	
0310	Radical excision of nailbed	20	38.000		R 473.60	
0311	Excision of large benign tumour (more than 5 cm)	20	55.000		R 685.40	
0313	Extensive resection for malignant soft tissue tumour including muscle	20	283.900		R 3 538.20	
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	20	104.000		R 1 296.00	
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	20	55.000		R 685.40	
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis – 20 square cm		13.900		R 173.30	
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis – add for every additional 20 square cm or part thereof		5.300		R 66.00	
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue – 20 square cm		36.000		R 448.50	
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue – add for every additional 20 square cm or part thereof		11.200		R 139.50	
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia – 20 square cm		62.500		R 778.70	
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia – add for every additional 20 square cm or part thereof		19.500		R 243.00	
4880	Biopsy soft tissue: Neck or thorax		46.400		R 578.00	
4881	Biopsy of soft tissue: Deep – back or flank		100.400		R 1 250.80	
4882	Biopsy of soft tissue: Deep – shoulder area		117.600		R 1 465.00	
4883	Biopsy of soft tissue: Deep (subfascial or intramuscular) – upper arm or elbow area		117.600		R 1 465.00	
4884	Biopsy of soft tissue: Deep (subfascial or intramuscular) – forearm and/or wrist		106.600		R 1 328.00	
4885	Biopsy of soft tissue: Deep (subfascial or intramuscular) – thigh or knee area		112.900		R 1 406.50	

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4886	Biopsy of soft tissue: Deep (subfascial or intramuscular) – leg or ankle area		119.500		R 1 488.70	
4887	Biopsy of soft tissue: Deep (subfascial or intramuscular) – pelvis and hip area		197.700		R 2 463.00	
2.5	Breasts					
0316	Fine needle aspiration for soft tissue (all areas)	20	15.000		R 187.00	
0317	Aspiration of cyst or tumour	20	9.000		R 112.20	
0319	Mastotomy with exploration, drainage of abscess or removal of mammary implant	20	42.000		R 523.40	
0321	Biopsy or excision of cyst, benign tumour, aberrant breast tissue, duct papilloma	20	94.200		R 1 173.90	
0323	Subareolar cone excision of ducts of wedge excision of breast	20	90.000		R 1 121.60	
0324	Wedge excision of breast and axillary dissection	20	225.000		R 2 804.00	
0325	Total mastectomy	20	155.000		R 1 931.80	
0327	Total mastectomy with axillary gland biopsy	20	185.000		R 2 305.60	
0329	Total mastectomy with axillary gland dissection	20	275.000		R 3 427.10	
0330	Nipple and areola reconstruction	20	95.000		R 1 183.90	
0331	Subcutaneous mastectomy for disease of breast – including reconstruction but excluding cost of prosthesis: Unilateral	20	234.000		R 2 916.00	
0333	Subcutaneous mastectomy for disease of breast – including reconstruction but excluding cost of prosthesis: Bilateral	20	410.000		R 5 109.40	
0334	Removal of breast implant by means of capsulectomy: Per breast	20	234.000		R 2 916.00	
0335	Implantation of internal subpectoral mammary prosthesis in post mastectomy patients	20	150.000		R 1 869.40	
0337	Reduction: Mammoplasty for pathological hypertrophy, unilateral	20	234.000		R 2 916.00	
0339	Reduction: Mammoplasty for pathological hypertrophy, bilateral	20	410.000		R 5 109.40	
0341	Gynaecomastia: Unilateral	20	92.000		R 1 146.60	
0343	Gynaecomastia: Bilateral	20	161.000		R 2 006.30	
2.6	Burns					
0351	Major burns: Resuscitation (including supervision and intravenous therapy – first 48 hours)	20	276.000		R 3 439.50	
0353	Tangential excision and grafting: Small	20	100.000		R 1 246.20	

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0354	Tangential excision and grafting: Large	20	200.000		R 2 492.40	
2.7	Hands (skin)					
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flag e.g. Cutler	20	147.400		R 1 836.90	
0357	Small skin graft in acute hand injury	20	45.000		R 560.90	
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing	20	192.000		R 2 392.80	
0361	Z-plasty	20	220.100		R 2 742.90	
0363	Local flap and skin graft	20	150.000		R 1 869.40	
0365	Cross finger flap (all stages)	20	192.000		R 2 392.80	
0367	Palmar flap (all stages)	20	192.000		R 2 392.80	
0369	Distant flap: First stage	20	158.000		R 1 969.10	
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	20	77.000		R 959.70	
0373	Transfer neurovascular island flap	20	230.500		R 2 872.50	
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)	20	242.400		R 3 020.70	
0375	Dupuytren's contracture: Fasciotomy	20	51.000		R 635.50	
0376	Dupuytren's contracture: Fasciectomy	20	218.000		R 2 716.70	
2.8	Acupuncture					
	Please note: General Rule M not applicable to section 2.8 of this price list					
0377	Standard acupuncture	20	10.000		R 161.80	
0378	Laser acupuncture using more than six points	20	14.000		R 226.70	
0379	Electro-acupuncture	20	14.000		R 226.70	
0380	Scalp acupuncture	20	10.000		R 161.80	
0381	Micro-acupuncture (ear, hand)	20	10.000		R 161.80	

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	RULES GOVERNING THE SECTION ACUPUNCTURE					
CC.	**Acupuncture** a. When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately. b. Not more than two separate techniques may be charged for at each session. c. The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, it should be negotiated with the patient. d. Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp					
3	**Musculo-skeletal system**					
	MODIFIERS GOVERNING ORTHOPAEDIC OPERATIONS AND ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS					
0047	A fracture NOT requiring reduction shall be charged on a fee per service basis					
0048	Where in the treatment of a fracture or dislocation, an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27,00 clinical procedure units (not including after-care).	20	27.000		R 336.60	
0049	Except where otherwise specified, in cases of compound fractures, 77,00 clinical procedure units (specialists) and 77,00 clinical procedure units (general practitioners) are to be added to the units for the fractures including debridement.	20	77.000		R 959.70	
0050	In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires, as well as fractures of hands and feet), the full amount according to either modifier 0049: Cases of compound fractures, or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either modifier 0049: Cases of compound fractures or modifier 0051: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting, as applicable).	20	115.500		R 1 439.40	
0051	Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77,00 clinical procedure units. General practitioners add 77,00 clinical procedure units.	20	77.000		R 959.70	
0052	Except where otherwise specified, fracture (traumatic or surgical, ie. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixtion/and or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as long bone or pelvis fracture/osteotomy (refer to modifier 0051) for specialist and general practitioners for HAND or FOOT fracture/osteotomy: Add		81.100		R 1 010.30	

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0053	Fracture requiring percutaneous internal fixation – insertion and removal of fixatives (wires) in respect of fingers and toes included: Specialists and general practitioners add 32,00 clinical procedure units.	20	32.000		R 398.80	
0055	Dislocation requiring open reduction: Units for the specific joint plus 77,00 clinical procedure units for specialists. General practitioners add 77,00 clinical procedure units.	20	77.000		R 959.70	
0057	Multiple procedures on feet: In multiple procedures on feet, fees for the first foot are calculated according to modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate fees for the second foot in the same way, reduce the total to 75% and add to the total for the first foot.					
0058	Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): Per fee for total joint replacement + 100%					
3.1	Bones					
3.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047)					
0383	Fracture (reduction under general anaesthetic): Scapula	20	3.000		R 1 399.10	
0384	Fracture: Scapula, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		284.200		R 3 540.60	
0386	Fracture: Clavicle, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		209.400		R 2 608.60	
0387	Fracture (reduction under general anaesthetic): Clavicle	20	77.000		R 959.70	
0388	Percutaneous pinning of supracondylar fracture: Elbow – stand alone procedure	20	175.700		R 2 189.60	
0389	Fracture (reduction under general anaesthetic): Humerus	20	111.600		R 1 390.80	
0390	Fracture: Humerus, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		255.300		R 3 180.50	
0391	Fracture (reduction under general anaesthetic): Radius and/or Ulna	20	77.000		R 959.70	
0392	Fracture (reduction under general anaesthetic): Open reduction of both radius and ulna (modifier 0051 not applicable)	20	210.000		R 2 617.10	
0401	Fracture: Carpal bone, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		208.700		R 2 599.90	
0402	Fracture (reduction under general anaesthetic): Carpal bone	20	64.000		R 797.70	
0403	Fracture (reduction under general anaesthetic): Bennett fracture-dislocation	20	51.000		R 635.50	
0404	Fracture: Bennett fracture/dislocation, open reduction and internal fixation (modifiers 0051, 0052, 0055 not applicable)		179.800		R 2 240.00	
0405	Fracture (reduction under general anaesthetic): Open treatment of metacarpal, simple	20	118.300		R 1 474.20	
0406	Fracture: Metacarpal bone, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		163.600		R 2 038.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0409	Fracture (reduction under general anaesthetic): Finger phalanx: Distal, simple	20	3.000		R 959.30	
0410	Fracture: Finger phalanx, distal, simple – open reduction and internal fixation (modifiers 0051, 0052 not applicable)		141.100		R 1 757.70	
0411	Fracture (reduction under general anaesthetic): Finger phalanx: Distal, sompound	20	52.000		R 648.10	
0413	Fracture (reduction under general anaesthetic): Proximal or middle, simple	20	48.000		R 598.20	
0414	Fracture: Finger phalanx, proximal or middle: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		169.900		R 2 116.60	
0415	Fracture (reduction under general anaesthetic): Proximal or middle, compound	20	102.000		R 1 271.20	
0417	Fracture (reduction under general anaesthetic): Pelvis fracture, closed	20	3.000		R 1 709.30	
0419	Fracture (reduction under general anaesthetic): Pelvis, operative reduction and fixation	20	320.000		R 3 987.90	
0420	Fracture: Acetabulum: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		560.000		R 6 976.40	
0421	Fracture (reduction under general anaesthetic): Femur, neck or Shaft	20	237.000		R 2 953.40	
0422	Fracture: Femur neck or shaft, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		392.300		R 4 887.10	
0425	Fracture (reduction under general anaesthetic): Patella	20	51.000		R 635.50	
0426	Fracture: Patella, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		219.500		R 2 734.50	
0429	Fracture (reduction under general anaesthetic): Tibia with or without fibula	20	128.000		R 1 595.20	
0430	Fracture: Tibia, with or without fibula: Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		293.200		R 3 652.60	
0433	Fracture (reduction under general anaesthetic): Fibula shaft	20	3.000		R 1 400.30	
0434	Fracture: Fibula shaft, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207.000		R 2 578.80	
0435	Fracture (reduction under general anaesthetic): Malleolus of ankle	20	58.000		R 722.80	
0436	Fracture: Ankle malleolus, open reduction and internal fixation (modifiers 0051, 0052 not applicable)		207.100		R 2 580.10	
0437	Fracture (reduction under general anaesthetic): Fracture-dislocation of ankle	20	128.000		R 1 595.20	
0438	Fracture (reduction under general anaesthetic): Open reduction Talus fracture (modifier 0051 not applicable)	20	198.700		R 2 476.10	
0439	Fracture (reduction under general anaesthetic): Tarsal bones (excluding talus and calcaneus)	20	64.000		R 797.70	
0440	Fracture (reduction under general anaesthetic): Open reduction Calcaneus fracture (modifier 0051 not applicable)	20	403.500		R 5 028.60	
0441	Fracture (reduction under general anaesthetic): Metatarsal	20	41.800		R 520.80	

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0442	Fracture: Metatarsal bones, open reduction with internal fixation (modifiers 0051, 0052 not applicable)		154.700		R 1 927.20	
0443	Fracture (reduction under general anaesthetic): Toe phalanx, distal simple	20	-			
0444	Fracture: Toe phalanx, distal: Open reduction with internal fixation (modifiers 0051, 0052 not applicable)		144.500		R 1 800.10	
0445	Fracture (reduction under general anaesthetic): Toe phalanx, compound	20	32.000		R 398.80	
0446	Fracture: Tarsal bones (excluding talus and calcaneus), open reduction with internal fixation (modifiers 0051, 0052 not applicable)		178.200		R 2 220.00	
0447	Fracture (reduction under general anaesthetic): Other, simple	20	26.000		R 324.00	
0448	Fracture: Calcaneus (reduction under general anaesthetic)		103.300		R 1 287.00	
0449	Fracture (reduction under general anaesthetic): Other, compound	20	52.000		R 648.10	
0451	Fracture (reduction under general anaesthetic): Sternum and/or ribs, closed	20	-			
0452	Fracture (reduction under general anaesthetic): Sternum and/or ribs, open reduction and fixation of multiple fractured ribs for flail chest	20	230.000		R 2 866.30	
0455	Fracture (reduction under general anaesthetic): Spine with or without paralysis, cervical	20	-			
0461	Fracture (reduction under general anaesthetic): Compression fracture, cervical	20	-			
0463	Fracture (reduction under general anaesthetic): Spinous or transverse processes, cervical	20	-			
0464	Fracture (reduction under general anaesthetic): Spinous or transverse processes, rest	20	-			
3.1.1.1	Bones: Fractures (reduction under general anaesthetic – refer to modifier 0047) – operations for fractures					
0465	Fractures involving large joints (includes the Item for the relative bone) – this item may not be used as a modifier	20	288.000		R 3 589.00	
0466	Fractures involving digital joints: Includes the metaphysis of the relative bone. Open reduction and internal fixation (modifiers 0051, 0052 not applicable)		210.900		R 2 627.40	
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care) – modifier 0005 not applicable	20	43.000		R 536.00	
0475	Bonegrafting or internal fixation for malunion or non-union: Femur, tibia, humerus, radius and ulna	20	282.000		R 3 514.40	
0479	Bonegrafting or internal fixation for malunion or non-union: Other bones	20	154.000		R 1 919.20	
0480	Radical resection of bone tumour/infection: Ilium including acetabulum, both pubic rami, or ischium and acetabulum		415.000		R 5 170.00	

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0481	Radical resection of bone tumour: Fibula		240.100		R 2 991.20	
0482	Radical resection of bone tumour: Femur or knee		371.800		R 4 631.90	
0483	Radical resection of malignant bone tumour: Scapula		237.700		R 2 961.20	
0484	Radical resection of bone tumour: Clavicle		413.800		R 5 155.10	
0485	Radical resection of bone tumour: Metatarsal		185.000		R 2 304.60	
3.1.2	Bony operations					
3.1.2.1	Bony operations: Bone grafting					
0497	Resection of bone or tumour with or without grafting (benign)	20	282.000		R 3 514.40	
0498	Resection of bone or tumour with or without grafting (malignant) – does not include digits	20	340.000		R 4 237.10	
0499	Grafts to cysts: Large bones	20	192.000		R 2 392.80	
0501	Grafts to cysts: Small bones	20	128.000		R 1 595.20	
0503	Grafts to cysts: Cartilage graft	20	206.000		R 2 567.10	
0505	Grafts to cysts: Inter-metacarpal bone graft	20	147.000		R 1 831.90	
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	20	50.000		R 623.20	
3.1.2.2	Bony operations: Acute or chronic osteomyelitis					
0509	Acute or chronic osteomyelitis: Conservative treatment	20	-			
0511	Acute or chronic osteomyelitis: Operation – tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care					
0512	Acute or chronic osteomyelitis: Sternum sequestrectomy and drainage, including six weeks after-care	20	128.000		R 1 595.20	
3.1.2.3	Bony operations: Osteotomy					
0514	Osteotomy: Sternum, repair of pectus excavatum	20	330.000		R 4 112.40	
0515	Osteotomy: Sternum, repair of pectus carinatum	20	330.000		R 4 112.40	
0516	Osteotomy: Pelvic	20	320.000		R 3 987.90	
0521	Osteotomy: Femoral, proximal	20	320.000		R 3 987.90	

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0527	Osteotomy: Knee region	20	320.000		R 3 987.90	
0528	Osteotomy: Os Calcis (Dwyer operation)	20	115.000		R 1 433.10	
0530	Osteotomy: Metacarpal and phalanx, corrective for malunion or rotation	20	120.000		R 1 495.30	
0531	Rotational osteotomy of tibia and fibula – stand alone procedure	20	278.900		R 3 475.50	
0532	Osteotomy: Rotation osteotomy of the radius, ulna or humerus	20	160.000		R 1 994.00	
0533	Osteotomy: Single metatarsal	20	60.000		R 747.80	
0534	Osteotomy: Multiple metatarsal osteotomies	20	150.000		R 1 869.40	
3.1.2.4	Bony operations: Exostosis					
0535	Exostosis: Excision – readily accessible sites	20	60.000		R 747.80	
0537	Exostosis: Excision – less accessible sites	20	96.000		R 1 196.30	
3.1.2.5	Bony operations: Biopsy					
0539	Needle Biopsy: Spine (no after-care) – modifier 0005 not applicable	20	50.000		R 623.20	
0541	Needle Biopsy: Other sites (no after-care) – modifier 0005 not applicable	20	32.000		R 398.80	
0543	Biopsy: Open (modifier 0005 not applicable) – readily accessible site	20	64.000		R 797.70	
0545	Biopsy: Open (modifier 0005 not applicable) – less accessible site	20	96.000		R 1 196.30	
3.2	Joints					
3.2.1	Joints: Dislocations					
0547	Joint: Dislocation, clavicle either end	20	38.000		R 473.60	
0549	Joint: Dislocation, shoulder	20	51.000		R 635.50	
0551	Joint: Dislocation, elbow	20	51.000		R 635.50	
0552	Joint: Dislocation, wrist	20	77.000		R 959.70	
0553	Joint: Dislocation, perilunar trans-scaphoid fracture dislocation	20	130.000		R 1 620.20	
0555	Joint: Dislocation, lunate	20	77.000		R 959.70	
0556	Joint: Dislocation, carpo-metacarpo dislocation	20	51.000		R 635.50	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0557	Joint: Dislocation, metacarpo-phalangeal or interphalangeal (hand)	20	26.000		R 324.00	
0559	Joint: Dislocation, hip	20	109.000		R 1 358.40	
0561	Joint: Dislocation, knee	20	96.000		R 1 196.30	
0563	Joint: Dislocation, patella	20	32.000		R 398.80	
0565	Joint: Dislocation, ankle	20	90.000		R 1 121.60	
0567	Joint: Dislocation, Sub-Talar dislocation	20	90.000		R 1 121.60	
0569	Joint: Dislocation, Intertarsal or Tarsometatarsal or Mid-tarsal	20	77.000		R 959.70	
0571	Joint: Dislocation, meta-tarsophalangeal or interphalangeal joints (foot)	20	14.000		R 174.40	
0573	Joint: Dislocation, spine with or without paralysis	20	-			
3.2.2	Joints: Operations for dislocations					
0578	Operations for dislocations: Recurrent dislocation of shoulder	20	200.000		R 2 492.40	
0579	Operations for dislocations: Recurrent dislocation of all other joints	20	161.000		R 2 006.30	
3.2.3	Joints: Capsular operations					
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	20	51.000		R 635.50	
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)	20	96.000		R 1 196.30	
0585	Capsulectomy digital joint	20	64.000		R 797.70	
0586	Multiple percutaneous capsulotomies of metacarpophalangeal joints	20	90.000		R 1 121.60	
0587	Release of digital joint contracture	20	128.000		R 1 595.20	
3.2.4	Joints: Synovectomy					
0589	Synovectomy: Digital joint	20	77.000		R 959.70	
0592	Synovectomy: Large joint	20	160.000		R 1 994.00	
0593	Tendon synovectomy	20	203.700		R 2 538.50	
3.2.5	Joints: Arthrodesis					
0597	Arthrodesis: Shoulder	20	224.000		R 2 791.50	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0598	Arthrodesis: Elbow	20	180.000		R 2 243.10	
0599	Arthrodesis: Wrist	20	180.000		R 2 243.10	
0600	Arthrodesis: Digital joint	20	128.000		R 1 595.20	
0601	Arthrodesis: Hip	20	320.000		R 3 987.90	
0602	Arthrodesis: Knee	20	180.000		R 2 243.10	
0603	Arthrodesis: Ankle	20	180.000		R 2 243.10	
0604	Arthrodesis: Sub-talar	20	130.000		R 1 620.20	
0605	Arthrodesis: Stabilisation of foot (triple-arthrodesis)	20	180.000		R 2 243.10	
0607	Arthrodesis: Mid-tarsal wedge resection	20	180.000		R 2 243.10	
3.2.6	Joints: Arthroplasty					
0614	Arthroplasty: Debridement large joints	20	160.000		R 1 994.00	
0615	Arthroplasty: Excision medial or lateral end of clavicle	20	116.000		R 1 445.60	
0617	Shoulder: Acromioplasty	20	192.000		R 2 392.80	
0619	Shoulder: Partial replacement	20	277.000		R 3 452.10	
0620	Shoulder: Total replacement	20	416.000		R 5 184.30	
0621	Elbow: Excision head of radius	20	96.000		R 1 196.30	
0622	Elbow: Excision	20	192.000		R 2 392.80	
0623	Elbow: Partial replacement	20	188.000		R 2 343.00	
0624	Elbow: Total replacement	20	282.000		R 3 514.40	
0625	Wrist: Excision distal end of ulna	20	96.000		R 1 196.30	
0626	Wrist: Excision single bone	20	110.000		R 1 370.90	
0627	Wrist: Excision proximal row	20	166.000		R 2 068.70	
0631	Wrist: Total replacement	20	249.000		R 3 103.00	
0635	Digital joint: Total replacement	20	192.000		R 2 392.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0637	Hip: Total replacement	20	416.000		R 5 184.30	
0641	Hip: Prosthetic replacement of femoral head	20	288.000		R 3 589.00	
0643	Hip: Girdlestone	20	320.000		R 3 987.90	
0645	Knee: Partial replacement	20	277.000		R 3 452.10	
0646	Knee: Total replacement	20	416.000		R 5 184.30	
0649	Ankle: Total replacement	20	290.400		R 3 619.00	
0650	Ankle: Astragalectomy	20	154.000		R 1 919.20	
3.2.7	Joints: Miscellaneous (joints)					
0661	Aspiration of joint or intra-articular injection (not including after-care) – modifier 0005 not applicable	20	9.000		R 146.00	
0663	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) – modifier 0005 not applicable, first joint	20	7.500		R 121.50	
0665	Multiple intra-articular injections for rheumatoid arthritis (excluding after-care) – modifier 0005 not applicable, additional (each)	20	4.000		R 65.00	
0667	Arthroscopy (excluding after-care) – modifiers 0005 and 0013 not applicable	20	60.000		R 747.80	
0669	Manipulation knee or shoulder joint under general anaesthetic (not including after-care) – modifier 0005 not applicable	20	14.000		R 174.40	
0669A	Manipulation hip joint under general anaesthetic (not including after-care) – modifier 0005 not applicable	20	14.000		R 174.40	
	Only the consultation fee should be charged when manipulation of a large joint is performed without general anaesthetic					
0673	Meniscectomy or operation for other internal derangement of knee	20	109.000		R 1 358.40	
3.2.8	Joints: Joint ligament reconstruction or suture					
0675	Joint ligament reconstruction or suture: Ankle, collateral	20	160.000		R 1 994.00	
0677	Joint ligament reconstruction or suture: Knee, collateral	20	160.000		R 1 994.00	
0678	Joint ligament reconstruction or suture: Knee, cruciate	20	160.000		R 1 994.00	
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee	20	280.000		R 3 489.60	
0680	Joint ligament reconstruction or suture: Digital joint ligament	20	165.000		R 2 056.30	

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3.3	Amputations					
3.3.1	Amputations: Specific amputations					
0681	Amputation Humerus: Includes primary closure		211.600		R 2 636.10	
0682	Amputation: Fore-quarter amputation	20	294.000		R 3 664.00	
0683	Amputation: Through shoulder	20	148.000		R 1 844.30	
0684	Amputation: Forearm		213.500		R 2 659.80	
0685	Amputation: Upper arm or forearm	20	116.000		R 1 445.60	
0686	Amputation: Ankle (e.g. Syme, Pirogoff type)		204.100		R 2 542.60	
0687	Partial amputation of the hand: One ray	20	102.000		R 1 271.20	
0688	Amputation: Foot, midtarsal (Chopart type)		165.700		R 2 064.30	
0691	Amputation: Whole or part of finger	20	116.800		R 1 455.50	
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		150.700		R 1 877.40	
0693	Hindquarter amputation	20	420.000		R 5 234.00	
0694	Scar revision/secondary closure: Amputated leg, through tibia and fibula, any level		173.900		R 2 166.50	
0695	Amputation: Through hip joint region	20	192.000		R 2 392.80	
0696	Re-amputation: Thigh, through femur, any level		217.300		R 2 707.10	
0697	Amputation: Through thigh	20	205.000		R 2 554.80	
0698	Re-amputation: Leg, through tibia and fibula		198.200		R 2 469.20	
0699	Amputation: Below knee, through knee or Syme	20	194.000		R 2 417.80	
0700	Scar revision/secondary closure: Amputated shoulder		128.100		R 1 595.80	
0701	Amputation: Trans-metatarsal or trans-tarsal	20	142.000		R 1 769.70	
0702	Scar revision/secondary closure: Amputated humerus		163.100		R 2 031.80	
0703	Amputation: Foot, one ray	20	97.000		R 1 209.00	

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0704	Scar revision/secondary closure: Amputated forearm		184.100		R 2 293.50	
0705	Amputation: Toe	20	66.000		R 822.40	
3.3.2	Amputations: Post-amputation reconstruction					
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	20	75.000		R 934.70	
0707	Post-amputation reconstruction: Krukenberg reconstruction	20	206.000		R 2 567.10	
0708	Re-amputation: Humerus		223.100		R 2 779.20	
0710	Re-amputation: Through forearm		206.000		R 2 566.40	
0711	Post-amputation reconstruction: Pollicisation of the finger (to include all stages)	20	282.000		R 3 514.40	
0712	Post-amputation reconstruction: Toe to thumb transfer	20	800.000		R 9 969.80	
3.4	Muscles, tendons and fasciae					
3.4.1	Muscles, tendons and fasciae: Investigations					
0713	Electromyography	20	75.000		R 1 215.20	
0714	Electro-myographic neuromuscular junctional study, including edrophonium response (not to be used with Item 2730)	20	57.000		R 923.50	
0715	Strength duration curve per session	20	10.500		R 170.00	
0717	Electrical examination of single nerve or muscle	20	9.000		R 146.00	
0718	Oxidative study for mitochondrial function	20	64.000		R 1 037.00	
0721	Voltage integration during isometric contraction	20	12.000		R 194.40	
0723	Tonometry with edrophonium	20	8.000		R 129.60	
0725	Isometric tension studies with edrophonium	20	10.000		R 161.80	
0727	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Unilateral	20	8.000		R 129.60	
0728	Cranial reflex study (both early and late responses) supra occulofacial or corneofacial or flabellofacial: Bilateral	20	14.000		R 226.70	
0729	Tendon reflex time	20	7.000		R 113.60	
0730	Limb brain somatosensory studies (per limb)	20	49.000		R 793.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0731	Vision and audio-sensory studies	20	49.000		R 793.90	
0733	Motor nerve conduction studies (single nerve)	20	26.000		R 421.30	
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	20	31.000		R 502.20	
0737	Biopsy for motor nerve terminals and end plates	20	20.000		R 324.00	
0739	Combined muscle biopsy with end plates and nerve terminal biopsy	20	34.000		R 550.80	
0740	Muscle fatigue studies	20	20.000		R 324.00	
0741	Muscle biopsy	20	20.000		R 324.00	
0742	Global fee for all muscle studies, including histochemical studies	20	262.000		R 4 244.50	
4701	Biochemical estimations on muscle biopsy specimens: Creatine kinase	20	20.250		R 328.00	
4703	Biochemical estimations on muscle biopsy specimens: Adenylate kinase	20	33.300		R 539.50	
4705	Biochemical estimations on muscle biopsy specimens: Pyruvate kinase	20	5.700		R 92.30	
4707	Biochemical estimations on muscle biopsy specimens: Lactate dehydrogenase	20	1.600		R 25.90	
4709	Biochemical estimations on muscle biopsy specimens: Adenylate deaminase	20	9.900		R 160.40	
4711	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate kinase	20	13.700		R 222.00	
4713	Biochemical estimations on muscle biopsy specimens: Phosphoglycerate mutase	20	25.900		R 419.60	
4715	Biochemical estimations on muscle biopsy specimens: Enolase	20	32.700		R 529.60	
4717	Biochemical estimations on muscle biopsy specimens: Phosphofructokinase	20	37.700		R 610.90	
4719	Biochemical estimations on muscle biopsy specimens: Aldolase	20	15.750		R 255.30	
4721	Biochemical estimations on muscle biopsy specimens: Glyceraldehyde 3 phosphate dehydrogenase	20	11.060		R 179.30	
4723	Biochemical estimations on muscle biopsy specimens: Phosphorylase	20	34.700		R 562.10	
4725	Biochemical estimations on muscle biopsy specimens: Phosphoglucomutase	20	40.300		R 652.90	
4727	Biochemical estimations on muscle biopsy specimens: Phosphohexose Isomerase	20	28.800		R 466.50	
4729	Biochemical estimations on muscle biopsy specimens: Muscle biopsy for muscle tension study	20	43.000		R 696.90	
4731	Biochemical estimations on muscle biopsy specimens: H-response study (per nerve)	20	14.000		R 226.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4733	Biochemical estimations on muscle biopsy specimens: Late response study (per nerve)	20	20.000		R 324.00	
4735	Biochemical estimations on muscle biopsy specimens: Single fibre studies	20	71.000		R 1 150.20	
4737	Biochemical estimations on muscle biopsy specimens: Somatosensory study (limb-spine)	20	69.000		R 1 117.60	
4739	Biochemical estimations on muscle biopsy specimens: Dystrophin estimation	20	82.000		R 1 328.70	
4744	Biochemical estimations on muscle biopsy specimens: Tension/caffeine/halothane procedure in malignant hyperthermia	20	143.000		R 2 316.70	
4745	Biochemical estimations on muscle biopsy specimens: Electron microscopy	20	75.000		R 1 215.20	
3.4.2	Muscles, tendons and fasciae: Decompression operations					
0743	Major compartmental decompression	20	132.000		R 1 645.00	
0744	Decompression operation: Fasciotomy only	20	60.000		R 747.80	
5550	Decompression faciotomy: Buttock compartments, unilateral		243.000		R 3 027.30	
5551	Decompression fasciotomy: Leg, anterior and/or lateral and posterior compartment(s). EXCLUDES debridement of nonviable muscle and/or nerve		151.900		R 1 892.40	
5552	Decompression fasciotomy: Leg, anterior and/or lateral and posterior compartment(s). INCLUDES debridement of nonviable muscle and/or nerve		253.100		R 3 153.00	
5553	Decompression fasciotomy: Leg, anterior and/or lateral compartment(s) only. EXCLUDES debridement of nonviable muscle and/or nerve		123.700		R 1 541.00	
5554	Decompression fasciotomy: Leg, anterior and/or lateral compartment(s) only. INCLUDES debridement of nonviable muscle and/or nerv		162.100		R 2 019.50	
5555	Decompression fasciotomy: Leg, posterior compartment only. EXCLUDES debridement of nonviable muscle and/or nerve		130.800		R 1 629.50	
5556	Decompression fasciotomy: Leg, posterior compartment only. INCLUDES debridement of nonviable muscle and/or nerve		171.500		R 2 136.50	
5557	Decompression fasciotomy: Fasciotomy/tenotomy, iliotibial		137.300		R 1 710.50	
5558	Decompression fasciotomy: Fasciotomy, foot and/or toe		86.600		R 1 078.90	
5559	Decompression fasciotomy: Forearm and/or wrist, flexor and extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		226.300		R 2 819.30	

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5560	Decompression fasciotomy: Forearm and/or wrist, flexor and extensor compartment. INCLUDES debridement of nonviable muscle or nerve		354.500		R 4 416.30	
5561	Decompression fasciotomy: Forearm and/or wrist, flexor or extensor compartment. EXCLUDES debridement of nonviable muscle or nerve		166.800		R 2 078.00	
5562	Decompression fasciotomy: Forearm and/or wrist, flexor or extensor compartment. INCLUDES debridement of nonviable muscle or nerve		321.100		R 4 000.20	
5563	Decompression Faciotomy: Fingers and/or hand		165.600		R 2 063.00	
3.4.3	Muscles, tendons and fasciae: Muscle and tendon repair					
0745	Muscle and tendon repair: Biceps humeri	20	109.000		R 1 358.40	
0746	Muscle and tendon repair: Removal of calcification in rotator cuff	20	96.000		R 1 196.30	
0747	Muscle and tendon repair: Rotator cuff	20	134.000		R 1 669.90	
0748	Muscle and tendon repair: Debridement rotator cuff	20	139.700		R 1 741.10	
0749	Muscle and tendon repair: Scapulopexy – stand alone procedure	20	271.900		R 3 388.60	
0755	Muscle and tendon repair: Infrapatellar of quadriceps tendon	20	128.000		R 1 595.20	
0757	Muscle and tendon repair: Achilles tendon repair	20	197.600		R 2 462.50	
0759	Muscle and tendon repair: Other single tendon	20	77.000		R 959.70	
0760	Hand: Flexor tendon suture: Primary, zone 1 (each) – modifier 0005 applicable		220.300		R 2 744.50	
0761	Hand: Flexor tendon repair: Primary, zone 2 (no mans land), each – modifier 0005 applicable		249.600		R 3 109.40	
0762	Hand: Flexor tendon suture: Primary, zone 3 and 4 (wrist and forearm), each – modifier 0005 applicable		191.300		R 2 383.30	
0763	Muscle and tendon repair: Tendon or ligament injection	20	9.000		R 112.20	
0764	Hand: Flexor tendon repair: Secondary, zone 1		243.900		R 3 038.50	
0765	Hand: Flexor tendon repair: Secondary, zone 2 (no mans land)		249.600		R 3 109.40	
0766	Hand: Flexor tendon repair: Secondary, zone 3 and 4 (wrist and forearm)		190.600		R 2 374.50	
0767	Hand: Flexor tendon suture: Primary (per tendon)	20	128.000		R 1 595.20	
0768	Repair: Intrinsic muscles of hand (each) – modifier 0005 applicable		125.300		R 1 560.90	

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0769	Hand: Flexor tendon suture, secondary (per tendon)	20	160.000		R 1 994.00	
0771	Extensor tendon suture: Primary (per tendon)	20	129.700		R 1 616.40	
0773	Extensor tendon suture: Secondary (per tendon)	20	80.000		R 997.10	
0774	Repair of Boutonniere deformity or Mallet finger with graft	20	183.700		R 2 289.20	
3.4.4	Muscles, tendons and fasciae: Tendon graft					
0775	Free tendon graft	20	160.000		R 1 994.00	
0776	Reconstruction of pulley for flexor tendon	20	50.000		R 623.20	
0777	Tendon graft: Finger, flexor	20	192.000		R 2 392.80	
0779	Tendon graft: Finger, extensor	20	122.000		R 1 520.40	
0780	Two stage flexor tendon graft using silastic rod	20	240.000		R 2 990.90	
3.4.5	Muscles, tendons and fasciae: Tendolysis					
0781	Tendon freeing operation, except where specified elsewhere	20	64.000		R 797.70	
0782	Carpal tunnel syndrome	20	98.700		R 1 230.20	
0783	Tenolysis: De Quervain	20	38.000		R 473.60	
0784	Trigger finger	20	38.000		R 473.60	
0785	Flexor tendon freeing operation following free tendon graft or suture	20	186.800		R 2 328.10	
0787	Extensor tendon freeing operation following graft or suture in finger, hand or forearm, each tendon	20	180.900		R 2 254.40	
0788	Intrinsic tendon release per finger	20	64.000		R 797.70	
0789	Central tendon tenotomy for Boutonniere deformity	20	64.000		R 797.70	
3.4.6	Muscles, tendons and fasciae: Tenodesis					
0790	Tenodesis: Digital joint	20	90.000		R 1 121.60	
3.4.7	Muscles, tendons and fasciae: Muscle tendon and facia transfer					
0791	Single tendon transfer	20	96.000		R 1 196.30	
0792	Multiple tendon transfer	20	128.000		R 1 595.20	

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0793	Hamstring to quadriceps transfer	20	141.000		R 1 757.10	
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	20	320.000		R 3 987.90	
0795	Tendon transfer at elbow	20	116.000		R 1 445.60	
0802	Radial club hand repair -– stand alone procedure	20	360.300		R 4 490.00	
0803	Hand tendons: Single tendon transfer (first)	20	96.000		R 1 196.30	
0809	Hand tendons: Substitution for intrinsic paralysis of hand	20	224.000		R 2 791.50	
0811	Hand tendons: Opponens tendon transfer (including obtaining of graft)	20	220.600		R 2 749.30	
3.4.8	Muscles, tendons and fasciae: Muscle slide operations and tendon lengthening					
0812	Percutaneous Tenotomy: All sites	20	38.000		R 473.60	
0813	Torticollis	20	96.000		R 1 196.30	
0815	Scalenotomy	20	132.000		R 1 645.00	
0817	Scalenotomy with excision of first rib	20	190.000		R 2 367.90	
0821	Tennis elbow	20	96.000		R 1 196.30	
0822	Open release elbow (Mitals) – stand alone procedure	20	278.200		R 3 466.90	
0823	Excision or slide for Volkmann's Contracture	20	192.000		R 2 392.80	
0825	Hip: Open muscle release	20	116.000		R 1 445.60	
0829	Knee: Quadriceps plasty	20	160.000		R 1 994.00	
0831	Knee: Open tenotomy	20	141.000		R 1 757.10	
0835	Calf	20	96.000		R 1 196.30	
0837	Open elongation tendon Achilles	20	96.000		R 1 196.30	
0838	Percutaneous "Hoke" elongation tendo Achilles	20	79.300		R 988.20	
0845	Foot: Plantar fasciotomy	20	70.000		R 872.40	
0846	Foot: Postero-medial release for club-foot	20	192.000		R 2 392.80	

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3.5	Bursae and ganglia					
0847	Excision: Semimembranosus	20	90.000		R 1 121.60	
0849	Excision: Prepatellar	20	45.000		R 560.90	
0851	Excision: Olecranon	20	81.800		R 1 019.30	
0853	Excision: Small bursa or ganglion	20	80.900		R 1 008.10	
0855	Excision: Compound palmar ganglion or synovectomy	20	128.000		R 1 595.20	
0857	Bursae and ganglia: Aspiration or injection (no after-care) – modifier 0005 not applicable	20	9.000		R 112.20	
3.6	Musculo-skeletal system: Miscellaneous					
3.6.1	Musculo-skeletal system: Miscellaneous: Leg equalisation and congenital hips and feet					
0859	Leg equalisation and congenital hips and feet: Leg shortening	20	282.000		R 3 514.40	
0861	Leg equalisation and congenital hips and feet: Leg lengthening	20	416.000		R 5 184.30	
0863	Leg equalisation and congenital hips and feet: Epiphysiodesis at one level	20	116.000		R 1 445.60	
0865	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast, one hip	20	109.000		R 1 358.40	
0867	Congenital dislocation of hip: Initial non-operative reduction and application of plaster cast, both hips	20	160.000		R 1 994.00	
0868	Open reduction of congenital dislocation of the hip	20	186.000		R 2 317.90	
0869	Subsequent plasters	20	32.000		R 398.80	
0873	Congenital club foot: Manipulation and plaster, one foot	20	26.000		R 324.00	
0874	Ponseti technique assistant (medical practitioner)	20	13.000		R 161.80	
3.6.2	Musculo-skeletal system: Miscellaneous, removal of internal fixatives of prosthesis					
0883	Removal of internal fixatives or prosthesis: Readily accessible	20	36.600		R 456.10	
0884	Removal of internal fixatives: Less accessible	20	75.500		R 941.00	
0885	Removal of prosthesis for infection soon after operation	20	128.000		R 1 595.20	
0886	Late removal of infected or not infected total joint replacement prosthesis (including six weeks after-care): Add to the Item for total joint replacement of the specific joint	20	64.000		R 797.70	

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3.7	Plasters (exclusive of after-care)					
0887	Limb cast (excluding after-care) – modifier 0005 not applicable	20	13.000		R 161.80	
0888	Application of short limb cast (forearm, lower leg, excluding after-care) – first cast included in procedure		18.400		R 229.20	
0889	Spica, plaster jacket or hinged cast brace (excluding after-care)	20	32.000		R 398.80	
0891	Turnbuckle cast for scoliosis (excluding after-care)	20	51.000		R 635.50	
0892	Application of cast: Revision (walker, window, bivalve) – excluding after-care		18.900		R 235.50	
0893	Adjustment or repair of turnbuckle cast for scoliosis (excluding after-care)	20	19.000		R 236.90	
0894	Application of cast: Clubfoot (excluding after-care) – first cast included in procedure		34.000		R 423.50	
3.8	Musculo-skeletal system: Special areas					
3.8.1	Special areas: Foot and ankle					
0895	Club foot: Revision club foot release – stand alone procedure	20	302.700		R 3 772.30	
0896	Club foot: Posterior release only – stand alone procedure	20	159.300		R 1 985.10	
0900	Excision tarsal coalition – stand alone procedure	20	141.500		R 1 763.40	
0901	Tenotomy: Single tendon	20	63.300		R 788.90	
0903	Hammer toe: One toe	20	99.500		R 1 240.10	
0905	Filleting of toe or Ruiz-Mora procedure	20	99.500		R 1 240.10	
0906	Arthrodesis Hallux	20	148.000		R 1 844.30	
0907	Silver bunionectomy or similar for Hallux Valgus	20	126.200		R 1 572.70	
	Not to be charged with Item 0911					
0909	Excision arthroplasty	20	145.200		R 1 809.40	
0910	Cheilectomy or metatarsophangeal implant Hallux	20	183.000		R 2 280.60	
0911	Metatarsal osteotomy or Lapidus or similar or Chevron – stand alone procedure	20	189.200		R 2 357.80	
	Not to be charged with Item 0907					
5730	Hallux Valgus double osteotomy etc.	20	182.600		R 2 275.60	

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5731	Distal soft tissue procedure for Hallux Valgus	20	173.600		R 2 163.40	
5732	Aitkin procedure or similar	20	166.800		R 2 078.80	
5734	Removal bony prominence foot e.g. bunionette (Bunionette not applicable to COID)	20	91.000		R 1 133.90	
5735	Repair angular deformity toe (lesser toes)	20	97.200		R 1 211.40	
5736	Sesamoidectomy	20	97.800		R 1 218.70	
5737	Repair major foot tendons e.g. Tib Post	20	147.300		R 1 835.70	
5738	Repair of dislocating peroneal tendons	20	173.200		R 2 158.40	
5739	Forefoot reconstruction for rheumatoid arthritis: Clayton or similar, one foot	20	202.300		R 2 521.10	
5740	Steindler strip – plantar fascia	20	97.200		R 1 211.40	
5741	Kelikian syndactilly (one web space)	20	97.200		R 1 211.40	
5742	Tendon transfer foot	20	172.000		R 2 143.60	
5743	Capsulotomy metatarsophalangeal joints: Foot	20	86.800		R 1 081.70	
3.8.2	Big toe (refer to section 3.8.1 for procedures on big toe)					
3.8.3	Special areas: Reimplantations					
0912	Replantation of amputated upper limb proximal to wrist joint	20	730.000		R 9 097.20	
0913	Replantation of thumb	20	670.000		R 8 349.70	
0914	Replantation of a single digit (to be motivated), for multiple digits – modifier 0005 applicable	20	580.000		R 7 228.10	
0915	Replantation operation through the palm	20	1270.000		R 15 827.00	
3.8.4	Special areas: Hands: (Note: Skin: See Integumentary System)					
0919	Tumours: Epidermoid cysts	20	35.000		R 436.20	
0920	Tumours: Ganglion or fibroma	20	77.500		R 965.80	
0921	Tumours: Nodular synovitis (giant cell tumour of tendon sheath)	20	86.000		R 1 071.60	
0922	Removal of foreign bodies requiring incision: Under local anaesthetic	20	19.000		R 236.90	
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic	20	32.000		R 398.80	

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0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale) – minimum	20	37.000		R 461.10	
	Item 0924: The number of units chargeable under this Item ranges from 37.00 to 110.00 for Specialists and general practitioners.					
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic	20	16.000		R 199.40	
3.8.5	Special areas: Spine					
	a. Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together: 1. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis. 2. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for in addition. b. Modifier 0005 (multiple procedures/operations under the same anaesthetic) would be applicable when arthrodesis is performed in addition to another procedure, e.g. osteotomy, laminectomy.					
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	20	207.000		R 2 579.90	
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	20	42.000		R 523.40	
0929	Manipulation of spine under general anaesthetic: no after-care – modifier 0005 not applicable	20	14.000		R 174.40	
0930	Posterior osteotomy of spine: One vertebral segment	20	339.000		R 4 224.70	
0931	Posterior spinal fusion: One level	20	385.000		R 4 797.90	
0932	Posterior osteotomy of spine: Each additional vertebral segment	20	103.000		R 1 283.50	
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	20	315.000		R 3 925.40	
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	20	103.000		R 1 283.50	
0938	Anterior fusion base of skull to C2	20	449.000		R 5 595.60	
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	20	160.000		R 1 994.00	
0940	Trans-thoracic anterior exposure of the spine if done by a second surgeon	20	160.000		R 1 994.00	
0941	Anterior interbody fusion: One level	20	360.000		R 4 486.40	
0942	Anterior interbody fusion: Each additional level	20	102.000		R 1 271.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0944	Posterior fusion: Occiput to C2	20	390.000		R 4 860.10	
0946	Posterior spinal fusion: Each additional level	20	111.000		R 1 383.30	
0948	Posterior interbody lumbar fusion: One level	20	364.000		R 4 536.10	
0950	Posterior interbody lumbar fusion: Each additional interspace	20	95.000		R 1 183.90	
0959	Excision of coccyx	20	96.000		R 1 196.30	
0961	Costo-transversectomy	20	198.000		R 2 467.40	
0963	Antero-lateral decompression of spinal cord or anterior debridement	20	326.000		R 4 062.80	
	MODIFIER					
0061	Combined procedures on the spine: In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.					
3.8.6	Special areas: Spinal deformities					
	Please note: Posterior fusion for spinal deformity (to be used for scoliosis more than 30 degrees or thoracic kyphosis more than 45 degrees).					
0952	Posterior fusion for spinal deformity: Up to six levels	20	359.000		R 4 473.90	
0954	Posterior fusion for spinal deformity: Seven to 12 levels	20	547.000		R 6 816.80	
0955	Posterior fusion for spinal deformity: 13 or more levels	20	593.000		R 7 389.90	
0956	Anterior fusion for spinal deformity: Two or three levels	20	410.000		R 5 109.40	
0957	Anterior fusion for spinal deformity: Four to seven levels	20	444.000		R 5 533.20	
0958	Anterior fusion for spinal deformity: Eight or more levels	20	539.000		R 6 717.10	
	MODIFIER					
0065	Additional operative procedures by same surgeon, under section 3.8.6: Spinal deformities, within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere.					
3.8.7	Special areas: All spinal problems					
0943	Laminectomy with decompression of nerve roots and disc removal: One level	20	240.000		R 2 990.90	
0960	Posterior non-segmental instrumentation	20	167.000		R 2 081.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0962	Posterior segmental instrumentation: Two to six vertebrae	20	176.000		R 2 193.20	
0964	Posterior segmental instrumentation: Seven to 12 vertebrae	20	201.000		R 2 504.80	
0966	Posterior segmental instrumentation: 13 or more vertebrae	20	245.000		R 3 053.40	
0968	Anterior instrumentation: Two to three vertebrae	20	159.000		R 1 981.50	
0969	Skull or skull-femoral traction including two weeks after-care	20	64.000		R 797.70	
0970	Anterior instrumentation: Four to seven vertebrae	20	185.000		R 2 305.60	
0971	Halo-splint and POP jacket including two weeks after-care	20	116.000		R 1 445.60	
0972	Anterior instrumentation: Eight or more vertebrae	20	206.000		R 2 567.10	
0974	Additional pelvic fixation of instrumentation other than sacrum	20	108.000		R 1 345.80	
5750	Reinsertion of instrumentation	20	276.000		R 3 439.50	
5751	Removal of posterior non-segmental instrumentation	20	173.000		R 2 156.00	
5752	Removal of posterior segmental instrumentation	20	175.000		R 2 181.00	
5753	Removal of anterior instrumentation	20	204.000		R 2 542.30	
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	20	295.000		R 3 676.30	
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	20	304.000		R 3 788.50	
5757	Laminectomy for decompression without foraminotomy or diskectory more than two levels	20	321.000		R 4 000.50	
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	20	63.000		R 785.10	
5759	Laminectomy for decompression diskectomy, etc. revision operation	20	352.000		R 4 386.60	
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	20	301.000		R 3 751.10	
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	20	68.000		R 847.40	
5763	Anterior disc removal and spinal decompression cervical: One level	20	344.000		R 4 286.80	
5764	Anterior disc removal and spinal decompression cervical: Each additional level	20	81.000		R 1 009.50	
5765	Vertebral corpectomy for spinal decompression: One level	20	466.000		R 5 807.40	
5766	Vertebral corpectomy for spinal decompression: Each additional level	20	88.000		R 1 096.60	

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5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	20	71.000		R 884.70	
3.9	Facial bone procedures					
	Please note: Modifiers 0046 to 0058 are not applicable to section 3.9					
0987	Repair of orbital floor (blowout fracture)	20	184.600		R 2 300.40	
0988	Genioplasty	20	263.000		R 3 277.50	
0989	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I	20	202.200		R 2 519.80	
0990	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II	20	302.000		R 3 763.60	
0991	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III	20	433.000		R 5 396.30	
0992	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort I Osteotomy	20	970.000		R 12 088.10	
0993	Open reduction and fixation of central mid-third facial fracture with displacement: Palatal Osteotomy	20	302.000		R 3 763.60	
0994	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort II Osteotomy (team fee)	20	1103.000		R 13 745.70	
0995	Open reduction and fixation of central mid-third facial fracture with displacement: Le Fort III Osteotomy (team fee)	20	1654.000		R 20 612.20	
0996	Open reduction and fixation of central mid-third facial fracture with displacement: Fracture of maxilla without displacement	20	-			
0997	Mandible: Fractured nose and zygoma, open reduction and fixation	20	302.000		R 3 763.60	
0998	Excision mandible bone, e.g. osteomyelitis,abscess		219.300		R 2 733.30	
0999	Mandible: Fractured nose and zygoma, closed reduction by inter-maxillary fixation	20	184.000		R 2 293.00	
1000	Excision facial bone e.g. osteomyelitis, abscess		144.300		R 1 798.40	
1001	Temporo-mandibular joint: Reconstruction for dysfunction	20	206.000		R 2 567.10	
1002	Harvesting: Bone for contouring of benign bony growths (e.g., fibrous dysplasia)		189.200		R 2 358.10	
1003	Manipulation: Immobilisation and follow-up of fractured nose	20	35.000		R 436.20	
1005	Nasal fracture without manipulation	20	-			
1007	Mandibulectomy	20	320.000		R 3 987.90	
1008	Excision: Torus Mandibularis		84.100		R 1 048.20	

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1009	Maxillectomy	20	382.500		R 6 196.70	
1010	Excision: Torus Palatinus		83.300		R 1 038.20	
1011	Bone graft to mandible	20	206.000		R 2 567.10	
1012	Adjustment of occlusion by ramisection	20	227.000		R 2 828.90	
1013	Fracture of arch of zygoma without displacement	20	-			
1015	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures), recent fracture (within four weeks)	20	131.000		R 1 632.50	
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures (after four weeks)	20	262.000		R 3 265.00	
4	**Respiratory system**					
4.1	Nose and sinuses					
1018	Flexible nasopharyngolaryngoscope examination	20	51.940		R 647.30	
1019	ENT endoscopy in rooms with rigid endoscope	20	12.000		R 149.50	
1020	Repair of perforated septum: Any method	20	141.900		R 1 768.40	
1022	Functional reconstruction of nasal septum	20	121.200		R 1 510.60	
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	20	30.000		R 373.80	
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side of nose)	20	64.600		R 805.00	
1027	Dacrocystorhinostomy	20	210.000		R 2 617.10	
1029	Turbinectomy (modifier 0005 to apply to opposite side of nose)	20	62.600		R 780.20	
1030	Endoscopic turbinectomy: Laser or microdebrider	20	90.000		R 1 121.60	
1031	Removal of single nasal polyp at rooms (at initial consultation only)	20	25.400		R 316.50	
1033	Removal of multiple polyps in hospital under general anaesthetic	20	81.800		R 1 019.30	
1034	Autogenous nasal bone transplant: Bone removal included	20	100.000		R 1 246.20	

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1035	Functional endoscopic sinus surgery: Unilateral	20	140.000		R 1 744.60	
1036	Functional endoscopic sinus surgery: Bilateral	20	245.000		R 3 053.40	
1037	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under local anaesthetic	20	8.000		R 99.60	
1039	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral: Under general anaesthetic	20	35.000		R 436.20	
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	20	40.000		R 498.40	
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior plugging	20	60.000		R 747.80	
1045	Ligation anterior ethmoidal artery	20	135.400		R 1 687.20	
1047	Caldwell-Luc operation: Unilateral	20	137.300		R 1 711.00	
1048	Endonasal frontal sinus drainage, with or without removal of tissue (modifier 0069 applies)		152.200		R 1 896.90	
1049	Ligation internal maxillary artery	20	196.000		R 2 442.50	
1050	Vidian neurectomy (transantral or transnasal)	20	113.000		R 1 408.30	
1051	Removal nasopharyngeal fibroma	20	285.000		R 3 551.80	
1052	Instrumental examination of the nasopharynx including biopsy under general anaesthetic	20	50.000		R 623.20	
1053	Frontal sinus drainage, trephine operation	20	93.100		R 1 160.30	
1054	Antroscopy through the canine fossa (modifier 0005 to apply to opposite side of nose)	20	37.300		R 464.90	
1055	External frontal ethmoidectomy	20	190.700		R 2 376.60	
1056	Anterior cranial fossa, craniofacial approach, extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration	20	433.300		R 5 399.60	
1057	External ethmoidectomy and/or sphenoidectomy	20	199.400		R 2 485.00	
1058	Sublabial transseptal sphenoidotomy	20	137.000		R 1 707.40	
1059	Frontal osteomyelitis	20	194.000		R 2 417.80	
1060	Obliteration of frontal sinus	20	291.100		R 3 627.80	
1061	Lateral rhinotomy	20	164.000		R 2 043.70	
1062	Excision nasolabial cyst	20	186.100		R 2 319.10	

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1063	Removal of foreign bodies from nose: At rooms	20	10.000		R 124.40	
1065	Removal of foreign body from nose: Under general anaesthetic	20	38.600		R 480.90	
1067	Proof puncture at rooms: Unilateral	20	10.000		R 124.40	
1069	Proof puncture, uni- or bilateral under general anaesthetic	20	35.000		R 436.20	
1071	Proetz treatment (consultation fee only to be charged for first treatment)	20	4.000		R 50.00	
1077	Septum abscess: At rooms, including after-care	20	8.000		R 99.60	
1079	Septum abscess: Under general anaesthetic	20	35.000		R 436.20	
1081	Oro-antral fistula (without Caldwell-Luc)	20	111.800		R 1 393.20	
1083	Choanal atresia: Intranasal approach	20	113.000		R 1 408.30	
1084	Choanal atresia: Transpalatal approach	20	194.000		R 2 417.80	
1085	Total reconstruction of the nose: Including reconstruction of nasal septum (septum plasty), nasal pyramid (osteotomy) and nasal tip	20	350.000		R 4 361.80	
1087	Sub-total reconstruction consisting of any two of the following: Septum plasty, osteotomy, nasal tip reconstruction	20	210.000		R 2 617.10	
1089	Forehead rhinoplasty (all stages): Total	20	552.000		R 6 879.10	
1091	Forehead rhinoplasty (all stages): Partial	20	414.000		R 5 159.40	
1093	Forehead rhinoplasty (all stages): Rhinophyma without skin graft	20	138.000		R 1 719.90	
1095	Full nasal reconstruction for secondary cleft lip deformity	20	357.900		R 4 460.20	
1097	Partial nasal reconstruction for cleft lip deformity	20	199.700		R 2 488.60	
1099	Columella reconstruction or lengthening	20	138.000		R 1 719.90	
4896	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, brow incision	20	220.100		R 2 742.60	
4897	Sinusotomy: Obliterative frontal, with ablation, without osteoplastic flap, coronal incision	20	232.900		R 2 902.20	
4898	Sinusotomy: Obliterative frontal, with osteoplastic flap, brow incision	20	181.600		R 2 263.10	
4899	Sinusotomy: Obliterative frontal, with osteoplastic flap, coronal incision	20	120.000		R 1 495.40	
4900	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, brow incision	20	196.600		R 2 449.50	

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4901	Sinusotomy: Non-obliterative frontal, with osteoplastic flap, coronal incision	20	195.400		R 2 435.80	
	MODIFIERS GOVERNING NASAL OPERATIONS					
0069	When endoscopic instruments are used during intranasal surgery: Add 10% of the fee of the procedure performed. Only applicable to Items 1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054 and 1083					
4.2	Throat					
1101	Tonsillectomy (dissection of the tonsils)	20	75.000		R 934.70	
1102	Laser tonsillectomy	20	75.000		R 934.70	
1105	Removal of adenoids	20	40.000		R 498.40	
1106	Laser assisted functional reconstruction of palate uvula: In the rooms (+ Item 5930 for hire of laser)	20	168.300		R 2 097.50	
1107	Opening of quinsy: At rooms	20	12.000		R 149.50	
1108	Laser assisted functional reconstruction of palate uvula: In the rooms (+ Item 5930 for hire of laser): Follow-up operation performed by the same surgeon	20	85.000		R 1 059.20	
1109	Opening of quinsy: Under general anaesthetic	20	35.000		R 436.20	
1110	Ludwig's Angina: Drainage	20	42.000		R 523.40	
1111	Post tonsillectomy or adenoidectomy haemorrhage	20	46.000		R 573.30	
1112	Pharyngeal pouch operation	20	231.800		R 2 888.70	
1113	Retropharyngeal abscess: Internal approach	20	35.000		R 436.20	
1115	Retropharyngeal abscess: External approach	20	85.000		R 1 059.20	
1116	Functional reconstruction of palate and uvula	20	168.300		R 2 097.50	
4.3	Larynx					
1117	Laryngeal intubation	20	10.000		R 161.80	
1118	Laryngeal stroboscopy with video capture	20	39.000		R 631.90	
1119	Laryngectomy without block dissection of the neck	20	430.000		R 6 966.10	
1122	Laryngeal function studies	20	11.600		R 188.00	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1123	Botulinus toxin injection for adductor disphonia (+ Item 0198 + Item 0201 + Item 0202)	20	35.000		R 567.00	
1125	Operative laryngoscopy with excision of tumour and/or stripping of vocal cords (excluding after-care)	20	81.100		R 1 010.50	
1126	Post laryngectomy for voice restoration	20	139.500		R 2 260.00	
1127	Tracheotomy	20	90.000		R 1 458.10	
1128	Endolaryngeal operations	20	75.000		R 934.70	
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor, paralysis, laryngocele-fissure	20	294.400		R 3 668.80	
1130	Direct laryngoscopy: Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	20	41.400		R 670.70	
1131	Direct laryngoscopy plus foreign body removal	20	64.600		R 1 046.50	
4916	Laryngoplasty: Laryngeal web, two stage, with keel insertion and removal	20	220.500		R 2 747.70	
4917	Laryngoplasty: Laryngeal stenosis, with graft or core mold, including tracheotomy	20	342.100		R 4 263.10	
4918	Laryngoplasty: Open reduction of fracture	20	293.800		R 3 660.90	
4919	Laryngoplasty: Cricoid split	20	184.200		R 2 984.80	
4922	Tracheostoma: Revision, without flap rotation, simple	20	102.400		R 1 659.00	
4923	Tracheostoma: Revision, with flap rotation, complex	20	133.800		R 1 667.90	
4926	Tracheostomy: Fenestration with skin flaps	20	144.300		R 2 338.10	
4927	Tracheostomy: Revision of scar	20	105.500		R 1 709.30	
4928	Tracheostomy/fistula: Closure, without plastic repair	20	104.000		R 1 296.10	
4929	Tracheostomy/fistula: Closure, with plastic repair	20	120.000		R 1 495.40	
4932	Tracheobronchoscopy: Through established tracheostomy incision	20	37.700		R 610.90	
4933	Tracheoplasty: Cervical	20	208.100		R 2 593.10	
4934	Tracheoplasty: Tracheopharyngeal fistulisation, per stage	20	263.200		R 3 280.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	MODIFIERS					
0067	Microsurgery of the larynx: Add 25% to the fee of the operation performed (òFor other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified elsewhare in the Tariff)					
4.4	Bronchial procedures					
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy					
1132	Bronchoscopy: Diagnostic bronchoscopy	20	65.000		R 1 052.90	
1133	Bronchoscopy: Diagnostic bronchoscopy with removal of foreign body	20	80.000		R 1 296.20	
1134	Bronchoscopy: Bronchoscopy with laser	20	75.000		R 1 215.20	
1136	Nebulisation (in rooms)	20	12.000		R 194.40	
1137	Bronchial lavage					
1138	Thoracotomy: For broncho-pleural fistula (including ruptured bronchus, any cause)	20	350.000		R 5 670.30	
4.5	Pleura					
1139	Pleural needle biopsy (no after-care) – modifier 0005 not applicable	20	50.000		R 810.20	
1141	Insertion of intercostal catheter (under water drainage)	20	50.000		R 810.20	
1142	Intra-pleural block	20	36.000		R 583.20	
1143	Paracentesis chest: Diagnostic	20	8.000		R 129.60	
1145	Paracentesis chest: Therapeutic	20	13.000		R 210.30	
1147	Pneumothorax: Induction (diagnostic)	20	25.000		R 405.00	
1149	Pleurectomy	20	250.000		R 4 050.30	
1151	Decortication of lung	20	350.000		R 4 361.80	
1153	Chemical pleurodesis (instillation of silver nitrate, tetracycline, talc, etc.)	20	55.000		R 891.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4.6	Pulmonary procedures					
4.6.1	Pulmonary procedures: Surgical					
1155	Needle biopsy lung (no after-care) – modifier 0005 not applicable	20	32.000		R 398.80	
1157	Pneumonectomy	20	350.000		R 4 361.80	
1159	Pulmonary lobectomy	20	389.500		R 4 853.90	
1161	Segmental lobectomy	20	365.000		R 4 548.60	
1163	Excision tracheal stenosis: Cervical	20	375.000		R 4 673.30	
1164	Excision tracheal stenosis: Intra thoracic	20	350.000		R 4 361.80	
1167	Thoracoplasty associated with lung resection or done by the same surgeon within six weeks	20	215.000		R 2 679.40	
1168	Thoracoplasty: Complete	20	250.000		R 3 115.60	
1169	Thoracoplasty: Limited (osteoplastic)	20	200.000		R 2 492.40	
1171	Drainage empyema (including six weeks after treatment)	20	170.000		R 2 118.70	
1173	Drainage of lung abscess (including six weeks after treatment)	20	170.000		R 2 118.70	
1175	Thoracotomy (limited): For lung or pleural biopsy	20	115.000		R 1 433.10	
1177	Major: Diagnostic, as for inoperable carcinoma	20	215.000		R 2 679.40	
1179	Thoracoscopy	20	89.000		R 1 441.90	
1181	Lung transplant: Unilateral	20	600.000		R 7 477.30	
1182	Harvesting donor lung: Unilateral	20	120.000		R 1 495.30	
1183	Excision or plication of emphysematous cyst: Unilateral	20	250.000		R 3 115.60	
1184	Excision or plication of emphysematous cyst: Bilateral synchronous (median sternotomy)	20	438.000		R 5 458.30	
1185	Excision or plication of emphysematous cyst: Re-exploration following sternal dehiscence	20	100.000		R 1 246.20	
4.6.2	Pulmonary function tests					
	When these procedures are performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1186	Flow volume test: Inspiration/expiration	20	30.000		R 485.90	
1187	Exhaled nitric oxide determination	20	4.900		R 79.50	
1188	Flow volume test: Inspiration/expiration/pre- and post bronchodilator (to be charged for only with first consultation – thereafter Item 1186 applies)	20	50.000		R 810.20	
1189	Forced expirogram only	20	10.000		R 161.80	
1190	Determination of resistance to airflow in paediatric patients, impulse oscilimetry	20	45.310		R 734.00	
1191	N2 single breath distribution	20	10.000		R 161.80	
1192	Peak expiratory flow only	20	5.000		R 81.00	
1193	Functional residual capacity or residual volume: Helium method, nitrogen open circuit method, or other method	20	37.760		R 611.80	
1195	Thoracic gas volume	20	37.930		R 614.60	
1196	Determination of resistance to airflow, oscillary or plethysmographic methods	20	45.310		R 734.00	
1197	Compliance and resistance, using oesophageal balloon	20	24.000		R 389.00	
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine, other chemical agent or after exercise, with subsequent spirometry	20	55.890		R 905.40	
1199	Pulmonary stress testing: For determination of VO2 max	20	96.500		R 1 563.20	
1200	Carbon monoxide diffusing capacity, any method	20	38.060		R 616.70	
1201	Maximum inspiratory/expiratory pressure	20	5.000		R 81.00	
4.7	Intensive care					
	RULES GOVERNING THIS SECTION					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
Q.	**Intensive care/high care** Units in respect of Items 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: a. Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit, which is, regarded as the assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive/high care unit. b. Cost of any drugs and/or materials. c. Any other cost which may be incurred before, during or after the consultation/visit and/or the therapy. d. Blood gases and chemistry tests, including the arterial puncture to obtain the specimen. Procedural Items 1202 and 1212 to 1221. but INCLUDE the following: e. Performing and interpretation of a resting ECG. f. Interpretation of chemistry tests and X-rays. g. Intravenous treatment (Items 0206 and 0207), except intravenous infusion in patients under the age of three years (Item 0205) that does not form a part of the daily ICU/high care fee and may be charged for separately on a daily basis (fee includes the introduction of the cannula as well as the daily management).					
R.	Multiple organ failure: Units for Items 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include resuscitation (i.e. Item 1211: Cardio-respiratory resuscitation)					
S.	**Ventilation** Units for Items 1212, 1213 and 1214 (ventilation) include the following: a. Measurement of minute volume, vital capacity, time- and vital capacity studies. b. Testing and connecting the machine. c. Putting patient on machine: setting machine, synchronising patient with machine. d. Instruction to nursing staff. e. All subsequent visits for 24 hours.					
T.	Ventilation (Items 1212 to 1214) does not form a part of normal post-operative care, but may not be added to Item 1204: Catogory 1: Cases requiring intensive monitoring					
4.7.1	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – neonatal procedures					
1202	Insertion of central venous catheter via peripheral vein in neonates	20	40.000		R 648.00	
4.7.2	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – tariff items for intensive care					
1204	Intensive care: Category 1 (high care) – cases requiring intensive monitoring (to include cases where physiological instability is anticipated e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc.), per day	20	30.000		R 485.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	i. Only one practitioner may charge category 1: Intensive monitoring of patient in high care unit. ii. Item 1204 may not be charged by the surgeon who performed a surgical procedure. Intensive monitoring is regarded as normal postoperative care, which is included in the global fee attached to that surgical procedure. iii. Practitioners involved in treating a patient in a high care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.					
1205	Intensive care: Category 2 (ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): First day	20	100.000		R 1 620.20	
1206	Intensive care: Category 2 (ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): Subsequent days, per day	20	50.000		R 810.20	
1207	Intensive care: Category 2(ICU) – cases requiring active system support (where active specialised intervention is required in cases such as acute myocardial infarction, diabetic coma, head injury, severe asthma, acute pancreatitis, eclampsia, flail chest, etc. Ventilation may or may not be part of the active system support): After two weeks, per day	20	30.000		R 485.90	
	Please note: i. The principal practitioner may charge Items 1205-1207, other participating practitioners must charge the consultation item, e.g. Item 0109 ii. Only one practitioner may charge category 2: Intensive monitoring of patient in intensive care unit. ii. Should a patient during the post-operative care period require active system support, the person who is responsible for the active systems support, may use Items 1205-1207 (as appropriate). iii. It would be acceptable for the surgeon who performed a surgical procedure of which the after-care is included, to ‘ charge fees according to the appropriate hospital follow-up visit (Item 0109). iv. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.					
1208	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (primary practitioner)	20	137.000		R 2 219.60	
1209	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: First day (per involved practitioner)	20	58.000		R 939.60	
1210	Intensive care: Category 3 (ICU) – cases with multiple organ failure or Category 2 patients which may require multidisciplinary intervention: Subsequent days (per involved practitioner)	20	50.000		R 810.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	Please note: i. Items 1208-1210 are used if more than one practitioner is involved in active system support on a category 2 patient in the intensive care unit. ii. Items 1208-1210 are used for category 3 patients with multiple organ failure. iv. Practitioners involved in treating a patient in the intensive care unit must come to an agreement on which practitioner should be regarded as the primary practitioner and to which category the patient is classified. This will ensure that each of the practitioners is remunerated correctly for the actual services they rendered.					
4.7.3	Intensive care (in intensive care or high care unit): Respiratory, cardiac, general – procedures					
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.					
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) – 50,00 clinical procedure units per half hour or part thereof for the first hour per practitioner, thereafter 25,00 clinical procedure units per half hour up to a maximum of 150,00 clinical procedure units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.					
1212	Ventilation: First day	20	75.000		R 1 215.20	
1213	Ventilation: Subsequent days, per day	20	50.000		R 810.20	
1214	Ventilation: After two weeks, per day	20	25.000		R 405.00	
1215	Insertion of arterial pressure cannula	20	25.000		R 405.00	
1216	Insertion of Swan Ganz catheter for haemodynamics monitoring	20	50.000		R 810.20	
1217	Insertion of central venous line via peripheral vein	20	10.000		R 161.80	
1218	Insertion of central venous line via subclavian or jugular veins	20	25.000		R 405.00	
1219	Hyperalimentation (daily tariff)	20	15.000		R 243.10	
1220	Patient-controlled analgesic pump: Hire fee, per 24 hours (Cassette to be charged for according to Item 0201 per patient)	20	30.000		R 485.90	
1221	Professional fee for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days charged the appropriate hospital follow-up consultation/visit code)	20	30.000		R 485.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4.8	Hyperbaric Oxygen Therapy					
	Internationally recognized scientific indications for Hyperbaric Oxygen Therapy: a. Arterial gas embolism (traumatic or iatrogenic) b. Decompression sickness ('the bends') c. Carbon monoxide poisoning d. Gas gangrene e. Crush injuries, compartment syndromes or acute traumatic ischaemias f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union) g. Necrotising soft tissue infections (e.g. necrotising fasciitis) h. Refractory osteomyelitis i. Bone and soft tissue radiation necrosis j. Compromised skin grafts and flaps k. Acute thermal burns l. Acute bloodloss anaemia (transfusion is contraindicated – e.g. Jehovah's Witnesses or haemolytic anaemia) m. Cerebral abscesses					
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment, and post treatment evaluation): Low pressure table (1,5-1,8 ATA x 45-60 mins) – PROFESSIONAL COMPONENT	20	30.000		R 485.90	
4820	Low pressure table (1,5-1,8 ATA x 45-60 mins): TECHNICAL COMPONENT	20	101.130		R 1 638.30	
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 mins) – PROFESSIONAL COMPONENT	20	60.000		R 972.20	
4821	Routine HBO table (2-2,5 ATA x 90-120 mins): TECHNICAL COMPONENT	20	131.260		R 2 126.40	
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 mins) – PROFESSIONAL COMPONENT	20	80.000		R 1 296.20	
4822	Emergency HBO table (2,5-3 ATA x 90-120 mins): TECHNICAL COMPONENT	20	131.260		R 2 126.40	
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 mins) – PROFESSIONAL COMPONENT	20	90.000		R 1 458.10	
4825	USN TT5 (2,8 ATA x 135 mins): TECHNICAL COMPONENT	20	214.180		R 3 469.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
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 mins) – PROFESSIONAL COMPONENT	20	190.000		R 3 078.20	
4826	USN TT6 (2,8 ATA x 285 mins): TECHNICAL COMPONENT	20	386.420		R 6 260.40	
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 mins) – PROFESSIONAL COMPONENT	20	327.000		R 5 297.60	
4827	USN TT6ext (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	680.850		R 11 030.30	
4828	USN 6A (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	678.280		R 10 988.60	
4829	USN Cx 30 (2,8-6 ATA x 305-490 mins): TECHNICAL COMPONENT	20	671.850		R 10 884.50	
4815	Prolonged attendance inside a hyperbaric chamber: 40,00 clinical procedure units per half hour or part thereof for the first hour, thereafter 20,00 clinical procedure units per half hour: Minimum 40,00 clinical procedure units; maximum 320,00 clinical procedure units					
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.					
5	**Mediastinal procedures**					
1222	Mediastinal tumours	20	285.000		R 3 551.80	
1223	Mediastinoscopy	20	95.000		R 1 183.90	
1224	Mediastinotomy	20	115.000		R 1 433.10	
1225	Excision of malignant chest wall tumours involving sternum and multiple ribs	20	350.000		R 4 361.80	
1226	Removal of single rib with a lesion	20	282.000		R 3 514.40	
6	**Cardiovascular system**					
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST OPERATING INTRA-AORTIC BALLOON PUMP					
6.1	Cardiovascular system: General					
1227	Prolonged neonatal resuscitation	20	20.000		R 324.00	
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1228	General Practitioner's fee for the taking of an ECG only: Without effort, ½ (Item 1232)					
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort, ½ (Item 1233)					
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added					
1230	Physician's fee for interpreting an ECG: Without effort	20	6.000		R 97.30	
1231	Physician's fee for interpreting an ECG: With and without effort	20	10.000		R 161.80	
	A specialist physician is entitled to the fees specified in Item 1230 and 1231 for interpretation of an ECG tracing referred for interpretation. This applies also to a paediatrician when an ECG of a child is referred to him for interpretation.					
1232	Electrocardiogram: Without effort	20	9.000		R 146.00	
1233	Electrocardiogram: With and without effort	20	13.000		R 210.30	
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	20	40.000		R 648.00	
1235	Multi-stage treadmill test	20	60.000		R 972.20	
1236	Electrocardiogram without effort: Under four years old	20	18.000		R 291.60	
1237	24-hour ambulatory blood pressure: Hire fee	20	30.000		R 373.80	
1238	24-hour ambulatory ECG monitoring (holter): Hire fee	20	55.000		R 685.40	
1239	24-hour ambulatory ECG monitoring (holter): Interpretation	20	27.000		R 437.60	
1240	Signal averaged electrocardiogram	20	80.000		R 1 296.20	
1241	X-ray Screening: Chest	20	4.000		R 65.00	
1242	X-ray screening: Prosthetic valves	20	10.000		R 161.80	
1243	Two week event triggered ambulatory ECG monitoring: Hire fee	20	55.000		R 685.40	
1244	Two week event triggered ambulatory ECG monitoring: Interpretation	20	25.000		R 405.00	
1245	Angiography cerebral: First two series	20	34.300		R 555.70	
1246	Angiography peripheral: Per limb	20	25.000		R 405.00	
1247	Cardioversion for arrhythmias (any method) with doctor in attendance	20	65.000		R 1 052.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1248	Paracentesis of pericardium	20	50.000		R 810.20	
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing	20	51.000		R 826.10	
	MODIFIER GOVERNING PAEDIATRIC CARDIAC CATHETERISATION BY PAEDIATRIC CARDIOLOGISTS WITH A "33" PRACTICE NUMBER					
0073	When Item 1288 (Cardiac catheterisation for congenital heart disease: All ages above 1 year old) or Item 1289 (Paediatric cardiac catheterisation: Infants below the age of one year) is performed by paediatric cardiologists ('33'): Fee for procedure + 100%					
6.2	Invasive cardiology					
6.2.1	Invasive cardiology: Cardiac catheterisation					
1249	Right and left cardiac catheterisation without coronary angiography (with or without biopsy)	20	140.000		R 2 268.00	
1250	Endomyocardial biopsy	20	70.000		R 1 134.20	
1251	Transeptal puncture	20	70.000		R 1 134.20	
1252	Left heart catheterisation with coronary angiography (with or without biopsy)	20	140.000		R 2 268.00	
1253	Right heart catheterisation (with or without biopsy)	20	70.000		R 1 134.20	
1254	Catheterisation of coronary artery bypass grafts and/or internal mammary grafts	20	40.000		R 648.00	
1255	Tilt test	20	31.300		R 507.20	
6.2.2	Invasive cardiology: Electrophysiological study					
1256	Ventricular stimulation study	20	160.000		R 2 592.10	
1257	Full electrophysiological study	20	300.000		R 4 860.20	
6.2.3	Invasive cardiology: Pacemakers					
1258	Pacemaker: Permanent – single chamber	20	155.000		R 2 511.30	
1259	Pacemaker: Permanent – dual chamber	20	230.000		R 3 726.10	
1260	AV nodal ablation	20	300.000		R 4 860.20	
1261	Accessory pathway ablation	20	600.000		R 9 720.50	
1262	Electrophysiological mapping	20	500.000		R 8 100.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1263	Insertion transvenous implantable defibrillator	20	212.000		R 3 434.70	
1264	Test for implantable transvenous defibrillator	20	120.000		R 1 943.90	
1265	Renewal of pacemaker unit only, team fee	20	125.000		R 2 025.20	
1266	Resiting pacemaker generator	20	80.000		R 1 296.20	
1267	Repositioning of catheter electrode	20	50.000		R 810.20	
1268	Threshold testing: Own equipment	20	15.000		R 243.10	
1269	Threshold testing: Hospital equipment	20	11.000		R 178.20	
1270	Programming of atrio-ventricular sequential pacemaker	20	50.000		R 810.20	
1273	Insertion of temporary pacemaker (modifier 0005 not applicable)	20	120.000		R 1 943.90	
1274	Percutaneous transluminal thrombectomy for clot extraction in native coronary arteries and venous and arterial bypass grafts	20	260.000		R 4 212.40	
1275	Termination of arrhythmia – programmed stipulation and lead insertion of temporary pacer	20	200.000		R 3 240.10	
6.2.4	Invasive cardiology: Percutaneous translumical angioplasty					
1276	Percutaneous transluminal angioplasty: First cardiologist, single lesion	20	260.000		R 4 212.40	
1277	Percutaneous transluminal angioplasty: Second cardiologist, single lesion	20	140.000		R 2 268.00	
1278	Percutaneous transluminal angioplasty: First cardiologist, second lesion	20	60.000		R 972.20	
1279	Percutaneous transluminal angioplasty: Second cardiologist, second lesion	20	40.000		R 648.00	
1280	Percutaneous transluminal angioplasty: First cardiologist, third or subsequent lesions (each)	20	60.000		R 972.20	
1281	Percutaneous transluminal angioplasty: Second cardiologist, third or subsequent lesions (each)	20	40.000		R 648.00	
1282	Use of balloon procedures including: First cardiologist: Atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty	20	260.000		R 4 212.40	
1283	Use of balloon procedure as in Item 1282: Second cardiologist	20	140.000		R 2 268.00	
1284	Atherectomy: Single lesion, first cardiologist	20	300.000		R 4 860.20	
1285	Atherectomy: Single lesion, second cardiologist	20	180.000		R 2 916.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1286	Insertion of intravascular stent: First cardiologist	20	100.000		R 1 620.20	
1287	Insertion of intravascular stent: Second cardiologist	20	50.000		R 810.20	
	The insertion of a stent(s) (Item 1286 & 1267) may only be charged once per vessel regardless of the number of stents inserted in this vessel.					
1290	Use of balloon procedures including: First paediatric cardiologist (33): Atrial septostomy, pulmonary valve valvuloplasty, aortic valve valvuloplasty, coarctation dilation, mitral valve valvuloplasty, closure atrial septal defect, closure of patient ductus arteriosus	20	300.000		R 4 860.20	
1291	Use of balloon procedure as in Item 1290: Second paediatric cardiologist (33)	20	160.000		R 2 592.10	
1292	Multi-slice computed tomography coronary angiography: Own equipment	20	655.260		R 10 615.70	
5961	Balloon angioplasty pulmonary mitral valve or tricuspid valve		437.700		R 7 088.80	
5962	Balloon angioplasty aortic valve (congenital aortic stenosis)		424.100		R 6 868.40	
5963	Balloon angioplasty, pulmonary artery branches: First vessel		202.000		R 3 271.40	
5964	Balloon angioplasty, pulmonary artery branches: Subsequent vessels (per vessel)		101.600		R 1 645.60	
5965	Balloon angioplasty aorta for congenital lesion/coarctation		629.700		R 10 198.20	
5966	Balloon/cutting balloon angioplasty, collateral vessel (incl MAPCA) or venous system (IVC, SVC, systemic vein): First vessel		451.400		R 7 310.40	
5967	Balloon angioplasty, collateral vessel (incl. MAPCA): Subsequent vessels (per vessel)		112.850		R 1 827.70	
5968	Balloon angioplasty venous system (IVC, SVC, systemic vein)		451.400		R 7 310.40	
5969	Cutting balloon angioplasty, cardiovascular structure: First vessel		451.400		R 7 310.40	
5970	Cutting balloon angioplasty, cardiovascular structure: Subsequent vessels (per vessel)		112.850		R 1 827.70	
6.2.5	Invasive cardiology: Paediatric cardiac catheterisation					
1288	Cardiac catheterisation for congenital heart disease: All ages above one year old	20	210.000		R 3 402.30	
1289	Paediatric cardiac catheterisation: Infants below the age of one year	20	263.000		R 4 260.70	
6.3	Cardiac surgery					
1294	Patent ductus arteriosus	20	320.000		R 3 987.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1295	Pericardiectomy for constrictive pericarditis	20	400.000		R 4 984.80	
1296	Fractional flow reserve (FFR): First vessel (add-on code)		28.000		R 453.50	
1297	Coarctation of aorta	20	425.000		R 5 296.30	
1298	Fractional flow reserve (FFR): Each additional vessel (add-on code)		22.400		R 362.80	
1299	Systemo-pulmonary anastomosis	20	425.000		R 5 296.30	
1300	Renal denervation (RDN), per artery (modifier 0005 applicable)		223.000		R 3 611.50	
1301	Mitral valvotomy: Closed heart technique	20	350.000		R 4 361.80	
1302	Heart transplant	20	875.000		R 10 904.40	
1303	Harvesting donor heart	20	75.000		R 934.70	
1305	Operative implantation of cardiac pacemaker by thoracotomy	20	220.000		R 2 741.70	
1307	Re-exploration after cardiac surgery	20	215.000		R 2 679.40	
1308	Heart and lung transplant	20	1000.000		R 12 462.10	
1309	Harvesting donor heart and lungs	20	120.000		R 1 495.30	
1311	Pericardial drainage	20	140.000		R 2 268.00	
6.3.1	Cardiac surgery: Open heart surgery					
1312	Evaluation of coronary angiogram by cardiothoracic surgeon	20	25.000		R 311.50	
1320	Repeat open heart surgery (additional fee above procedure fee)	20	250.000		R 3 115.60	
1321	Stand-by fee for coronary angioplasty	20	30.000		R 485.90	
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc. – per hour	20	20.000		R 324.00	
6.3.1.1	Cardiac surgery: Open heart surgery – congenital conditions					
1323	Atrial septal defect: Osteum secundum	20	500.000		R 6 231.00	
1325	Atrial septal defect: Sinus venosus or osteum primum	20	563.000		R 7 016.10	
1327	Atrial septal defect: Ventricular septal defect	20	603.800		R 7 524.70	
1329	Atrial septal defect: Fallot's tetralogy	20	563.000		R 7 016.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1330	Atrial septal defect: Pulmonary stenosis	20	500.000		R 6 231.00	
1331	Transposition of large vessels (venous repair)	20	563.000		R 7 016.10	
1332	Transposition of great arteries (arterial repair)	20	750.000		R 9 346.60	
1333	Ebstein's Anomaly	20	563.000		R 7 016.10	
1334	Aorto-coronary bypass operation as a MidCab procedure (thoracotomy with coronary grafting without bypass or hypothermal)	20	548.800		R 6 839.20	
1335	Total anomalous venous drainage	20	563.000		R 7 016.10	
1336	Aorto-coronary bypass operation as a OpCab procedure (sternotomy with coronary grafting without bypass or hypothermia)	20	658.900		R 8 211.30	
1337	Creation of atrial septal defect by thoracotomy with or without cardiac bypass	20	500.000		R 6 231.00	
1338	Fontan type repair	20	750.000		R 9 346.60	
6.3.1.2	Cardiac surgery: Open heart surgery – acquired conditions					
1339	Mitral valve replacement	20	657.000		R 8 187.60	
1340	Mitral valvuloplasty	20	688.000		R 8 573.90	
1341	Aortic valve replacement	20	623.800		R 7 773.90	
1342	Tricuspid annulo plasty	20	188.000		R 2 343.00	
1343	Double valve replacement	20	968.900		R 12 074.40	
1344	Acute dissecting aneurysm repair	20	750.000		R 9 346.60	
1345	Aortic arch aneurysm repair utilising deep hypothermal and circulatory arrest	20	1000.000		R 12 462.10	
1346	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins, unilateral (modifier 0005 not applicable)	20	100.000		R 1 246.20	
1347	Aorta-coronary bypass operation (including interpretation of angiogram): Harvesting of saphenous veins, bilateral (modifier 0005 not applicable)	20	175.000		R 2 181.00	
1348	Aorta-coronary bypass operation (including interpretation of angiogram): Utilising saphenous veins	20	750.000		R 9 346.60	
1349	Aorta-coronary bypass operation (including interpretation of angiogram): Additional arterial implant, any artery	20	781.000		R 9 732.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1350	Aorta-coronary bypass operation (including interpretation of angiogram): Additional double arterial implant, any artery	20	813.000		R 10 131.70	
1351	Aorta-coronary bypass operation with valve replacement or excision of cardiac aneurysm	20	875.000		R 10 904.40	
1352	Cardiac aneurysm	20	563.000		R 7 016.10	
1353	Ascending/descending thoracic aortic aneurysm repair	20	625.000		R 7 788.80	
1354	Arrhythmia surgery	20	688.000		R 8 573.90	
1355	Cardiac tumour	20	625.000		R 7 788.80	
1356	Insertion and removal of intra-aortic balloon pump (modifier 0005 not applicable)	20	188.000		R 2 343.00	
1358	Harvesting of radial artery	20	175.000		R 2 181.00	
6.4	Peripheral vascular system					
	MODIFIER GOVERNING THIS SECTION					
0072	Non-invasive peripheral vascular tests: The number of tests in a single case is restricted to two per diagnosis. Tests are not justified in cases of uncomplicated varicose veins.					
6.4.1	Peripheral vascular system: Investigations					
1357	Skin temperature test: Response to reflex heating	20	15.000		R 243.10	
1359	Skin temperature test: Response to reflex cooling	20	15.000		R 243.10	
1360	Closure: Left atrial appendage (LAA)		828.000		R 13 409.70	
1361	Cold sensitivity test	20	17.000		R 275.40	
1362	Trans-aortic valve implantation (TAVI)/Transcatheter aortic valve replacement (TAVR)		397.500		R 6 437.70	
1363	Oscillometry test	20	5.000		R 81.00	
1365	Sweating test	20	17.000		R 275.40	
1366	Transcutaneous oximetry: Transcutaneous oximetry – single site	20	26.300		R 426.20	
1367	Doppler blood tests	20	6.000		R 97.30	
5369	Doppler arterial pressures	20	6.000		R 97.30	
5371	Doppler arterial pressures with exercise	20	10.000		R 161.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5373	Doppler segmental pressures and wave forms	20	12.000		R 194.40	
5375	Venous doppler examination (both limbs)	20	9.000		R 146.00	
5377	Venous plethysmography	20	16.000		R 259.20	
5379	Supra-orbital doppler test	20	5.000		R 81.00	
5381	Carotid non-invasive complex tests	20	39.000		R 631.90	
6.4.2	Peripheral vascular system: Arterio-venous abnormalities					
1369	Fistula or aneurysm (as for grafting of various arteries)					
6.4.3	Arteries					
6.4.3.1	Peripheral vascular system: Arteries – aorta-iliac and major branches					
1372	Abdominal aorta and iliac artery: Unruptured	20	540.000		R 6 729.50	
1373	Abdominal aorta and iliac artery: Ruptured	20	600.000		R 7 477.30	
1375	Grafting and/or thrombo-endarterectomy for thrombosis	20	444.000		R 5 533.20	
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis	20	594.000		R 7 402.50	
6.4.3.2	Peripheral vascular system: Arteries – iliac artery					
1379	Prosthetic grafting and/or thrombo-endarterectomy	20	300.000		R 3 738.60	
6.4.3.3	Peripheral vascular system: Arteries – peripheral					
1385	Prosthetic grafting	20	255.000		R 3 177.80	
1387	Grafting vein: Vein grafting proximal to knee joint	20	300.000		R 3 738.60	
1388	Grafting vein: Distal to knee joint	20	444.000		R 5 533.20	
1389	Grafting vein: Endarterectomy when not part of another specified procedure	20	264.000		R 3 290.10	
1390	Grafting vein: Carotid endarterectomy	20	321.000		R 4 000.50	
1393	Embolectomy: Peripheral embolectomy transfemoral	20	168.000		R 2 721.80	
1395	Miscellaneous arterial procedures: Arterial suture, trauma	20	125.000		R 2 025.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1396	Suture major blood vessel (artery or vein) – trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery). The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure.	20	264.000		R 3 290.10	
1397	Profundoplasty	20	210.000		R 2 617.10	
1399	Distal tibial (ankle region)	20	456.000		R 5 682.70	
1401	Femoro-femoral	20	254.000		R 3 165.30	
1402	Carotid-subclavian	20	288.000		R 3 589.00	
1403	Axillo-femoral: (Bifemoral + 50%)	20	288.000		R 3 589.00	
6.4.4	Peripheral vascular system: Veins					
1407	Ligation of saphenous vein	20	50.000		R 623.20	
1408	Placement of Hickman catheter or similar	20	91.000		R 1 133.90	
1410	Litigation of inferior vena cava: Abdominal	20	180.000		R 2 243.10	
1412	Umbrella operation on inferior vena cava: Abdominal	20	100.000		R 1 246.20	
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – unilateral	20	141.000		R 1 757.10	
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated – bilateral	20	247.000		R 3 078.10	
1417	Extensive sub-fascial ligation of perforating veins	20	125.000		R 1 557.90	
1419	Lesser varicose vein procedures	20	31.000		R 386.30	
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)	20	9.000		R 112.20	
1425	Thrombectomy: Inferior vena cava (trans-abdominal)	20	240.000		R 2 990.90	
1427	Thrombectomy: Illio-femoral	20	175.000		R 2 835.20	
6.4.5	Peripheral vascular system: Portal hypertension					
1429	Porto-caval shunt	20	500.000		R 8 100.30	

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6.5	Cardiac rehabilitation					
1431	Cardiac rehabilitation: Phase II: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 5 patients per group	20	12.000		R 194.40	
1432	Cardiac rehabilitation: Phase III: Exercise rehabilitation: Per patient per 60 minute session with a maximum of 10 patients per group	20	6.000		R 97.30	
	Please note : a. A practitioner is only allowed to instruct one group at a time. b. Benefits are limited to 3 times per week for a period of 60 minutes with a maximum of 3 months.					
7	**Lympho reticular system**					
7.1	Spleen					
1435	Splenectomy (in all cases)	20	221.300		R 2 757.90	
1436	Splenorrhaphy	20	231.800		R 2 888.70	
1437	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic donor lymphocyte infusions – PROFESSIONAL COMPONENT		28.100		R 350.10	
1438	Bone marrow or blood-derived peripheral stem cell transplantation: allogeneic – PROFESSIONAL COMPONENT		36.900		R 459.80	
7.2	Lymph nodes and lymphatic channels					
1439	Excision of lymph node for biopsy: Neck or axilla	20	65.000		R 810.00	
1440	Bone marrow or blood-derived peripheral stem cell transplantation: autologous – PROFESSIONAL COMPONENT		36.800		R 458.40	
1441	Excision of lymph node for biopsy: Groin	20	65.000		R 810.00	
1442	Lymphadenectomy: Modified radical neck dissection, cervical	20	293.100		R 3 653.00	
1443	Simple excision of lymph nodes for tuberculosis	20	91.000		R 1 133.90	
1444	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: allogeneic – PROFESSIONAL COMPONENT		23.500		R 292.70	
1445	Radical excision of lymph nodes of neck: Total, unilateral	20	315.000		R 3 925.40	
1446	Blood-derived haematopoetic progenitor cell harvesting for transplantation, per collection: autologous – PROFESSIONAL COMPONENT		23.800		R 296.40	

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1447	Radical excision of lymph nodes of neck: Total, suprahyoid unilateral	20	235.000		R 2 928.30	
1448	Bone marrow harvesting for transplant – PROFESSIONAL COMPONENT		101.000		R 1 258.30	
1449	Radical excision of lymph nodes of axilla	20	160.000		R 1 994.00	
1450	Bone marrow transplantation: Cryopreservation of bone marrow or peripheral blood stem cells	20	58.000		R 722.80	
1451	Radical excision of lymph nodes of groin: Ilio-inguinal	20	175.000		R 2 181.00	
1453	Radical excision of lymph nodes of groin: Inguinal	20	150.000		R 1 869.40	
1454	Bone marrow transplantation: Plasma/cell separation using designated cell separator equipment (per hour) – specify time used	20	39.000		R 486.00	
1455	Retroperitoneal lymph adenectomy including pelvic, aortic and renal nodes	20	275.000		R 3 427.10	
1456	Bone marrow transplantation: Preparation for extra-corporeal equipment by the medical practitioner for plasma, platelet and leucocyte phaeresis	20	42.000		R 523.40	
1457	Bone marrow biopsy: By trephine	20	13.000		R 210.30	
1458	Bone marrow biopsy: Simple aspiration of marrow by means of trocar or cannula	20	8.000		R 129.60	
1459	Staging laparotomy for lymphoma, including splenectomy	20	245.000		R 3 053.40	
1460	Sentinel lymph node(s): Intra-operative indentification – INCLUDES injection of non-radioactive dye, when performed		40.400		R 503.30	
8	**Digestive system**					
	MODIFIERS GOVERNING THIS SECTION					
0074	Endoscopic procedures performed with own equipment: The basic procedure fee plus 33.33% (1/3) of that fee (“+” codes excluded) will apply where endoscopic procedures are performed with own equipment.					
0075	Endoscopic procedures performed in own procedure room: The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in rooms with own equipment. This fee is chargeable by medical practitioners who own or rent the facility. Please note: Modifier 0075 is not applicable to any of the Items for diagnostic procedures in the otorhinolaryngology sections of the tariff.	20	21.000		R 261.80	
8.1	Oral cavity					
1461	All dental procedures				R 0.00	
1463	Surgical biopsy of tongue or palate: Under general anaesthetic	20	35.000		R 436.20	

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1465	Surgical biopsy of tongue or palate: Under local anaesthetic	20	15.000		R 187.00	
1467	Drainage of intra-oral abscess	20	31.000		R 386.30	
1469	Local excision of mucosal lesion of oral cavity	20	23.000		R 286.70	
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure	20	549.000		R 6 841.70	
1473	Complicated reconstruction following major ablative procedure for head and neck cancer	20	-			
1475	Cleft palate: Repair primary deformity with or without pharyngoplasty	20	215.000		R 2 679.40	
1477	Cleft palate: Secondary repair	20	174.200		R 2 171.10	
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair)	20	240.000		R 2 990.90	
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)	20	227.000		R 2 828.90	
1480	Repair of oronasal fistula (large) e.g. distant flap	20	227.000		R 2 828.90	
1481	Repair of oronasal fistula (small) e.g. trapdoor: One stage or first stage	20	138.000		R 1 719.90	
1482	Repair of oronasal fistula (large): Second stage	20	138.000		R 1 719.90	
1483	Alveolar periosteal or other flaps for arch closure	20	138.000		R 1 719.90	
1486	Closure of anterior nasal floor	20	138.000		R 1 719.90	
8.2	Lips					
1484	Cleft lip repair: Lip adhesion (cleft lip)	20	95.000		R 1 183.90	
1485	Local excision of benign lesion of lip	20	27.000		R 336.60	
1487	Resection for lip malignancy	20	91.000		R 1 133.90	
1489	Cleft lip repair: Repair unilateral cleft lip (with muscle reconstruction)	20	227.000		R 2 828.90	
1490	Cleft lip repair: Bilateral cleft lip repair (with muscle reconstruction) – one of two stages	20	251.600		R 3 135.60	
1491	Cleft lip repair: Repair bilateral cleft lip (with muscle reconstruction) – one stage	20	329.900		R 4 111.10	
1492	Cleft lip repair: Bilateral cleft lip repair – second stage	20	227.000		R 2 828.90	
1493	Cleft lip repair: Total revision of secondary cleft lip deformities	20	251.600		R 3 135.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1494	Cleft lip repair: Partial revision of secondary cleft lip deformity	20	91.000		R 1 133.90	
1495	Abbé or Estlander type flap (all stages included)	20	273.100		R 3 403.30	
1497	Vermilionectomy	20	94.900		R 1 182.60	
1499	Lip reconstruction following an injury: Direct repair	20	105.600		R 1 316.10	
1501	Lip reconstruction following an injury or tumour removal: Flap repair	20	206.000		R 2 567.10	
1503	Lip reconstruction following an injury or tumour removal: Total reconstruction (first stage)	20	206.000		R 2 567.10	
1504	Lip reconstruction following an injury or tumour removal: Subsequent stages (see Item 0297)	20	104.000		R 1 296.00	
8.3	Tongue					
1505	Partial glossectomy	20	225.000		R 2 804.00	
1507	Local excision of lesion of tongue	20	27.000		R 336.60	
8.4	Palate, uvula and salivary glands					
1509	Wide excision of lesion of palate	20	100.000		R 1 246.20	
1511	Radical resection of palate (including skin graft)	20	250.000		R 3 115.60	
1513	Excision of ranula	20	85.600		R 1 066.90	
1515	Excision of sublingual salivary gland	20	120.000		R 1 495.30	
1517	Excision of submandibular salivary gland	20	146.000		R 1 819.40	
1519	Excision of submandibular salivary gland with suprahyoid dissection	20	150.000		R 1 869.40	
1521	Excision of submandibular salivary gland with radical neck dissection	20	352.000		R 4 386.60	
1523	Local resection of parotid tumour	20	169.600		R 2 113.50	
1525	Partial parotidectomy	20	310.000		R 3 863.20	
1526	Total parotidectomy with preservation of facial nerve	20	358.500		R 4 467.80	
1527	Total parotidectomy	20	358.500		R 4 467.80	
1529	Parotidectomy: Extracapsular	20	300.000		R 3 738.60	
1531	Drainage of parotid abscess	20	25.000		R 311.50	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1533	Closure of salivary fistula	20	91.000		R 1 133.90	
1535	Dilatation of salivary duct	20	10.000		R 124.40	
1537	Operative removal of salivary calculus	20	55.000		R 685.40	
1538	Sialolithotomy: Submandibular/submaxillary, intraoral approach, complicated	20	58.500		R 729.00	
1539	Salivary duct: Meatotomy	20	20.000		R 249.30	
1541	Branchial cyst and/or fistula: Excision	20	140.000		R 1 744.60	
1543	Excision of cystic hygroma	20	140.000		R 1 744.60	
1544	Ludwig's Angina: Drainage	20	42.000		R 523.40	
8.5	Oesophagus					
1545	Oesophagoscopy with rigid instrument: First and subsequent	20	47.000		R 761.40	
1549	Oesophagoscopy with dilatation of stricture	20	70.000		R 1 134.20	
1550	Oesophagoscopy with removal of foreign body	20	70.000		R 1 134.20	
1551	Oesophagoscopy with insertion of indwelling oesophageal tube	20	80.000		R 1 296.20	
1552	Injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	80.000		R 1 296.20	
1553	Subsequent injection and/or ligation of oesophageal varices (endoscopy inclusive)	20	65.000		R 1 052.90	
1555	Repair of tracheal oesophageal fistula and oesophageal atresia	20	400.000		R 4 984.80	
1556	Oesophagogastric fundoplication (e.g. Nissen, Toupet, Watson): Laparoscopic		314.700		R 3 920.50	
1557	Oesophageal dilatation	20	40.000		R 648.00	
1558	Oesophagogastric fundoplasty: Thal-Nissen procedure		389.800		R 4 856.00	
1559	Oesophagectomy: Two stage	20	500.000		R 6 231.00	
1560	Oesophagectomy: Three stage	20	550.000		R 6 854.30	
1561	Thoraco-abdominal oesophagogastrectomy	20	500.000		R 6 231.00	
1563	Hiatus hernia and diaphragmatic hernia repair, with anti-reflux procedure	20	300.000		R 3 738.60	
1564	Oesophagogastric fundoplication (e.g. Nissen, Belsey): Thoracotomy		357.100		R 4 448.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1565	Hiatus hernia and diaphragmatic hernia repair, with Collis Nissen oesophageal lengthening procedure	20	350.000		R 4 361.80	
1566	Private fee: Gastroplasty	20	325.000		R 4 050.10	
1567	Bochdalek hernia repair in newborn	20	250.000		R 3 115.60	
1568	Hiatus hernia and diaphragmatic repair: Revision after previous repair	20	375.000		R 4 673.30	
1569	Heller's operation	20	250.000		R 3 115.60	
1570	Oesophagomyotomy: Laparoscopic, with fundoplication if performed (Heller type procedure)		377.700		R 4 705.40	
1571	Oesophagomyotomy: Thoracic approach (Heller type procedure)		313.100		R 3 900.50	
1575	Insertion of indwelling oesophageal tube by laparotomy	20	142.000		R 1 769.70	
1576	Oesophagogastric lengthening procedure (e.g. Collis or wedge gastroplasty): Add to major procedure (modifier 0005 does not apply)		48.300		R 601.80	
1578	Oesophageal motility (4 channel + pneumograph)	20	100.000		R 1 620.20	
1579	Oesophageal substitution (without oesophagectomy) using colon, small bowel or stomach	20	400.000		R 6 480.20	
1580	Oesophageal motility (6 Channel + pneumograph + pH pull-through)	20	110.000		R 1 782.20	
1581	Removal of benign oesophageal tumours	20	285.000		R 3 551.80	
1582	Oesophageal motility (4 or 6 channel + pneumograph – ECG + provocative tests for oesophageal spasm vs. myocardial ischaemia)	20	150.000		R 2 430.20	
1583	Excision of intrathoracic oesophageal diverticulum	20	250.000		R 4 050.30	
1584	24 hour oesophageal pH studies: Hire fee (Item 0201 applicable for pro-rata of probe: 50 examinations per glass electrode pH probe and 10 examinations per antimone pH probe)	20	55.000		R 891.00	
1585	24 hour oesophageal pH studies: Interpretation	20	27.000		R 437.60	
5710	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		348.200		R 4 337.80	
5711	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparotomy (not applicable to neonatal surgery)		378.100		R 4 710.20	
5712	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		382.200		R 4 761.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5713	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoracotomy (not applicable to neonatal surgery)		411.800		R 5 130.20	
5714	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		451.200		R 5 621.00	
5715	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Thoraco-abdominal approach (not applicable to neonatal surgery)		492.500		R 6 135.60	
5716	Para-oesophageal hiatal hernia repair, including fundoplication, without mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		463.600		R 5 775.40	
5717	Para-oesophageal hiatal hernia repair, including fundoplication, with mesh or other prosthesis: Laparoscopic (not applicable to neonatal surgery)		520.900		R 6 489.30	
8.6	Stomach					
1587	Upper gastro-intestinal endoscopy: Hospital equipment	20	48.750		R 789.90	
1588	Plus polypectomy: Add to gastro-intestinal endoscopy (Item 1587)	20	25.000		R 405.00	
1589	Endoscopic control of gastrointestinal haemorrhage from upper gastrointestinal tract, intestines or large bowel by injection, ligation or application of energy device (endoscopic haemostasis) to be added to gastroscopy (Item 1587) or colonoscopy (Item 1653)	20	34.000		R 550.80	
1591	Plus removal of foreign bodies (stomach): Add to gastro-intestinal endoscopy (Item 1587)	20	25.000		R 405.00	
1593	Augmented histamine test: Gastric intubation with X-ray screening	20	5.000		R 81.00	
1597	Gastrostomy or gastrotomy	20	147.500		R 2 389.70	
1598	Gastrotomy with suture repair of bleeding ulcer	20	251.200		R 4 069.60	
1599	Pyloromyotomy (Rammstedt)	20	116.000		R 1 879.30	
1601	Local excision of ulcer or benign neoplasm	20	195.600		R 2 437.80	
1603	Vagotomy: Abdominal	20	150.000		R 1 869.40	
1604	Vagotomy: Thoracic	20	150.000		R 1 869.40	
1605	Truncal or selective with drainage procedures	20	250.000		R 3 115.60	
1607	Vagotomy and antrectomy	20	320.000		R 3 987.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1609	Highly selective vagotomy	20	250.000		R 3 115.60	
1611	Pyloroplasty	20	180.200		R 2 245.60	
1613	Gastroenterostomy	20	203.600		R 2 537.40	
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	20	200.000		R 2 492.40	
1617	Partial gastrectomy	20	328.300		R 4 091.40	
1619	Total gastrectomy	20	384.430		R 4 790.80	
1621	Revision of gastrectomy or gastro-enterostomy	20	375.000		R 4 673.30	
1625	Gastro-esophageal operation for portal hypertension (Tanner)	20	375.000		R 4 673.30	
8.7	Duodenum					
1626	Endoscopic examination of the small bowel beyond the duodenojenunal flexure with biopsy with or without polypectomy with or without arrest of haemorrhage (enteroscopy)	20	120.000		R 1 943.90	
1627	Duodenal intubation (under X-ray screening)	20	8.000		R 129.60	
1629	Duodenal intubation with biliary drainage after gall bladder stimulation	20	21.000		R 340.30	
1631	Duodenal intubation: Under 3 years of age	20	15.000		R 243.10	
8.8	Intestines					
1632	H2 breath test (intestines)	20	9.000		R 146.00	
1633	Complete test using lactose or lactulose	20	27.000		R 437.60	
1634	Enterotomy or enterostomy	20	202.600		R 2 524.90	
1635	Intestinal obstruction of the newborn	20	240.000		R 2 990.90	
1636	Oral food challenge test		14.100		R 228.40	
1637	Operation for relief of intestinal obstruction	20	240.000		R 2 990.90	
1638	Resection of small bowel for congenital atresia, proximal segment, without tapering	20	195.900		R 2 441.70	
1639	Resection of small bowel with enterostomy or anastomosis	20	244.900		R 3 051.90	
1640	Resection of small bowel for congenital atresia, proximal segment, with tapering	20	431.100		R 5 372.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1641	Entero-enterostomy or entero-colostomy for bypass	20	213.100		R 2 655.60	
1642	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy): Hire fee (Item 0201 applicable for video capsule – disposable single patient use). Please note: All patients should have had a normal gastroscopy and colonoscopy.	20	150.000		R 1 869.40	
1643	Gastrointestinal tract imaging, intraluminal (e.g. video capsule endoscopy), oesophagus through ileum: Doctor interpretation and report	20	90.000		R 1 458.10	
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	20	185.200		R 2 308.00	
1647	Closure of intestinal fistula	20	258.000		R 3 215.20	
1649	Excision of Meckel's diverticulum	20	179.800		R 2 240.60	
1651	Excision of lesion of mesentery	20	171.600		R 2 138.50	
1652	Laparotomy for mesenteric thrombosis	20	300.000		R 3 738.60	
1653	Total colonoscopy: With hospital equipment (including biopsy)	20	90.000		R 1 458.10	
1654	Plus removal of polyps: Add to colonoscopy (Item 1653)	20	30.000		R 485.90	
1656	Left-sided colonoscopy	20	60.000		R 972.20	
1657	Right or left hemicolectomy or segmental colectomy	20	325.000		R 4 050.10	
1658	Reconstruction of colon after Hartman's procedure	20	359.400		R 4 478.90	
1659	Surgeon present assisting with air enema for reduction of intussuception (paediatric surgeons add modifier 0016)		60.600		R 755.00	
1660	Mini-laparotomy and insertion of peritoneal drain for perforated necrotising enterocolitis in Neonatal Intensive Care Unit (NICU) (paediatric surgeons add modifier 0016)		20.500		R 255.40	
1661	Colotomy: Including removal of tumour or foreign body	20	205.700		R 2 563.60	
1663	Total colectomy	20	390.000		R 4 860.10	
1665	Colostomy or ileostomy isolated procedure	20	233.800		R 2 913.50	
1666	Continent ileostomy pouch (all types)	20	300.000		R 3 738.60	
1667	Colostomy: Closure	20	179.100		R 2 231.90	
1668	Revision of ileostomy pouch	20	375.000		R 4 673.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1669	Total proctocolectomy and ileostomy	20	480.000		R 5 981.70	
1670	Proctocolectomy, ileostomy and ileostomy pouch	20	540.000		R 6 729.50	
1671	Colomyotomy (Reilly operation)	20	185.000		R 2 305.60	
8.9	Appendix					
1673	Drainage of appendix abscess	20	150.000		R 1 869.40	
1675	Appendicectomy	20	160.000		R 1 994.00	
8.10	Rectum and anus					
1676	Flexible sigmoidoscopy (including rectum and anus): Hospital equipment	20	48.750		R 789.90	
1677	Sigmoidoscopy: First and subsequent, with or without biopsy	20	13.000		R 210.30	
1678	Plus polypectomy: Add to sigmoidoscopy (Item 1676)	20	25.000		R 405.00	
1679	Sigmoidoscopy with removal of polyps, first and subsequent	20	30.000		R 485.90	
1681	Proctoscopy with removal of polyps: First time	20	21.000		R 340.30	
1683	Proctoscopy with removal of polyps: Subsequent times	20	15.000		R 243.10	
1685	Endoscopic fulguration of tumour	20	50.000		R 810.20	
1687	Anterior resection of rectum performed for carcinoma of rectum including excision of any part of proximal colon necessary	20	381.300		R 4 751.90	
1688	Total mesorectal excision with colo-anal anastomosis and defunctioning enterostomy or colostomy	20	445.000		R 5 545.70	
1689	Perineal resection of rectum	20	141.000		R 1 757.10	
	Please note: Items 1691 and 1692 – abdominal and/or perineal assistant's fee to be charged additionally					
1691	Abdomino-perineal resection of rectum: Abdominal surgeon	20	409.300		R 5 100.90	
1692	Abdomino-perineal resection of rectum: Perineal surgeon	20	158.500		R 1 975.30	
1693	Abdomino-perineal resection of rectum: Local excision of rectal tumour (posterior approach)	20	200.000		R 2 492.40	
1695	Abdomino-perineal resection of rectum: Combined abdomino-anal pull-through procedure for Hirschsprung's disease, rectal agenesis or tumour	20	400.000		R 4 984.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1697	Repair of prolapsed rectum: Abdominal – Roscoe Graham Moskovitz	20	300.000		R 3 738.60	
1699	Repair of prolapsed rectum: Abdominal – Ivalon sponge	20	200.000		R 2 492.40	
1701	Repair of prolapsed rectum: Abdominal – Perineal	20	150.000		R 1 869.40	
1703	Repair of prolapsed rectum: Abdominal – Thierisch suture	20	35.000		R 436.20	
1705	Incision and drainage of peri-anal abscess	20	40.000		R 498.40	
1707	Drainage of submucous abscess	20	40.000		R 498.40	
1709	Drainage of ischio-rectal abscess	20	87.000		R 1 084.20	
1711	Excision of pelvi-rectal fistula	20	200.000		R 2 492.40	
1713	Excision of fistula-in-ano	20	105.000		R 1 308.50	
1715	Operation for fissure-in-ano	20	66.800		R 832.40	
1716	Rectal Tumour: Destruction (any method) – transanal approach		167.900		R 2 091.70	
1717	Rectal tumour: Excision, transanal approach, EXCLUDING muscularis propria (partial thickness)		96.400		R 1 201.00	
1718	Rectal tumour: Excision, transanal approach, INCLUDING muscularis propria (full thickness)		143.600		R 1 788.90	
1719	Rubber band ligation of haemorrhoids: Per haemorrhoid	20	10.000		R 124.40	
1721	Sclerosing injection for haemorrhoids: Per injection	20	5.000		R 62.30	
1723	Haemorrhoidectomy	20	120.000		R 1 495.30	
1725	Drainage of external thrombosed pile	20	12.500		R 155.80	
1727	Multiple procedures (haemorrhoids, fissure, etc.)	20	90.000		R 1 121.60	
1728	Biopsy of ano-rectal wall, for congenital megacolon	20	60.600		R 755.30	
1729	Excision of anal skin tags	20	25.000		R 311.50	
1731	Operation for low imperforate anus	20	105.000		R 1 308.50	
1733	Anoplasty: Y-V-plasty	20	41.000		R 511.00	
1734	Radio frequency energy delivery or implantation of biopolymers to the anal canal muscle for the treatment of faecal incontinency (endoscopy inclusive)	20	90.000		R 1 121.60	

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1735	Anal sphincteroplasty for incontinence	20	120.000		R 1 495.30	
1737	Dilation of ano-rectal stricture	20	12.500		R 155.80	
1739	Closure of recto-vesical fistula	20	241.000		R 3 003.40	
1741	Closure of recto-urethral fistula	20	241.000		R 3 003.40	
1742	Bio-feedback training for faecal incontinence during anorectal manometry performed by doctor	20	27.000		R 437.60	
8.11	Liver					
1743	Needle biopsy of liver	20	30.300		R 490.90	
1745	Biopsy of liver by laparotomy	20	125.000		R 1 557.90	
1747	Drainage of liver abscess or cyst	20	179.100		R 2 231.90	
1748	Body composition measured by bio-electrical impedance	20	3.000		R 48.60	
1749	Hemi-hepatectomy: Right	20	564.000		R 7 028.60	
1751	Hemi-hepatectomy: Left	20	521.100		R 6 493.90	
1752	Extended right or left hepatectomy	20	570.900		R 7 114.60	
1753	Partial or segmental hepatectomy	20	378.000		R 4 710.70	
1754	Hepatico-jejunostomy	20	369.200		R 4 600.90	
1755	Liver transplant	20	1400.800		R 17 457.00	
1756	Harvesting donor hepatectomy	20	616.200		R 7 679.20	
1757	Suture of liver wound or injury	20	214.200		R 2 669.50	
8.12	Biliary tract					
1759	Cholecystostomy	20	171.600		R 2 138.50	
1761	Cholecystectomy	20	225.000		R 2 804.00	
1762	Cholecystectomy and operative cholangiogram	20	255.000		R 3 177.80	
1763	With exploration of common bile duct	20	264.500		R 3 296.30	
1765	Exploration of common bile duct: Secondary operation	20	327.700		R 4 083.90	

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1767	Reconstruction of common bile duct	20	371.700		R 4 632.20	
1768	Resection bile duct tumour with reconstruction	20	327.700		R 4 083.90	
1769	Cholecysto-enterostomy or gastrostomy	20	236.300		R 2 944.80	
1772	Endoscopic placement of a nasobiliary drainage tube: Add to ERCP (Item 1778)	20	25.600		R 319.10	
1773	Transduodenal sphincteroplasty	20	225.000		R 2 804.00	
1774	Balloon dilatation of common bile duct strictures	20	125.000		R 1 557.90	
1775	Excision choledochal cyst with reconstruction	20	327.700		R 4 083.90	
1777	Porto-enterostomy for biliary atresia	20	400.000		R 4 984.80	
8.13	Pancreas					
1778	Endoscopic Retrograde Cholangiopancreatography (ERCP): Endoscopy + catheterisation of pancreas duct or choledochus	20	105.900		R 1 715.80	
1779	Endoscopic retrograde removal of stone(s) as for biliary and/or pancreatic duct: Add to ERCP (Item 1778)	20	15.820		R 256.30	
1780	Gastric and duodenal intubation	20	8.000		R 129.60	
1781	Procedure (excluding laboratory tests)	20	21.000		R 340.30	
1782	Endoscopic Sphincterotomy: Add to ERCP (Item 1778)	20	30.000		R 485.90	
1783	Drainage of pancreatic abscess	20	239.300		R 2 982.10	
1784	Debridement pancreatic necrosis	20	348.400		R 4 341.60	
1785	Internal drainage of pancreatic cyst	20	250.600		R 3 122.90	
1770	Endoscopic placement of biliduodenal endoprosthesis: Add to ERCP (Item 1778)	20	30.000		R 485.90	
1786	Internal drainage of pancreatic cyst with Roux-Y	20	306.800		R 3 823.40	
1787	Operative pancreatogram: Add	20	10.000		R 124.40	
1788	Biopsy of pancreas	20	177.700		R 2 214.60	
1789	Pancreatico-duodenectomy	20	704.800		R 8 783.10	
1791	Local, partial or subtotal pancreatectomy	20	351.300		R 4 377.90	

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1793	Distal pancreatectomy with internal drainage	20	377.400		R 4 703.20	
8.14	Peritoneal cavity					
1797	Pneumo-peritoneum: First	20	13.000		R 161.80	
1799	Pneumo-peritoneum: Repeat	20	6.000		R 74.90	
1800	Peritoneal lavage	20	20.000		R 249.30	
1801	Diagnostic paracentesis: Abdomen	20	8.000		R 99.60	
1803	Therapeutic paracentesis: Abdomen	20	13.000		R 161.80	
1807	ADD to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027)	20	45.000		R 560.90	
1808	Omentectomy (separate procedures)		189.200		R 2 357.00	
1809	Laparotomy	20	196.000		R 2 442.50	
1810	Radical removal of retro-peritoneal malignant tumours (including sacro-coccygeal and pre-sacral)	20	350.000		R 4 361.80	
1811	Suture of burst abdomen	20	188.300		R 2 346.80	
1812	Laparotomy for control of surgical haemorrhage	20	105.000		R 1 308.50	
1813	Drainage of sub-phrenic abscess	20	180.000		R 2 243.10	
1815	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transabdominal	20	248.400		R 3 095.50	
1817	Drainage of other intraperitoneal abscess (excluding appendix abscess): Transrectal drainage of pelvic abscess	20	75.000		R 934.70	
9	**Herniae**					
1819	Inguinal or femoral hernia: Adult	20	125.000		R 1 557.90	
1821	Inguinal or femoral hernia: Child under 14 years	20	90.000		R 1 121.60	
1823	Inguinal hernia: Infant under one year	20	100.000		R 1 246.20	
1825	Recurrent inguinal or femoral hernia	20	155.000		R 1 931.80	
1827	Strangulated hernia or femoral hernia	20	238.000		R 2 966.00	
1829	Epigastric hernia	20	93.300		R 1 162.70	
1831	Umbilical hernia: Adult	20	140.000		R 1 744.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1833	Umbilical hernia: Child under 14 years	20	60.000		R 747.80	
1835	Incisional hernia	20	166.800		R 2 078.80	
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (list separately in addition to item for the incisional or ventral hernia repair)	20	77.000		R 959.70	
1837	Repair of omphalocele in new-born (one or more procedures)	20	275.000		R 3 427.10	
10	**Urinary system**					
	RULES GOVERNING THE SECTION URINARY SYSTEM					
FF.	a. When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transurethral (TUR) prostatectomy. b. When a cystoscopy precedes an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair. c. No modifier applies to Item 1949: Cystoscopy, when performed together with any of Items 1951 to 1973.					
10.1	Kidney					
1839	Renal biopsy: Per kidney, open	20	71.000		R 1 150.20	
1841	Renal biopsy: Needle	20	30.000		R 485.90	
1843	Peritoneal dialysis: First day	20	33.000		R 534.70	
1845	Peritoneal dialysis: Every subsequent day	20	33.000		R 534.70	
1847	Haemodialysis: Per hour or part thereof	20	21.000		R 340.30	
1849	Haemodialysis: Maximum, eight hours	20	168.000		R 2 721.80	
1851	Haemodialysis: Thereafter per week	20	55.000		R 891.00	
1852	Continuous haemodiafiltration per day in intensive or high care unit	20	33.000		R 534.70	
1853	Nephrectomy: Primary nephrectomy	20	225.000		R 2 804.00	
1855	Nephrectomy: Secondary nephrectomy	20	267.000		R 3 327.50	
1857	Radical with regional lymph adenectomy for tumour	20	280.000		R 3 489.60	
1859	Nephrectomy: Partial	20	267.000		R 3 327.50	
1861	Symphysiotomy for horse-shoe kidney	20	287.000		R 3 576.50	

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1863	Nephro-ureterectomy	20	305.000		R 3 800.90	
1865	Nephrotomy with drainage nephrostomy	20	189.000		R 3 062.00	
1868	Nephrolithotomy, for congenital kidney abnormality, complicated	20	268.400		R 3 344.80	
1869	Nephrolithotomy	20	227.000		R 2 828.90	
1870	Nephrolithotomy: Multiple calculi: Repeat open operation + 25%	20	284.000		R 3 539.10	
1871	Staghorn stone: Surgical	20	341.000		R 4 249.60	
1873	Suture renal laceration (renorraphy)	20	193.000		R 2 405.20	
1875	Percutaneous aspiration cyst: Nephrostomy, pyelostomy	20	34.000		R 550.80	
1877	Operation for renal cyst: Marsupialisation or excision	20	189.000		R 2 355.40	
1878	Ablation of 1 or more renal tumour(s): Cryotherapy, percutaneous, unilateral	20	106.000		R 1 717.30	
1879	Closure renal fistula	20	189.000		R 3 062.00	
1881	Pyeloplasty	20	252.000		R 3 140.30	
1882	Pyeloplasty, complicated; with or without plastic procedure on ureter; nephropexy; nephrostomy; pyelostomy; ureteral splinting. (Secondary procedure for congenital kidney abnormality or solitary kidney)	20	327.700		R 4 083.70	
1883	Pyelostomy	20	189.000		R 2 355.40	
1885	Pyelolithotomy	20	189.000		R 2 355.40	
1887	Complicated pyelo-lithotomy (e.g. solitary, ectopic, horse-shoe kidney or secondary operation)	20	223.000		R 2 779.00	
1889	Nephrectomy for Allograft: Living or dead	20	255.000		R 3 177.80	
1891	Perinephric abscess or renal abscess: Drainage	20	200.000		R 2 492.40	
1893	Aberrant renal vessels: Repositioning with pyeloplasty	20	210.000		R 2 617.10	
1894	Auto transplantation of kidney	20	420.000		R 5 234.00	
1895	Allo transplantation of kidney	20	420.000		R 5 234.00	
10.2	Ureter					
1897	Ureterorraphy: Suture of ureter	20	147.000		R 1 831.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1898	Ureterorraphy: Lumbar approach	20	189.000		R 2 355.40	
1899	Ureteroplasty	20	181.000		R 2 255.50	
1901	Ureterolysis	20	118.000		R 1 470.50	
1902	Ureterolysis: Lumbar approach	20	189.000		R 2 355.40	
1903	Ureterectomy only	20	137.000		R 1 707.40	
1905	Ureterolithotomy	20	265.800		R 3 312.30	
1907	Cutaneous ureterostomy: Unilateral	20	108.000		R 1 345.80	
1909	Cutaneous ureterostomy: Bilateral	20	189.000		R 2 355.40	
1911	Uretero-enterostomy: Unilateral	20	137.000		R 1 707.40	
1913	Uretero-enterostomy: Bilateral	20	240.000		R 2 990.90	
1915	Uretero-ureterostomy	20	137.000		R 1 707.40	
1917	Transuretero-ureterostomy	20	155.000		R 1 931.80	
1919	Closure of ureteric fistula	20	147.000		R 1 831.90	
1921	Immediate deligation of ureter	20	147.000		R 1 831.90	
1923	Ureterolysis for retrocaval ureter with anastomosis	20	168.000		R 2 093.70	
1924	Ureterocalicostomy	20	20.000		R 3 301.00	
1925	Uretero-pyelostomy	20	252.000		R 3 140.30	
1927	Uretero-neo-cystostomy: Unilateral	20	316.100		R 3 939.30	
1929	Uretero-neo-cystostomy: Bilateral	20	474.150		R 5 909.00	
1931	Uretero-neo-cystostomy with Boariplasty	20	351.800		R 4 384.10	
1933	Uretero-sigmoidostomy with rectal bladder and colostomy	20	252.000		R 3 140.30	
1935	Uretero-ileal conduit	20	388.000		R 4 835.40	
1937	Replacement of ureter by bowel segment: Unilateral	20	277.000		R 3 452.10	
1939	Replacement of ureter by bowel segment: Bilateral	20	485.000		R 6 044.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1941	Ureterostomy-in-situ: Unilateral	20	100.000		R 1 246.20	
1943	Ureterostomy-in-situ: Bilateral	20	175.000		R 2 181.00	
10.3	Bladder					
1952	J J Stent catheter	20	44.000		R 548.50	
1953	With hydrodilatation of the bladder for interstitial cystitis	20	5.000		R 62.30	
1954	Uretroscopy	20	35.000		R 436.20	
1955	And bilateral ureteric catheterisation with differential function studies requiring additional attention time	20	35.000		R 436.20	
1957	With dilatation of the ureter or ureters	20	25.000		R 311.50	
1959	With manipulation of ureteral calculus	20	20.000		R 249.30	
1961	With removal of foreign body or calculus from urethra or bladder	20	20.000		R 249.30	
1963	With fulguration or treatment of minor lesions, with or without biopsy	20	15.000		R 187.00	
1964	And control of haemorrhage and blood clot evacuation	20	15.000		R 187.00	
1965	And catheterisation of the ejaculatory duct	20	10.000		R 124.40	
1967	With ureteric meatotomy: Unilateral or bilateral	20	15.000		R 187.00	
1969	And cold biopsy	20	15.000		R 187.00	
1971	With cryosurgery for bladder or prostatic disease	20	55.000		R 685.40	
1973	With incision fulguration, or resection of bladder neck and/or posterior urethra for congenital valves or obstructive hypertrophic bladder neck in a child	20	35.000		R 436.20	
1975	Ultraviolet cystoscopy for bladder tumour	20	60.000		R 747.80	
1976	Optic urethrotomy	20	80.000		R 997.10	
1977	Transurethral resection of ejaculatory duct	20	60.700		R 756.30	
1979	Internal urethrotomy: Female	20	50.000		R 623.20	
1981	Internal urethrotomy: Male	20	76.200		R 949.70	
1983	Transurethral resection of bladder tumour	20	100.000		R 1 246.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
1984	Transurethral resection of bladder tumours: Large multiple tumours	20	115.000		R 1 433.10	
1985	Transurethral resection of bladder neck: Female or child	20	105.000		R 1 308.50	
1986	Transurethral resection of bladder neck: Male	20	125.000		R 1 557.90	
1987	Litholapaxy	20	80.000		R 997.10	
1989	Cystometrogram	20	25.000		R 311.50	
1991	Flometric bladder, studies with videocystograph	20	40.000		R 498.40	
1992	Without videocystograph	20	25.000		R 311.50	
1993	Voiding cysto-urethrogram	20	21.000		R 261.80	
1994	Rigiscan examination	20	66.000		R 822.40	
1995	Percutaneous aspiration of bladder	20	10.000		R 124.40	
1996	Bladder catheterisation: Male (not at operation)	20	6.000		R 74.90	
1997	Bladder catheterisation: Female (not at operation)	20	3.000		R 37.40	
1999	Percutaneous cystostomy	20	24.000		R 299.30	
1945	Instillation of radio-opaque material for cystography or urethrocystography	20	5.000		R 62.30	
1947	Instillation of anti-carcinogenic agent including retention time, but not cost of material or hydro-dilatation of bladder	20	10.000		R 124.40	
1949	Cystoscopy: Hospital equipment	20	44.000		R 548.50	
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	20	10.000		R 124.40	
2001	Total cystectomy: After previous urinary diversion	20	294.000		R 3 664.00	
2003	Total cystectomy: With conduit construction and ureteric anastomosis	20	554.700		R 6 912.70	
2005	Cystectomy with substitute bowel bladder construction with anastomosis to urethra or trigone	20	650.000		R 8 100.40	
2006	Cystectomy with continent urinary diversion (e.g. Kocks Pouch)	20	700.000		R 8 723.40	
2007	Partial cystectomy	20	147.000		R 1 831.90	
2008	Continent urinary diversion without cystectomy (e.g. Kocks Pouch)	20	600.000		R 7 477.30	
2009	Radical total cystectomy with block dissection, ileal conduit and transplantation of ureters	20	462.000		R 5 757.50	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2010	Reversion of temporary conduit	20	360.000		R 4 486.40	
2011	Partial cystectomy with uretero-neo-cystostomy	20	202.000		R 2 517.30	
2012	Reversion of conduit with major urinary tract reconstruction	20	600.000		R 7 477.30	
2013	Diverticulectomy (independent procedure): Multiple or single	20	137.000		R 1 707.40	
2014	Closure of cystostomy (stand alone procedure)	20	120.000		R 1 495.40	
2015	Suprapubic cystostomy	20	67.000		R 835.00	
2016	Abdomino-neo-urethrostomy	20	252.000		R 3 140.30	
2017	Open loop fulguration or excision of bladder tumour	20	101.000		R 1 258.60	
2019	Operation for vesico-vaginal or urethra-vaginal fistula	20	155.000		R 1 931.80	
2020	Repair of vesico vaginal fistula: Abdominal approach	20	255.000		R 3 177.80	
2021	Vesico-plication (Hamilton Stewart)	20	118.000		R 1 470.50	
2023	Vesico-urethropexy for correction or urinary incontinence: Abdominal approach	20	195.000		R 2 430.10	
2025	Vesico-urethropexy with rectus sling	20	229.400		R 2 858.90	
2027	Open operation for ureterocele: Unilateral	20	118.000		R 1 470.50	
2029	Open operation for ureterocele: Bilateral	20	207.000		R 2 579.90	
2031	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Initial	20	264.000		R 3 290.10	
2033	Reconstruction of ectopic bladder exclusive of orthopaedic operation (if required): Subsequent	20	53.000		R 660.60	
2035	Cutaneous vesicostomy	20	118.000		R 1 470.50	
2037	Cystoplasty, cysto-urethraplasty, vesicolysis	20	126.000		R 1 570.30	
2039	Operation for ruptured bladder	20	137.000		R 1 707.40	
2042	Enterocystoplasty plus bowel anastomosis	20	419.900		R 5 232.90	
2043	Cysto-lithotomy	20	132.000		R 1 645.00	
2045	Excision of patent-urachus or urachal cyst	20	112.000		R 1 395.80	
2047	Drainage of perivesical or prevesical abscess	20	105.000		R 1 308.50	

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2049	Evacuation of clots from bladder: Other than post-operative	20	132.100		R 2 140.00	
2050	Evacuation of clots from bladder: Post-operative					
2051	Simple bladder lavage: Including catheterisation	20	12.000		R 194.40	
2053	Bladder neck plasty: Male	20	137.000		R 1 707.40	
2057	Bladder neck plasty: Female	20	137.000		R 1 707.40	
10.4	Urethra					
2059	Open biopsy of urethra: Male	20	45.000		R 560.90	
2061	Open biopsy of urethra: Female	20	45.000		R 560.90	
2063	Dilatation of urethra stricture: By passage sound, initial (male)	20	20.000		R 249.30	
2065	Dilatation of urethra stricture: By passage sound, subsequent (male)	20	10.000		R 124.40	
2067	Dilatation of urethra stricture: By passage sound, by passage of filiform and follower (male)	20	20.000		R 249.30	
2069	Dilatation of female urethra	20	5.000		R 62.30	
2071	Urethrorraphy: Suture of urethral wound or injury	20	139.000		R 1 732.20	
2073	External urethrotomy: Pendulous urethra (anterior)	20	67.000		R 835.00	
2075	Urethraplasty: Pendulous urethra, first stage	20	71.000		R 884.70	
2077	Urethraplasty: Pendulous urethra, second stage	20	145.000		R 1 807.10	
2079	Reconstruction of female urethra	20	147.000		R 1 831.90	
2081	Reconstruction or repair of male anterior urethra (one stage)	20	261.600		R 3 260.10	
2083	Reconstruction or repair of prostatic or membranous urethra: First stage	20	168.000		R 2 093.70	
2085	Reconstruction or repair of prostatic or membranous urethra: Second stage	20	168.000		R 2 093.70	
2086	Reconstruction or repair of prostatic or membranous urethra: If done in one stage	20	294.000		R 3 664.00	
2087	Urethral diverticulectomy: Male or female	20	147.000		R 1 831.90	
2088	Peri-urethral teflon injection: Male or female – fee as for cystoscopy (Item 1949) plus 42,00 clinical procedure units	20	86.000		R 1 071.60	
2089	Marsupialisation of urethral diverticula: Male or female	20	115.100		R 1 434.40	

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2091	Total urethrectomy: Female	20	147.000		R 1 831.90	
2093	Total urethrectomy: Male	20	189.000		R 2 355.40	
2095	Drainage of simple localised perineal urinary extravasation	20	128.800		R 1 605.10	
2097	Drainage of extensive perineal and/or abdominal urinary extravasation	20	137.000		R 1 707.40	
2099	Fulguration for urethral caruncle or polyp	20	53.600		R 668.00	
2101	Excision of urethral caruncle	20	53.600		R 668.00	
2103	Simple urethral meatotomy	20	26.300		R 327.80	
2105	Incision of deep peri-urethral abscess: Female	20	123.100		R 1 534.20	
2107	Incision of deep peri-urethral abscess: Male	20	123.100		R 1 534.20	
2108	Sling operation for male urinary incontinence (fascia or synthetic)	20	169.000		R 2 105.70	
2109	Badenoch pull-through for intractable stricture or incontinence	20	181.000		R 2 255.50	
2110	Removal/revision: Sling for male urinary incontinence (fascia or synthetic)	20	120.000		R 1 495.40	
2111	External sphincterotomy	20	108.000		R 1 345.80	
2112	Insertion of inflatable sphincter, includes pump, reservoir and cuff	20	217.600		R 2 711.70	
2113	Drainage of Skene gland abscess or cyst	20	42.300		R 527.20	
2114	Repair: Inflatable sphincter, includes pump, reservoir and cuff	20	142.500		R 1 775.70	
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	20	168.000		R 2 093.70	
2116	Urethral meatoplasty	20	101.500		R 1 264.80	
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure)	20	150.300		R 1 873.00	
2118	Removal: Inflatable sphincter, includes pump, reservoir and cuff	20	154.400		R 1 924.20	
2119	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff	20	123.500		R 1 539.30	
2120	Removal and replacement: Inflatable sphincter, includes pump, reservoir and cuff, plus debridment of infected tissue	20	278.200		R 3 466.50	
2121	Closure of urethrovaginal fistula: Including diversionary procedures	20	189.000		R 2 355.40	

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11	**Male genital system**					
11.1	Penis					
2123	Biopsy of penis (independent procedure)	20	52.100		R 649.10	
2125	Destruction of condylomata/chemo- or cryotherapy: Limited number (see Item 2317)	20	16.600		R 206.90	
2127	Destruction of condylomata/chemo-or cryotherapy: Multiple extensive	20	41.600		R 518.40	
2129	Electrodesiccation: Limited number	20	20.800		R 259.40	
2131	Electrodesiccation: Multiple extensive	20	41.600		R 518.40	
2132	Ligation of abnormal venous drainage	20	106.100		R 1 322.20	
2133	Circumcision: Clamp procedure	20	42.300		R 527.20	
2137	Circumcision: Surgical excision other than by clamp or dorsal slit, any age	20	60.000		R 747.80	
2139	Circumcision: Dorsal slit of prepuce (independent procedure)	20	36.800		R 458.50	
2141	Reconstructive operation of penis: Reconstructive operation for insertion of prostheses	20	101.000		R 1 258.60	
2143	Reconstructive operation of penis: For straightening of chordee e.g. hypospadias with or without mobilisation of urethra	20	188.600		R 2 350.30	
2145	Reconstructive operation of penis: For straightening of chordee with transplantation of prepuce	20	224.600		R 2 799.00	
2147	Reconstructive operation of penis: For injury, including fracture of penis and skin graft (if required)	20	168.000		R 2 093.70	
2149	Reconstructive operation of penis: For epispadias distal to the external sphincter	20	168.000		R 2 093.70	
2153	Reconstructive operation for epispadias with incontinence	20	168.000		R 2 093.70	
2154	Induction of artificial erection	20	16.000		R 199.40	
2155	Hypospadias: Urethral reconstruction	20	187.000		R 2 330.60	
2157	Hypospadias: Subsequent procedures for repair of urethra, total	20	84.000		R 1 046.60	
2159	Hypospadias: Urethraplasty – complete, one stage for hypospadias	20	300.000		R 3 738.60	
2161	Total amputation of penis without gland dissection	20	210.000		R 2 617.10	
2163	Total amputation of penis with gland-dissection	20	336.000		R 4 187.30	
2165	Partial amputation of penis with gland-dissection	20	210.000		R 2 617.10	

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2167	Partial amputation of penis without gland-dissection	20	84.000		R 1 046.60	
2169	Injection procedure for Peyronie's disease	20	14.000		R 174.40	
2171	Priapism operation: Irrigation of corpora cavernosa for priapism	20	42.000		R 523.40	
2173	Priapism operation: Shunt procedure, any type	20	252.000		R 3 140.30	
2174	Priapism operation: Stab shunt	20	114.400		R 1 425.80	
11.2	Testis and epididymis					
0078	When a testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure					
2175	Testis biopsy: Needle (independent procedure)	20	18.500		R 230.60	
2177	Testis biopsy: Incisional – independent procedure, unilateral	20	58.900		R 734.10	
2179	Testis biopsy: Incisional – independent procedure, bilateral	20	58.900		R 734.10	
2181	Epididymis biopsy: Needle	20	86.100		R 1 073.10	
2183	Puncture aspiration hydrocele with or without injection of medication	20	10.000		R 124.40	
2185	Operation for maldescended testicle: Including herniotomy	20	135.000		R 1 682.40	
2187	Operation for torsion appendix testis	20	119.200		R 1 485.60	
2189	Operation for torsion testis with fixation of contralateral testis	20	119.200		R 1 485.60	
2191	Orchidectomy (total or subcapsular): Unilateral	20	98.000		R 1 221.40	
2193	Orchidectomy (total or subcapsular): Bilateral	20	147.000		R 1 831.90	
2195	Radical operation for malignant testis: Excluding gland dissection	20	155.300		R 1 935.30	
2197	Operation for hydrocele or spermatocele	20	99.800		R 1 243.50	
2199	Varicocelectomy	20	106.100		R 1 322.20	
2201	Abdominal ligation of spermatic vein for varicocele	20	112.800		R 1 405.80	
2203	Epididymectomy: Unilateral	20	114.400		R 1 425.80	
2205	Epididymectomy: Bilateral	20	158.200		R 1 971.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2207	Vasectomy: Unilateral or bilateral (no extra fee to be charged if done in combination with prostatectomy)	20	55.900		R 696.60	
2209	Vasotomy: Unilateral or bilateral	20	70.400		R 877.40	
2210	Vasogram, seminal vesiculogram: Unilateral	20	58.100		R 724.10	
2211	Vasogram, seminal vesiculogram: Bilateral	20	58.100		R 724.10	
2212	Insertion of testicular prosthesis: Independent procedure (exclusive of cost of material)	20	91.200		R 1 136.30	
2213	Suture or repair of testicular injury	20	110.300		R 1 374.60	
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma	20	90.000		R 1 121.60	
2217	Excision of local lesion of testis or epididymis	20	90.800		R 1 131.50	
2219	Vaso-vasostomy: Unilateral	20	67.000		R 835.00	
2221	Vaso-vasostomy: Bilateral	20	117.000		R 1 458.10	
2223	Epididymo-vasostomy: Unilateral	20	67.000		R 835.00	
2225	Epididymo-vasostomy: Bilateral	20	117.000		R 1 458.10	
2227	Incision and drainage of scrotal wall abscess	20	42.700		R 532.10	
2229	Excision of Mullerian duct cyst	20	189.000		R 2 355.40	
2231	Excision of lesion of spermatic cord	20	84.000		R 1 046.60	
2233	Seminal Vesiculectomy	20	220.000		R 2 741.70	
11.3	Prostate					
2235	Biopsy prostate: Needle or punch, single or multiple, any approach	20	23.300		R 290.40	
2237	Biopsy prostate: Incisional, any approach	20	105.000		R 1 308.50	
2239	Transurethral drainage of prostatic abscess	20	117.400		R 1 463.20	
2241	Perineal drainage of prostatic abscess	20	77.000		R 959.70	
2243	Trans-urethral cryo-surgical removal of prostate	20	126.000		R 1 570.30	
2245	Trans-urethral resection of prostate	20	252.000		R 3 140.30	
2247	Trans-urethral resection of residual prostatic tissue 90 days post-operative or longer	20	126.000		R 1 570.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2249	Trans-urethral resection of post-operative bladder neck contracture	20	126.000		R 1 570.30	
2250	Laparoscopic prostatectomy: Retropubic, radical, including nerve sparing		501.800		R 6 251.40	
2251	Prostatectomy: Perineal, sub-total	20	252.000		R 3 140.30	
2253	Prostatectomy: Perineal, radical	20	336.000		R 4 187.30	
2254	Pelvic lymph adenectomy	20	175.000		R 2 181.00	
2255	Supra-pelvic, transversical	20	252.000		R 3 140.30	
2257	Retropubic: Sub-total	20	252.000		R 3 140.30	
2259	Retropubic: Radical	20	336.000		R 4 187.30	
2260	Prostate brachytherapy	20	230.000		R 2 866.30	
12	**Female genital system**					
12.1	Vulva and introitus					
2271	Removal of tag or polyp	20	6.000		R 74.90	
2272	Removal of small superficial benign lesions	20	23.000		R 286.70	
2273	Biopsy with suture in theatre (excluding after-care)	20	27.000		R 336.60	
2274	Laser therapy of vulva and/or vagina (colposcopically directed)	20	71.000		R 884.70	
2275	Reduction labial hypertrophy	20	67.000		R 835.00	
2277	Removal of extensive benign vulva tumour	20	67.000		R 835.00	
2279	Secondary perineal repair: Repair second degree tear	20	45.000		R 560.90	
2280	Secondary perineal repair: Repair third degree tear	20	96.000		R 1 196.30	
2281	Excision of inclusion cyst	20	43.000		R 536.00	
2283	Hymenectomy	20	43.000		R 536.00	
2285	Drainage haematocolpos	20	54.000		R 672.80	
2287	Clitoris repair for injury: Including skin graft, if required	20	67.000		R 835.00	
2288	Clitoral reduction	20	160.000		R 1 994.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2289	Denervation or alcohol infiltration vulva (Woodruff)	20	54.000		R 672.80	
2291	Vulva: Undercutting skin (ball)	20	58.000		R 722.80	
2293	Vulva and introitus: Drainage of abscess	20	27.000		R 336.60	
2295	Bartholin gland: Bartholin abscess marsupialisation	20	36.000		R 448.60	
2297	Bartholin gland: Bartholin gland excision	20	45.000		R 560.90	
2299	Bartholin gland: Bartholin radical excision for malignant lesion	20	357.000		R 4 449.00	
2301	Operation for enlarging introitus: Fenton plasty	20	50.000		R 623.20	
2303	Operation for enlarging introitus: Bilateral Z-plastic	20	88.000		R 1 096.60	
2305	Vulvectomy: Partial	20	161.000		R 2 006.30	
2307	Vulvectomy	20	225.000		R 2 804.00	
2309	Radical vulvectomy with bilateral lymphdenectomy	20	357.000		R 4 449.00	
2311	Radical vulvectomy with bilateral lymphadenectomy, plus deep lymph gland dissection	20	402.000		R 5 009.70	
12.2	Vaginal procedures and operations					
2312	Artificial insemination	20	13.000		R 161.80	
2313	Examination under anaesthetic when no other procedures are performed (not limited to female patients only) – stand alone procedure	20	25.500		R 317.80	
2314	Intra uterine insemination	20	18.000		R 224.30	
2315	Simms Hühner test plus wet smear	20	5.000		R 62.30	
2316	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: First lesion	20	14.000		R 174.40	
2317	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Repeat – limited	20	7.000		R 87.40	
2318	Destruction of condylomata by chemo-, cryo-, or electrotherapy, or harmonic scalpel: Widespread	20	56.000		R 697.90	
2319	Excision of cysts or tumours	20	54.000		R 672.80	
2321	Drainage of vaginal abscess	20	54.000		R 672.80	
2322	Pudendal nerve block	20	15.000		R 187.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2323	Reconstruction of vagina after atresia	20	107.000		R 1 333.50	
2324	Revision of prosthetic vaginal graft: Vaginal approach (removal included)	20	120.000		R 1 617.70	
2325	Construction of artificial vagina: Labial fusion	20	179.000		R 2 230.60	
2326	Revision of prosthetic vaginal graft: Abdominal approach (removal included)	20	199.100		R 2 481.50	
2327	Construction of artificial vagina: Macindoe type	20	196.000		R 2 442.50	
2329	Construction of vagina: Bowel pull-through operation: Two surgeons, each	20	241.000		R 3 003.40	
2330	Fitting/insertion of pessary or other intravaginal support device	20	11.998		R 149.50	
2331	Vaginal septum removal	20	107.000		R 1 333.50	
2333	Vaginal prolapse: Abdominal approach: Sacrocolpopexy with use of mesh	20	243.300		R 3 032.20	
2334	Vaginal prolapse: Abdominal approach: Use of rectus sheath or tape	20	243.300		R 3 032.20	
2335	Vaginal prolapse: Vaginal approach: Sacrospinous fixations	20	166.900		R 2 079.80	
2336	Vaginal prolapse: Vaginal approach: Use of mesh or tape	20	166.900		R 2 079.80	
2339	Colpotomy: Diagnostic (excluding after-care)	20	20.000		R 249.30	
2341	Colpotomy: Therapeutic, with or without sterilisation	20	103.000		R 1 283.50	
2343	Vaginal hysterectomy: Without repair	20	210.500		R 2 623.40	
2345	Vaginal hysterectomy: With repair	20	231.700		R 2 887.50	
2355	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy		110.300		R 1 374.80	
2357	Vaginal hysterectomy and repair with unilateral or bilateral salpingo-oophorectomy	20	320.000		R 3 987.90	
2359	Colporrhaphy: Anteroposterior, with enterocele repair	20	163.900		R 2 042.80	
2361	Vaginal hysterectomy and repair for total prolapse	20	320.000		R 3 987.90	
2363	Fothergill or Manchester repair operation	20	196.000		R 2 442.50	
2365	Repair of recurrent enterocele or vault prolapse (except at the time of hysterectomy)	20	232.000		R 2 891.10	
2366	Posterior repair alone	20	107.000		R 1 333.50	
2367	Other operations for prolapse: Anterior repair – with or without posterior repair	20	161.000		R 2 006.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2368	Uterovesical fistula	20	210.000		R 2 617.10	
2369	Repair of Vesico- or urethro-vaginal fistula	20	179.000		R 2 230.60	
2370	Repair of VVF – obstetric or radiation	20	232.000		R 2 891.10	
2371	Closure of uretero-vaginal fistula	20	250.000		R 3 115.60	
2372	Closure of uretero-vaginal fistula: Obstetric or radiation	20	250.000		R 3 115.60	
2373	Closure of recto-vaginal fistula	20	134.000		R 1 669.90	
2374	Closure of recto-vaginal fistula: Obstetric or radiation	20	151.000		R 1 881.70	
2375	Colpocleisis	20	129.000		R 1 607.70	
2377	Le Fort operation	20	129.000		R 1 607.70	
2379	Schauta operation	20	357.000		R 4 449.00	
2381	Vaginectomy	20	268.000		R 3 339.90	
2383	Synchronous combined hysterocolpectomy: One or two surgeons – total fee	20	429.000		R 5 346.30	
2385	Vaginal laceration or trauma: Repair	20	50.000		R 623.20	
2386	Repair: Paravaginal defect repair (including repair of cystocele, if performed), abdominal approach	20	172.800		R 2 153.60	
2387	Repair: Paravaginal defect repair (including repair of cystocele, if performed), vaginal approach	20	140.100		R 1 745.70	
12.3	Cervix					
2389	Paracervical (pelvis) nerve block (for neck refer to Item 3294)	20	20.000		R 249.30	
2391	Cervix: Canal reconstruction	20	147.000		R 1 831.90	
2392	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): In consulting room	20	14.000		R 174.40	
2395	Cryo- or electro-cauterisation, or Lletz of cervix (excluding cost of disposable loop electrode): Under anaesthetic	20	22.000		R 274.20	
2396	Laser or harmonic scalpel treatment of the cervix	20	80.000		R 997.10	
2397	Dilation of cervix for stenosis and insertion of prosthesis and Budge suture	20	31.000		R 386.30	
2399	Punch biopsy (excluding after-care)	20	9.000		R 112.20	
2400	Biopsy during pregnancy (excluding after-care)	20	13.000		R 161.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2403	Wedge biopsy: Cervix (excluding after-care)	20	18.000		R 224.30	
2404	Biopsy: Wedge during pregnancy: Cervix (excluding after-care)	20	24.000		R 299.30	
2405	Cone biopsy: Cervix (excluding after-care)	20	54.000		R 672.80	
2407	Amputation: Cervix	20	67.000		R 835.00	
2409	Cervix encirclage: McDonald stitch	20	35.000		R 436.20	
2411	Cervix encirclage: Shirodkar suture	20	60.000		R 747.80	
2413	Cervix encirclage: Lash	20	49.000		R 610.70	
2415	Cervix encirclage: Removal Items 2409 and 2411, without anaesthetic	20	5.000		R 62.30	
2416	Cervix: Removal Items 2409 and 2411, with anaesthetic in theatre	20	30.000		R 373.80	
2417	Repair of tears: Emmet repair of tears	20	45.000		R 560.90	
2418	Repair of tears: Sturmdorff repair of tears	20	54.000		R 672.80	
2421	Extirpation of cervical stump: Vaginal	20	134.000		R 1 669.90	
2423	Extirpation of cervical stump: Abdominal	20	134.000		R 1 669.90	
2425	Removal of cervical polyps (excluding after-care)	20	13.000		R 161.80	
2427	Removal of cervical myomata	20	54.000		R 672.80	
2429	Colposcopy (excluding after-care)	20	27.000		R 336.60	
12.4	Uterus					
2432	Hysteroscopic bilateral tubal occlusion with permanent implants (includes hysteroscopy)	20	120.000		R 1 495.40	
2433	Embryo transfer	20	45.000		R 560.90	
2434	Endometrial biopsy (excluding after-care)	20	18.000		R 224.30	
2435	Hysterosalpingogram (excluding after-care)	20	22.000		R 274.20	
2436	Hysteroscopy (excluding after-care)	20	40.000		R 498.40	
2437	Hysteroscopy and D&C (excluding after-care)	20	58.000		R 722.80	
2438	Hysteroscopy and removal of uterine septum (excluding after-care)	20	80.000		R 997.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2439	Hysteroscopy and division of endometrial and endocervical bands (excluding after-care)	20	63.000		R 785.10	
2440	Hysteroscopy and polypectomy (excluding after-care)	20	75.000		R 934.70	
2441	Hysteroscopy and myomectomy (excluding after-care)	20	130.000		R 1 620.20	
2442	Insertion of intra uterine contraceptive device (IUCD) – excluding after-care	20	18.000		R 224.30	
2443	Dilatation and curettage (D&C) – excluding after-care	20	35.000		R 436.20	
2444	Fractional dilatation and curettage (D&C) – excluding after-care	20	45.000		R 560.90	
2445	Evacuation of uterus: Incomplete abortion, before 12 weeks gestation	20	50.000		R 623.20	
2447	Evacuation of uterus, incomplete abortion, after 12 weeks gestation	20	71.000		R 884.70	
2448	Termination of pregnancy before 12 weeks	20	50.000		R 623.20	
2449	Evacuation: Missed abortion, before 12 weeks gestation	20	50.000		R 623.20	
2451	Evacuation: Missed abortion, after 12 weeks gestation	20	80.000		R 997.10	
2452	Termination of pregnancy after 12 weeks – administration of intra/extra amniotic prostaglandin	20	54.000		R 672.80	
2453	Evacuation hydatidiform mole	20	80.000		R 997.10	
2455	Evacuation uterus post-partum	20	54.000		R 672.80	
2461	Ventrosuspension	20	80.000		R 997.10	
2463	Uteroplasty: Strassman	20	143.000		R 1 782.10	
2465	Uteroplasty: Tompkins	20	143.000		R 1 782.10	
2467	Myomectomy	20	143.000		R 1 782.10	
2469	Subtotal hysterectomy with or without unilateral or bilateral salpingo-oophorectomy	20	254.100		R 3 166.70	
2471	Total abdominal hysterectomy: With or without unilateral or bilateral salpingo-oophorectomy – uncomplicated	20	252.200		R 3 143.00	
2473	Total abdominal hysterectomy plus vaginal cuff with or without unilateral or bilateral salpingo-oophorectomy	20	355.000		R 4 424.10	
2475	Radical abdominal hysterectomy with bilateral lymphadenectomy (Wertheim)	20	472.800		R 5 892.10	
2477	Abdominal hysterotomy with or without sterilisation	20	188.000		R 2 343.00	
2478	Non-surgical endometrial destruction, any method, not utilising hysteroscopic instrumentation or assistance	20	200.000		R 2 492.40	

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2479	Surgical endometrial destruction: Any method, utilising hysteroscopic instrumentation or assistance	20	225.000		R 2 804.00	
2480	Laparoscopy by second gynaecologist during endometrial ablation (Item 2479)	20	120.000		R 1 495.30	
12.5	Fallopian tubes					
0066	Microsurgery of the fallopian-tubes and ovaries: Where micro-surgical techniques are used, with the aid of a microscope, 25% may be added to the fee					
2481	Insufflation fallopian tubes (excluding after-care)	20	16.000		R 199.40	
2483	Salpingolysis	20	125.000		R 1 557.90	
2485	Salpingostomy	20	161.000		R 2 006.30	
2487	Tuboplasty tubal anastomosis or re-implantation	20	196.000		R 2 442.50	
2489	Ectopic pregnancy under 12 weeks (salpingectomy)	20	125.000		R 1 557.90	
2490	Ectopic pregnancy under 12 weeks (salpingostomy)	20	161.000		R 2 006.30	
2491	Ectopic pregnancy after 12 weeks	20	225.000		R 2 804.00	
2492	Salpingectomy: Uni- or bilateral or sterilisation for accepted medical reasons	20	94.000		R 1 171.40	
	Note: Use Item 1807 for open procedures performed with a laparoscope instead of Item 2493. Item 1807 may only be added once, and may not be charged together with Item 2493 for more than one procedure performed laparoscopically.					
2493	Diagnostic laparoscopy (excluding after-care)	20	94.400		R 1 176.40	
2496	Laparoscopy: Plus aspiration of a cyst (excluding after-care)	20	18.000		R 224.30	
2497	Laparoscopy: Plus sterilisation	20	40.000		R 498.40	
2499	Laparoscopy: Plus biopsy (excluding after-care)	20	18.000		R 224.30	
2500	Laparoscopy: Plus ablation of endometriosis by laser, harmonic scalpel or cautery	20	51.000		R 635.50	
2501	Laparoscopy: Plus cauterisation and/or lysis of adhesions	20	18.000		R 224.30	
2502	Laparoscopy: Plus aspiration of follicles (IVF) – excluding after-care	20	52.000		R 648.10	
2503	Laparoscopy: Plus ovarian drilling	20	40.000		R 498.40	
2504	Laparoscopy: Plus Gamete intra fallopian tube transfer (includes follicle aspiration) – GIFT	20	107.000		R 1 333.50	

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2505	Laparoscopy: Plus laparoscopic uterosacral nerve ablation	20	52.000		R 648.10	
2506	Transcervical gamete/embryo intra-fallopian tube transfer (TET/TEST)	20	58.000		R 722.80	
12.6	Ovaries					
2525	Wedge resection of ovaries, unilateral or bilateral	20	105.000		R 1 308.50	
2527	Removal of ovarian tumour or cyst	20	187.000		R 2 330.60	
2529	Oophorectomy: Uni- or bilateral	20	134.500		R 1 676.20	
2531	Ovarian carcinoma debulking and omentectomy	20	357.000		R 4 449.00	
2532	Ovarian carcinoma: Abdominal hysterectomy, bilateral salpingo-oophorectomy, debulking and omentectomy	20	469.000		R 5 844.80	
12.7	Miscellaneous procedures					
2535	Exenteration: Anterior Exenteration	20	402.000		R 5 009.70	
2537	Exenteration: Posterior Exenteration	20	402.000		R 5 009.70	
2539	Exenteration: Total	20	625.000		R 7 788.80	
2541	Presacral neurectomy	20	98.000		R 1 221.40	
2542	Removal/revision: Sling for stress incontinence (e.g. fascia or synthetic)	20	151.400		R 1 886.20	
2543	Moschowitz operation	20	120.000		R 1 495.30	
2544	Laparoscopic vaginal suspension for stress incontinence (Item 1807 may not be used together with this item)	20	193.100		R 2 406.50	
2545	Operations for stress incontinence: Marshall-Marchetti-Kranz operation	20	195.000		R 2 430.10	
2546	Operations for stress incontinence: Urethro-vesicopexy, abdominal approach	20	149.000		R 1 856.70	
2547	Operations for stress incontinence: Burch colposuspension	20	161.000		R 2 006.30	
2548	Operation for stress incontinence: Use of tape	20	229.400		R 2 858.90	
2550	Operations for stress incontinence: Urethro-vesicopexy, combined abdominal and vaginal approach	20	196.000		R 2 442.50	
2551	Laparotomy	20	196.000		R 2 442.50	
2552	Removal benign retroperitoneal tumour	20	223.000		R 2 779.00	
2553	Radical removal of malignant retroperitoneal tumour	20	350.000		R 4 361.80	

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2554	Drainage of pelvic abscess per abdomen	20	180.000		R 2 243.10	
2556	Drainage of pelvic abscess per vagina (refer to Item 2341)	20	75.000		R 934.70	
2558	Drainage intra-abdominal abscess: Delayed closure	20	268.000		R 3 339.90	
2560	Surgery for moderate endometriosis (AFS stages 2 + 3): Any method	20	150.000		R 1 869.40	
2561	Surgery for severe endometriosis (AFS stage 4 – retrovaginal septum): Any method (may not be used with another procedure or as a modifier)	20	210.000		R 2 617.10	
2562	Treatment of endometriosis (any method) found as an incidental finding during surgery for unrelated condition (histology required)	20	51.000		R 635.50	
2565	Implantation hormone pellets (excluding after-care)	20	3.000		R 37.40	
2570	Ligation of internal iliac vessels (when not part of another procedure)	20	225.000		R 2 804.00	
13	**Obstetric procedures**					
	RULES GOVERNING THIS SECTION					
U.	**Obstetric procedures** a. When a general practitioner treats a patient in the ante-natal period and, after starting the confinement, requests an obstetrician to take over the case, the general practitioner shall be entitled to charge for all the ante-natal consultations he/she has performed. i. If the patient has been in labour for less than six hours, the general practitioner shall charge 50,00 clinical procedure units according to Item 2614: Global obstetric care. ii. If the patient has been in labour for more than six hours, the general practitioner shall charge 80,00 clinical procedure units according to Item 2614: Global obstetric care. b. When a general practitioner calls an obstetrician to help with a confinement, take over the management of a confinement, and treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2614: Global obstetric care. c. When a general practitioner calls an obstetrician (specialist or general practitioner) to help with a confinement, or take over the management of a confinement, but the general practitioner treats the patient until after the post-partum visit, the obstetrician shall charge according to Item 2616: Intrapartum obstetric care by obstetrician in consultation, and the general practitioner according to Item 2614: Global obstetric care.					
13.1	Pre-natal care and procedures					
2603	External cephalic version (excluding after-care)	20	22.000		R 274.20	

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2605	Amniocentesis (excluding after-care)	20	36.000		R 448.60	
2607	Amnioscopy (excluding after-care)	20	18.000		R 224.30	
2609	Intra-uterine transfusion of foetus or cordocentesis	20	134.000		R 1 669.90	
2610	Tococardiography – pre-natal and intrapartum (including stress and non-stress test: Own machine), excluding after-care	20	16.000		R 199.40	
2611	Chorion villus sampling (excluding after-care)	20	54.000		R 672.80	
13.2	Confinements					
2614	Global obstetric care: All inclusive fee that includes all modes of vaginal delivery (excluding caesarean section) and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit)	20	282.000		R 4 090.30	
2615	Global obstetric care: All inclusive fee for caesarean section and obstetric care from the commencement of labour until after the post-partum visit (six weeks visit)	20	267.000		R 4 090.30	
2616	Intrapartum obstetric care by obstetrician in consultation (excluding after-care)	20	190.000		R 2 367.90	
	Global obstetric care includes: • All modes of delivery (including caesarean) • All inductions of labour (medical or surgical) • Intrapartum paracervical and pudential blocks • Intrapartum amnioscopy • Foetal blood sampling • Application of scalp leads • Symphysiotomy • Manual removal of placenta • Repair cervical tears • Correction of uterine inversion • Drainage of vulval haematoma • Repair third degree tear • Repair second degree tear • Repair episiotomy • Resuscitation of newborn by obstetrician • Tracheal intubation • Missed confinement					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	Global obstetric care excludes: • Prenatal consultations • Prenatal procedures (Items 2603-2611) • Emergency hysterectomy for obstetrical reasons • Abdominal operation for repair of ruptured gravid uterus • Intensive care for obstetrical emergencies • Tubal ligation performed as a post-partum procedure • Post-partum complications occurring after discharge from the hospital					
13.3	Operative procedures (excluding antenatal care)					
2653	Caesarean-hysterectomy	20	335.000		R 4 174.70	
2657	Post-partum hysterectomy	20	300.000		R 3 738.60	
2669	Abdominal operation for ruptured gravid uterus: Repair	20	250.000		R 3 115.60	
14	**Nervous system**					
14.1	Diagnostic procedures					
2680	Haemodynamic and autonomic nervous system testing with task Force system – PROFESSIONAL COMPONENTS		29.00		R 469.60	
2681	Visual evoked potentials (VEP): Unilateral	20	50.000		R 810.20	
2682	Visual evoked potentials (VEP): Bilateral	20	88.000		R 1 425.60	
2683	Electro-retinography (Ganzfeld method): Unilateral	20	60.000		R 972.20	
2684	Electro-retinography (Ganzfeld method): Bilateral	20	105.000		R 1 701.10	
2685	Electro-oculography: Unilateral	20	30.000		R 485.90	
2686	Electro-oculography: Bilateral	20	53.000		R 858.70	
2687	VEP stable condition (photic drive): Unilateral	20	50.000		R 810.20	
2689	VEP stable condition (photic drive): Bilateral	20	88.000		R 1 425.60	
2690	Total fee for full evaluation of visual tracts including bilateral electroretinography and VEP	20	150.000		R 2 430.20	
	Note: See Items 2691 to 2702 under section 17.5.1: Audiometry					

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2703	Somatosensory evoked potentials (SEP) single nerve examination to brachial or lumbosacral plexus, spinal cord and cortex	20	48.000		R 777.60	
2704	Neurostimulation, percutaneous: Sacral nerve		120.800		R 1 956.50	
2705	Transcutaneous nerve stimulation in the treatment of post-operative and chronic intractable pain, per treatment	20	6.000		R 97.30	
2706	Neurostimulation, percutaneous: Posterior tibial nerve, single treatment – includes programming		8.800		R 142.50	
2707	Full fee for complete neurological evoked potential evaluation including neurological AEP, bilateral VEP, and bilateral median and/or posterior tibial stimulation	20	220.000		R 3 564.10	
2708	Evaluation of cognitive evoked potential with visual or audiology stimulus	20	80.000		R 1 296.20	
2709	Full spinogram including bilateral median and posterior-tibial studies	20	140.000		R 2 268.00	
2710	Morphia saturation testing in rooms (consultation x 2 plus Item 0206: Intravenous infusion) – excluding injection material					
2711	Electro-encephalography: Taking of record	20	36.100		R 585.00	
2712	Electro-encephalography: Interpretation	20	24.000		R 389.00	
2713	Spinal (lumbar) puncture. For diagnosis, for drainage of spinal fluid or for therapeutic indications	20	18.400		R 298.00	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.					
2714	Cisternal puncture and/or intrathecal injections	20	15.000		R 243.10	
2715	8 Hour ambulatory EEG monitoring (Holter): Hire	20	136.000		R 1 694.90	
2716	8 Hour ambulatory EEG monitoring (Holter): Interpretation	20	30.000		R 485.90	
2717	Electromyography: First	20	75.000		R 1 215.20	
2718	Electromyography: Subsequent	20	75.000		R 1 215.20	
2719	Overnight polysomnogram and sleep staging: Hire	20	125.000		R 1 557.90	
2720	Overnight polysomnogram and sleep staging: Interpretation	20	23.000		R 372.60	
2721	Daytime polysomnogram: Hire	20	125.000		R 1 557.90	
2722	Daytime polysomnogram: Interpretation	20	17.000		R 275.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2723	Multiple sleep latency test: Interpretation	20	125.000		R 2 025.20	
2724	Overnight continuous positive airways pressure (CPAP) titration	20	155.000		R 2 511.30	
2725	Angiography carotis: Unilateral	20	25.000		R 405.00	
2726	Angiography carotis: Bilateral	20	44.000		R 713.10	
2727	Vertebral artery: Direct needling	20	50.000		R 810.20	
2728	Unattended overnight home-based polysomnogram: Interpretation		24.500		R 396.80	
2729	Vertebral catheterisation	20	50.000		R 810.20	
2730	Neostigmine Test, the diagnostic test for Myasthenia Gravis under the supervision of a neurologist ('20') – not to be used with Item 0714	20	60.000		R 972.20	
2731	Air encephalography and posterior fossa tomography: Injection of air (independent procedure)	20	14.500		R 234.80	
2732	Overnight home-based polysomnogram: Interpretation		24.500		R 396.80	
2733	Cortical stimulation	20	58.900		R 954.20	
2734	Sodium Amytal Testing (WADA test)	20	88.700		R 1 436.80	
2735	Air encephalography and posterior fossa tomography: Posterior fossa tomography attendance by clinician	20	31.500		R 510.10	
2737	Air encephalography and posterior fossa tomography: Visual field charting on Bjerrum Screen	20	7.000		R 113.60	
2739	Ventricular needling without burring: Tapping only	20	16.000		R 259.20	
2741	Ventricular needling without burring: Plus introduction of air and/or contrast dye for ventriculography	20	43.000		R 696.90	
2743	Subdural tapping: First sitting	20	15.000		R 243.10	
2745	Subdural tapping: Subsequent	20	10.000		R 161.80	
6001	Sleep electro-encephalography: Infants that fit into a perambulator – taking of record	20	36.100		R 585.00	
6002	Sleep electro-encephalography: Infants that fit into a perambulator – interpretation	20	24.500		R 397.20	
6003	Sleep electro-encephalography: Adults and children over infant age – taking of record	20	36.100		R 585.00	
6004	Sleep electro-encephalography: Adults and children over infant age – interpretation	20	24.500		R 397.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6010	Electroenchephalogram monitoring: Monitoring for localisation of cerebral seizure focus using computerised sixteen or more channel EEG, which may include video recording (e.g. for pre-operative localisation) – each full 24-hour period	20	294.600		R 4 772.80	
6011	Interpretation of Item 6010: Electro-encephalogram monitoring – to be charged once only for each full 24-hour period of monitoring	20	128.600		R 2 083.40	
14.2	Introduction of burr holes for					
2746	Biopsy: Temporal artery		91.000		R 1 133.70	
2747	Ventriculography	20	150.000		R 1 869.40	
2749	Catheterisation for ventriculography and/or drainage	20	150.000		R 1 869.40	
2751	Biopsy of brain tumour	20	150.000		R 1 869.40	
2753	Subdural haematoma or hygroma	20	150.000		R 1 869.40	
2755	Subdural empyema	20	150.000		R 1 869.40	
2757	Brain abscess	20	150.000		R 1 869.40	
14.3	Nerve procedures					
2759	Nerve biopsy: Peripheral	20	37.000		R 599.30	
2763	Nerve biopsy: Cranial nerves, extra-cranial	20	20.000		R 324.00	
2765	Nerve biopsy: Nerve conduction studies (see Items 0733 and 3285)	20	26.000		R 421.30	
6005	Botulinus toxin injections: For blepharospasm (+ 0198 + Item 0201 + Item 0202)	20	25.000		R 405.00	
6006	Botulinus toxin injections: For hemifacial spasm or for hyperhidrosis per region (+ Item 0198 + Item 0201 + Item 0202)	20	30.000		R 485.90	
6007	Botulinus toxin injections: For adductor disphonia (+ Item 0198 + 0201 + Item 0202)	20	35.000		R 567.00	
6008	Botulinus toxin injections: In extra-ocular muscles (+ Item 0198 + Item 0201 + Item 0202)	20	35.000		R 567.00	
6009	Botulinus toxin injections: For spasmodic torticollis and/or cranial dystonia or for spasticity or for focal dystonia (+ Item 0198 + Item 0201 + Item 0202)	20	50.000		R 810.20	
14.3.1	Nerve procedures: Nerve repair or suture					
2767	Suture brachial plexus (see also Items 2837 and 2839)	20	300.000		R 3 738.60	
2769	Suture: Large nerve, primary	20	134.000		R 1 669.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2771	Suture: Large nerve, secondary	20	202.000		R 2 517.30	
2773	Digital nerve: Primary	20	65.000		R 810.00	
2775	Digital nerve: Secondary	20	96.000		R 1 196.30	
2777	Nerve graft: Simple	20	202.000		R 2 517.30	
2779	Fascicular: First fasciculus	20	202.000		R 2 517.30	
2781	Fascicular: Each additional fasciculus	20	50.000		R 623.20	
2782	Nerve pedicle transfer: First stage (not to be used together with Item 2783)		309.100		R 3 852.50	
2783	Fascicular: Nerve flap – to include all stages	20	224.000		R 2 791.50	
2784	Nerve pedicle transfer: Second stage (not to be used together with Item 2783)		338.300		R 4 216.40	
2785	Fascicular: Facio-accessory or facio-hypoglossal anastomosis	20	124.000		R 1 545.20	
2787	Fascicular: Grafting of facial nerve	20	215.000		R 2 679.40	
14.3.2	Nerve procedures: Neurectomy					
2789	Trigeminal ganglion: Injection of alcohol	20	150.000		R 2 430.20	
2791	Trigeminal ganglion: Injection of cortisone	20	65.000		R 1 052.90	
2793	Trigeminal ganglion: Coagulation through high frequency	20	170.000		R 2 754.30	
2799	Procedures for pain relief: Intrathecal injections for pain	20	36.000		R 583.20	
2800	Procedures for pain relief: Plexus nerve block	20	36.000		R 583.20	
2801	Procedures for pain relief: Epidural injection for pain (refer to modifier 0045 for post-operative pain relief) – refer to modifier 0021 for epidural anaesthetic	20	36.000		R 583.20	
	When this procedure is performed by an anaesthetist he/she acts as the clinician and not an anaesthetist and the indicated clinical procedure units should be charged and not the anaesthetic tariff or units.					
2802	Procedures for pain relief: Peripheral nerve block	20	25.000		R 405.00	
2803	Alcohol injection in peripheral nerves for pain: Unilateral	20	20.000		R 324.00	
2804	Inserting an indwelling nerve catheter (includes removal of catheter) – not for bolus technique	20	10.000		R 161.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2805	Alcohol injection in peripheral nerves for pain: Bilateral	20	35.000		R 567.00	
2809	Peripheral nerve section for pain	20	45.000		R 729.20	
2811	Pudendal neurectomy: Bilateral	20	116.000		R 1 445.60	
2813	Obturator or Stoffels	20	96.000		R 1 196.30	
2815	Interdigital	20	82.300		R 1 025.60	
2825	Excision: Neuroma, peripheral	20	109.500		R 1 364.60	
14.3.3	Nerve procedures: Other nerve procedures					
2827	Transposition of ulnar nerve	20	100.000		R 1 246.20	
2829	Neurolysis: Minor	20	51.000		R 635.50	
2831	Neurolysis: Major	20	132.000		R 1 645.00	
2833	Neurolysis: Digital	20	96.000		R 1 196.30	
2834	Neuroplasty: Sciatic nerve		168.800		R 2 103.90	
2835	Scalenotomy	20	132.000		R 1 645.00	
2837	Neuroplasty: Brachial Plexus	20	223.000		R 2 779.00	
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	20	895.200		R 11 156.00	
2841	Carpal tunnel	20	64.000		R 797.70	
2843	Lumbar sympathectomy: Unilateral	20	153.000		R 1 906.80	
2845	Lumbar sympathectomy: Bilateral	20	268.000		R 3 339.90	
2846	Cervical sympathectomy: Trans-thoracic approach (use Item 2847 or Item 2848 as appropriate)					
2847	Cervical sympathectomy: Unilateral	20	153.000		R 1 906.80	
2848	Cervical sympathectomy: Bilateral	20	268.000		R 3 339.90	
2849	Sympathetic block: Other levels, unilateral	20	20.000		R 324.00	
2851	Sympathetic block: Other levels, bilateral	20	35.000		R 567.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2853	Sympathetic block: Other levels, diagnostic/therapeutic nerve block (unassociated with surgery) – either intercostal, or brachial, or peripheral, or stellate ganglion	20	20.000		R 324.00	
14.4	Skull procedures					
2855	Removal of skull tumour: With or without plastic repair, small	20	170.000		R 2 118.70	
2857	Removal of skull tumour: With or without plastic repair, major	20	200.000		R 2 492.40	
2859	Repair of depressed fracture of skull: Without brain laceration, major	20	200.000		R 2 492.40	
2860	Repair of depressed fracture of skull: Without brain laceration, small	20	170.000		R 2 118.70	
2861	Repair of depressed fracture of skull: With brain lacerations, small	20	200.000		R 2 492.40	
2862	Repair of depressed fracture of skull: With brain lacerations, major	20	375.000		R 4 673.30	
2863	Cranioplasty	20	280.000		R 3 489.60	
2864	Encephalocele (excluding frontal)	20	200.000		R 2 492.40	
2865	Craniostenosis: Few suturae	20	213.000		R 2 654.40	
2867	Craniostenosis: Multiple suturae	20	280.000		R 3 489.60	
14.5	Shunt procedures					
2869	Ventriculo-cisternostomy	20	280.000		R 3 489.60	
2871	Ventriculo-caval shunt	20	280.000		R 3 489.60	
2873	Ventriculo-peritoneal shunt	20	280.000		R 3 489.60	
2875	Theco-peritoneal C.S.F. shunt	20	280.000		R 3 489.60	
14.6	Aneurysm repair					
2876	Repair of aneurysms or arteriovenous anomalies (intracranial)	20	700.000		R 8 723.40	
2877	Extracranial to intracranial vascular	20	700.000		R 8 723.40	
2878	Posterior fossa arteriovenous anomalies	20	700.000		R 8 723.40	
14.7	Craniectomy or craniotomy					
2879	Glosso pharyngeal nerve	20	480.000		R 5 981.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2881	Eighth nerve: Intracranial	20	480.000		R 5 981.70	
2883	Eighth nerve: Extracranial	20	480.000		R 5 981.70	
2884	Sub-temporal section of the trigeminal nerve	20	375.000		R 4 673.30	
2885	Trigeminal tractotomy	20	480.000		R 5 981.70	
2886	Posterior fossa decompression with or without laminectomy with or without dural insertion for Arnold Chiarri malformation or obstructive cysts e.g. Dandy Walker or parasites	20	450.000		R 5 607.90	
2887	Vestibular nerve	20	480.000		R 5 981.70	
2889	Posterior fossa tumour removal: Acoustic neuroma, benign cerebello-pontine tumours, meningioma, clivus meningioma, chordoma, clivus chordoma or cholesteatoma	20	700.000		R 8 723.40	
2891	Posterior fossa tumour removal: Glioma, secondary deposits	20	450.000		R 5 607.90	
2893	Posterior fossa tumour removal: Abscess	20	450.000		R 5 607.90	
2895	Excision of tumour of glomus jugulare: Intracranial	20	420.000		R 5 234.00	
2897	Excision of tumour of glomus jugulare: Extracranial	20	420.000		R 5 234.00	
2898	Excision of tumour of glomus jugulare: Hemispherectomy	20	500.000		R 6 231.00	
14.7.1	Posterior fossa surgery: Supratentorial procedures					
2899	Craniectomy for extra-dural haematoma or empyema	20	375.000		R 4 673.30	
14.8	Craniotomy for					
2900	Craniotomy for extra-dural orbital decompression or excision of orbital tumour	20	700.000		R 8 723.40	
2901	Craniotomy for osteoplastic flap for removal of: Meningioma, basal extracerebral mass, intra ventricular tumours, pineal tumours, pituitary adenoma, total excision cranio-pharyngioma/pharyngioma	20	700.000		R 8 723.40	
2903	Craniotomy for abscess, glioma	20	450.000		R 5 607.90	
2904	Craniotomy for haematoma, foreign body: Cerebral or cerebellar	20	450.000		R 5 607.90	
2905	Craniotomy for focal epilepsy: Excision of cortical scar	20	450.000		R 5 607.90	
2906	Craniotomy with anterior fossa meningocele and repair of bony skull defect	20	375.000		R 4 673.30	
2907	Craniotomy for temporal lobectomy	20	450.000		R 5 607.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2908	Craniotomy for Torkildsen anastomosis	20	375.000		R 4 673.30	
2909	Craniotomy for CSF-leaks	20	450.000		R 5 607.90	
2910	Craniotomy for removal of arteriovenous malformation	20	700.000		R 8 723.40	
14.8.1	Stereotaxis, stereotactic radiosurgery (cranial), neurostimulators (intracranial)					
2911	Stereo-tactic cerebral and spinal cord procedure: First sitting	20	280.000		R 3 489.60	
2913	Stereo-tactic cerebral and spinal cord procedure: Repeat	20	196.000		R 2 442.50	
2915	Transnasal hypophysectomy	20	300.000		R 3 738.60	
2916	Transfrontal hypophysectomy	20	480.000		R 5 981.70	
2917	Transnasal hypophyseal implants	20	172.000		R 2 143.60	
2918	Non-operative supervision of paraplegics for all disciplines except urologists. Per service (specified)	20	-			
14.9	Spinal operations					
	See section 3.8.7 for laminectomy procedures					
2923	Chordotomy: Unilateral	20	178.000		R 2 218.20	
2925	Chordotomy: Open	20	350.000		R 4 361.80	
2927	Rhizotomy: Extradural, but intraspinal	20	320.000		R 3 987.90	
2928	Rhizotomy: Intradural	20	350.000		R 4 361.80	
2929	Removal of spinal cord tumour: Intramedullar, posterior approach	20	700.000		R 8 723.40	
2930	Removal of spinal cord tumour: Intramedullar, anterio-lateral approach	20	700.000		R 8 723.40	
2931	Removal of spinal cord tumour: Extramedullary, but intradural – posterior approach	20	350.000		R 4 361.80	
2932	Removal of spinal cord tumour: Extramedullary, but intradural – anterio-lateral approach	20	350.000		R 4 361.80	
2933	Removal of spinal cord tumour: Extramedullary, but intradural – intraspinal, but extradural: Posterior approach	20	320.000		R 3 987.90	
2935	Removal of spinal cord tumour: Extramedullary, but intradural – transcutaneous chordotomy	20	225.000		R 2 804.00	
2937	Repair of meningocele, involving nerve tissue	20	250.000		R 3 115.60	
2938	Simple	20	150.000		R 1 869.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
2939	Excision of arterial vascular malformations and cysts of the spinal cord	20	700.000		R 8 723.40	
2940	Lumbar osteophyte removal	20	187.000		R 2 330.60	
2941	Cervical or thoracic osteophyte removal	20	285.000		R 3 551.80	
14.10	Arterial ligations					
2951	Carotis: Trauma	20	120.000		R 1 495.30	
2953	Carotis: For aneurysm (AV anomaly)	20	150.000		R 1 869.40	
2955	Removal of carotid body tumour (without vascular reconstruction)	20	335.600		R 4 182.30	
14.11	Medical psychotherapy					
2957	Individual psychotherapy (specify type): Including play therapy for children, per short session (20 minutes)					
2962	Directive therapy to family, parent(s), spouse – per 20-minute session					
2963	Pairs, marriage or sex therapy: Per 20-minute session					
2968	Group therapy: Adults (specify number) – tariff per person per 80-minute session; Children (specify number): Tariff per person per 80-minute session					
2974	Individual psychotherapy (specify type): Including play therapy for children, per intermediate session (40 minutes)					
2975	Individual psychotherapy (specify type): Including play therapy for children, per extended session (60 minutes or longer)					
2976	Intermediate treatment where either Items 2962 or 2963 are used: Per 40-minute session					
2977	Extended treatment where either Items 2962 or 2963 are used: Per 60-minute session					
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY					
V.	a. Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods					
0079	When a first 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).					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
0099	Stat basis tests: For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos: • Stat test requesting may only be done by the referring practitioner and not by the pathologist. • Specimens must be collected on a stat basis where applicable. • Test must be performed on a stat basis. • Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained. • This modifier will only apply during normal working hours and will never be used in combination with Item 4547: After-hours service.					
14.12	Physical treatment methods					
2970	Electro-convulsive treatment (ECT): Each time (see rule V.a.)					
14.13	Psychiatric examination methods					
2972	Narco-analysis (maximum of 3 sessions per treatment): Per 60-minute session					
2973	Psychometry (specify examination): Per session (maximum of 3 sessions per examination)					
15	**Endocrine system**					
15.1	Thyroid					
2983	Lobectomy: Partial	20	198.100		R 2 468.90	
2985	Lobectomy: Total	20	200.000		R 2 492.40	
2987	Thyroidectomy: Subtotal	20	266.000		R 3 315.00	
2989	Thyroidectomy: Total	20	279.000		R 3 476.90	
2990	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: Cervical approach		335.300		R 4 177.10	
2991	Thyroglossal cyst or fistula excision	20	126.200		R 1 572.70	
15.2	Parathyroid					
2992	Parathyroid: Re-exploration for hyperparathroidism, INCLUDES removal of parathyroid glands or lesions: With mediastinal exploration, sternal slit or transthoracic approach		370.700		R 4 618.10	
2993	Exploration of parathyroid glands for hyperparathyroidism including removal	20	275.000		R 3 427.10	

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15.3	Adrenals					
2994	Parathyroid: Autotransplantation of parathyriod – Add to major procedure (modifier 0005 does not apply)		70.500		R 878.20	
2995	Adrenalectomy: Unilateral	20	225.000		R 2 804.00	
2997	Bilateral exploration of adrenal glands: Including removal	20	394.000		R 4 910.10	
15.4	Hypophysis					
2999	Transethmoidal hypophysectomy	20	300.000		R 3 738.60	
3000	Transnasal hypophysectomy (see also Item 2915)	20	300.000		R 3 738.60	
15.5	Endocrine system: General					
3001	Implantation of pellets (excluding cost of material) – excluding after-care	20	3.000		R 37.40	
16	**Eye**					
16.1	Eye: Procedures performed in rooms					
	a. Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions. b. Material used is excluded. c. The fee for photography is not related to the number of photographs taken.					
16.1.1	Eye investigations					
3002	Gonioscopy	20	7.000		R 87.40	
3003	Fundus contact lens or 90 D lens examination (not to be charged with Item 3004 or Item 3012)	20	7.000		R 87.40	
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with Item 3003 and/or Item 3012)	20	7.000		R 87.40	
3006	Keratometry	20	7.000		R 87.40	
3009	Basic capital equipment used in own rooms by ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations.	20	11.680		R 145.40	
3012	Pre-surgical retinal examination before retinal surgery	20	32.000		R 398.80	
3013	Ocular motility assessment: Comprehensive examination	20	12.000		R 149.50	
3014	Tonometry per test with maximum of two tests for provocative tonometry (one or both eyes)	20	7.000		R 87.40	

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3021	Special eye investigations: Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	20	9.000		R 112.20	
16.1.2	Special eye investigations					
3005	Endothelial cell count	20	7.000		R 87.40	
3007	Potential acuity measurement	20	7.000		R 87.40	
3008	Contrast sensitivity test	20	7.000		R 87.40	
3010	Orthoptics consultation	20	10.000		R 124.40	
3011	Orthoptic subsequent sessions	20	5.000		R 62.30	
3015	Charting of visual field with manual perimeter	20	28.000		R 349.00	
3016	Retinal threshold test without storage facilities	20	30.000		R 373.80	
3017	Retinal threshold test inclusive of computer disc storage for Delta of Statpak programs	20	74.000		R 922.10	
3018	Retinal threshold trend evaluation (additional to Item 3017)	20	16.000		R 199.40	
3019	Ocular muscle function with Hess screen or perimeter	20	16.000		R 199.40	
3020	Special eye investigations: Pachymetry – only when own instrument is used, per eye. Only in addition to corneal surgery.	20	46.000		R 573.30	
3022	Digital fluorescein video angiography	20	68.000		R 847.40	
3023	Digital indocyanine video angiography	20	110.000		R 1 370.90	
3024	Infusion of dye used during Fluorescein Angiography, Indocyanine Green Video Angiography and Photodynamic therapy. Linked to Items 3022, 3023, 3031, 3039.	20	12.000		R 149.50	
3025	Electronic tonography	20	19.000		R 236.90	
3026	Digital Tomography of optic nerve with Scanning Laser Ophthalmoscope (SLO). Limited to two exams per annum.	20	19.300		R 240.70	
3027	Fundus photography	20	21.000		R 261.80	
3028	Optical Coherent Tomography (OCT) of optic nerve or macula: Per eye	20	40.000		R 498.40	
3029	Anterior segment microphotography	20	21.000		R 261.80	
3031	Fluorescein Angiography: One or both eyes (not to be used with Item 3022)	20	45.000		R 560.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3032	Eyelid and orbit photography	20	9.000		R 112.20	
3033	Interpretation of Items 3022, 3023 and 3031 referred by other clinicians	20	16.000		R 199.40	
3034	Determination of lens implant power per eye	20	15.000		R 187.00	
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged	20	22.000		R 274.20	
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery – may be charged once pre-operative and once post-operative per sitting (for one or both eyes)	20	36.000		R 448.60	
16.2	Retina					
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy	20	306.900		R 3 824.80	
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	20	105.000		R 1 308.50	
3041	Pan retinal photocoagulation (per eye): Done in one sitting	20	150.000		R 1 869.40	
3044	Removal of encircling band and/or buckling material	20	105.000		R 1 308.50	
16.3	Cataract					
3045	Cataract: Intra-capsular	20	210.000		R 2 617.10	
3047	Cataract: Extra-capsular (including capsulotomy)	20	210.000		R 2 617.10	
3049	Insertion of lenticulus in addition to Item 3045 or Item 3047 (cost of lens excluded) – modifier 0005 not applicable	20	57.000		R 710.30	
3050	Repositioning of intra ocular lens	20	171.100		R 2 132.20	
3051	Needling or capsulotomy	20	130.000		R 1 620.20	
3052	Laser capsulotomy	20	105.000		R 1 308.50	
3057	Removal of lenticulus	20	210.000		R 2 617.10	
3058	Exchange of intra ocular lens	20	236.000		R 2 941.20	
3059	Insertion of lenticulus when Item 3045 or Item 3047 was not executed (cost of lens excluded)	20	210.000		R 2 617.10	

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3060	Use of own surgical microscope for surgery or examination (not for slit lamp microscope) – for use by ophthalmologists only	20	4.000		R 50.00	
16.4	Glaucoma					
3061	Drainage operation	20	247.600		R 3 085.60	
3062	Implantation of aqueous shunt device/seton in glaucoma (additional to Item 3061)	20	60.000		R 747.80	
3063	Cyclocryotherapy or cyclodiathermy	20	105.000		R 1 308.50	
3064	Laser trabeculoplasty	20	105.000		R 1 308.50	
3065	Removal of blood from anterior chamber	20	105.000		R 1 308.50	
3067	Goniotomy	20	210.000		R 2 617.10	
16.5	Intra-ocular foreign body					
3071	Intra-ocular foreign body: Anterior to Iris	20	127.000		R 1 582.80	
3073	Intra-ocular foreign body: Posterior to Iris (including prophylactic thermal treatment to retina)	20	210.000		R 2 617.10	
16.6	Strabismus					
3074	Strabismus (whether operation performed on one eye or both): Adjustment of sutures if not done at the time of the operation. Additional fee for sterile tray (refer to Item 0202)	20	20.000		R 249.30	
3075	Strabismus (whether operation performed on one eye or both): Operation on one or two muscles	20	175.600		R 2 188.30	
3076	Strabismus (whether operation performed on one eye or both): Operation on three or four muscles	20	200.000		R 2 492.40	
3077	Strabismus (whether operation performed on one eye or both): Subsequent operation one or two muscles	20	120.000		R 1 495.30	
3078	Strabismus (whether operation performed on one eye or both): Subsequent operation on three or four muscles	20	150.000		R 1 869.40	
16.7	Globe					
3079	Transcleral biopsy	20	132.000		R 1 645.00	
3080	Examination of eyes under general anaesthetic where no surgery is done	20	80.000		R 997.10	
3081	Treatment of minor perforating injury	20	161.600		R 2 013.90	
3083	Treatment of major perforating injury	20	267.500		R 3 333.60	

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3085	Enucleation or Evisceration	20	105.000		R 1 308.50	
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	20	160.000		R 1 994.00	
3088	Hydroxyapetite insertion (additional to Item 3087)	20	40.000		R 498.40	
3089	Subconjunctival injection if not done at time of operation	20	10.000		R 124.40	
3090	Intra vitreal injection drug	20	47.600		R 593.30	
3091	Retrobulbar injection (if not done at time of operation)	20	16.000		R 199.40	
3092	External laser treatment for superficial lesions	20	53.000		R 660.60	
3093	Treatment of tumours of retina or choriod by radioactive plaque and/or diathermy and/or cryotherapy and/or laser therapy and/or photocoagulation	20	209.000		R 2 604.60	
3094	Implantation of intra vitreal drug delivery system	20	247.600		R 3 085.60	
3095	Biopsy of vitreous body or anterior chamber contents	20	105.000		R 1 308.50	
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumo-retinopexy	20	130.000		R 1 620.20	
3097	Anterior vitrectomy	20	280.000		R 3 489.60	
3098	Removal of silicon from globe	20	280.000		R 3 489.60	
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	20	419.000		R 5 221.50	
3100	Lensectomy done at time of posterior vitrectomy	20	30.000		R 373.80	
16.8	Orbit					
3101	Drainage of orbital abscess	20	105.000		R 1 308.50	
3103	Orbit: Removal of tumour	20	240.000		R 2 990.90	
3104	Removal orbital prosthesis	20	212.700		R 2 650.80	
3105	Orbit: Exenteration	20	275.000		R 3 427.10	
3107	Orbitotomy requiring bone flap	20	393.000		R 4 897.50	
3108	Eye socket reconstruction	20	206.000		R 2 567.10	
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	20	300.000		R 3 738.60	

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3110	Second stage hydroxyapetite implantation	20	110.000		R 1 370.90	
16.9	Cornea					
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	20	-			
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens as for corneal erosion, ulcer, abrasion or corneal wound.	20	12.200		R 152.10	
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fitting of the contact lenses and further post-fitting visits for one year	20	200.000		R 2 492.40	
3114	Wavefront analysis (Aberometry) for customised ablation of pathological corneas prior to LASIK surgery – EQUIPMENT component only	20	78.850		R 982.80	
3115	Fitting of only one contact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included	20	166.000		R 2 068.70	
3116	Astigmatic correction with T-cuts or wedge resection in pathological corneal astigmatism following trauma, intra-ocular surgery or penetrating keratoplasty	20	135.200		R 1 684.80	
3117	Removal of foreign body: On the basis of fee per consultation	20	-			
3118	Curettage of cornea after removal of foreign body (after-care excluded)	20	10.000		R 124.40	
3119	Tattooing	20	26.000		R 324.00	
3120	Excimer laser (per eye) for refractive keratectomy or Holmium laser thermo keratoplasty (LTK) – for machine hire fee for LTK: Use Item 3201	20	150.000		R 1 869.40	
3121	Corneal graft (Lamellar or full thickness)	20	289.000		R 3 601.50	
3122	Epikeratophakia	20	289.000		R 3 601.50	
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery	20	254.000		R 3 165.30	
3124	Removal of corneal stitches under microscope (maximum of 2 procedures). Additional fee for sterile tray (see Item 0202)	20	9.000		R 112.20	
3125	Keratectomy	20	127.000		R 1 582.80	
3126	Additional to Item 3120 for the use of own microkeratome used with a excimer laser	20	52.180		R 650.30	
3127	Cauterisation of cornea (by chemical, thermal or cryotherapy methods)	20	10.000		R 124.40	

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3128	Radial keratotomy or keratoplasty for astigmatism (cosmetic unless medical reasons can be proved)	20	150.000		R 1 869.40	
3129	Additional to Item 3128 for the use of own diamond knives	20	40.000		R 498.40	
3130	Pterygium or conjunctival cyst or conjunctival tumour. No conjunctival flap or graft used	20	96.900		R 1 207.60	
3131	Cornea: Paracentesis	20	53.000		R 660.60	
3132	Lamellar keratectomy for refractive surgery (LK, ALK, MLK)	20	150.000		R 1 869.40	
3134	Pterygium or conjunctival cyst or conjunctival tumour. Conjunctival flap or graft used – stand alone procedure	20	116.300		R 1 449.20	
3136	Conjunctival flap or graft (not for use with pterigium surgery)	20	95.700		R 1 192.70	
3138	Removal corneal epithelium and chelating agent for band keratopathy	20	69.500		R 866.00	
4980	Corneal transplant: Endothelial	20	219.800		R 2 739.80	
4981	Preparation of corneal endothelial allograft prior to transplantation (backbench)	20	-			
4985	Corneal cross linking	20	150.000		R 1 869.30	
4986	Cross linking equipment hire	20	54.000		R 673.10	
16.10	Ducts					
3133	Probing and/or syringing, per duct	20	10.000		R 124.40	
3135	Insert polythene tubes	20	51.800		R 645.50	
3137	Excision of lacrimal sac: Unilateral	20	132.000		R 1 645.00	
3139	Dacrocystorhinostomy (single) with or without polythene tube	20	210.000		R 2 617.10	
3141	Sealing Punctum surgical or by cautery: Per eye	20	24.900		R 310.30	
3142	Sealing Punctum with plugs: Per eye	20	20.000		R 249.30	
3143	Three-snip operation	20	10.000		R 124.40	
3145	Repair of caniculus: Primary procedure	20	132.000		R 1 645.00	
3147	Repair of caniculus: Secondary procedure	20	175.000		R 2 181.00	
16.11	Iris					
3149	Iridectomy or iridotomy by open operation as isolated procedure	20	132.000		R 1 645.00	

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3151	Excision of iris tumour	20	185.000		R 2 305.60	
3153	Iridectomy or iridotomy by laser or photocoagulation as isolated procedure (maximum one procedure)	20	105.000		R 1 308.50	
3155	Iridocyclectomy for tumour	20	266.000		R 3 315.00	
3157	Division of anterior synechiae as isolated procedure	20	132.000		R 1 645.00	
3158	Repair iris as in dialysis: Anterior chamber reconstruction	20	142.400		R 1 774.70	
16.12	Lids					
3161	Tarsorrhaphy	20	47.000		R 585.70	
3163	Excision of superficial lid tumour	20	47.000		R 585.70	
3165	Repair of skin laceration lid: Simple	20	27.300		R 340.20	
3167	Diathermy to wart on lid margin	20	12.000		R 149.50	
3169	Electrolysis of any number of eyelashes: Per eye	20	15.000		R 187.00	
3171	Excision of Meibomian cyst. Additional fee for sterile tray (see Item 0202)	20	20.400		R 254.20	
3173	Epicanthal folds	20	128.700		R 1 603.80	
3174	Botulinus toxin injection for blepharospasm (+ Item 0198 + Item 0201 + Item 0202)	20	25.000		R 311.50	
3175	Botulinus toxin injection in extra-ocular muscles (+ Item 0198 + Item 0201+ Item 0202)	20	35.000		R 436.20	
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material	20	187.000		R 2 330.60	
16.12.1	Lids: Entropion or ectropion by					
3177	Cautery	20	10.000		R 124.40	
3179	Suture	20	49.400		R 615.60	
3181	Open operation	20	111.500		R 1 389.50	
3183	Free skin, mucosal grafting or flap	20	122.600		R 1 527.90	
16.12.2	Lids: Reconstruction of eyelid					
3185	Staged procedure for partial or total loss of eyelid: First stage	20	259.000		R 3 227.60	

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3187	Staged procedure for partial or total loss of eyelid: Subsequent stage	20	206.000		R 2 567.10	
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	20	136.500		R 1 701.20	
3191	Blepharoplasty: Upper lid for improvement in function (unilateral)	20	150.200		R 1 871.80	
3172	Blepharoplasty: Lower eyelid plus fat pad	20	125.800		R 1 567.80	
16.12.3	Lids: Ptosis					
3193	Repair by superior rectus, levator or frontalis muscle operation	20	190.000		R 2 367.90	
3195	Ptosis: By lesser procedure e.g. sling operation: Unilateral	20	137.600		R 1 714.90	
3197	Ptosis: By lesser procedure e.g. sling operation: Bilateral	20	166.000		R 2 068.70	
16.13	Conjunctiva					
3199	Repair of conjunctiva by grafting	20	132.000		R 1 645.00	
3200	Repair of lacerated conjunctiva	20	47.000		R 585.70	
16.14	Eye: General					
	Own equipment used in treatment: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.					
3190	Holmium laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting	20	109.000		R 1 358.40	
3192	Applicable to Medical Scheme Benefits only: Item 3192: If a practitioner performs the procedure in his own facility an excimer laser theatre fee of the indicated amount per minute may be charged	20	2.250		R 28.00	
3196	Diamond knife: Use of own diamond knife during intraocular surgery	20	12.000		R 149.50	
3198	Excimer laser: Hire fee (per eye)	20	284.130		R 3 540.80	
3201	Laser apparatus (ophthalmic): Hire fee for one or both eyes done in one sitting (not to be used with IOL Master)	20	109.000		R 1 358.40	
3202	Phako emulsification apparatus: Hire fee	20	109.000		R 1 358.40	
3203	Vitrectomy apparatus: Hire fee	20	120.000		R 1 495.30	
3208	Biopsy: External auditory canal	20	15.497		R 193.20	

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17	**Ear**					
	Fitting/orientation/checking of a hearing aid: report this service using the appropriate consultation code					
	Repair/modification of hearing aid: report this service using Item 0201 and supply invoice					
17.1	External ear (Pinna)					
	Fitting/orientation/checking of a hearing aid: report this service using the appropriate consultation code					
	Repair/modification of hearing aid: report this service using 0201 and supply invoice					
3267	Major congenital deformity reconstruction of external ear: Unilateral	20	138.000		R 1 719.90	
3269	Major congenital deformity reconstruction of external ear: Bilateral	20	242.000		R 3 015.80	
3270	Excision of superficial pre-auricular fistula	20	55.000		R 685.40	
3271	Partial or total reconstruction for congenital or traumatic absence or following tumour excision of external ear	20	-			
3272	Excision of complicated pre-auricular fistula	20	140.000		R 1 744.60	
5170	Drainage: Haematoma or abscess of external ear	20	34.800		R 433.80	
5173	Biopsy: External ear	20	12.400		R 154.60	
5175	Excision: External ear, partial, simple repair	20	63.500		R 791.30	
5176	Excision: External ear, complete	20	66.800		R 832.40	
17.2	External ear canal					
3204	External ear canal: Removal of foreign body, at rooms	20	-			
3205	External ear canal: Removal of foreign body, under general anaesthetic	20	21.000		R 261.80	
3215	Meatus atresia: Repair of stenosis of cartilaginous portion	20	164.000		R 2 043.70	
3217	Meatus atresia: Congenital	20	277.000		R 3 452.10	
3218	Remove impacted wax (one or both ears) with the use of a microscope (excludes loupe) – not to be used combined with Item 3206	20	17.420		R 217.00	
3219	Meatus atresia: Removal of osteoma from meatus, solitary	20	77.000		R 959.70	

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3220	Debridement mastoidectomy cavity with the use of a microscope (excludes loupe) – not to be used combined with Item 3206	20	23.100		R 288.40	
3221	Meatus atresia: Removal of osteoma from meatus, multiple	20	215.000		R 2 679.40	
17.3	Middle ear					
3206	Microscopic examination of tympanic membrane including microsuction	20	8.000		R 99.60	
3207	Myringotomy: Unilateral	20	28.000		R 349.00	
3209	Myringotomy: Bilateral	20	46.000		R 573.30	
3211	Unilateral myringotomy with insertion of ventilation tube	20	38.000		R 473.60	
3212	Bilateral myringotomy with insertion of unilateral ventilation tube	20	57.000		R 710.30	
3213	Bilateral myringotomy with insertion of bilateral ventilation tube (modifier 0005 not applicable)	20	65.000		R 810.00	
3214	Reconstruction of middle ear ossicles (ossiculoplasty)	20	255.000		R 3 177.80	
3237	Exploratory tympanotomy	20	158.900		R 1 980.20	
3242	Fenestration: Revision	20	20.000		R 1 969.90	
3243	Myringoplasty	20	138.000		R 1 719.90	
3245	Functional reconstruction of tympanic membrane	20	277.000		R 3 452.10	
3249	Stapedotomy and stapedectomy	20	277.000		R 3 452.10	
3257	Cortical mastoidectomy	20	188.500		R 2 349.20	
3259	Radical mastoidectomy (excluding minor procedures)	20	277.400		R 3 456.90	
3261	Muscle grafting to mastoid cavity without tympanoplasty	20	180.000		R 2 243.10	
3263	Autogenous bone graft to mastoid cavity	20	180.000		R 2 243.10	
3264	Tympanomastoidectomy	20	375.000		R 4 673.30	
3265	Reconstruction of posterior canal wall, following radical mastoid	20	320.000		R 3 987.90	
3266	Gentamycin steroids instillation into the middle ear for Ménière's disease (myringotomy and cost of material excluded)	20	30.000		R 485.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
17.4	Facial nerve					
17.4.1	Facial nerve: Facial nerve tests					
3223	Percutaneous stimulation of the facial nerve	20	9.000		R 146.00	
3224	Electroneurography (ENOG)	20	75.000		R 1 215.20	
17.4.2	Facial nerve: Facial nerve surgery					
3227	Exploration of facial nerve: Exploration of tympanomastiod segment	20	297.000		R 3 701.40	
3228	Exploration of facial nerve: Grafting of the tympanomastoid section (including Item 3227)	20	436.000		R 5 433.50	
3230	Exploration of facial nerve: Extratemporal grafting of the facial nerve	20	436.000		R 5 433.50	
3232	Exploration of facial nerve: Facio-assessory or facio-hypoglossal anastomosis	20	124.000		R 1 545.20	
17.5	Inner ear					
17.5.1	Inner ear: Audiometry					
2691	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Unilateral	20	50.000		R 810.20	
2692	Short latency brainstem evoked potentials (AEP) neurological examination, single decibel: Bilateral	20	88.000		R 1 425.60	
2693	AEP: Audiological examination: Unilateral at a minimum of four decibels	20	60.000		R 972.20	
2694	AEP: Audiological examination: Bilateral at a minimum of four decibels	20	105.000		R 1 701.10	
2695	Audiology 40Hz response: Unilateral	20	30.000		R 485.90	
2696	Audiology 40Hz response: Bilateral	20	53.000		R 858.70	
2697	Mid- and long latency auditory evoked potentials: Unilateral	20	30.000		R 485.90	
2698	Mid- and long latency auditory evoked potentials: Bilateral	20	53.000		R 858.70	
2699	Electro-cochleography: Unilateral	20	50.000		R 810.20	
2700	Electro-cochleography: Bilateral	20	88.000		R 1 425.60	
2702	Total fee for audiological evaluation including bilateral AEP and bilateral electro-cochleography	20	140.000		R 2 268.00	
3248	Otoacoustic emission performed as a screening test	20	33.240		R 538.70	
3250	Otoacoustic emission (high-risk patients only)	20	66.480		R 1 077.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3273	Pure tone audiometry (air conduction)	20	6.500		R 105.40	
3274	Pure tone audiometry (bone conduction with masking)	20	6.500		R 105.40	
3275	Impedance audiometry (tympanometry)	20	6.500		R 105.40	
3276	Impedance audiometry (stapedial reflex) – no charge for volume, compliance etc.	20	6.500		R 105.40	
3277	Speech audiometry: Fee includes speech audiogram, speech reception threshold, discrimination score	20	10.000		R 161.80	
3278	Recruitment tests: Inclusive fee (Bekesy, Fowler, etc.)	20	6.500		R 105.40	
17.5.2	Inner ear: Balance tests					
3251	Minimal caloric test (excluding consultation fee)	20	10.000		R 161.80	
3252	Bithermal Halpike caloric test (excluding consultation fee)	20	20.000		R 324.00	
3253	Electro-nystagmography for spontaneous and positional nystagmus	20	25.000		R 405.00	
3254	Video nystagmoscopy (monocular)	20	25.000		R 405.00	
3255	Caloric test done with electronystamography	20	70.000		R 1 134.20	
3256	Video nystagmoscopy (binocular)	20	50.000		R 810.20	
3258	Otolith repositioning manoeuvre	20	14.000		R 226.70	
3260	Computerised static posturography consists of standing a patient on a Piezo-electric platform which tests the vestibular and proprioceptive systems	20	71.480		R 1 157.90	
17.5.3	Middle and inner ear surgery					
3233	Labyrinthectomy via the middle ear or mastoid	20	277.000		R 3 452.10	
3240	Endolymphatic sac surgery	20	277.000		R 3 452.10	
3244	Fenestration and occulasion of the posterior semicircular canal (FOS) for benign paroxysmal positioning vertigo (BPPV)	20	310.000		R 3 863.20	
3246	Cochlear implant surgery	20	340.500		R 4 243.40	
5196	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, without mastoidectomy	20	212.300		R 2 646.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5197	Inplantation: Osseo-integrated temporal bone implant, percutaneous attachment to external speech processor or cochlear stimulator, with mastoidectomy	20	269.000		R 3 351.80	
5199	Revision: Stapedectomy or stapedotomy	20	251.900		R 3 139.60	
17.6	Microsurgery of the skull base					
17.6.1	Microsurgery of the skull base: Middel fossa approach (i.e transtemporal or supralabyrinthine)					
3229	Facial nerve: Exploration of the labyrinthine segment	20	420.000		R 5 234.00	
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment are included)	20	510.000		R 6 355.50	
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)	20	620.000		R 7 726.40	
5223	Vestibular neurectomy, removal of supra-labyrinthine tumours or similar procedures	20	530.000		R 6 604.80	
5224	Removal of acoustic neuroma via the middle fossa approach	20	660.000		R 8 225.00	
17.6.2	Microsurgery of the skull base: Translabyrinthe approach					
3239	Acoustic neuroma removal translabyrinthine	20	660.000		R 8 225.00	
5227	Cochleo-vestibular neurectomy	20	530.000		R 6 604.80	
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting is required, the grafting and harvesting of graft are included)	20	660.000		R 8 225.00	
17.6.3	Microsurgery of the skull base: Transotic approach to the cerebellopontime angle					
5232	Removal of acoustic neuroma or cyst of the internal auditory canal	20	660.000		R 8 225.00	
17.6.4	Microsurgery of the skull base: Intratemporal fossa approach type A					
5235	Removal of tumour for the jugular foramen, internal carotid artery, petrous apex and large intratemporal tumours	20	710.000		R 8 848.10	
17.6.5	Microsurgery of the skull base: Intratemporal fossa approach type B					
5238	Removal of tumour of the petrous apex	20	620.000		R 7 726.40	
5239	Removal of tumour of the clivus	20	620.000		R 7 726.40	
17.6.6	Microsurgery of the skull base: Intrafemoral approach type C					
5242	Removal of nasopharyngeal angiofibroma or carcinoma	20	520.000		R 6 480.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5243	Removal of tumour from the intratemporal fossa, pterygopalatine fossa, parasellar region or nasopharynx	20	520.000		R 6 480.30	
17.6.7	Microsurgery of the skull base: Subtotal petrosectomy					
5246	Subtotal petrosectomy for removal of temporal bone tumour	20	600.000		R 7 477.30	
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	20	480.000		R 5 981.70	
17.6.8	Microsurgery of the skull base: Petrosectomy and radical dissection of petromandibular fossa					
5250	Partial mastoido-tympanectomy for malignancy of the deep lobe of the parotid gland	20	520.000		R 6 480.30	
5251	Total mastoido-tympanectomy for more extensive malignancy of the deep lobe of the parotid gland	20	600.000		R 7 477.30	
5252	Extended petrosectomy for extensive malignancy of the deep lobe of the parotid gland	20	660.000		R 8 225.00	
18	**Physical treatment**					
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	20	0.750		R 9.38	
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	20	13.500		R 168.10	
3281	Ultrasonic therapy	20	10.000		R 124.40	
3282	Shortwave diathermy	20	10.000		R 124.40	
3284	Sensory nerve conduction studies	20	31.000		R 386.30	
3285	Motor nerve conduction studies	20	26.000		R 324.00	
3287	Spinal joint and ligament injection	20	20.000		R 249.30	
3288	Epidural injection	20	36.000		R 448.60	
3289	Multiple injections: First joint	20	7.500		R 93.50	
3290	Multiple injections: Each additional joint	20	4.500		R 56.10	
3291	Tendon or ligament injection	20	9.000		R 112.20	
3292	Aspiration of joint or inter-articular injection	20	9.000		R 112.20	
3293	Aspiration or injection of bursa or ganglion	20	9.000		R 112.20	
3294	Paracervical (neck) nerve block (for pelvis refer to Item 2389)	20	20.000		R 249.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3295	Paravertebral root block: Unilateral	20	20.000		R 249.30	
3296	Paravertebral root block: Bilateral	20	30.000		R 373.80	
3297	Manipulation of spine performed by a specialist in Physical Medicine	20	14.000		R 174.40	
3298	Spinal traction	20	6.000		R 74.90	
3299	Manipulation of large joints: Under general anaesthesia	20	14.000		R 174.40	
3299a	Manipulation of large joints: Under general anaesthesia	20	14.000		R 174.40	
3300	Manipulation of large joints: Without anaesthetic	20	-			
3301	Muscle fatigue studies	20	20.000		R 249.30	
3302	Strength duration curve per session	20	10.500		R 130.70	
3303	Electromyography	20	75.000		R 934.70	
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment. For subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment. A fee for the treatment only, is applicable: See general rules L and M.	20	10.000		R 124.40	
	SPECIAL MODIFIER: SECTION ON PHYSICAL TREATMENT					
0077	Physical treatment: When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine).					
5431	Physical status modifier: Normal health patient, ASA 1 – Add 0.00 anaesthetic units					
5432	Physical status modifier: A patient with mild systemic disease, ASA 2 – Add 0,00 anaesthetic units					
5436	Physical status modifier: A declared brain-dead patient whose organs are being removed for donor purposes ASA 6 – Add 0,00 anaesthetic units					
19	**Radiology**					
	Please note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology unit values.					
	RULES GOVERNING THE SECTION RADIOLOGY					
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used.					

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Z.	No fee is subject to more than one reduction.					
GG.	Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.					
RR.	The radiology section in this price list is not for use by registered specialist radiology practices (Pr No “038”) or nuclear medicine practices (Pr No “025”), but only for use by other specialist practices or general practitioners. A separate radiology schedule is for the exclusive use of registered specialist radiology practices (Pr No “038”) and nuclear medicine practices (Pr No “025”).					
	MODIFIERS GOVERNING THE SECTION					
0002	Written report on X-rays: The lowest level code for a new patient office (consulting rooms) visit, is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him. The above mentioned item and the lowest level initial hospital visit code, as appropriate are not to be used for routine reporting of X-rays taken elsewhere.					
0080	Multiple examinations: Full fee					
0081	Repeat examinations: No reduction					
0082	“+” means that this item is complementary to a preceding item and is therefore not subject to reduction.					
0083	A reduction of 33,33% (1/3) in the fee will apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used.					
0084	Film costs: In the case of radiological items where films are used, practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit. This information is obtainable from the Radiological Society of SA.					
19.1	Skeleton					
19.1.1	Skeleton: Limbs					
3305	Finger, toe		6.300		R 144.60	
3309	Smith-Petersen or equivalent control, in theatre		38.700		R 888.20	
3311	Stress studies, e.g. joint		7.700		R 176.90	
3313	Full length study, both legs		15.500		R 355.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3315	Skeletal survey under 5 years					
3317	Skeletal survey over 5 years		28.000		R 642.60	
3319	Arthrography per joint		15.400		R 353.40	
3320	Introduction of contrast medium or air: Add		13.800		R 316.80	
6500	Hand		7.700		R 176.90	
6501	Wrist (specify region)		7.700		R 176.90	
6503	Scaphoid		7.700		R 176.90	
6504	Radius and ulna		7.700		R 176.90	
6505	Elbow		7.700		R 176.90	
6506	Humerus		7.700		R 176.90	
6507	Shoulder		7.700		R 176.90	
6508	Acromio-Clavicula joint		7.700		R 176.90	
6509	Clavicle		7.700		R 176.90	
6510	Scapula		7.700		R 176.90	
6511	Foot		7.700		R 176.90	
6512	Ankle		7.700		R 176.90	
6513	Calcaneus		7.700		R 176.90	
6514	Tibia and fibula					
6515	Knee		7.700		R 176.90	
6516	Patella		7.700		R 176.90	
6517	Femur		7.700		R 176.90	
6518	Hip		7.700		R 176.90	
6519	Sesamoid bone		7.700		R 176.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
19.1.2	Skeleton: Spinal column					
3321	Per region, e.g. cervical, sacral, lumbar coccygeal, one region thoracic		11.000		R 252.40	
3325	Stress studies		11.000		R 252.40	
3329	Scoliosis studies		21.000		R 482.20	
3331	Pelvis (sacro-iliac or hip joints only to be added where an extra set of view is required)		11.000		R 252.40	
3333	Myelography: Lumbar		28.900		R 663.30	
3334	Myelography: Thoracic		22.200		R 509.60	
3335	Myelography: Cervical		35.500		R 814.60	
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)					
3344	Introduction of contrast medium		18.700		R 429.30	
3345	Discography		34.600		R 794.10	
3347	Introduction of contrast medium per disc level: Add		28.200		R 647.30	
19.1.3	Skeleton: Skull					
3349	Skull studies		15.700		R 360.30	
3351	Paranasal sinuses		11.000		R 252.40	
3353	Facial bones and/or orbits		12.600		R 289.10	
3355	Mandible		9.400		R 215.70	
3357	Nasal bone		7.800		R 178.90	
3359	Mastoid: Bilateral					
3361	Teeth: One quadrant		3.700		R 85.20	
3363	Teeth: Two quadrants		6.300		R 144.60	
3365	Teeth: Full mouth		11.000		R 252.40	
3366	Teeth: Rotation tomography of the teeth and jaws		13.300		R 305.10	
3367	Teeth: Tempero-mandibular joints, per side		11.000		R 252.40	

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3369	Teeth: Tomography, per side		11.000		R 252.40	
3371	Localisation of foreign body in the eye		15.700		R 360.30	
3381	Ventriculography		27.300		R 626.90	
3385	Post-nasal studies: Lateral neck		6.300		R 144.60	
3387	Maxillo-facial cephalometry		8.800		R 202.30	
3389	Dacrocystography		11.000		R 252.40	
3391	For introduction of contrast medium: Add		11.000		R 252.40	
19.2	Alimentary tract					
3393	Bowel washout: Add		4.800		R 110.10	
3395	Sialography (plus 80% for each additional gland)		12.700		R 291.70	
3397	Introduction of contrast medium (plus 80% for each additional gland: Add)		11.000		R 252.40	
3399	Pharynx and oesophagus		12.700		R 291.70	
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through		20.000		R 459.10	
3405	Double contrast: Add					
3406	Small bowel meal (control film of abdomen included except when part of Item 3408)		20.000		R 459.10	
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)		28.900		R 663.30	
3409	Barium enema (control film of abdomen included)		18.300		R 420.30	
3411	Air contrast study: Add		19.300		R 443.00	
3415	Biliary Tract: ERCP own equipment: Choledogram and/or pancreatography screening included		23.300		R 534.70	
3416	Pancreas: ERCP hospital equipment: Choledogram and/or pancreatography screening included		15.500		R 355.70	
	Note: For Items 3415 and 3416: Endoscopy (see Item 1778)					
3417	Gastric/oesophageal/duodenal intubation control		5.900		R 135.50	
3419	Gastric/oesophageal intubation insertion of tube: Add		5.600		R 128.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3421	Duodenal intubation: Insertion of tube: Add		11.000		R 252.40	
3423	Hypotonic duodenography (Item 3403 and Item 3405 included)		29.300		R 672.60	
19.3	Biliary tract					
3425	Oral cholecystography		15.700		R 360.30	
3427	Cholangiography: Intravenous		22.000		R 504.70	
3431	Operative cholangiography: First series – add Item 3607 only when the radiologist attends personally in theatre		21.000		R 482.20	
3433	Post operative: T-tube		16.700		R 383.30	
3435	Introduction of contrast medium: Add		5.600		R 128.40	
3437	Trans hepatic, percutaneous		18.300		R 420.30	
3439	Introduction of contrast medium: Add		33.100		R 759.70	
3441	Tomography of biliary tract: Add		9.400		R 215.70	
19.4	Chest					
3443	Larynx (tomography included)		12.500		R 286.70	
3445	Chest (Item 3601 included)		9.400		R 215.70	
3447	Chest and cardiac studies (Item 3601)		12.600		R 289.10	
3449	Ribs					
3451	Sternum or sterno-clavicular joints					
3453	Bronchography: Unilateral		12.600		R 289.10	
3455	Bronchography: Bilateral		22.100		R 507.40	
3457	Introduction of contrast medium included		35.700		R 819.40	
3461	Pleurography					
3463	For introduction of contrast medium: Add					
3465	Laryngography					
3467	For introduction of contrast medium: Add					

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3468	Thoracic inlet					
19.5	Abdomen					
3477	Control films of the abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)					
3479	Acute abdomen or equivalent studies		15.700		R 360.30	
19.6	Urinary tract					
3487	Excretory urogram: Control film included and bladder views before and after micturition (intravenous pyelogram) – Item 0206 not applicable		25.100		R 576.10	
3493	Waterload test: Add		12.200		R 280.10	
3497	Cystography only or urethrography only (retrograde)		19.300		R 443.00	
3499	Cysto-urethrography: Retrograde		31.900		R 732.00	
3503	Cysto-urethrography: Introduction of contrast medium		3.700		R 85.20	
3505	Retrograde-prograde pyelography		18.300		R 420.30	
3511	Aspiration renal cyst		18.400		R 422.20	
3513	Tomography of renal tract: Add		9.400		R 215.70	
19.7	Gynaecology and obstetrics					
3515	Pregnancy					
3517	Pelvimetry					
3519	Hystero-salpingography					
3521	Introduction of contrast medium: Add					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
19.8	Vascular studies					
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (Items 3536 to 3550) includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii. All fluoroscopy (Item 3601 does not apply). iv. All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)					
	MODIFIER GOVERNING VASCULAR STUDIES					
0086	Vascular groups: “Film series” and “Introduction of Contrast Media” are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of modifier 0080: Multiple examinations.					
6300	If a procedure lasts less than 30 minutes, only 50% of the machine fees for Items 3536-3550 will be allowed (specify time of procedure on account).					
6301	If a procedure is performed by a radiologist in a facility not owned by himself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).					
6302	When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged).					
6303	When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.					
6305	When multiple catheterisation procedures are used (Items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20,00 radiological units for each procedure after the initial catheterisation. The first catheterisation is charged at 100% of the unit value.					

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19.8.1	Vascular studies: Film series					
	Note: In the case of selective catheterisation of a branch of the aorta, the fee for catheterisation of the aorta is not added.					
3536	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment					
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment					
3538	Analogue monoplane table with DSA attachment					
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment					
3545	Venography: Per limb		16.500		R 378.80	
3548	Analogue monoplane screening table					
3550	Digital monoplane screening table					
3551	Lymphangiogram per limb (global fee) including lymphatic catheterisation (no machine fee applicable)		166.800		R 3 628.90	
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram		48.600		R 1 115.50	
3558	Translumbar aortic puncture, with full study		69.600		R 1 597.50	
3559	Selective first order catheterisation, arterial or venous, with angiogram/venogram		57.000		R 1 308.40	
3560	Selective second order catheterisation, arterial or venous, with angiogram/ venogram		65.400		R 1 501.10	
3562	Selective third order catheterisation, arterial or venous, with angiogram/venogram		73.200		R 1 680.20	
3564	Direct femoral arterial or venous or jugular venous puncture		37.200		R 854.00	
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous malformation (AVM)		85.800		R 1 969.30	
3569	Intravascular pressure studies, arterial or venous, once off per case		19.800		R 454.50	
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)		130.800		R 3 002.20	
3572	Transcatheter selective blood sampling, arterial or venous		32.400		R 743.50	
3574	Spinal angiogram (global fee) including all selective catheterisations		480.000		R 11 017.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
19.8.2	Vascular studies: Introduction of contrast medium					
3563	Direct intravenous for limb		7.400		R 169.70	
3575	Cut-downs for venography: Add		11.000		R 252.40	
19.9	Tomography and cinematography					
	Please note: The calculated amounts in this section are calculated according to the computed tomography unit values					
3577	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations.					
3579	Tomography (multi-dimensional in motion): Add 150%					
3581	Cinematography: For first series – add 100%					
3583	Cinematography: For each series after the first – add 80% of the primary fee					
19.9.1	Tomography and cinematography: Computed tomography					
3592	Where a fully digital C-arm portable X-ray unit, with angiography/interventional capability is used in hospital or theatre, per half hour					
3597	Contrast media: General Rule Y applies (Please note: Item 0201 is not applicable for contrast media)					
3598	Electron beam computed tomography (EBCT) for assessment of coronary artery calcification (complete fee – no additions)					
3599	Electron beam computed tomography (EBCT) of the heart. Total fee for contract examination excluding cost of contrast medium (not to be used for coronary artery calcium assessment or scoring – see Item 3598)					
6400	Plus spiral CT					
6401	Plus 3D reconstruction					
6402	Plus high resolution study					
6403	CT limb uncontrasted					
6404	CT limb with contrast only					
6405	CT limb pre- AND post contrast					
6406	CT joint uncontrasted					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6407	CT joint with contrast only					
6408	CT joint pre AND post contrast					
6409	CT brain uncontrasted (including posterior fossa)					
6410	CT brain with contrast only (including posterior fossa)					
6411	CT brain pre AND post contrast (including posterior fossa)					
6412	CT orbits complete study, axial OR coronal, uncontrasted					
6413	CT orbits complete study, axial AND coronal, uncontrasted					
6414	CT orbits complete study, axial OR coronal pre AND post contrast					
6415	CT orbits complete study, axial AND coronal pre AND post contrast					
6416	CT paranasal sinuses limited study axial OR coronal					
6417	CT paranasal sinuses limited study axial AND coronal					
6418	CT paranasal sinuses complete study, axial OR coronal, uncontrasted					
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted					
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast					
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast					
6422	CT pituitary fossa, uncontrasted					
6423	CT pituitary fossa, pre AND post contrast					
6424	CT internal auditory meati, uncontrasted					
6425	CT internal audiory meati, pre AND post contrast					
6426	CT mastoids					
6427	CT ear structures, limited study					
6428	CT middle AND inner ear, complete study including reconstructions					
6429	CT facial bones					
6430	CT neck soft tissue, uncontrasted					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6431	CT neck soft tissue with contrast only					
6432	CT neck pre AND post contrast					
6433	CT cervical spine uncontrasted					
6434	CT cervical spine pre AND post contrast					
6435	CT cervical spine post myelogram					
6436	CT dorsal spine uncontrasted					
6437	CT dorsal spine pre AND post contrast					
6438	CT dorsal spine post myelogram					
6439	CT lumbar spine uncontrasted					
6440	CT lumbar spine pre AND post contrast					
6441	CT lumbar spine post myelogram					
6442	CT pelvimetry (topogram only)					
6443	CT chest uncontrasted					
6444	CT chest with contrast					
6445	CT chest pre AND post contrast					
6446	CT chest high resolution lungs, limited study					
6447	CT high resolution lungs, complete study					
6448	CT abdomen uncontrasted					
6449	CT abdomen with contrast					
6450	CT abdomen pre AND post contrast					
6451	CT abdomen triphasic study					
6452	CT pelvis uncontrasted					
6453	CT pelvis with contrast					
6454	CT pelvis pre AND post contrast					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6455	CT abdomen AND pelvis uncontrasted					
6456	CT abdomen AND pelvis with contrast					
6457	CT abdomen AND pelvis pre AND post contrast					
6458	CT chest, abdomen AND pelvis with contrast					
6459	CT base of skull to symphysis pubis with contrast					
6460	CT for dental implants maxilla OR mandible					
6461	CT for dental implants maxilla AND mandible					
6462	CT angiography per limited region (including spiral, high resolution, AND all reconstructions)					
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)					
6464	CT limited study, any region. Region to be identified on the account					
6465	CT guidance for aspiration, biopsy or drainage					
6466	CT guidance for aspiration at time of CT diagnostic study					
6467	CT stereotactic localisation for biopsy					
6468	CT for radiotherapy planning (not to be used as an add-on)					
6469	Quantitative CT for bone mineral density					
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast					
6471	CT of the chest, triphasic study of the liver, abdomen and pelvis with contrast					
6472	Computer Aided Diagnosis for Mammography					
19.10	Radiology: Miscellaneous					
3594	Mammogram of surgically removed breast biopsy specimen					
3600	Peripheral bone densitometry utilising ionising radiation	40	13.000		R 298.50	
3601	Fluoroscopy: Per half hour – add (not applicable for Items 3445 and 3447)		7.700		R 176.90	
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour – add		10.700		R 245.60	
3603	Sinography		18.400		R 422.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	40	77.000		R 1 767.00	
3605	Mammography: Unilateral or bilateral, including ultrasound and doppler ultrasound examination, where necessary. This item may not be used together with an item from the ultrasound section. Note that when an ultrasound of the breast is requested without mammography, Item 3629 is used.		33.000		R 757.60	
3606	Repeat mammography, unilateral or bilateral, for localisation of tumour.		21.000		R 482.20	
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in X-ray department (except Item 3309): Per half hour, plus fee or examination performed. Only to be used by radiological technical staff.					
3608	Repeat mammography procedure with minimally invasive breast biopsy, core biopsy or fine needle aspiration biopsy utilising dedicated stereotactic equipment with patient in erect or prone position.		40.000		R 918.10	
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done.					
3611	Foreign body localisation: Introduction of sterile needle markers: Add					
3613	Setting of sterile trays		3.300		R 75.80	
5029	Mammotome – stereotaxis: Hand held		59.000		R 1 354.20	
5034	Fine needle aspiration or biopsy or core biopsy of mamma		25.000		R 573.80	
19.10.2	Radiology: Miscellaneous: Mammography					
19.11	Ultrasound investigations					
	Please note: The calculated amounts in this section are calculated according to the ultrasound unit values					
	Note: See rule GG for requirements for reports and the keeping of records which are also applicable to ultrasonic investigations.					
3596	Intravascular ultrasound per case, arterial or venous, for intervention	60	30.000		R 463.50	
3610	Transrectal ultrasonographic prostate volume study for prostate brachytherapy (own equipment)	60	110.000		R 1 698.60	
3612	Ultrasonic bone densitometry	60	19.000		R 293.40	
3614	Transvaginal aspiration of ova	60	110.000		R 1 698.60	
3615	Routine obstetric ultrasound at 10 to 20 weeks gestational age preferable at 10 to 14 weeks gestational age to include nuchal translucency assessment	60	50.000		R 772.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3616	Contrast media: General Rule Y applies					
3617	Routine obstetric ultrasound at 20 to 24 weeks to include detailed anatomical assessment	60	50.000		R 772.10	
3618	Pelvic organs ultrasound transabdominal probe (this is a gynaecological ultrasound examination and may not be used in pregnancy)	60	40.000		R 617.80	
3619	Intravascular ultrasound imaging assesses the atheroschlerotic process to guide the placement of an intracoronary stent. This item may be applied once per vessel (left anterior descending territory, circumflex territory and/or right coronary territory) in which a stent or multiple stents are deployed	60	30.000		R 463.50	
3620	Cardiac examination plus Doppler colour mapping	60	50.000		R 772.10	
3621	Cardiac examination (MMode)	60	25.000		R 386.30	
3622	Cardiac examination: 2 Dimensional	60	50.000		R 772.10	
3623	Cardiac examination + effort	60	10.000		R 154.60	
3624	Cardiac examinations + contrast	60	10.000		R 154.60	
3625	Cardiac examinations + doppler	60	50.000		R 772.10	
3626	Cardiac examination + phonocardiography	60	10.000		R 154.60	
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)	60	60.000		R 926.40	
3628	Renal tract	60	50.000		R 772.10	
3629	High definition (small parts) scan: Thyroid, breast lump, scrotum, etc.	60	50.000		R 772.10	
3631	Ophthalmic examination	60	50.000		R 772.10	
3632	Axial length measurement and calculation of intra ocular lens power, per eye. Not to be used with Item 3034	60	50.000		R 772.10	
3633	Neonatal head scan	60	50.000		R 772.10	
3634	Peripheral vascular study, B mode only	60	39.000		R 602.30	
3635	+ Doppler	60	39.000		R 602.30	
3636	Trans-oesophageal echocardiography including passing the device	60	100.000		R 1 544.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to Items 3605, 5110, 5111, 5112, 5113 or 5114)	60	78.000		R 1 204.50	
5026	Ultrasound guided amniocentesis	60	39.000		R 602.30	
5100	Pelvic organs ultrasound: Transvaginal or trans rectal probe	60	50.000		R 772.10	
5101	Pleural space ultrasound	60	50.000		R 772.10	
5102	Ultrasound of joints (e.g. shoulder, hip, knee), per joint	60	50.000		R 772.10	
5103	Ultrasound soft tissue, any region	60	50.000		R 772.10	
5106	Obstetric ultrasound before 10 weeks gestational age for complicated pregnancy i.e. suspected ectopic pregnancy abortion or discrepancy between gestational age and dates. Not to be used for routine diagnosis of pregnancy	60	25.000		R 386.30	
5107	Ultrasound after 24 weeks – motivation required	60	25.000		R 386.30	
5108	Second opinion obstetric ultrasound may be charged by practitioners accepted by SASOG or RSSA (list of names available from SASOG or RSSA)	60	50.000		R 772.10	
5110	Carotid ultrasound vascular study: B mode, pulsed and colour Doppler; bilateral study, internal, external and common carotid flow and anatomy	60	128.000		R 1 976.50	
5111	Full ultrasonic and colour Doppler evaluation of entire extracranial vascular tree: Carotids, vertebral and subclavian vessels (not to be used together with Items 5110, 5112, 5113 or 5114)	60	206.000		R 3 180.90	
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	60	117.000		R 1 806.70	
5113	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; to evaluate deep vein thrombosis	60	117.000		R 1 806.70	
5114	Peripheral venous ultrasound vascular study; B mode, pulsed and colour Doppler; in erect and supine position including compression manoeuvres and reflux in superficial and deep systems, bilaterally	60	178.000		R 2 748.70	
5115	Intra-operative ultrasound study	60	50.000		R 772.10	
5117	Diagnostic intravascular ultrasound (IVUS) imaging or wave wire mapping (without accompanying angioplasty). May be used only once per angiographic procedure	60	88.000		R 1 358.90	
5118	Diagnostic intravascular ultrasound imaging or wave wire imaging (with accompanying angioplasty or accompanying intravascular ultrasound imaging or wave wire mapping in a different coronary artery – LAD (left anterior desending), Circumflex or right coronary artery. May be used a maximum of twice per angiographic procedure.	60	44.000		R 679.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	MODIFIERS GOVERNING ULTRASONIC INVESTIGATIONS					
0160	Aspiration of biopsy procedure performed under direct ultrasound control by an ultrasound aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units					
0165	Use of contrast during ultrasound study: Add 6.00 ultrasound units	60	6.000		R 92.70	
5104	Ultrasound in pregnancy, multiple gestation, after 20 weeks: plus 30%					
	GENERAL RULE GOVERNING ULTRASONIC EXAMINATIONS DURING PREGNANCY					
EE.	**Ultrasound examinations** The international norm approved for use in South Africa for NORMAL PREGNANCY is two ultrasound exams: a. The first scan should preferably include a nuchal thickness estimation and be performed between 10 and 14 weeks gestation. The second scan should be performed between 20 and 24 weeks and should include a full anatomical report. All subsequent ultrasound scans are excluded from the benefits of medical schemes unless accompanied by proper motivation. An ultrasound scan to assess an abnormal early pregnancy may be formed before 10 weeks but this scan may not be used to diagnose a normal uncomplicated pregnancy. Item 3618 is a gynaecological scan and its use is not approved for use in pregnancy. b. In cases where the scan is performed by the attending practitioner, a clear indication for such a scan must be entered on the account rendered, or a letter of motivation must be attached to the account (the practitioner must elect one of the two options). c. In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the patient (by the radiologist or the other practitioner doing the scan) and must be attached to the first account submitted to the medical scheme by the patient or the doctor, as the case may be. d. In case of a referral to a radiologist, no motivation should be required from the radiologist					
19.12	Portable unit examinations					
3639	Where portable X-ray unit is used in the hospital or theatre: Add		7.000		R 160.70	
3640	Theatre investigations with fixed installation					
19.13	Diagnostic procedures requiring the use of radio-isotopes					
AA.	Procedures to exclude cost of isotope					
3641	Tracer test	40	33.200		R 762.10	
3642	Repeat of further tracer tests for same investigation: Half of above fee	40	16.600		R 380.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee					
3644	Tracer test of complete body or brain tumour location	40	82.200		R 1 886.40	
3645	Other organ scanning with use of relevant radio isotopes	40	82.200		R 1 886.40	
3646	Thyroid scanning	40	28.800		R 661.10	
6474	Positron Emission Tomography (PET) imaging of the whole body using a Coincidence Camera					
6475	Positron Emission Tomography (PET) imaging of a limited body region using a Coincidence Camera					
19.14	Interventional radiological procedures					
	The following rules are applicable to Section 19.8 (Vascular studies) and Section 19.14 (Interventional Radiological Procedures): a. The machine fee (Items 3536 to 3550 includes the cost of the following: i. All runs (runs may not be billed for separately). ii. All film costs (modifier 0084 is not applicable). iii All fluoroscopy (Item 3601 does not apply). iv All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, embolic agents, drugs and contrast media). b. The machine fee (Items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices. c. If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team will fee at their respective full rates as per modifiers and the applicable items. d. If a procedure is performed by a non-radiologists and a radiologist as a team, in a facility not owned by the radiologist, modifiers 6301 and 6302 applies. Please note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)					
	Note: In regard to multiple examinations see modifier 0080					
5002	Percutaneous transluminal angioplasty: Aortic/IVC		102.600		R 2 355.00	
5004	Percutaneous transluminal angioplasty, arterial or venous, iliac vessel/subclavian vessel		102.600		R 2 355.00	
5006	Percutaneous transluminal angioplasty: Femoral to popliteal bifurcation, axillary and brachial		102.600		R 2 355.00	
5008	Percutaneous transluminal angioplasty: Sub-popliteal sub-brachial		139.200		R 3 195.00	
5010	Percutaneous transluminal angioplasty: Renal/Visceral/Brachiocephalic		139.200		R 3 195.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5012	Percutaneous transluminal angioplasty: Extracranial Carotid/Vertebral – stand alone procedure		172.200		R 3 952.50	
5014	Atherectomy (per vessel)		204.600		R 4 696.30	
5016	Aspiration thrombectomy (per vessel)					
5017	Endoscopic ultrasound: Colon		79.900		R 1 293.90	
5018	On-table thrombolysis/transcatheter infusion performed in angiography suite		106.800		R 2 451.20	
5019	Endoscopic ultrasound: Colon, with aspiration or biopsy		100.700		R 1 630.90	
5021	Proctosigmoidoscopy with endoscopic ultrasound examination		41.900		R 678.70	
5022	Embolisation non-intracranial, per vessel		106.800		R 2 451.20	
5023	Proctosigmoidoscopy with endoscopic ultrasound examination, with ultrasound-guided aspiration and/or biopsy		64.100		R 1 038.10	
5024	Endoscopic ultrasound: Oesophagus		50.900		R 824.50	
5025	Endoscopic ultrasound: Oesophagus with aspiration or biopsy		70.200		R 1 136.90	
5030	Percutaneous nephrostomy for further procedure or drainage		73.800		R 1 693.90	
5031	Antegrade ureteric stent insertion		69.600		R 1 597.50	
5033	Percutaneous cystostomy in radiology suite		30.000		R 688.50	
5035	Urethral balloon dilatation in radiology suite		22.800		R 523.50	
5036	Percutaneous abdominal/pelvic/other drain insertion, any modality		34.200		R 785.00	
5037	Urethral stenting in radiology suite		102.600		R 2 355.00	
5038	Intracranial/spinal AVM embolisation (per session)		335.400		R 7 698.30	
5039	Intracranial thrombolysis (on-table) per session		139.200		R 3 195.00	
5040	Intracranial aneurysm occlusion		286.800		R 6 582.80	
5041	Balloon occlusion/Wada test		106.800		R 2 451.20	
5042	Carotico/cavernous fistula/head and neck AV fistula embolisation		286.800		R 6 582.80	
5043	Intracranial angioplasty		204.600		R 4 696.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5044	Transhepatic portogram		139.200		R 3 195.00	
5045	Hepatic arterial infusion catheter insertion		156.000		R 3 580.50	
5046	Percutaneous biliary drainage (external)		102.600		R 2 355.00	
5047	Combined internal/external biliary drainage		102.600		R 2 355.00	
5048	Biliary stent insertion		139.200		R 3 195.00	
5049	Percutaneous gall bladder drainage		69.600		R 1 597.50	
5050	Percutaneous or renal gall bladder stone removal		172.200		R 3 952.50	
5058	Stent insertion: Aortic/IVC – including percutaneous transluminal angioplasty (PTA)		139.200		R 3 195.00	
5060	Stent insertion: Iliac/subclavian/AV fistula – including percutaneous transluminal angioplasty (PTA)		139.200		R 3 195.00	
5062	Stent insertion: Femoral popliteal bifurcation, axillary and brachial – including percutaneous transluminal angioplasty (PTA)		139.200		R 3 195.00	
5064	Stent insertion: Sub-popliteal – including percutaneous transluminal angioplasty (PTA)		172.200		R 3 952.50	
5066	Stent insertion: Renal/visceral/brachiocephalic – including percutaneous transluminal angioplasty (PTA)		204.600		R 4 696.30	
5068	Stent insertion: Extracranial carotid/vertebral – including percutaneous transluminal angioplasty (PTA) – stand alone procedure		204.600		R 4 696.30	
5070	Stent insertion: Aorto-iliac stent graft – including percutaneous transluminal angioplasty (PTA)		311.400		R 7 147.90	
5072	Tunnelled/subcutaneous arterial/venous line performed in radiology suite		82.200		R 1 886.70	
5074	IVC filter insertion jugular or femoral route		156.000		R 3 580.50	
5076	Intravascular foreign body removal, arterial or venous, any route		204.600		R 4 696.30	
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM)		70.200		R 1 611.40	
5080	Transjugular intrahepatic porto-systemic shunt		335.400		R 7 698.30	
5082	Transjugular liver biopsy		69.600		R 1 597.50	
5084	Endoluminal fallopian tube recanalisation					
5086	Renal cyst aspiration/ablation		22.800		R 523.50	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY			Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31			
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5088	Oesophageal stent insertion in radiology suite		102.600		R 2 355.00	
5090	Tracheal stent insertion		102.600		R 2 355.00	
5091	GIT balloon dilatation under fluoroscopy		66.600		R 1 528.70	
5092	Other GIT stent insertion		102.600		R 2 355.00	
5093	Percutaneous gastrostomy in radiology suite		85.800		R 1 969.30	
5094	Cutting needle biopsy with image guidance		22.800		R 523.50	
5095	Chest drain insertion in radiology suite		32.400		R 743.50	
5096	Percutaneous cyst or tumour ablation (non aspiration)		54.600		R 1 253.20	
5097	Vertebroplasty – introduction of stabilising material under screening or CT control, per level					
5098	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate		81.400		R 1 318.30	
5099	Endoscopic ultrasound: Upper gastro-intestinal tract. Includes oesophagus, stomach, duodenum and/or jejunum, as appropriate, with ultrasound-guided aspiration and/or biopsy		113.800		R 1 843.10	
5955	3D Echocardiography for congenital cardiac abnormality: Transthoracic, Volumetric and functional evaluation – PROFESSIONAL COMPONENT		61.900		R 1 002.60	
5956	3D Echocardiography for congenital abnormality: Trans-oesophageal – PROFESSIONAL COMPONENT		84.000		R 1 360.40	
5972	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA), venous system (IVC, SVC, systemic vein or patent ductus arteriosus): First vessel		132.520		R 2 146.30	
5973	Stent placement right ventricular outflow tract, branch pulmonary artery, coarctation of the aorta, collateral vessel (incl. MAPCA) or venous system (IVC, SVC, systemic vein or patent ductus arteriosus): Subsequent vessels (per vessel)		81.490		R 1 319.60	
5974	Stent placement,branch pulmonary artery: First vessel		132.520		R 2 146.30	
5975	Stent placement, branch pulmonary artery: Subsequent vessels (per vessel)		76.980		R 1 246.70	
5976	Stent placement coarctation of the aorta		132.520		R 2 146.30	
5980	Stent patent ductus arteriosus and interatrial communication		132.520		R 2 146.30	
5981	Percutaneous stent placement in systemic to pulmonary shunt (e.g. Blalock-Taussig/Sano)		132.520		R 2 146.30	
5985	ASD/PFO/Interatrial communication closure percutaneous, device placement		310.800		R 5 033.50	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5986	VSD closure, percutaneous, device placement		412.400		R 6 678.90	
5987	PFO closure with device		310.800		R 5 033.50	
5989	PDA closure-coil or ductal device		276.500		R 4 478.00	
5990	Closure, arterio-venous shunt (incl. Blalock, Sano) any method		276.500		R 4 478.00	
5991	Transcatheter occlusion or embolisation any method, non-central nervous system, non-head or neck		276.500		R 4 478.00	
5992	Closure interatrial communication (Fontan fenestration etc)		310.800		R 5 033.50	
5995	Rapid right ventricular pacing for percutaneous procedure		51.000		R 825.90	
5996	Removal of embolised device/materials		80.600		R 1 305.40	
5998	Biopsy: Endomyocardial		236.100		R 3 823.70	
6000	Actigraphy: Patient monitored for a minimum of 72 hours (includes equipment fee and interpretation)		47.300		R 766.10	
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES					
0090	Radiologist's fee for participation in a team: 30,00 radiology units per ½ hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or X-ray procedures. Only to be charged if radiologist is hands-on, and not for interpretation of images only.					
19.15	Magnetic Resonance Imaging (MRI)					
6100	In order to charge the full fee (600,00 magnetic resonance units) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.					
6101	Where a limited series of a specific anatomical region is performed (except bone tumour), e.g a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.					
6102	All post-contrast studies (except bone tumour), including perfusion studies, to be charges at 50% of the fee.					
6103	Post-contrast study: Bone tumour, 100% of the fee					
6104	Limited examination of the hypophysis e.g. where a coronal T1 and sagittal T1 series are performed, two-thirds (2/3) of the fee is applicable					
6105	Where, in a limited hypophysis examination, Gadolinium is administered and coronal T1 and sagittal T1 series are repeated, a single full fee for the entire examination is applicable + cost of Gadolinium + disposable items					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6106	Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.					
6107	Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognised angiographic software package with reconstruction capability.					
6108	Where only a gradient echo series is performed with a machine without a recognised angiographic software package with reconstruction ability, 20% of the full fee is applicable specifying that it is a “flow sensitive series”.					
6109	Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.					
6110	MRI spectroscopy: 50% of fee					
	Please note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.					
	Items 6200 to 6255 reflect the anatomical region examined. The modifiers above reflect what was done and how the fee was arrived at.					
6200	Magnetic Resonance Imaging: Per anatomical region, brain					
6201	Magnetic Resonance Imaging: Per anatomical region, orbitae					
6202	Magnetic Resonance Imaging: Per anatomical region, paranasal sinuses					
6203	Magnetic Resonance Imaging: Per anatomical region – soft tissue, face/skull					
6204	Magnetic Resonance Imaging: Per anatomical region, skull basis/cranio-cervical joint					
6205	Magnetic Resonance Imaging: Per anatomical region, middle and internal ears					
6206	Magnetic Resonance Imaging: Per anatomical region –soft tissue, neck					
6207	Magnetic Resonance Imaging: Per anatomical region – thyroid/para-thyroid					
6208	Magnetic Resonance Imaging: Per anatomical region , hypophysis (see modifiers 6104 and 6105 for limited examinations)					
6209	Magnetic Resonance Imaging: Per anatomical region, bone tumour (see modifier 6103)					
6210	Magnetic Resonance Imaging: Per anatomical region, cervical vertebrae					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6211	Magnetic Resonance Imaging: Per anatomical region, thoracic vertebrae					
6212	Magnetic Resonance Imaging: Per anatomical region, lumbar vertebrae					
6213	Magnetic Resonance Imaging: Per anatomical region, sacrum					
6214	Magnetic Resonance Imaging: Per anatomical region, pelvis					
6215	Magnetic Resonance Imaging: Per anatomical region, pelvic organs					
6216	Magnetic Resonance Imaging: Per anatomical region, abdomen					
6217	Magnetic Resonance Imaging: Per anatomical region, thorax wall					
6218	Magnetic Resonance Imaging: Per anatomical region, mediastinum					
6219	Magnetic Resonance Imaging: Per anatomical region – soft tissue, back					
6220	Magnetic Resonance Imaging: Per anatomical region, left shoulder					
6221	Magnetic Resonance Imaging: Per anatomical region, right shoulder					
6222	Magnetic Resonance Imaging: Per anatomical region, both hips					
6223	Magnetic Resonance Imaging: Per anatomical region, left hip					
6224	Magnetic Resonance Imaging: Per anatomical region, right hip					
6225	Magnetic Resonance Imaging: Per anatomical region, left upper-arm					
6226	Magnetic Resonance Imaging: Per anatomical region, right upper-arm					
6227	Magnetic Resonance Imaging: Per anatomical region, left elbow					
6228	Magnetic Resonance Imaging: Per anatomical region, right elbow					
6229	Magnetic Resonance Imaging: Per anatomical region, left forearm					
6230	Magnetic Resonance Imaging: Per anatomical region, right forearm					
6231	Magnetic Resonance Imaging: Per anatomical region, left wrist and hand					
6232	Magnetic Resonance Imaging: Per anatomical region, right wrist and hand					
6233	Magnetic Resonance Imaging: Per anatomical region, left upper-leg					
6234	Magnetic Resonance Imaging: Per anatomical region, right upper-leg					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
6235	Magnetic Resonance Imaging: Per anatomical region, left knee					
6236	Magnetic Resonance Imaging: Per anatomical region, right knee					
6237	Magnetic Resonance Imaging: Per anatomical region, left lower-leg					
6238	Magnetic Resonance Imaging: Per anatomical region, right lower-leg					
6239	Magnetic Resonance Imaging: Per anatomical region, left ankle					
6240	Magnetic Resonance Imaging: Per anatomical region, right ankle					
6241	Magnetic Resonance Imaging: Per anatomical region, left foot					
6242	Magnetic Resonance Imaging: Per anatomical region, right foot					
6250	Magnetic Resonance angiography (see modifiers 6106 to 6108): Brain					
6251	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, neck					
6252	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, chest					
6253	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, abdomen					
6254	Magnetic Resonance angiography (see modifiers 6106 to 6108): Large vessels, legs					
6255	Magnetic Resonance angiography (see modifiers 6106 to 6108): Heart					
6260	Contrast medium: Current price according the regular price list published by the Radiology Society of SA					
6270	Low field strength peripheral joint magnetic resonance imaging: Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine or head examinations					
20	**Radiation oncology**					
	GENERAL RULES REGARDING THIS SECTION OF THE NATIONAL REFERENCE PRICE LIST a. Unless specifically stated in this section of the NRPL-HS, the general descriptors between the professional and technical component apply to both components of the services. b. The items reflecting the technical component in this section of the NRPL-HS may only be charged by the owner of the equipment.					
BB.	The fees in this section (radiation oncology) do NOT include the cost of radium or isotopes.					
	Please note: The calculated amounts in this section are calculated according to the radiotherapy unit values.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
20.1	Kilovolt therapy					
20.2	Radium therapy					
20.3	Isotope therapy					
0096	Radio-isotope therapy patients who fail to keep their appointments: Fee will include cost of isotope					
20.4	Megavolt therapy					
20.5	Beta-ray therapy with strontium-90-applicator					
20.6	Planning of therapy					
20.7	Technical aids					
5141	Radiation materials (see modifier 0095)					
20.8	Oncological surgical procedures					
20.9	Special procedures					
20.10	Chemotherapy					
	Where patients are not treated in chemotherapy facilities, Items 0213, 0214 and 0215 are used instead of Items 5790, 5793 and 5795. Codes 0213, 0214 and 0215 are applicable to providers who only administer the drugs i.e. don't own or rent a facility and do not manage the patient.					
	Codes 5790 to 5795 are for exclusive use by oncology trained doctors working within chemotherapy facilities.					
5790	Non-infusional chemotherapy: Global Fee for the management of and for related services delivered in the treatment of cancer with oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day – for exclusive use by doctors with appropriate oncology training (consultations to be charged separately). Not applicable to oral hormonal therapy.	20	42.950		R 535.20	
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 charged this fee.	20	24.490		R 305.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5792	Non-infusional chemotherapy facility fee: A facility where oncology medicines are purchased, stored and dispensed during oral chemotherapy (per cycle), intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy or oncology specific drug administration per treatment day. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with Item 5790). Not applicable to oral hormonal therapy – only one of the parties are to charge this fee.	20	30.610		R 381.60	
	Non-infusional chemotherapy: Consultations are charged separately					
	Non-infusional chemotherapy: In the case of intramuscular (IMI), subcutaneous, intrathecal or bolus chemotherapy administration the management fee can only be charged once per treatment day. Consultations are charged separately.					
5793	Infusional chemotherapy: Global fee for the management of and for services delivered during infusional chemotherapy per treatment day – for exclusive use by doctors with appropriate oncology training using recognised chemotherapy facilities (consultations to be charged separately).	20	159.470		R 1 987.20	
5794	Infusional chemotherapy facility fee: A facility where oncology medicines are procured, stored, admixed and administered, and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with Item 5793) – only one of the parties are to charge this fee.	20	90.030		R 1 121.90	
5795	Infusional chemotherapy facility fee: A facility where oncology medicines are purchased, stored, dispensed, admixed and administered and in which appropriately-trained medical, nursing and support staff are in attendance. This fee is chargeable by doctors with appropriate oncology training who owns or rents the facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (to be used in conjunction with Item 5793) – only one of the parties are to charge this fee	20	112.540		R 1 402.40	
	Item 5795 is chargeable in addition to Item 5793 by the oncologist who owns or rents the chemotherapy facility, and by others e.g. hospitals or clinics that provide the services as per the appropriate billing structure. Said facilities are to be accredited under the auspices of SASMO and/or SASCRO (only to be added to Item 5793 if own or rented facility is used).					
20.11	Radiation therapy planning					
20.11.1	Manual radiotherapy planning procedures					
5801	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT	50	42.560		R 644.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5601	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT	50	99.320		R 1 504.20	
5802	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	56.180		R 850.90	
5602	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	131.100		R 1 985.40	
5803	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT	50	76.620		R 1 160.50	
5603	Manual radiotherapy planning procedures: No Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT	50	178.770		R 2 707.40	
20.11.2	Conventional radiotherapy planning procedures					
5808	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT	50	170.260		R 2 578.60	
5608	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT	50	397.270		R 6 016.70	
5809	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	238.360		R 3 609.80	
5609	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	556.180		R 8 423.50	
5810	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – PROFESSIONAL COMPONENT	50	297.950		R 4 512.60	
5610	Conventional radiotherapy planning: Simulation, Limited Graphic Planning, Special Technique – TECHNICAL COMPONENT	50	695.220		R 10 529.30	
20.11.3	Three dimensional radiotherapy planning procedures					
5820	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	240.230		R 3 638.30	
5620	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Single Volume of Interest – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	977.200		R 14 799.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5821	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	407.750		R 6 175.50	
5621	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Multiple Volumes of Interest – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1368.070		R 20 719.90	
5822	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	554.330		R 8 395.40	
5622	Three dimensional radiotherapy planning procedures: 3-Dimensional Simulation and Graphic Planning, Special Technique – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1710.090		R 25 899.60	
20.11.4	Intensity modulated radiotherapy planning procedures					
5823	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	642.920		R 9 737.20	
5623	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Radical Course – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	1916.810		R 29 030.50	
5825	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) -– PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	232.180		R 3 516.50	
5625	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, Booster Volumes (not for use with other IMRT planning codes) – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	958.400		R 14 515.10	
5826	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques – PROFESSIONAL COMPONENT (excludes imaging costs for CT and MRI)	50	753.350		R 11 409.60	
5626	Intensity modulated radiotherapy planning procedures: Intensity Modulated Radiotherapy Simulation, Inverse Planning, CT Scan with Magnetic Resonance Imaging or other Similar Imaging Fusion Techniques – TECHNICAL COMPONENT (excludes imaging costs for CT and MRI)	50	2174.480		R 32 932.90	
20.11.5	Kilovolt radiation treatment		–			
5834	Kilovolt radiation treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof – PROFESSIONAL COMPONENT	50	49.080		R 743.40	
5634	Kilovolt radiation treatment: Weekly Treatment, Kilovolt or Similar, per week or part thereof – TECHNICAL COMPONENT	50	114.520		R 1 734.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
20.11.6	Short course radiation treatment					
5835	Short course radiation treatment: Short course treatment, Single Volume of Interest – PROFESSIONAL COMPONENT	50	105.740		R 1 601.50	
5635	Short course radiation treatment: Short course treatment, Single Volume of Interest – TECHNICAL COMPONENT	50	246.730		R 3 737.00	
5836	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	148.040		R 2 242.20	
5636	Short course radiation treatment: Short course treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	345.410		R 5 231.40	
5837	Short course radiation treatment: Short course Treatment, Special Technique – PROFESSIONAL COMPONENT	50	190.330		R 2 882.50	
5637	Short course radiation treatment: Short course Treatment, Special Technique – TECHNICAL COMPONENT	50	444.110		R 6 726.10	
20.11.7	Weekly radiation treatment sessions					
20.11.7.1	Weekly radiation treatment sessions – conventional techniques					
5839	Weekly radiation treatment sessions – Conventional Techniques: Weekly Treatment, Single Volume of Interest – PROFESSIONAL COMPONENT	50	193.860		R 2 936.10	
5639	Weekly radiation treatment sessions– Conventional Techniques: Weekly Treatment, Single Volume of Interest – TECHNICAL COMPONENT	50	452.330		R 6 850.50	
5840	Weekly radiation treatment sessions– Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	246.730		R 3 737.00	
5640	Weekly radiation treatment sessions– Conventional Techniques: Weekly Treatment, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	575.690		R 8 718.90	
5841	Weekly radiation treatment sessions– Conventional Techniques: Weekly Treatment, Special Technique – PROFESSIONAL COMPONENT	50	317.220		R 4 804.40	
5641	Weekly radiation treatment sessions– Conventional Techniques: Weekly Treatment, Special Technique – TECHNICAL COMPONENT	50	740.180		R 11 210.10	
20.11.7.2	Weekly radiation treatment sessions – advanced techniques					
5849	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – PROFESSIONAL COMPONENT	50	236.240		R 3 578.00	
5649	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Single Volume of Interest – TECHNICAL COMPONENT	50	551.210		R 8 348.10	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5850	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – PROFESSIONAL COMPONENT	50	330.730		R 5 009.00	
5650	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Multiple Volumes of Interest – TECHNICAL COMPONENT	50	771.710		R 11 687.80	
5851	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – PROFESSIONAL COMPONENT	50	425.230		R 6 440.20	
5651	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Multi Leaf Collimators, Special Technique – TECHNICAL COMPONENT	50	992.190		R 15 026.80	
5854	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – PROFESSIONAL COMPONENT	50	348.870		R 5 283.70	
5654	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Intensity Modulated Radiotherapy – TECHNICAL COMPONENT	50	814.030		R 12 328.60	
5855	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – PROFESSIONAL COMPONENT	50	826.830		R 12 522.40	
5655	Weekly radiation treatment sessions – advanced techniques: Weekly Treatment, Total Body Radiotherapy or Similar – TECHNICAL COMPONENT	50	1929.260		R 29 218.90	
20.11.8	Stereotactic radiation					
5860	Stereotactic radiation: Stereotactic Radiation, Single or up to 4 (four) Fractions, Global Fee – PROFESSIONAL COMPONENT	50	3719.340		R 56 330.20	
5660	Stereotactic radiation: Stereotactic Radiation, Single Fraction, Global Fee – TECHNICAL COMPONENT	50	8678.460		R 131 436.60	
5861	Stereotactic radiation: Stereotactic Radiation, 5 (five) or more Fractions, Full course, Global Fee – PROFESSIONAL COMPONENT	50	4277.240		R 64 779.40	
5661	Stereotactic radiation: Stereotactic Radiation, Fractionated, Full course, Global Fee – TECHNICAL COMPONENT	50	9980.230		R 151 152.00	
20.12	Brachytherapy					
20.12.1	Isotope/Applicator Therapy					
5870	Isotope/Applicator Therapy: Isotopes – low complexity, administration of low dose oral isotopes or use of surface applicators, up to five applications. Typically an out patient procedure. The cost of any isotopes and materials are not included.	50	108.400		R 1 641.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
5872	Isotope/Applicator Therapy: Isotopes – intermediate complexity, administration of isotopes requiring invasive techniques such as intravenous, intracavitary or intra-articular radioactive isotopes. Typical out patient procedure or admission and monitoring less than 48 hours. The cost of any isotopes and materials are not included.	50	216.800		R 3 283.60	
5873	Isotope/Applicator Therapy: Isotopes – high complexity, surface application of seed arrays requiring dosimetric assessment and/or high dose radio-active isotopes requiring admission and monitoring. Typically requires in patient admission and monitoring for more than 48 hours. The cost of any isotopes and materials are not included.	50	601.160		R 9 104.70	
20.12.2	Brachytherapy implants					
5882	Brachytherapy implants: Implants – low complexity, placement of a single guide tube for the administration of brachytherapy requiring <8 dwell points. The cost of materials are not included.	50	216.800		R 3 283.60	
5883	Brachytherapy implants: Implants – intermediate complexity, planar implants requiring >1 guide tube for the administration of brachytherapy, or the use of >8 dwell points in a single guide tube, or any procedure requiring <8 dwell points but which requires general anaesthesia for insertion. The cost of materials are not included.	50	786.800		R 11 916.20	
5885	Brachytherapy implants: Implants – high complexity requiring complex volumetric studies. Inclusive fee for implant under local or general anaesthetic. The cost of materials are not included.	50	1049.070		R 15 888.20	
20.12.3	Brachytherapy treatment					
5890	Brachytherapy treatment: Global fee for manual afterloading – includes storage, handling, calibration, planning (manual or computerized), manual loading, daily treatment, monitoring, removal and disposal of the isotopes. The cost of any isotopes and materials are not included.	50	613.040		R 9 284.60	
5892	Brachytherapy treatment: Global fee for remote afterloading – includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included – PROFESSIONAL COMPONENT	50	415.960		R 6 299.70	
5893	Global fee for remote afterloading – includes input in calibration, graphic planning, daily treatment, monitoring, removal and disposal of implant materials on completion. The cost of materials are not included – TECHNICAL COMPONENT	50	970.560		R 14 699.30	
20.12.4	Brachytherapy imaging					
5895	Brachytherapy imaging: Brachytherapy – special imaging where needed and if used, unusual to be added to any code other than Items 5883 or 5885.	50	156.770		R 2 374.40	
21	**Clinical pathology**					
0097	Pathology tests performed by non-pathologists: Where items under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists fee.					

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
	Please note: The calculated amounts in this section are calculated according to the clinical pathology unit values. Note: For fees for Histology and Cytology refer to Items 4561-4593 under Section 22: Anatomical Pathology.					
21.1	Haematology					
3705	Alkali resistant haemoglobin	80	4.500		R 64.70	
3709	Antiglobulin test (Coombs' or trypsinzied red cells)	80	3.650		R 52.50	
3710	Antibody titration	80	7.200		R 103.60	
3712	Antibody identification	80	8.450		R 121.60	
3713	Bleeding time (does not include the cost of the simplate device)	80	6.940		R 99.90	
3714	Blood volume, dye method	80	7.200		R 103.60	
3715	Buffy layer examination	80	19.900		R 286.80	
3716	Mean Cell Volume	80	2.250		R 32.60	
3717	Bone marrow cytological examination only	80	19.900		R 286.80	
3719	Bone marrow: Aspiration	80	8.400		R 121.10	
3720	Bone marrow trephine biopsy	80	32.600		R 469.80	
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	80	36.800		R 530.10	
3722	Capillary fragility: Hess	80	2.020		R 29.10	
3723	Circulating anticoagulants	80	5.850		R 84.20	
3724	Coagulation factor inhibitor assay	80	57.560		R 829.30	
3726	Activated protein C resistance	80	26.000		R 374.50	
3727	Coagulation time	80	3.160		R 45.60	
3728	Anti-factor Xa Activity	80	53.600		R 772.10	
3729	Cold agglutinins	80	3.600		R 52.00	
3730	Protein S: Functional	80	37.500		R 540.20	
3731	Compatibility for blood transfusion	80	3.600		R 52.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3732	Cryoglobulin	80	3.600		R 52.00	
3734	Protein C (chromogenic)	80	30.290		R 436.40	
3735	Anti-thrombin III (chromogenic)	80	22.000		R 316.90	
3736	Plasminogen (chromogenic)	80	61.650		R 888.20	
3737	Lupus Russel Viper method	80	17.000		R 245.00	
3738	Lupus Kaolin Exner method	80	25.000		R 360.20	
3739	Erythrocyte count	80	2.250		R 32.60	
3740	Factors V and VII: Qualitative	80	7.200		R 103.60	
3741	Coagulation factor assay: Functional	80	9.450		R 136.20	
3743	Erythrocyte sedimentation rate	80	3.000		R 43.30	
3744	Fibrin stabilizing factor (urea test)	80	4.500		R 64.70	
3746	Fibrin monomers	80	2.700		R 39.00	
3748	Plasminogen activator inhibitor (PAI-I)	80	65.950		R 950.10	
3750	Tissue plasminogen Activator (tPA)	80	67.790		R 976.60	
3753	Osmotic fragility (before and after incubation)	80	18.000		R 259.50	
3754	ABO Reverse Group	80	3.600		R 52.00	
3755	Full blood count (including Items 3739, 3762, 3783, 3785, 3791)	80	10.500		R 151.30	
3756	Full cross match	80	7.200		R 103.60	
3757	Coagulation factors: Quantitative	80	32.200		R 463.80	
3758	Factor VIII related antigen	80	60.460		R 871.10	
3759	Coagulation factor correction study	80	11.720		R 168.90	
3761	Factor XIII related antigen	80	61.110		R 880.20	
3762	Haemoglobin estimation	80	1.800		R 25.90	
3763	Contact activated product assay	80	16.200		R 233.30	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3764	Grouping: A B and O antigens	80	3.600		R 52.00	
3765	Grouping: Rh antigen	80	3.600		R 52.00	
3766	PIVKA	80	43.490		R 626.50	
3767	Euglobulin Lysis time	80	25.580		R 368.60	
3768	Haemoglobin A2 (column chromatography)	80	15.000		R 216.10	
3769	Haemoglobin electrophoresis	80	26.820		R 386.30	
3770	Haemoglobin-S (solubility test)	80	3.600		R 52.00	
3772	Haptoglobin: Quantitative	80	9.450		R 136.20	
3773	Ham's acidified serum test	80	8.000		R 115.30	
3775	Heinz bodies	80	2.250		R 32.60	
3776	Haemosiderin in urinary sediment	80	2.250		R 32.60	
3783	Leucocyte differential count	80	6.200		R 89.50	
3785	Leucocytes: Total count	80	1.800		R 25.90	
3786	QBC malaria concentration and fluorescent staining	80	25.000		R 360.20	
3787	LE-cells	80	8.300		R 119.50	
3789	Neutrophil alkaline phosphatase	80	28.000		R 403.30	
3791	Packed cell volume: Haematocrit	80	1.800		R 25.90	
3792	Plasmodium falciparum: Monoclonal immunological identification	80	9.000		R 129.80	
3793	Plasma haemoglobin	80	6.750		R 97.20	
3794	Platelet sensitivities	80	18.640		R 268.60	
3795	Platelet aggregation per aggregant	80	12.140		R 174.90	
3797	Platelet count	80	2.250		R 32.60	
3799	Platelet adhesiveness	80	4.500		R 64.70	
3801	Prothrombin consumption	80	5.850		R 84.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3803	Prothrombin determination (two stages)	80	5.850		R 84.20	
3805	Prothrombin index	80	6.000		R 86.30	
3806	Therapeutic drug level: Dosage	80	4.500		R 64.70	
3809	Reticulocyte count	80	3.000		R 43.30	
3810	Schumm's test	80	3.600		R 52.00	
3811	Sickling test	80	2.250		R 32.60	
3814	Sucrose lysis test for PNH	80	3.600		R 52.00	
3816	T and B-cells EAC markers (limited to ONE marker only for CD4/8 counts)	80	21.100		R 304.00	
3820	Thrombo – elastogram	80	26.000		R 374.50	
3825	Fibrinogen titre	80	3.600		R 52.00	
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	80	8.000		R 115.30	
3830	Glucose 6-phosphate-dehydrogenase: Quantitative	80	16.000		R 230.60	
3832	Red cell pyruvate kinase: Quantitative	80	16.000		R 230.60	
3834	Red cell Rhesus phenotype	80	9.900		R 142.60	
3835	Haemoglobin F in blood smear	80	5.850		R 84.20	
3837	Partial thromboplastin time	80	5.850		R 84.20	
3841	Thrombin time (screen)	80	7.160		R 103.10	
3843	Thrombin time (serial)	80	7.650		R 110.30	
3847	Haemoglobin H	80	2.250		R 32.60	
3851	Fibrin degeneration products (diffusion plate)	80	10.350		R 149.20	
3853	Fibrin degeneration products (latex slide)	80	4.500		R 64.70	
3854	XDP (Dimer test or equivalent latex slide test)	80	8.500		R 122.50	
3855	Haemagglutination inhibition	80	9.900		R 142.60	
3856	D-Dimer (quantitative)	80	27.520		R 396.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3857	Ristocetin Cofactor	80	35.530		R 511.80	
3858	Heparin removal	80	28.880		R 416.20	
21.2	Microscopic and miscellaneous tests					
3863	Autogenous vaccine	80	12.600		R 181.40	
3864	Entomological examination	80	20.700		R 298.20	
3865	Parasites in blood smear	80	5.600		R 80.70	
3867	Miscellaneous (body fluids, urine, exudate, fungi, puss, scrapings, etc.)	80	4.900		R 70.70	
3868	Fungus identification	80	8.300		R 119.50	
3869	Faeces (including parasites)	80	4.900		R 70.70	
3873	Transmission electron microscopy	80	85.000		R 1 224.50	
3874	Scanning electron microscopy	80	100.000		R 1 440.60	
3875	Inclusion bodies	80	4.500		R 64.70	
3878	Crystal identification polarised light microscopy	80	4.500		R 64.70	
3879	Campylobacter in stool: Fastidious culture	80	9.900		R 142.60	
3880	Antigen detection with polyclonal antibodies	80	4.500		R 64.70	
3881	Mycobacteria	80	3.000		R 43.30	
3882	Antigen detection with monoclonal antibodies	80	10.800		R 155.50	
3883	Concentration techniques for parasites	80	3.000		R 43.30	
3884	Dark field, phase or interference contrast microscopy, Nomarski or Fontana	80	6.300		R 90.70	
3885	Cytochemical stain	80	5.450		R 78.40	
21.3	Bacteriology					
3887	Antibiotic susceptibility test: Per organism	80	8.000		R 115.30	
3888	Adhesive tape preparation	80	2.700		R 39.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3889	Clostridium difficile toxin: Monoclonal immunological	80	12.400		R 178.70	
3890	Antibiotic assay of tissues and fluids	80	13.900		R 200.30	
3891	Blood culture: Aerobic	80	5.850		R 84.20	
3892	Blood culture: Anaerobic	80	5.850		R 84.20	
3893	Bacteriological culture: Miscellaneous	80	6.300		R 90.70	
3894	Radiometric blood culture	80	10.800		R 155.50	
3895	Bacteriological culture: Fastidious organisms	80	9.900		R 142.60	
3896	In vivo culture: Bacteria	80	16.000		R 230.60	
3897	In vivo culture: Virus	80	16.000		R 230.60	
3899	Bacterial exotoxin production (in vivo assay)	80	20.700		R 298.20	
3901	Fungal culture	80	4.500		R 64.70	
3902	Clostridium difficile (cytotoxicity neutralisation)	80	30.000		R 432.20	
3903	Antibiotic level: Biological fluids	80	11.700		R 168.50	
3904	Rotavirus latex slide test	80	5.620		R 81.10	
3905	Identification of virus or rickettsia	80	20.700		R 298.20	
3906	Identification: Chlamydia	80	16.000		R 230.60	
3908	Anaerobe culture: Comprehensive	80	9.900		R 142.60	
3909	Anaerobe culture: Limited procedure	80	4.500		R 64.70	
3911	Beta-lactamase assay	80	4.500		R 64.70	
3914	Sterility control test: Biological method	80	4.500		R 64.70	
3915	Mycobacterium culture	80	4.500		R 64.70	
3916	Radiometric tuberculosis culture	80	10.800		R 155.50	
3918	Mycoplasma culture: Comprehensive	80	9.900		R 142.60	
3919	Identification of mycobacterium	80	9.900		R 142.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3920	Mycobacterium: Antibiotic sensitivity	80	9.900		R 142.60	
3921	Antibiotic synergistic study	80	20.700		R 298.20	
3922	Viable cell count	80	1.350		R 19.40	
3923	Biochemical identification of bacterium: Abridged	80	3.150		R 45.50	
3924	Biochemical identification of bacterium: Extended	80	12.500		R 180.10	
3925	Serological identification of bacterium: Abridged	80	3.150		R 45.50	
3926	Serological identification of bacterium: Extended	80	10.200		R 146.90	
3927	Grouping for streptococci	80	7.300		R 105.20	
3928	Antimicrobic substances	80	3.800		R 54.80	
3929	Radiometric mycobacterium identification	80	14.000		R 201.80	
3930	Radiometric mycobacterium antibiotic sensitivity	80	25.000		R 360.20	
3931	Helicobacter: Monoclonal immunological	80	12.400		R 178.70	
4650	Antibiotic MIC per organism per antibiotic	80	8.000		R 115.30	
4651	Non-radiometric automated blood cultures	80	13.900		R 200.30	
4652	Rapid automated bacterial identification per organism	80	15.000		R 216.10	
4653	Rapid automated antibiotic susceptibility per organism	80	17.000		R 245.00	
4654	Rapid automated MIC per organism per antibiotic	80	17.000		R 245.00	
4655	Mycobacteria: MIC determination – E Test	80	16.500		R 237.60	
4656	Mycobacteria: Identification HPLC	80	35.000		R 504.30	
4657	Mycobacteria: Liquefied, consentrated, fluorochrome stain	80	9.900		R 142.60	
21.4	Serology					
3958	Anti Gad/Ia2 Ab	80	67.950		R 978.90	
3959	Rose Waaler agglutination test	80	4.500		R 64.70	
3960	Gonococcal, listeria or echinococcus agglutination	80	9.500		R 136.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3961	Slide agglutination test	80	2.630		R 37.80	
3963	Serum complement level: Each component	80	3.150		R 45.50	
3965	Anti Ia2 Antibodies	80	36.000		R 518.50	
3966	Anti Gad Antibodies	80	36.000		R 518.50	
3967	Auto-antibody: Sensitised erythrocytes	80	4.500		R 64.70	
3968	Herpes virus typing: Monoclonal immunological	80	20.690		R 298.00	
3969	Western blot technique	80	74.000		R 1 066.20	
3932	Antibodies to human immunodeficiency virus (HIV): ELISA	80	14.100		R 203.00	
3933	IgE: Total: EMIT or ELISA	80	11.700		R 168.50	
3934	Auto antibodies by labelled antibodies	80	16.000		R 230.60	
3935	Sperm antibodies	80	16.000		R 230.60	
3936	Virus neutralisation test: First antibody	80	75.000		R 1 080.60	
3937	Virus neutralisation test: Each additional antibody	80	15.000		R 216.10	
3938	Precipitation test per antigen	80	4.500		R 64.70	
3939	Agglutination test per antigen	80	5.500		R 79.30	
3940	Haemagglutination test: Per antigen	80	9.900		R 142.60	
3941	Modified Coombs' test for brucellosis	80	4.500		R 64.70	
3942	Hepatitis Rapid Viral Ab	80	12.240		R 176.20	
3943	Antibody titer to bacterial exotoxin	80	3.600		R 52.00	
3944	IgE: Specific antibody titer: ELISA/EMIT: Per Ag	80	12.400		R 178.70	
3945	Complement fixation test	80	5.850		R 84.20	
3946	IgM: Specific antibody titer:ELISA/EMIT: Per Ag	80	14.050		R 202.40	
3947	C-reactive protein	80	10.840		R 156.10	
3948	IgG: Specific antibody titer: ELISA/EMIT: Per Ag	80	12.950		R 186.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
3949	Qualitative Kahn, VDRL or other flocculation	80	2.250		R 32.60	
3950	Neutrophil phagocytosis	80	25.200		R 363.10	
3951	Quantitative Kahn, VDRL or other flocculation	80	3.600		R 52.00	
3952	Neutrophil chemotaxis	80	67.950		R 978.90	
3953	Tube agglutination test	80	4.150		R 59.90	
3955	Paul Bunnell: Presumptive	80	2.250		R 32.60	
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	80	8.500		R 122.50	
3971	Immuno-diffusion test: Per antigen	80	3.150		R 45.50	
3972	Respiratory syncytial virus (ELISA technique)	80	35.000		R 504.30	
3973	Immuno electrophoresis: Per immune serum	80	9.450		R 136.20	
3974	Polymerase chain reaction	80	75.000		R 1 080.60	
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	80	12.000		R 172.80	
3978	Lymphocyte transformation	80	51.700		R 744.80	
3980	Bilharzia Ag Serum/Urine	80	14.500		R 209.00	
3982	Histone Ab	80	16.000		R 230.60	
4600	Anti-CCP	80	17.460		R 251.60	
4601	Panel typing: Antibody detection – Class I	80	36.000		R 518.50	
4602	Panel typing: Antibody detection – Class II	80	44.000		R 633.80	
4603	HLA test for specific locus/antigen – serology	80	27.000		R 389.00	
4604	HLA typing: Class I – serology	80	52.000		R 749.20	
4605	HLA typing: Class II – serology	80	52.000		R 749.20	
4606	HLA typing: Class I & II – serology	80	90.000		R 1 296.60	
4607	Cross matching T-cells (per tray)	80	18.000		R 259.50	
4608	Cross matching B-cells	80	38.000		R 547.40	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4609	Cross matching T- & B-cells	80	48.000		R 691.50	
4610	Helicobacter: Pylori antigen test	80	34.600		R 498.40	
4611	Erythropoietin	80	20.000		R 288.10	
4612	HTLV I/II	80	20.000		R 288.10	
4613	Anti-Gm1 Antibody Assay	80	75.000		R 1 080.60	
4614	HIV Ab – Rapid Test	80	12.000		R 172.80	
21.5	Skin tests					
	For skin-prick allergy tests, please refer to Items 0218, 0220 and 0221 in Section 2: Integumentary Section					
21.6	Biochemical tests: Blood					
3991	Abnormal pigments: Qualitative	80	4.500		R 64.70	
3993	Abnormal pigments: Quantitative	80	9.000		R 129.80	
3995	Acid phosphate	80	5.180		R 74.60	
3998	Amino acids Quantitative (Post derivatisation HPLC)	80	78.120		R 1 125.50	
3999	Albumin	80	4.800		R 69.00	
4000	Alcohol	80	12.400		R 178.70	
4001	Alkaline phosphatase	80	5.180		R 74.60	
4002	Alkaline phosphatase-iso-enzymes	80	11.700		R 168.50	
4003	Ammonia: Enzymatic	80	7.710		R 111.10	
4004	Ammonia: Monitor	80	4.500		R 64.70	
4005	Alpha-1-antitrypsin: Total	80	7.200		R 103.60	
4006	Amylase	80	5.180		R 74.60	
4007	Arsenic in blood, hair or nails	80	36.250		R 522.30	
4008	Bilirubin – reflectance	80	4.770		R 68.70	
4009	Bilirubin: Total	80	4.770		R 68.70	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4010	Bilirubin: Conjugated	80	3.620		R 52.20	
4011	Breath Hydrogen Test	80	21.560		R 310.50	
4012	CSF Nicotinic Acid	80	12.420		R 178.90	
4013	CSF Glutamine	80	11.250		R 161.90	
4014	Cadmium: Atomic absorption	80	18.120		R 261.00	
4016	Calcium: Ionised	80	6.750		R 97.20	
4017	Calcium: Spectrophotometric	80	3.620		R 52.20	
4018	Calcium: Atomic absorption	80	7.250		R 104.50	
4019	Carotene	80	2.250		R 32.60	
4020	Carnitine (total or free) in biological fluid: Each	80	11.690		R 168.30	
4021	Carnitine (total or free) in muscle: Each	80	23.380		R 336.90	
4022	Acyl Carnitine	80	23.380		R 336.90	
4023	Chloride	80	2.590		R 37.40	
4025	Chol/HDL/LDL/Trig	80	27.070		R 390.00	
4026	LDL cholesterol (chemical determination)	80	6.900		R 99.30	
4027	Cholesterol total	80	5.340		R 76.90	
4028	HDL cholesterol	80	6.900		R 99.30	
4029	Cholinesterase: Serum or erythrocyte, each	80	7.480		R 107.60	
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	80	9.000		R 129.80	
4031	Total CO2	80	5.180		R 74.60	
4032	Creatinine	80	3.620		R 52.20	
4033	CSF-Immunoglobulin G	80	9.450		R 136.20	
4034	C1-Esterase Inhibitor	80	9.450		R 136.20	
4035	CSF-Albumin	80	9.450		R 136.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4036	CSF-IgG Index	80	22.050		R 317.70	
4038	Glutamic acid	80	29.060		R 418.70	
4040	Homocysteine (random)	80	15.300		R 220.40	
4041	Homocysteine (after Methionine load)	80	18.100		R 260.70	
4042	D-Xylose absorption test: Two hours	80	13.150		R 189.40	
4045	Fibrinogen: Quantitative	80	3.600		R 52.00	
4049	Glucose tolerance test (two specimens)	80	8.970		R 129.30	
4050	Glucose strip-test with photometric reading	80	1.800		R 25.90	
4051	Galactose	80	11.250		R 161.90	
4052	Glucose tolerance test (three specimens)	80	13.170		R 189.70	
4053	Glucose tolerance test (four specimens)	80	17.370		R 250.00	
4057	Glucose: Quantitative	80	3.620		R 52.20	
4061	Glucose tolerance test (five specimens)	80	21.560		R 310.50	
4062	Galactose-1-phosphate uridyl transferase	80	16.000		R 230.60	
4063	Fructosamine	80	7.200		R 103.60	
4064	HbA1C	80	14.250		R 205.20	
4066	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46.880		R 675.40	
4067	Lithium: Flame ionisation	80	5.180		R 74.60	
4068	Lithium: Atomic absorption	80	7.480		R 107.60	
4071	Iron	80	6.750		R 97.20	
4073	Iron-binding capacity	80	7.650		R 110.30	
4076	Blood gases: Astrup/pO2 and ancillary tests – can only be charged to a maximum of 6 times per patient per day	80	19.100		R 275.10	
4078	Oximetry analysis: MetHb, COHb, O2Hb, RHb, SulfHb	80	6.750		R 97.20	
4079	Ketones in plasma: Qualitative	80	2.250		R 32.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4081	Drug level-biological fluid: Quantitative	80	10.800		R 155.50	
4082	Tacrolimus assay	80	20.100		R 289.60	
4083	Lysosomal enzyme assay	80	36.560		R 526.70	
4084	Thymidine kinase	80	20.000		R 288.10	
4085	Lipase	80	5.180		R 74.60	
4086	Lactate	80	16.000		R 230.60	
4091	Lipoprotein electrophoresis	80	9.000		R 129.80	
4092	Orosmucoid	80	9.450		R 136.20	
4093	Osmolality: Serum or urine	80	6.750		R 97.20	
4094	Magnesium: Spectrophotometric	80	3.620		R 52.20	
4095	Magnesium: Atomic absorption	80	7.250		R 104.50	
4096	Mercury: Atomic absorption	80	18.120		R 261.00	
4098	Copper: Atomic absorption	80	18.120		R 261.00	
4105	Protein electrophoresis	80	9.000		R 129.80	
4106	IgG sub-class 1, 2, 3 or 4: Per sub-class	80	20.000		R 288.10	
4109	Phosphate	80	3.620		R 52.20	
4113	Potassium	80	3.620		R 52.20	
4114	Sodium	80	3.620		R 52.20	
4117	Protein: Total	80	3.110		R 44.70	
4121	pH, pCO2 or pO2: Each	80	6.750		R 97.20	
4123	Pyruvic acid	80	4.500		R 64.70	
4125	Salicylates	80	4.500		R 64.70	
4127	Caeruloplasmin	80	4.500		R 64.70	
4128	Phenylalanine: Quantitative	80	11.250		R 161.90	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4130	Aspartate aminotransferase (AST)	80	5.400		R 77.80	
4131	Alanine aminotransferase (ALT)	80	5.400		R 77.80	
4132	Creatine kinase (CK)	80	5.400		R 77.80	
4133	Lactate dehidrogenase (LD)	80	5.400		R 77.80	
4134	Gamma glutamyl transferase (GGT)	80	5.400		R 77.80	
4135	Aldolase	80	5.400		R 77.80	
4136	Angiotensin converting enzyme (ACE)	80	9.000		R 129.80	
4137	Lactate dehydrogenase isoenzyme	80	10.800		R 155.50	
4138	CK-MB: Immunoinhibition/precipitation	80	10.800		R 155.50	
4139	Adenosine deaminase	80	5.400		R 77.80	
4143	Serum/plasma enzymes	80	5.400		R 77.80	
4144	Transferrin	80	11.700		R 168.50	
4146	Lead: Atomic absorption	80	15.000		R 216.10	
4147	Triglyceride	80	7.930		R 114.30	
4148	Tay – Sachs Study	80	36.560		R 526.70	
4149	Red cell magnesium	80	11.700		R 168.50	
4151	Urea	80	3.620		R 52.20	
4152	CK-MB: Mass determination – quantitative (automated)	80	12.400		R 178.70	
4153	CK-MB: Mass determination – quantitative (not automated)	80	17.470		R 251.70	
4154	Myoglobin quantitative: Monoclonal immunological	80	12.400		R 178.70	
4155	Uric acid	80	3.780		R 54.50	
4156	Vitamin D3	80	12.420		R 178.90	
4157	Vitamin A-saturation test	80	15.300		R 220.40	
4158	Vitamin E (tocopherol)	80	3.600		R 52.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4159	Vitamin A	80	6.300		R 90.70	
4161	Troponin isoforms: Each	80	20.000		R 288.10	
4163	Apoprotein AI: Turbidometric method	80	8.280		R 119.30	
4165	Apoprotein AII: Turbidometric method	80	8.280		R 119.30	
4167	Apoprotein B: Turbidometric method	80	8.280		R 119.30	
4170	Lipoprotein a.(Lpa.) assay	80	12.420		R 178.90	
4171	Sodium + potassium + chloride + CO2 + urea	80	15.840		R 228.30	
4172	ELISA/EMIT technique	80	12.420		R 178.90	
4173	Sirolimus Assay	80	78.000		R 1 123.70	
4181	Quantitative protein estimation: Mancini method	80	7.760		R 111.70	
4182	Quantitative protein estimation: Nephelometer or Turbidometeric method	80	8.280		R 119.30	
4183	Quantitative protein estimation: Labelled antibody	80	12.420		R 178.90	
4184	C-reactive protein (Ultra sensitive)	80	11.680		R 168.10	
4185	Lactose	80	10.800		R 155.50	
4186	Vitamin B6	80	15.300		R 220.40	
4187	Zinc: Atomic absorption	80	18.120		R 261.00	
21.7	Biochemical tests: Urine					
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	80	1.500		R 21.50	
4189	Abnormal pigments	80	4.500		R 64.70	
4193	Alkapton test: Homogentisic acid	80	4.500		R 64.70	
4194	Amino acids: Quantitative (Post derivatisation HPLC)	80	78.120		R 1 125.50	
4195	Amino laevulinic acid	80	18.000		R 259.50	
4197	Amylase	80	5.180		R 74.60	
4198	Arsenic	80	18.120		R 261.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4199	Ascorbic acid	80	2.250		R 32.60	
4201	Bence-Jones protein	80	2.700		R 39.00	
4204	Calcium: Atomic absorption	80	7.250		R 104.50	
4205	Calcium: Spectrophotometric	80	3.620		R 52.20	
4209	Lead: Atomic absorption	80	15.000		R 216.10	
4210	Urine collagen telopeptides	80	36.500		R 525.90	
4211	Bile pigments: Qualitative	80	2.250		R 32.60	
4213	Protein: Quantitative	80	2.250		R 32.60	
4216	Mucopolysaccharides: Qualitative	80	3.600		R 52.00	
4217	Oxalate	80	9.380		R 135.20	
4218	Glucose: Quantitative	80	2.250		R 32.60	
4219	Steroids: Chromatography (each)	80	7.200		R 103.60	
4221	Creatinine	80	3.620		R 52.20	
4223	Creatinine clearance	80	7.650		R 110.30	
4227	Electrophoresis: Qualitative	80	4.500		R 64.70	
4228	Fetal Lung Maturity	80	36.560		R 526.70	
4230	Urine/fluid – specific gravity	80	0.900		R 12.90	
4231	Metabolites HPLC (High Pressure Liquid Chromatography)	80	37.500		R 540.20	
4232	Metabolites (Gaschromatography/Mass spectrophotometry)	80	46.800		R 674.30	
4233	Pharmacological/Drugs of abuse: Metabolites HPLC (High Pressure Liquid Chromatography)	80	37.500		R 540.20	
4234	Pharmacological/Drugs of abuse: Metabolites (Gaschromatography/Mass spectrophotometry)	80	46.800		R 674.30	
4237	5-Hydroxy-indole-acetic acid: Screen test	80	2.700		R 39.00	
4238	5HIAA (Hplc)	80	78.120		R 1 125.50	
4247	Ketones: Excluding dip-stick method	80	2.250		R 32.60	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4248	Reducing substances	80	1.800		R 25.90	
4251	Metanephrines: Column chromatography	80	22.050		R 317.70	
4252	Metanephrine (Hplc)	80	78.120		R 1 125.50	
4253	Aromatic amines (gas chromatography/mass spectrophotometry)	80	27.000		R 389.00	
4254	Nitrosonaphtol test for tyrosine	80	2.250		R 32.60	
4255	Orotic acid – urine	80	9.450		R 136.20	
4256	Very long chain fatty acids	80	129.380		R 1 863.90	
4261	Micro Albumin: Quantitative	80	12.420		R 178.90	
4262	Micro Albumin: Qualitative	80	4.500		R 64.70	
4263	pH: Excluding dip-stick method	80	0.900		R 12.90	
4265	Thin layer chromatography: One way	80	6.750		R 97.20	
4266	Thin layer chromatography: Two way	80	11.250		R 161.90	
4268	Organic acids: Quantitative: GCMS	80	109.380		R 1 575.80	
4269	Phenylpyruvic acid: Ferric chloride	80	2.250		R 32.60	
4270	Chromium Total Urine	80	18.120		R 261.00	
4271	Phosphate excretion index	80	22.050		R 317.70	
4272	Porphobilinogen qualitative screen: Urine	80	5.000		R 72.00	
4273	Porphobilinogen/ALA: Quantitative each	80	15.000		R 216.10	
4283	Magnesium: Spectrophotometric	80	3.620		R 52.20	
4284	Magnesium: Atomic absorption	80	7.250		R 104.50	
4285	Identification of carbohydrate	80	7.650		R 110.30	
4287	Identification of drug: Qualitative	80	4.500		R 64.70	
4288	Identification of drug: Quantitative	80	10.800		R 155.50	
4293	Urea clearance	80	5.400		R 77.80	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4297	Copper: Spectrophotometric	80	3.620		R 52.20	
4298	Copper: Atomic absorption	80	18.120		R 261.00	
4301	Chloride	80	2.590		R 37.40	
4309	Urobilinogen: Quantitative	80	6.750		R 97.20	
4313	Phosphates	80	3.620		R 52.20	
4315	Potassium	80	3.620		R 52.20	
4316	Sodium	80	3.620		R 52.20	
4319	Urea	80	3.620		R 52.20	
4321	Uric acid	80	3.620		R 52.20	
4323	Total protein and protein electrophoresis	80	11.250		R 161.90	
4325	VMA: Quantitative	80	11.250		R 161.90	
4326	Catecholamines (HPLC)	80	78.120		R 1 125.50	
4327	Immunofixation: Total protein, IgG, IgA, IgM, Kappa, Lambda	80	46.880		R 675.40	
4328	Immunoglobulin D	80	9.450		R 136.20	
4335	Cystine: Quantitative	80	12.600		R 181.40	
4336	Dinitrophenol hydrazine test: Ketoacids	80	2.250		R 32.60	
21.8	Biochemical tests: Faeces					
4339	Chloride	80	2.590		R 37.40	
4343	Fat: Qualitative	80	3.150		R 45.50	
4345	Fat: Quantitative	80	22.050		R 317.70	
4347	Ph	80	0.900		R 12.90	
4351	Occult blood: Chemical test	80	2.250		R 32.60	
4352	Occult blood: Monoclonal antibodies	80	10.000		R 144.20	
4357	Potassium	80	3.620		R 52.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4358	Sodium	80	3.620		R 52.20	
4359	Secretory IgA	80	9.450		R 136.20	
4362	Elastase quantitative ELISA	80	47.000		R 677.10	
4363	Stercobilinogen: Quantitative	80	6.750		R 97.20	
21.9	Biochemical tests: Miscellaneous					
4366	Porphyrin screen qualitative: Urine, stool, red blood cells: Each	80	5.000		R 72.00	
4367	Porphyrin qualitative analysis by TLC: Urine, stool, red blood cells: Each	80	20.000		R 288.10	
4368	Porphyrin: Total quantisation: Urine, stool, red blood cells: Each	80	20.000		R 288.10	
4369	Porphyrin quantitative analysis by TLC/HPLC: Urine, stool, red blood cells: Each	80	30.000		R 432.20	
4370	Drug level in biological fluid: Monoclonal immunological	80	12.400		R 178.70	
4371	Amylase in exudate	80	5.180		R 74.60	
4372	Fluoride in biological fluids and water	80	15.620		R 225.10	
4374	Trace metals in biological fluid: Atomic absorption	80	18.130		R 261.30	
4375	Calcium in fluid: Spectrophotometric	80	3.620		R 52.20	
4376	Calcium in fluid: Atomic absorption	80	7.250		R 104.50	
4377	Gallstone analysis: (Bilirubin, Ca, P, Oxalate, Cholesterol)	80	21.880		R 315.30	
4378	Urea breath test	80	58.000		R 835.70	
4380	Lecithin in amniotic fluid: L/S ratio	80	27.000		R 389.00	
4381	Lamellar body count in amniotic fluid	80	10.000		R 144.20	
4390	Foam test: Amniotic fluid	80	3.150		R 45.50	
4391	Renal calculus: Chemistry	80	5.400		R 77.80	
4392	Renal calculus: Crystallography	80	16.250		R 234.20	
4395	Sweat: Sodium	80	3.620		R 52.20	
4396	Sweat: Potassium	80	3.620		R 52.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4397	Sweat: Chloride	80	2.590		R 37.40	
4399	Sweat collection by iontophoresis (excluding collection material)	80	4.500		R 64.70	
4400	Tryptophane loading test	80	22.050		R 317.70	
21.10	Cerebrospinal fluid					
4401	Cell count	80	3.450		R 49.90	
4407	Cell count, protein, glucose and chloride	80	7.650		R 110.30	
4409	Chloride	80	2.590		R 37.40	
4416	Sodium	80	3.620		R 52.20	
4417	Protein: Qualitative	80	0.900		R 12.90	
4419	Protein: Quantitative	80	3.110		R 44.70	
4421	Glucose	80	3.620		R 52.20	
4423	Urea	80	3.620		R 52.20	
4425	Protein electrophoresis	80	12.600		R 181.40	
21.11	RNA/DNA based tests and andrology					
21.11.1	RNA/DNA based tests and andrology: RNA/DNA based tests					
4424	HLA test for specific allele DNA-PCR	80	36.000		R 518.50	
4426	HLA typing low resolution Class I DNA-PCR per locus	80	100.000		R 1 440.60	
4427	HLA typing low resolution Class II DNA-PCR per locus	80	74.000		R 1 066.20	
4428	HLA typing high resolution Class I or II DNA-PCR per locus	80	66.000		R 950.90	
4429	Quantitative PCR (DNA/RNA)	80	84.300		R 1 214.30	
4430	Recombinant DNA technique	80	25.000		R 360.20	
4431	Ribosomal RNA targeting for bacteriological identification	80	35.000		R 504.30	
4432	Ribosomal RNA amplification for bacteriological identification	80	75.000		R 1 080.60	
4433	Bacteriological DNA identification (LCR)	80	25.000		R 360.20	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4434	Bacteriological DNA identification (PCR)	80	75.000		R 1 080.60	
4439	Quantitative PCR – viral load (not HIV) – hepatitis C, hepatitis B, CMV, etc.	80	150.000		R 2 160.90	
21.11.2	RNA/DNA based tests and andrology: Andrology					
4435	Mixed antiglobulin reaction: Semen	80	6.600		R 95.00	
4436	Friberg test: Semen	80	14.500		R 209.00	
4437	Kremer test: Semen	80	3.600		R 52.00	
4440	Semen analysis: Cell count	80	7.650		R 110.30	
4441	Semen analysis: Cytology	80	7.200		R 103.60	
4442	Semen analysis: Viability + motility – 6 hours	80	6.000		R 86.30	
4443	Semen analysis: Supravital stain	80	5.440		R 78.30	
4445	Seminal fluid: Alpha glucosidase	80	20.000		R 288.10	
4446	Seminal fluid fructose	80	3.150		R 45.50	
4447	Seminal fluid: Acid phosphatase	80	5.180		R 74.60	
21.12	Immunology					
4448	HCG: Latex agglutination: Qualitative (side room)	80	4.000		R 57.50	
4449	HCG: Latex agglutination: Semi-quantitative (side room)	80	9.310		R 134.10	
4450	HCG: Monoclonal immunological: Qualitative	80	10.000		R 144.20	
4451	HCG: Monoclonal immunological: Quantitative	80	12.400		R 178.70	
4452	Bone Specific Alk Phosphatase	80	20.000		R 288.10	
4455	Anti IgE receptor antibody test (10 samples and dilution)	80	161.560		R 2 327.40	
4456	Eosinophil cationic protein	80	27.810		R 400.70	
4457	Mast cell tryptase	80	96.870		R 1 395.70	
4458	Micro-albuminuria: Radio-isotope method	80	12.420		R 178.90	
4459	Acetyl choline receptor antibody	80	158.120		R 2 278.00	

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Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4460	CA-199 tumour marker	80	20.000		R 288.10	
4461	Nuclear Matrix Protein 22	80	35.000		R 504.30	
4462	CA-125 tumour marker	80	20.000		R 288.10	
4463	C6 complement functional essay	80	45.000		R 648.30	
4466	Beta-2-microglobulin	80	12.420		R 178.90	
4467	Chromograqnin A	80	47.000		R 677.10	
4468	CA-549	80	20.000		R 288.10	
4469	Tumour markers: Monoclonal immunological (each)	80	20.000		R 288.10	
4470	CA-195 tumour marker	80	20.000		R 288.10	
4471	Carcino-embryonic antigen	80	20.000		R 288.10	
4473	TSH Receptor Ab	80	17.480		R 251.80	
4474	Cast Per Allergen	80	27.810		R 400.70	
4475	CA-724	80	20.000		R 288.10	
4477	Neuron specific enolase	80	20.000		R 288.10	
4478	Osteocalcin	80	31.400		R 452.30	
4479	Vitamin B12-absorption: Shilling test	80	11.700		R 168.50	
4480	Serotonin	80	18.750		R 270.30	
4482	Free thyroxine (FT4)	80	17.480		R 251.80	
4484	Thyrotropin (TSH) + Free Thyroxine (FT4)	80	37.080		R 534.20	
4485	Insulin	80	12.420		R 178.90	
4486	C-Peptide	80	12.420		R 178.90	
4487	Calcitonin	80	18.900		R 272.50	
4488	B-Type Natriuretic Peptide	80	47.040		R 677.60	
4490	Releasing hormone response	80	50.000		R 720.40	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4491	Vitamin B12	80	12.420		R 178.90	
4492	Vitamin D3: Calcitroil (RIA)	80	75.000		R 1 080.60	
4493	Drug concentration: Quantitative	80	12.420		R 178.90	
4494	Free hormone assay	80	17.480		R 251.80	
4495	Growth hormone	80	12.420		R 178.90	
4496	Hormone concentration: Quantitative	80	12.420		R 178.90	
4497	Carbohydrate deficient transferrin	80	29.060		R 418.70	
4499	Cortisol	80	12.420		R 178.90	
4500	DHEA sulphate	80	12.420		R 178.90	
4501	Testosterone	80	12.420		R 178.90	
4502	Free testosterone	80	17.480		R 251.80	
4503	Oestradiol	80	12.420		R 178.90	
4505	Oestriol	80	10.800		R 155.50	
4506	Multiple antigen specific IgE screening test for Atopy	80	37.260		R 536.80	
4507	Thyrotropin (TSH)	80	19.600		R 282.50	
4508	Combined antigen specific IgE	80	24.480		R 352.60	
4509	Free tri-iodothyronine (FT3)	80	17.480		R 251.80	
4511	Renin activity	80	18.900		R 272.50	
4512	Parathormone	80	17.080		R 246.00	
4513	IgE: Total	80	12.420		R 178.90	
4514	Antigen specific IgE	80	12.420		R 178.90	
4515	Aldosterone	80	12.420		R 178.90	
4516	Follitropin (FSH)	80	12.420		R 178.90	
4517	Lutropin (LH)	80	12.420		R 178.90	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4518	Soluble transferrin receptor	80	11.250		R 161.90	
4519	Prostate specific antigen	80	14.490		R 208.80	
4520	17 Hydroxy progesterone	80	12.420		R 178.90	
4521	Progesterone	80	12.420		R 178.90	
4522	Alpha-feto protein	80	12.420		R 178.90	
4523	ACTH	80	21.740		R 313.20	
4524	Free PSA	80	20.000		R 288.10	
4526	Sex hormone binding globulin	80	12.420		R 178.90	
4527	Gastrin	80	12.420		R 178.90	
4528	Ferritin	80	12.420		R 178.90	
4529	Anti-DNA antibodies	80	12.420		R 178.90	
4530	Antiplatelet antibodies	80	15.300		R 220.40	
4531	Hepatitis: Per antigen or antibody	80	14.490		R 208.80	
4532	Transcobalamine	80	12.420		R 178.90	
4533	Folic acid	80	12.420		R 178.90	
4534	Prostatic acid phosphatase	80	12.420		R 178.90	
4536	Erythrocyte folate	80	17.480		R 251.80	
4537	Prolactin	80	12.420		R 178.90	
4538	Procalcitonin: Semi-quantitative	80	32.000		R 461.10	
4539	Procalcitonin: Quantitative	80	46.000		R 662.80	
4540	HCG: Quantitative as used for Down’s screen	80	15.000		R 216.10	
4546	First trimester Downs screen	80	53.500		R 770.80	
4552	Second Trimester Down’s screen	80	33.620		R 484.50	
4553	Thyroglubulin	80	20.000		R 288.10	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4554	SCC marker	80	20.000		R 288.10	
21.13	Clinical pathology: Miscellaneous					
4544	Attendance in theatre	80	27.000		R 389.00	
4547	After-hours service: (Monday to Friday) 17:00 to 08:00, Saturday 13:00 to Monday 08:00 and public holidays – Refer to General Rule B.					
4551	Unlisted pathology service: Fees for items not listed in the current Pathology schedule (sections 21, 22 and 23) will be based on the fee for a comparable service in the coding structure. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted pathology service which will be based on the fee for a comparable service in the coding structure. New items for these unlisted services should be added to the coding structure within six months or that specific unlisted pathology service should no longer be performed. Please note General Rule C and Item 6999 are not applicable to pathology services (sections 21, 22 and 23).					
4555	Where pharmacological preparations (hormones, etc.) are administered as part of metabolic function tests, the cost of such preparation shall be charged separately.					
22	**Anatomical pathology**					
	Please note: The calculated amounts in this section are calculated according to the anatomical pathology unit values.					
22.1	Exfoliative cytology					
4561	Sputum, all body fluids and tumour aspirates: First unit	90	13.400		R 222.60	
4563	Sputum, all body fluids and tumour aspirates: Each additional unit	90	7.800		R 129.80	
4564	Performance of fine-needle aspiration for cytology	90	15.000		R 249.30	
4565	Examination of fine needle aspiration in theatre	90	90.000		R 1 495.10	
4566	Vaginal or cervical smears, each	90	11.000		R 182.80	
22.2	Histology					
4567	Histology per sample	95	20.000		R 314.50	
4571	Histology per additional block, each	95	11.600		R 182.50	
4575	Histology and frozen section in laboratory	95	22.700		R 357.00	
4577	Histology and frozen section in theatre	95	90.000		R 1 415.60	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4578	Second and subsequent frozen sections, each	95	20.000		R 314.50	
4579	Attendance in theatre – no frozen section performed	95	45.000		R 707.80	
4582	Serial step sections (including Item 4567)	95	23.300		R 366.30	
4584	Serial step sections per additional block, each	95	13.500		R 212.20	
4587	Histology consultation	95	10.100		R 159.00	
4589	Special stains	95	6.700		R 105.30	
4591	Immunofluorescence studies	95	20.700		R 325.60	
4592	Immunoperoxidase studies	95	40.000		R 629.20	
4593	Electron microscopy	95	94.000		R 1 478.30	
4595	Foetal autopsy excluding histology	95	73.000		R 1 148.10	
23	Human Genetics					
	Please note: The calculated amounts in this section are calculated according to the human genetics unit values					
23.1	Cytogenitc					
4750	Cell culture: Lymphocytes, cord blood	100	15.000		R 221.30	
4751	Cell culture: Amniotic fluid, fibroblasts, leukaemia bloods, bone marrow, other specialised cultures	100	45.000		R 664.00	
4752	Cell culture: Chorionic villi	100	60.000		R 885.50	
4754	Cytogenetic analysis: Lymphocytes: Idiograms, karyotyping, one staining technique	100	135.000		R 1 991.90	
4755	Cytogenetic analysis: Amniotic fluid, fibroblasts, chorionic villi, products of conception, bone marrow, leukamia bloods: Idiograms, karyotyping, one straining technique	100	270.000		R 3 983.90	
4757	Specified additional analysis e.g. mosaicism, Fanconi anaemia, Fra X, additional staining techniques	100	70.000		R 1 032.80	
4760	FISH procedure, including cell culture	100	115.000		R 1 696.90	
4761	FISH analysis per probe system	100	35.000		R 516.30	
23.2	DNA-testing					
4763	Blood: DNA extraction	100	45.000		R 664.00	

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
4764	Blood: Genotype per person: Southern blotting	100	89.000		R 1 313.30	
4765	Blood: Genotype per person: PCR	100	60.000		R 885.50	
4766	HIV Drug Resistance Testing	100	513.000		R 7 569.10	
4767	Prenatal diagnosis: Amniotic fluid or chorionic tissue: DNA extraction	100	90.000		R 1 327.90	
4768	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: Southern blotting	100	188.000		R 2 773.90	
4769	Prenatal diagnosis: Amniotic fluid or chorionic tissue: Genotype per person: PCR	100	120.000		R 1 770.60	
IV.	**Travelling expenses**					
P.	**Travelling fees** a. Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if he had to travel more than 16 kilometres in total. b. If more than one patient would be attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. c. A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms. d. Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled). e. Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled). f. For voluntarily scheduled services, fees for travelling expenses may only be charged where the patient and the practitioner have entered into an agreement to this effect. Medical scheme benefits will not be applicable in such instances.					
5003	The indicated amount for each kilometre in excess of 16 kilometres travelled in own car e.g. where a practitioner has to travel 19 kilometres in total to visit a patient, the fees shall be calculated as follows: 19-16= 3 X indicated amount	20	1.000		R 16.10	
5005	Normal hours: Specialist: 18,00 clinical procedure units per hour or part thereof	20	18.000		R 291.60	
5007	Normal hours: General practitioner – 18,00 clinical procedure units per hour or part thereof					
5013	Travelling fees are not payable to practitioners who assisted at operations on cases referred to surgeons by them					

GEMS TARIFF FOR SERVICES BY CONTRACTED PHYSICIANS EFFECTIVE FROM 1 JANUARY 2017 FOR REO OPTIONS ONLY		Practice Type: Physicians Only Disciplines: 17, 18, 19, 20, 21 and 31				
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**Flag**	**2017 value**	**Flag**
V.	**LIST OF PROCEDURES WHICH ARE OFTEN DONE IN THE DOCTORS' ROOMS TO WHICH MODIFIER 0004 SHOULD NOT BE APPLIED**					
	Modifier 0004 is not applicable to the following sections: • All anaesthetic services • Section 19: Radiology • Section 20: Radiation Oncology • Section 21: Clinical Pathology (except for Items 3719, 3720 and 3721 where modifier 0004 may be applied) • Section 22: Anatomical Pathology • Section 23: Human Genetic Please note: This is not a conclusive list and practitioners should not be penalised when patients need to be admitted to hospital for these procedures.					

CONTRACTED PSYCHIATRIST – REO OPTION

GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED PSYCHIATRIST FOR REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017		Practice Type: Psychiatrist Medical Practitioner Code: 12200		
Tariff Code	**Descripton of Tariff Code**	**CF**	**Units**	**2017 value**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.			
I.b	Specialists tiered consultation structure			
I.b.1	New and established patients: Consultations/visits by psychiatrists (22) only			
0161	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient between 10 and 20 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).	11	15,000	R 468,10
0162	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with detailed history, clinical examination and straightforward decision making and counselling. Typically occupies the doctor personally with the patient between 21 and 35 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).	11	27,500	R 858,10
0163	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient between 36 and 45 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).	11	40,000	R 1 247,90
0164	Psychiatry (22): New and established patients: Consultation/visit of new or established patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counselling. Typically occupies a doctor personally with the patient between 46 and 60 minutes (for hospital consultation/visit by psychiatrist – refer to Items 0166-0169).	11	52,500	R 1 637,90
0166	Psychiatry (22): First hospital consultation/visit with problem focused history, clinical examination and straightforward decision making for minor problem. Typically occupies the doctor personally with the patient for between 10 and 20 minutes.	11	15,000	R 468,10
0167	Psychiatry (22): First 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 and 35 minutes.	11	27,500	R 858,10
0168	Psychiatry (22): First hospital consultation/visit with detailed history, complete clinical examination and moderately complex decision making and counselling. Typically occupies the doctor personally with the patient for between 36 and 45 minutes.	11	40,000	R 1 247,90
0169	Psychiatry (22): First hospital consultation/visit 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.	11	52,500	R 1 637,90

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GEMS TARIFF FOR CONSULTATIVE SERVICES BY CONTRACTED PSYCHIATRIST FOR REO OPTIONS ONLY EFFECTIVE FROM 1 JANUARY 2017		Practice Type: Psychiatrist Medical Practitioner Code: 12200		
Tariff Code	**Descripton of Tariff Code**	**CF**	**Units**	**2017 value**
	Medical psychotherapy			
2957	Individual psychotherapy (specify type), including play therapy for children: Per short session (20 minutes)	11	20,000	R 624,10
2958	Psychoanalytic therapy: Per 60-minute session	11	60,000	R 1 871,80
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session	11	20,000	R 624,10
2963	Pairs, marriage or sex therapy: Per 20-minute session	11	20,000	R 624,10
2968	Group therapy: Adults (specify number), tariff per person per 80-minute session. Children (specify number): Tariff per person per 80-minute session	11	26,000	R 811,20
2974	Individual psychotherapy (specify type), including play therapy for children: Per intermediate session (40 minutes)	11	40,000	R 1 247,90
2975	Individual psychotherapy (specify type), including play therapy for children: Per extended session (60 minutes or longer)	11	60,000	R 1 871,80
2976	Intermediate treatment where either Items 2962 or 2963 are used: Per 40-minute session	11	40,000	R 1 247,90
2977	Extended treatment where either Items 2962 or 2963 are used: Per 60-minute session	11	60,000	R 1 871,80
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY			
V.	a. Electro-convulsive treatment: Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. b. Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof, provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.			
0079	When a first 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).			
	Physical treatment methods			
2970	Electro-convulsive treatment (ECT): Each time (see rule V.a.)	11	15,000	R 468,10
	Psychiatric examination methods			
2972	Narco-analysis (maximum of three sessions per treatment): Per 60-minute session	11	60,000	R 1 871,80
2973	Psychometry (specify examination): Per session (maximum of three sessions per examination)	11	20,000	R 624,10

DENTAL TECHNICIANS

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
1	**Preparatory work**					
	The following section includes comsumables, however it excludes materials.					
9301	Casting and trimming of model in plaster (yellow/white), per model	560	2,714	1,0	R 35,20	
9303	Casting and trimming of model in super-hard stone (die-stone), per model	560	3,857	1,0	R 50,00	
9305	Casting and trimming of study model, per model	560	7,143	1,0	R 92,60	
9307	Casting and trimming of gnathostatic model, per model	560	9,286	1,0	R 120,60	
9309	New trimmed base to supplied model, per model	560	3,286	1,0	R 42,50	
9311	Trimming of supplied model, per model	560	2,000	1,0	R 26,20	
9312	Gingival tissue mask, per implant	560	15,429	1,0	R 200,40	
9313	Duplicating model, per model	560	8,286	1,0	R 107,70	
9314	Refractory model, per unit	560	8,143	1,0	R 105,80	
9315	Models and duplicate models (virgin model) for crown and bridge, work inclusive of one removable die	560	11,286	1,0	R 146,40	
9317	Sectional models for crown and bridge, work inclusive of one removable die	560	10,000	1,0	R 129,70	
9319	Each additional removable die for Items 9315 and 9317 per die	560	2,571	1,0	R 33,20	
9320	Indexed or model tray per die (not more than 9319)	560	2,571	1,0	R 33,20	
9321	Occlusion block, per block	560	9,857	1,0	R 127,90	
9323	Occlusion block on baseplate, per block	560	12,429	1,0	R 161,50	
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	560	1,857	1,0	R 24,10	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9329	Fit and supply of disposable articulator	560	4,857	1,0	R 63,10	
9330	Delivery/collection fee per completed procedure (maximum 4)	560	5,143	1,0	R 66,90	
	The tariff under all sections excludes the fees for models, occlusion blocks and delivery charge				R 0,00	
2	**Prosthetic services using acrylic**					
	The tariff under this section excludes the fees for models and occlusion blocks					
	The following section includes consumables, however it excludes materials					
A	Full dentures					
9331	Full upper and lower dentures	560	132,571	1,0	R 1 720,90	
9333	Full upper or lower denture	560	77,571	1,0	R 1 006,90	
9335	Set-up and waxing of full upper and lower dentures	560	45,714	1,0	R 593,40	
9337	Set-up and waxing of full upper or lower denture	560	30,571	1,0	R 396,80	
9339	Waxing and finishing of full upper and lower dentures	560	81,286	1,0	R 1 055,10	
9341	Waxing and finishing of full upper or lower denture	560	45,429	1,0	R 589,90	
9343	Additional fee for dentures on fully adjustable articulator at request of dentist	560	129,429	1,0	R 1 680,20	
9345	Additional fee for immediate dentures, or tooth socketed	560	1,857	1,0	R 24,10	
9346	Additional fee for immediate dentures, per tooth not socketed	560	1,000	1,0	R 13,00	
9347	Additional fee for each retry from the third and upwards at an agreed quantum of time to be calculated at hourly rate	560	29,429	1,0	R 382,10	
B	Partial dentures					
9351	Set-up and finish of one-tooth denture	560	35,571	1,0	R 461,70	
9352	Set-up and finish of two-tooth denture	560	37,857	1,0	R 491,40	
9353	Set-up and finish of three-tooth denture	560	40,571	1,0	R 526,60	
9354	Set-up and finish of four-tooth denture	560	42,857	1,0	R 556,30	
9355	Set-up and finish of five-tooth denture	560	46,286	1,0	R 600,90	
9356	Set-up and finish of six-tooth denture	560	55,286	1,0	R 717,60	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9357	Set-up and finish of seven-tooth denture	560	65,714	1,0	R 853,00	
9358	Set-up and finish of eight-tooth denture	560	69,714	1,0	R 905,10	
9359	Set-up and finish of nine or more tooth denture	560	71,429	1,0	R 927,40	
9361	Set-up and waxing of one-tooth denture	560	10,143	1,0	R 131,60	
9362	Set-up and waxing of two-tooth denture	560	12,286	1,0	R 159,60	
9363	Set-up and waxing of three-tooth denture	560	14,000	1,0	R 181,70	
9364	Set-up and waxing of four-tooth denture	560	16,286	1,0	R 211,40	
9365	Set-up and waxing of five-tooth denture	560	18,000	1,0	R 233,60	
9366	Set-up and waxing of six-tooth denture	560	21,286	1,0	R 276,30	
9367	Set-up and waxing of seven-tooth denture	560	23,429	1,0	R 304,10	
9368	Set-up and waxing of eight-tooth denture	560	25,143	1,0	R 326,40	
9369	Set-up and waxing of nine or more tooth denture	560	26,857	1,0	R 348,70	
9371	Waxing and finishing of one-tooth denture	560	27,857	1,0	R 361,50	
9372	Waxing and finishing of two-tooth denture	560	28,429	1,0	R 369,00	
9373	Waxing and finishing of three-tooth denture	560	28,857	1,0	R 374,60	
9374	Waxing and finishing of four-tooth denture	560	29,429	1,0	R 382,10	
9375	Waxing and finishing of five-tooth denture	560	30,571	1,0	R 396,80	
9376	Waxing and finishing of six-tooth denture	560	31,714	1,0	R 411,70	
9377	Waxing and finishing of seven-tooth denture	560	39,571	1,0	R 513,80	
9378	Waxing and finishing of eight-tooth denture	560	41,143	1,0	R 534,00	
9379	Waxing and finishing of nine or more tooth denture	560	43,429	1,0	R 563,80	
9383	Additional fee for finishing denture in tooth colour material, per tooth	560	6,857	1,0	R 89,20	
9385	Additional fee for supplying finished denture on duplicate model	560	13,000	1,0	R 168,70	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
C	Repair service					
9391	Basic charge which includes repair of one fracture, or addition of one tooth, or addition of one clasp	560	22,571	1,0	R 293,00	
9393	Additional charge for each additional fracture, or tooth, or clasp	560	7,000	1,0	R 91,00	
9395	Additional fee for using wire strengthener	560	8,000	1,0	R 104,00	
9397	Additional fee for using pre-formed strengthener	560	8,571	1,0	R 111,10	
9398	Additional fee for using mesh strengthener in repair procedure	560	13,571	1,0	R 176,30	
D	Additional services					
9401	Clear base	560	10,000	1,0	R 129,70	
9403	Dox grinding of upper and lower dentures	560	12,714	1,0	R 164,90	
9405	Inlay to artificial tooth, one surface only, per inlay	560	21,857	1,0	R 283,60	
9406	Inlay to artificial tooth, multi-surfaces e.g. horseshoe or L-type inlay, per inlay	560	28,000	1,0	R 363,40	
9407	Heka base technique per upper or lower denture	560	30,000	1,0	R 389,40	
9409	Frego frame	560	13,000	1,0	R 168,70	
9410	Bleaching tray	560	14,429	1,0	R 187,20	
9411	Template per upper or lower denture	560	35,857	1,0	R 465,50	
9413	Reline/rebase of single denture	560	45,143	1,0	R 586,10	
9415	Remodel of single denture	560	69,429	1,0	R 901,20	
9417	Soft base reline per denture	560	114,000	1,0	R 1 479,80	
9419	Soft base to new denture, per denture	560	114,000	1,0	R 1 479,80	
9421	Gum tinting per denture	560	21,143	1,0	R 274,40	
9423	Lingual or palatal bar	560	17,000	1,0	R 220,80	
9425	Cleaning and polishing of existing denture, per denture	560	13,857	1,0	R 180,00	
9427	Mesh strengthener	560	11,857	1,0	R 153,90	
9429	Theatre/consultation out of laboratory per hour or part thereof	560	29,429	1,0	R 382,10	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9431	Special tray, acrylic, each	560	11,143	1,0	R 144,70	
9432	Special tray light cure, each	560	12,143	1,0	R 157,80	
9433	Special tray in base plate material, each	560	11,429	1,0	R 148,40	
9435	Provision of single arm clasp, to partial denture	560	5,857	1,0	R 76,10	
9437	Provision of double arm clasp, to partial denture	560	10,143	1,0	R 131,60	
9439	Provision of single arm clasp with rest, to partial denture	560	13,143	1,0	R 170,60	
9441	Provision of double arm clasp with rest, to partial denture	560	17,714	1,0	R 230,10	
9443	Provision of preformed Roach clasp, to partial denture	560	7,571	1,0	R 98,40	
9445	Provision of rest only to partial denture	560	7,571	1,0	R 98,40	
9447	Cast clasp	560	26,571	1,0	R 344,90	
9448	Casting and trimming of model from impression inside occlusion block or wax try in... missing text	560	4,857	1,0	R 63,10	
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	560	10,143	1,0	R 131,60	
3	**Cobalt chrome/gold prosthetic services**					
	The tariffs under this section excludes the tariff for models.					
	The following section includes consumables, however it excludes materials.					
A	Full metal dentures					
9451	Metal base for full upper or full lower denture each	560	91,000	1,0	R 1 181,30	
B	Partial metal dentures					
9453	Basic charge which excludes models and any special trays which may be required by the dentist, but includes refractory model	560	79,571	1,0	R 1 032,90	
9455	Additional charge for each one arm clasp	560	3,286	1,0	R 42,50	
9457	Additional charge for each Roach clasp	560	5,571	1,0	R 72,30	
9459	Additional charge for each rest	560	3,000	1,0	R 39,10	
9461	Additional charge for continuous clasp, per tooth	560	3,286	1,0	R 42,50	
9463	Additional charge for lingual bar, per tooth passed	560	7,714	1,0	R 100,10	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9465	Additional charge for palatal bar	560	12,286	1,0	R 159,60	
9467	Additional charge for onlay	560	32,714	1,0	R 424,60	
9469	Additional charge for saddle with finishing line, per tooth	560	5,429	1,0	R 70,40	
9471	Additional charge for saddle without finishing line, per tooth	560	3,143	1,0	R 40,80	
9473	Additional charge for horseshoe saddle, per tooth	560	5,429	1,0	R 70,40	
9475	Additional charge for fitting of tooth to metal backing, per tooth	560	3,714	1,0	R 48,20	
9479	Additional charge for fitting one distal-extension hinge	560	11,000	1,0	R 142,90	
9480	Additional charge per milled edge per tooth	560	9,571	1,0	R 124,30	
9481	Additional charge for each soldering joint	560	13,429	1,0	R 174,30	
9483	Additional charge for soldering retention	560	16,286	1,0	R 211,40	
9485	Additional charge for each additional retention soldering joint	560	5,000	1,0	R 65,00	
9487	Additional charge for each welding joint	560	16,429	1,0	R 213,20	
9489	Additional charge for fitting swing lock	560	13,429	1,0	R 174,30	
9491	Additional charge for each backing cast	560	13,143	1,0	R 170,60	
9493	Additional charge for each Steels backing or pontic cast (plastic work to be charged in addition)	560	14,286	1,0	R 185,60	
C	Chrome cobalt and repairs					
9495	Basic fee for the repairing of or addition to any appliance necessitating the casting of a model (9301)	560	20,714	1,0	R 268,80	
9497	Basic fee if a new section is to be fabricated and where Item 9495 does not apply (9301)	560	23,571	1,0	R 305,90	
4	**Crown and bridge prosthetic services**					
	The tariffs under this section excludes the tariff for models.					
	The following section includes consumables, however it excludes materials.					
A	Porcelain (ceramic) services					
9501	Ceramic jacket crown/Ceromer crown or pontic	560	90,429	1,0	R 1 173,80	
9502	Ceramic metal substitute coping	560	73,000	1,0	R 947,70	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9505	Ceramic bonded crown or pontic	560	119,429	1,0	R 1 550,20	
9507	Post-solder invested joint, per joint	560	24,429	1,0	R 317,10	
9511	Inlay in porcelain veneer crown	560	39,429	1,0	R 511,80	
9512	Ceramic, inlay/onlay, bridge retainer	560	92,714	1,0	R 1 203,50	
9515	Porcelain shoulder per unit (not applicable to pontics)	560	8,000	1,0	R 104,00	
9520	Additional fee for crown and bridge work performed on a movable condyle articulator per unit	560	3,857	1,0	R 50,00	
B	Gold and acrylic veneer services					
9521	Full metal crown, MOD, three-quarter crown	560	73,857	1,0	R 958,80	
9524	Indirect composite resin inlay	560	20,000	1,0	R 259,70	
9525	Class IV, MO, DO, cervical/occlusal inlay	560	60,857	1,0	R 790,00	
9526	Additional fee for one piece casting of crown or inlay on post	560	18,571	1,0	R 241,10	
9531	Pin-ledge inlay	560	69,000	1,0	R 895,70	
9533	Full metal pontic	560	54,571	1,0	R 708,60	
9535	Abutment thimble cast	560	51,143	1,0	R 664,00	
9537	Precision lock and rest cast	560	72,571	1,0	R 942,20	
9538	Lock and rest cast	560	34,714	1,0	R 450,70	
9539	Casting of rest only	560	20,714	1,0	R 268,80	
9541	Metal inlay or post, cast direct	560	22,000	1,0	R 285,60	
9543	Gold/pre-solder invested joint	560	21,857	1,0	R 283,60	
9545	Cast post with thimble, indirect	560	36,429	1,0	R 473,00	
9546	Multiple post	560	60,286	1,0	R 782,60	
9547	Manufacture cast post and core to existing crown	560	47,571	1,0	R 617,60	
9549	C.S.P. attachment (Steiger)	560	160,571	1,0	R 2 084,40	
9550	Milling milled edge per unit	560	51,143	1,0	R 664,00	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9551	Telescope crown	560	126,000	1,0	R 1 635,50	
9553	Composite/acrylic veneer crown/pontic, indirect	560	100,714	1,0	R 1 307,30	
9557	Composite/acrylic jacket crown, indirect	560	71,143	1,0	R 923,60	
9559	Composite/acrylic veneer post crown	560	99,571	1,0	R 1 292,60	
9560	Indirect composite resin veneer	560	42,143	1,0	R 547,10	
9561	Composite/acrylic jacket crown, direct	560	48,571	1,0	R 630,40	
9563	Temporary acrylic/composite crown per unit	560	34,714	1,0	R 450,70	
9564	Heat formed template supplied to dentist for the manufacture of temporary restorations	560	17,429	1,0	R 226,20	
9565	Composite/acrylic-facing replaced	560	40,429	1,0	R 524,90	
9566	Porcelain/Ceromer facing replaced	560	73,286	1,0	R 951,20	
9569	Waxing of crown to existing denture	560	28,571	1,0	R 370,70	
9570	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	560	29,429	1,0	R 382,10	
5	**Orthodontic appliances**					
	The tariffs under this section excludes the tariff for models.					
	The following section includes consumables, however it excludes materials.					
A	Orthodontic services					
9571	Basic charge which includes acrylic base	560	36,143	1,0	R 469,20	
9572	Basic charge non-acrylic base	560	17,429	1,0	R 226,20	
9573	Additional charge for fitting first expansion screw	560	6,857	1,0	R 89,20	
9575	Additional fee for fitting subsequent expansion screws	560	5,857	1,0	R 76,10	
9576	Additional fee for full aclusal bite plate	560	20,286	1,0	R 263,40	
9577	Additional fee for bite plate anterior	560	6,857	1,0	R 89,20	
9578	Additional fee for bite plate posterior	560	6,857	1,0	R 89,20	
9579	Additional fee for fitting tongue guard	560	8,571	1,0	R 111,10	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9581	Additional fee for flat or inclined plane	560	5,286	1,0	R 68,50	
9583	Additional fee for Adams Crib	560	6,286	1,0	R 81,60	
9585	Additional fee for Jackson Crib	560	6,571	1,0	R 85,30	
9587	Additional fee for ball clasp	560	7,429	1,0	R 96,40	
9589	Additional fee for single arm clasp	560	5,714	1,0	R 74,10	
9591	Additional fee for double arm clasp	560	10,000	1,0	R 129,70	
A.1	Springs					
9593	Additional fee for fitting single loop finger spring	560	4,714	1,0	R 61,20	
9595	Additional fee for fitting double loop finger spring	560	5,571	1,0	R 72,30	
9597	Additional fee for fitting Buccal retraction spring	560	4,143	1,0	R 53,90	
9599	Additional fee for fitting apron spring	560	10,714	1,0	R 139,20	
9603	Additional fee for fitting coffin spring	560	10,286	1,0	R 133,50	
9605	Additional fee for fitting Quad Helix	560	11,429	1,0	R 148,40	
9607	Additional fee for fitting flapper or “T” spring	560	8,571	1,0	R 111,10	
9609	Additional fee for fitting all springs with tubing, each	560	9,571	1,0	R 124,30	
A.2	Arches					
9611	Additional fee for fitting labial arch	560	5,429	1,0	R 70,40	
9613	Additional fee for fitting buccal arch	560	6,429	1,0	R 83,40	
9615	Additional fee for fitting Roberts retractor	560	12,000	1,0	R 155,80	
9617	Invisible retainer	560	15,857	1,0	R 205,70	
9619	Additional fee for fitting twin wire arch extra-oral arch	560	15,000	1,0	R 194,90	
9620	Additional fee lip bumper	560	6,286	1,0	R 81,60	
9621	Additional fee for fitting extra-oral arch	560	14,286	1,0	R 185,60	
9622	Additional fee for fitting space maintainer arch	560	6,286	1,0	R 81,60	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
A.3	Welding and soldering					
9623	Additional fee for each spot-welding joint	560	2,857	1,0	R 37,10	
9625	Additional fee for each soldering joint	560	4,571	1,0	R 59,40	
9627	Additional fee for each invested soldering joint	560	12,714	1,0	R 164,90	
9629	Additional fee for each hook for elastic traction	560	4,143	1,0	R 53,90	
B	Mouth protectors and MYO functional appliances					
9631	Mouth protector (gum guard)	560	26,857	1,0	R 348,70	
9633	Oral screen	560	33,000	1,0	R 428,50	
9635	Andresen or Norwegian appliance	560	59,000	1,0	R 765,90	
9637	Tooth positioner	560	68,000	1,0	R 882,70	
9639	Gunning splint	560	90,571	1,0	R 1 175,70	
9641	Frankel appliance	560	87,429	1,0	R 1 134,90	
9643	Chin cap	560	29,000	1,0	R 376,60	
9645	Bionator	560	59,143	1,0	R 767,80	
9646	Diagnostic set-up	560	56,857	1,0	R 738,00	
9647	Snoring appliance	560	53,714	1,0	R 697,30	
C	Fixed appliances					
9651	Pinched or swaged band with welded attachment (excluding cost of attachment)	560	17,429	1,0	R 226,20	
9653	Pinched or swaged band with soldered attachment	560	22,857	1,0	R 296,90	
D	Additional services					
9662	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	560	29,429	1,0	R 382,10	
6	**Materials**					
A	Prosthetic/restorative services					
9700	Diatorics 1 X 6/8	560	-	1,0	R 0,00	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9702	Diatorics, odds, anterior	560	-	1,0	R 0,00	
9704	Diatorics, odds, posterior	560	-	1,0	R 0,00	
9706	Cost of bleaching tray material	560	-	1,0	R 0,00	
9720	Soft base material per denture	560	-	1,0	R 0,00	
9722	Acrylic per denture	560	-	1,0	R 0,00	
9724	Cost of precision attachment, per attachment	560	-	1,0	R 0,00	
9726	Preformed Ball or Roach clasp	560	-	1,0	R 0,00	
9728	Cost of lingual/palatal bar	560	-	1,0	R 0,00	
9729	Cost of mesh strengthener	560	-	1,0	R 0,00	
9730	Cost of pre-fabricated burn-out component, per component	560	-	1,0	R 0,00	
9732	Cost of other attachment components e.g. nylon caps, sleeves etc	560	-	1,0	R 0,00	
9734	Cost of dolder bar and clips, per gram or per clip	560	-	1,0	R 0,00	
9736	Cost of implant components	560	-	1,0	R 0,00	
9738	Cost of preformed strengthener	560	-	1,0	R 0,00	
9739	Additional charge gold plating	560	-	1,0	R 0,00	
B	Metal					
9740	Cost of gold wire, per gram	560	-	1,0	R 0,00	
9741	Cost of cobalt chrome casting alloy	560	-	1,0	R 0,00	
9742	Cost of specialised cobalt chrome casting metal e.g. vitallium, titanium	560	-	1,0	R 0,00	
9744	Cost of precious casting alloy	560	-	1,0	R 0,00	
9746	Cost of semi-precious casting alloy	560	-	1,0	R 0,00	
9748	Cost of non-precious casting alloy	560	-	1,0	R 0,00	
9752	Cost of platinum foil	560	-	1,0	R 0,00	
9754	Cost of gold solder, per gram	560	-	1,0	R 0,00	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9755	Etching for bonding (metal or ceramic)	560	-	1,0	R 0,00	
9756	Cost of silver solder, per gram	560	-	1,0	R 0,00	
9757	Ceromer material, per unit	560	-	1,0	R 0,00	
9758	Fiber reinforced material per unit	560	-	1,0	R 0,00	
9760	Composite restoration material	560	-	1,0	R 0,00	
9761	Ceramic material	560	-	1,0	R 0,00	
C	Orthodontic services					
9762	Cost of anterior orthodontic attachment, per attachment	560	-	1,0	R 0,00	
9763	Orthodontic material	560	-	1,0	R 0,00	
9764	Cost of posterior orthodontic attachment, per attachment	560	-	1,0	R 0,00	
9765	Preformed components	560	-	1,0	R 0,00	
9766	Cost of expansion screw, per screw	560	-	1,0	R 0,00	
9767	Soldering material	560	-	1,0	R 0,00	
9768	Cost of buccal tube/transfer tube, per tube	560	-	1,0	R 0,00	
9770	Cost of J-hook, per hook	560	-	1,0	R 0,00	
9772	Cost of lingual buttons, per button	560	-	1,0	R 0,00	
9774	Cost of invisible retainer material	560	-	1,0	R 0,00	
9775	R/A case	560	-	1,0	R 0,00	
9776	Cost of mouth protector material	560	-	1,0	R 0,00	
9778	Cost of arch wire	560	-	1,0	R 0,00	
9779	Dual laminate material	560	-	1,0	R 0,00	
7	**Precision attachments and implant services**					
	The following section includes consumables, however it excludes materials.					
9780	Positioning and finishing of complete (male and female) prefabricated burn-out attachment	560	45,000	1,0	R 584,10	

GEMS TARIFF FOR DENTAL TECHNICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dental Technology Code: 49300	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 value**	**Flag**
9782	Positioning and soldering of complete (male and female) precision attachment	560	37,571	1,0	R 487,70	
9783	Implant stent per unit	560	34,714	1,0	R 450,70	
9784	Alignment of dolder bar and clips	560	47,429	1,0	R 615,50	
9786	Trimming, waxing and finishing of implant abutment – crown and bridge work only, per abutment	560	20,429	1,0	R 265,00	
9787	Waxing, milling and finishing of a custom abutment	560	39,857	1,0	R 517,60	
9788	Implant superstructure (edentulous cases) including placing of preformed parts, per section cast	560	217,857	1,0	R 2 828,00	
9789	Finishing of prosthesis on implant structure per arch	560	79,571	1,0	R 1 032,90	

DIETETICS

GEMS TARIFF FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dietetics Code: 38400	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 Value**	**Flag**
	In calculating the GEMS Tariff, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed. ALL GEMS TARIFFS ARE VAT INCLUSIVE.					
	GENERAL RULES					
003	Dietary services are per individual patient.					
004	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB: Every account shall contain the following particulars: • the name and practice code number of the referring practitioner • the name of the member • the name of the patient • the name of the medical scheme • the membership number of the member • the nature of the treatment • the date on which the service was rendered • the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered					
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.					
010	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.					
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.					
	MODIFIERS					
0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.					

GEMS TARIFF FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2017					Practice Type: Dietetics Code: 38400	
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 Value**	**Flag**
	ITEMS					
1.	**Individual assessment, counselling and/or treatment**					
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).					
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10mins	200	0,500	1,0	R 42,40	
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20mins	200	1,500	1,0	R 127,40	
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30mins	200	2,500	1,0	R 212,60	
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40mins	200	3,500	1,0	R 297,60	
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50mins	200	4,500	1,0	R 382,70	
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60mins	200	5,500	1,0	R 467,60	
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70mins	200	6,500	1,0	R 552,80	
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80mins	200	7,500	1,0	R 637,70	
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90mins	200	8,500	1,0	R 722,90	
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100mins	200	9,500	1,0	R 807,90	
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110mins	200	10,500	1,0	R 892,90	
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120mins	200	11,500	1,0	R 977,90	
2.	**Group assessment, counselling and/or treatment**					
	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients					
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10mins	200	0,100	1,0	R 8,53	
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20mins	200	0,300	1,0	R 25,40	
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30mins	200	0,500	1,0	R 42,40	
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40mins	200	0,700	1,0	R 59,50	
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50mins	200	0,900	1,0	R 76,50	
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60mins	200	1,100	1,0	R 93,60	

GEMS TARIFF FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2017						Practice Type: Dietetics Code: 38400
Tariff Code	**Description of Tariff Code**	**CF**	**Units**	**BF**	**2017 Value**	**Flag**
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70mins	200	1,300	1,0	R 110,60	
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80mins	200	1,500	1,0	R 127,40	
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90mins	200	1,700	1,0	R 144,50	
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100mins	200	1,900	1,0	R 161,70	
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110mins	200	2,100	1,0	R 178,60	
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120mins	200	2,300	1,0	R 195,50	