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NO. 7279 **20 March 2026**

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GOVERNMENT NOTICE

DEPARTMENT OF EMPLOYMENT AND LABOUR

No. ..... **DATE: .....**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT No. 130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Nomakhosazana Meth, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2026.

2. Medical Tariffs will increase by 6% for the financial year 2026/27.

3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2026 and exclude 15% VAT

Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

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

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

- To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

  a. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)
  b. Register on the CompEasy application having the following documents to upload
     - A certified copy of identity document (not older than a month from the date of application)
     - Latest copy of valid BHF certificate
     - Proof of address not older than 3 months

- In the case where a medical service provider has appointed a third party to administer their COID claims with the Fund, the following ADDITIONAL documents must be uploaded:

  - An appointment letter for proxy (the template is available online)
  - The proxy's certified identity document (not older than a month from the date of application)
  - There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

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3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

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

4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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

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

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

5. OVERVIEW OF THE COID CLAIMS PROCESS

- All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

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

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

Submission of Medical Reports

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

Submission of Medical Invoices

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

Minimum Information Requirements for Medical Invoices

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

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

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

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

VAT and Tariff Application

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

Pharmaceuticals and Referrals

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

Enforcement and Non-Compliance

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

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

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

ICD-10 Validations

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

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

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

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

8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

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

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

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

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

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

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
35	Treating Doctor BHF practice number	9	Alpha	
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*

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MSPs PAID BY THE COMPENSATION FUND

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

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

POPI ACT COMPLIANCE

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

DOCTORS
RULES
2026

GENERAL MEDICAL DOCTOR AND SPECIALIST TARIFF OF FEES AS FROM 01 APRIL 2026	
GENERAL RULES	
	PLEASE NOTE: The interpretations/comments as published in the SAMA Medical Doctors' Coding Manual (MDCM) must also be adhered to when rendering health care services under the Compensation for Occupational Injuries and Diseases Act, 1993
RULE	**RULE DESCRIPTION**
A.	**Consultation Definitions:** **(a) New and established patients:** A consultation/visit refers to a clinical situation where a medical doctor personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receives additional remuneration. **(b) Subsequent visits**: Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling. **(c) Hospital visits**: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and fees may be charged (unless otherwise indicated). Where no procedure or operation was carried out,fees may be charged for hospital visits according to the appropriate hospital or in patient follow up visit code.
B.	**Normal hours and after hours:** Normal working hours comprise the periods 08:00 to 17:00 on Mondays to Fridays, 08:00 to 13:00 on Saturdays, and all other periods voluntarily scheduled (even when for the convenience of the patient) by a medical medical doctor for the rendering of services. All other periods are regarded as after hours. Public holidays are not regarded as normal working days and work performed on these days is regarded as after-hours work. Services are scheduled involuntarily for a specific time, if for medical reasons the doctor should not render the service at an earlier or later opportunity. **Note:** Items 0146 and 0147 (emergency consultations) as well as modifier 0011 (emergency theatre procedures) are only applicable in the after hours period.
C.	**Comparable services:** The fee that may be charged in respect of the rendering of a service not listed in this tariff of fees or in the SAMA guideline, shall be based on the fee in respect of a comparable service. For procedures/services not in this tariff of fees but in the SAMA guideline, item 6999 (unlisted procedure or service code), should be used with the SAMA code. Motivation for the use of a comparable item must be provided. **Note**: Rule C and item 6999 may not be used for comparable pathology services (sections 21, 22 and 23) To be pre-authorised by the Fund.
D.	**Cancellation of appointments:** Unless timely steps are taken to cancel an appointment for a consultation the relevant consultation fee may be charged. In the case of an injured employee, the relevant consultation fee is payable by the employee.) In the case of a general medical doctor "timely" shall mean two hours and in the case of a specialist two hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be.
E.	**Pre-operative visits:** The appropriate consultation may be charged for all pre-operative visits with the exception of a routine pre-operative visit at the hospital, since that routine pre-operative visit is included in the global surgical period for the procedure.
F.	**Administering of injections and/or infusions:** Where applicable, administering injections and/or infusions may only be coded when done by the medical doctor him-/herself.

G.	**Post-operative care:** **(a)** Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding FOUR (4)months (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed) . **(b)** If the normal after-care is delegated to any other registered health professional and not completed by the surgeon it shall be his/her own responsibility to arrange for the service to be rendered without extra charge. **(c)** When the care of post-operative treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the Compensation Fund may be charged. **(d)** Aftercare refers to all treatment and the post -operative period not requiring any further surgical intervention. **(e)** Abnormal aftercare refers to post-operative complications and treatment not requiring any further incisions and will be considered for payment.
H.	**Removal of lesions:** Items involving removal of lesions include follow-up treatment for four months.
I.	**Pathological investigations performed by clinicians:** Fees for all pathological investigations performed by members of other disciplines (where permissible) - refer to modifier 0097: Items that resort under Clinical and Anatomical Pathology: See section for Pathology.
K.	**Services of a specialist, upon referral:** In exceptional cases the services of a specialist shall be available only on the recommendation of the attending general medical doctor. Medical medical doctors referring cases to other medical medical doctors shall, if known to them, indicate in the referral letter that the patient was injured in an "accident" and this shall also apply in respect of specimens sent to pathologists.
L.	**Procedures performed at time of visits:** If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged.
M.	**Surgical procedure planned to be performed later:** In cases where, during a consultation/visit, a surgical procedure is planned to be performed at a later occasion,a routine pre-operative visit may not be charged for again at such later occasion,since that routine pre-operative visit is included in the global surgical period for the procedure.
N.	**Rendering of invoices for occupational injuries and diseases:** **(a)** "Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention. **(b** Where a fee for a service is prescribed in this guideline, the medical medical doctor shall not be entitled to payment calculated on a basis of the number of visits or examinations made where such calculation would result in the prescribed fee being exceeded. **(c)** The number of consultations/visits must be in direct relation to the seriousness of the injury and should more than 20 visits be necessary, the Compensation Fund must be furnished with a detailed motivation. **(d)** A single fee for a consultation/visit shall be paid to a medical medical doctor for the once-off treatment of an injured employee who thereafter passes into the permanent care of another medical medical doctor, not a partner or assistant of the first. The responsibility for furnishing the First Medical Report in such a case rests with the second medical doctor.

O.	**Costly or prolonged medical services or procedures:** **(a)** An employee should be hospitalised only when and for the length of period that his condition justifies full-time medical assistance. **(b)** Occupational therapy/Physiotherapy: The same principals as set out in modifier 0077: Two areas treated simultaneously for totally different conditions, will apply when an employee is referred to a therapist. **(c)** In case of costly or prolonged medical services or procedures the medical medical doctor shall first ascertain in writing from the Compensation Fund if liability is accepted for such treatment.
P.	**Travelling fees:** **(a)** Where, in cases of emergency, a medical doctor was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if the medical doctor had to travel more than 16 kilometres in total. **(b)** If more than one patient is attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients. **(c)** A medical doctor is not entitled to charge for any travelling expenses or travelling time to his rooms. **(d)** Where a medical doctor's residence is more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such a hospital, except in cases of emergency (services not voluntarily scheduled). **(e)** Where a medical doctor conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled).
	INTENSIVE CARE
	RULES GOVERNING THIS SPECIFIC SECTION OF THE TARIFF CODE
Q.	**Intensive Care/High Care:** Units in respect of item codes 1204 to 1210 (Categories 1 to 3) EXCLUDE the following: **(a)** Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit fee for the initial assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive care/high care unit. **(b)** Cost of any drugs and/or materials. **(c)** Any other cost that may be incurred before, during or after the consultation/visit and/or the therapy. **(d)** Blood gases and chemistry tests, including arterial puncture to obtain specimens. **(e)** Procedural item codes 1202 and 1212 to 1221. **But INCLUDE the following** **(f)** Performing and interpreting of a resting ECG. **(g)** Interpretation of blood gases, chemistry tests and x-rays. **(h)** Intravenous treatment (item codes 0206 and 0207).
R.	**Multiple organ failure:** Units for item codes 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include item 1211: Cardio-respiratory resuscitation.
S.	**Ventilation:** Units for item codes 1212, 1213 and 1214 (ventilation) include the following: **(a)** Measurement of minute volume, vital capacity, time and vital capacity studies. **(b)**Testing and connecting the machine. **(c)** Setting up and coupling patient to machine: setting machine, synchronising patient with machine. **(d)** Instruction to nursing staff. **(e)** All subsequent visits for the first 24 hours.
T.	**Ventilation:** Item codes 1212 to 1214 does not form part of normal post-operative care, but may not be added to item code 1204: Catogory 1: Cases requiring intensive monitoring.

	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY
	NOTE: (a) Prior approval must be obtained from the Compensation Fund before any treatment resorting under this section is carried out. (b) Where approval has been obtained, treatment must be limited to 12 sessions only, after which the patient must be referred back to the referring doctor for an evaluation and report to the Compensation Fund.
V.	**Electro-convulsive treatment:** (a) Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure. **(b)** When adding psychotherapy items to a first or follow-up consultation item, the clinician must ensure that the time stipulated in the psychotherapy items are adhered to (i.e. item 2957 - minimum 10 minutes, item 2974 - minimum 30 minutes, and item 2975 - minimum 50 minutes).
	RULES GOVERNING THE SECTION RADIOLOGY: MAGNETIC RESONANCE IMAGING
	NOTE: In the event of Complex medical cases (Poly-trauma, Traumatic Brain injury, Spinal injuries, etc.), the first Radiological investigations (e.g MRI, CT scan, Ultrasound and Angiography), Authorisation will not be required provided there was a valid indication. All second and Subsequent specialised Radiological investigations for Complex medical cases,will need a pre-authorisation. Non-Complex medical cases/elective cases will need pre-authorisation for all specialised radiological investigations.
W.	**Magnetic Resonance Imaging:** **(a)** Complete Annexure A and Annexure B, submit report of the investigation and an invoice. **(b)** Item code 6270- Proper motivation must be submitted upon which the Compensation Fund will consider approval for payment.
	RULES GOVERNING THE SECTION RADIOLOGY
Y.	**Contrast material:** Except where otherwise indicated, radiologists are entitled to charge for contract material used.
	RULE GOVERNING THE SUBSECTION ON DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIO-ISOTOPES
AA.	**Radio-Isotopes:** Procedures exclude the cost of isotope used.
	RULE GOVERNING THE SECTION RADIATION ONCOLOGY
BB.	**Oncology:** The fees in the radiation oncology section do NOT include the cost of radium or isotopes.
	RULE GOVERNING ULTRASOUND EXAMINATIONS
EE.	**Ultrasound examinations:** **(a)** In case of a referral, the referring doctor must submit a letter of motivation to the Radiologist or other medical doctor performing the scan. A copy of the letter of motivation must be attached to the first account rendered to the Compensation Fund by the Radiologist. **(b)** In case of a referral to a Radiologist, no motivation is required from the Radiologist.
	RULES GOVERNING THE SECTION URINARY SYSTEM

FF.	**Cystoscopy:** **(a)** When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transuretral (T U R) prostatectomy. **(b)** When a cystoscopy 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 code 1949: Cystoscopy, when performed together with any of item codes 1951 to 1973.
	RULE GOVERNING THE SECTION RADIOLOGY
GG.	**Capturing and recording of examinations:** Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.
RR.	**The radiology section in this 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 medical doctors. 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).

DOCTORS
MODIFIERS
2026

MODIFIER DESCRIPTIONS AND STANDARDS							
AM	**Addition Modifier** This modifier will add a value by using a percentage value or a unit value to a procedure code. The modifier should be quoted on a separate line with its own value instead of adding its value to the code. **Note**: This modifiers should follow a procedure code on a separate line.						
CM	**Compound Modifier** The modifier should be quoted on a separate line with its own value at the end of the invoice instead of adding its value to the code. It should be indicated on each procedure code where the modifier is applicable. **Note:** This modifiers should follow a procedure code on a separate line.						
RM	**Reduction Modifier** This modifier reduces the value of a procedure code/s by using a percentage or unit value. It should be quoted on the procedure codes where the modifier is applicable. **Note**: This modifier should be quoted on the same line with procedure code where applicable.						
IM	**Information Modifier** This modifier provides additional information to a procedure code and carries no financial value. **Note:** This modifier should be quoted on the same line with procedure code where applicable.						
			Specialist		**General Practitioner**		**Anaesthetic**
MODIFIER	**MODIFIER DESCRIPTION**	**U**	**R**	**U**	**R**	**U**	**R**
	MODIFIERS GOVERNING THE CODING STRUCTURE						
	MODIFIER GOVERNING THE RADIOLOGY AND RADIATION ONCOLOGY SECTIONS OF THE CODING STRUCTURE						
0001	**Emergency or unscheduled radiological services:** For emergency or unscheduled radiological services (Refer to rule B) the additional fee shall be 50% of the fee for the particular service (section 19.12: Portable unit examinations excluded). Emergency and unscheduled MR scans, a maximum levy of 100.00 Radiological units is applicable.	*100*	**3,654.00**				
	MODIFIER GOVERNING A RADIOLOGIST REQUESTED TO PROVIDE A REPORT ON X-RAYS						
0002	**Written report on X-rays:** The lowest level item code for a new patient (consulting rooms) consultation is applicable only when a radiologist is requested to provide a written report on X-rays taken elsewhere and submitted to him. The above mentioned item code and the lowest level item code for an initial hospital consultation are not to be utilised for the routine reporting on X-rays taken elsewhere.						

0005	**Multiple therapeutic procedures/operations under the same anaesthetic:** **(a)** Unless otherwise identified in the tariff structure , when multiple procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identifiable and defined, the following values shall prevail: **100%** (full value) for the first or major procedure/operation, **75%** for the second procedure/operation, **50%** for the third procedure/operation , **25%** for the fourth and subsequent procedures/operations. This modifier does not apply to purely diagnostic procedures . **(b)** In case of multiple fractures and/or dislocations the above values also prevail. **(c)** When purely diagnostic endoscopic procedures or diagnostic endoscopic procedures unrelated to any therapeutic procedure are performed under the same general anaesthetic, modifier 0005 is not applicable to the fees for such diagnostic endoscopic procedures as the fees for endoscopic procedures do not provide for after-care. Specify unrelated endoscopic procedures and provide a diagnosis to indicate diagnostic endoscopic procedure(s) unrelated to other therapeutic procedures performed under the same anaesthetic. **(d) Please note**: When more than one small procedure are performed and the tariff code provides for item codes for "subsequent" or "maximum for multiple additional procedures" (see Section 2. Integumentary System) modifier 0005 is not applicable as the fee is already a reduced fee. **(e)** Plus ("+") means that this item is used in addition to another definitive procedure and is therefore not subject to reduction according to modifier 0005 (see also modifier 0082) Application of modifier 0005 in cases where bonegraft procedures and instrumentaion are performed in combination with arthrodesis (fusion). **(f)** Modifier 0005 (multiple procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together *1*. Bone graft procedures and instrumentation are to be charged in addition to arthrodesis. *2*. When vertebral procedures are performed by arthrodesis, bone grafts and instrumentation may be charged for additionally. **(g)** Modifier 0005 (Multiple procedures/operations under the same anaesthetic) would be applicable when an arthrodesis is performed in addition to another procedure, e.g. osteotomy or laminectomy.
0006	**IM:** 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. A 25% reduction in the fee for a subsequent operation for the same condition within one month shall be applicable if the operations are performed by the same surgeon (an operation subsequent to a diagnostic procedure is excluded). After a period of one month the full fee is applicable.

0007	**AM:** **(a) Use of own monitoring equipment in the rooms:** Remuneration for the use of any type of own monitoring equipment in the rooms for procedures performed under intravenous sedation – Add 15.00 clinical procedure units irrespective of the number of items of equipment provided [Modifier 0074 and modifier 0075 may be used in conjunction with modifier 0007(a)]. **(b)** Use of own equipment in hospital or unattached theatre unit: Remuneration for the use of any type of own equipment for procedures performed in a hospital theatre or unattached theatre unit when appropriate equipment is not provided by the hospital - Add 15.00 clinical procedure units irrespective of the number of items of equipment provided [Modifier 0074 and modifier 0075 may not be used in conjucttion with modifier 0007(b)]. **NOTE**: Equipment is included in hospital fee and therefore modifier is not payable. Medical Doctors to make payment arrangement with the hospital for using own equipment during theatre procedures.	15	**524.10**	15	**524.10**		
0008	**CM:** **Specialist surgeon assistant:** The units of the procedure(s) for a specialist surgeon acting as assistant surgeon in procedures of specialised nature, is **40%** of the units for the procedure(s) performed by specialist surgeon.						
0009	**CM:** **Assistant:** The fee for an assistant is **20%** of the fee for the specialist surgeon, with a **minimum of 36,00** clinical procedure units. The minimum fee payable may not be **less than 36,00** clinical procedures units	36	**1,257.84**	36	**1,257.84**		
0010	**AM:** **Local anaesthetic** **(a)** A fee for a local anaesthetic administered by the practitioner may only be charged for (1) an operation or a procedure with a value of greater than 30.00 clinical procedure units (i.e. 31.00 or more clinical procedure units allocated to a single item) or (2) where more than one operation or procedure is done at the same time with a combined value of greater than 50.00 clinical procedure units. **(b)** The fee for a local anaesthetic administered shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per modifier 0035: Anaesthetic administered by an anaesthesiologist/ anaesthetist, shall be applicable in such a case. **(c)** The fee for a local anaesthetic administered is not applicable to radiological procedures such as angiography and myelography. **(d)** No fee may be levied for the topical application of local anaesthetic. **(e)** Please note: Modifier 0010: Local anaesthetic administered by the operator may not be added onto the surgeon's account for procedures that were performed under general anaesthetic.						

0011	**CM:** **Theatre procedures for emergency surgery:** Any bona fide, justifiable emergency procedure only applicable during after hour periods-see general Rule B undertaken in an operating theatre will justify the charging of an additional 12.00 clinical procedure units per half-hour or part thereof of the operating time for all members of the surgical team. Modifier 0011 does not apply to patients on scheduled lists. (**Note**: A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment).	12	**419.28**	12	**419.28**	12	**419.28**
0013	**RM:** **Endoscopic examinations done at operations**: Where a related endoscopic examination is performed at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.						
0014	**IM:** **Operations previously performed by other surgeons** **(a)** Use modifier 0014(a) for information only as an indicator that the operation was previously performed by another surgeon. **(b)** Where an operation is performed which has previously been performed by another surgeon, e.g. a revision or repeat operation, the fee maybe be calculated according to the tariff for the full operation plus an additional fee to be negotiated under general rule J: In exceptional cases where the fee is disproportionately low in relation to actual service rendered, except where already specified in the tariff.						
	INJECTIONS, INFUSIONS AND INHALATION SEDATION: **MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF STRUCTURE**						
0015	**IM:** **Intravenous infusions**: Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after an operation, no extra fees shall be charged as the after-treatment is included in the global fee for the procedure. Should the practitioner performing the operation prefer to request another practitioner to perform post-operative intravenous infusions, the practitioner (and not the Compensation Fund) shall be responsible for remunerating such practitioner for the infusions.						
0017	**RM:** **Injections administered by practitioners**: When desensitisation, intravenous, intramuscular or subcutaneous injections are administered by the practitioner to patients who attend the consulting rooms, a first injection forms part of the consultation/visit and only all subsequent injections for same condition shoul be charged at 7.50 consultative service units using modifier 0017 to reflect the amount. (not claimed together with a consultation item).						
	MODIFIER GOVERNING SURGERY ON PERSONS WITH A BODY MASS INDEX (BMI) OF MORE THAN 35						
0018	Surgical modifier for persons with a BMI of higher than 35 (calculated according to kg/m2 = weight in kilograms divided by height in metres squared): Fee for the procedure +50% of the fee for surgeons; 50% increase in anaesthetic time units for anaesthesiologists.						

	MODIFIERS GOVERNING THE ADMINISTRATION OF ANAESTHESIA FOR ALL THE PROCEDURES AND OPERATIONS INCLUDED IN THIS GUIDE TO TARIFF STRUCTURE						
0021	**IM:** . **Determination of anaesthetic fees:** Anaesthetic fees are determined by adding the basic anaesthetic units (allocated to each procedure that can be performed under anaesthesia indicated in the anaesthetic column[refer to modifier 0027 for more than one procedure under the same anaesthetic])) and the time units (calculated according to the formula in modifier 0023) and the appropriate modifers (see modifiers 0037-0044). In case of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures or dislocations, add units as laid down by modifiers 5441 to 5448.						
0023	**AM:** The basic anaesthetic units are laid down in the guide to tariffs and are reflected in the anaesthetic column. These basic anaesthetic units reflect the anaesthetic risk, the technical skill required of the anaesthesiologist/anaesthetist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T") will be added to the listed basic anaesthetic units in all cases on the following basis.						
	Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthesia, at 2.00 anaesthetic units is per 15 minute period or part thereof for the first hour. Should the duration of the anaesthesia be longer than one (1) hour the number of units shall be increased to 3.00 anaesthetic units per 15 minute period or part thereof after the first hour.			2	**326.54**	2	**326.54**
0024	**IM:** **Pre-operative assessment not followed by a procedure:** If a pre-operative assessment of a patient by the anaesthesiologist/anaesthetist is not followed by an operation, the assessment will be regarded as a consultation at a hospital or nursing home and the appropriate hospital consultation fee should be charged.			3	**489.81**	3	**489.81**
0025	**IM:** **Calculation of anaesthesia time:** Anaesthesia time is calculated from the time that the anaesthesiologist/ anaesthetist begins to prepare the patient for the induction of anaesthesia in the operating theatre or in a similar equivalent area and ends when the anaesthesiologist/anaesthetist is no longer required to give his/her personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative nursing supervision. Where prolonged personal professional attention is necessary for the well-being and safety of a patient, the additional time spent can be charged for at the same rate as indicated above for anaesthesia time. The anaesthesiologist/anaesthetist must record the exact anaesthesia time and the additional time spent supervising the patient on the invoice submitted.						
0027	**IM:** **More than one procedure under the same anaesthesia:** Where more than one operation is performed under the same anaesthesia, the basic anaesthetic units will be that of the operation/procedure with the highest number of anaesthetic units.						
0029	**CM:** **Assistant anaesthesiologists:** When rendered necessary by the scope of the anaesthesia, an assistant anaesthesiologist/anaesthetist may be employed. The remuneration of the assistant anaesthesiologist/anaesthetist may be employed. The remuneration of the assistant anaesthesiologist/anaesthetist shall be calculated on the same basis as in the case where a general practitioner administered the anaesthesia.						

0031	**IM:** **Intravenous infusion and transfusions**:Administering intravenous infusions and transfusions are considered to a normal part of admnistering anaesthesia. No Additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.						
0032	**AM:** **Patients in the prone position**: Anaesthesia administered to patients in the prone position shall carry a minimum of 5.00 basic anaesthetic units. When the basic anaesthetic units for the procedure are 3.00, two additional anaesthetic units should be added. If the basic anaesthetic units for the procedure are 5.00 or more, no additional units should be added.			2	**326.54**	2	**326.54**
0033	**IM:** **Participating in the general care of patients**: When an anaesthesiologist/anaesthetist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthesia, such services may be remunerated at full anaesthetic rate, subject to the provisions of modifier 0035: Anaesthetic administered by a anaesthesiologist/ anaesthetist and modifier 0036: Anaesthetic administered by a general practitioner.			2	**326.54**	2	**326.54**
0034	**AM:** **Head and neck procedures:** All anaesthesia administered for diagnostic, surgical or X-ray procedures on the head and neck shall carry a minimum of 4.00 basic anaesthetic units. When the basic anaesthetic units for the procedure are 3.00, one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure are 4.00 or more, no extra units should be added.			1	**163.27**	1	**163.27**
0035	**AM:** **Anaesthesia administered by an anaesthesiologist/ anaesthetist:** No anaesthesia administered by an anaesthesiologist/anaesthetist shall carry a total value of less than 7.00 anaesthetic units comprising basic units, time units and the appropriate modifiers.			7	**1,142.89**	7	**1,142.89**

0036	**AM:** **Anaesthesia administered by general practitioners:** The anaesthetic units (basic units plus time units plus the appropriate modifiers) used to calculate the fee for anaesthesia administered by a general practitioner lasting one hour or less shall be the same as that for an anaesthesiologist. For anaesthesia lasting more than one hour, the units used to calculate the fee for anaesthesia administered by a general practitioner will be 4/5 (80%) of that applicable to a specialist anaesthesiologist, provided that no anaesthesia shall have a total value of less than 7.00 anaesthetic units. Please note that the 4/5 (80%) principle will be applied to all anaesthesia administered by general practitioners with the provision that no anaesthesia totalling more than 11.00 units would be reduced to less than 11.00 units in total. The monetary value of the unit is the same for both anaesthesiologists/anaesthetists. **NOTE**: Modifying units may be added to the basic anaesthetic unit value according to the following modifiers (0037-0044, 5441-5448).			7	**1,142.89**	7	**1,142.89**
0037	**AM:** **Body hypothermia:** Utilisation of total body hypothermia: Add 3.00 anaesthetic units.			3	**489.81**	3	**489.81**
0038	**AM:** **Peri-operative blood salvage**: Add 4.00 anaesthetic units for intra-operative blood salvage and 4.00 anaesthetic units for post-operative blood salvage.			4	**653.08**	4	**653.08**
0039	**AM:** **Deliberate control of blood pressure**: All cases up to one hour: Add 3.00 anaesthetic units, thereafter add 1 (one) additional anaesthetic unit per quarter hour (15 Min) or part thereof (PLEASE INDICATE THE TIME IN MINUTES).			3	**489.81**	3	**489.81**
0041	**AM:** **Hyperbaric pressurisation:** Utilisation of hyperbaric pressurisation: Add 3.00 anaesthetic units.			3	**489.81**	3	**489.81**
0042	**AM:** **Extracorporeal circulation**: Utilisation of extracorporeal circulation: Add 3.00 anaesthetic units.			3	**489.81**	3	**489.81**

	MUSCULO-SKELETAL SYSTEM : **MODIFIERS GOVERNING ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS**						
	Modifiers 5441 to 5448 **Note**: Modification of the anaesthetic fee in cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures and dislocations is governed by adding units indicated by modifiers 5441 to 5448. (The letter "M" is annotated next to the number of units of the appropriate items, for facilitating identification of the relevant items).						
5441	**AM:** Add one (1.00) anaesthetic unit, except where the procedure refers to the bones named in modifiers 5442 to 5448.			1	**163.27**	1	**163.27**
5442	**AM:** Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and tempero-mandibular joint: Add two (2.00) anaesthetic units. **Note**: Not appropriate where arthroscopy only is performed.			2	**326.54**	2	**326.54**
5443	**AM:** Maxillary and orbital bones: Add three (3.00) anaesthetic units.			3	**489.81**	3	**489.81**
5444	**AM:** Shaft of femur: Add four (4.00) anaesthetic units			4	**653.08**	4	**653.08**
5445	**AM:** Spine (except coccyx), pelvis, hip, neck of femur: Add five (5.00) anaesthetic units.			5	**816.35**	5	**816.35**
5448	**AM:** Sternum and/or ribs and musculo-skeletal procedures which involve an intra-thoracic approach: Add eight (8.00) anaesthetic units.			8	**1306.16**	8	**1306.16**
	MODIFIER GOVERNING FEES FOR AN ANAESTHESIOLOGIST UTILISING AN INTRA-AORTIC BALLOON PUMP (CARDIOVASCULAR SYSTEM)						
0100	**AM:** **Intra-aortic balloon pump:** Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75.00 clinical procedure units is applicable.					75	**2,620.50**
	MUSCULO-SKELETAL SYSTEM **MODIFIERS GOVERNING THIS SPECIFIC SECTION OF THE TARIFF**						
0046	**RM:** Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed **within one month** by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of that fracture or dislocation shall be reduced by 50%. **Note:** This reduction does not include the assistant's fee where applicable. After one month, a full fee for the initial treatment is applicable.						
0047	**IM:** A fracture NOT requiring reduction shall be charged on a fee per service basis PROVIDED that the cumulative amount does NOT exceed the fee for a reduction.						

0048	**AM**: Where in the treatment of a fracture or dislocation an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27.00 clinical procedure units (not including after-care).	27	**943.38**	27	**943.38**		
0049	**AM**: Except where otherwise specified, in cases of compound [open] fractures, 77.00 clinical procedure units (specialists and general practitioners) are to be added to the units for the fractures including debridement [a fee for the debridement may not be charged for separately].	77	**2,690.38**	77	**2,690.38**		
0051	**AM**: Fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists and general practitioners add 77.00 clinical procedure units.	77	**2,690.38**	77	**2,690.38**		
0052	**AM:** Except where otherwise specified, fracture (traumatic or surgical, ie. osteotomy) requiring open reduction and/or internal fixation, external skeletal fixation and/or bone grafting (excluding fixation with Kirschner wires (refer to modifier 0053), as well as long bone or pelvis fracture/osteotomy (refer to modifier 0051) for specialist and general practitioners for HAND or FOOT fracture/osteotomy: Add to the appropriate procedure code.	81.1	**2,833.63**	81	**2,833.63**		
0053	**AM:** Fractures requiring percutaneous internal fixation [insertion and removal of fixatives (wires) in respect of fingers and toes]: Specialists and general practitioners add 32.00 clinical procedure units.	32	**1,118.08**	32	**1,118.08**		
0055	**AM:** Dislocation requiring open reduction: Units for the specific joint plus 77.00 clinical procedure units for specialists and general practitioners.	77	**2,690.38**	77	**2,690.38**		
0057	**RM:** Multiple procedures on feet: In multiple procedures of feet, the units for the first foot are calculated according to modifier 0005: Multiple procedures/operations under the same anaesthetic. Calculate units for the second foot in the same way. The total units for the second foot are reduce the total to 50% and add to the total for the first foot.						
0058	**AM:** Revision operation for total joint replacement and immediate re-substitution (infected or non-infected): per fee for total joint replacement + 100% of the fee.						
	MODIFIER GOVERNING COMBINED PROCEDURES ON THE SPINE						
0061	**IM:** **Combined procedures on the spine:** In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full units for the relevant part of the operation performed by him/her. Each surgeon may be remunerated as an assistant for the procedures performed by the other surgeon, at general practitioner units (refer to modifier 0009).						

	MODIFIERS GOVERNING THE SUBSECTION REPLANTATION SURGERY						
0063	**RM:** Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.						
0064	**RM:** Where a replantation procedure (or toe to thumb transfer) is unsuccessful no further surgical fee is payable for amputation of the non-viable parts.						
	MODIFIER GOVERNING THE SECTION LARYNX						
0067	**AM:** Microsurgery of the larynx: Add 25% to the fee for the procedure performed. (For other operations requiring the use of an operation microscope, the fee include the use of the microscope, except where otherwise specified in the Tariff Guide).						
	MODIFIER GOVERNING NASAL SURGERY						
0069	**AM:** When endoscopic instruments are used during intranasal surgery: Add 10% of the fee for the procedure performed. Only applicable to items **1025, 1027, 1030, 1033, 1035, 1036, 1039, 1047, 1054** and **1083.**						
	MODIFIER GOVERNING OPEN PROCEDURE(S) WHEN PERFORMED THROUGH THORACOSCOPE						
0070	**AM:** Add 45.00 clinical procedure units to procedure(s) performed through a thoracoscope.	45	**1,572.30**	45	**1,572.30**		
	MODIFIERS GOVERNING FEES FOR ENDOSCOPIC PROCEDURES						
0074	**AM:** Endoscopic procedures performed with own equipment: The basic procedure fee plus 33,33% (1/3) of that fee (plus ("+") codes excluded) will apply where endoscopic procedures are performed with own equipment.						
0075	**AM:** Endoscopic procedures performed in own procedure room: **(a)**The fee plus 21,00 clinical procedure units will apply where endoscopic procedures are performed in own procedure rooms. **(b)**This modifier is chargeable by medical doctors who own or rent the facility. **(c)**Please note:Modifier 0075 is not applicable to any of the items for diagnostic procedures in the otorhinolaryngology sections of the tariff guide.	21	**733.74**	21	**733.74**		

	MODIFIER GOVERNING THE SECTION ON PHYSICAL TREATMENT
0077	**IM:** **(a)** When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatment modalities for which separate fees may be charged (Only applicable if services are provided by a specialist in physical medicine). **(b)** The number of treatment sessions for a patient for which the Commissioner shall accept responsibility is limited to 20. If further treatment sessions are necessary, liability for payment must be arranged in advance with the Compensation Fund. **Note:** Physiotherapy administered by a non-specialist medical practitioner who is already in charge of the general treatment of the employee concerned, or by any partner, assistant or employee of such practitioner, or any other practitioner or radiologist should be embarked upon only with the express approval of the Commissioner. Such approval should be requested in advance.
	MODIFIER GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY
0079	**IM:** When a first consultation/visit proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure are calculated according to the appropriate individual psychotherapy code (Items **2957, 2974 or 2975**): Individual psychotherapy (specify type).
	MODIFIERS GOVERNING THE SECTION DIAGNOSTIC RADIOLOGY
	NOTE: In respect of fees payable when X-rays are taken by general practitioners If the services of a radiologist were normally available, it is expected that these should be utilised. Should circumstances be unfavourable for obtaining such services at the time of the first consultation, the general practitioner may take the initial X-ray photograph himself provided he submitted a report to the effect that it was in the best interest of the employee for him to have done so. Subsequent X-ray photographs of the same injury, however, must be taken by a radiologist who has to submit the relevant reports in the normal manner. **1**. When a general practitioner takes X-ray photographs with his own equipment, if the services of a specialist radiologist were not available, he may claim at the prescribed fee. **2.(i)** If a general practitioner ordered an X-ray examination at a provincial hospital where the services of a specialist radiologist are available, it is expected that the radiologist shall read the photographs for which he is entitled to one third of the prescribed fee. **(ii)** If the radiographer of the hospital was not available and the general practitioner had to take the X-ray photographs himself, he may claim 50% of the prescribed fee for the service. In that case, however, he should get written confirmation of his X-ray findings from the radiologist as soon as possible. The radiologist may then claim one third of the prescribed fee for such service. **3**. If a general practitioner ordered an X-ray examination at a provincial hospital where no specialist radiological services are available, the general practitioner will not be paid for reading the X-ray photographs as such a service is considered to be an integral part of routine diagnosis, but if he was requested by the Compensation Fund to submit a written report on the X-ray findings, he may claim two thirds of the prescribed fee in respect thereof. **4**. If a general practitioner had to take and read X-ray photographs at a provincial hospital where the services of a radiographer and a specialist radiologist are not available he/she may claim 50% of the prescribed fee for such service.

0080	Multiple examinations: Full Fee
0081	**IM:** Repeat examinations: No reduction
0082	**IM:** Plus ("+") Means that this item is complementary to a preceding item and is therefore not subject to reduction The amount for plus ("+") procedures must not be added to the amount for the definitive item and must appear on a separate line on the invoice.
0083	**RM:** A reduction of 33,33% (1/3) in the fee apply to radiological examinations as indicated in section 19: Radiology where hospital equipment is used. **NOTE:** Modifier 0083 is not applicable to Section 19.8 of the tariff
0084	**IM:** **Charging for films and thermal paper by non-radiologists:** In the case of radiological services rendered by non-radiologists where films, thermal paper or magnetic media are used, these media is charged for according to the film price of 2007, as compiled by the Radiological Society of South Africa (this list is available on request at radsoc@iafrica.com).
0085	**IM:** **Left side:** Add to items 6500-6519 as appropriate when the left side is examined. **NOTE:** The absence of the modifier indicates that the right side is examined.
	MODIFIER GOVERNING VASCULAR STUDIES
	Rules applicable to vascular studies **(a)** The machine fee (items 3536 to 3550) includes the cost of the following: All runs (runs may not be billed for separately) All film costs (modifier 0084 is not applicable) All fluoroscopies (item 3601 does not apply) All minor consumables (defined as any item other than catheters, guidewires, introducer sets, specialised catheters, balloon catheters, stents, anti-embolic agents, drugs and contrast media). **(b)** The machine fee (item codes 3536 to 3550) may only be charged for once per case per day by the owner of the equipment and is only applicable to radiology practices. **(c)** If a procedure is performed by a non-radiologist together with a radiologist as a team, in a facility owned by the radiologist, each member of the team should charge at their respective full rates as per modifiers and the applicable codes.

0086	**IM:** Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to an increase in terms of modifier 0080: Multiple examinations.
6300	**RM:** If a procedure lasts less than 30 minutes, only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on Invoice).
6302	**RM:** When the procedure is performed by a non-radiologist, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)
6303	**RM:** When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non radiologist performing the procedure.
6305	**RM:** When multiple catheterisation procedures are used (items 3557, 3559, 3560, 3562) and an angiogram investigation is performed at each level, the unit value of each such multiple procedure will be reduced by 20.00 radiological units for each procedure after the initial catheterisation. The first catheterisation is coded at 100% of the unit value.
	MODIFIER GOVERNING INTERVENTIONAL RADIOLOGICAL PROCEDURES
	MODIFIERS GOVERNING DIAGNOSTIC SERVICES
0091	**IM:** Diagnostic services rendered to hospital inpatients: Quote Modifier 0091 on all Invoices for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients officially admitted to hospital or day clinic (refer to Rule XX)
0092	**IM:** Diagnostic services rendered to outpatients: Quote Modifier 0092 on all accounts for diagnostic services (e.g. MRI, X-rays, pathology tests) performed on patients NOT officially admitted to hospital or day clinic (could be within the confines of a hospital) (refer to Rule YY)
	MODIFIERS GOVERNING THE RADIATION ONCOLOGY SECTION
0095	**IM:** Radiation materials: Exclusively for use where radiation materials supplied by the practice are used by clinical and radiation oncologists, modifier 0095 should be used to identify these materials. A material code list with descriptions and guideline costs for these materials, maintained and updated on a regular basis, will be supplied by the Society of Clinical and Radiation Oncology. This modifier is only chargeable by the practice responsible for the cost of this material and where the hospital did not charge therefore. **Please note that item 0201 should not be used for these materials.**
	MODIFIERS GOVERNING THE SECTION PATHOLOGY
0097	**Pathology tests performed by non-pathologists:** Where item codes resorting under Clinical Pathology (section 21) and Anatomical Pathology (section 22) fall within the province of other specialists or general practitioners, the fee should be charged at two-thirds of the pathologists tariff.

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

DOCTORS CONSULTATIONS 2026

CONSULTATIVE SERVICES AS FROM 01 APRIL 2026
(GENERAL PRACTITIONERS and ALL SPECIALISTS)

I. CONSULTATIVE SERVICES

		Specialist		General Practitioner		Anaesthetist	
Code	**Code Description**	**U**	**R**	**U**	**R**	**U**	**R**
	CONSULTATION CODES						
	Notes: Items 0190-0192 and items 0173-0175 (as appropriate) should be used by all medical doctors, except for psychiatrists who should use items 0161-0163 and items 0166-0169 (as appropriate) for basic consultative services. The below applies: (a) Only one of items 0190-0192 and items 0173-0175 (as appropriate), may be used for a single service and not combinations thereof. (b) The ICD-10 codes should appear on the invoice. (c) These services must be face-to-face with the patient and excludes the time spent doing special investigations which receive addition. (d) Only one of the add-on items 0145, 0146 or 0147 (as appropriate) and not combinations thereof. (e) A subsequent visit refers to a voluntarily scheduled visit performed for the same condition within four (4) months after the first visit (although the symptoms or complaints may differ from those presented during the first visit). (f) Use item 0186 as a single service and not combinations with other consultation items (0190 ,0191 and 0192). (g) Items 0190 - 0192 include the remuneration for a visit and /or to complete the first and progress reports. (h) Item 0186 include the remuneration for a visit and /or to complete a final medical report. **NB!!** **Item code 0184 has been discontinued.**						
	OUT OF HOSPITAL CONSULTATION						
0190	New and established patient: Consultation/visit of established patient of an **average duration and/or complexity.** Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure.	*17*	**605.03**	*15*	**533.85**	*16.5*	**587.24**
0191	New and established patient: Consultation/visit of new or established patient of a **moderately above average** duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0174 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to anaesthetic structure.	*32*	**1,138.88**	*30*	**1,067.70**	*31.5*	**1,121.09**
0192	New and established patient: Consultation/visit of new or established patient of **long duration** and/or high complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (for hospital consultation/visit - refer to item 0173-0175 or item 0109) - not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure.	*36*	**1,281.24**	*33*	**1,174.47**	*36*	**1,281.24**

	HOSPITAL CONSULTATION / VISITS						
0173	First hospital consultation/visit of an **average duration and/or complexity**. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	*16.5*	**576.51**	*15*	**524.10**	*16.5*	**576.51**
0174	First hospital consultation/visit: Consultation/visit of a **moderately above average duration and/or complexity**. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient.(not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	*31.5*	**1,100.61**	*30*	**1,048.20**	*31.5*	**1,100.61**
0175	First hospital consultation/visit of **long duration and/or high complexity**. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient (not appropriate for pre-anaesthetic assessment followed by the appropriate anaesthetics - refer to new anaesthetic structure).	*36*	**1,257.84**	*33*	**1,153.02**	*36*	**1,257.84**
	FOLLOW-UP VISIT						
Note: For follow up visits use items (0190 ,0191 and 0192)							
	FINAL VISIT						
0186	Follow-up visit for the evaluation and management of a patient with a Final Medical Report **(Rule G not applicable)**	*31.5*	**1,121.09**	*30*	**1,067.70**	*31.5*	**1,121.09**
	ADD-ON CONSULTATIONS SERVICES						
0145	For consultation / visit away from the doctor's home or rooms: ADD to item 0190. Confirm where visit took place. Please note that item 0145 is not applicable for pre-anaesthetic assessments and may not be added to items 0151/ 0152	*6*	**209.64**	*6*	**209.64**		
0146	Emergency or unscheduled consultation/visit at the doctors home or rooms: ADD to items 0164-0169 or 0190-0192 or 0173-0175 as appropriate. **(General Rule B refers)**	*8*	**279.52**	*8*	**279.52**		
0147	For after hours emergency or unscheduled consultation/ visit away from the doctor's home or rooms: ADD to items 0164-0169 or 0190-0192 as appropriate **(General Rule B refers)**	*14*	**489.16**	*14*	**489.16**		
	HOSPITAL CONSULTATION/VISIT						
0109	Hospital follow-up visit to patient in ward or nursing facility **- (Refer to general rule G**(a) for post-operative care) (may only be charged once per day) (not to be used with items 0146 or ICU items 1204-1214)	*15*	**524.10**	*15*	**524.10**		
	PRE- ANAESTHETIC ASSESSMENT						
	a. Pre-anaesthetic consultations for all major vascular, cardio-thoracic and orthopaedic cases will attract a unit value of at least 32.00 units **b.** Only item 0146 may be charged by PR:10 **c.** Items 0151 may not be billed with 0152 **d.** The ICD-10 codes should appear on the invoice.						
0151	Pre-anaesthetic assessment of patient (all hours). **Problem focused history**, clinical examination and decision making	*32*	**1,138.88**	*32*	**1,138.88**	*32*	**1,138.88**
0152	**Pre-anaesthetic assessment:** Pre-anaesthetic assessment of patient (all hours). **Detailed history** and clinical examination and straightforward decision making and counselling. Typically occupies the doctor face-to-face with the patient for between 20 and 35min	*31.5*	**1,121.09**	30	**1,067.70**	30	**1,067.70**

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

DOCTORS
CLINICAL PROCEDURES
2026

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
III.	**PROCEDURES**								
	The amounts in this section are calculated according to the **Clinical Procedure** unit values								
	UNLISTED PROCEDURE/SERVICE								
6999	Unlisted procedure/service code: A procedure/service may be provided that is not listed in the Compensation Fund tariffs. Please quote the correct SAMA code with tariff code 6999 (Refer to General Rule C) **Note**:To be authorised by the Fund.								
1.	**GENERAL**								
1.1									
	Note: How to charge for intravenous infusions Practitioners are entitled to charge according to the appropriate tariff code whenever they personally insert the cannula (but may only charge for this service once every 24 hours) for managing the infusion as such e.g. checking it when visiting the patient or prescribing the substance, no fee may be charged since this service is regarded as part of the services the doctor renders during consultation.								
0206	Intravenous infusions (push-in) Insertion of cannula - chargeable once per 24 hours. Not appropriate for managing infusion in daily hospital, High Care and Intensive Care patients (code 0109, 1204 -1206 and 1208- 1210). Tariff code is considered part of anaesthetic administration		*6*	**209.64**	*6*	**209.64**			
0207	Intravenous infusions (cut-down): Cut-down and insertion of cannula - chargeable once per 24 hours . Not appropriate for managing infusion in daily hospital, High Care and Intensive Care patients (code 0109, 1204 -1206 and 1208 -1210). Tariff code is considered part of anaesthetic administration		*8*	**279.52**	*8*	**279.52**			
0208	Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)		*6*	**209.64**	*6*	**209.64**			
0210	Collection of blood specimen(s) by medical practitioner for pathology examination, per venesection (not to be used by pathologists)		3.25	**113.56**	3.25	**113.56**			
2.	**INTEGUMENTARY SYSTEM**								
2.1	**Allergy** **Note:**Fees for reading allergy patch tests as per subsequent consultations.								
0217	Allergy: Patch tests: First patch		*4*	**139.76**	*4*	**139.76**			
0219	Allergy: Patch tests: Each additional patch. Add to code 0217, code may not be billed alone	+	*2*	**69.88**	*2*	**69.88**			
0218	Allergy: Skin-prick tests: Skin-prick testing: Insect venom, latex and drugs		*2.8*	**97.83**	*2.8*	**97.83**			

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0220	Allergy: Skin-prick tests: Immediate hypersensitivity testing (Type I reaction): Per antigen: Inhalant and food allergens. Only a maximum of five can be charged.		*1.9*	**66.39**	*1.9*	**66.39**			
0221	Allergy: Skin-prick tests: Delayed hypersensitivity testing (Type IV reaction): Per antigen Only a maximum of five can be charged.		*2.8*	**97.83**	*2.8*	**97.83**			
2.2	**Skin (general)**								
0222	Intralesional injection into areas of pathology, e.g. Keloid: Single Pre-authorisation with motivational letter detailing how the lesion affects functionality is required.		4	**139.76**	4	**139.76**			
0223	Intralesional injection into areas of pathology, e.g. Keloids: Multiple. Tariff code inappropropriate to use with tariff code 0222 Pre-authorisation with motivational letter detailing how the lesion affects functionality is required.		8	**279.52**	8	**279.52**			
0244	Repair of nail bed		30	**1,048.20**	30	**1,048.20**	*3*	**489.81**	
0255	Drainage of subcutaneous abscess, onychia, paronychia, pulp space or avulsion of nail .		*20*	**698.80**	*20*	**698.80**	*3*	**489.81**	+T
0257	Drainage of major hand or foot infection; drainage of major abscess with necrosis of tissue, involving deep fascia or requiring debridement; complete excision of pilonidal cyst or sinus.		*87*	**3,039.78**	*87*	**3,039.78**	*3*	**489.81**	+T
0259	Removal of foreign body: Muscle or tendon sheath, simple Not appropriate for orthopaedic wires and pins removal.		*20*	**698.80**	*20*	**698.80**	*3*	**489.81**	+T
0260	Incision/removal of foreign body: Subcutaneous tissue, complicated		*55.5*	**1,939.17**	*55.5*	**1,939.17**	*3*	**489.81**	+T
0261	Removal of foreign body: Muscle or tendon sheath, deep/complicated. Not appropriate for orthopaedic wires and pins removal		*31*	**1,083.14**	*31*	**1,083.14**	*3*	**489.81**	+T
2.3	**Major Plastic Repair**								
	Note: The tariff does not cover elective or cosmetic operations, since these procedures may not have the effect of reducing the percentage of permanent disablement as laid down in the Second Schedule to the Act. It is incumbent upon the treating doctor to obtain the prior consent of the Commissioner before embarking upon such treatment.								
0288	Harvesting of graft: Fascia lata graft, complex or sheet		127.4	**4,451.36**	120	**4,192.80**	*4*	**653.08**	+T
0289	Large skin graft, composite skin graft, large full thickness free skin graft		*234*	**8,175.96**	*187.2*	**6,540.77**	*4*	**653.08**	+T
0290	Reconstructive procedures (including all stages) and skin graft by myo-cutaneous or fascio-cutaneous flap		*410*	**14,325.40**	*328*	**11,460.32**	*4*	**653.08**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0291	Reconstructive procedures (including all stages) grafting by micro-vascular re-anastomosis		800	27,952.00	640	22,361.60	4	653.08	+T
0292	Distant flaps: First stage		206	7,197.64	164.8	5,758.11	4	653.08	+T
0293	Contour grafts (excluding cost of material)		206	7,197.64	164.8	5,758.11	4	653.08	+T
0294	Vascularised bone graft with or without soft tissue with one or more sets micro-vascular anastomoses		1200	41,928.00	960	33,542.40	6	979.62	+T
0295	Local skin flaps (large, complicated)		206	7,197.64	164.8	5,758.11	4	653.08	+T
0296	Other procedures of major technical nature		206	7,197.64	164.8	5,758.11	4	653.08	+T
0297	Subsequent major procedure for repair of same lesion (modifier 0006 not applicable)		104	3,633.76	104	3,633.76	4	653.08	+T
2.4	**Lacerations, Scars, Cysts and Other Skin lesions**								
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): Including normal after-care		14	489.16	14	489.16	3	489.81	+T
0301	Stitching of soft-tissue injuries: Additional wounds stitched at same session (each)	+	7	244.58	7	244.58	3	489.81	+T
0302	Stitching of soft-tissue injuries: Deep laceration involving limited muscle damage		64	2,236.16	64	2,236.16	4	653.08	+T
0303	Stitching of soft-tissue injuries: Deep laceration involving extensive muscle damage		128	4,472.32	120	4,192.80	4	653.08	+T
0304	Major debridement of wound, sloughectomy or secondary suture		50	1,747.00	50	1,747.00	3	489.81	+T
0305	Needle biopsy - soft tissue		25	873.50	25	873.50	3	489.81	+T
4830	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; <= 20 square cm		13.9	485.67	13.9	485.67	3	489.81	+T
4831	Debridement of subcutaneous tissue: INCLUDES epidermis and dermis; ADD for every additional 20 square cm or part thereof	+	5.3	185.18	5.3	185.18	3	489.81	+T
4832	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; <= 20 square cm		36	1,257.84	36	1,257.84	5	816.35	+T
4833	Debridement of muscle and/or fascia: INCLUDES epidermis, dermis and subcutaneous tissue; ADD for every additional 20 square cm or part thereof	+	11.2	391.33	11.2	391.33	5	816.35	+T
4834	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; <= 20 square cm		62.5	2,183.75	62.5	2,183.75	6	979.62	+T+M
4835	Debridement, bone: INCLUDES epidermis, dermis, subcutaneous tissue, muscle and/or fascia; ADD for every additional 20 square cm or part thereof	+	19.5	681.33	19.5	681.33	6	979.62	+T+M
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude		27	943.38	27	943.38	3	489.81	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0308	Each additional small procedure done at the same time		14	489.16	14	489.16	3	489.81	+T
0310	Radical excision of nailbed		38	1,327.72	38	1,327.72	3	489.81	+T
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude		104	3,633.76	104	3,633.76	4	653.08	+T
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude		55	1,921.70	55	1,921.70	3	489.81	+T
4856	Split thickness autograft of the trunk, arms and/or legs <=100 ² cm		153.6	5,366.78	122.88	4,293.43	5	816.35	+T
4857	Split thickness autograft of the trunk, arms and/or legs; each additional 100² cm or part thereof (modifier 0005 not applicable)	+	31.5	1,100.61	31.5	1,100.61	5	816.35	+T
4858	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100² cm		172	6,009.68	137.6	4,807.74	5	816.35	+T
4859	Split thickness autograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 ² cm or part thereof (modifier 0005 not applicable)	+	51.6	1,802.90	51.6	1,802.90	5	816.35	+T
4862	Full thickness graft of the trunk, freegrafting including direct closure of donor site <=20cm^2		136.5	4,769.31	120	4,192.80	5	816.35	+T
4863	Full thickness graft of the trunk, freegrafting including closure of donor site, each addditional 20cm^2 (modifier 0005 not applicable)	+	25.6	894.46	25.6	894.46	5	816.35	+T
4864	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site: <=20cm^2		140.3	4,902.08	120	4,192.80	5	816.35	+T
4865	Full thickness graft of the scalp, arms and legs free grafting including direct closure of donor site, each addditional 20cm^2 (modifier 0005 not applicable)	+	23	803.62	23	803.62	5	816.35	+T
4866	Full thickness graft of the face, neck, axilla, genitalia, hands and /or feet , free grafting including donor site: <=20cm^2		163.4	5,709.20	130.72	4,567.36	5	816.35	+T
4867	Full thickness graft of the face, neck, axilla, genitalia, hands and /or feet , free grafting including direct closure of donor site, each additional 20cm^2 (modifier 0005 not applicable)	+	36.2	1,264.83	36.2	1,264.83	5	816.35	+T
4868	Full thickness graft of the nose,ears, eyelids, and /or lips free grafting including direct closure of donor site: <=20cm^2		183.5	6,411.49	146.8	5,129.19	5	816.35	+T
4869	Full thickness graft of the nose,ears, eyelids, and /or lips free grafting including direct closure of donor site; each additional 20cm^2 (modifier 0005 not applicable)	+	43.1	1,505.91	43.1	1,505.91	5	816.35	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
4872	Acellular dermal allograft of the trunk, arms and/or legs <=100 ² cm Use code once only		66.3	2,316.52	66.3	2,316.52	5	816.35	+T
4873	Acellular dermal allograft of the trunk, arms and/or legs; each additional 100 ² cm or part thereof (modifier 0005 not applicable) Use in conjunction with primary code 4872	+	15.3	534.58	15.3	534.58	5	816.35	+T
4874	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits <=100 ² cm		74	2,585.56	74	2,585.56	5	816.35	+T
4875	Acellular dermal allograft of the face, scalp, neck, ears, genitalia, hands, feet and/or multiple digits; each additional 100 ² cm or part thereof (modifier 0005 not applicable)	+	21.8	761.69	21.8	761.69	5	816.35	+T
2.6	**Burns**								
0345	Minor burns **Note**:Only one of the items 0345,0347 or 0351 can be claimed.								
0347	Moderate burns **Note**:Only one of the items 0345,0347 or 0351 can be claimed								
0351	Major burns: Resuscitation (including supervision and intravenous therapy - first 48 hours) **Note**:Only one of the items 0345,0347 or 0351 can be claimed		276	9,643.44	220.8	7,714.75	5	816.35	+T
0353	Tangential excision and grafting: Small		100	3,494.00	100	3,494.00	5	816.35	+T
0354	Tangential excision and grafting: Large		200	6,988.00	160	5,590.40	5	816.35	+T
2.7	**Hands (skin)**								
0355	Skin flap in acute hand injuries where a flap is taken from a site remote from the injured finger or in cases of advancement flap e.g. Cutler		147.4	5,150.16	120	4,192.80	4	653.08	+T
0357	Small skin graft in acute hand injury		45	1,572.30	45	1,572.30	3	489.81	+T
0359	Release of extensive skin contracture and/or excision of scar tissue with major skin graft resurfacing		192	6,708.48	153.6	5,366.78	3	489.81	+T
0361	Z-plasty		220.1	7,690.29	176.08	6,152.24	3	489.81	+T
0363	Local flap and skin graft		150	5,241.00	120	4,192.80	3	489.81	+T
0365	Cross finger flap (all stages)		192	6,708.48	153.6	5,366.78	3	489.81	+T
0367	Palmarflap (all stages)		192	6,708.48	153.6	5,366.78	3	489.81	+T
0369	Distant flap: First stage		158	5,520.52	126.4	4,416.42	3	489.81	+T
0371	Distant flap: Subsequent stage (not subject to Modifier 0005)		77	2,690.38	77	2,690.38	3	489.81	+T
0373	Transfer neurovascular island flap		230.5	8,053.67	184.4	6,442.94	3	489.81	+T
0374	Syndactyly: Separation of, including skin graft for one web (with skin flap and graft)		242.4	8,469.46	193.92	6,775.56	3	489.81	+T
0375	Dupuytren's contracture: Fasciotomy		51	1,781.94	51	1,781.94	3	489.81	+T
0376	Dupuytren's contracture: Fasciectomy		218	7,616.92	174.4	6,093.54	3	489.81	+T

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0552	Dislocation: Wrist		115.5	4,035.57	115.5	4,035.57	3	489.81	+T+M
0553	Dislocation: Perilunar transscaphoid fracture dislocation		130	4,542.20	120	4,192.80	3	489.81	+T+M
0555	Dislocation: Lunate		136.3	4,762.32	120	4,192.80	3	489.81	+T+M
0556	Dislocation: Carpo-metacarpo joint		117.2	4,094.97	117.2	4,094.97	3	489.81	+T+M
0557	Dislocation: Metacarpo-phalangeal or interphalangeal joints (hand)		107.3	3,749.06	107.3	3,749.06	3	489.81	+T+M
0559	Dislocation: Hip		220.5	7,704.27	176.4	6,163.42	3	489.81	+T+M
0561	Dislocation: Knee, with manipulation		181.2	6,331.13	145	5,066.30	3	489.81	+T+M
0563	Dislocation: Patella		136.9	4,783.29	120	4,192.80	3	489.81	+T+M
0565	Dislocation: Ankle		98.6	3,445.08	98.6	3,445.08	3	489.81	+T+M
0567	Dislocation: Sub-Talar dislocation		92	3,214.48	92	3,214.48	3	489.81	+T+M
0569	Dislocation: Intertarsal or Tarsometatarsal or Mid-tarsal		77	2,690.38	77	2,690.38	3	489.81	+T+M
0571	Dislocation: Meta-tarsophalangeal or interphalangeal joints (foot)		39.4	1,376.64	39.4	1,376.64	3	489.81	+T+M
3.2.2	**Operations for dislocations**								
0578	Recurrent dislocation of shoulder		200	6,988.00	160	5,590.40	3	489.81	+T+M
0579	Recurrent dislocation of all other joints		161	5,625.34	128.8	4,500.27	3	489.81	+T+M
3.2.3	**Capsular Operations**								
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)		51	1,781.94	51	1,781.94	3	489.81	+T+M
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care)		96	3,354.24	96	3,354.24	3	489.81	+T+M
0585	Capsulotomy or arthrotomy or biopsy or drainage of joint: Capsulectomy digital joint		64	2,236.16	64	2,236.16	3	489.81	+T+M
0586	Multiple percutaneous capsulotomies of metacarpo-phalangeal joints		90	3,144.60	90	3,144.60	3	489.81	+T+M
0587	Release of digital joint contracture		128	4,472.32	120	4,192.80	3	489.81	+T+M

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3.2.7	**Miscellaneous (Joints)**								
0658	Aspiration and/or injection: Small joint, bursa (e.g. fingers, toes) (excluding aftercare, Modifier 0005 not applicable)		11.4	398.32	11.4	398.32	3	489.81	+T+M
0659	Aspiration and/or injection: Intermediate joint, bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) (excluding aftercare, Modifier 0005 not applicable)		12	419.28	12	419.28	3	489.81	+T+M
0660	Aspiration and/or injection: Major joint, bursa (e.g. shoulder, hip, knee joint, subacromial bursa) (excluding aftercare, Modifier 0005 not applicable)		14.6	510.12	14.6	510.12	3	489.81	+T+M
0661	Aspiration of joint or intra-articular injection (not subject to rule G) (Modifier 0005 not applicable)		9	314.46	9	314.46	3	489.81	+T
0668	Manipulation of knee joint under general anaesthesia (includes application of traction or other fixation devices) (excluding aftercare) (Modifier 0005 is not applicable)		43.1	1,505.91	43.1	1,505.91	3	489.81	+T
0667	Arthroscopy (excluding after-care), Modifiers 0005 and 0013 not applicable		60	2,096.40	60	2,096.40	3	489.81	+T
0669	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)-Anaesthetic: Knee/Shoulder.		14	489.16	14	489.16	3	489.81	Hip+T
0669(a)	Manipulation large joint under general anaesthetic (not subject to rule G) (Modifier 0005 not applicable)-Anaestheic: Hip						4	653.08	Knee / Shoulder + T
0673	Menisectomy or operation for other internal derangement of knee: Medial OR lateral		185.7	6,488.36	148.6	5,192.08	3	489.81	+T+M
3.2.8	**Joint ligament reconstruction or suture**								
0675	Joint ligament reconstruction or suture: Ankle: Collateral		160	5,590.40	128	4,472.32	3	489.81	+T+M
0676	Joint ligament reconstruction or suture: Ankle (e.g. Watson-Jones type)		191.5	6,691.01	153.2	5,352.81	3	489.81	+T+M
0677	Joint ligament reconstruction or suture: Knee: Collateral		196.8	6,876.19	157.44	5,500.95	3	489.81	+T+M
0678	Joint ligament reconstruction or suture: Knee: Cruciate		227.6	7,952.34	182.1	6,362.57	3	489.81	+T+M
0679	Joint ligament reconstruction or suture: Ligament augmentation procedure of knee		324.4	11,334.54	259.5	9,066.93	3	489.81	+T+M
0680	Joint ligament reconstruction or suture: Digital joint ligament		229.8	8,029.21	183.84	6,423.37	3	489.81	+T+M
3.3	**Amputations**								
3.3.1	**Specific Amputations**								
0681	Amputation: Humerus, includes primary closure		211.6	7,393.30	169.28	5,914.64	4	653.08	+T+M
0682	Amputation: Fore-quarter amputation		397.8	13,899.13	318.24	11,119.31	9	1469.43	+T+M

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0683	Amputation: Through shoulder		323	11,285.62	258.4	9,028.50	5	816.35	+T+M
0684	Amputation: Forearm		213.5	7,459.69	170.48	5,956.57	3	489.81	+T+M
0686	Amputation: Ankle (eg., Syme, Pirogoff type)		204.1	7,131.25	163.28	5,705.00	4	653.08	+T+M
0687	Amputation: Metacarpal: One ray		206.1	7,201.13	164.9	5,761.61	3	489.81	+T+M
0688	Amputation: Foot, midtarsal (Chopart type)		165.7	5,789.56	132	4,612.08	3	489.81	+T+M
0691	Amputation: Finger or thumb		183.9	6,425.47	146.4	5,115.22	3	489.81	+T+M
0692	Scar revision/secondary closure: amputated thigh, through femur, any level		150.7	5,265.46	120.56	4,212.37	3	489.81	+T+M
0693	Hindquarter amputation		470.7	16,446.26	376.6	13,158.40	6	979.62	+T+M
0694	Scar revision/secondary closure: amputated leg, through tibia and fibula, any level		173.9	6,076.07	139.12	4,860.85	3	489.81	+T+M
0695	Amputation: Through hip joint region		373.1	13,036.11	298.5	10,429.59	6	979.62	+T+M
0696	Re-amputation: Thigh, through femur, any level		217.3	7,592.46	173.84	6,073.97	3	489.81	+T+M
0697	Amputation: Through thigh		245	8,560.30	196	6,848.24	6	979.62	+T+M
0698	Re-amputation: Leg, through tibia and fibula		198.2	6,925.11	158.56	5,540.09	3	489.81	+T+M
0699	Amputation: Below knee, through knee/Syme		277.2	9,685.37	221.8	7,749.69	5	816.35	+T+M
0701	Amputation: Trans-metatarsal or trans-tarsal		223.8	7,819.57	179.04	6,255.66	3	489.81	+T+M
0705	Amputation: Toe (skin flap included)		167.1	5,838.47	133.68	4,670.78	3	489.81	+T+M
3.3.2	**Post-Amputation Reconstruction**								
0706	Post-amputation reconstruction: Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler		186.3	6,509.32	149.04	5,207.46	3	489.81	+T+M
	Note: If not performed on thumb or index finger it must be motivated.								
0707	Post-amputation reconstruction: Krukenberg reconstruction		331.7	11,589.60	265.4	9,273.08	3	489.81	+T+M
0711	Post-amputation reconstruction: Pollicization of the finger (Prior permission must be obtained from the Commissioner at all times)		455.9	15,929.15	364.72	12,743.32	3	489.81	+T+M
0712	Post-amputation reconstruction: Toe to thumb transfer (Prior permission must be obtained from the Commissioner at all times)		800	27,952.00	640	22,361.60	3	489.81	+T+M
0700	Scar revision/secondary closure: Amputated shoulder		128.1	4,475.81	120	4,192.80	3	489.81	+T
0702	Scar revision/secondary closure: Amputated humerus		163.1	5,698.71	130.48	4,558.97	3	489.81	+T
0704	Scar revision/secondary closure: Amputated forearm		184.1	6,432.45	147.28	5,145.96	3	489.81	+T
0708	Re-amputation: Humerus		223.1	7,795.11	178.48	6,236.09	6	979.62	+T+M
0710	Re-amputation: Through forearm		206	7,197.64	164.8	5,758.11	3	489.81	+T+M

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

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

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
0651	Exploration with removal of deep foreign body: Forearm or wrist Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*122.8*	**4,290.63**	*120*	**4,192.80**	*3*	**489.81**	+T
0652	Removal of foreign body: Pelvis or hip, subcutaneous tissue Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*45.3*	**1,582.78**	*45.3*	**1,582.78**	*6*	**979.62**	+T
0653	Removal of foreign body: Pelvis or hip, subfascial or intramuscular Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053,0055 and 0058 is not applicable.		*186.9*	**6,530.29**	*149.52*	**5,224.23**	*6*	**979.62**	+T
0654	Removal of foreign body: Thigh or knee area, subfascial or intramuscular Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*120.6*	**4,213.76**	*120*	**4,192.80**	*4*	**653.08**	+T
0655	Removal of foreign body: Foot, subcutaneous Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*40*	**1,397.60**	*40*	**1,397.60**	*3*	**489.81**	+T
0656	Removal of foreign body: Foot, deep Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*94.2*	**3,291.35**	*94.2*	**3,291.35**	*3*	**489.81**	+T
0657	Removal of foreign body: Foot, complicated Use tariff code 0473 for removal of Kirshner wires and Steinmann pins post operatively Modifier 0049- 0051, 0053, 0055 and 0058 is not applicable.		*110.5*	**3,860.87**	*110.5*	**3,860.87**	*3*	**489.81**	+T
3.7	**Plasters (Not subject to rule G)**								
	Note: The initial application of a plaster cast is included in the scheduled fee.								
	Note: The Commissioner will only consider payment i.r.o. splinting material (Scotchcast, Dynacast, etc.) in the following cases (not applicable when Plaster of Paris is used):								
	Where extremity splints are applied for at least five weeks.								
	A maximum of one application for an upper extremity injury.								
	A maximum of two applications for a lower extremity injury.								

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
5743	Capsulotomy metatarsophalangeal joints – foot		86.8	3,032.79	86.8	3,032.79	3	489.81	+T
3.8.2	**Replantation**								
0912	Replantation of amputated upper limb proximal to wrist joint		730	25,506.20	584	20,404.96	3	489.81	+T+M
0913	Replantation of thumb		670	23,409.80	536	18,727.84	3	489.81	+T+M
0914	Replantation of a single digit (to be motivated), for multiple digits, modifier 0005 applicable		580	20,265.20	464	16,212.16	3	489.81	+T+M
0915	Replantation operation through the palm		1270	44,373.80	1016	35,499.04	3	489.81	+T+M
3.8.3	**Hands: (Note: Skin: See Integumentary system)**								
0919	Tumours: Epidermiod cysts		35	1,222.90	35	1,222.90	3	489.81	+T+M
0922	Removal of foreign bodies requiring incision: Under local anaesthetic		19	663.86	19	663.86	3	489.81	+T+M
0923	Removal of foreign bodies requiring incision: Under general or regional anaesthetic		32	1,118.08	32	1,118.08	3	489.81	+T+M
0924	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		37	1,292.78	37	1,292.78	3	489.81	+T+M
0924a	Crushed hand injuries: Initial extensive soft tissue toilet under general anaesthetic (sliding scale)		110	3,843.40	110	3,843.40	3	489.81	+T+M
0925	Crushed hand injuries: Subsequent dressing changes under general anaesthetic		16	559.04	16	559.04	3	489.81	+T+M
0926	Initial treatment of fractures, tendons, nerves, loss of skin and blood vessels, including removal of dead tissue under general anaesthesia and six weeks after-care		269	9,398.86	215.2	7,519.09	3	489.81	+T+M
3.8.4	**Spine**								
	Note: Notes regarding the use of Modifier 0005 in cases where bone graft procedures and instrumentation are performed in combination with arthrodesis (fusion): **i.** Modifier 0005 (multiple therapeutic procedures/operations under the same anaesthetic) is not applicable if the following procedures are performed together: - Bone graft procedures and instrumentation are to be coded in addition to arthrodesis (fusion). - When vertebral procedures are performed by arthrodesis (fusions), bone grafts and instrumentation may be coded for additionally. **ii.** Modifier 0005 (multiple therapeutic procedures/operations under the same anaesthetic) would be applicable when arthrodesis (fusion) is perfomed in addition to another procedure, e.g. osteotomy, laminectomy.								
0927	Excision of one vertebral body, for a lesion within the body (no decompression)		207	7,232.58	165.6	5,786.06	3	489.81	+T+M
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression).	+	42	1,467.48	42	1,467.48	3	489.81	+T+M

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1001	Temporo-mandibular joint: Reconstruction for dysfunction		206	7,197.64	164.8	5,758.11	4	653.08	+T+M
1003	Manipulation: Immobilisation and follow-up of fractured nose		35	1,222.90	35	1,222.90	3	489.81	+T+M
1005	Nasal fracture without manipulation								
1006	Fracture: Nose and septum, open reduction Modifier 0049 to 0051 and 0053 do not apply		177.4	6,198.36	141.92	4,958.68	5	816.35	+T+M
1007	Mandibulectomy		320	11,180.80	256	8,944.64	5	816.35	+T+M
1009	Maxillectomy Modifier 0005 does not apply		382.5	13,364.55	306	10,691.64	4	653.08	+T+M
1011	Bone graft to mandible		206	7,197.64	164.8	5,758.11	4	653.08	+T+M
1012	Adjustment of occlusion by ramisection		227	7,931.38	181.6	6,345.10	4	653.08	+T+M
1013	Fracture of arch of zygoma without displacement								
1015	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures; recent fractures (within four weeks)		131	4,577.14	120	4,192.80	3	489.81	+T+M
1017	Fracture of arch of zygoma with displacement requiring operative manipulation (not including associated fractures) (after four weeks)		262	9,154.28	209.6	7,323.42	3	489.81	+T+M
4.	**RESPIRATORY SYSTEM**								
4.1	**Nose and Sinuses**								
1018	Flexible nasopharyngolaryngoscope examination		51.94	1,814.78	51.94	1,814.78			
1019	ENT endoscopy in rooms with rigid endoscope		12	419.28					
1020	Repair of perforated septum: Any method		141.9	4,957.99	120	4,192.80	4	653.08	+T
1022	Functional reconstruction of nasal septum Procedures of the septum including correction of caudal septal deflection is included. Tariff code 1087 may apply if a tip deformity and valve obstruction is present.		121.2	4,234.73	120	4,192.80	4	653.08	+T
1023	Harvesting of graft: Cartilage graft of nasal septum May not be used with tariff code 1034.		124.8	4,360.51	120	4,192.80	5	816.35	+T
1024	Insertion of silastic obturator into nasal septum perforation (excluding material).		30	1,048.20	30	1,048.20	4	653.08	+T
1025	Intranasal antrostomy (Modifier 0005 to apply to opposite side of nose)		64.6	2,257.12	64.6	2,257.12	4	653.08	+T
1027	Dacrocystorhinostomy		210	7,337.40	168	5,869.92	5	816.35	+T
1029	Turbinectomy (Modifier 0005 to apply to opposite side of nose)		62.6	2,187.24	62.6	2,187.24	4	653.08	+T
1030	Endoscopic turbinectomy: laser or microdebrider		90	3,144.60	90	3,144.60	5	816.35	+T
1034	Autogenous nasal bone transplant: Bone removal included		100	3,494.00	100	3,494.00	4	653.08	+T

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1171	Drainage empyema (including six weeks after-treatment)		170	5,939.80	136	4,751.84	11	1795.97	+T
1173	Drainage of lung abscess (including six weeks after-treatment)		170	5,939.80	136	4,751.84	11	1795.97	+T
1175	Thoracotomy: Limited: For lung or pleural biopsy		115	4,018.10	115	4,018.10	11	1795.97	+T
1177	Thoracotomy: Major: Diagnostic, as for inoperable carcinoma		215	7,512.10	172	6,009.68	11	1795.97	+T
1179	Thoracoscopy		89	3,109.66	89	3,109.66	11	1795.97	+T
4.6.2	**Pulmonary Function Tests**								
4.6.2.1	**Pulmonary function tests: General**								
4.6.2.1	**Note:** When these procedures are performed by an anaesthesiologist he/she acts as the clinician and not an anaesthesiologist and the indicated clinical procedure units should be used and not the anaesthetic units.								
1186	Flow volume test: Inspiration/expiration May not be used with tariff codes 1189 and 1192		30	1,048.20	30	1,048.20		Fees as for specialist	
1188	Flow volume test: Inspiration/expiration pre - and post - bronchodilator (to be charged for only with first consultation - thereafter tariff code 1186 applies)		50	1,747.00	50	1,747.00		Fees as for specialist	
1189	Forced expirogram only		10	349.40	10	349.40			
1191	N2 single breath distribution		10	349.40	10	349.40			
1192	Peak expiratory flow only		5	174.70	5	174.70			
1197	Compliance and resistance, using oesophageal balloon		24	838.56	24	838.56		Fees as for specialist	
1198	Prolonged postexposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent or after excercise, with subsequent spirometry		55.89	1,952.80	55.89	1,952.80			
1199	Pulmonary stress testing: For determination of VO2 max		96.5	3,371.71	96.5	3,371.71			
1201	Maximum inspiratory/expiratory pressure		5	174.70	5	174.70		Fees as for specialist	

4.6.2.2	**Pulmonary function tests: Specialised services**		Pulmonologists and Practitioners accredited to SATS		Other Specialists and General practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1193	Functional residual capacity or residual volume: helium method, nitrogen open circuit method, or other method		37.76	1,319.33					
1195	Thoracic gas volume		37.93	1,325.27					
1196	Determination of resistance to airflow, oscillatory or plethysmographic methods		45.31	1,583.13					
1200	Carbon monoxide diffusing capacity, any method		38.06	1,329.82					

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1217	**Insertion** of central venous line via peripheral vein Can be used with any of the ICU items		*10*	**349.40**	*10*	**349.40**		Fees as for specialist	
1218	**Insertion** of central venous line via subclavian or jugular veins Can be used with any of the ICU items Appropriate for insertion or placement of a Quinton line or haemodialysis catheter Not to use with tariff code 3569		*25*	**873.50**	*25*	**873.50**		Fees as for specialist	
1219	Hyperalimentation (daily fee)		*15*	**524.10**	*15*	**524.10**		Fees as for specialist	
1220	**Patient-controlled analgesic pump**: Hire fee: Per 24 hours (Cassette to be charged for according to tariff code 0201 per patient)		*30*	**1,048.20**	*30*	**1,048.20**		Fees as for specialist	
1221	**Professional fee** for managing a patient-controlled analgesic pump: First 24 hours (for subsequent days, charge appropriate hospital follow-up consultation)		*30*	**1,048.20**	*30*	**1,048.20**		Fees as for specialist	

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
4.8	**HYPERBARIC OXYGEN TREATMENT**								
	Note: 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 min)** PROFESSIONAL COMPONENT		*30*	**1,048.20**	*30*	**1,048.20**			
4820	Low pressure table (1,5-1,8 ATA x 45-60 min): TECHNICAL COMPONENT		*101.13*	**3,533.48**	*101.13*	**3,533.48**			
4805	**Monitoring of a patient** at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): Routine HBO table (2-2.5 ATA x 90-120 min) PROFESSIONAL COMPONENT		*60*	**2,096.40**	*60*	**2,096.40**			
4821	Routine HBO table (2-2,5 ATA x 90-120 min): TECHNICAL COMPONENT		*131.26*	**4,586.22**	*131.26*	**4,586.22**			
4806	**Monitoring of a patient** at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment monitoring during treatment and post treatment evaluation): **Emergency HBO table (2.5-3 ATA x 90-120 min)** PROFESSIONAL COMPONENT		*80*	**2,795.20**	*80*	**2,795.20**			
4822	Emergency HBO table (2,5-3 ATA x 90-120 min): TECHNICAL COMPONENT		*131.26*	**4,586.22**	*131.26*	**4,586.22**			
4809	**Monitoring of a patient** at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT5 (2.8 ATA x 135 min) PROFESSIONAL COMPONENT		*90*	**3,144.60**	*90*	**3,144.60**			
4825	USN TT5 (2,8 ATA x 135 min): TECHNICAL COMPONENT		*214.18*	**7,483.45**	*214.18*	**7,483.45**			

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
4810	**Monitoring of a patient** at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT6 (2.8 ATA x 285 min) PROFESSIONAL COMPONENT		*190*	**6,638.60**	*190*	**6,638.60**			
4826	USN TT6 (2,8 ATA x 285 min): TECHNICAL COMPONENT		*386.42*	**13,501.51**	*386.42*	**13,501.51**			
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment, monitoring during treatment and post treatment evaluation): USN TT6ext/6A or Cx 30 (2.8-6 ATA x 305-490 min) PROFESSIONAL COMPONENT		*327*	**11,425.38**	*327*	**11,425.38**			
4827	USN TT6ext (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		*680.85*	**23,788.90**	*680.85*	**23,788.90**			
4828	USN 6A (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		*678.28*	**23,699.10**	*678.28*	**23,699.10**			
4829	USN Cx 30 (2,8-6 ATA x 305-490 min): TECHNICAL COMPONENT		*671.85*	**23,474.44**	*671.85*	**23,474.44**			
4815	**Prolonged attendance** inside a hyperbaric chamber: 40 clinical procedure units per half hour or part thereof for the first hour. Thereafter 20 clinical procedure units per half hour; minimum 40 clinical procedure units; maximum 320 clinical procedure units (Please indicate time in minutes and not per half hour).								
5.	**MEDIASTINAL PROCEDURES**								
1223	Mediastinoscopy		*95*	**3,319.30**	*95*	**3,319.30**	*5*	**816.35**	+T
1224	Mediastinotomy		*115*	**4,018.10**	*115*	**4,018.10**	*11*	**1795.97**	+T
6.	**CARDIOVASCULAR SYSTEM**								
6.1	**General**								
	General practitioner's fee for the taking of an ECG only								
	Note: Tariff codes 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added. Where an ECG is done by a general practitioner and interpreted by a physician, the general practitioner is entitled to his full consultation fee, plus half of fee determined for ECG.								
1228	General Practitioner's fee for the taking of an ECG only: Without effort: (1232)				*4.5*	**157.23**			
1229	General Practitioner's fee for the taking of an ECG only: Without and with effort: 1/2 (tariff code 1233)				*6.5*	**227.11**			
	Note: Physician's fee for interpreting an ECG (Tariff Codes 1230 and 1231) A specialist physician is entitled to the following fees for interpretation of an ECG tracing referred for interpretation.								
1230	Professional component for a physician interpreting an ECG: Without effort		*6*	**209.64**					
1231	Physician's fee for interpreting an ECG: With and without effort		*10*	**349.40**					
1232	Electrocardiogram: Without effort (interpretation included)		*9*	**314.46**	*9*	**314.46**			
1233	Electrocardiogram: With and without effort (Interpretation included)		*13*	**454.22**	*13*	**454.22**			

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
6.3.1	**Open heart surgery**								
1322	Attendance at other operations for monitoring at bedside, by physician heart block, etc: Per hour		*20*	**698.80**					
6.4	**Peripheral Vascular System**								
6.4.1	**Peripheral vascular system: Investigations**								
1357	Skin temperature test: Response to reflex heating		*15*	**524.10**	*15*	**524.10**			
1359	Skin temperature test: Response to reflex cooling		*15*	**524.10**	*15*	**524.10**			
1366	Transcutaneous oximetry: Transcutaneous oximetry - single site		*26.3*	**918.92**	*26.3*	**918.92**			
1367	Doppler blood tests		*6*	**209.64**	*6*	**209.64**			
5369	Doppler arterial pressures		*6*	**209.64**	*6*	**209.64**			
5371	Doppler arterial pressures with exercise		*10*	**349.40**	*10*	**349.40**			
5373	Doppler segmental pressures and wave forms		*12*	**419.28**	*12*	**419.28**			
5375	Venous doppler examination (both limbs)		*9*	**314.46**	*9*	**314.46**			
6.4.2	**Peripheral vascular system: Arterio-venous-abnormalities**								
1369	Fistula or aneurysm (as for grafting of various arteries)								
6.4.3	**Arteries**								
6.4.3.1	**Peripheral vascular system: Arteries: Aorta-iliac and major branches**								
1373	Abdominal aorta and iliac artery: Ruptured		*600*	**20,964.00**	*480*	**16,771.20**	*15*	**2449.05**	+T
1375	Grafting and/or thrombo-endarterectomy for thrombosis		*444*	**15,513.36**	*355.20*	**12,410.69**	*15*	**2449.05**	+T
1376	Aorta bi-femoral graft, including proximal and distal endarterectomy and preparation for anastomosis		*594*	**20,754.36**	*475.2*	**16,603.49**			
6.4.3.2	**Iliac artery**								
1379	Prosthetic grafting and/or Thrombo-endarterectomy		*300*	**10,482.00**	*240*	**8,385.60**	*13*	**2122.51**	+T
6.4.3.3	**Peripheral Vascular System:Arteries:Peripheral**								
1385	Prosthetic grafting		*255*	**8,909.70**	*204*	**7,127.76**	*5*	**816.35**	+T
1387	Vein grafting proximal to knee joint		*300*	**10,482.00**	*240*	**8,385.60**	*5*	**816.35**	+T
1388	Vein grafting distal to knee joint		*444*	**15,513.36**	*355.2*	**12,410.69**	*5*	**816.35**	+T
1389	Endarterectomy when not part of another specified procedure		*264*	**9,224.16**	*211.2*	**7,379.33**	*5*	**816.35**	+T
1393	Embolectomy: Peripheral embolectomy transfemoral		*168*	**5,869.92**	*134.4*	**4,695.94**	*5*	**816.35**	+T
1395	Miscellaneous arterial procedures: Arterial suture: Trauma		*125*	**4,367.50**	*100*	**3,494.00**	*5*	**816.35**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessels are defined as aorta, innominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, iliac artery, common femoral and popliteal arteries are included because of popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessibility of the arteries and difficult surgical exposure) - Anaesthetic: Except where a specific code already exist elsewhere		264	9,224.16	211.2	7,379.33	15	2449.05	+T
1397	Profundoplasty		210	7,337.40	168	5,869.92	5	816.35	+T
1399	Distal tibial (ankle region)		456	15,932.64	364.8	12,746.11	5	816.35	+T
1401	Femoro-femoral		254	8,874.76	203.2	7,099.81	5	816.35	+T
1402	Carotid-subclavian		288	10,062.72	230.4	8,050.18	8	1306.16	+T
1403	Axillo-femoral (Bifemoral + 50% of the fee)		288	10,062.72	230.4	8,050.18	8	1306.16	+T
6.4.4	**Veins**								
1407	Ligation of saphenous vein		50	1,747.00	50	1,747.00	3	489.81	+T
1408	Placement of Hickman catheter or similar May not be used for insertion or placement of a Quinton line or haemodialysis catheter		91	3,179.54	91	3,179.54	4	653.08	+T
1410	Ligation of inferior vena cava: Abdominal		180	6,289.20	144	5,031.36	8	1306.16	+T
1412	Umbrella operation on inferior vena cava: Abdominal		100	3,494.00	100	3,494.00	8	1306.16	+T
1413	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Unilateral		141	4,926.54	120	4,192.80	3	489.81	+T
1415	Combined procedure for varicose veins: Ligation of saphenous vein stripping, multiple ligation including of perforating veins as indicated: Bilateral		247	8,630.18	197.6	6,904.14	3	489.81	+T
1417	Extensive sub-fascial ligation of perforating veins		125	4,367.50	120	4,192.80	3	489.81	+T
1419	Lesser varicose vein procedure		31	1,083.14	31	1,083.14	3	489.81	+T
1421	Compression sclerotherapy of varicose veins: Per injection to a maximum of nine injections per leg (excluding cost of material)		9	314.46	9	314.46			
1425	Thrombectomy: Inferior vena cava (Trans-abdominal)		240	8,385.60	192	6,708.48	11	1795.97	+T
1427	Thrombectomy: Ilio-femoral		175	6,114.50	140	4,891.60	6	979.62	+T
7.	**LYMPHO RETICULAR SYSTEM**								
7.1	**Spleen**								
1435	Splenectomy (trauma cases only)		221.3	7,732.22	177.04	6,185.78	9	1469.43	+T
1436	Splenorrhaphy		231.8	8,099.09	185.44	6,479.27	9	1469.43	+T

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
8.	**DIGESTIVE SYSTEM**								
8.1	**Oral Cavity**								
1462	Removal of embedded foreign body: Vestibule of mouth, simple		*41.1*	**1,436.03**	*41.1*	**1,436.03**	*5*	**816.35**	+T
1464	Removal of embedded foreign body: Vestibule of mouth, complicated		*73.1*	**2,554.11**	*73.1*	**2,554.11**	*5*	**816.35**	+T
1466	Removal of embedded foreign body: Dentoalveolar structures, soft tissues		*52.8*	**1,844.83**	*52.8*	**1,844.83**	*5*	**816.35**	+T
1467	Drainage of intra-oral abscess		*31*	**1,083.14**	*31*	**1,083.14**	*4*	**653.08**	+T
1469	Local excision of mucosal lesion of oral cavity		*23*	**803.62**	*23*	**803.62**	*4*	**653.08**	+T
1471	Resection of malignant lesion of buccal mucosa including radical neck dissection (Commando operation), but not including reconstructive plastic procedure		*549*	**19,182.06**	*439.2*	**15,345.65**	*7*	**1142.89**	+T
1478	Velopharyngeal reconstruction with myoneuro-vascular transfer (dynamic repair) Pre-authorisation and motivation letter required		*240*	**8,385.60**	*192*	**6,708.48**	*6*	**979.62**	+T
1479	Velopharyngeal reconstruction with or without pharyngeal flap (static repair)		*227*	**7,931.38**	*181.6*	**6,345.10**	*6*	**979.62**	+T
1480	Repair of oronasal fistula (large), e.g. distant flap Tariff Code 1480 cannot be used with tariff codes 1481 and 1482.		*227*	**7,931.38**	*181.6*	**6,345.10**	*6*	**979.62**	+T
1481	Repair of oronasal fistula (small), e.g. trapdoor: One stage or first stage Tariff Code 1481 cannot be used with tariff codes 1480 and 1482.		*138*	**4,821.72**	*120*	**4,192.80**	*5*	**816.35**	+T
1482	Repair of oronasal fistula (large): Second stage Tariff Code 1482 cannot be used with tariff codes 1480 and 1481.		*138*	**4,821.72**	*120*	**4,192.80**	*5*	**816.35**	+T
1483	Alveolar periosteal or other flaps for arch closure		*138*	**4,821.72**	*120*	**4,192.80**	*4*	**653.08**	+T
1486	Closure of anterior nasal floor		*138*	**4,821.72**	*120*	**4,192.80**	*5*	**816.35**	+T
8.2	**Lips**								
1485	Local excision of benign lesion of lip		*27*	**943.38**	*27*	**943.38**	*4*	**653.08**	+T
1499	Lip reconstruction following an injury: Directed repair Cannot be used with tariff codes 1501 to 1504		*105.6*	**3,689.66**	*105.6*	**3,689.66**	*4*	**653.08**	+T
1501	Lip reconstruction following an injury only: Flap repair May not be used with tariff codes 1499,1503 and 1504		*206*	**7,197.64**	*164.8*	**5,758.11**	*4*	**653.08**	+T
1503	Lip reconstruction following an injury only: Total reconstruction (first stage) Cannot be used with tariff codes 1499 and 1501		*206*	**7,197.64**	*164.8*	**5,758.11**	*4*	**653.08**	+T
1504	Lip reconstruction following an injury only: Subsequent stages (see tariff code 0297) Cannot be used with tariff codes 1499, 1501 and 1503		*104*	**3,633.76**	*104*	**3,633.76**	*4*	**653.08**	+T

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
1836	Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for the incisional or ventral hernia repair) ADD to tariff codes 1825 and1835 where appropriate only (modifier 0005 does not apply) Does not apply to simple, primary or small hernia; applies to recurrent and complicated hernias only.	+	77	2,690.38	77	2,690.38	4	653.08	+T
10.	**URINARY SYSTEM**								
10.1	**Kidney**								
1839	Renal biopsy, per kidney, open		71	2,480.74	71	2,480.74	5	816.35	+T
1841	Renal biopsy (needle)		30	1,048.20	30	1,048.20	3	489.81	+T
1843	Peritoneal dialysis: First day Appropriate for the prescription and supervision of peritoneal dialysis May be used with tariff codes 1204 to 1210 and consultation codes		33	1,153.02	33	1,153.02			
1845	Peritoneal dialysis: Every subsequent day Appropriate for the prescription and supervision of peritoneal dialysis May be used with tariff codes 1204 to 1210 and consultation codes		33	1,153.02	33	1,153.02			
1847	Acute haemodialysis: Subsequent calendar day, per hour with a maximum of 4 hours per calendar day (e.g. Item 1847 x 4). Appropriate for haemodialysis in ICU or High Care Unit (the medical doctor does not have to be present for the duration of the treatment) **a)** Appropriate for the prescription and supervision of acute intermittent haemodialysis session in ICU or High Care Unit on subsequent days **b)** Cannot be used with item 1849 **c)** Use item once per hour up to a maximum of 4 hours of dialysis per day (1847 X 4). **d)** Applies to all form of haemodialysis provided in ICU or High Care Unit on the first day of dialysis, that is; intermittent, continuous and hybrid modlities. **e)** Can be used with items 1204 to 1210 and consultation codes		21	733.74	21	733.74			

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

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

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

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

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.3.3	**Other nerve procedures**								
2827	Transposition of ulnar nerve		*170*	**5,939.80**	*136*	**4,751.84**	*3*	**489.81**	+T
2829	Neurolysis: Minor Cannot be used with tariff code 2831		*51*	**1,781.94**	*51*	**1,781.94**	*3*	**489.81**	+T
2831	Neurolysis: Major Cannot be used with tariff code 2829		*141*	**4,926.54**	*120*	**4,192.80**	*3*	**489.81**	+T
2833	Neurolysis: Digital		*141*	**4,926.54**	*120*	**4,192.80**	*3*	**489.81**	+T
2835	Scalenotomy		*132*	**4,612.08**	*120*	**4,192.80**	*6*	**979.62**	+T
2837	Neuroplasty: Brachial plexus		*300*	**10,482.00**	*240*	**8,385.60**	*6*	**979.62**	+T
2839	Total brachial plexus exposure with graft, neurolysis and transplantation		*895.2*	**31,278.29**	*716.16*	**25,022.63**	*6*	**979.62**	+T
2843	Lumbar sympathectomy: Unilateral		*153*	**5,345.82**	*122.4*	**4,276.66**	*4*	**653.08**	+T
2845	Lumbar sympathectomy: Bilateral		*268*	**9,363.92**	*214.4*	**7,491.14**	*6*	**979.62**	+T
2849	Sympathetic block: Other levels: Unilateral		*20*	**698.80**	*20*	**698.80**	*3*	**489.81**	+T
2851	Sympathetic block: Other levels: Bilateral Cannot be used with tariff code 2849		*35*	**1,222.90**	*35*	**1,222.90**	*3*	**489.81**	+T
14.4	**Skull procedures**								
2855	Craniectomy: Includes excision of tumour or other bone lesion of skull (total procedure)		396	**13,836.24**	317.2	**11,082.97**	*11*	**1795.97**	+T
2859	Depressed skull fracture: Elevation of fracture, compound or comminuted, extradural (total procedure)		*377.9*	**13,203.83**	*302.32*	**10,563.06**	*9*	**1469.43**	+T
2860	Depressed skull fracture: Elevation of fracture, simple, extradural (total procedure)		*307.1*	**10,730.07**	*245.68*	**8,584.06**	*9*	**1469.43**	+T
2862	Depressed skull fracture: Elevation of fracture with repair of dura and/or debridement of brain (total procedure) Replaces tariff code 2861		*455.1*	**15,901.19**	*364.08*	**12,720.96**	*11*	**1795.97**	+T
2863	Cranioplasty: Skull defect =<5 cm diameter: With/without prosthesis		*309.1*	**10,799.95**	*247.28*	**8,639.96**	*9*	**1469.43**	+T
6043	Cranioplasty: Skull defect; >5 cm diameter		*340.80*	**11,907.55**	*272.64*	**9,526.04**	*9*	**1469.43**	+T
6044	Removal of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/infection or inflammatory reaction due to device, implant and/or graft		*264.90*	**9,255.61**	*211.92*	**7,404.48**	*9*	**1469.43**	+T
6045	Replacement of bone flap or prosthetic plate of skull: For malignancy/acquired deformity of head/open fracture /late effect of fracture/ infection or inflammatory reaction due to device, implant or graft (total procedure)		*311.40*	**10,880.32**	*249.12*	**8,704.25**	*9*	**1469.43**	+T
6046	Cranioplasty: Skull defect, with reparative brain surgery: With/without prosthesis Cannot be used with tariff codes 6047 and 6048		*421.70*	**14,734.20**	*337.36*	**11,787.36**	*11*	**1795.97**	+T
6047	Cranioplasty: Includes autograft and obtaining bone grafts; =<5 cm diameter (total procedure) Cannot be used with tariff codes 6046 and 6048		*371.40*	**12,976.72**	*297.12*	**10,381.37**	*9*	**1469.43**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
6048	Cranioplasty: Includes autograft and obtaining bone grafts; >5 cm diameter (total procedure) Cannot be used with tariff codes 6046 to 6047		*432.70*	**15,118.54**	*346.16*	**12,094.83**	*9*	**1469.43**	+T
6049	Incision and retrieval: Cranial bone graft for cranioplasty, subcutaneous. ADD to primary procedure 6046 to 6048	+	*37.30*	**1,303.26**	*37.30*	**1,303.26**			
14.5	**Shunt procedures and neuroendoscopy**								
2869	Ventriculocisternostomy: From the third ventricle to the cisterna magna (total procedure)		*409.00*	**14,290.46**	*327.20*	**11,432.37**	*10*	**1632.70**	+T
2871	Creation of shunt: Ventriculo-atrial, -jugular, -auricular Cannot be used with tariff code 2873		*307.20*	**10,733.57**	*245.76*	**8,586.85**	*10*	**1632.70**	+T
2873	Creation of shunt: Ventriculo-peritoneal, -pleural, other terminus Cannot be used with tariff code 2871		*315.40*	**11,020.08**	*252.32*	**8,816.06**	*10*	**1632.70**	+T
2875	Theco-peritoneal cerebrospinal fluid (CSF) shunt		*280*	**9,783.20**	*224*	**7,826.56**	*8*	**1306.16**	+T
6055	Neuroendoscopy: Intracranial placement or replacement of ventricular catheter and attachment to shunt system or external drainage. ADD to main procedure	+	*56.00*	**1,956.64**	*56.00*	**1,956.64**	*8*	**1306.16**	+T
6058	Neuroendoscopy: Intracranial, with retrieval of foreign body		*364.80*	**12,746.11**	*291.84*	**10,196.89**	*11*	**1795.97**	+T
6061	Creation of subarachnoid/subdural-peritoneal shunt: Pleural or peritoneal space or other terminus, through burr hole and directing and tunneling the distal end of the shunt subcutaneously towards the draining site (non-neuroendoscopic procedure) (total procedure)		*290.80*	**10,160.55**	*232.64*	**8,128.44**	*10*	**1632.70**	+T
6062	Replacement or irrigation: Subarachnoid or subdural catheter, non-neuroendoscopic procedure (total procedure)		*111.40*	**3,892.32**	*111.40*	**3,892.32**	*10*	**1632.70**	+T
6063	Ventriculocisternostomy of the third ventricle: Stereotactic, neuroendoscopic method (under CT guidance for stereotactic positioning) (tariff codes 6055 and 6148 cannot be added)		*358.80*	**12,536.47**	*287.04*	**10,029.18**	*10*	**1632.70**	+T
6064	Replacement/irrigation: Previously placed intraoperative ventricular catheter		*158.30*	**5,531.00**	*126.64*	**4,424.80**	*10*	**1632.70**	+T
6065	Replacement/revision: Cerebrospinal fluid (CSF) shunt/obstructed valve/distal catheter in shunt system		*252.30*	**8,815.36**	*201.84*	**7,052.29**	*10*	**1632.70**	+T
6066	Reprogramming of programmable cerebrospinal shunt, at the time of a routine office visit		*26.00*	**908.44**	*26.00*	**908.44**	*10*	**1632.70**	+T
6067	Removal: Complete cerebrospinal fluid shunt system only (non-neuroendoscopic procedure)		*180.00*	**6,289.20**	*144.00*	**5,031.36**	*10*	**1632.70**	+T
6068	Cerebrospinal fluid (CSF) shunt system: Complete removal, with replacement by similar or other shunt at same operation		*335.50*	**11,722.37**	*268.40*	**9,377.90**	*10*	**1632.70**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.6	**Aneurism Repair**								
2876	Repair of aneurism or arteriovenous anomalies(Intracranial)		*700.00*	**24,458.00**	*560.00*	**19,566.40**	*15*	**2449.05**	+T
14.7	**Craniectomy or Craniotomy**								
2879	Glosso-pharyngeal nerve		*480*	**16,771.20**	*384*	**13,416.96**	*6*	**979.62**	+T
2881	Eighth nerve: Intracranial		*480*	**16,771.20**	*384*	**13,416.96**	*8*	**1306.16**	+T
2887	Vestibular nerve		*480*	**16,771.20**	*384*	**13,416.96**	*9*	**1469.43**	+T
2891	Craniectomy for excision of brain tumour: Infratentorial or posterior fossa for excision of brain tumour. Excludes meningioma, cerebellopontine angle tumour or midline tumour at base of skull		819	**28,615.86**	655.76	**22,912.25**	*13*	**2122.51**	+T
2892	Micro vascular decompression of cranial nerve (suboccipital)		553	**19,321.82**	442	**15,443.48**	*6*	**979.62**	+T
2893	Craniectomy for excision of brain abscess: Infratentorial or posterior fossa for excision of brain abscess		648.3	**22,651.60**	518.64	**18,121.28**	*13*	**2122.51**	+T
2899	Craniectomy/craniotomy: With evacuation of infratentorial haematoma, subdural or extradural		*375*	**13,102.50**	*300*	**10,482.00**	*11*	**1795.97**	+T
2900	Craniotomy for extra-dural orbital decompression		*700*	**24,458.00**	*560*	**19,566.40**	*11*	**1795.97**	+T
6085	Craniectomy/craniotomy: With exploration of the infratentorial area (below the tentorium of the cerebellum), posterior fossa (total procedure)		596.4	**20,838.22**	477.12	**16,670.57**	*13*	**2122.51**	+T
6086	Craniectomy/craniotomy: With evacuation of infratentorial, intracerebellar haematoma (total procedure)		614.3	**21,463.64**	491.44	**17,170.91**	*13*	**2122.51**	+T
6087	Craniectomy/craniotomy: With drainage of intracranial abscess in the infratentorial region with suction and irrigating the area while monitoring for haemorrhage (total procedure)		631.8	**22,075.09**	505.44	**17,660.07**	*13*	**2122.51**	+T
6088	Cranial decompression caused by excess fluid (e.g. blood and pathological tissue), using posterior fossa approach by drilling/sawing through the occipital bone (total procedure)		605.1	**21,142.19**	484.08	**16,913.76**	*13*	**2122.51**	+T
6090	Craniectomy at base of skull (suboccipital): With freeing and section of one or more cranial nerves (total procedure)		624	**21,802.56**	499.2	**17,442.05**	*11*	**1795.97**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.8	**Craniotomy**								
2903	Craniectomy for abscess, glioma		*450*	**15,723.00**	*360*	**12,578.40**	*11*	**1795.97**	+T
2904	Craniectomy/craniotomy: With evacuation of supratentorial, intracerebral haematoma		*590.2*	**20,621.59**	*472.16*	**16,497.27**	*11*	**1795.97**	+T
2905	Craniotomy with elevation of bone flap: Excision of epileptogenic focus without electrocorticography during surgery		*489*	**17,085.66**	*391.2*	**13,668.53**	*11*	**1795.97**	+T
2906	Craniotomy: Skull based repair of encephalocele (total procedure)		*493.5*	**17,242.89**	*394.8*	**13,794.31**	*11*	**1795.97**	+T
2909	Craniotomy: Repair of dural/cerebrospinal fluid (CSF) leak. Includes surgery for rhinorrhea/otorrhea Cannot be used with tariff codes 6196 and 6197		*450*	**15,723.00**	*360*	**12,578.40**	*11*	**1795.97**	+T
6115	Craniectomy/craniotomy: Supratentorial exploration		487.1	**17,019.27**	389.68	**13,615.42**	*11*	**1795.97**	+T
6116	Incision and subcutaneous placement of cranial bone graft (e.g. split- or full thickness); shaving graft or bone dust; with donor site already exposed for the main procedure.		25.9	**904.95**	25.9	**904.95**			
6117	Craniectomy/craniotomy: Drainage of intracranial abscess in the supratentorial region (total procedure)		564.7	**19,730.62**	451.76	**15,784.49**	*11*	**1795.97**	+T
6118	Decompressive craniectomy/craniotomy: With or without duraplasty, for treating intracranial hypertension (most commonly caused by severe closed-head trauma) without evacuation of associated intraparenchymal haematoma or lobectomy		705.1	**24,636.19**	564.08	**19,708.96**	*11*	**1795.97**	+T
6120	Decompression of (roof of) orbit only: Transcranial approach (total procedure)		548.6	**19,168.08**	438.88	**15,334.47**	*11*	**1795.97**	+T
6125	Craniectomy/trephination (bone flap craniotomy): Supratentorial excision of brain abscess		566.2	**19,783.03**	452.96	**15,826.42**	*11*	**1795.97**	+T
6141	Craniectomy/craniotomy: Excision of foreign body from brain		554.3	**19,367.24**	443.44	**15,493.79**	*11*	**1795.97**	+T
6142	Craniectomy/craniotomy: Treatment of penetrating wound of brain		589.9	**20,611.11**	471.92	**16,488.88**	*11*	**1795.97**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.8.2	**Surgery of skull base**								
14.8.2.1	**Repair and/or Reconstruction of Surgical Defects of Skull Base**								
6196	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary repair, anterior, middle or posterior cranial fossa following surgery of the skull base, by free tissue graft (e.g. pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts) Cannot be used with tariff code 6197		*388.7*	**13,581.18**	*310.96*	**10,864.94**	*11*	**1795.97**	+T
6197	Repair of dura for cerebrospinal fluid (CSF) leak: Secondary anterior, middle or posterior cranial fossa following surgery of the skull base; by local or regionalised vascularised pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle) Cannot be used with tariff code 6196		*437.8*	**15,296.73**	*350.24*	**12,237.39**	*11*	**1795.97**	+T
14.9	**Spinal operations**								
	Note: See section 3.8.7 for laminectomy procedures								
2923	Chordotomy: Unilateral		*178*	**6,219.32**	*142.4*	**4,975.46**	*3*	**489.81**	+T+M
2925	Chordotomy: Open		*350*	**12,229.00**	*280*	**9,783.20**	*3*	**489.81**	+T+M
2927	Rhizotomy: Extradural, but intraspinal		*320*	**11,180.80**	*256*	**8,944.64**	*3*	**489.81**	+T+M
2928	Rhizotomy: Intradural		*350*	**12,229.00**	*280*	**9,783.20**	*3*	**489.81**	+T+M
2940	Lumbar osteophyte removal		*187*	**6,533.78**	*149.6*	**5,227.02**	*3*	**489.81**	+T+M
2941	Cervical or thoracic osteophyte removal		*285*	**9,957.90**	*228*	**7,966.32**	*3*	**489.81**	+T+M
14.10	**Arterial ligations**								
2951	Carotis: Trauma		*120*	**4,192.80**	*120*	**4,192.80**	*8*	**1306.16**	+T
			Specialists		**General Practitioner**		**Psychiatrists**		
			U	R	U	R	U	R	T
14.11	**Medical Psychotherapy**								
2957	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per short session (20 minutes)		*20*	**698.80**	*16*	**559.04**	*20*	**698.80**	
2974	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per intermediate session (40 minutes)		*40*	**1,397.60**	*32*	**1,118.08**	*40*	**1,397.60**	
2975	Individual Psychotherapy (specific psychotherapy with approved evidence based method): Per extended session (60 minutes and longer)		*60*	**2,096.40**	*48*	**1,677.12**	*60*	**2,096.40**	
2968	Group therapy: Adults (specify number): Code per person per 80-minute session.		*8*	**279.52**	*8*	**279.52**			

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
14.12	**Physical treatment methods**								
2970	Electro-convulsive treatment (ECT) : Each time; inpatient (may be combined with Consultations/Treatment) Therapy) (C/T) codes if both perfromed on the same day)		*17*	**593.98**	*17*	**593.98**	*17*	**593.98**	+T
14.13	**Psychiatric examination methods**								
2972	Narco-analysis (maximum of 3 sessions per treatment) - per session						*24*	**838.56**	
2973	Psychometry by Psychiatrist (specify examination) - per session (maximum of 3 sessions per examination)						*24*	**838.56**	
			Specialist		**General practitioner**		**Anaesthetic**		
			U	R	U	R	*U*	R	T
15.	**ENDOCRINE SYSTEM**								
15.1	**Endocrine system: General**								
3001	Implantation of pellets (excluding cost of material) (excluding aftercare)		*3*	**104.82**	*3*	**104.82**			
16.	**EYE**								
16.1	**Procedures performed in rooms**								
16.1.1	**Eye investigations**								
	Note: Not more than three (3) tariff codes in this section may be charged during one visit. **a.** Eye investigations and photography refer to both eyes except where otherwise indicated. No extra item may be coded where each eye is examined separately on two different occasions. **b.** Material used is excluded. **c.** The cost for photography is not related to the number of photographs taken.								
3002	Gonioscopy		*7*	**244.58**	*7*	**244.58**			
3003	Fundus contact lens or 90D lens examination(not to be charged with tariff code 3004 and/or tariff code 3012)		*7*	**244.58**	*7*	**244.58**			
3004	Peripheral fundus examination with indirect ophthalmoscope (not to be charged with tariff code 3003 and/or tariff code 3012)		*7*	**244.58**	*7*	**244.58**			
3009	Basic capital equipment used in own rooms by Ophthalmologists. Only to be charged at first and follow-up consultations. Not to be charged for post-operative follow-up consultations		*11.68*	**408.10**	-				
3013	Sensorimotor examination: With multiple measurements of ocular deviation; one or both eyes (e.g. restrictive or paretic muscle with diplopia) with interpretation and report, for patients over 7 years of age		*12*	**419.28**	*12*	**419.28**			
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)		*7*	**244.58**	*7*	**244.58**			
3021	Retinal function assessment including refraction after occular surgery (within four months), maximum two examinations		*9*	**314.46**	*9*	**314.46**		-	

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
16.1.2	**Special eye investigations**								
3008	Contrast sensitivity test		*7*	**244.58**	*7*	**244.58**			
3015	Charting of visual field with manual perimeter		*28*	**978.32**	*28*	**978.32**			
3016	Retinal threshold test without storage facilities		*30*	**1,048.20**	*30*	**1,048.20**			
3017	Retinal threshold test inclusive of computer disc storage for Delta or Statpak programs		*74*	**2,585.56**	*74*	**2,585.56**			
3018	Retinal threshold trend evaluation (additional to 3017)		*16*	**559.04**	*16*	**559.04**		-	
3020	Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery		*46*	**1,607.24**	*46*	**1,607.24**		-	
3025	Electronic tonography		*19*	**663.86**	*19*	**663.86**		-	
3027	Fundus photography		*21*	**733.74**	*21*	**733.74**		-	
3029	Anterior segment microphotography		*21*	**733.74**	*21*	**733.74**		-	
3031	Fluorescein angiography: One or both eyes		*45*	**1,572.30**	*45*	**1,572.30**	*4*	**653.08**	+T
3032	Eyelid and orbit photography		*9*	**314.46**	*9*	**314.46**		-	
3033	Interpretation of items 3031 referred by other clinicians		*15*	**524.10**	*15*	**524.10**		-	
3034	Determination of lens implant power per eye		*15*	**524.10**	*15*	**524.10**		-	
3035	Where a minor procedure usually done in the consulting rooms requires a general anaesthetic or use of an operating theatre, an additional fee may be charged		*22*	**768.68**	*22*	**768.68**		As per procedure	
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post-operative per sitting (for one or both eyes)		*36*	**1,257.84**	*36*	**1,257.84**			
16.2	**Retina**								
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy		*306.9*	**10,723.09**	*245.52*	**8,578.47**	*6*	**979.62**	+T
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye		*105*	**3,668.70**	*105*	**3,668.70**	*6*	**979.62**	+T
3041	Pan retinal photocoagulation (per eye): Done in one session (aftercare excluded)		*150*	**5,241.00**	*120*	**4,192.80**	*6*	**979.62**	+T
	(Subsequent sittings: Modifier 0005)								
3044	Removal of encircling band and/or buckling material		*105*	**3,668.70**	*105*	**3,668.70**	*6*	**979.62**	+T
16.3	**Cataract**								
3045	Cataract: Intra-capsular extraction		*210*	**7,337.40**	*168*	**5,869.92**	*7*	**1142.89**	+T
3047	Cataract: Extra-capsular (including capsulotomy)		*210*	**7,337.40**	*168*	**5,869.92**	*7*	**1142.89**	+T
3049	Insertion of lenticulus in addition to 3045 or 3047 (cost of lens excluded) Modifier 0005 not applicable		*57*	**1,991.58**	*57*	**1,991.58**	*7*	**1142.89**	+T
3050	Repositioning of intra ocular lens		*171.1*	**5,978.23**	*136.88*	**4,782.59**	*7*	**1142.89**	+T
3051	Needling or capsulotomy		*130*	**4,542.20**	*120*	**4,192.80**	*4*	**653.08**	+T

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
3088	Hydroxyapetite insertion (Additional to tariff code 3087)	+	40	1,397.60	40	1,397.60	5	816.35	+T
3089	Subconjunctival injection if not done at time of operation		10	349.40	10	349.40	5	816.35	+T
3091	Retrobulbar injection (if not done at time of operation)		16	559.04	16	559.04	4	653.08	+T
3092	External laser treatment for superficial lesions		53	1,851.82	53	1,851.82			
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumoretinopexy		130	4,542.20	120	4,192.80	7	1142.89	+T
3097	Anterior vitrectomy		280	9,783.20	224	7,826.56	6	979.62	+T
3098	Removal of silicon from globe		280	9,783.20	224	7,826.56	6	979.62	+T
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement Cannot be used with tariff code 3097		419	14,639.86	335.2	11,711.89	6	979.62	+T
3100	Lensectomy done at time of posterior vitrectomy		30	1,048.20	30	1,048.20	7	1142.89	+T
16.8	**Orbit**								
3101	Drainage of orbital abscess		105	3,668.70	105	3,668.70	5	816.35	+T
3104	Removal orbital prosthesis		212.7	7,431.74	170.16	5,945.39	5	816.35	+T
3105	Exenteration		275	9,608.50	220	7,686.80	5	816.35	+T
3107	Orbitotomy requiring bone flap		393	13,731.42	314.4	10,985.14	5	816.35	+T
3108	Eye socket reconstruction		206	7,197.64	164.8	5,758.11	5	816.35	+T
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously		300	10,482.00	240	8,385.60	5	816.35	+T
3110	Second stage hydroxyapetite implantation		110	3,843.40	110	3,843.40	5	816.35	+T
16.9	**Cornea**								
3111	Contact lenses: Assessment involving preliminary fittings and tolerance		15	524.10	10	349.40			
3112	Fitting of contact lens for treatment of disease including supply of lens. Bandage contact lens in pathological corneal conditions such as:Corneal erosion, Ulcer, Abrasion or Corneal wound.		12	419.28	12	419.28			
3113	Fitting of contact lenses and instructions to patient: Includes eye examination, first fittings of the contact lenses and further post-fitting visits for one year		200	6,988.00	160	5,590.40			
3115	Fitting of only one cantact lens and instructions to the patient: Eye examination, first fitting of the contact lens and further post-fitting visits for one year included		166	5,800.04	132.8	4,640.03			
3116	Astigmatic correction with T cuts or wedge resection in pathological corneal astigmatism following trauma, intra ocular surgery or penetrating keratoplasty		135.2	4,723.89	120	4,192.80	6	979.62	+T

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

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

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

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

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
17.6	**Microsurgery of the skull base**								
	Note: Skull base surgery, used for the management of lesions, often requires the skills of medical doctors of different disciplines working together during the operation. The procedures are categorised in three parts: **1.** The approach in order to expose the area in which the lesion is situated. **2.** The definitive procedure which involves the repair, biopsy, resection or excision of the lesion. It also involves the primary closure of the dura, mucous membranes and skin. **3.** Repair/reconstruction procedure: Is coded separately if extensive dural grafting cranioplasty, local or regional myocutaneous pedical flaps, or extensive skin grafts are performed. **Note:** codes for repair and closure with local, pedicled or free flaps and grafts can be found in the relevant sections of the coding structure								
17.6.1	**Middle fossa approach (i.e. transtemporal or supralabyrinthine)**								
3229	Facial nerve : Exploration of the Labyrinthine segment.		*420*	**14,674.80**	*336*	**11,739.84**	*5*	**816.35**	+T
5221	Facial Nerve: Grafting of labyrinthine segment (graft removal and exploration of labynthine segment are included)		*510*	**17,819.40**	*408*	**14,255.52**	*11*	**1795.97**	+T
5222	Facial nerve surgery inside the internal auditory canal (if grafting is required, the grafting and harvesting of graft are included)		*620*	**21,662.80**	*496*	**17,330.24**	*11*	**1795.97**	+T
17.6.7	**Subtotal petrosectomy**								
5247	Petrous apicectomy: Includes radical mastoidectomy through postaural or endaural incision		*480*	**16,771.20**	*384*	**13,416.96**	*11*	**1795.97**	+T

			Specialist		General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
			Confined to specialist in Physical Medicine		Other Specialists and General Practitioner		Anaesthetic		
			U	R	U	R	U	R	T
18.	**PHYSICAL TREATMENT**								
3279	Domiciliary or nursing home treatment (only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient)	+	0.75	26.21					
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)		13.5	471.69					
3281	Ultrasonic therapy		10	349.40					
3282	Shortwave diathermy		10	349.40					
3284	Sensory nerve conduction studies		31	1,083.14					
3285	Motor nerve conduction studies		26	908.44					
3287	Spinal joint and ligament injection		20	698.80	20	698.80			
3288	Epidural injection (Other specialists/General practitioners use tariff code 2801)		36	1,257.84					
3289	Multiple injections - First joint		7.5	262.05					
3290	Each additional joint	+	4.5	157.23					
3291	Tendon or ligament injection		9	314.46					
3292	Aspiration of joint or interarticular injection		9	314.46					
3293	Aspiration or injection of bursa or ganglion		9	314.46					
3294	Paracervical (neck) nerve block		20	698.80	20	698.80			
3295	Paravertebral root block - unilateral		20	698.80		-			
3296	Paravertebral root block - bilateral		30	1,048.20					
3297	Manipulation of spine performed by a specialist in Physical Medicine (Pr "034")		14	489.16					
3298	Spinal traction		6	209.64					
3299	Manipulation large joint under general anaesthetic-Anaesthetic: Knee/Shoulder		14	489.16			3	489.81	Hip+T
3299a	Manipulation of large Joints:Under general anaesthesia-Anaesthetic: Hip						4	653.08	Knee / Shoulder + T
3300	Manipulation of large joints without anaesthetic		*		*	*			
3301	Muscle fatigue studies		20	698.80					
3302	Strength duration curve per session		10.5	366.87					
3303	Electromyography		75	2,620.50					
3304	All other physical treatments carried out: Complete physical treatment: Specify treatment (for subsequent treatments by a general practitioner, for the same condition within 4 months after intial treatment: A fee for the treatment only is applicable: See Rules L and M)		10	349.40	10	349.40			