DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 927 OF 2022

DENTAL GAZETTE 2022

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

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Thembelani Waltermade Nxesi, Minister of Employment & Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from **1 April 2022.**

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

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

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

Kommunikasie-en-inligtingstelsel • Dithaeletsano tsa Puso • Tekuchumana faHulumende • EzokuXhumana koMbuso • Dikgokahano tsa Mmuso
Vhudzhiidzani ha Muvhuso • Dikgokagano tsa Mmuso • iiNkonzo zoNxibeleleiwano lukaRhulumente • Vuhlanganisi bya Mfumo • UkuThintanisa koMbuso

Batho Pele - putting people first

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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

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

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

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

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

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

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

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

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

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

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

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

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

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

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

BILLING PROCEDURE

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

   1.1 Medical reports should always have a clear and detailed clinical description of injury.
   1.2 A progress medical report covering a period of 30 days will be required, with an exception where a procedure was performed during that period.
   1.3 In a case where a procedure is done, an operation report is required.
   1.4 Only one medical report is required when multiple procedures are done on the same service date.
   1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
   1.6 Referrals to another medical service provider should be indicated on the medical report.

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

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.

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

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

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

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

6. Service providers should not generate the following:

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

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

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

MINIMUM REQUIREMENTS FOR INVOICES RENDERED

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

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

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

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

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

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

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

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

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

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

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

	DENTAL SERVICES TARIFF OF FEES AS FROM 1 APRIL 2022
	GENERAL RULES
RULE	**DESCRIPTION**
	The following Rules apply to all practitioners
001	Code 8101 refers to a Full Mouth Examination, charting and treatment planning and no further examination fees shall be chargeable for an oral examination (code 8101) or comprehensive examination (code 8102) until the treatment plan resulting from these type of examinations is completed. This includes the issuing of a prescription where only medication is prescribed. Item code 8104 refers to a consultation for a specific problem and not to a full mouth examination, charting and treatment planning. This includes the issuing of a prescription where only medication is prescribed.
003	In the case of a prolonged or costly dental service or procedure, the dental practitioner shall ascertain beforehand from the Commissioner whether financial responsibility in respect of such treatment will be accepted.
004	In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a practitioner, such higher fee as may be mutually agreed upon between the dental practitioner and the Commissioner may be charged and Rule 004 must be indicated together with the tariff code.
005	Except in exceptional cases the service of a specialist shall be available only on the recommendation of the attending dental or medical practitioner. Referring practitioners shall indicate to the specialist that the patient is being treated in terms of the Compensation for Occupational Injuries and Diseases Act
007	"Normal consulting hours" are between 08:00 and 17:00 on weekdays, and between 08:00 and 13:00 on Saturdays
008	A dental practitioner shall submit his or her invoice for treatment to the employer of the employee concerned and to the Compensation Fund.
009	Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment that is not listed in the schedule for dentists in general practice . Benefits in respect of specialists charging treatment procedures not listed in the schedule for that specialty, shall be allocated as follows : General Dental Practitioners Schedule 100% Other Dental Specialists Schedules 2/3
010	Fees charged by dental technicians for their services (PLUS L) shall be indicated on the dentist's invoice against the code 8099. Such dentist's invoice shall be accompanied by the actual invoice of the dental technician (or a copy thereof) and the invoice of the dental technician shall bear the signature of the dentist (or the person authorised by him) as proof that it has been compiled correctly. "L" comprises the fee charged by the dental technician for his services as well as the cost of gold and of teeth. For example, code 8231 is specified as follows (gold only applicable with prior authorization) Rc 8231 ..... X 8099(8231) ..... Y Total ..... R(X+Y)
011	Modifiers. Modifiers may only be used where (M/W) appears against the item code in the schedule **8001** Assistant surgeon - specialist (1/3 of the appropriate benefit) **8002** Specialist fee/benefit (Plus 50% of the appropriate benefit) **8005** Maximum multiple procedures (same incision) - MFO surgeon **8006** Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit) **8007** Assistant surgeon - general dental practitioner (15% of the appropriate benefit) **8008** Emergency surgery - after hours (PLUS 25% of the appropriate benefit) **8009** Multiple surgical procedures - second procedure (75% of the appropriate benefit) **8010** Open reduction (PLUS 75% of the appropriate benefit)
012	In cases where treatment is not listed in the schedule for dentists in general practice or specialists, the appropriate fee listed in the medical schedules shall be charged and the relevant code in the medical schedules indicated
013	Cost of material (VAT inclusive): This item provides for the charging of material costs where indicated against the relative item codes by the words "(See Rule 013)". Material should be charged for at cost plus a handling fee not exceeding 35%, up to **R4876.67**. A maximum handling fee of 10% shall apply above a cost of **R4876.67**. A maximum handling fee of **R7314.88** will apply Note: Item 8220 (suture) is applicable to all registered practitioners.
EXPLANATIONS	**DESCRIPTION**
Additions, deletions and revisions	
	A summary listing all additions, deletions and revisions applicable to this Schedule is found in Appendix A.New codes added to the Schedule are identified with the symbol * placed before the code. In instances where a code has been revised, the symbol * is placed before the code
Tooth identification and designation of areas of the oral cavity:	
	Tooth identification and designation of areas of the oral cavity is compulsory for all invoices rendered. Tooth identification is applicable to procedures identified with the letter (T), and other designation of areas of the oral cavity with the letter (Q) for a quadrant and the letter (M) for the maxillary or mandibular area in the mouth part (MP) column of the Dental Coding. The International Standards Organisation (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used. For supernumeraries, the abbreviation SUP should be used.
Treatment categories:	
	Treatment categories (TC) of dental procedures are identified in the TC column of the Dental Coding as follows:
	Basic dentistry - designated as (B) in the treatment category column Advanced dentistry - designated as (A) in the treatment category column Surgery - designated as (S) in the treatment category column

Abbreviations used in Dental Coding	
	DM - Direct Material Column +D - Add fee for denture + L - Add laboratory fee + M - Add material fee
MP - Mouth Part Column	
	M- Maxilla/ Mandible Q - Quadrant S- Sextant T- Tooth
TC - Treatment Category Column	
	A - Advanced Dentistry B - Basic Dentistry S - Surgery
Practice type codes:	
	5400 General Dental Practitioner 6200 Specialist Maxillo Facial and Oral Surgeon 9400 Specialist Prosthodontist
VAT	
	Fees are VAT exclusive
	I. GENERAL DENTAL PRACTITIONERS
(1).	**PREAMBLE** The dental procedure codes for general dental practitioners are divided into twelve (12) categories of services. The procedures have been grouped according to the category with which the procedures are most frequently identified. The categories are created solely for convenience in using the Schedule and should not be interpreted as excluding certain types of Oral Care Providers from performing or reporting such procedures. These categories are similar to that in the *"Current Dental Terminology" Third Edition (CDT-3).*
(2). (M/W)	Procedures not described in the general practitioner's schedule should be reported by referring to the relevant specialist's schedule. Dentists in general practice shall be entitled to charge two-thirds of the fees of specialists only for treatment codes that are not listed in the schedule for dentists in general practice.(See Rules 009 and 011).
(3). (M/W)	Oral and maxillofacial surgery (Section J of the Schedule): The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum (see Modifier 8007). The Compensation Fund must be informed beforehand that another dentist will be assisting at the operation and that a fee will be payable to the assistant. The assistant's name must appear on the invoice rendered to the Compensation Fund.

I	**GENERAL DENTAL PRACTITIONERS**						
Code	**Procedure description**	**DM/+**	**MP**	**TC**	**General Dental Practice**	**Maxillo-facial and Oral Surgery**	**Prosthodontics**
A. DIAGNOSTIC							
8101	Oral examination (charting and treatment planning (see Rule 001)			B	**320.72**	-	-
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 001).						
8102	Comprehensive oral examination			B	**418.64**	-	-

	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A omprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ).The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 001)						
8104	Examination or consultation for a specific problem not requiring a full mouth examination, charting and treatment planning			B	**126.63**	-	-
	An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment. Comment: This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g.,recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.						
Radiographs / Diagnostic imaging							
8107	Intraoral radiograph - periapical			B	**122.36**	**122.36**	**122.36**
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.						
8108	Intraoral radiographs - complete series			B	**920.27**	**975.92**	**975.92**
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded						
8112	Intraoral radiograph - bitewing			B	**122.36**	**122.36**	**122.36**
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.						
8113	Intraoral radiograph - occlusal			B	**190.62**	**190.62**	**190.62**
8115	Extraoral radiograph - panoramic			B	**503.76**	**503.76**	**503.76**
8116	Extraoral radiograph - cephalometric			B	**503.76**	**503.76**	**503.76**
8118	Extraoral radiograph - skull/facial bone			B	**503.76**	**503.76**	**503.76**
OTHER DIAGNOSTIC PROCEDURES							
8117	Diagnostic models	+L		B	**137.49**	**137.67**	**137.67**
	Also known as study models or diagnostic casts.Models used to aid diagnosis and treatment planning. Diagnostic models should be retained as part of the patient's clinical record and may only be used for diagnostic purposes. Includes diagnostic models mounted on a hinge articulator.						
8119	Diagnostic models mounted	+L		B	**353.50**	**353.50**	**353.50**
	See code 8117. Report this code when models are mounted on a movable condyle articulator.						
8121	Oral and/or facial image (digital/conventional)			B	**137.49**	**137.67**	**137.67**
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.						

B. PREVENTIVE							
C. RESTORATIVE							
AMALGAM RESTORATIONS(including polishing)							
	All adhesives, liners and bases are included as part of the restoration. If pins are used, they should be reported separately.						
8341	Amalgam - one surface		T	B	**327.31**	-	-
8342	Amalgam - two surfaces		T	B	**409.73**	-	-
8343	Amalgam - three surfaces		T	B	**492.33**	-	-
8344	Amalgam - four or more surfaces		T	B	**490.97**	-	-
RESIN-BASED COMPOSITE RESTORATIONS							
Resin refers to a broad category of materials including but not limited to composites and may include bonded composite, light -cured							
8351	Resin - one surface, anterior		T	B	**320.14**	-	-
8352	Resin - two surfaces, anterior		T	B	**408.95**	-	-
8353	Resin - three surfaces, anterior		T	B	**540.80**	-	-
8354	Resin - four or more surfaces, anterior		T	B	**600.51**	-	-
	Use to report the involvement of four or more surfaces or the incisal line angle. The Incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.						
8367	Resin one surface, posterior		T	B	**387.04**	-	-
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth.						
8368	Resin two surfaces, posterior		T	B	**530.33**	-	-
8369	Resin three surfaces, posterior		T	B	**578.42**	-	-
8370	Resin - four or more surfaces, posterior		T	B	**613.51**	-	-
Inlay / Onlay restorations							
METAL INLAYS/ONLAYS							
8361	Inlay, metallic - one surface, posterior	+L	T	A	**656.36**	-	**984.54**
8362	Inlay/onlay - metal - two surfaces	+L	T	A	**849.10**	-	**1 273.65**
8363	Inlay/onlay - metal - three surfaces	+L	T	A	**1 751.12**	-	**2 626.68**
8364	Inlay/onlay - metal - four or more surfaces	+L	T	A	**1 751.32**	-	**2 626.98**
CERAMIC AND / OR RESIN INLAYS							
Porcelain / ceramic inlays include either all ceramic or porcelain inlays. Composite / resin inlays must be laboratory processed							
8371	Inlay - porcelain - one surface	+L	T	A	**594.31**	-	**891.47**
8372	Inlay/onlay - porcelain - two surfaces	+L	T	A	**868.29**	-	**1 302.44**
8373	Inlay/onlay - porcelain - three surfaces	+L	T	A	**1 449.04**	-	**2 173.56**
8374	Inlay/onlay - porcelain - four or more surfaces	+L	T	A	**1 751.32**	-	**2 626.98**
CROWNS-SINGLE RESTORATIONS							
	Use these codes for single crown restorations. See the Fixed Prosthodontic Service section for crown bridge retainers and the						
8401	Crown - full cast metal	+L	T	A	**2 079.97**	-	**2 885.44**
8403	Crown - 3/4 cast metal	+L	T	A	**2 079.97**	-	**2 885.44**
8404	Crown - 3/4 porcelain/ceramic	+L	T	A	**2 079.97**	-	**2 885.44**
8405	Crown - resin laboratory	+L	T	A	**2 079.97**	-	**2 885.44**
	Refers to all resin-based crowns that are indirectly fabricated. All fiber, porcelain or ceramic reinforced polymer materials/systems are considered resin-based crowns						
8407	Crown - resin with metal	+L	T	A	**2 220.36**	-	**3 211.77**
8409	Crown - porcelain/ceramic	+L	T	A	**2 220.36**	-	**2 885.44**
8411	Crown - porcelain with metal	+L	T	A	**2 220.36**	-	**3 602.87**
Other restorative							
8133	Recement inlay, onlay, crown or veneer.		T	B	**190.62**	-	**285.93**
	Use to report the recementation of a permanent single inlay, onlay, crown or veneer. See code 8514 in the Fixed Prosthodontic Section for the recementation of a bridge retainer. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration.						
8135	Removal of inlays and crowns (per unit) and bridges (per abutment) or sectioning of a bridge, part of which is to be retained as a crown following the failure of a bridge		T	A	**374.43**	-	**374.43**
	This procedure involves the removal of a permanent inlay, onlay or crown. Comment: This code may not be used for the removal of temporary or provisional restorations, which is included as part of the restoration						
8137	Emergency crown (chair-side)	+L	T	A	**640.47**	-	**640.47**

	A temporary crown, usually made of resin and in the surgery, which is fitted over a damaged tooth for the immediate protection in tooth injury. Includes emergency crowns manufactured for the replacement of previously fitted, lost or damaged permanent crowns. Comment: This code should not be used as an interim restoration during restorative treatment and should not be reported on the same day on which an impression is taken to replace a previously fitted lost or damaged permanent crown.						
8330	Removal of root canal obstruction		T	B	**250.73**	-	-
	This procedure involves the treatment of a non-negotiable root canal blocked by foreign bodies (e.g.,removal and/or bypassing of a fractured instrument) or calcification of 50% or more of a root to achieve an apical seal and forego surgical treatment – Report per canal. This code may be submitted by the servicing provider and on the same day as a root canal therapy if the obstruction is not iatrogenic by that provider.						
8345	Prefabricated post retention, per post (in addition to restoration)		T	B	**276.90**	-	-
	Should not be used with codes 8398 or 8376 (Core build-ups) Remuneration excludes cost of posts – See code 8379						
8347	Pin retention - first pin (in addition to restoration)		T	B	**190.62**	-	-
	Should not be used with codes 8398 or 8376 (Core build-ups).						
8348	Pin retention - each additional pin (in addition to restoration)		T	B	**164.63**	-	-
	Should not be used with codes 8398 or 8376 (Core build-ups). Limitation: A maximum of two additional pins may be levied.						
8355	Veneer - resin (chair-side)		T	B	**607.11**	-	**607.11**
	Involves direct layering of material over tooth. No laboratory processing.						
8357	Prefabricated metal crown		T	B	**403.13**	-	**403.13**
	Includes all preformed metal crowns e.g. stainless steel, nickel-chrome and gold anodised crowns, with or without resin window.						
8366	Pin retention as part of cast restoration, irrespective of number of pins		T	A	**294.35**	-	**441.53**
8376	Core build-up with prefabricated posts		T	B	**982.50**	-	**982.50**
	The direct build-up of a mutilated crown around a prefabricated post to provide a rigid base for retention of a crown restoration. This procedure includes posts and core material. Remuneration excludes cost of posts – See code 8379.						
8379	Cost of prefabricated posts - add on to 8376		T	A	Rule 013	-	Rule 013
	Applicable to pre-fabricated noble metal, ceramic, iridium and titanium posts – see code 8345 and 8376.						
8391	Cast core with single post	+L	T	A	**446.17**	-	-
	Report in addition to crown.						
8392	Cast post (each additional)	+L	T	A	**357.00**	-	-
	To be used with 8391 for each additional cast posts on the same tooth.						
8397	Cast core with pins (any number of pins)	+L	T	A	**714.15**	-	**1 071.23**
	The cast core with pins is intended to be used on grossly broken down vital teeth. Report in addition to crown.						
8398	Core build -up, including any pins Refers to the building up of an anatomical crown when a restorative crown will be placed, irrespective of the number of pins used.		T	B	**714.15**	-	**714.15**
	The direct build-up of a mutilated crown to provide a rigid base for retention of a crown restoration irrespective of the number of pins used. This code should not be reported when the procedure only involves a filler to eliminate any undercut, concave irregularity in the preparation, etc.						
8413	Repair crown (permanent or provisional)	+L	T	A	**436.02**	-	**436.02**
	This procedure involves the repair of a permanent crown (e.g. facing replacement). Excludes the removal (8153) and recementation (8133) of the crown. This code may also be reported for the repair/replacement of a provisional crown (8410) after a period of two months. This code may not be used for the repair/replacement of a temporary restorations, which is included as part of the restoration						
8414	Additional fee for provision of a crown within an existing clasp or rest	+L	T	A	**136.73**	-	-

D. ENDODONTICS

* Preamble:

1.The Health Professions Council of SA has ruled that, with the exception of diagnostic intra -oral radiographs, fees for only three further intra -oral radiographs may be charged for each completed root canal therapy on a single -canal tooth; or a further five intra -oral radiographs for each completed root canal therapy on a multi -canal tooth

2. The fee for the application of a rubber dam (See code 8304 in the category "Adjunctive General Services ") may only be charged concurrent with the following procedures:

- Gross pulpal debridement, primary and permanent teeth, for the relief of pain (code 8132
- Apexification of a root canal (code 8305)'
- Ceramic and or resin inlays (codes 8371 to 8374)
- Pulpotomy (code 8307)- Complete root canal therapy (codes 8328, 8329 and 8332 to 8340)
- Removal or bypass of a fractured post or instrument (code 8330).
- Bleaching of non vital teeth (codes 8325 and 8327) and
- Ceramic and or resin inlays (codes 8371 to 8374)

3. After endodontic preparatory visits (codes 8332, 8333 and 8334) have been charged, fees for endodontic treatment completed at a single visit (codes 8329, 8338, 8339 and 8340) may not be levied

4. Where code 8132 is charged, no other endodontic procedures may be charged at the same visit on the same tooth. Codes 8338, 8329, 8339 and 8340 (single visit) may be charged at the subsequent visit, even if code 8132 was used for the initial relief of pain.

5.No other endodontic procedure may, in respect of the same tooth, be charged concurrent to code 8307 and a completed root canal therapy should not be envisaged (code 8304 excluded)

PULP CAPPING							
8301	Direct pulp capping		T	B	**231.41**	-	-
	This procedure involves the covering of the exposed dental pulp with a pretective material to stimulate repair of the injured pulpal tissue. Excludes the final restoration.						
8303	Indirect pulp capping The permanent filling is not completed at the same visit		T	B	**231.41**	-	-
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.						
PULPOTOMY							
8307	Amputation of pulp (pulpotomy)		T	B	**148.92**	-	-
	This procedure involves the removal of a portion of the tooth's pulp and the placement of a medicament to fix or modify the superficial pulp tissue. Excludes the final restoration. This code should not be used as the first stage of root canal therapy and may not be reported with other root canal therapy codes on the same tooth. Report code 8304 (application of a rubber dam) in addition to this code						
8132	Pulp removal (pulpectomy)		T	B	**307.92**	-	-
	This procedure involves the removal of the complete pulp from the pulp chamber and root canal(s) for the relief of acute pain prior to root canal therapy. The code is intended to be used for the emergency treatment of acute pain and should not be reported as the first stage of scheduled endodontic treatment. The practitioner reappoints the patient for complete root canal theray at a later date. Report code 8304 (application of a rubber dam) in addition to this code.						
ENDODONTIC THERAPY (including the treatment plan, clinical procedures and follow -up care)							
	Does not include diagnostic evaluation and necessary radiographs/ diagnostic images. Limitation: Intra-operative radiographs/ diagnostic images are limited to three on a single canal tooth and five on a multi-canal tooth for each completed endodontic therapy. Report code 8304 (application of a rubber dam) in addition to these codes						
Preparatory Visits (Obturation not done at same visit)							
8332	Root canal preparatory visit - single canal tooth		T	B	**190.62**	-	-
	Limitation: A maximum of four visits per tooth may be charged.						
8333	Root canal preparatory visit - multi canal tooth		T	B	**464.78**	-	-
	Limitation: A maximum of four visits per tooth may be charged.						
Obturation of canals at a subsequent visit							
	Codes 8328, 8335, 8336 and 8337 (obturation of root canals at a subsequent visit) are intended to be used in conjunction with codes 8332, 8333 and 8334 (endodontic preparatory visits and repreparation of previously obturated canal).						
8335	Root canal obturation - anteriors and premolars - first canal		T	B	**868.49**	-	-
8328	Root canal obturation - anteriors and premolars - each additional canal		T	B	**334.29**	-	-
8336	Root canal obturation - posteriors - first canal		T	B	**1 193.27**	-	-
8337	Root canal obturation - posteriors - each additional canal		T	B	**353.50**	-	-
Complete Therapy (Preparation and obturarion of root canals completed at a single visit)							
	Codes 8329, 8338, 8339 and 8340 (endodontic treatment completed at a single visit) may not be used with codes 8332, 8333 and 8334 (endodontic preparatory visits and re-preparation of previously obturated canal).						

8338	Root canal therapy - anteriors and premolars - first canal		T	B	1 325.12	-	-
8329	Root canal therapy - anteriors and premolars - each additional canal		T	B	421.16	-	-
8339	Root canal therapy - posteriors - first canal		T	B	1 820.13	-	-
8340	Root canal therapy - posteriors - each additional canal		T	B	443.85	-	-
ENDODONTIC RETREATMENT							
8334	Re- preparation of previously obturated canal, per canal		T	B	281.94	-	422.91
	This procedure includes the removal of old root canal filling material and the procedures necessary to prepare the canals to place the canal filling. Report 8334 per canal. See codes 8328, 8335, 8336 and 8337 for the obturation of root canals. This procedure excludes the removal of endodontic posts (code 8330). Report code 8304 (application of a rubber dam) in addition to this code. Note (Applicable to prosthodontist only): Procedure codes 8631, 8633 and 8334 include all X-rays and repeat visits.						
9015	Apicectomy including retrograde root filling where necessary anterior tooth		T	S	931.67	1 397.44	1 397.44
9016	Apicectomy including retrograde root filling where necessary posterior tooth		T	S	1 391.77	2 797.99	2 087.55
Other endodontic procedures							
8136	Access through a prosthetic crown or inlay to facilitate root canal treatment		T	B	148.54	-	-
8325	Bleaching of non -vital teeth, per tooth as a separate procedure		T	A	429.70	-	429.70
8327	Each additional visit for bleaching of non -vital tooth as a separate procedure		T	A	204.19	-	204.19
E. PERIODONTICS							
F. PROSTHODONTICS (REMOVABLE)							
8231	Full upper and lower dentures inclusive of soft base or metal base, where applicable	+L	M	B	3 033.01	-	4 549.52
8232	Full upper or lower dentures inclusive of soft base or metal base, where applicable.	+L	M	B	1 869.40	-	2 804.10
8643	Complete dentures - maxillary and mandibular (with complications)	+L		B	-	-	9 360.76
8645	Complete upper and lower dentures with major complications	+L		B	-	-	11 513.24
8649	Complete denture - maxillary or mandibular (with complications)	+L	M	B	-	-	5 764.29
8651	Complete upper or lower denture with major complications	+L	M	B	-	-	6 482.70
PARTIAL DENTURES (including routine post -delivery care)							
8233	Partial denture, one tooth	+L	M	B	868.29	-	-
8234	Partial denture, two teeth	+L	M	B	868.29	-	-
8235	Partial denture, three teeth	+L	M	B	1 297.97	-	-
8236	Partial denture, four teeth	+L	M	B	1 297.97	-	-
8237	Partial denture, five teeth	+L	M	B	1 297.97	-	-
8238	Partial denture, six teeth	+L	M	B	1 730.19	-	-
8239	Partial denture, seven teeth	+L	M	B	1 730.19	-	-
8240	Partial denture, eight teeth	+L	M	B	1 730.19	-	-
8241	Partial denture, nine or more teeth	+L	M	B	1 730.19	-	-
8281	Metal (e.g. chrome cobalt, etc.) base to partial denture, per denture.	+L	M	B	2 309.95	-	-
	The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e., 8251, 8253, 8255 and 8257). See codes 8233 to 8241 for the resin denture base required concurrent to 8281						
8671	Metal (e.g. Chrome cobalt or gold) partial denture	+L	M	A	-	-	5 764.29
Adjustments to dentures							
8275	Adjust complete or partial denture				131.09	-	133.79
	After six months or for patient of another practitioner						
8662	Remounting and occlusal adjustment of dentures	+L		B	-	-	829.71
Repairs to complete or partial dentures							
	Professional fees should not be levied for the repair of dentures/intra-oral appliances if the practitioner did not examine the patient. Laboratory costs, however, may be recovered.						
8269	Repair of denture or other intra -oral appliance	+L	M	B	248.70	-	292.21
	See code 8273 (Impression to repair/modify a denture)						
8270	Add clasp to existing partial denture (One or more clasps) Code 8270 is in addition to code 8269.	+L	M	B	164.63	-	-
	One or more clasps. Code 8270 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).						
8271	Add tooth to existing partial denture (One or more teeth) Code 8271 is in addition to code 8269.	+L	M	B	164.63	-	-

	One or more teeth. Code 8271 may be reported in addition to code 8269. See code 8273 (Impression to repair/modify a denture).						
8273	Impression to repair or modify a denture or other intra-oral appliance	+L		B	131.06	-	133.79
	May be reported in addition to the appropriate code in this subsection when an impression is required. Includes any number of impressions.						
DENTURE REBASE PROCEDURES							
	Rebase – The partial or complete removal and replacement of the denture base.						
8259	Re -base of denture (laboratory)	+L	M	B	714.15	-	1 071.23
8261	Re -model of denture	+L	M	B	1 172.72	-	-
DENTURE RELINE PROCEDURES							
	Reline - The addition of material to the fitting surface of a denture base						
8263	Reline of denture in selfcuring acrylic (intra -oral)		M	B	446.17	-	669.26
8267	Reline complete or partial denture (laboratory)	+L	M	B	1 029.43	-	1 029.43
	Soft base re -line per denture (heat cured) Code 8267 may not be charged concurrent with codes 8231 to 8241						
OTHER REMOVABLE PROSTHETIC PROCEDURES							
8255	Stainless steel clasp or rest, per clasp or rest	+L		B	179.17	-	-
	Codes 8255, 8257 may not be charged concurrent with codes 8269 (repair of denture) or 8281 (metal framework).						
8257	Lingual bar or palatal bar	+L	M	B	216.79	-	-
8265	8265 Tissue conditioner and soft self -cure interim re -line, per denture				296.29	-	444.44
G. MAXILLOFACIAL PROSTHETICS							
H. IMPLANT SERVICES							
J. ORAL AND MAXILLOFACIAL SURGERY							
EXTRACTIONS							
8201	Extraction - tooth or exposed tooth roots (first per quadrant)		T	B	190.62	285.93	-
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.						
8202	Extraction - each additional tooth or exposed tooth roots		T	B	87.45	131.18	-
	To be reported for an additional extraction in the same quadrant at the same visit.						
SURGICAL EXTRACTIONS (includes routine postoperative care)							
8213	Surgical removal of residual tooth roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.		T	S	845.41	-	-
	This procedure requires mucoperiosteal flap elevation with bone removal, removal of tooth roots and closure. Report per tooth. The removal of more than one root of the same tooth should be reported as one surgical removal. A residual root is defined as the remaining root structure following the loss of the major portion (over 75%) of the crown.						
8214	Surgical removal of residual tooth roots (cutting prcedure), each subsequent tooth		T	S	599.15	-	-
8937	Surgical removal of tooth		T	S	575.54	863.26	-
	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap, removal of bone and / or other section of tooth. Includes cutting of gingiva and bone, removal of tooth structure and closure. Code 8220 is applicable when suture material is provided by the practitioner (Rule 013)						
8953	Surgical removal of residual roots roots (cutting procedure) Includes cutting of gingiva and bone, removal of tooth structure and closure.		T	S	-	1 241.36	-
K. ORTHODONTICS							
L. ADJUNCTIVE GENERAL SERVICES							
MISCELLANEOUS SERVICES							
8131	Palliative [emergency] treatment for dental pain This is typically reported on a "per visit" basis for emerency treatment of dental pain where no other treatment item is applicable or applied for treatment of the same tooth		T	B	190.62	-	285.93

	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative -report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).						
ANAESTHESIA							
8141	Inhalation sedation - first 15 minutes or part thereof			B	**168.89**	-	-
8143	Inhalation sedation - each additional 15 minutes			B	**91.33**	-	-
	No additional fee/benefit to be charged for gases used in the case of items 8141 and 8143.						
8144	Intravenous sedation			B	**88.81**	-	-
8145	Local anaesthetic, per visit Code 8145 includes the use of the wand			B	**41.70**	**41.70**	**41.70**
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.						
8499	General anaesthetic			B			
	The relevant codes published in the Government Gazette for Medical Practitioners shall apply to general anaesthetics for dental procedures						
PROFESSIONAL VISITS							
8129	Office/hospital visit – after regularly scheduled hours			B	**461.10**	-	-
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.						
8140	House/extended care facility/hospital call			B	**294.15**	-	-
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan						
Drugs, medication and materials							
8183	Intra- muscular or sub -cutaneous injection therapy, per injection (Not applicable to local anaesthetic)			B	**79.50**	-	-
8220	Use of suture material provided by practitioner			B	Rule 013	Rule 013	
8109	Infection control, per dentist, per hygienist, per dental assistant, per visit Code 8109 includes the provision by the dentist of new rubber gloves, masks, etc. for each patient				**28.12**	**28.12**	**28.12**
8110	Provision of sterilized and wrapped instrumentation in consulting rooms .The use of this code is limited to heat, autoclave or vapour sterilised and wrapped instruments				**79.32**	**79.32**	**79.32**
8304	Rubber dam, per arch (Refer to the guidelines for the application of a rubber dam in the preamble to the category D "Endodontics ")				**140.01**	-	**140.01**
8306	Cost of Mineral Trioxide Aggregate			B	Rule 013	-	Rule 013
II	**SPECIALIST PROSTHODONTIST**						
	A. DIAGNOSTIC PROCEDURES						
8501	Consultation - Prosthodontist			B	-	-	**353.50**
8503	Occlusal analysis on adjustable articulator			A	**482.07**	-	**723.07**
8505	Pantographic recording			A	**703.25**	-	**1 054.82**
8506	Detailed consultation - Prosthodontist			A	-	-	**1 172.92**
	Detailed clinical examination, recording, radiographic interpretation, diagnosis, treatment planning and case presentation. Note: Code 8506 is a separate procedure from 8507 and is applicable to craniomandibular disorders, implant placement or orthognatic surgery where extensive restorative procedures will be required						
8507	Comprehensive consultation - Prosthodontist			A	-	-	**723.07**

	Examination, diagnosis and treatment planning						
8508	Electrognathographic recording			A	782.37	-	1 173.50
8509	Electroganathographic recording with computer analysis.			A	1 254.22	-	1 881.24
B. Preventive procedures							
C. Treatment procedures							
8514	Recement bridge		T	B	184.61		276.90
	Use to report the recementation of a permanent inlay-, onlay-, or crown retainer - reported per retainer. May be used to report the recementation of a Maryland bridge. Report code 8133 for the recementation of a single permananet inlay, onlay or crown. Comment: This code may not be used for the recementation of temporary or provisional restorations, which is included as part of the restoration. Previously code 8133 included the recementation of bridge retainers.						
8517	Re-implantation of an avulsed tooth, including fixations as required	+L	T	S	492.79	-	739.15
Provisional treatment							
8723	Provisional splinting - extracoronal (wire) - per sextant	+L	M	A			594.31
8725	Provisional splinting - extracoronal (wire plus resin) - per sextant	+L	M	A			870.23
8727	Provisional splinting - intracoronal - per tooth	+L	T	A			276.90
8410	Provisional crown	+L	T	A	476.12	-	714.15
	The intended use of a provisional crown is to allow adequate time (of at least six weeks duration) for healing or completion of other procedures during restorative treatment and should not to be used as a temporary prosthesis.						
Occlusal adjustment							
8551	Major occlusal adjustment This procedure can not be carried out without study models mounted on an adjustable articulator.			A	550.97	-	826.42
	Comment: (1) A complete occlusal adjustment involves the grinding of teeth to the equivalent of two or more quadrants. (2) Several appointments of varying length and sedation to attain relaxation of the muscularity muscles may be necessary. Submit code 8551 for payment at the last visit if several appointments to complete the procedure are required.						
8553	Minor occlusal adjustment			A	427.00	-	640.47
	An occlusal adjustment involves the grinding of the occluding surfaces of teeth to develop harmonious relationships between each other, their supporting structures, muscles of mastication and temporomandibular joints. Comment: (1) Partial occlusal adjustment for the relief of symptomatic teeth involves the selective grinding of teeth to the equivalent of one quadrant or less. (2) Payment for this procedure is limited to one visit per treatment plan. (3) May not be submitted for the adjustment of dentures or restorations provided as part of a treatment plan (including opposing teeth).						
VENEERS							
8554	Veneer - resin (laboratory)	+L	T	A	1 388.66	-	2 082.89
	Involves an impression being taken and laboratory processing.						
Posts and copings							
8581	Cast core with single post	+L	T	A	-	-	715.66
	See also GDP code 8391						
8582	Cast core with double post	+L	T	A	-	-	1 029.43
	See also GDP code 8392						
8583	Cast core with triple post	+L	T	A	-	-	1 290.42
	See also GDP code 8392						
8587	Coping metal	+L	T	A	410.83	-	616.22
	A thimble coping may utilise pins for additional retention. Generally used to parallel an abutment tooth for bridge and splints. May be similarly used to parallel an implant abutment where implant bodies are not parallel. A dome-shaped coping is generally used on an endodontically treated abutment tooth for an overdenture.						
OTHER IMPLANT SERVICES							
8592	Crown - implant/abutment supported	+L	T	A	-	-	4 410.28
	An artificial crown that is retained, supported, and stabilised by an implant or an abutment on an implant; may be screw retained or cemented.						

8600	Cost of implant components				Rule 013	-	Rule 013
Connectors							
8597	Locks and milled rests	+L	T	A	194.82	-	292.21
8599	Precision attachments	+L	M	A	476.12	-	714.15
	Each set of male and female components should be reported as one precision attachment. Includes semi-precision attachments						
Bridges							
8611	Sanitary pontic	+L	T	A	-	-	2 176.92
8613	Posterior pontic	+L	T	A	-	-	2 682.82
8615	Anterior pontic	+L	T	A	-	-	2 885.44
Resin bonded retainers							
8617	Retainer cast metal (Maryland type retainer)	+L	T	A	592.59	-	888.84
	Use for Maryland type bridges; Report per retainer (see codes 8611, 8613, 8615)						
Endodontic procedures							
8631	Root canal therapy, first canal		T	B	-	-	2 525.18
8633	Root canal therapy - each additional canal		T	B	-	-	630.96
8635	Apexification of root canal, per visit		T	B	281.18	-	421.74
8640	Removal of fractured post or instrument from root canal		T	B	-	-	738.76
8765	Hemisection of a tooth, resection of a root or tunnel preparation (isolated procedure)		T	A	785.15	-	1 177.66
	Includes separation of a multirooted tooth into separate sections containing the root and overlying portion of the crown. It may also include the removal of one or more of those sections.						
OTHER REMOVABLE PROSTHETIC PROCEDURES							
8661	Diagnostic dentures (inclusive of tissue conditioning treatment)	+L		A	-	-	5 764.29
8663	Chrome cobalt base base for full denture (extra charge)	+L	M	B	1 157.90	-	1 736.77
8664	Remount of crown or bridge for extensive prosthetics			A	563.63	-	845.41
8667	Soft base, per denture (heat cured)	+L	M	B	1 157.00	-	1 735.41
8672	Additional fee for altered cast technique for partial denture	+L	M	B	170.48	-	255.70
8674	Additive partial denture	+L	M	B	1 741.45	-	2 612.04
III	**SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS**						
	PREAMBLE						
1. (M/W)	If extractions (codes 8201 and 8202) are carried out by specialists in maxillo- facial and oral surgery, the fees shall be equal to the appropriate tariff fee plus 50 per cent (See Modifier 8002).						
2. (M/W)	The fee for more than one operation or procedure performed through the same incision shall be calculated as the fee for the major operation plus the tariff fee for the subsidiary operation to the indicated maximum **of R582.07** for each such subsidiary operation						
3. (M/W)	The fee for more than one operation or procedure performed under the same anaesthetic but through another incision shall be calculated on the tariff fee for the major operation plus: 75% for the second procedure / operation (Modifier 8009)						
4. (M/W)	The fee payable to a general practitioner assistant shall be calculated as 15% of the fee of the practitioner performing the operation, with the indicated minimum of **R295.99** (See Modifier 8007). The assistant's fee payable to a maxillo- facial and oral						
5. (M/W)	The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the fee for the procedure or procedures performed (8008).						
6.	In cases where treatment is not listed in this schedule for general practitioners or specialists, the appropriate fee listed in the medical schedule(s) shall be charged, and the relevant medical tariff code must be indicated (See Rule 012).						
III	**SPECIALIST MAXILLO- FACIAL AND ORAL SURGEONS**						**(M) See**
Code	**Procedure description**						
CONSULTATIONS AND VISITS							
8901	Consultation - MFOS			S	-	-	349.80
8902	Consultation - MFOS (detailed)			S	-	-	980.76
	Detailed clinical examination, radiographic interpretation, diagnosis, treatment planning and case presentation.Code 8902 is a separate procedure from code 8901 and is applicable to craniomandibular disorders, implant placement and orthognathic and maxillofacial reconstruction				-	-	
8903	House/Hosp/Nursing home consultation - MFOS			S	-	-	390.52
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS			S	-	-	190.62
8905	After regularly hours consultation - MFOS			S	-	-	562.31
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS			S	-	-	645.69
	Subsequent consultations, per week, to a maximum of "Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation."						
REMOVAL OF TEETH							
8957	Alveolotomy or alveolectomy - concurrent with or independent of extractions (per jaw)		M	S	1 135.81	1 703.63	-
8961	Auto -transplantation of tooth	+L		S	1 861.81	2 792.57	-

Post Surgical Complications							
8931	Local treatment of post- extraction haemorrhage (excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)			S	**623.36**	**935.00**	-
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service						
8933	Treatment of haemorrhage in the case of blood dyscrasias, e.g. hemophilia, per week			S	**2 211.62**	**3 317.26**	-
8935	Treatment of post- extraction septic socket where patient is referred by another registered practitioner			S	**165.08**	**247.61**	-
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.						
OTHER SURGICAL PROCEDURES							
8909	Closure of oral -antral fistula - acute or chronic			S	**2 170.77**	**3 255.99**	-
8911	Caldwell -Luc procedure			S	**851.66**	**1 277.42**	-
8917	Biopsies - intra -oral		M	S	**449.87**	**674.77**	-
	Incisional/excisional (e.g. epulis). This procedure does not include the cost of the essential pathological evaluations.						
8919	Biopsy of bone - needle		M	S	**827.23**	**1 240.78**	-
8921	Biopsy – extra-oral bone/soft tissue		M	S	**880.48**	**1 320.66**	-
8965	Peripheral neurectomy			S	**1 861.81**	**2 792.57**	-
8966	Functional repair of oronasal fistula (local flaps)			S	**2 636.29**	**3 954.23**	-
8962	Harvest illiac crest graft			S	**1 877.05**	**2 815.44**	-
8963	Harvest rib graft			S	**2 159.52**	**3 239.12**	-
8964	Harvest cranium graft			S	**1 688.19**	**2 532.16**	-
8977	Surgical repair of maxilla or mandible - major			S	**4 426.21**	**6 638.98**	-
	Major repairs of upper or lower jaw (i.e. by means of bone grafts or prosthesis, with jaw splintage)Modifiers 8005 and 8006 are not applicable in this instance. The full fee may be charged irrespective of whether this procedure is carried out concomitantly with procedure 8975 or as a separate procedure.						
8979	Harvesting of autogenous grafts (intra -oral)			S	**304.58**	**456.84**	-
9048	Removal of internal fixation devices, er site			S	**978.10**	**1 467.07**	-
SURGICAL PREPARATION OF JAWS FOR PROSTHETICS							
8995	Gingivectomy, per jaw	+L	M	S	**1 690.39**	**2 535.46**	-
8997	Sulcoplasty / Vestibuloplasty	+L	M	S	**4 267.59**	**6 401.06**	-
9003	Repositioning mental foramen and nerve, per side	+L	M	S	**2 586.76**	**3 879.95**	-
9004	Lateralization of inferior dental nerve (including bone grafting)			S	**5 128.80**	**7 692.82**	-
9005	Total alveolar ridge augmentation by bone graft	+L	M	S	**4 342.82**	**6 513.90**	-
9007	Total alveolar ridge augmentation by alloplastic material	+L	M	S	**2 800.33**	**4 200.29**	-
9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites.	+L	M	S	**1 789.93**	**2 684.76**	-
9009	Alveolar ridge augmentation across 3 or more tooth sites	+L	M	S	**1 996.25**	**2 994.22**	-
9010	Sinus lift procedure	+L	M	S	**2 826.32**	**4 239.27**	-
EXCISION OF BONE TISSUE							
8987	Reduction of mylohyoid ridges, per side	+L		S	**1 905.89**	**2 858.69**	-
8989	Removal torus mandibularis	+L		S	**1 905.89**	**2 858.69**	-
8991	Removal of torus palatinus	+L		S	**1 905.89**	**2 858.69**	-
8993	Reduction of hypertrophic tuberosity, per side	+L	M	S	**847.26**	**1 270.83**	-
SURGICAL INCISION							
8908	Removal of roots from maxillary antrum involving Caldwell -Luc procedure and closure of oral -antral communication			S	**2 826.32**	**4 239.27**	-
9011	Incision and drainage of pyogenic abscesses (intra -oral approach)		M	S	**531.31**	**796.93**	-
9013	*Incision & drainage of abscess - extra-oral (pyogenic)*		M	S	**722.91**	**1 084.30**	-
	E.g., Ludwig's angina.						-
9017	Decortication, saucerisation and sequestrectomy for osteomyelitis of the mandible		M	S	**3 835.95**	**5 753.63**	-
9019	Sequestrectomy - intra -oral, per sextant and / or per ramus		M	S	**826.58**	**1 239.80**	-
REPAIR OF TRAUMATIC WOUNDS							
8192	Appositioning (i.e., suturing) of soft tissue injuries			S	**955.17**	-	-

	Use to report the suturing of recent small wounds. Excludes the closure of surgical incisions.						
COMPLICATED SUTURING							
Reconstruction requiring delicate handling of tissues and undermining for meticulous closure. Excludes the closure of surgical incisions.							
9021	Suture - reconstruction, minor (excludes closure of surgical incisions)			S	**931.67**	**1 397.44**	-
9023	Suture - reconstruction, major (excludes closure of surgical incisions)			S	**1 967.04**	**2 950.41**	-
TREATMENT OF FRACTURES							
Alveolus Fractures							
9024	Dento -alveolar fracture, per sextant	+L		S	**931.67**	**1 397.44**	-
Mandibular Fractures							
9025	Treatment by closed reduction, with intermaxillary fixation			S	**2 067.08**	**3 100.47**	-
9027	Treatment of compound fracture, involving eyelet wiring			S	**2 901.69**	**4 352.31**	-
9029	Treatment by metal cap splintage or Gunning's splints	+L		S	**3 216.85**	**4 825.03**	-
9031	Treatment by open reduction with restoration of occlusion by splintage	+L		S	**4 763.73**	**7 145.24**	-
Maxillary fractures with special attention to occlusion When open reduction is required for Items 9035 and 9037, Modifier 8010 may be applied							
9035	Le Fort I or Guerin fracture	+L		S	**2 908.65**	**4 362.76**	-
9037	Le Fort II or middle third of face fracture	+L		S	**4 763.73**	**7 145.24**	-
9039	**Le Fort III** or craniofacial dislocation or comminuted mid -facial fractures requiring open reduction and splintage	+L		S	**6 829.13**	**10 243.19**	-
Zygoma / Orbit / Antral - complex fractures							
9041	Zygomatic arch fracture - closed reduction			S	**2 067.08**	**3 100.47**	-
	Gillies or temporal elevation						
9043	Zygomatic arch fracture - open reduction			S	**4 140.51**	**6 210.46**	-
	Unstable and / or comminuted zygoma fractures, treatment by open reduction or Caldwell -Luc operation						
9045	Zygomatic arch fracture - open reduction (requiring osteosynthesis and/or grafting)			S	**6 207.33**	**9 310.53**	-
9046	Placement of zygomaticus fixture, per fixture			S	**5 191.63**	**7 787.05**	-
FUNCTIONAL CORRECTION OF MALOCCLUSIONS							
For items 9063 to 9072 the full fee may be charged i.e. notes 2 and 3 (Rule 011) will not apply							
9047	Operation for the improvement or restoration of occlusal and masticatory function, e.g. bilateral osteotomy, open operation (with immobilisation)				**8 690.93**	**13 035.75**	-
9049	Anterior segmental osteotomy of mandible (Köle)				**7 240.88**	**10 860.77**	-
9050	Total subapical osteotomy				**14 622.13**	**21 932.10**	-
9051	Genioplasty				**4 140.51**	**6 210.46**	-
9052	Midfacial exposure (for maxillary and nasal augmentation or pyramidal Le Fort II osteotomy)				**6 698.70**	**10 047.55**	-
9055	Maxillary posterior segment osteotomy (Schukardt) 1 or 2 stage procedure				**7 240.88**	**10 860.77**	-
9057	Maxillary anterior segment osteotomy (Wassmund) - 1 or 2 stage procedure				**7 240.88**	**10 860.77**	-
9059	Le Fort I osteotomy - one piece				**13 654.01**	**20 479.99**	-
9062	Le Fort I osteotomy - multiple segments				**17 741.64**	**26 611.13**	-
9060	Le Fort I osteotomy with inferior repositioning and inter -positional grafting				**15 878.55**	**23 816.64**	-
9061	Palatal osteotomy				**4 763.73**	**7 145.24**	-
9063	Le Fort II osteotomy for the correction of facial deformities or faciostenosis and post- traumatic deformities	+L		S	**17 272.12**	**25 906.89**	-
9069	Functional tongue reduction (partial glossectomy)			S	**3 107.87**	**4 661.57**	-
9071	Geniohyoidotomy				**1 861.81**	**2 792.57**	-
9072	Functional closure of a secondary oro -nasal fistula and associated structures with bone grafting corn fete procedure	+L		S	**13 654.01**	**20 479.99**	-
TEMPORO- MANDIBULAR JOINT PROCEDURES							
9073	Bite plate for TMJ dysfunction				**731.96**	**1 097.88**	-
9074	Diagnostic arthroscopy			S	**2 094.75**	**3 141.97**	-
9075	Condylectomy or coronoidectomy or both (extra -oral approach)			S	**4 276.25**	**6 414.05**	-
9076	Arthrocentesis TMJ			S	**1 252.93**	**1 879.30**	-
9053	Coronoidectomy (intra -oral approach)			S	**2 586.76**	**3 879.95**	-
9077	Intra- articular injection, per injection			S	**311.30**	**466.92**	-
9079	Trigger point injection, per injection			S	**245.11**	**367.65**	-

9081	Condylectomy (Ward/Kostecka)			S	2 067.35	3 100.87	-
9083	Temporo- mandibular joint arthroplasty			S	5 174.43	7 761.26	-
9085	Reduction of temporomandibular joint dislocation without anaesthetic			S	411.22	616.80	-
9087	Reduction of temporo -mandibular joint dislocation, with anaesthetic			S	827.23	1 240.78	-
9089	Reduction of temporo -mandibular joint dislocation, with anaesthetic and immobilisation			S	2 067.35	3 100.87	-
9091	Reduction of temporo- mandibular joint dislocation requiring open reduction			S	4 346.31	6 519.14	-
9092	Total joint reconstruction with alloplastic material or bone (includes cond lectom and coronoidectomy	+L		S	14 052.30	21 077.40	-
SALIVARY GLANDS							
9095	Removal of sublingual salivary gland				2 485.93	3 728.71	-
9096	Removal of salivary gland (extra -oral)				3 630.52	5 445.51	-
IMPLANTS							
For codes 9180 to 9192 the full fee may be charged, i.e. note 2 of Rule 011 will not apply							
9180	Placement of sub -periosteal implant - Preparatory procedure / operation		M	S	2 857.46	4 285.98	-
9181	Placement of sub -periosteal implant prosthesis / operation	+L	M	S	2 857.46	4 285.98	-
9182	Surgical placement of endosteal implant plate	+L		S	1 434.21	2 151.21	-
9183	Placement of a single osseo- integrated implant, per jaw	+M	T	S	1 890.77	2 836.01	-
	Also known as a root form implant; endosseus or an osseo-integrated implant. This procedure involves (1) the surgical placement of a one stage and/or the first stage of a two stage surgery endosteal implant (fixture) and (2) the placement of a healing abutment/cap (when appropriate). Code 9183 includes the surgical placement of a one-piece endosteal implant (incorporating both the implant and integral fixed abutment) and should also be used to report the placement of an endosteal plate form implant. In such instances laboratory fees applies. See code 9190 hereunder for second stage surgery and code 9189 to report the cost of the endosteal implant body						
9184	Placement of a second osseo- integrated implant in the same jaw	+M	T	S	1 416.84	2 125.15	-
9185	Placement of a third and subsequent osseo- integrated implant in the same jaw, per implant	+M	T	S	945.12	1 417.61	-
9189	Cost of implants				Rule 013	Rule 013	-
9190	Surgical placement of abutment - first per jaw	+M	T	S	698.47	1 047.66	1 047.84
	This procedure involves the (1) surgical re-exposure (uncovery or second stage surgery) of that portion of the submerged endosteal implant that receives the attachment device, and (2) the connection of a healing abutment or temporary prosthesis. This is usually done after the implant has matured in the bone for several months. The purpose of a healing abutment or collar is to create an emergence profile in the gum tissues for the future implant crown. Some implants are designed to remain exposed in the mouth right after they are placed, abolishing an uncovery procedure. See Code 9189 to submit the cost of other implant components						
9191	Surgical placement of abutment - second per jaw	+M	T	S	523.83	785.70	785.70
9192	Surgical placement of abutment - third and subsequent per jaw	+M	T	S	348.78	523.15	523.15
9198	Implant removal		T	S	1 161.34	1 741.92	-
	This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant, and closure						
8761	Masticatory mucosal autograft - one to four teeth (isolated procedure)	+L	M	A	1 263.27	1 894.81	-
8762	Masticatory mucosal autograft - four or more teeth (isolated procedure)	+L	M	A	1 894.90	2 842.22	-
8772	Submucosal connective tissue autograft (isolated procedure)			A	1 438.04	2 156.95	-
8767	Bone regenerative / repair procedure at a single site Excluding cost of regenerative material - see code 8770			A	1 540.04	2 309.95	-
8769	Membrane removal (used for guided tissue regeneration)			A	613.54	920.27	-
Codes 8761, 8762, 8767 and 8769 should be claimed only as part of implant surgery							
ADMINISTRATIVE AND LABORATORY SERVICES							
8099	Dental laboratory service						
	Use to submit dental laboratory services. See Rule 010.						

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

Field	Description	Max length	Data Type
BATCH HEADER			
1	Header identifier = 1	1	Numeric
2	Switch internal Medical aid reference number	5	Alpha
3	Transaction type = M	1	Alpha
4	Switch administrator number	3	Numeric
5	Batch number	9	Numeric
6	Batch date (CCYYMMDD)	8	Date
7	Scheme name	40	Alpha
8	Switch internal	1	Numeric
DETAIL LINES			
1	Transaction identifier = M	1	Alpha
2	Batch sequence number	10	Numeric
3	Switch transaction number	10	Numeric
4	Switch internal	3	Numeric
5	CF Claim number	20	Alpha
6	Member surname	20	Alpha
7	Member initials	4	Alpha
8	Member first name	20	Alpha
9	BHF Practice number	15	Alpha
10	Switch ID	3	Numeric
11	Patient reference number (account number)	10	Alpha
12	Type of service	1	Alpha
13	Service date (CCYYMMDD)	8	Date
14	Quantity / Time in minutes	7	Decimal
15	Service amount	15	Decimal
16	Discount amount	15	Decimal
17	Description	30	Alpha
18	Tariff	10	Alpha

Field	Description	Max length	Data Type
19	Service fee	1	Numeric
20	Modifier 1	5	Alpha
21	Modifier 2	5	Alpha
22	Modifier 3	5	Alpha
23	Modifier 4	5	Alpha
24	Invoice Number	10	Alpha
25	Practice name	40	Alpha
26	Referring doctor's BHF practice number	15	Alpha
27	Medicine code (NAPPI CODE)	15	Alpha
28	Doctor practice number -sReferredTo	30	Numeric
29	Date of birth / ID number	13	Numeric
30	Service Switch transaction number – batch number	20	Alpha

31	Hospital indicator	1	Alpha
32	Authorisation number	21	Alpha
33	Resubmission flag	5	Alpha
34	Diagnostic codes	64	Alpha
35	Treating Doctor BHF practice number	9	Alpha
36	Dosage duration (for medicine)	4	Alpha
37	Tooth numbers		Alpha
38	Gender (M ,F)	1	Alpha
39	HPCSA number	15	Alpha
40	Diagnostic code type	1	Alpha
41	Tariff code type	1	Alpha
42	CPT code / CDT code	8	Numeric
43	Free Text	250	Alpha
44	Place of service	2	Numeric
45	Batch number	10	Numeric
46	Switch Medical scheme identifier	5	Alpha
47	Referring Doctor's HPCSA number	15	Alpha
48	Tracking number	15	Alpha
49	Optometry: Reading additions	12	Alpha
50	Optometry: Lens	34	Alpha
51	Optometry: Density of tint	6	Alpha
52	Discipline code	7	Numeric
53	Employer name	40	Alpha
54	Employee number	15	Alpha

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

TRAILER

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