GOVERNMENT GAZETTE

OF THE

REPUBLIC OF NAMIBIA

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MINISTRY OF LABOUR

No. 138 2003

EMPLOYEES' COMPENSATION ACT, 1941:
TARIFF OF FEES FOR CHIROPRACTIC SERVICES

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tariff of Fees for Chiropractic Services and the general rules and general modifiers applicable thereto, as set out in the Schedule;

(b) repeals Government Notice 133 of 1997.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

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A. GENERAL RULES GOVERNING THE TARIFF

DC001 "After hour treatment" shall mean a procedure performed on request of a medical or dental practitioner between 18:00 and 07:00 hours on the following day or during weekends between 13:00 hours on Saturday and 07:00 hours on Monday. Public holidays are regarded as Sundays.

This rule shall apply to all treatments whether provided in the practitioner's rooms, at a health facility, nursing home or private residence only on written instructions from the attending medical or dental practitioner when the injured employee's condition necessitates it.

The fee for all treatments under this rule shall be the tariff fee plus 50 % and must be motivated. Modifier DC001 must then be quoted after the appropriate tariff code number to indicate that this rule is applicable.

In case where the chiropractor scheduled working hours extend after 18:00 hours during the week e.g. 19:00 hours, or 13:00 hours on a Saturday, the above rule shall not apply for services rendered during this extended period of time and Modifier DC001 shall not be charged.

DC002

(a) Where a chiropractor performs treatments away from his treatment rooms, travelling costs shall be charged as follows: N$ 1.50 per km for each kilometre in excess of 16 kilometres total travelled in own car e.g. 19 km total = 3 x N$ 1.50 = N$ 4.50.

(b) If more than one employee would be attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees.

(c) A practitioner is not entitled to charge for any travelling expenses to his rooms.

DC003 After a series of 20 treatments in respect of one injured employee for the same condition, the attending medical or dental practitioner must re-evaluate the injured employee's condition. If further treatment is required the practitioner must submit a Final/Progress Medical Report (Form E.Cl.5) to the Commission, indicating the necessity for further treatment and advise accordingly the chiropractor.

DC004 In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by the chiropractor, such higher fee may be agreed upon between the chiropractor and the Commission. Conversely, if the fee is disproportionately high in relation to the actual services rendered a lower fee than the tariff fee should be charged.

DC005 No more than four physical procedures and modalities will be reimbursed in one visit. Multiple physical procedures and modalities shall be reimbursed as follows:

- Major (highest valued procedure or modality): 100% of listed value
- Second (secondary-highest or equivalent valued procedure or modality): 50% of listed value
- Third (third-highest or equivalent valued procedure or modality): 50% of listed value
- Fourth (fourth-highest or equivalent valued procedure or modality): 50% of listed value

DC006 Unless timely steps (i.e. 4 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged but shall not be payable by the Commission, but shall be payable by the injured employee. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged.

DC007 The services of a chiropractor shall be payable by the Commission, provided that:

a) The chiropractor is registered in terms of relevant legislation pertaining in the Republic of Namibia;

b) Registered chiropractors may diagnose and treat the human body by the application of manipulative, manual, mechanical methods, including the use of therapeutic modalities, orthotics, supportive appliances and diagnostic x-rays.

DC008 Every chiropractor must acquaint herself/himself with the regulations promulgated under the Employees Compensation Act, 1941 (Act 30 of 1941) especially in connection with the rendering of services and submission of accounts.

Every account shall be signed by the service provider and shall contain the following particulars:

1) The name, address, telephone number and practice code number of the chiropractor.
2) The name and practice code number of the referring medical or dental practitioner.
3) The surname, first name, date of birth, Social Security Number, date of accident and claim number of the injured employee.
4) The nature of the treatment.
5) The date on which the service was rendered.
6) The tariff code number and fee of the procedure used in this Schedule;

and shall be accompanied by

7) A copy of the completed Employer's Report of Accident (Form E.Cl.2) page 1.
8) A copy of the referral letter from the medical or dental practitioner concerned;
9) The First Medical Report and Account (E.CL4), where applicable and/or;
10) The Final/Progress Medical Report (E.CL5), where applicable.

B. PROCEDURES

Remarks	Code Previous	CODE new	PROCEDURE	N$
		1.	**CONSULTATIONS**	
	DC01	DC001	Initial consultation and manipulation	98.50
	DC02	DC002	Subsequent consultation and manipulation	73.90
new		DC003	Subsequent consultation where no treatment is required	50.60
		2.	**MODALITIES/ADJUNCTIVE THERAPY** Modalities or adjunctive therapy: Fee covering the utilisation of supportive therapy considered necessary and relevant to the respective condition/diagnosis. Maximum of 3 modalities per visit. See Rule DC005	
		2.1	**Soft tissue manipulation**	
	DC04	DC101	Massage	27.00
	DC05	DC103	Myofacial pain therapy	27.00
		2.2	**Deep heating radiation treatment**	
	DC06	DC111	Short wave diathermy	40.50
	DC07	DC113	Microwave diathermy	40.50
	DC08	DC115	Ultra sound	40.50
		2.3	**Superficial healing therapy**	
	DC09	DC121	Hydrocullator packs	27.00
	DC10	DC123	Infra-red	27.00
	DC11	DC125	Ultra –violet	27.00
	DC12	DC127	Paraffin bath/Wax unit	27.00
	DC13	DC129	Whirlpool/Hubbard tank immersion	27.00
	DC14	DC131	Fluidotherapy	27.00
	DC15	DC133	Sitz bath	27.00
		2.4	**Non heating modalities**	
	DC16	DC141	Galvanism, faradism and sine wave	27.00
	DC17	DC143	Low voltage galvanic lontopresis	27.00
	DC18	DC145	Combined ultra sound and electric stimulation	31.50
new		DC147	Stimulation	32.30
	DC19	DC149	Interferential current	40.50
	DC20	DC151	Vacutron	31.50
	DC21	DC153	Combined interferential and vacutron	31.50
	DC22	DC155	Vibration therapy	35.30
	DC23	DC157	High voltage pulsed direct current (includes under-water application)	32.30
	DC24	DC159	Electro-Stim. 180	27.00
	DC25	DC125	T.E.N.S.	27.00
	DC26	DC163	Micro current modalities	31.50
	DC27	DC165	Traction = Mechanical/static/intermittent	31.50
	DC28	DC167	Laser therapy	45.90
		2.5	**Cold application**	
	DC29	DC171	Cryomatic	27.00
	DC30	DC173	Cold Packs	27.00
		2.6	**Acupuncture**	
new		DC181	One or more needles without electrical stimulation	53.90
new		DC183	One or more needles with electrical stimulation	53.90
		2.7	**Therapeutic Exercise**	
	DC33	DC187	Proprioceptive neuromuscular facilitation	31.50
	DC34	DC189	Gait training	31.50
modified	DC35	DC191	Prosthetic fitting and training	31.50
new		DC193	Orthotic fitting and training	31.50
		2.8	**Immobilisation**	
	DC36	DC201	Hard and soft immobilisation	31.50
	DC37	DC203	Supportive strapping, bracing, splinting and taping	31.50
	DC38	DC205	Supportive devices	31.50
	DC42		Remedies prescribed and supplies - Cost + 35%	

Remarks	Code Previous	CODE new	PROCEDURE	N$
		3.	**RADIOLOGY** MOHSS Radiation Protection number to be on account if x-rays are charged. Note: Items DC066, DC067, DC076, DC079, and DC080 cannot be charged in conjunction with item DC073.	
		DC0084	Modifier DC00084: Film charges - Add 10% per view	41.70
	DC49	DC049	Ankel - AP/LAT	59.70
	DC51	DC051	Cervical - AP/LAT	41.70
	DC55	DC055	Elbow - AP/LAT	41.70
	DC57	DC057	Foot - AP/LAT	62.30
	DC59	DC059	Femur AP/LAT	41.70
	DC60	DC060	Hand - AP/LAT	41.70
	DC62	DC062	Hip - unilateral - a view	41.70
	DC64	DC064	Knee - AP/LAT	59.70
	DC66	DC066	Lumbo-Sacral 3 views	99.30
	DC67	DC067	Lumbar spine and pelvis - 5 views	59.70
	DC68	DC068	Pelvis AP	66.70
	DC70	DC070	Ribs - unilateral - 2 views	41.70
	DC72	DC072	Radius/ Ulna	179.50
	DC73	DC073	Spine - Full spine study - AP/LAT	59.70
	DC76	DC076	Spine - 14 x 17 - single study	41.70
	DC77	DC077	Shoulder - per view	59.70
	DC79	DC079	Thoraco-Lumbar AP/LAT	59.70
	DC80	DC080	Thoracic - AP/LAT	41.70
	DC81	DC081	Tibia/Fibula AP/LAT	41.70
	DC82	DC082	Wrist - AP/LAT	
		4.	**CONSUMABLES**	
		DC100	Consumables at cost plus 10%	

MINISTRY OF LABOUR

No. 139 2003

EMPLOYEES' COMPENSATION ACT, 1941:
TARIFF OF FEES OCCUPATIONAL THERAPY SERVICES

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tariff of Fees for Occupational Therapy Services and the general rules and general modifiers applicable thereto, as set out in the Schedule;

(b) repeals Government Notice 174 of 1997.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

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A. GENERAL RULES GOVERNING THE TARIFF

OT001 Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment for a consultation the relevant consultation fee may be charged, but shall not be payable by the Commission, but shall be payable by the injured employee. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged.

OT002 In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by the practitioner, such higher fee may be agreed upon between the practitioner and the Commission. Conversely, if the fee is disproportionately high in relation to the actual services rendered a lower fee than the tariff fee should be charged.

OT003 The services of an occupational therapist shall be payable by the Commission, provided that:

1) The occupational therapist is registered in terms of relevant legislation pertaining in the Republic of Namibia;
2) Occupational Therapy services are provided on written referral by a registered medical or dental practitioner.

OT004 In the case of prolonged or costly treatment this should only be embarked upon after agreement between the referring medical or dental practitioner and the Commission.

OT005 After a series of 80 treatments in respect of one injured employee for the same condition, the medical or dental practitioner must re-evaluate the injured employee's condition and submit a Progress Report (Form E.CL.5) to the Commission, in which the necessity for further treatment is motivated.

OT006 "After hour treatment" shall mean a procedure performed on request of a medical or dental practitioner between 18:00 and 07:00 hours on the following day or during weekends between 13:00 hours on Saturday and 07:00 hours on Monday. Public holidays are regarded as Sundays.

This rule shall apply to all treatments whether provided in the practitioner's rooms, at a health facility, a nursing home or private residence only on written instructions from the attending medical or dental practitioner when the injured employee's condition necessitates it.

The fee for all treatments under this rule shall be the tariff fee plus 50 % and must be motivated. Modifier 660006 must then be quoted after the appropriate tariff code number to indicate that this rule is applicable.

In cases where the occupational therapist's scheduled working hours extend after 18:00 hours during the week e.g. to 19:00 hours, or 13:00 hours on a Saturday the above rule shall not apply for services rendered during this extended period of time and Modifier 660006 shall not be charged.

OT008 The provision of aids or assistive devices shall be charged at cost. Modifier 660008 must be quoted after the appropriate tariff code number to indicate that this rule is applicable.

OT009 Materials used in the construction of orthosis or pressure garments will be charged at cost plus 20%. Modifier 660009 must be quoted after the appropriate tariff code number to indicate that this rule is applicable.

OT010 Materials used in treatment shall be charged at cost plus 20%. Modifier 660010 must be quoted after the appropriate tariff code number to indicate that this rule is applicable.

OT011 Where the occupational therapist performs treatments away from her/his treatment rooms, travelling costs shall be charged as follows: N$ 1.50 per km for each kilometre in excess of 16 kilometres total travelled in own car e.g. 19 km total = 3 x N$ 1.50 = N$ 4,50.

OT012 Every occupational therapist must acquaint herself/himself with the regulations promulgated under the Employees' Compensation Act, 1941 (Act No. 30 of 1941) especially in connection with the rendering of services and submission of accounts.

Every account shall be signed by the service provider and contain the following particulars

1) The name, address and practice code number of the occupational therapist.
2) The name and practice code number of the referring medical or dental practitioner.
3) The surname, first name, date of birth and Social Security Number of the injured employee.
4) Date of Accident.
5) The nature of the injury, the condition treated and the nature of treatment.
6) The date on which the service was rendered.
7) The tariff code number and fee for the procedure used in this Schedule,

and shall be accompanied by:

8) A copy of the completed "Employer's Report of Accident" (Form E.Cl.2), page 1.
9) A copy of the referral letter of the medical or dental practitioner concerned.
10) Continuation of treatment prescription after each 20 treatments, where applicable

B. MODIFIERS GOVERNING THE TARIFF

660006 Add 50 % of the total fee for the treatment.

660008 Aids or assistive devices to be charged at cost.

660009 Materials used for orthosis or pressures garments to be charged at cost plus 20%.

660010 Materials used in treatment to be charged at cost plus 20%.

660011 Travelling cost as indicated in Rule OT011.

C. PROCEDURES

Remarks	Code Previous	PROCEDURE	N$
	1.	**PROCEDURES OF INTERVIEWING, GUIDANCE AND CONSULTANCY**	
modified	66101	First interview	58.10
new	66103	Guidance	48.30
new	66105	Consultation - irrespective of duration	96.60
	2.	**PROCEDURES OF INITIAL EVALUATION TO DETERMINE THE TREATMENT**	
	66201	Observation and screening	23.10
new	66203	Specific evaluation for a single aspect of disfunction (specify which aspect)	23.10
new	66205	Specific evaluation of dysfunction involving one part of the body for a specific functional problem (specify parts and aspects evaluated)	72.20
new	66207	Specific evaluation for dysfunction involving the whole body (specify condition and which aspects evaluated)	144.70
new	66209	Specific in depth evaluation of certain functions affecting the total person (specify aspects evaluated)	241.10
new	66211	Comprehensive in depth evaluation of the total person (specify aspects evaluated)	337.70
		Measurement for designing	
	66213	A static orthosis	24.10
	66215	A dynamic orthosis	24.10
	66217	A pressure garment for one limb	24.10
	66219	A pressure garment for one hand	24.10
	66221	A pressure garment for the trunk	24.10
	66223	A pressure garment for the face (chin strap only)	24.10
	66225	A pressure garment for the face (full face mask)	24.10
		The whole body or parts thereof will be the sum total of the parts.	
	3.	**PROCEDURES OF THERAPY**	
modified	66301	Group treatment in a task-centered activity, per injured employee (treatment time 60 minutes or more)	27.90
	66303	Placement of an injured employee in an appropriate treatment situation Requiring structuring the environment adapting equipment and positioning the injured employee. This does not require individual attention for the whole treatment session, per injured employee	36.30
new	66305	Groups directed to achieve common aims, per injured employee (treatment time 60 minutes or more)	56.20
new	66307	Simultaneous treatment with two to four injured employees each with specific problems, utilising individual activities, per injured employee (treatment up to 60 minutes).	77.90
new	66308	Simultaneous treatment with two to four neurobehavioral and stress related conditions or severe head injury injured employees, each with specific problems, utilising individual activities, per injured employee (treatment time 90 minutes or more)	115.50
		Individual and undivided attention during treatment sessions utilising specific activity and/or techniques in an integrated treatment session	
	66309	On level one (15 minutes)	37.40
	66311	On level two (30 minutes)	83.80
	66313	On level three (45 minutes)	116.80
	66315	On level four (60 minutes)	167.60
	66317	On level five (90 minutes)	206.30
	66319	On level six (120 minutes)	254.70
	4.	**PROCEDURES REQUIRED TO PROMOTE TREATMENT**	
new	66401	Recommendations regarding assistive devices, environmental adaptations, alternative/compensatory methods, handling the injured employee	35.00

Remarks	Code Previous	PROCEDURE	N$
		Designing and constructing a custom-made adaptation or assistive device for treatment in a task-centred activity (specify the adaptation or device)	
	66403	On level one	35.00
	66405	On level two	68.60
	66407	On level three	103.60
	66409	On level four	137.60
	66411	On level five	172.50
	66413	On level six	207.60
	66415	Designing and constructing a static orthosis	137.60
	66417	Designing and constructing a dynamic orthosis	275.10
		Desiging and making pressure garment for:	
	66419	Limb (per limb)	137.60
	66421	Face (chin strap only)	103.60
	66423	Face (full face mask)	137.60
	66425	Trunk	207.60
	66427	Hand (per hand)	207.60
		The whole body or part thereof will be the sum total of the parts for the firsst garment and 75% of the fee for any additional garments made on the same pattern.	
new	66429	Designing and planning an environmental adaptation.	90.20
new	66431	Planning and preparing an in-depth home programme on a monthly basis.	270.50
new	66433	Designing and planning an environmental control unit.	541.40

MINISTRY OF LABOUR

No. 140 2003

EMPLOYEES' COMPENSATION ACT, 1941:
TARIFF OF FEES PHYSIOTHERAPY SERVICES

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tariff of Fees for Physiotherapy Services and the general rules and general modifiers applicable thereto, as set out in the Schedule;

(b) repeals Government Notice 175 of 1999.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

SCHEDULE

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SCHEDULE

TARIFF OF FEES FOR PHYSIOTHERAPY SERVICES

A. GENERAL RULES GOVERNING THE TARIFF

P001 Unless timely steps (i.e. 24 hours prior to the appointment) are taken to cancel an appointment the relevant fee may be charged but shall not be payable by the Commission, but shall be payable by the injured employee. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged.

P002 In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by the practitioner, such higher fee may be agreed upon between the practitioner and the Commission. Conversely, if the fee is disproportionately high in relation to the actual services rendered a lower fee than the tariff fee should be charged.

P003 The services of a physiotherapist shall be payable by the Commission, provided that:

1) The physiotherapist is registered in terms of relevant legislation pertaining in the Republic of Namibia;
2) Physiotherapy is provided as a supplementary service to medicine and on written referral by a registered medical or dental practitioner.

P004 In the case of prolonged or costly treatment this should only be embarked upon after agreement between the referring medical or dental practitioner and the Commission.

P005 After a series of 20 treatments in respect of one injured employee for the same condition, the medical or dental practitioner must re-evaluate the injured employee's condition. If further physiotherapy treatment is required the medical practitioner must submit a Final/Progress Medical Report (Form E.Cl.5) to the Commission, indicating the necessity for further treatment and where indicated, prescribe further physiotherapy treatment.

P006 "After hours treatment" shall mean a procedure performed on request of a medical or dental practitioner between 18:00 and 07:00 hours on the following day or during weekends between 13:00 hours on Saturday and 07:00 hours on Monday. Public holidays are regarded as Sundays.

This rule shall apply to all treatments whether provided in the practitioner's rooms, at a health facility, nursing home or private residence only on written instructions from the attending medical or dental practitioner when the patient's (injured employee's) condition necessitates it.

The fee for all treatments under this rule shall be the tariff fee plus 50 % and must be motivated. Modifier 720006 must then be quoted after the appropriate tariff code number to indicate that this rule is applicable.

In case where the physiotherapist's scheduled working hours extend after 18:00 hours during the week e.g. 19:00 hours, or 13:00 hours on a Saturday, the above rule shall not apply for services rendered during this extended period of time and Modifier 720006 shall not be charged.

P007 Where a practitioner uses equipment that is not owned by that practitioner, a reduction of 15% of the relevant tariff fee will be applicable. Modifier 72007 must be quoted after the appropriate tariff code number to indicate that this rule is applicable.

P008 The fee in respect of more than one procedure (excluding evaluation and visiting items 72407, 72501, 72502, 72701, 72702, 72703. 72704, 72705, 72801, 72803, 72901 and 72903) performed at the same consultation or visit, shall be the fee for the major procedure plus 50% in respect of each additional procedure, but under no circumstances may fees be charged for more than three procedures carried out in the treatment of any one condition. Modifier 720008 must then be quoted after the appropriate tariff code number for the additional procedures to indicate that his rule is applicable.

P009 Where more than one condition requires treatment and each of these conditions necessitates an individual treatment, they shall be charged as individual treatments. Full details of the nature of the treatments must be stated. Modifier 720009 must then be quoted after the appropriate tariff code number to indicate that this rule is applicable.

P010 Where the treatment times of two completely separate and different conditions overlap, the fee shall be the full tariff fee for the one condition and 50% of the fee for the other condition. Modifier 720010 must then be quoted after the appropriate tariff code number to indicate that this rule is applicable.

P011 Where the physiotherapist performs treatments away from his treatment rooms, travelling costs shall be charged as follows: N$ 1.50 per km for each kilometre in excess of 16 kilometres total travelled in own car e.g. 19 km total = 3 x N$ 1.50 = N$ 4.50.

P012 Every physiotherapist must acquaint herself/himself with the regulations promulgated under the Employees' Compensation Act, 1941 (Act 30 of 1941) especially in connection with the rendering of services and submission of accounts.

Every account shall be signed by the service provider and contain th following particulars:

1) The name, address and practice code number of the physiotherapist.
2) The name and practice code number of the referring medical or dental practitioner.
3) The surname, first name, date of birth, Social Security Number and date of accident of the injured employee.
4) The nature of the injury, the condition treated and the nature of treatment.
5) The date on which the service was rendered.
6) The tariff code number and fee of the procedure used in this Schedule.

and shall be accompanied by

7) A copy of the completed Employer's Report of Accident (Form E.Cl.2) page 1.
8) A copy of the referral letter from the medical or dental practitioner concerned.
9) Continuation of treatment prescription after each 20 treatments, where applicable.

P013 Item 72305, 72501 and 72503 cannot be claimed simultaneously

B. MODIFIERS GOVERNING THE TARIFF

720006 Add 50 % (percent) of the total fee for the treatment.

720007 15 % (percent) of the relevant tariff fee to be deducted where equipment used is not owned by the practitioner

720008 Only 50 % (percent) of the fee for these additional procedures may be charged.

720009 The full tariff fee for the additional condition may be charged.

720010 Only 50 % (percent) of the fee for the second condition may be charged.

720011 Travelling costs as indicated in Rule P011

NOTE: Monetary value of 1 unit = N$ 2.60, VAT inclusive.

C. PROCEDURES

Remarks	Code	PROCEDURE	Units	N$
	1.	**RADIATION THERAPY/MOIST HEAD THERAPY/ CRYOTHERAPY**		
	72001	Infra-red, Radiant Heat, Wax Therapy, Hot Packs	10	26.00
	72005	Ultraviolet light	17	44.20
	72006	Laser beam	17	44.20
	72007	Cryotherapy	10	26.00
	2.	**LOW FREQUENCY CURRENTS**		
	72103	Galvanism, Diodynamic current, Tens	10	26.00
	72105	Muscle and nerve stimulating currents	12	31.20
	72107	Interferential Therapy	15	39.00
	3.	**HIGH FREQUENCY CURRENTS**		
	72201	Short-wave diathermy	15	39.00
modified	72203	Ultrasound	17	44.20
	72205	Microwave	15	39.00
	4.	**PHYSICAL MODALITIES**		
new	72300	Vibration	13	33.80
	72301	Percussion	16	41.60
new	72302	Massage	10	26.00
modified	72303	Myofacial release/soft tissue mobilization, one or more body parts	20	52.00
new	72304	Acupuncture	20	52.00
	72305	Re-education of movement/exercises (excluding ante- and post-natal exercises)	10	26.00
	72307	Pre- and post-operative exercises and/or breathing exercises	10	26.00
new	72308	Group exercises (excluding ante- and post-natal exercises) - maximum of 10 in a group	10	26.00
new	72309	Isokinetic treatment	20	52.00
	72310	Neural tissue mobilization	20	52.00
	72314	Lymph drainage	10	26.00
	72315	Postural drainage	10	33.80
	72317	Traction	20	52.00
modified	72318	Upper respiratory nebulisation	10	26.00
	72319	Nebulisation	15	39.00
new	72321	Intermittent positive pressure ventilation	15	39.00
	72323	Suction: Level 1 (including sputum specimen taken by suction)	10	26.00
new	72325	Suction: Level 2 (Suction with involvement of lavage as a treatment in a special unit situation or in the respiratory compromised patient)	20	52.00
new	72327	Bagging (used on the intubated unconscious patient or in the severely respiratory distressed patient)	10	26.00
new	72328	Dry needling	20	52.00
	5.	**MANIPULATION/MOBILISATION OF JOINTS OR IMMOBOLISATION**		
	72401	Spinal	25	65.00
new	72402	Pre-meditated manipulation	20	52.00
	72405	All other joints	20	52.00
	72407	Immobilization (excluding materials). Rule P008 does not apply.	15	39.00
	6.	**REHABILITATION**		
	72501	Rehabilitation and/or hydrotherapy where the patient requires the undivided attention of the physiotherapist. Rule P008 does not apply.	25	65.00
new	72502	Hydrotherapy where the patient requires the undivided attention of the physiotherapist. Rule P008 does not apply.	25	65.00

Remarks	Code	PROCEDURE	Units	N$
	72503	Rehabilitation of Central Nervous System disorders - condition to be clearly stated and fully documented (for brain injuries, quadriplegics and paraplegics only). (No other treatment modality may be used in conjunction with this)	55	143.00
new	72504	EMG Bio-feedback treatment	20	52.00
new	72505	Group rehabilitation. Treatment of a patient with disabling pathology in an appropriate facility requiring specific equipment and supervision, without individual attention for the whole treatment session, in accredited venue only and no charge may be levied by facility	35	91.00
new	72507	Respiratory Re-education and Training	22	57.20
	7.	**EVALUATION/DIAGNOSTIC**		
	72701	Evaluation/counseling at the first visit only (to be fully documented) Please note: Item 72701 should not be used for examination of each so-called "condition" at the first visit	15	39.00
new	72702	Complex evaluation/counseling at the first visit only (to be fully documented).	30	78.00
	72703	One complete re-assessment of a patient's condition during the course of treatment, and/or counseling of the patient or his family to be used with procedures 72501 or 72503 - refer to Rule P011	15	39.00
new	72704	Lung function: Peak flow (once per treatment).	5	13.00
new	72705	Computerized/Electronic test for lung pathology	15	39.00
	72801	Electrical test for diagnostic purpose (including IT curve and Isokinetic tests) for specific medical condition	35	91.00
new	72803	Effort test - multistage treadmill.	35	91.00
	8.	**VISITING CODES**		
	72901	Treatment at a nursing home (once per day only): Relevant fee plus (to be charged only once per day and not with every hospital visit)	10	26.00
	72903	Domiciliary treatments – Apply only when medically motivated: Relevant fee plus	20	52.00
	9.	**OTHER**		
new	72937	Bird or equivalent freestanding nebuliser excluding oxygen at hospital per day	20	52.00
new	72938	Bird or equivalent freestanding nebuliser excluding oxygen at domiciliary per day.	20	52.00
new	72939	Cost of material: Single items below N$1208.00 plus VAT (unless the service provider is not registered as a VAT vendor) may be charged for at cost price plus 20%.		
new	72940	Cost of appliances: Single items below N$1208.00 plus VAT (unless the service provider is not registered as a VAT vendor) may be charged for at cost price plus 20%. **Note:** For cost of material and appliances exceeding N$1 208.00 plus VAT (unless the service provider is not registered as a VAT vendor) authorization from the Commission is requested.		

MINISTRY OF LABOUR

No. 141 2003

EMPLOYEES' COMPENSATION ACT, 1941: TARIFF OF FEES FOR DENTAL SERVICES

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tariff of Fees for Dental Services and the general rules and general modifiers applicable thereto, as set out in the Schedule;

(b) repeals Government Notice 177 of 1999.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

SCHEDULE

TARIFF OF FEES FOR DENTAL SERVICES

This Schedule includes procedures performed by general dental practitioners, maxillo-facial and oral surgeons, orthodontists, periodontists, prosthodontists and oral pathologists

The dental procedure codes for general dental practitioners are divided into twelve (12) categories of services. The procedures have been grouped under the category with which the procedures are most frequently identified. The categories are 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. General practitioners are advised to become familiar with the details of these categories since it is similar to the Current Dental Terminology, Second Edition (CDT-2), which was adopted in principle by NAMAF and SADA.

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A. GENERAL RULES GOVERNING THE TARIFF

D001 Item 8101 refers to a full mouth examination, charting and treatment planning and no further examination fees shall be chargeable until the treatment plan resulting from this consultation is completed with the exception of code 8102. This includes the issuing of a prescription where only medication is prescribed. Item 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.

D002 Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in this schedule shall be based on the fee in respect of a comparable service that is listed therein and Rule D002 must be indicated together with the tariff item.

D003 In the case of a prolonged or costly dental service or procedure, the dental practitioner or specialist shall ascertain beforehand from the Commission whether it will accept financial responsibility in respect of such treatment.

D004 In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a dental practitioner or a specialist, such higher fee as may be agreed upon between the dental practitioner or specialist and the Commission, may be charged and Rule D004 must be indicated together with the tariff code.

Conversely, if the fee is disproportionately high in relation to the actual services rendered, a lower fee than that in the Tariff of Fees should be charged.

D005 Save in exceptional cases the services of a specialist shall be available only on the re-commendation of the attending dental or medical practitioner. Referring practitioners shall indicate to the specialist that the patient is being treated under the Employees' Compensation Act 1941 (Act 30 of 1941).

D007 "Normal consulting hours" are between 07:00 and 17:00 on weekdays, and between 07:00 and 13:00 on Saturdays.

D008

(a) Every dentist shall render a monthly invoice for every procedure, which has been completed irrespective of whether the total treatment plan has been concluded.

(b) Every invoice shall be signed by the service provider and shall contain the following particulars:

1) The surname, first name/s and date of birth of the injured employee;
2) the Social Security Number of the injured employee;
3) The date of accident;
4) The claim number allocated by the Social Security Commission, Employee's Compensation Fund, where available;

5) A copy of the completed Employer's Report of Accident (Form E.Cl.2), page 1;
6) The date on which every service was rendered;
7) The tariff number and fee used in this Schedule of every procedure or service, and the nature of every procedure or service;
8) Where the account is a photocopy of the original, certification by way of a rubber stamp or the signature of the dentist;
9) A copy of the referral letter from the medical or dental practitioner concerned, where applicable.
10) The name, address, and practice number of the dental practitioner or specialist rendering the service must be shown on the account.

D009 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 and Modifier 8004 must be shown against any such item. 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

D010 Fees charged by dental technicians for their services (PLUS L) shall be shown on the dentist's account against the code 8099. Such dentist's account shall be accompanied by the actual account of the dental technician (or a copy thereof) and the account of the dental technician shall bear the signature of the dentist (or the person authorized by him/her) 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 teeth. For example, tariff item 8231 is specified as follows:

	N$
8231	X
8099 (8231)	Y
Total	N$ X+Y

D012 In the case where treatment is not listed for dentists in general practice or specialists, then the appropriate tariff fee listed in the Schedule for Medical Aid shall be charged and the relevant tariff code must be indicated.

D013 Cost of material (VAT inclusive - unless the service provider is not a registered VAT vendor): This item provides for a charge for material where indicated against the relevant item codes by the words "See Rule D013". Material to be charged for in these instances at cost plus a handling fee not exceeding 35%, up to N$1280.90. A maximum handling fee of 10% shall apply above a cost of N$1280.90.
Note: Item 8220 (suture) is applicable to all registered persons

D014 Cost of prosthesis: cost price + 20% with a maximum of N$ 1800.00

D015 Payment shall only be made for services required as a direct result of the accident. No liability would be accepted for e.g. gold fillings in broken dentures for cosmetic purposes only.

D016 Where a dental practitioner administers a general anaesthetic, the fee charged shall be set out in item 8499.

D017 Code 8279 and 8281 - Metal base to full and partial dentures: The fees for these items refer to the metal base only. An additional fee is then charged for the partial or full denture, which is fitted, to the base**.**

D018 Payment of a fee in respect of treatment not listed in the Tariff of Fees but for which the Commission has agreed to accept liability, and of any fee reflected in respect of a service listed in the Tariff of Fees, shall be in full and final settlement for the treatment or procedure given to the injured employee.

D019 Unless timely steps are taken to cancel an appointment for a consultation the relevant consultation fee shall be payable by the injured employee.

B. MODIFIERS

Modifiers may only be used where (M) appears against the item in the Schedule

For the adjustment of specific tariff items to certain circumstances, it is necessary to show the following modifiers on the account**:**

8001 33 1/3% of the appropriate scheduled fe**e**
8002 The appropriate scheduled fee plus 50%
8003 The appropriate scheduled fee plus 10%
8004 Two-thirds of appropriate scheduled fee (see Rule D009**)**
8005 The appropriate scheduled fee up to a maximum of N$ 175.00
8006 50% of the appropriate scheduled fe**e**
8007 15% of the appropriate scheduled fee
8008 The appropriate scheduled fee plus 25%
8009 75% of the appropriate scheduled fee/benefit
8010 The appropriate schedule fee plus 75%

C. EXPLANATIONS

a) Tooth identification (T)

Tooth identification is compulsory for all accounts rendered. Tooth identification is only applicable to procedures identified with the letter (T) in the mouthpart (MP) column. The International Standards Organization (ISO) in collaboration with the FDI designated system for teeth and areas of the oral cavity should be used.

b) Treatment categories (TC)

Treatment categories (TC) of dental procedures are identified in the TC column of the schedule as follows:
Basic dentistry designated as (B) in this schedule
Intermediate dentistry designated as (I) in this schedule
Advanced dentistry designated as (A) in this schedule
Maxillo-facial and oral surgery designated as (S) in this schedule

c) Abbreviations used in the Schedule

+D	Add fee/benefit for denture
+L	Add laboratory fee
An	Advanced dentistry (TC)
B	Basic dentistry (TC)
GP	General practitioner
I	Intermediate dentistry (TC)
S	Maxillo-facial and oral surgery (TC)
M	Modifier
MP	Mouth part
T	Tooth (MP)
TC	Treatment category

D. PROCEDURES

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	I.	**GENERAL DENTAL PRACTITIONERS**				
	1.1.	**<u>Diagnostic</u>**				
		Clinical oral evaluations				
modified	8101	Full mouth examination, charting and treatment planning (see Rule D001)	92.40			B
new	8102	Comprehensive consultation A comprehensive consultation shall include treatment planning at a separate appointment where a diagnosis is made with the help of study models, full-mouth x-rays and other relevant diagnostic aids. Following on such a consultation, the patient and the Commission must be supplied with a comprehensive written treatment plan which must also be recorded on the patient's file and which must include the following: • Soft tissue examination • Hard tissue examination • Screening/probing of periodontal pockets • Mucogingival examination • Plaque index • Bleeding index • Occlusal Analysis • TMJ examination • Vitality screening of complete dentition	141.60			B
	8104	Examination or consultation for a specific problem not requiring full mouth examination, charting and treatment planning	40.80			B
		Radiographs/Diagnostic imaging				
	8107	Intra-oral radiographs, per film	39.60			B
	8108	Maximum for 8107	310.80			B
	8113	Occlusal radiographs	68.40			B
	8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA) Chargeable to a maximum of two films per treatment plan	160.80			B
		Tests and laboratory examinations				
	8117	Study models - unmounted or mounted on a hinge articulator	43.20	+L		B
new	8119	Study models - mounted on a movable condyle articulator	109.20			B
	8121	Photographs (for diagnostic, treatment or dento-legal purposes) per photograph	43.20	+L		B
new	8122	Bacteriological studies for determination of pathological agents (May include, but is n ot limited to tests for susceptibility to periodontal disease. A period of risk assessment must on request be made available at no charge).	19.20			B
	8811	Tracing and analysis of extra-oral film	19.20			B
	1.2	**<u>Preventative</u>**				
		Dental phophylaxis				
new	8155	Polishing only (including removal of plaque) - complete definition	61.20			B
new	8159	Scaling and polishing Where item 8159 is applied, item 8155 cannot be charged	120.00			B
new	8161	Topical application of fluoride (prophylaxis excluded) - complete dentition (excluding scaling and/or polishing)	61.20			B

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Other preventive services				
new	8151	Oral hygiene instructions	61.20			B
new	8153	Follow-up visit for re-evaluation of oral hygiene	44.40			B
new	8163	Fissure sealant - per tooth	39.60		T	B
		Chargeable to a maximum of two teeth per quadrant				B
		Space maintenance (passive appliances)				B
		Passive appliances are designed to prevent tooth movement.				
new	8173	Space maintainer - fixed, per abutment unit	112.80	+L		B
new	8175	Space maintainer - removable (all-inclusive fee)	145.20	+L		B
	1.3.	**<u>Restorative</u>**				
		Note: Restorative material factor - an additional 10% can be added to codes 8341, 8342, 8343, 8344, 8351, 8352, 8353, 8354, 8367, 8368, 8369, 8370 by general dental practitioners only. See code 8346.	M8003			
	8346	Restorative material factor. (See above note)	M8003			
		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. See Codes 8345, 8347, and 8348 for post and/or pin retention. Inclusive of direct pulp capping (code 8301).				
	8341	Amalgam - one surface	110.40		T	B
	8342	Amalgam - two surfaces	138.60		T	B
	8343	Amalgam - three surfaces	165.60		T	B
	8344	Amalgam - four or more surfaces	184.40		T	B
		Resin restorations				
		Resin refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Light-curing, acid etching and adhesives (including resin bonding agents) are included as part of the restoration. Glass ionomers and compomers, when used, as restorations should be reported with these codes. If pins are used, they should be reported separately. See Codes 8345, 8347, and 8348 for post and/or pin retention, inclusive of direct pulp capping (code 8301) and rubber dam application (code 8304)				
	8351	Resin – one surface, anterior	121.20		T	B
	8352	Resin - two surfaces, anterior	154.40		T	B
	8353	Resin - three surfaces, anterior	182.40		T	B
	8354	Resin - four or more surfaces, anterior	202.80		T	B
	8367	Resin - one surface, posterior	130.80		T	B
	8368	Resin - two surfaces, posterior	162.00		T	B
	8369	Resin - three surfaces, posterior	195.60		T	B
	8370	Resin - four or more surfaces, posterior	211.20		T	B
		Notes to Amalgam and Resin Restorations**:** For anterior teeth, tariff fee for resin restorations, per restoration placed e.g. a Class V and a Class IV and for restoration on a central incisor code 8351 and 8354 is applicable. On posterior teeth, tariff fee to be charged per surface treated if a similar material was used and not per restoration e.g., for a Class I occlusal amalgam and a Class V buccal amalgam on tooth 28 code 8342 is applicable. In rare cases, it may occur that an occlusal amalgam on tooth 16 and a buccal resin on the same tooth in a patient with an unusually wide smile, may be necessary and code 8341 and 8367 is applicable. Items 8351 to 8354 are applicable per restoration (more than once per tooth), whereas items 8341 to 8344 or 8367 to 8370 are applicable once only per tooth				

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Inlay/Onlay restorations **Metal Inlays** For metal inlays on anterior teeth (incisors and canines) pre-arrangement with the Com-mission in writing required				
new	8358	Inlay, metallic – one surface, anterior			T	A
new	8359	Inlay, metallic – two surfaces, anterior			T	A
new	8360	Inlay, metallic – three surfaces, anterior			T	A
new	8365	Inlay, metallic – four or more surfaces, anterior			T	A
	8361	Inlay, metallic – one surface, posterior	186.00	+L	T	A
	8362	Inlay, metallic – two surfaces, posterior	271.20	+L	T	A
	8364	Inlay, metallic – three surfaces, posterior	452.40	+L	T	A
		Inlay, metallic – four or more surfaces, posterior	547.20	+L	T	A
		Ceramic and/or Resin Inlays Porcelain/ceramic inlays presently include all ceramic or porcelain inlays. Composite/resin inlays must be laboratory processed. NOTE: The application of a rubber dam (code 8304) is excluded				
	8371	Inlay, ceramic/resin - one surface	223.20	+L	T	A
	8372	Inlay, ceramic/resin - two surfaces	330.00	+L	T	A
	8373	Inlay, ceramic/resin - three surfaces	543.60	+L	T	A
	8374	Inlay, ceramic/resin - four or more surfaces	657.80	+L	T	A
	8560	Cost of ceramic block Applicable to computer generated prosthesis only NOTE: 1. In some of the above cases (e.g. Direct hybrid inlays) +L does not apply 2. In cases where the direct hybrid inlays are used and +L does not apply, Modifier 8008 may be used 3. See the General Practitioner's Guideline to the correct use of treatment codes for computer-generated inlays.	Rule D003		T	A
		Crowns - single restorations The tariff fees include the cost of temporary and/or intermediate crowns. See code 8193 (osseo iintegrated abutment restoration) in the "fixed prosthodontic" category for crowns on osseo-integrated implants				
	8401	Cast full crown	697.20	+L	T	A
	8403	Cast three-quarter crown	697.20	+L	T	A
	8405	Acrylic jacket crown. (By written prearrangement with the Commission)	697.20	+L	T	A
	8407	Acrylic veneered crown	697.20	+L	T	A
	8409	Porcelain jacket crown	697.20	+L	T	A
	8411	Porcelain veneered crown				
		Other restorative services				
	8133	Re-cementing of inlays, crowns or bridges – per abutment In cases where item 8133 is used +L does not apply	61.20	+L	T	B
	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	121.20	+L	T	A
	8137	Temporary crown placed as an emergency procedure Not applicable to temporary crowns placed during routine crown and bridge preparations i.e. where the impression for the final crown is taken at the same visit	208.80	+L	T	A
new	8146	Resin bonding for restorations Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges (By written arrangement with the Commission)	61.20			
	8157	Re-burnishing and polishing of restorations - complete dentition (Not applicable to restorations recently done)	61.20	+L		B
	8330	Removal of fractured post or instrument and/or Bypassing fractured endodontic instrument.	80.40	+L	T	B

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Note: Excluding the application of a rubber dam (code 8304).				
	8345	Preformed post retention, per post (See Item 8379)	120.00			B
	8347	Pin retention for restoration, first pin	60.00			B
	8348	Pin retention for restoration, each additional pin. A maximum of two additional pins may be charged	55.20			B
new	8349	Carving or contouring a plastic restoration to accommodate an existing removable prosthesis	24.00			B
	8355	Composite veneers (Direct)	211.20			B
	8357	Preformed metal crown	124.80			B
	8366	Pin retention as part of cast restoration, irrespective of number of pins	90.00			A
	8376	Prefabricated post and core in addition to crown. The core is built around a prefabricated post(s)	332.40			B
new	8379	Cost of posts. Applicable to pre-fabricated noble metal, ceramic, iridium and pure titanium posts - see code 8345 Cast post	Rule D013			A
	8391	and core - single	140.40	+L	T	A
	8393	Cast post and core - double	223.20	+L	T	A
	8395	Cast post and core - triple	322.80	+L	T	A
	8396	Cast coping	91.20	+L	T	A
	8397	Cast core with pins On grossly broken-down vital teeth only. May not be charged when a post has been inserted in the tooth in question	223.20	+L	T	A
	8398	Core build-up, including any pins refers to building up of anatomical crown when restorative crown will be placed, irrespective of the number of pins used	271.20		T	B
	8413	Facing replacement	135.60	+L	T	A
	8414	Additional fee for provision of crown within an existing clasp or rest	39.60	+L	T	A
	1.4	**<u>Endodontics</u>** 1. 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. 2. Fees 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: • Extirpation of the pulp chamber contents for the relief of pain (code 8132) • Apexification of a root canal (code 8305); 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); • Ceramic and or resin inlays (codes 8371 to 8374) 3. After endodontic preparatory visits (codes 8332, 8333 and 8334) have been charged, endodontic treatment completed at a single visit (codes 8329, 8338, 8339 and 8340) may not be charged				
		Pulp capping				
	8301	Direct pulp capping (No benefit)	0.00		T	B
	8303	Indirect pulp capping The permanent filling is not completed at the same visit	81.60		T	B
		Pulpotomy				
	8307	Amputation of pulp (pulpotomy) 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)	80.40		T	B
		Endodontic therapy (including treatment plan, clinical procedures and follow-up care).				

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Preparatory Visits (obturation not done at same visit)				
	8332	Single-canal tooth, per visit	61.20		T	B
	8333	Multi-canal tooth, per visit	85.20			
		A maximum of four visits per tooth may be charged				
		Obturation of root canals at a subsequent visit				
	8335	First canal - anteriors and premolars	277.20		T	B
new	8328	Each additional canal – anteriors and premolars	112.80		T	B
	8336	First canal – molars	381.60		T	B
	8337	Each additional canal – molars	112.80		T	B
		Preparation and obturation of root canals completed at a single visit				
	8338	First canal - anteriors and premolars	423.60		T	B
new	8329	Each additional canal – anteriors and pre-molars	141.60		T	B
	8339	First canal – molars	582.00		T	B
	8340	Each additional canal – molars	141.60		T	B
		Endodontic retreatment				
	8334	Re-preparation of previously obturated canal, per canal	90.00		T	B
		Apexification/recalcification procedures				
new	8305	Apexification of root canal, per visit No other endodontic procedures may, in respect of the same tooth, be charged con-current to code 8305 at the same visit (code 8304 excluded)	81.60		T	B
		Apicoectomy/Periradicular services				
	8229	Apicoectomy including retrograde filling where necessary - incisors and canines	301.20		T	S
		Other endodontic procedures				
		Gross pulpal debridement				
	8132	Where Code 8132 is charged, no other endodontic codes may be charged at the same visit on the same tooth. Codes 8338, 8329, 8339 and 8340 (single visits) may be charged at the subsequent visit, even if Code 8132 was used for the initial relief of pain. (See note 2 under section 1.4.)	99.60		T	B
	8136	Access through a prosthetic crown or inlay to facilitate root canal treatment	54.00		T	B
new	8306	Cost of Mineral Trioxide Aggregate	Rule D013			B
	1.5	**<u>Periodontics</u>** **Surgical services including usual post-operative Care)**				
new	8185	Gingivectomy-gingivoplasty, per quadrant	319.20			A
new	8186	Gingivectomy-gingivoplasty, per sextant	254.40			A
	1.6.	**<u>Prosthodontics (removable)</u>** **Complete dentures**				
	8231	Full upper and lower dentures inclusive of soft bases or metal bases, where applicable	984.00	+L		B
	8232	Full upper or lower dentures inclusive of soft base or metal base, where applicable	607.20	+L		B
		Partial dentures	282.00	+L		B
	8233	Partial denture, one tooth	282.00	+L		B
	8234	Partial denture, two teeth	422.40	+L		B
	8235	Partial denture, three teeth	422.40	+L		B
	8236	Partial denture, four teeth	422.40	+L		B
	8237	Partial denture, five teeth	421.50	+L		B

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	82 38	Partial denture, sixth teeth	560.40	+L		B
	8239	Partial denture, seven teeth	560.40	+L		B
	8240	Partial denture, eight teeth	560.40	+L		B
	8241	Partial denture, nine or more teeth	560.40	+L		B
	8281	Metal (e.g. chrome cobalt, etc.) base to partial denture, per denture	560.40	+L		B
		The procedure refers to the metal framework only, and includes all clasps, rests and bars (i.e. code 8251, 8253, 8255, and 8257). See codes 8233 to 8241 for the resin denture base required concurrent to code 8281.	657.60	+L		B B B
		Adjustments to dentures				
new	8275	Adjustment of denture (After six months or for patient of another practitioner)	44.40			B
		Repairs to complete or partial dentures				
	8269	Repair of denture or other intra-oral appliance A dentist may not charge professional fees for the repair of dentures if the patient was not personally examined; laboratory fees, however, may be recovered.	78.00	+L		B
new	8270	Add clasp to existing partial denture (One or more Clasps). Code 8270 is in addition to code 8269	55.20	+L		B
new	8271	Add tooth to existing partial denture (One or more teeth). Code 8271 is in addition to code 8269	55.20	+L		B
	8273	Additional fee/benefit where one or more impressions are required for 8269, 8270 and 8271	44.40	+L		B
		Denture rebase procedures				
	8259	Re-base of denture (laboratory)	230.40	+L		B
	8261	Re-model of denture	368.40	+L		B
		Denture reline procedures				
	8263	Reline of denture in self curing acrylic (intra-oral)	145.20	+L		B
	8267	Soft base re-line per denture (heat cured). Code 8267 may not be charged concurrent with Codes 8231 to 8241.	336.00	+L		B
		Other removable prosthetic services				
	8243	Soft base to new denture (No benefit)	0.00	+L		B
	8255	Stainless steel clasp or rest per clasp or rest	58.80	+L		B
	8257	Lingual bar or palatal bar Codes 8255 and 8257 may not be charged concurrent to codes 8169, 8175, 8269 (repair of denture) or code 8281.	68.40	+L		B
	8265	Tissue conditioner and soft self-cure interim re-line, Per denture	96.00			B
	8279	Metal (e.g. chrome cobalt, gold, etc.) base to full denture. (No benefit)	0.00			
	1.7.	**<u>Maxillofacial Prosthetics</u>** See III. Specialist Prosthodontists				
	1.8.	**<u>Implant Services</u>** Prior permission must be obtained from the Commission. The Commission does not approve of the re-use of any implant components because of the hazards to the patient. Report surgical implant procedures using the codes in this section; prosthetic devices should be reported using existing fixed or removable prosthetic codes.				
		Endosteal implants Endosteal dental implants are placed into the alveolar and/or basal bone of the mandible or maxilla and transect only one cortical plate				
	8194	Placement of a single osseo-integrated implant per jaw	582.00		T	S
	8195	Placement of a second osseo-integrated implant in the same jaw	435.60		T	S
	8196	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	291.60		T	
	8197	Cost of implants (By arrangement)	Rule D013			

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	8198	Exposure of a single osseo-integrated implant and Placement of a transmucosal element	216.00		T	S
	8199	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	162.00		T	S
	8200	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	108.00		T	S
		Eposteal implants Eposteal (subperiosteal) dental implants receive their primary bone support by means of resting on the alveolar bone. See VI. Specialist Maxillo-Facial and Oral Surgeons' Schedule				
		Transosteal implants Transosteal dental implants penetrate both cortical plates and pass through the full thickness of the alveolar bone. See the specialist maxillo-facial and oral surgeons schedule				
	1.9	**Prosthodontics, fixed** The words 'bridge' and 'bridgework' have been replaced by the statement 'fixed partial denture'. Each abutment and each pontic constitutes a unit in a fixed partial denture.				
		Fixed partial denture pontics				
	8420	Sanitary pontic	330.60	+L	T	A
	8422	Posterior pontic	452.40	+L	T	A
	8424	Anterior pontic (including premolars)	568.80	+L	T	A
		Fixed partial denture retainers inlays/onlays See inlay/onlay restorations for inlay/onlay retainers				
	8356	Bridge per abutment - only applicable to Maryland type bridges. Report per abutment. Report pontics separately (see codes 8420, 8422 and 8424)	271.20		T	
		Fixed partial denture retainers – crowns See crowns, single restorations for crown retainers				
	8193	Osseo-integrated abutment restoration, per abutment	904.80	+L	T	A
	1.10	**0ral and Maxillofacial Surgery** See VI. Specialist Maxillo-facial and Oral Surgeons Schedule for surgical services not listed in this section of the Schedule.				
		Extractions				
	8201	Single tooth. Code 8201 is charged for the first extraction in a quadrant	60.40		T	B
	8202	Each additional tooth in the same quadrant. Code 8202 is charged for each additional extraction in the same quadrant	24.00		T	B
		Surgical extractions (includes routine postoperative care)				
	8209	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (including cutting of gingiva and bone, removal of tooth structure and closure) Code 8220 is applicable when sutures are provided by practitioner	262.80		T	S
	8210	Removal of unerupted or impacted tooth - first tooth	436.80		T	S
	8211	Removal of unerupted or imptacted tooth - second tooth	234.00		T	S
	8212	Removal of unerupted or imptacted tooth - each additional tooth	133.20		T	S
	8213	Surgical removal of residual roots (cutting procedure - includes cutting of gingiva and bone, removal of tooth structure and closure). Code 8220 is applicable when sutures are provided by practitioner.	262.80		T	S
	8214	Surgical removal of residual roots (cutting procedure - includes cutting of soft tissue and bone, removal of tooth structure and	202.74		T	S

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Other surgical procedures				
	8188	Biopsy - intra-oral. This item does not include the cost of the essential pathological evaluations	154.80			S
	8215	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	487.20		T	S
		Reduction of dislocation and management of other temporomandibular joint dysfunction				
	8169	Bite plate for the treatment of TMJ dysfunction, or occlusal guards.	234.00	+L		B
		Repair of traumatic wounds				
	8192	Appositioning (i.e. suturing) of soft tissue injuries	301.20			S
	1.11.	**Orthodontics**				
		See V. Specialist Orthodontists				
	1.12.	**Adjunctive General Services**				
		Unclassified Treatment				
	8131	Palliative [emergency] treatment for dental pain This is typically reported on a "per visit" basis for Emergency treatment of dental pain where no other treatment item is applicable or applied for treatment of the same tooth	61.20			B
	8221	Local treatment of post-extraction haemorrhage –initial visit (excluding treatment of bleeding in the case of blood dyscrasias, e.g. haemophilia)	44.40			S
	8223	Local treatment of post-extraction haemorrhage –each additional visit	28.80			S
	8225	Treatment of septic socket – initial visit	44.40			S
	8227	Treatment of septic socket – each additional visit	28.80			S
		Anaesthesia				
	8141	Inhalation sedation - first quarter-hour or part-thereof	44.40			B
	8143	Inhalation sedation - each additional quarter-hour or part thereof No additional fee/benefit to be charged for gases used in the case of codes 8141 and 8143	22.80			B
	8144	Intravenous sedation	26.40			B
new	8147	Use of own monitoring equipment in rooms for procedures performed under intravenous sedation	96.00			B
	8145	Local anaesthetic, per visit. Item 8145 includes the use of the Wand	10.80			B
	8499	The relevant tariff code and fee in the Schedule for Medical Aid shall apply to general anaesthetics for dental procedures.				
		Professional consultations				
new	8106	Provision of a written treatment plan and quotation where prior authorization is required (prior permission from the Commission must be obtained) This code is not applicable to routine inquiries, to assess benefit available, or responses to inquiries by the Commission to verify charges by dental practitioners. Also not applicable to furnishing copies of existing and necessary records.	102.00			A
		Professional visits				
	8129	Additional fee for emergency treatment rendered outside normal working hours (including emergency treatment carried out at hospital). Not applicable where a practice offers an extended hours service as the norm.	150.00			B
	8140	Fee for treatment at a venue other than the surgery, inclusive of hospital visists, treatment under general anaesthetic, home visits; per visit. Code 8140 may be applied concurrent with codes 8101 or 8104, but in accordance with rule D001	98.40			B
		Drugs, medicaments and materials				
new	8183	Intra-muscular or sub-cutaneous injection therapym per injection. (Not applicable to local anaesthetic)	26.40			B

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
new	8220	Use of suture provided by practitioner	RuleD013			
		Miscellaneous services				
new	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	8.40			B
new	8110	Provision of sterilized and wrapped instrumentation in consulting rooms. (The use of this code is limited to heat, autoclave or vapour sterilized and wrapped instruments)	22.80			S
new	8167	Treatment of hypersensitive dentine, per visit	46.80			B
new	8170	Minor occlusal adjustment (Not applicable to adjustment of restorations placed as part of a current treatment plan)	134.40			B
	8304	Rubber dam, per arch	48.00			B
new	**II.**	**ORAL PATHOLOGISTS** See Rule D012 In cases where services are not listed in this Schedule, the appropriate fee(s) listed in the Schedule for Medical Aid (section pathologists) shall be charged and the relevant tariff code and fee in the medical schedule must be indicated.				
new	9201	Consultation at rooms	98.40			
new	9203	Consultation at hospital, nursing home or house	111.60			
new	9205	Subsequent consultation	73.20			
new	9207	Night consultation	162.00			
	III.	**SPECIALIST PROSTHODONTIST**				
	3.1.	**<u>Diagnostic Procedures</u>**				
	8501	Consultation	98.00			A
	8107	Intra-oral radiographs, per film	39.60			B
	8108	Maximum for 8107	310.80			B
	8113	Occlusal radiographs	68.40			B
	8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA) Chargeable to a maximum of two films per treatment plan.	160.80			B
	8811	Tracing and analysis of extra-oral film	19.20			B
	8117	Study models – unmounted	43.20	+L		B
	8119	Study models – mounted on adjustable articulator	109.20	+L		B
	8121	Diagnostic photographs, per photograph	43.20			B
	8503	Occlusal analysis on adjustable articulator	202.80			A
	8505	Pantographic recording	294.00			A
	8507	Examination, diagnosis and treatment planning	202.80			A
new	8506	Detailed clinical examination, records, radiographic interpretation, diagnosis, treatment planning and case presentation Code 8506 is a separate procedure from code 8507 and is applicable to craniomandibular disorders; implant placement or orthognathic surgery where extensive restorative procedures will be required. In the case of treatment planning requiring the combined services of a prosthodontist and/or orthodontist and/or a maxillo-facial and oral surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.	331.20			A
	8508	Electrognathographic recording	315.60			A
	8509	Electrognathographic recording with computer analysis	524.40			A
	3.2.	**<u>Preventive Procedures</u>**				
new	8711	Oral hygiene instruction	122.40			
	8713	Oral hygiene evaluation	58.80			B
	8155	Polishing only (including removal of plaque complete dentition)	61.20			B
	8159	Scaling and polishing. Where code 8159 is applied, code 8155 cannot be charged	120.00			B
	8161	Topical application of fluoride preparations - complete dentition (excluding scaling and/or polishing)	61.20			B
	8163	Fissure sealant, per tooth. Chargeable to a maximum of two teeth per quadrant	39.60		T	B
	8165	Application of fluoride using laboratory processed applicators	64.80	+L		B
	8167	Treatment of hypersensitive dentine, per visit	46.80			B

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	3.3	**Treatment Procedures**				
		Emergency treatment				
	8511	Emergency treatment for relief of pain (where no other tariff item is applicable)	124.80			B
	8513	Emergency crown. (Not applicable to temporary crowns placed during routine crown and bridge preparations)	206.40	+L	T	A
	8515	Recementing of inlay, crown or bridge, per abutment	78.00		T	B
	8517	Re-implantation of an avulsed tooth, including fixation as required	211.20	+L	T	S
		Provisional treatment				
	8521	Provisional splinting - extracoronal wire, per sextant	170.40			A
	8523	Provisional splinting - extracoronal wire plus resin, per sextant	247.20			A
	8527	Provisional splinting - intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint	78.00	+L		A
	8529	Provisional crown. Crown utilized as an interim restoration of at least six weeks during restorative treatment to allow adequate time for healing or completion of other procedures. This includes, but is not limited to, changing vertical dimension, completing periodontal therapy, or cracked tooth syndrome. This is not to be used as a temporary crown for a routine prosthetic restoration	202.80	+L	T	A
	8530	Preformed metal crown	171.60		T	A
		Occlusal adjustment				
	8551	Major occlusal adjustment This procedure cannot be carried out without study models mounted on an adjustable articulator.	578.40			A
	8553	Minor occlusal adjustment	184.40			A
		Ceramic and/or resin bonded inlays and veneers: In some of the procedures below (e.g. Direct hybrid Inlays) +L may not apply.				
new	8554	Bonded veneers	702.00	+L	T	A
	8555	One surface	441.60	+L	T	A
	8556	Two surfaces	636.00	+L	T	A
	8557	Three surfaces	987.60	+L	T	A
	8558	Four or more surfaces	987.60	+L	T	A
	8560	Cost of ceramic block (Applicable to computer generated prosthesis only)	Rule D013	+L	T	A
		Gold restorations				
	8571	One surface	366.00	+L	T	A
	8572	Two surfaces	530.40	+L	T	A
	8573	Three surfaces	822.00	+L	T	A
	8574	Four or more surfaces	822.00	+L	T	A
	8577	Pin retention	122.40		T	A
		Posts and copings				
	8581	Single post	206.40	+L	T	A
	8582	Double post	294.00	+L	T	A
	8583	Triple post	366.00	+L	T	A
	8587	Copings	170.40	+L	T	A
	8589	Cast core with pins	290.40	+L	T	A
		Preformed posts and cores				
Modified	8591	Core build-up, including any pins Refers to building up of anatomical crown when restorative crown will be placed, whether or not pins are used	271.20		T	B
new	8593	Prefabricated post and core in addition to crown Core is built around a prefabricated post(s).	308.40		T	B
	8596	Cost of posts Applicable to pre-fabricated noble metal, ceramic, Iridium and pure titanium posts. Applicable to pre-fabricated noble metal, ceramic, Iridium and pure titanium posts.	Rule D013		T	A

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Implants				
		Prior permission must be obtained from the Commission.				
		The Commission does not approve of the re-use of any implant components because of the hazards to the patient.	124.80			
	8592	Osseo-integrated abutment restoration, per abutment/	1231.20	+L	T	A
	8600	Cost of implant components (By arrangement)	Rule D013			
new	8590	Periodic maintenance of existing implant prosthesis, per abutment	78.00		T	A
	9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	292.80			
	9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	219.60			
	9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant.	147.60			
		For codes 9190 to 9192 the full fee may be charged i.e. section 2 of Rule D011 will not apply.				
		Connectors	82.80	+L	T	A
	8597	Locks and milled rests	202.80	+L	T	A
	8599	Precision attachments				
		Crowns				
	8601	Cast three-quarter crown	1026.00	+L	T	A
new	8605	Acrylic veneered gold crown		+L	T	A
	8607	Porcelain jacket crown	1026.00	+L	T	A
	8609	Porcelain veneered metal crown	1026.00	+L	T	A
		Bridges				
		(Retainers as above)	620.40	+L	T	A
	8611	Sanitary pontic	758.40	+L	T	A
	8613	Posterior pontic	819.60	+L	T	A
	8615	Anterior pontic				
		Resin bonded retainers				
	8617	Per abutment	530.40	+L	T	A
		Per pontic (see 8611, 8613, 8615)				
	8618	Resin bonding for restorations				
		Applicable to any metal restorations, crowns or conventional bridges, per abutment except Maryland type bridges				
		Prior permission from the Commission is required				
	8625	**Conservative treatment for temporomandibular joint dysfunction**	308.40	+L		S
	8621	Bite plate for TMJ dysfunction	84.00			
	8623	First visit for treatment of TMJ dysfunction	64.00			
		Follow-up visit for TMJ dysfunction				
		The number of visits and charge depends on the relation between the practitioner and the patient, and the problems involved in the case.				
		Endodontic procedures, etc.				
		Root Canal Therapy				
		Codes 8631, 8633, and 8636 include all X-rays and repeat				
	8631	visits.	718.80		T	B
	8633	Root canal therapy, first canal	181.20		T	B
	8636	Each additional canal	109.20		T	B
		Re-preparation of previously obturated canal, per canal				
	8635	**Other Endodontic Procedure**	120.00		T	B
	8637	Apexification of root canal, per visit	398.40		T	B
	9015	Hemisection of a tooth, resection of a root or tunnel preparation (as an isolated procedure)	398.40		T	B
	9016	Apicectomy including retrograde root filling where necessary - anterior teeth	795.60		T	B
	8640	Apicectomy including retrograde root filling where necessary - posterior teeth	211.20		T	B
		Removal of fractured post or instrument from root canal				

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Prosthetics (Removable)				
	8641	Complete upper and lower dentures without primary Complications	2054.40	+L		B
	8643	Complete upper and lower dentures without major complications	2666.40	+L		B
	8645	Complete upper and lower dentures with major	3279.60	+L		B
	8657	complications	1437.60	+L		B
		Complete upper or lower denture without primary				
	8649	complications	1641.60	+L		B
	8651	Complete upper or lower denture without major	1845.60	+L		B
	8661	complications Complete upper or lower denture with major complications	1641.60	+L		A
	8662	Diagnostic dentures (inclusive of tissue conditioning	236.40	+L		B
	8663	treatment)	494.40	+L		A
	8664	Remounting and occlusal adjustment of dentures	236.40			A
	8665	Chrome cobalt base or gold base for full denture (extra	332.40	+L		B
	8667	charge) Remount of crown or bridge for extensive	494.40	+L		I
	8668	prosthetics	122.40			B
	8669	Re-base, per denture	182.40	+L		B
	8671	Soft base, per denture (heat cured)	1641.60	+L		A
	8672	Tissue conditioner, per denture	63.60	+L		B
		Intra-oral reline of complete or partial denture.				
	8674	Metal (e.g. Chrome cobalt or gold) partial denture	744.00	+L		B
	8679	Additional fee/benefit for altered cast technique for partial	82.80	+L		B
	8273	denture	44.40	+L		B
		Additive partial denture				
new	8275	Repairs	44.40			B
		Additional fee/benefit where impression is required for code 8269+/or 8679				
		Adjustment of denture (After six months or for a patient of another practitioner)				
	3.4	**<u>Maxillo-Facial Prosthodontic Prostheses</u>**				
		Where "+D" appears the practitioner may charge the relevant tariff code and fee for the denture in the prosthodontic section plus the tariff code and fee indicated.				
		Maxillary prostheses	122.40	+L		
new	9101	Surgical obturator - Modified denture	331.20	+L		
new	9102	Surgical obturator - continuous base	493.20	+L		
new	9103	Surgical obturator - split base	744.00	+L		
new	9104	Interim obturator on existing denture	2299.20	+L		
new	9105	Interim obturator on new denture	744.00	+L		
new	9106	Definitive obturator - open/ hollow box	1437.60	+L		
new	9107	Definitive obturator - silicone glove				
		Mandibular resection prostheses	1765.20	+L		
new	9108	Prosthesis with guide flange	1641.60	+L		
new	9109	Prosthesis without guide flange	331.20	+D		
new	9110	Prosthesis - Palatal augmentation				
		Glossal resection prostheses	691.20	+D		
new	9111	Simple prosthesis.	1034.40	+D		
new	9112	Complex prosthesis				
		Radiotherapy appliances	744.00	+L		
new	9113	Carriers – simple	2054.40	+L		
new	9114	Carriers – complex	744.00	+L		
new	9115	Shields – simple	2054.40	+L		
new	9116	Shields – complex	744.00	+L		
new	9117	Cone locators				
		Chemotherapy appliances	744.00	+L		
new	9118	Chemotherapeutic agent carriers				
		Intermediate/Definitive prostheses				
new	9125	Speech aid/obturator with palatal modification	332.40	+D		
new	9126	Speech aid/obturator with velar modification	744.00	+D		
new	9127	Speech aid/ obturator with pharyngeal modification	1641.60	+D		
new	9128	Speech aid/obturator adjustment	82.80	+D		
new	9129	Speech aid/obturator surgical prosthesis	658.80	+D		

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		Speech appliances				
new	9130	Palatal lift	331.20	+L		
new	9131	Palatal stimulating	744.00	+L		
new	9132	Speech bulb	1641.60	+L		
new	9133	Adjustments	82.80	+L		
	9134	Other (By arrangement)				
		Extra-oral appliances				
new	9135	Auricular prosthesis – simple	2054.40	+L		
new	9136	Auricular prosthesis – complex	2666.40	+L		
new	9137	Nasal prosthesis – simple	2054.40	+L		
new	9138	Nasal prosthesis – complex	2666.40	+L		
new	9139	Ocular prosthesis – conformer	744.00	+L		
new	9140	Ocular prosthesis using modified stock appliance	1846.80	+L		
new	9141	Ocular prosthesis using custom appliance	2666.40	+L		
new	9142	Orbital prosthesis - simple (excluding ocular section)	1846.80	+L		
new	9143	Orbital prosthesis - complex (excluding ocular section)	2666.40	+L		
new	9144	Combination facial prostheses - small (By Arrangement)				
new	9145	Combination facial prostheses - medium (By Arrangement)				
new	9146	Combination facial prostheses - large (By Arrangement)				
new	9147	Combination facial prostheses - complex (By Arrangement)				
new	9148	Other body prostheses – simple	1846.80	+L		
new	9149	Other body prostheses – complex	2666.40	+L		
new	9150	Surgical facial prostheses – simple	1437.60	+L		
new	9151	Surgical facial prostheses – complex	1846.80	+L		
new	9152	Additional prostheses (from mould at time of first prosthesis)	M8006	+L		
new	9153	Replacement prosthesis (from original mould)	M8006	+L		
new	9155	Cranial prosthesis	744.00	+L		
		Custom implants				
new	9156	Cranial - acrylic, elastomeric, metallic	924.00	+L		
new	9157	Facial – simple	462.00	+L		
new	9158	Facial – complex	924.00	+L		
new	9159	Ocular - custom made	462.00	+L		
new	9160	Body - special prosthesis	2054.00	+L		
		Surgical appliances				
new	9161	Splints – simple	202.80	+L		
new	9162	Splints – complex	744.00	+L		
new	9163	Templates – simple	202.80	+l		
new	9164	Templates – complex	744.00	+L		
new	9165	Conformers – simple	202.80	+L		
new	9166	Conformers – complex	744.00	+L		
		Trismus appliances	82.80	+L		
new	9167	Trismus appliance – simple	744.00	+L		
new	9168	Trismus appliance – complex	1641.60	+L		
new	9169	Orthoses (for paralyzed patients)	493.20	+L		
new	9170	Facial palsy appliances	202.80	+L		
new	9171	Oral splints (per commissure)	202.80	+L		
new	9172	Dynamic oral retractors (per arm)				
new	9173	Hand splints (By arrangement)				
new	9174	Other (By arrangement)				
		Attendance in theatre				
new	9175	Attendance in theatre, per hour	274.80			

IV. SPECIALISTS IN ORAL MEDICINE AND PERIODONTICS/ PERIODONTISTS

(1) Pre-arrangement for payment with the Commission is required.

(2) The expenses appurtenant to diagnostic tests, laboratory procedures, special materials, medicaments, etc., shall be charged over and above the fee for treatment (See Rule D013)

(3) If the extent of a procedure carried out is less than that specified in the tariff of fees, or if multiple procedures are carried out at a single visit and the value of the time factor is consequently reduced, the specialist may charge a reduced fee or reduced fees as per modifiers. (See Rule D011).

(4) Fees for surgical procedures include any post-surgical complications not exceeding three months.

(5) 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 fee for an assistant who is a specialist in oral medicine and periodontics shall be 33 1/3 % (see modifier 8001) of the fee for the procedure. The assistant's name must appear on the invoice rendered.

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	4.1.	**Diagnostic Procedures**				
		Codes 8701, 8703, 8705 and 8707 cannot be charged at one and the same visit.				A
new	8701	Consultation	98.40			
		A periodontal consultation comprises a reasonably detailed examination and presentation and explanation of the findings to enable the patient to make a decision as to future treatment				
	8107	Intra-oral radiographs, per film	39.60			B
	8108	Maximum for 8107	310.80			B
	8113	Occlusal radiographs	68.40			B
	8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA). Maximum of two films per treatment plan.	160.80			B
	8811	Tracing and analysis of extra-oral film	19.20			B
	8117	Study models – unmounted	43.20	+L		B
	8119	Study models - mounted on adjustable articulator	109.20	+L		B
	8140	Fee for treatment at a venue other than the surgery, inclusive of hospital visits, treatment under general anaesthetic, home visits; per visit	98.40			B
new	8703	Detailed clinical examination, records, radiographic interpretation, probing, percussion, diagnosis, treatment planning and case presentation for periodontal and/or implant cases Code 8703 is always a separate procedure from code 8701 and comprises inspection, percussion, probing and other diagnostic procedures and the systematic recording of every important feature in order to permit correct treatment planning.	331.20			A
new	8705	Periodic re-examination	98.40			A
new	8707	Periodontal screening A periodontal screening consists of the measurement and recording of a plaque index, a bleeding index, probing depths, a periodontal disease index, a microbiological assay and/or gingival crevicular fluid assay.	98.40			B
new	8711	Oral hygiene instruction	122.40			B
new	8713	Oral hygiene evaluation (If oral hygiene re-instruction is necessary, only code 8711 shall apply)	58.80			B
new	8714	Full mouth clinical plaque removal	84.00			B
new	8715	Scaling	169.20			B
new	8721	Occlusal adjustment per visit	184.80			A
new	8723	Provisional splinting - extracoronal wire, per sextant	170.40	+L		A
new	8725	Provisional splinting - extracoronal wire plus resin, per sextant	247.20	+L		A
new	8727	Provisional splinting - intracoronal wire or pins or cast bar, plus amalgam or resin, per dental unit included in the splint	78.00	+L		A
	4.2	**Temporamandibular Joint Procedures**				
	8625	Bite plate for TMJ dysfunction	308.40	+L		S
	4.3	**Surgical Procedures**				
new	8731	Periodontal abscess - treatment of acute phase (with or without flap procedure)	145.20			A
new	8737	Root planing with or without periodontal curettage, per quadrant	331.20			A
new	8739	Root planing with or without periodontal curettage, per sextant	264.00			A
new	8741	Gingivectomy-gingivoplasty, per quadrant	436.80			A
new	8743	Gingivectomy-gingivoplasty, per sextant	346.80			A
new	8749	Flap operation with root planning and curettage and which may include not more than 3 of the following: bone contouring, chemical treatment of root surfaces, root resection,	992.40			A

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
new	8755	As item 8753, per sextant Note: 1. Each root resection, tooth hemisection, muco-gingival procedure, wedge resection and clinical crown lengthening shall be deemed to be one procedure. 2. Where a bone regeneration/repair procedure is included within a flap operation, Item 8766 shall apply in addition to the Item for the flap operation. 3. Where an apicectomy is included within a flap operation, either item 8760 or item 8764 with Modifier 8006 shall apply to the item for the flap operation.	997.20			A
new	8756	Flap operation with bone removal to increase the Clinical crown length of a single tooth (as an isolated procedure)	604.80			A
new	8757	Frenectomy	486.00			A
new	8758	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	663.60			A
new	8759	Pedicle flapped graft e.g. lateral sliding double papilla, rotated and similar (as an isolated procedure)	454.80			A
new	8761	Masticatory mucosal autograft extending across not more than four teeth (isolated procedure)	493.20	+L		A
new	8762	Masticatory mucosal autograft extending across more than four teeth (isolated procedure)	741.60	+L		A
new	8772	Submucosal connective tissue autograft (isolated procedure)	499.20			A
new	8773	Cost of intrapocket chemotherapeutic agent used to report intrapocket chemotherapeutic agents provided by the practitioner	Rule D013			A
new	8763	Wedge resection (as an isolated procedure)	290.40		T	A
new	8760	Apicectomy including retrograde filling where Necessary - anterior teeth. When Code 8760 is part of a flap operation that requires an apicectomy, Modifier 8006 applies	398.40		T	S
new	8764	Apicectomy including retrograde filling where Necessary, posterior teeth. When Code 8764 is part of a flap operation that requires an apicectomy, Modifier 8006 applies	795.60			S
new	8765	Hemisection of a tooth, resection of a root or tunnel preparation (as an isolated procedure).	398.40			A
new	8766	Bone regenerative/ repair procedure excluding cost of regenerative material as part of a flap operation as described in Items 8749, 8751, 8753 and 8755, per procedure	347.60			A
new	8767	Bone regenerative/ repair procedure at a single site (Excluding cost of regenerative material - see code 8770)	615.60			A
new	8769	Subsequent removal of membrane used for guided tissue regeneration procedure	290.40			A
new	8770	Cost of bone regenerative/repair material	Rule D013			
		Any other periodontal procedure involving a single tooth	290.40		T	A
new	8979	Harvesting of autogenous grafts (intra-oral)	441.60	+L		S
new	9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth	804.00	+L		S
new	9009	Alveolar ridge augmentation across 3 or more tooth sites	1208.40	+L		S
new	9010	Sinus lift procedure				
	4.4	**<u>Implant Procedures</u>** Prior permission from the Commission is required. The Commission does not approve of the re-use of any implant components because of the hazards to the patient.				
	9182	Placement of endosteal implant, per implant	620.40	+L		S
	9283	Placement of a single osseo-integrated implant per jaw	790.80			S
	9384	Placement of a second osseo-integrated implant in the same jaw	592.80			S
	9185	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	397.20			S
	9189	Cost of implants (see section 4.4).				
	9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	292.80			S
	9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	147.60			S
	9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant.	147.60			S
new	9198	Implant removal. This procedure involves the surgical removal of an implant, i.e. cutting of soft tissue and bone, removal of implant, and closure.	403.20			

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	4.5	**Oral Medical Procedures**				
new	8781	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporo-mandibular joint disorders or myofascial pain-dysfunction: Straight forward case	98.40			S
new	8782	Consultation, examination, diagnosis and treatment of oral diseases, pathological conditions of the surrounding tissues, temporomandibular joint disorders or myofascial pain dysfunction: Complex case	174.00			S
new	8783	Subsequent consultation for same disease/condition	73.20			S
new	8785	Biopsy – incisional/excisional (e.g. epulis)	205.20			S
new	8786	Surgical treatment of soft tissue tumors (e.g. epulis)	355.20			S
		Any other procedure connected with the practice of oral medicine	104.40			S
	V.	**SPECIALIST ORTHODONTISTS**				
	5.1	**Consultations**				
new	8801	First consultation	98.40			A
new	8803	Subsequent consultation, retention and/ or post-treatment consultation	73.20			A
	5.2	**Records and Investigations**				
	8107	Intra-oral radiographs, per film	39.60			B
	8108	Maximum for 8107	310.80			B
	8113	Occlusal radiograph	68.40			B
	8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA) Chargeable to a maximum of two films per treatment plan.				
	8811	Tracing and analysis of extra-oral film	19.20			B
	8117	Study models – unmounted	43.20	+L		B
	8119	Study models - mounted on adjustable articulator	109.20	+L		B
	8121	Diagnostic photographs, per photograph	43.20			B
new	8837	Diagnosis and treatment planning	58.80			A
new	8839	Orthodontic diagnostic setup	124.80			A
	5.3	**Orthognathic Surgery and Treatment Planning** In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.				
	8840	Treatment planning orthognathic surgery	428.40	+L		A
		Retainers, Repairs and/or Replacements				
	8846	Removable: Repairs	84.00	+L		A
	8847	Removable: Replacement	290.40	+L		A
	8848	Fixed: Repair or replacement per unit (As a result of the patient's negligence)	124.80	+L		A
	8849	Retainer	290.40	+L		A
		Corrective Therapy **Treatment of MPDS**				
new	8850	First consultation	140.40			A
new	8851	Subsequent consultation	73.20			A
new	8852	Bite plate for TMJ dysfunction	308.40	+L		S
		Occlusal adjustment				
new	8853	Major occlusal adjustment	578.40			A
new	8854	Minor occlusal adjustment	184.80			A
		Removable appliance therapy				
new	8862	Removable (single)	1027.20	+L		A
new	8863	Removable (per additional) (Code 8862 may only be charged once per malocclusion. A maximum of two additional removable appliances per treatment plan may be charged)	516.00	+L		A
		Functional appliance therapy A removable functional appliance is an appliance with no fixed dental component, which is designed to harness the forces				

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
		generated by the muscles of mastication and the associated soft tissues of the oro-facial region. This appliance incorporates components which act on both the maxillary and mandibular arches and should be differentiated from a simple removable appliance including appliances incorporating an anterior and posterior bite plane	98.40			
new	8858	Functional appliance If additional functional appliances are required, +L can be charged but no further fee/benefit	1849.20	+L		A
		Fixed appliance therapy **Partial fixed appliance therapy – Preliminary Treatment** The intention of this phase in treatment is to intercept and modify the development of functional components of developing mal-occlusion Usually in the mixed dentition The application of codes 8865 and/or 8866 requires the use of fixed bands and/or brackets as a major component of the appliances				
new	8865	Maxillary or mandibular arch	1849.20			A
new	8866	Combined maxillary and mandibular arch	3280.80			A
new	8861	Minor fixed appliance	45112.00			A
		Comprehensive fixed appliance therapy This form of therapy requires the placement of fixed bands and or brackets on the majority of teeth within each arch and the subsequent placement of active arch wires to treat the case through to completion of active treatment excluding the retention phase				
		Single Arch Treatment				
new	8867	Mild	3526.80			A
new	8868	Moderate	4350.00			A
new	8869	Severe	5088.00			A
		Combined Maxillary and Mandibular Arch Therapy **Class I Malocclusions**				
new	8873	Mild	6453.60			A
new	8875	Moderate	7922.40			A
new	8877	Severe	9235.20			A
new	8879	Severe plus complications	10378.80			A
		Class II and III Malocclusions				
new	8881	Mild	9235.20			
new	8883	Moderate	10378.80			
new	8885	Severe	11650.80			
new	8887	Severe plus complications	13128.00			
		Lingual orthodontics This form of therapy requires the placement of bands and or brackets on the lingual aspect of the majority of teeth within at least one arch and must include the placement of active arch wires				
		Single Arch Treatment				A
new	8841	Mild	6627.60			A
new	8842	Moderate	7789.20			A
new	8843	Severe	8874.00			
		Combined Maxillary and Mandibular Arch Therapy **Class I Malocclusions**				A
new	8874	Mild	12643.20			A
new	8876	Moderate	14803.20			A
new	8878	Severe	16800.00			A
new	8880	Severe plus complications	18640.80			
		Class II and III Malocclusions				
new	8882	Mild	15432.00			
new	8884	Moderate	17263.20			
new	8886	Severe	19227.60			
new	8888	Severe plus complications	21394.80			

VI. SPECIALIST MAXILLO-FACIAL AND ORAL SURGEONS

1. If procedures under tariff codes 8201 to 8218 are carried out by specialists in maxillo-facial and oral surgery, the fees shall be equal to the tariff fee plus 50 %. (Modifier 8002).
2. 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 a maximum of N$ 175.00 for each such subsidiary operation or procedure. (Modifier 8005).
3. 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 operations plus-75% for the second procedure/operation (Modifier 8009) and 50% for the third procedure/operation (Modifier 8006).
4. This rule shall not apply where practitioners in different specialities perform two or more unrelated operations, in which case each practitioner shall be entitled to the full for his/her operations.
5. If, within six months, a second operation for the same condition or injury is performed, the fee for the second operation shall be half of that for the first operation. The tariff fee for an operation shall, unless otherwise stated, include normal post-operative care for a period not exceeding four months. If a practitioner does not herself/himself complete the post-operative care, she/he shall arrange for it to be completed without extra charge: Provided that in the case of post-operative treatment of prolonged or specialised nature, such fee as may be agreed upon between the practitioner and the Commission may be charged.
6. The fee payable to a general practitioner assistant shall be calculated at 20% (per cent) of the fee of the practitioner performing the operation, with a minimum of N$ 85.10 (Modifier 8007).
7. The assistant's fee payable to a maxillo-facial and oral surgeon shall be calculated at 33,33% of the appropriate scheduled fee (Modifier 8001). The assistant's name must appear on the account rendered.
8. The additional fee to all members of the surgical team for after hours emergency surgery shall be calculated by adding 25% to the tariff fee of the procedure or procedures performed (Modifier 8008).
9. In cases where treatment is not listed in the dental tariff of fees for general practitioners or specialists then the appropriate tariff fee listed in the Schedule for Medical Aid shall be charged, and the medical tariff item must be indicated.

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	6.1	**Consultations and Visits**				
	8901	Consultation at consulting rooms	98.40			S
new	8902	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 maxillo-facial re-construction.	331.20			S
	8903	Consultation at hospital, nursing home or house	111.60			S
	8904	Subsequent consultation at consulting rooms, hospital, nursing home or house	73.20			S
	8905	Weekend visits and night visits between 18h00 -07h00 the following day	162.00			S
	8907	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	184.40			S
	6.2	**Investigations and Records**				
	8107	Intra-oral radiographs, per film	39.60			B
	8108	Maximum for 8107	310.80			B
	8113	Occlusal radiograph	68.40			B
	8115	Extra-oral radiograph, per film (i.e. panoramic, cephalometric, PA). Chargeable to a maximum of two films per treatment plan.	160.79			
	8811	Tracing and analysis of extra-oral film	19.20			B
	8117	Study models – unmounted	43.20	+L		B
	8119	Study models - mounted on adjustable articulator	109.20	+L		B
	8121	Diagnostic photographs, per photograph	43.20			B
	8917	Biopsies - intra-oral	205.20			S
	8919	Biopsy of bone – needle	355.20			S
	8921	Biopsy of bone – open	582.00			S
	6.3	**Orthognathic Surgery and Treatment Planning**				
	8840	In the case of treatment planning requiring the combined services of a Prosthodontist and/or Orthodontist and/or a Maxillo-Facial and Oral Surgeon, Modifier 8009 (75%) may be applied to the fee charged by each specialist.				
		Treatment planning for orthognathic surgery	428.40	+L		A

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	6.4	**Removal of Teeth**				
	8201	Modifier 8002 is applicable to codes 8201 and 8202	98.40			S
		Extractions during a single visit				
	8201	Single tooth. Code 8201 is charged for the first extraction in a quadrant	60.40		T	B
	8202	Each additional tooth in the same quadrant Code 8202 is charged for each additional extraction in the same quadrant.	24.00		T	B
	8957	Alveolotomy or alveolectomy - concurrent with or independent of extractions (per jaw)	486.00			S
	8961	Auto-transplantation of tooth: (See Rule 10)	795.60	+L		S
	8931	Local treatment of post-extraction haemorrhage (Excluding treatment of bleeding in the case of blood dyscrasias, e.g. hemophilia)	267.60			S
	8933	Treatment of haemorrhage in the case of blood dyscrasias, e.g. haemophilia, per week	926.40			S
	8935	Treatment of post-extraction septic socket where patient is referred by another registered person	69.60			S
	8937	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (includes cutting of gingiva and bone, removal of tooth structure and closure) Code 8220 is applicable when practitioner provides sutures.	355.20			S
		Removal of roots				
	8953	Surgical removal of residual roots (cutting procedure) (includes cutting of soft tissue and bone, removal of tooth structure and closure. Code 8820 is applicable when sutures are provided by practitioner	355.20		T	S
	8955	Surgical removal of residual tooth roots (cutting procedure - includes cutting of gingiva and bone, removal of tooth structure and closure) each subsequent tooth root. Code 8220 is applicable when sutures are provided by practitioner (See Rule D011 and Notes 2 and 3)			T	S
		Unerupted or impacted teeth				
	8941	First tooth	574.80		T	S
	8943	Second tooth	309.60		T	S
	8945	Third tooth	175.20		T	S
	8947	Fourth and subsequent tooth	175.20		T	S
	6.5	**<u>Diverse Procedures</u>**				
	8908	Removal of roots from maxillary antrum involving Caldwell-Luc and closure of oral antral communication	1208.40			S
	8909	Closure of oral antral fistula - acute or chronic	926.40			S
	8911	Caldwell-Luc procedure	362.40			S
	8965	Peripheral neurectomy	795.60			S
	8966	Functional repair of oronasal fistula (local flaps)	1106.40			S
	8977	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)	1858.80			S
new	8979	Harvesting of autogenous grafts (intra-oral)	153.60			S
new	8962	Harvest iliac crest graft	292.80			S
new	8963	Harvest rib graft	337.20			S
new	8964	Harvest cranium graft	262.80			S
new	9048	Removal of internal fixation devices, per site	339.60			S
	6.6	**Cysts of Jaws**				
new	8967	Intra-oral approach	1105.20			S
new	8969	Extra-oral approach	1771.20			S
	6.7	**Neoplasm**				
new	8971	Surgical treatment of soft tissue tumors	355.20			S

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
new	8973	Surgical treatment of tumors of the jaws	1771.20			S
new	8975	Hemiresection of jaw, with splintage of segments	1860.00			S
	6.8	**Para-Orthodontic Surgical Procedures**				
new	8981	Surgical exposure of impacted or unerupted teeth for orthodontic reasons	663.30		T	S
new	8983	Corticotomy - first tooth	529.20		T	S
new	8984	Corticotomy - adjacent or subsequent tooth	267.60		T	S
new	8985	Frenectomy	486.00			S
	6.9	**Surgical Preparation of Jaws for Prosthetics**				
	8987	Reduction of mylohyoid ridges, per side	795.60	+L		S
	8989	Torus mandibularis reduction, per side	795.60	+L		S
	8991	Torus palatinus reduction	795.60	+L		S
	8993	Reduction of hypertrophic tuberosity, per side See procedure code 8971 for excision of denture Granuloma	355.20	+L		S
	8995	Gingivectomy, per jaw	708.00	+L		S
	8997	Sulcoplasty/Vestibuloplasty	1824.00	+L		S
	9003	Repositioning mental foramen and nerve, per side	1105.20	+L		S
new	9004	Lateralization of inferior dental nerve (including bone grafting)	1780.80			S
	9005	Total alveolar ridge augmentation by bone graft	1860.00	+L		S
	9007	Total alveolar ridge augmentation by alloplastic material	1171.20	+L		S
new	9008	Alveolar ridge augmentation across 1 to 2 adjacent tooth sites	441.60	+L		S
new	9009	Alveolar ridge augmentation across 3 or more tooth sites	804.00	+L		S
new	9010	Sinus lift procedure	1208.40	+L		S
	6.10	**Sepsis**				
	9011	Incision and drainage of pyogenic abscesses (intra-oral approach)	226.80			S
	9013	Extra-oral approach, e.g. Ludwig's angina	309.61			S
	9015	Apicectomy including retrograde filling where necessary - anterior teeth	398.40		T	S
	9016	Apicectomy including retrograde filling where necessary, posterior teeth	795.60	+L	T	S
	9017	Decortication, saucerisation and sequestrectomy for Osteomyelitis of the mandible	1639.20			S
	9019	Sequestrectomy - intra-oral, per sextant and/or per Ramus	355.20			S
	6.11	**Trauma**				
		Treatment of associated soft tissue injuries				
	9021	Minor	398.40	+L		S
	9023	Major	840.00			S
new	9024	Dento-alveolar fracture, per sextant	398.40	+L		S
		Mandibular fractures				
	9025	Treatment by closed reduction, with inter-maxillary fixation	883.20			S
	9027	Treatment of compound fracture, involving eyelet wiring	1240.80			S
	9029	Treatment by metal cap splintage or Gunning's splints	1374.00	+L		S
	9031	Treatment by open reduction with restoration of occlusion by splintage	2036.40	+L		S
		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	1243.20	+L		S
	9037	Le Fort II or middle third of face	2036.40	+L		S
	9039	Le Fort III or craniofacial disjunction or comminuted mid-facial fractures requiring open reduction and splintage	2920.80	+L		S
		Zygoma/Orbit				
	9041	Gillies or temporal elevation	883.20			S
	9043	Unstable and/or comminuted zygoma, treatment by open reduction or Caldwell-Luc operation	1771.20			S
	9045	Requiring multiple osteosynthesis and/ or grafting	2653.20			S

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	6.12	**Functional Correction of Malocclusions** For items 9047 to 9072 the full fee may be charged i.e. notes 2 and 3 (re Rule 011) will not apply				
	9047	Operation for the improvement or restoration of Occlusal and masticatory function, e.g. bilateral Osteotomy, open operation (with immobilization)	3712.80	+L		S
	9049	Anterior segmental osteotomy of mandible (Köle)	3094.80	+L		S
	9050	Total subapical osteotomy	5661.60			S
	9051	Genioplasty	1771.20			S
	9052	Midfacial exposure (for maxillary and nasal augmentation or pyramidal Le Fort II osteotomy)	2803.20			S
	9055	Maxillary posterior segment osteotomy (Schukardt) –1 or 2 stage procedure	3094.80	+L		S
	9057	Maxillary anterior segment osteotomy (Wassmund) –1 or 2 stage procedure	3094.80	+L		S
	9059	Le Fort I osteotomy - one piece	5823.60	+L		S
	9062	Le Fort I osteotomy - multiple segments	7432.80	+L		S
	9060	Le Fort I osteotomy with inferior repositioning and inter positional grafting	6536.40	+L		S
	9061	Palatal osteotomy	2036.40	+L		S
	9063	Le Fort II osteotomy for correction of facial deformities or faciostenosis and post-traumatic deformities	7436.40	+L		S
new	9065	Le Fort III osteotomy for correction of malunited craniomaxillary disjunction	1114560	+L		S
new	9066	Surgical assisted maxillary or mandibular expansion Note: This procedure is to expand the maxilla or mandible to facilitate orthodontic aligning of constricted dental arches.	1771.20	+L		S
	9069	Functional tongue reduction (partial glossectomy)	1327.20	+L		S
	9071	Geniohyoidotomy	795.60	+L		S
	9072	Functional closure of the secondary oro-nasal fistula and associated structures with bone grafting (complete procedure)	5823.60	+L		S
	6.13	**Temporomandibular Joint Procedures** For items 9081, 9083 and 9092 the full fee may be charged per side				
	9073	Bite plate for TMJ dysfunction	308.40	+L		S
	9074	Diagnostic arthroscopy	878.40			S
	9075	Condylectomy or coronoidectomy or both (extra-oral approach)	2209.20			S
	9076	Arthrocentesis TMJ/ Arthrosintese TMG	486.00			S
	9053	Coronoidectomy (intra-oral approach)	1104.00			S
	9077	Intra-articular injection, per injection	132.00			S
	9079	Trigger point injection, per injection	103.20			S
	9081	Condyle neck osteotomy (Ward/ Kostecka)	883.20			S
	9083	Temporomandibular joint arthroplasty	2209.20			S
	9085	Reduction of temporomandibular joint dislocation without anaesthetic	175.20			S
	9087	Reduction of temporomandibular joint dislocation, with anaesthetic	355.20			S
	9089	Reduction of temporomandibular joint dislocation, with anaesthetic and immobilization	833.20			S
	9091	Reduction of temporomandibular joint dislocation requiring open reduction	2209.20			S
	9092	Total joint reconstruction with alloplastic material or bone (includes condylectomy and coronoidectomy)	5896.80			S
	6.14	**Salivary Glands**				
	9093	Removal of salivary calculus	398.40			S
	9095	Removal of sublingual salivary gland	982.80			S
	9096	Removal of salivary gland (extra-oral)	1456.80			S
	6.15	**Implants** Prior permission from the Commission is required. The Commission does not approve of the re-use of any implant components because of the hazards to the patient. For items 9180 to 9192 the full fee may be charged, i.e. Note 2 of Rule D011 will not apply.				

Remarks	Code	PROCEDURE	N$	LAB	MP	TC
	9180	Placement of subperiosteal implant – Preparatory procedure/ operation	1238.40			S
	9181	Placement of sub-periosteal implant prosthesis/ operation	1238.40			S
	9182	Placement of endosteal implant, per implant	620.40	+L		S
	9183	Placement of a single osseo-integrated implant per jaw/	790.80			S
	9184	Placement of a second osseo-integrated implant in the same jaw	592.80			S
	9185	Placement of a third and subsequent osseo-integrated implant in the same jaw, per implant	397.20			S
	9189	Cost of implants (see section 6.15)				
	9190	Exposure of a single osseo-integrated implant and placement of a transmucosal element	292.80			S
	9191	Exposure of a second osseo-integrated implant and placement of a transmucosal element in the same jaw	219.60			S
	9192	Exposure of a third and subsequent osseo-integrated implant in the same jaw, per implant	147.60			S
	9046	Placement of Zygomaticus fixture, per fixture	403.20			S
	9198	Implant removal 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 extending across not more than four teeth (isolated procedure)	493.20	+L		A
	8772	Submucosal connective tissue autograph (isolated procedure)	499.20			A
	8767	Bone regenerative/ repair procedure at a single site	615.60			A
	8769	Subsequent removal of membrane used for guided tissue regeneration procedure	290.40			A
	8770	Cost of bone regenerative/repair material Codes 8761, 8767 and 8769 to be used only as part of implant surgery	RuleD013			

MINISTRY OF LABOUR

No. 142 2003

EMPLOYEES' COMPENSATION ACT, 1941: TARIFF OF FEES FOR PRIVATE HOSPITALS, SAME-DAY SURGICAL FACILITIES, MENTAL HEALTH INSTITUTIONS, REHABILITATION HOSPITALS AND HOSPICE FACILITIES

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tariff of Fees for Private Hospitals, Same-day Surgical Facilities, mental Health Institutions, Rehabilitation Hospitals and Hospice Facilities and the general rules and general modifiers applicable thereto, as set out in the Schedule; and

(b) repeals Government Notice 176 of 1999.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

SCHEDULE
INDEX

A. GENERAL RULES GOVERNING THE TARIFF

H01 The Tariff of Fees is set out as follows:
Sections I,1 - 6 hereof, shall apply in respect of private hospitals and unattached operating theatre units registered in terms of the Hospitals and Health Facilities Act, 1994. (Act 36 of 1994) and with practice code numbers commencing with the digits 57, 58 or 77.
Section II shall apply to rehabilitation hospitals registered in terms of the Hospitals and Health Facilities Act, 1994 (Act 36 of 1994) and with practice code numbers commencing with the digits 59
Section III shall apply to Mental Health Institutions registered in terms of the Hospitals and Health Facilities Act, 1994 (Act 36 of 1994) and with practice code numbers commencing with the digits 55; and
Section IV shall apply to unattached operating theatre units/day clinics registered in terms of the Hospitals and Health Facilities Act, 1994 (Act 36 of 1994) and with practice code numbers commencing with the digits 76.
Section V shall apply to hospice or similar facilities registered in terms of the Hospitals and Health Facilities Act, 1994 (Act 36 of 1994) and with practice code numbers commencing with the digits 79.

H02 The charges relating to each types of hospital/unattached operating theatre unit are indicated in the relevant column opposite the item codes.

H03 The charges indicated in section 5 hereof, are applicable to both categories of such hospitals and unattached operating theatre units.

H04 The amounts stipulated in this Schedule shall be deemed to be inclusive of Value Added Tax (VAT).

H05 The Commission preserves the right to inspect and re-classify all registered health facilities with practice code numbers commencing with the digits 57, 58, 77, 59, 76 and 79 as it considers desirable for the purpose of this Schedule and to appoint, where indicated, an independent agency to act on behalf of the Commission in this matter.

H06 All accounts submitted by private hospitals/unattached operating theatre units/ day clinics, mental health institutions, rehabilitation hospitals and hospice facilities shall comply with the requirements of the Employees' Compensation Act 1941 (Act 30 of 1941) as amended. Where applicable, such accounts shall also reflect the name and the practice code number of the medical or dental practitioner in charge of the injured employee and/or of the surgeon, the anaesthetist and of any assistant surgeon who may have been present during the course of an operation.

H07 All accounts shall be accompanied by a copy of the relevant theatre accounts specifying all details of items charged, as well as the procedure performed. The Commission shall have the right to inspect the original source documents at the health facilities concerned.

H08 All accounts containing items, which are subject to a discount in terms of the Schedule, shall indicate such items individually and shall show separately the gross amount of the discount.

H10 All accounts shall be signed by the service provider and shall also reflect

1. The name, address, telephone number and practice code number of the service provider,
2. The surname, first name, date of birth, Social Security Number and date of accident of the injured employee,
3. The claim number allocated by the Commission, where available,

and shall be accompanied by

4. A copy of the completed Employer's Report of Accident (Form E.Cl.2), page 1.

B. PROCEDURES

Note: Fees include VAT

I. PRIVATE HOSPITALS "57/58" and SAME-DAY SURGICAL UNITS "77"

1. ACOMMODATION - WARD FEES

Hospitals and unattached operating theatre units shall indicate the exact time of admission and discharge on all accounts.

In the case of hospitals, ward fees (code 001 to 004) shall be charged at full daily rate if the injured employee is not discharged before 23h00 and day admission fees (code 007) shall be charged in respect of all injured employees admitted as day injured employees and discharged before 23h00 on the same date.

Ward fees (items 001 to 004, 015, 020, 200, 201, and 215) shall be charged at the full daily rate if admission takes place before 12h00 and at half the daily rate if admission takes place after 12h00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12h00 and at the full daily rate if the discharge takes place after 12h00.

Two half-day fees would be applicable when an injured employee is transferred internally between any ward and any specialized unit.

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
		1.	**ACCOMMODATION**		
		1.1	**General Wards**		
		001	Surgical Cases: per day	610.80	
		002	Thoracic and neuro-surgical cases: (Including laminectomies and spinal fusion): per day	641.80	
new		003	Psychiatric general ward fee: per day	505.70	
		004	Medical and neurological cases: per day	610.80	
		007	Day admission which includes all patients discharged by 23h00 on date of admission	390.90	324.50
new		019	Outpatient's facility fees for ambulatory admission – chargeable for injured employees admitted for local anaesthetic procedures - No ward fees applicable. Note: Item 019 may only be used in conjunction with item 071 for pre-booked patients and may not be used in conjunction with items 301, 302, 061, and 335.	180.80	180.80
		014	Overnight fee - for complications only (subject to ongoing review and a maximum of one night) Note: Each account should be accompanied by a report from the practitioner indicating the nature of the complication		147.20
			Maternity Cases The maternity fees are a fixed per diem fee and replace all other charges. Note: A neonate shall be considered to be a patient in its own right and, for that reason, the Commission shall not be liable for the relevant costs unless otherwise agreed upon with the Commission.		
			Natural Births		
	023	009	First day (day of confinement)	2954.90	
new		017	Subsequent day(s) excluding nursery fee	740.40	
			Caesarian		
	029	012	First day (day of confinement)	4589.90	
new		018	Subsequent day(s) excluding nursery fee Note: The following fees (items 016) are included in the above per diem fees, and may only be charged on a fee for service account.	727.70	

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
new		016	Delivery room.	1232.20	
	027	011	Epidural fee - Use of epidural anaesthesia for maternity cases only. Note: This item includes all surgical and nursing but not ethicals)	448.90	
		1.2	**Private Wards**		
	041	020	Private ward – on request of the attending medical or dental practitioner only Hospitals shall obtain a certificate motivating the necessity for accommodation in a private ward from the attending medical or dental practitioner, and such certificate shall be forwarded to the Commission together with the account.	789.40	
modified	043	021	Private ward on injured employee's request or for convenience of hospital will be funded at tariff fee for general ward. If the Commission undertakes to pay for a private ward requested by an injured employee, a 10% discount on the ruling private ward rate will apply if the Commission pays the hospital direct.		
		1.3	**Special Care Ward** Hospitals shall obtain a certificate motivating the necessity for accommodation in any specialized or other intensive care unit or in high care ward from the attending medical or dental practitioner, and such certificate showing also the date and time of admission, and discharge from the unit shall be forwarded to the Commission together with the account. No charge may be levied for special or private nursing whilst an injured employee is accommodated in a specialized intensive care unit, intensive care unit or high ward care.		
	061	200	Specialized ICU: per day	3304.30	
modified			Suhject to a maximum of 1 day. Where more than I day is essential, the medical practitioner in charge of the case (i.e. specialist) is required to submit a written motivation stating the necessity for further specialised ICU care together with the account. Item 201 will apply if a letter of motivation is not submitted with the account. Use of this unit shall be limited to cardio-thoracic surgery, major vascular surgery and neurosurgery cases involving the brain and spinal cord		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
	063	201	Intensive Care Unit: per day	2514.90	
			The charges referred to under items 200 and 201 include the use of all equipment except: Bennett MA, Servo- and Bear ventilators or equivalent apparatus plus the cost of oxygen).		
	065	215	High Care Ward: per day	1610.90	
		2.	**Emergency Unit**		
		2.1	**Emergency Unit Fee**		
	101	301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.		
modified		302	For all consultations that require the use of a procedure room or nursing input e.g. for application of plaster of Paris, stitching of wounds, insertion of IV therapy. Includes the use of the procedure room. No per minute charge may be levied.	178.40	178.40
			Note: Item 071 (procedure room, minor theatre) cannot be charged in addition to 302.		
new		105	Resuscitation fee charged only if injured employee has been resuscitated and intubated in an approved trauma unit.	776.80	
new		**2.2.**	**Theatre Fees** The items under code 181 that are listed as non-recoverable under section 5.4 shall be deemed to be included in major theatre or minor theatre fees, and no charge in respect thereof may be levied.		
new		061	Eximer Laser Theatre fee, per minute	11.00	11.00
			Minor Theatre, regardless of type of theatre available, the incident is procedure driven and not facility driven.		
			A facility where simple procedures that require limited instrumentation and drapery, minimum nursing input and short or no general anaesthetic are carried out. No sophisticated monitoring is required but resuscitation equipment (trolley) must be available in the procedure room. Conscious sedation by arrangement with the Commission		
			Time in Minor Theatre The exact time of admission to and discharge from the minor theatre shall be stated upon which the minor theatre charges shall be calculated as follows:		
	121	071	Charge per minute (which includes 0.14c per minute for those items in the surgical basket).	8.50	7.10

Remarks	Previous Code	New Code	PROCEDURES	57 / 58 N$	77 N$
		2.3	**Major Theatre**		
			Specialized Theatre Modifiers In addition to the theatre charge calculated as above, a surcharge (Modifier H0002 and/or Modifier H0003) shall be allowed in cases where specialized theatres are utilized for the performance of any of the under-mentioned procedures, whether carried out individually or in combination with each other. This surcharge shall be deemed to cover the use of all specialized equipment for such procedures.		
		H0002	**Orthopaedic, Neurosurgical and Vascular:**		
			* Joint replacements (only hip, knee, shoulder, ankle or elbow)	818.30	
			* Femoral popliteal bypasses	818.30	
			* Carotid endarterectomies	818.30	
new			* Neurosurgery (Brain and spinal chord surgery only, excludes neurolysis	818.30	
		H0003	**Cardiac Surgery**	1874.80	
			Cardio-thoracic and Cardio-vascular Surgery * All open-heart surgery, with or without the insertion of prosthesis, coronary artery bypass grafts and heart transplants. Includes all equipment, no additional fees may be charged.		
			Time in Theatre The exact time of admission to and discharge from theatre shall be stated, upon which the theatre charge shall be calculated as follows:		
	123	081	Charge per minute (which includes 0.14c per minute for those items in the surgical basket).	26.30	21.80
		3.	**Procedural Fees** Note: A certificate indicating the level of the catheterization laboratory used, should be signed by the relevant medical practitioner, indicating the information and is attached to the account.		
			The fees quoted for items 052 to 056, 070 and 073 shall be all-inclusive and no additional charges of whatsoever nature may be raised, except for any item chargeable in terms of section 5 hereof.		
			Note: Ward fees may however be chargeable together with items 053, 054, 055, 056, 070 and 073.		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
		3.1	**Procedures**		
new		052	Procedures carried out in X-ray department using hospital owned equipment under general anaesthetic.	242.90	242.90
	203	053	Angiograms	242.90	
	205	055	Electroconvulsive therapy (ECT)	242.90	242.90
		3.2	**Catheterization Laboratory Procedures**		
	207	054	Cardiac angiography and catheterization, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy) when carried out in a registered facility equipped with a recognized analogue monoplane unit, and in a hospital equipped to perform the relevant surgery	871.40	
new		073	Cardiac angiography and catheterization, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy) when carried out in a facility equipped with a recognized digital monoplane unit, and in a hospital equipped to perform the relevant surgery	3154.30	
	211	056	Cardiac angiography and catheterization, and other intravascular procedures, (angioplasty, placement of pacemakers, stents, and embolisation or embolectomy) when carried out in a facility equipped with a recognized analogue bi-plane unit, and in a hospital equipped to perform the relevant surgery	1641.80	
new		070	Cardiac angiography and catheterization, and other intravascular procedures, (angioplasty, placement of pacemakers, stents and embolisation or embolectomy) when carried out in a facility equipped with a recognized digital bi-plane unit, and in a hospital equipped to perform the relevant surgery, as approved to perform the relevant surgery	4265.00	
new		075	Catheterization laboratory film price (once per procedure)	93.90	
		3.3	**Radiation Oncology**		
			Simulation – Fixed custom made		
	251	902	Simple – Simulation of a single area with either a single port or parallel opposed ports. Simple or no blocking or use of custom/home simulation	258.50	
	253	903	Intermediate – Simulation of three or more converging ports, two separate treatment areas or multiple blocks	394.40	

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
	255	904	Complex – Simulation of tangential portals, three or more treatment areas, rotation or arc therapy, complex blocks, custom shielding blocks, brachytherapy source verification, hypothermia probe verification, any use of contrast	517.10	
	257	905	Computerized Tomographic	517.10	
			Treatment Planning		
	261	906	Manual	-	-
	263	907	Simple - Planning requiring single treatment area of interest in a single port or simple parallel opposed ports with simple or no blocking	243.60	
	265	908	Computerized (intermediate) – Planning requiring three or more ports, two separate treatment areas, multiple blocks or special time dose constraints	371.70	
	267	909	Computerized (complex) - Planning requiring highly complex blocking, custom shielding blocks, tangential ports, special wedges or compensators, three or more separate treatment areas, rotational or special beam considerations or a combination of therapeutic modalities	486.80	
			Technical Aids		
	271	910	Control films as per radiology film price list)	-	-
	273	911	Dosimetric procedures	14.20	
	275	912	Artefacts: Simple - design and construction (simple block or bolus)	35.50	
	275	913	Artefacts: Intermediate - design and construction (multiple blocks, scents, bite blocks, special bolus)	96.60	
	279	914	Artefacts: Complex (specify) - design and construction (irregular blocks, special shields, compensators, wedges, molds and casts)	193.20	
			Linear Accelerator Treatment		
modified	291	915	Photon treatment - single field	377.50	
	292	916	Photon treatment multiple fields	543.70	
modified	917	917	Electron treatment -	377.50	
new		919	Brachytherapy - global fee per injured employee	2869.10	

Remarks	Previous Code	New Code	PROCEDURES	57 / 58 N$	77 N$
new		3.4.	**Stereotactic Radiosurgery** By arrangement with the Commission only		
new		399	Linear Accelerator radiosurgery - Global Fee Item 399 are an all-inclusive single global radiosurgery fee, payable to a hospital. This item includes item 430, all imaging and all clinical fees. The hospital is responsible for reimbursement of all fees to all professional providers of service involved in the treatment rendered under this item.	62381.00	
		430	Global fee for stereotactic radiosurgery included in item 430: Stereotactic frames and attachments Linear Accelerator; Specialized graphic planning, hardware and software; Simulator and dark rooms; 10 dental films; Stereotactic masks; All disposables; 4 to 20 Graphic transparencies (including 1 week of planning); 2 trained radiographers; Fixation and immobilization; Nuclear Specialist Medical Physicist; Duration 1 to 4 hours; 2 treatment radiographers; Excluded from fee: Other medical practitioners, CT & MRI	42693.30	
		4.	**Standard Charges for Equipment and Material**		
	401	224	Stone basket for the removal of kidney-, bladder-, gallstones: Per case	851.30	851.30
	403	225	Stereotactic equipment for use in neuro-surgical procedures, when used in conjunction with X-rays, MRI scans or CAT scans: Per case	813.60	813.60
	405	226	Continuous Passive Exerciser: Per day	64.50	64.50
	407	227	Operating microscope – motorized. This is applicable to a binocular operating microscope with motorized focusing, positioning, and zoom magnification changer. Spinal, intra cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	179.60	179.60
	409	228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning, and multistep magnification changer. Microscopic surgery only. Per case	88.80	88.80
modified	411	360	**Category 1** – Diagnostic laparoscopy and thoracoscopy, Cyst Aspiration: per case. See Annexure A for category list. Includes reusable laparoscopic instrumentation as follows: Light Guide	454.30	454.30

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
			Cable; Hi Frequency Cord; Graspers; Dissector; Electro Surgical Instrument		
new		364	**Category 2** - Including all other laparoscopic procedures and this includes thoracic and urological procedures, per case. See Annexure A for category list. Includes the following reusable/ resposable laparoscopic instrumentation: Light Guide Cable; Hi Frequency Cord; Endoscopic Needle Holder (2); Graspers; Graspers - a-traumatic; Dissectors; Scissors; Suction Irrigation; Instrument Suction/Cautery instrument; Electro Surgical Instrument;	539.80	539.80
	413	230	Patient-controlled analgesia pumps, being a programmable analgesia infusion system, providing patient control and/or continuous analgesia modes with mechanisms to limit self-administration per time period and with lockout interval. Applicable only to administration of analgesics. Per day Note: Chargeable in the following instances: Major joint replacement; Open, upper abdominal surgery; Severe burns; Thoracotomies (motivation by practitioner), intractable pain associated with malignancy Not applicable in ICU and specialized units. 1 per patient for maximum 48 hours in ward	68.10	68.10
modified	415	231	Cardiac monitors - in private, general and high care wards monitors: per day or part thereof	74.00	
new		232	Bird or equivalent free standing nebuliser (excluding oxygen) per day	53.00	53.00
	419	233	Croupettes (excluding oxygen) per day or part thereof	15.10	
		234	Incubators		
	423	235	Oxygen tents (excluding oxygen) per day or part thereof	24.70	
modified	425	236	Mechanical ventilators or equivalent - only in ICU and high care ward where no ICU is available (excluding oxygen): Per day or part thereof	236.40	
	427	237	CUSA (plus lowest available manufacturer's price, excluding VAT, or CUSA pack, plus 25.4% which shall be inclusive of mark-up and Value Added Tax)	1148.40	
	429	238	Lasers Argon (ophthalmic)	355.80	355.80
	431	239	Lasers - C02 (surgical)	459.70	459.70

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
new		241	Lasers - Candella (Rates by arrangement with the Commission)		
new		335	Excimer Lasers: Hire Fee per eye	1254.90	1254.90
new		337	Microkeratome used with an excimer laser, per operation	230.50	230.50
	435	242	Occutomes	151.30	151.30
	437	243	Lasers – YAG (ophthalmic)	401.20	401.20
	439	244	Lasers – YAG (surgical)	499.50	499.50
	441	220	Ballistic Lithotripsy/Lithoclast: First lithotripsy treatment for one or more stones in the same kidney which are eliminated in one treatment	363.80	363.80
	443	221	Ballistic Lithotripsy/Lithoclast: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically indicated)	243.80	243.80
new		339	Ballistic lithotripsy magnetic: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	140.30	140.25
new		341	Ballistic lithotripsy magnetic: Second lithotripsy treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically indicated).	93.50	93.50
	445	222	Laser Lithotripsy: First lithotripsy treatment for one or more stones in same kidney which are eliminated in one treatment	2111.10	2111.10
	447	223	Laser Lithotripsy: Second lithotripsy treatment on same kidney. (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically indicated)	1406.20	1406.20
	449	245	First ESWL treatment for one or more stones in same kidney which are eliminated in one treatment	4621.70	4621.70
	451	246	Second ESWL treatment on same kidney (Hospitals shall provide a certificate by the attending surgeon certifying that a second treatment was medically indicated)	3078.10	3078.10
			Note: The fees in respect of items 220 to 223, 245, 246 and 339 to 341 are inclusive of all equipment and components but exclusive of theatre items and items chargeable under section 5		
			The C-arm (item 249) and screening table (item 251) are not chargeable with these equipment fees.		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
	457	249	C Arm (not chargeable when Modifiers H0002 or H0003 or item 251 apply)	149.30	149.30
	459	250	Ultrasonic imaging equipment (Limited to real-time imaging equipment for transrectal applications with needle-biopsy capability or Doppler ultrasound for vascular anatomy and haemo-dynamics)	249.60	249.60
	461	251	Screening table - fixed base urology table (incl. all radiographic equipment)(See item 249) (May not be used in conjunction with items 220 to 223, 245, 246 and 339 to 341)	336.80	336.80
	463	252	Gastroscope (fibre optic/flexible only)	196.80	196.80
	465	253	Colonoscope (fibre optic/flexible only)	220.10	220.10
	467	254	Duodenoscope fibre (fibre optic/flexible only)	208.50	208.50
	469	255	Sigmoidoscope (fibre optic/flexible)	169.10	169.10
new		343	Sigmoidoscope (rigid, adults)	34.80	34.80
new		256	Bronchoscope (flexible, fibre optic, adults)	138.90	138.90
			Note: For codes 252-256 and 343 to 347 reusable biopsy and polyp forceps are included in the fees.		
new		348	Bronchoscope (rigid)	55.60	55.60
	473	257	Laryngoscope (fibre optic/flexible excluding routine intubation)	81.10	81.10
		258	Sinoscope (fibre optic/rigid only)	92.50	92.50
	477	259	Oesophagoscope (rigid only).	46.20	46.20
	483	262	Colposcope (not chargeable when item 239 applies)	81.10	81.10
	485	263	Cysto Urethroscope	69.60	69.60
new		519	Uretho Reno Fibroscope, per case	248.30	248.30
modified	487	264	Arthroscope (including basic reusable instruments and equipment)	189.80	189.80
			Note: The basic reusable instruments and equipment (which would always include the equivalent to the items named) are included in the fee of item 264 (see list below): * Telescope, light source, cable * Monitor * Electrosurgical Instrument * High frequency cord * Obulator * Camera * Focussing camera coupler * Control console		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58 N$	77 N$
			* Probe, scissors, (hooked, parrot beak), grasper, forceps (punch basket, duckbill), camelback handle, powered arthroplasty system, handpiece		
	491	266	Large disposable sterile trays - per tray (excluding theatre)		
	493	267	Sterile disposable swabbing and ENT trays - per tray (excluding theatre)		
	495		Specialized instruments/equipment for integrated osseous implants. (Hospitals/ unattached operating theatre units shall provide a certificate by the practitioner concerned that the instrument/equipment were used)		
	501	269	Soluble bags for barrier nursing only, limited to 2 per patient per day		
	503	294	Transcranial Doppler	413.60	
	505	295	Ultrasonic Cutting and Coagulation Devices e.g. Harmonic scalpel or equivalent. (See section 5.5.2 for reusable components)	113.80	113.80
	507	507	Argon Beamer	46.10	46.10
			Note: The Argon Beamer will not apply where a standard electrosurgery unit is used. It can only be used with surgery on internal organs and in neurosurgery.		
	509	509	Endometrial Resection	278.20	278.20
	511	511	Colour Doppler (external)	832.80	832.80
	513	513	Transoesophageal Colour Doppler	1004.80	1004.80
	515	515	Cardiorhythm Ablater	547.30	547.30
	517	517	Phacoemulsifier	298.50	298.50
new		521	OAS Frameless Stereotaxy	2928.70	
new		523	OPD Tacography	47.40	
new		525	RFG3C Lesion Generator (Rhizotomy)	948.20	
new		527	Swift Laser Kit (Tonsillectomy)	184.80	
new		529	Bard Apparatus	709.50	
new		531	Densitometer	437.30	
new		533	Civus (Cardiac Intra-Vascular Ultrasound)	1187.60	
new		535	Ivus (Intra Vascular Ultrasound	2608.80	
new		537	Reusable patient return electrode/grounding pad using a capacitive coupling technique for use in electrosurgery	10.90	

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
			Disposable cover is non-chargeable. This item may not be charged together with any disposable monitoring style gel pads or when techniques other than electrosurgery are used. e.g. not to be charged with the ultrasonic cutting and coagulating device or equivalent		
new		550	Equipment fees for dynamic (non-frame based - Stealth Station) stereotactic image guided referencing surgery and treatment planning used in conjunction with CT or MRI imaging in pre-authorised cranial, spinal and ENT procedures, per procedure	3061.90	
new		560	Low pressure hyperbaric oxygen treatment protocol (by arrangement with the Commission)	-	-
new		562	Standard pressure hyperbaric oxygen treatment protocol (by arrangement with the Commission)	-	-
new		574	Pressure relieving mattress hire fee, per day	-	-
new		576	Infrared Coagulator: per use	-	-
new		582	Selector ultrasonic aspirator	-	-
new		606	Epilepsy monitoring equipment	-	-
new		610	Intraoperative multi-frequency probe	-	-
new		612	Flexible laparoscopic probe	-	-
		5.	**Standard Drug Material, Consumable and Disposable Charges** Only substances controlled by the relevant Medicine Control Authority		
		5.1	**Inpatients and day patients: Dispensed items including ampoules, over the counter and proprietary items issued to inpatients, day patients and TTO's** The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT, unless the facility is not a registered VAT vendor) plus 25.4 % (which shall be inclusive of markup and VAT) plus a dispensing fee of N$ 4.00, which is inclusive of VAT. All items which patients take home as TTO's must be shown on accounts.		
	601	272	Pharmacy		
	605	278	Ward Stock		
	607	282	Theatre		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
	603	273	To take out		
		5.3	**Emergency Room: Dispensed items including ampoules, over the counter and proprietary items and TTO's issued to patients treated in the emergency room (items 301 and 302) - not admitted to a ward.** The amount charged for any item shall not exceed the net acquisition price (inclusive of VAT, unless the facility is not a registered VAT vendor), plus 25.4 % (which shall be inclusive of markup and VAT) plus a dispensing fee of N$ 4.00, which is inclusive of VAT. All items which patients take home as TTO's must be shown on accounts.		
	601	407	Pharmacy		
	607	411	Theatre		
	603	413	To take out		
		5.4	**Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities**		
new		181	Consumable & disposable items charged in respect of theatre - Refer to Annexure B.		
new		182	Consumable & disposable items charged in respect of Wards, High Care and all IC units - Refer to Annexure B		
new		**5.5**	**Fractional Charges** Note: Fractional charges can only apply to reusable and resposable products. Net acquisition price (inclusive of VAT) (unless the facility is not a registered VAT vendor) to be charged at the fractional rates indicated below.		
		5.5.1	**Disposable/ Resposable drills, burrs, cutters, blades (e.g. Stryker or equivalent)**		
	621	280	Neuro/Craniotomy -	33.33%	33.33%
	623	432	Arthroscopy -	20.00%	20.00%
	625	433	Orthopaedic -	33.33%	33.33%
new		437	Mastoidectomy and major ear surgery -	33.33%	33.33%
	629	439	Maxillo-facial drills and burrs -	33.33%	33.33%

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
		5.5.2	**Surgical laser fibre optic leads, hand pieces and probes, scalpels, argon beamer instruments (reusable/resposable components)**		
	621	281	Vascular surgery -	100%	100%
	623	443	General Surgery -	12.5%	12.5%
new		445	Gynaecology -	12.5%	12.5%
new		447	Ophthalmic -	12.5%	12.5%
new		449	Urology -	12.5%	12.5%
new		451	ENT -	12.5%	12.5%
new		453	Orthopaedic -	12.5%	12.5%
			Hospitals/ unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name, and the Commission shall have the right to call for such invoices from the the service providers concerned		
new		5.5.3	**Ultrasonic Cutting and Coagulating Devices (reusable and resposable components)**		
			General surgery, Cardio-Vascular and Urology		
new		455	Handpiece and Cable Assembly (one unit) -	1.00%	1.00%
new		456	Coagulating Shear (Laparoscopic/open) -	33.33%	33.33%
new		457	Blades (sharp hook, dissecting hook, ball) -	12.50%;	12.50%
new		458	Coagulating Shear - Single use (Laparoscopic/open): Refer to section 5.6.		
new		459	Blades - Single use (sharp hook, dissecting hook, ball): Refer to section 5.6		
new		5.5.4	**Reusable/resposable warm air blankets, laryngeal masks, fluoroshield gloves and diathermy pencils - see also section 5.4 and Annexure B**		
			The warm air blanket should be charged in the following cases: Elderly patients, patients exposed for a long period of time e.g. orthopaedic table post traumatic hypothermia (items 429 or 436), cardio-thoracic hypothermic patients in recovery and ICU (items 429 or 436)		
new		429	Disposable warm air blanket (adhesive/non adhesive)- single use- for above cases only –	100%	100%
new		431	Diathermy pencils -	33.33%	33.33%
	627	435	Laryngeal masks -	4.00 %	4.00 %

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
new		436	Reusable/resposable warm air blankets (adhesive/non-adhesive) for above cases only	33.33%	33.33%
	631	441	Fluoroshield gloves (1 pair per procedure) -	33.33%	33.33%
		5.6.	**Consumable, disposable and surgical items** (including sutures, skin graft blades, trephines, external fixators and Beaver blades (Beaver blades not chargeable in myringotomy) and disposable small and large dressing trays, and items not otherwise dealt with in section 5) (when used in ward or theatre) Net acquisition price inclusive of VAT, unless the facility is not a registered VAT vendor. Items to be fully specified.		
	601	417	Pharmacy		
	605	419	Ward stock		
	607	421	Theatre		
		5.7	**Gases**		
			Oxygen and Nitrous Oxygen		
			(For both gasses together per minute)		
modified		712N	Windhoek, Okahandja, Rehoboth, Walvis Bay, Henties Bay, Swakopmund	4.60	
modified		712O	All other areas within the Rep. of Namibia	6.10	
New		7121N	Any other area outside the Rep. of Namibia (as agreed upon with the Commission)		
			Oxygen - Ward use (Fee for oxygen, per quarter hour or part thereof, outside the operating theatre)		
modified		725N	Windhoek, Okahandja, Rehoboth, Walvis Bay, Henties Bay, Swakopmund	8.10	
new		725O	All other areas within the Rep. of Namibia	10.80	
new		725IN	Any other area outside of the Rep. of Namibia (as agreed upon with the Commission)		
new			**Oxygen - Recovery room** (Flat rate for oxygen per case)		
modified		736N	Windhoek, Okahandja, Rehoboth, Walvis Bay, Henties Bay, Swakopmund	16.20	

Remarks	Previous Code	New Code	PROCEDURES	57 / 58 N$	77 N$
new		736O	All other areas within the Rep. of Namibia	21.50	
new		736IN	Any other area outside the Rep. of Namibia (as agreed upon with the Commission)		
new			**Oxygen in theatre** (Fee for oxygen per minute in the operating theatre when no other gas administered)		
new		735N	Windhoek, Okahandja, Rehoboth, Walvis Bay, Henties Bay, Swakopmund	0.60	
new		735O	All other areas within the Rep. of Namibia	0.70	
new		735IN	Any other area outside the Rep. of Namibia (as agreed upon with the Commission)	0.70	
	741	291	Carbon Dioxide, per minute	0.40	
	743	292	Laser Mix, per minute	6.10	
	745	293	Entonox, per 30 minutes	57.90	
		5.8	**Inhalation Anaesthtetics**		
	747	285	Halothane: per minute	0.80	
	749	752	Ethrane (Enflurane): per minute	3.60	
	751	753	Forane (Isoflurane): per minute	3.30	
new		754	Isofor (Isoflurane): per minute	3.40	
new		759	Fluothane (Halothane): per minute	0.70	
new		758	Alyrane (Enflurane): per minute	3.00	
new		757	Aerrane (Isoflurane): per minute	3.00	
new		756	Suprane (Desflurane): per minute	4.50	
new		755	Ultane (Sevoflurane): per minute	6.10	
		5.9	**Prostheses (surgically implanted)**		
	651	286	A prosthesis shall mean a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral and necessary part of the device so implanted, and shall be charged as a single unit. Pins, rods, screws, plates or similar items, when used independently of a prosthesis and for the purpose of furthering any healing process, shall be chargeable under item 421		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58 N$	77 N$
			Hospitals/unattached operating theatre units shall show the name and reference number of each item together with the manufacturer's name, and the Commission shall have the right to call for such invoices from the institution concerned. Lowest available manufacturer's price exclusive of VAT, plus 25,4% (which shall be inclusive of markup and VAT)		
		5.10	**Medical Artificial Items (non-prosthesis)**		
	661	287	According to prior agreement with the Commission (examples of items included hereunder shall be wheelchairs, crutches and exertion bags). Copies of invoices shall be supplied to the Commission		
		5.12	**Transportation Charges** An additional charge may be made to cover the costs of railage paid on items sent to areas outside the supplier's free delivery area (not applicable to instruments).		
		5.13	**Price Increases** Should a change occur in the manufacturer's price of any item listed under 283 to 285, 291 and 292, the new price shall be as agreed upon with the Commission.		
		5.14	**Blood Collection Charges**		
modified	681	289	Blood collection charges, when incurred in respect of blood or related products procured form a recognized blood bank for transfusion purposes, may be charged at N$ 12.50 per collection, plus N$ 2.50 per kilometer traveled. This fee is applicable to all modes for collecting blood including hospital ambulances.		
new		288	Emergency non-crossmatched blood ex hospital (i.e. on stand-by) – Number of units and nature of emergency to be specified and copy of invoice included. This item is only chargeable when a private hospital supplies 0-negative whole blood to an injured employee in an emergency situation. A motivation stating the reason for administering this blood must accompany the account and no mark-up is permitted on this item.		

Remarks	Previous Code	New Code	PROCEDURES	57 / 58	77
				N$	N$
		5.15	**Incise Drapes**		
	691	298	Incise drapes: a maximum benefit of N$57.50 per procedure, except for the following types of procedures: Surgery in respect of hip, knee, shoulder and elbow joint replacements; All open heart and cardiac bypass surgery with or without the insertion of prosthesis; All vascular surgery, with or without the insertion of prostheses; Neuro-surgery; Spinal surgery Note: The name, item number and cost must be shown		
	695	299	Ophthalmic drapes: a maximum benefit of N$43.10 per procedure.		
		5.16	**Disposable Patent Controlled Analgesia Pump** Chargeable in the following instances: Major joint replacement; open upper abdominal surgery; severe burns; thoracotomies (motivation by practitioner required) intractable pain associated with malignancy. The PCA Pump will be limited to 1 per injured employee per 48 hours		
new		6.	**Non-Standard Items/Services**		
new		290	The Commission does, not cover items/services such as telephone calls/hire, television hire, extra meals, cleaning of clothing, extra nursing in ward, etc.		
		121	**Procedures: Open heart, cardiac by-pass surgery and all organ transplants:** Payment to be pre-authorized by the Commission		

II. GLOBAL FEE FOR PHYSICAL REHABILITATION FACILITIES WITH A PRACTICE CODE NUMBER COMMENCING WITH "59"

This section is only applicable to facilities registered as physical rehabilitation hospitals and not sub-acute facilities.
The following rehabilitation categories will be treated in recognized and accredited rehabilitation hospitals: Stroke, Brain dysfunction (traumatic and non-traumatic), Spinal cord dysfunction (traumatic and non-traumatic), Orthopaedic (lower joint replacements), Amputation (lower extremity), Cardiac, Pulmonary, Major multiple trauma. Other neurological or orthopaedic impairments will require specific letters of motivation.
Pre-arrangement with the Commission is required

Remarks	Previous Code	New Code	DESCRIPTION	59 N$
new		59100	Outpatients, 3 hours per day (maximum 18 days).	247.10
new		59101	Outpatients, 6 hours per day (maximum 18 days).	521.50
new		59105	General care (maximum 27 days).	1038.20
new		59107	High care (maximum 36 days).	1223.70
new		59109	Rehabilitation ICU (maximum 7 days).	2199.40

NOTE: The maximum days may be modified by the Commission in individual cases on specific motivation from the medical/dental practitioner in charge

III. INSTITUTIONS REGISTERED IN TERMS OF THE HOSPITALS AND HEALTH FACILITIES ACT, 1994 (ACT 36 OF 1994) AND WITH A PRACTICE NUMBER COMMENCING WITH "55"

Remarks	Previous Code	New Code	DESCRIPTION	55 N$
new		55004	General ward fee: with overnight stay	505.70
new		55005	General ward fee: without overnight stay	357.50
new		55006	General ward fee: under 5 hours stay	185.00
new		55055	Electroconvulsive therapy (ECT) (No theatre fee chargeable)	242.90
new		55231	Monitors	74.00
new		55045	Ward and Dispensary Drugs: The amount charged shall not exceed the net acquisition price	

IV. UNATTACHED OPERATING THEATRE UNITS AND DAY CLINICS WITH A PRACTICE CODE NUMBER COMMENCING WITH '76"

Remarks	Previous Code	New Code	DESCRIPTION	76 N$
new		76005	Local anaesthetic theatre: Per minute	4.90
new		76010	General anaesthetic theatre; Per minute	15.30
new		76015	Dental anaesthetic theatre (applicable to units registered for dental procedures only), per minute	10.30
new		76061	Excimer laser theatre fee, per minute	11.00
			WARD FEES (including recovery room)	
new		76025	Day rate	207.50
new		76019	Out injured employees facility fee for ambulatory admission - chargeable for injured employees NOT requiring general anaesthetic- No ward fees applicable Item 76019 may only be used in conjunction with item 76071, which is for pre-booked injured employees and may not be used in conjunction with items 76301, 76302, 76061 and 76335.	180.80
			NON-CHARGEABLE ITEMS Theatre items: Refer to Annexure B. Ward items: Refer to Annexure B. The charge for a monitor has been included in the theatre fee. no extra charge is payable	
			EMERGENCY UNITS	
		76301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	178.40
		76302	For all consultations that require the use of a procedure room or nursing input, e.g. for application of plaster of Paris, stitching of wounds, insertion of IV Therapy. Includes the use of the procedure room. No per minute charge may be levied.	
		76035	Theatre drugs. The amount charged shall not exceed the net acquisition price (inclusive of VAT, unless the facility is not a registered VAT vendor).	
		76040	Theatre items. Refer to Annexure B	

Remarks	Previous Code	New Code	DESCRIPTION	76 N$
		76060	Wards. Refer to Annexure B The charge for a monitor has been included in the theatre fee. No extra charge is payable.	
			STANDARD CHARGES FOR EQUIPMENT AND MATERIALS	
		76227	Operating microscope - motorized. This is applicable to a binocular operating microscope with motorized focusing, positioning and zoom magnification changer. Spinal, intra-cranial and ophthalmic surgery only (all ENT and other surgery excluded): Per case	179.60
		76228	Operating microscope - manually operated. Applicable to a binocular operating microscope with manual focusing, positioning and multistep magnification changer. Microscopic surgery only: Per case	88.80
		76335	Excimer laser: Hire fee per eye	1254.90
		76337	Microkeratome used with an excimer laser, per operation	230.50
			GASES AND INHALATION ANAESTHETICS See section 5.7.	

V. HOSPICE OR SIMILAR APPROVED AND REGISTERED FACILITIES WITH A PRACTICE NUMBER COMMENCING WITH "79"

Remarks	Previous Code	New Code	DESCRIPTION	79 N$
new		79950	Ward fee per day (with a maximum of 2 weeks and inclusive of disposables).	314.60
new		79955	Home health care, per visit (Maximum of 15 visits)	60.70

ANNEXURE A
LAPAROSCOPIC AND THORACOSCOPIC CPT CODES AND CATEGORIES

PROCEDURE	CODE
CATEGORY 1 (CPT4 2000 code numbers included where possible)	
Diagnostic laparoscopy	49320
Hysteroscopy diagnostic	58555
Hysteroscopy, with sampling of endometrium and/or polypectomy, with/without D&C	58558
THORACOSCOPY, DIAGNOSTIC	
THORACOSCOPY, DIAGNOSTIC with biopsy	
THORACOSCOPY, DIAGNOSTIC lungs and pleural space, with biopsy	
THORACOSCOPY, DIAGNOSTIC pericardial sac, without biopsy	
THORACOSCOPY, DIAGNOSTIC pericardial sac with biopsy	
THORACOSCOPY, DIAGNOSTIC mediastinal space without biopsy	
THORACOSCOPY, DIAGNOSTIC mediastinal space with biopsy	
CATEGORY 2	
Laparoscopy, surgical; with salpingostomy (salpingoneostomy)	58673
Laparoscopy, surgical; with fimbrioplasty	58672
Laparoscopy, surgical; with fulgeration or excision of the ovary, pelvic viscera or peritoneal surface, any methods	58662
Laparoscopy, surgical; with lysis of adhesions (changed 1998 to salpigolysis, ovariolysis)	58660
Laparoscopy, surgical; with removal leiomyomata	58551
Laparoscopy surgical; with enterolysis (freeing intestinal adhesion)	44200
Laparoscopy, surgical; with retropritoneal node sampling (biopsy)	38570
Laparoscopy, surgical, abdomen, peritoneum, omentum; with drainage lymphocele to peritoneal cavity	49323
Laparoscopy, surgical, abdomen, peritoneum and omentum; with biopsy	49321
Laparoscopy, surgical, abdominal, peritoneum and omentum; with aspiration of cavity or cyst (e.g. ovarian cyst) single or multiple	49322
Laparoscopy, surgical; with removal of adnexal structures (partial or total oopherectomy And/or salpingectomy)	58661
Laparoscopy, surgical; ligation spermatic veins for varicocele	55550
Laparoscopy, surgical; ablation of renal cysts	50541
Laparoscopy, surgical; urethral suspension for stress incontinence	51990
Laparoscopy, surgical; sling operation for stress incontinence	51992
Hysteroscopy with removal leiomyomata	58561
Hysteroscopy with endometrial ablation	58563
Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy	38571
Laparoscopy, surgical; with bilat. Total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy)	38572
Laparoscopy with adrenalectomy	60650
Laparoscopy, surgical; pyeloplasty	50544
Laparoscopy, surgical; nephrectomy	50540
Laparoscopy, surgical; donor nephrectomy	50547
Laparoscopically assisted nephroureterectomy	50548
Laparoscopy, surgical, ureterolithotomy	50945
Laparoscopy, surgical; transection of Vagus nerve, truncal	43651
Laparoscopy, surgical; transection of Vagus nerves, selective or highly selective	43652
Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy	47560
Laparoscopy, surgical; with guided transhepatic cholangiography, with biopsy	47561
Laparoscopy, surgical; cholecystoenterostomy	47570
Laparoscopy, surgical; cholecystectomy with cholangiography	47563

Laparoscopy, surgical; cholecystectomy with explor, common bile duct	47564
Laparoscopy, surgical; splenectomy	38120
Laparoscopy, surgical; gastrostomy, without construction of gastric tube (e.g. Stamm procedure)	43653
Laparoscopy, surgical; jejunostomy	44201
Laparoscopy, surgical; intestinal resection, with anastomosis	44202
Laparoscopy, surgical; oesophagogastric fundoplasty eg Nissen, Toupet procedures)	43280
Unlisted laparoscopic spleen procedure	38129
Unlisted laparoscopic lymphatic procedure	38589
Unlisted laparoscopic oesophagus procedure	43289
Unlisted laparoscopic stomach procedure	43659
Unlisted laparoscopic intestinal procedure (except rectum)	44209
Unlisted laparoscopic biliary tract procedure	47579
Unlisted laparoscopy procedure, abdomen, peritoneum & omentum	49329
Unlisted laparoscopic hernia procedure	49659
Unlisted laparoscopic renal procedure	50549
Unlisted laparoscopic procedure, testis	54699
Unlisted laparoscopic endocrine procedure	60659

THORACOSCOPY, SURGICAL

THORACOSCOPY, SURGICAL pleurodesis
THORACOSCOPY, SURGICAL partial pulmonary decortication
THORACOSCOPY, SURGICAL total pulm. Decortication
THORACOSCOPY, SURGICAL removal interpleural foreign body
THORACOSCOPY, SURGICAL control traum. Haemorrhage
THORACOSCOPY, SURGICAL exc./plication bullae
THORACOSCOPY, SURGICAL parietal pleurectomy
THORACOSCOPY, SURGICAL wedge resection
THORACOSCOPY, SURGICAL removal clot/foreign body from pericardial space
THORACOSCOPY, SURGICAL creation pericardial window
THORACOSCOPY, SURGICAL total pericardectomy
THORACOSCOPY, SURGICAL exc pericard. Cyst, tumor, mass
THORACOSCOPY, SURGICAL exc mediastinal cyst, tumor, mass
THORACOSCOPY, SURGICAL lobectomy, total or segmental
THORACOSCOPY, SURGICAL with sympathectomy
THORACOSCOPY, SURGICAL with esophagomyotomy

NEW CORDES FOR CATEGORY 2

Laparoscopy, surgical; radical nephrectomy	50545
Laparoscopy, surgical; nephrectomy including partial ureterectomy	50546
Laparoscopy, surgical; nephrectomy with total ureterectomy	50548
Laparoscopy, surgical; ureteroneocystostomy with cystoscopy and ureteral stent placement	50948
Laparoscopy, surgical; ureteroneocystostomy without cystoscopy and ureteral stent placement	50948
Unlisted laparoscopic procedure, ureter	50949

ANNEXURE B.1

GUIDE TO REIMBURSEMENT FOR CONSUMABLE AND DISPOSABLE ITEMS CHARGED BY PRIVATE HOSPITALS AND SAME DAY SURGERY FACILITIES

RULES

1. At all times best clinical practice must be adhered too.
2. No consumable or disposable item is free of charge. The cost of consumable and disposable items used on an injured employee in a hospital must be recovered by means of the tariff mechanism as follows:
   - Items included in the per minute theatre fee.
   - Items included in the per day ward or unit fee.
3. Disposable items marked "for single use only" should never be reused.
   - Single use items may be charged at 100% (See Tariff of Fees).
   - Hospitals will adhere to an ethical undertaking that single use items will only be used once. If a hospital does not conform it may be reported to the Commission. If an acceptable explanation is not supplied within 14 days, payment on that account may be withheld.
4. Items listed in the Guide to Reimbursement for Consumable and Disposable Items charged by Private Hospitals and Same Day Surgery Facilities are described generically according to product classification and function. Trade names may be included, by means of example, for clarification purposes only.
5. Reusable products are products that are endorsed as such by the manufacturer. Such products will be charged according to the "Fractional" charges as detailed in this Tariff of Fees and are under continual review.
6. Where a hospital uses an excessively priced product, pre-arrangement for payment with the Commission is required or appropriate price adjustment made.
7. TTO's will be issued and charged according to the rules of this Tariff of Fees.
8. All prescribed items will be recoverable according to the rules of this Tariff of Fees
9. Specialized units are defined as: Intensive Care Unit (ICU), Cardio-Thoracic Intensive Care Unit (CTICU), High Care (HC), A & B.

GUIDE TO REIMBURSEMENT FOR CONSUMABLE AND DISPOSABLE ITEMS LIST

Key Indicators:

THEATRE	Theatre consumable and disposable items
WARD	Ward consumable and disposable items
NR	Item is non-recoverable
C	Item is chargeable under certain circumstances
L	Item chargeable in Limited Circumstances
R	Item is recoverable
P	Item is recoverable from injured employee
F	Fractional (reusable) and is charged out on a pro-rata basis (as per Tariff of Fees, section 5.5.1-5.5.4).
N/A	Not used/not applicable
Disposable	Means the manufacturer states one time use only. S/U (Single use) Item = payable 100%
Practice Code	References to the Tariff of Fees include 57/58, 76 and 77.

No	PRODUCT	THEATRE	WARD	COMMENT
1	Abdominal Swabs	R	C	Chargeable in theatre. Chargeable in ward for: Severe septic cases, e.g. burns, laparotomy cases, unsutured chests in Cardio- thoracic ICU. For other cases on motivation only and subject to case management.
2	Acetone	NR	NR	
3	Adapters reusable	NR	NR	
4	Adapters disposable	C	C	Chargeable in cardio-thoracic packs only. To be specified if not part of the pack
5	Aerochamber	C	C	One per stay.
6	Alcohol/Spirits	NR	NR	
7	Alcohol Swabs (e.g. Preptic, Webcol)	C	C	For appropriate use in theatre and ward and/or on prescription
8	Amalgam Caplets and all dental composites	NR	N/A	
9	Ambubag	NR	NR	
10	Anaesthetic Circuits & Masks - reusable	NR	N/A	Included in theatre basket
11	Anaesthetic Circuits & Masks – disposable components	NR	N/A	Included in theatre basket
12	Anaesthetic Tray	NR	NR	Blue and Green gauze chargeable separately
13	Antipeol Ointment	NR	C	When prescribed by a medical practitioner as a full unit or part of a mixture.
14	Antiseptics/Soaps (e.g. Hibiscrub)	NR	NR	Non-chargeable when used by staff or for prepping of skin.
15	Antiseptics/Soaps to injured employee (e.g. Hibiscrub)	NR	C	Chargeable for use in burns. On prescriptions for therapeutic reasons only.
16	Aortic/Vascular Punch - reusable	NR	NR	
17	Aortic/Vascular Punch - disposable	R	N/A	Single Use
18	Aquapak, Respiflo, Sterimist or equivalent disposable humidifiers.	N/A	C	One per 24 hours or part thereof with administration of oxygen.
19	Aqueous Cream - used as body lotion	NR	NR	
20	Aqueous Cream - other uses	NR	C	Chargeable when used as a therapeutic agent, as part of the mixture and prescribed by a doctor.
21	Arm Immobiliser (Sling)	C	C	Chargeable when procedure related, e.g. sling. One per arm per stay.

No	PRODUCT	THEATRE	WARD	COMMENT
22	Arthrowand Disposable	C	NR	Chargeable if used in the following Procedures:
22.1	Arthrowand	C	NR	Arthroscopy – knee, shoulder, ankle, acromioplasty, sinovectomy – wrist, lateral release – knee, wrist, acromioclavicular release, decompresion of shoulder, "frozen" shoulder, meniscectomy, ACL reconstruction, PCL reconstruction Note: Arthrowand can be used together with Dyonic Blades for different requirements per procedure eg. Tissue and Bone.
22.2	Spinal Arthrowand	C	NR	Spinal and Revision surgery, lumbar discectomy, cervical discectomy, spinal tumour removal, intra-cranial tumour removal, pliff-cage procedure, lumbar revision surgery, lumbar instrumentation and fusion, cervical cage infusion, percutaneous lumbar disc coblatio
22.3	Plansmowand/Entecwand	C	NR	Soft Pallate channeling, Nasal passage channeling
26	Bacterial/Viral Filters and Humidifier Moisture Filters	C	C	One per theatre case. One per 24 hours ventilation in specialized units One per 48 hours ventilation for Pall breathing filters in specialized units.
27	Baumanometer	NR	NR	
28	Bentley Connectors- reuseable	NR	NR	
29	Bentley Connectors- disposable	C	C	To be specified if not a part of a pack.
30	Betadine Products other than antiseptics & soaps	NR	C	Chargeable when procedure related e.g. burns.
30	Biocide	NR	NR	
32	Biopsy Forceps – disposable	R	N/A	
33	Bipolar Forceps and Cables-reusable	NR	NR	
34	Blades (scalpel) – disposable	R	R	
35	Blades – disposable (e.g. Dyonics, Anspach and all other disposable brands)	R	N/A	Guideline maximum of 3 blades for an appropriate shoulder procedure or 2 for an appropriate knee procedure. The use of more to be motivated.
36	Blades – reusable	F	N/A	Part chargeable as per this Tariff of Fees, section 5.5.1
37	Blankets: Warm Air, disposable	C	C	Chargeable 100% when complying to the criteria as per this Tariff of Fees, section 5.5.4 Other uses to be motivated by doctor.

No	PRODUCT	THEATRE	WARD	COMMENT
38	Blankets: Warm Air, reuseable	F	F	Part chargeable 33.3% as per Tariff of Fees, section 5.5.4. Other uses to be motivated by doctor.
39	Body Lotions, Powders, Creams, Oils and Shampoos	N/A	C	Chargeable when procedure related.
42	Bulb Syringes - glass	NR	NR	
43	Bulb Syringes - disposable	R	C	One per injured employee per stay. Bladder irrigation only in wards.
44	Burrs - reusable	F	N/A	Part charge as per this Tariff of Fees, section 5.5.1
45	Burrs: Dental surgery including disposable	NR	NR	Included in the dental practitioners' fee
46	Burrs – disposable	R	N/A	
49	Capnograph Set – disposable	NR	NR	Included in Zero based Tariff
50	Cetavlon	NR	NR	
51	Chlorhexidine Solution	NR	NR	
52	Chloromycetin Applicaps	R	C	Two per day in ICU for unconscious or sedated ventilated injured employees on prescription.
53	Chlorine Antiseptics (e.g. Biocide)	NR	NR	
54	Cidex	NR	NR	
55	Codman Markers - sterile			See Marking Pen
56	Collection Charges - Pathology	NR	NR	
57	Connectors - reusable	NR	NR	
58	Connectors - disposable	C	C	To be specified if not a part of pack. (e.g. Bentley or Cobe)
59	Creams & Ointments e.g. Terra-Cortril, Anethaine	C	C	Only full tube chargeable. Prescription required.
62	Cutters - reusable	F	N/A	Part chargeable as per this Tariff of Fees, section 5.5.1
63	Cutters – disposable	R	N/A	Single Use
64	Cytology Brushes - disposable	C	N/A	Fully recoverable if supplied by hospital.
65	Datex Sampling Line	NR	NR	
66	Daylee Towels	NR	NR	
67	Depilatory Creams	NR	NR	

No	PRODUCT	THEATRE	WARD	COMMENT
68	Dettol			
69	Diagnostic Strips -- Blood & Urine (Routine Testing)	NR	NR	
70	Diagnostic Strips – Blood	N/A	C	Diabetic injured employee -account to state Diabetic. Chargeable in the case of injured employees receiving hyperalimentation or in ICU/HC /NICU/ NHC units
72	Diathermy Equipment	NR	NR	
73	Diathermy reusable – pencils, handles	F	N/A	Part charge as per this Tariff of Fees, section 5.5.4
74	Diathermy disposable items –e.g. pencils, handles	R	N/A	Single Use
75	Diathermy Plates – disposable	R	N/A	Chargeable 100% to a maximum of N$70.00/each (7%)
76	Dinamapp Machine & Cuff	NR	NR	
77	Disinfectants	NR	NR	
78	Douche Cans – Reusable	NR	NR	Reusables never chargeable
80.1	Drapes - Camera Towel- disposable	NR	N/A	Included in the tariff
80.2	Drapes - Camera Towel- reusable	NR	N/A	
80.3	Drapes – Instrument Holders	C	N/A	Cranial Procedures only
80.4	Drapes - Incise	R	N/A	As per this Tariff of Fees, section 5.15
80.5	Drapes - Mayo Covers	NR	NR	
80.6	Drapes - Microscope	NR	N/A	Included in the tariff
80.7	Drapes – Non-Woven and Paper Based, Plastic or Polyethylene based– disposable (e.g. Barrier Drapes)	C	N/A	Chargeable when used in the following procedures: Hip, knee, shoulder and elbow joint replacements, open heart and cardiac bypass surgery, vascular surgery (angiography in cath lab), neuro-surgery (brain and spinal cord), arthroscopy of hip, shoulder, knee or elbow joints, spinal surgery
80.8	Drapes - Ophthalmic	R	N/A	As per this Tariff of Fees, section 5.15
80.9	Drapes - Waterproof	C	NR	As per this Tariff of Fees for section 5.6. Procedure indicated e.g cystoscopy, arthroscopy
81	Draw Sheets	NR	NR	

No	PRODUCT	THEATRE	WARD	COMMENT
82	Drills - reusable	F	N/A	Part chargeable as per Tariff of Fees section 5.5.1 eg Maxilla Facial Procedures
83	Drills – disposable	R	N/A	Single use (chargeable in Maxilla Facial Procedures)
84	Drills – disposable- Dental Surgery	NR	NR	Included in the dental practitioners' fee
85	Drops – Eye/Ear/Nose	C	NR	Theatre – eye drops only in theatre When prescribed by doctor.
86	Duratears, Cleargel	NR	C	For long term sedated ventilated injured employees. (Only when full tube is used.) Prescribed by a doctor.
87	EABS	NR	NR	
88	ECG – Equipment	NR	NR	
89	ECG – Electrodes	R	R	Single Use
90	ECG – Paper	NR	R	Theatre/Recovery – Case Manager to motivate.
91	Elastoplast Rolls/Strapping	C	C	Rolls chargeable when appropriate eg skin transplants. Non-recoverable when used as restraining strapping.
92	Electro Surgical Diathermy - Handles and Pencils Disposable	R	N/A	See item 74
93	Electrode Tip Cleaner – disposable (e.g. Scrape Eeze, Friction Pads)	NR	NR	
94	Endoscopic – disposables	C	N/A	See Endoscopic Procedure List attached.
95	Endotracheal Introducers - reusable	NR	NR	
96	ENT Burrs	C	N/A	
99	Epidural Kit/Set	C	N/A	Epidural Kit chargeable in all cases except maternity. Not to be charged when fee is charged.
100	Ether	NR	NR	
101	Eusol	NR	C	For septic wound dressing
102	External Fixators	R	N/A	Pre-authorisation by the Commission required. Supplier's invoice to accompany account.
103	Face Cloth & Toothbrush	NR	NR	
104	Face Masks	NR	L	For reverse barrier nursing only (Head covers and overshoes non-chargeable.)

No	PRODUCT	THEATRE	WARD	COMMENT
105	Films, Video Prints, Compact Discs, Thermal Paper	C	NR	Refer to this Tariff of Fees for section 3.3 - item 075: one fee per procedure
106	Films, Video Prints, Compact Discs – disposables (Endoscopic Procedures)	NR	NR	
107	Fluoroshield Gloves	F	N/A	As per Tariff of Fees for section 5.5.4, item 441
108	Foley's Temp Catheter	C	N/A	On motivation Maximum of N$400.00 (12%) Cardiac only
109	Formalin in Saline	NR	NR	
110	Fosenema / Len-o-lax	N/A	R	When prescribed.
111	Funnel Tubing See tubing			
112	Gigly Saw Blade – disposable	R		Single Use
113	Gigly Saw Blades – reusable	F	N/A	As per Tariff of Fees for section 5.5.1
114	Glass Syringes	NR	NR	
115	Gloves – Non-Sterile	NR	L	Chargeable only for reverse barrier nursing, motivation required.
116	Gloves – Sterile (Surgical)	R	C	Chargeable for incisional procedures, e.g. CVP lines and major wound dressing (burns). Not chargeable with tray
117	Gloves - Sterile (Examination)	N/A	C	For minor sterile procedures in the ward e.g. suction, catheterisation. Non-chargeable with tray
118	Glucometer	N/A	N/A	TTO only if authorised by Commission. Otherwise for injured employee's private account.
119	Gowns – disposable Theatre	C	N/A	Chargeable for specific procedures only: Hip, knee, shoulder and elbow joint replacements, open heart and cardiac bypass surgery, vascular surgery, neuro-surgery (brain and spinal cord), arthroscopy of hip, shoulder, knee or elbow joints, spinal surgery For surgical team only (max 4). (20%) Maximum price N$130 per gown (to be revised with price changes.)
120	Gowns – disposable Wards	N/A	C	Chargeable for reverse barrier nursing and severe burns – motivation to accompany account.
121	Hand/Foot Switching Pencil – reusable	F	N/A	Part chargeable as per this Tariff of Fees, section 5.5.4 (see item 73)

No	PRODUCT	THEATRE	WARD	COMMENT
122	Hand/Foot Switching Pencil - disposable	R	N/A	See item 74. Single use
123	Harmonic Scalpel, or equivalent components – reusable.	F	N/A	Chargeable as per Tariff of Fees for section 5.5.3
124	Harmonic Scalpel, or equivalent – disposable components	R	N/A	Single use
125	Head Strap for CPAP	N/A	C	Chargeable when diagnosis related, e.g. burns/infectious diseases.
126	Heart/Lung Machine	NR	NR	
127	Hibitane Solution - sachets	NR	NR	On prescription to take home
129	Hoods, Shield and Gown combination – disposable (e.g. Charnley)	C	N/A	On motivation Up to N$500.00 per set (15%) Maximum of 3 charges
131	Humidifier - disposable	N/A	C	One per 24 hours or part thereof whilst on oxygen on active humidification.
132	Humidifying Chamber – disposable (e.g. Fisher Paykel)	N/A	C	One per LOS in specialized units
133	Hydrogen Peroxide	NR	NR	
134	Ice Pack/Cold Pack-disposable	N/A	C	Appropriate procedures only.
135	Incontinence Products - Linen Savers	NR	C	Chargeable for incontinent patients only.
136	Incontinence Products - Pads (e.g. sanitary)	C	C	Procedure related or to replace the dressing. Others to be charged to patient's private account.
137	Incontinence Products - Draw Sheet	NR	NR	
138	Incontinence Products – Pads e.g. Besure/Molicare	N/A	P	
141	Jacques Catheters	NR	NR	
142	K Y Jelly – Tubes	NR	NR	On prescription
143	K Y Jelly – Sachets	R	R	Procedure related
144	Lacrilube	NR	C	For long term sedated ventilated injured employees. (Only when full tube is used). Prescribed by a doctor.
145	Lancets, Autolets, Softclix	NR	C	For diabetic patients -account to state Diabetic. For hyperalimentation Chargeable in ICU /NICU /HC /NHC A&B Units
146	Laryngeal Masks	F	N/A	4% as per Tariff of Fees for section 5.5.4, item 435

No	PRODUCT	THEATRE	WARD	COMMENT
147	Laser Components - reusable	F	N/A	Part chargeable as per Tariff of Fees for section 5.5.2
148	Laser Components - disposable	R	N/A	Single Use
149	Latex Tubing			Refer to Tubing
150	Laundry Bags - Soluble	NR	C	Chargeable for barrier nursing (septic cases only). 2 bags per day per injured employee as per item 269
151	Ligasure Electrode – Disposable components only	R	N/A	See item 74, Single Use
152	Limb Holder – disposable (Restrainer)	N/A	C	1 per limb per injured employee per stay on motivation.
153	Liquid Soaps	NR	NR	Non-chargeable when used by staff or for prepping of skin.
154	Loan Set Fee	NR	NR	
155	Magil Mapleson Circuit	NR	NR	Included in theatre basket
156	Marking Pen – sterile (e.g. Codman Marker)	C	NR	Procedure related: Craniotomy, neuro & spinal, skin flaps, keratotomy
157	Mask for Anaesthetics	NR	NR	
158	Maternity Per Diem Fee	C	N/A	Ethical products are chargeable
160	Meal Supplements	NR	NR	On motivation
161	Medically prescribed meals	N/A	C	Based on diagnosis Refer to attached Medically Prescribed Meals
163	Mentor Cable - reusable	NR	NR	
164	Mentor Cable - disposable	NR	NR	Included in Zero Based
165	Mercurochrome & Methiolate	NR	L	Chargeable when prescribed for therapeutic reasons.
166	Micro Retractor	NR	NR	
167	Milk Substitutes	NR	NR	
168	Milton	NR	NR	
169	Mixing Systems for Cement	C	N/A	Chargeable as part of prosthesis, to be included in prosthesis invoice, which accompanies account. Note: Cement containing anti-biotic to be charged separately
170	Monitors	NR	C	Equipment fee chargeable in High Care and Wards when an injured employee is monitored. Item 231. Non-Chargeable in ICU.

No	PRODUCT	THEATRE	WARD	COMMENT
173	Nasal Cannula - disposable	N/A	C	One per stay if oxygen is administered.
174	Nebulising Mask - disposable	N/A	C	One per stay if injured employee is nebulised.
175	Nebulising Mask - Trachea	N/A	C	One per stay if injured employee is nebulised.
177	Neuro Sucker - disposable	C	N/A	Neuro cases only
178	Nursing Services	NR	NR	
179	Operating Instruments-reusable	NR	NR	
180	Opticlude in Theatre	NR		Eyepads in theatre basket
181	Oximeter	NR	NR	
184	Oxygen Analysers, Hoods, Attachments - reusable	NR	NR	
185	Oxygen Analysers, Hoods, Attachments - disposable	C	C	
186	Oxygen Mask + tubing-disposable	C	C	In recovery if oxygen is administered post operatively. One per hospital stay in total.
187	Pacing Wire and Cables - disposable	C	N/A	Must be procedure related. Maximum 1 cable and 2 wires, excess to be motivated.
188	Packing Fee	NR	NR	
189	PCA Pump - reusable (equipment fee and disposables)	NR	C	As per Tariff of Fees for item 230. One per injured employee per day, maximum 48 hours. Not applicable in ICU and specialized units. 1 per injured employee for maximum of 48 hours in ward Chargeable in the following instances: Major joint replacement, open, upper abdominal surgery, severe burns, thoracotomies (motivation by practitioner), intractable pain associated with malignancy
190	PCA Pumps – disposable	C	C	As per Tariff of Fees for section 5.16. One per injured employee per 48 hours. Chargeable in theatre if injured employee goes directly into ward. Not to be charged in specialized units, ICU and High Care units Chargeable in the following instances: Major joint replacement, open, upper abdominal surgery, severe burns, thoracotomies (motivation by practitioner), intractable pain associated with

No	PRODUCT	THEATRE	WARD	COMMENT
				malignancy
191	Peak Flow Meter	NR	NR	
192	Peak Flow Meter – disposable Mouth Piece	N/A	R	
193	Peep Valve and/or CPAP mask – disposable	N/A	C	Max of one CPAP mask per injured employee per stay Max of two valves per injured employee per stay. More to be motivated
194	Plaster (e.g. Elastoplast)	C	C	Rolls chargeable for appropriate conditions. Non-recoverable when used as restraining strapping. Non-chargeable for positioning.
195	Plastic Bags	NR	NR	
196	Pour Bottle – Saline	C	C	Chargeable when procedure related, e.g. for wound irrigation. Excessive usage to be motivated. Not to be charged with pour bottle water
197	Pour Bottle – Water	C	C	Not to be charged with pour bottle saline Only chargeable for injured employees' related conditions: _flushing of wounds, under water drains and bladder irrigation in theatre and wards, ventilated injured employees 1 litre per 24 hours
198	Premi-Probe Thermometer - disposable			See Temperature Probe
199	Preparation Items, Shaving Trays, Razor, Scrub Brush	NR	NR	
200	Preptic Swabs			See alcohol swabs
201	Pressure Monitoring Kit – disposable	R	R	
202	Pressure relieving products e.g. Novogel/Reston foam	N/A	C	On motivation
204	Prosthesis	C	N/A	Benefit by pre-arrangement with the Commission. Supplier's invoice to accompany account. Refer to this Tariff of Fees, section 5.9
205	Protective Covers (Cath Lab)	NR	NR	
206	Rebreathing Bags	NR	NR	
207	Recovery Room	NR	NR	

No	PRODUCT	THEATRE	WARD	COMMENT
208	Receptal Liners & Shut Off Valves	NR	C	Chargeable in ICU, specialized units and High Care for injured employees with severe respiratory complications
209	Rectal Temperature Probe – reusable	NR	NR	
210	Rectal Temperature Probe / Core – disposable / Probe Covers			See Temperature Probes
211	Remicaine Jelly – fractional	NR	NR	
212	Remicaine Jelly	C	C	Full tube when applicable TUR, Urinary Cath introduction –male only (wards)
213	Razor	NR	NR	
213	Safety Pin			
215	Sanitary Towels			Refer to Incontinence Products.
216	Savlon & Savlodil	NR	NR	
217	Sequential Stockings – Disposable	R	N/A	Diagnosis related on motivation
218	Servo Ventilator (equipment)	N/A	C	Chargeable only in ICU and High Care where applicable.
219	Sheepskin	NR	NR	
220	Silicone Tubing			See Tubing
221	Skin Markers – Sterile (e.g. Codman)			See Marking Pen
222	Skin Prep Solutions	NR	NR	
223	Space blanket	R	R	Not to be charged with a warm air blanket
224	Spatulas, Tongue Depressors	NR	NR	
225	Specimen Containers	NR	NR	
226	Spigots – reusable	NR	NR	
227	Spirometer – Incentive	NR	NR	Chargeable as TTO
228	Spray Top Bottles	NR	NR	
229	Sputum Cups	NR	NR	
230	Sterilising of Instruments or Materials	NR	NR	
231	Sterilising Solutions, Gases and Tablets	NR	NR	
232	Steripeel & Equivalents	NR	NR	
233	Stethoscopes	NR	NR	
234	Stitch Cutter	NR	NR	

No	PRODUCT	THEATRE	WARD	COMMENT
235	Stone Baskets – reuseable	NR		Reusable chargeable as per this Tariff of Fees, item 224.
236	Stone Baskets – Disposable	R	N/A	1 basket only to a maximum of (N$2400.00) May not be used together with item 224 in this Tariff of Fees.
237	Strapping – all adhesive and non-adhesive strapping	C	C	Rolls chargeable when appropriate to condition. Non-recoverable when used as restraining strapping.
238	Suction Nozzle – disposable	R	R	
239	Suction Tubing			See Tubing
240	Swabs, including Blue and Green	C	C	
241	Swivel Connector – reusable	NR	NR	
242	Swivel Connector – disposable	NR	NR	Part of Ventilator Circuit
243	Tantol Cleanser / Lotion	N/A	P	
244	Taps & Reamers	NR	N/A	
245	Tears Plus Natural	NR	C	For long term sedated ventilated injured employees. (Only when full tube is used). Prescribed by a doctor.
246	Thermometer	NR	NR	
247	Temperature Probe – disposable (Oesophageal or Rectal, Etc)	C	C	Chargeable in cardio-thoracic cases (one rectal and one oesophageal) or theatre cases longer than 3 hours at anaesthetist's discretion Probe Covers one per day
249	Thoraguide Kit (for underwater drainage)	R	L	Chargeable in I.C.U and Emergency Room
250	Topical Anaesthetics – fractional	NR	NR	
251	Topical Anaesthetics	C	C	When full tube used per injured employee. Male catheterisation
252	Transducers – disposable	R	R	Single Use
253	Trays – sterile	NR	C	Tray and contents not to be charged together If price exceeds max. then contents must be charged Disposable contents only chargeable Ready made packs – list of contents and price to be supplied. Small trays, swabbing, ENT – N$8.00 (7%) Large trays – dressing, cath, multipack – N$14.00 (7%)
254	TTO's			See this Tariff of Fees

No	PRODUCT	THEATRE	WARD	COMMENT
255	Tubing – disposable (e.g. Bubble, Funnel, Latex, Suction, Silicone)	C	C	Maximum N$30.00 payable on tubing per stay unless injured employee returns to theatre then an additional N$30.00 may be charged per additional visit
256	Tubing – reusable (e.g. Elephant)	NR	NR	
257	Ung Emulsificans	NR	C	When used in treatment on prescription.
258	Unisolve Wipe	NR	NR	
259	Valley Lab Pencil			See item 73 and 74
260	Varimask	C	C	One in recovery if oxygen is administered post operatively. One per stay in total
261	Vascular Punch - reusable	NR	NR	
262	Vaseline	NR	C	Chargeable when part of mixture.
263	Ventilators (e.g. Servo, Bennett) - equipment	N/A	C	Chargeable only in ICU and High Care where applicable.
264	Ventilator Circuits – reusable	NR	NR	
265	Ventilator Circuits disposable + disposable items: Tubing, Cath Mounts, Connectors,	N/A	NR	
266	Water Bottle – Pour			Refer to Pour Bottles
267	Webcol Swabs			See alcohol swabs
268	X-Ray Detectable Swabs	R	C	As for abdominal swabs
269	Xylocaine Spray	NR	NR	
270	Yankauer Suction – Plain Yankauer Suction with Control	C	L	Disposable max. 2 per case. (One of each). In ward for resuscitation and trauma only
271	Zinc & Castor Oil Cream	N/A	N/A	Chargeable if part of prescribed mixture.

ANNEXURE B.2
ENDOSCOPIC (laparoscopic & thoracoscopic) GENERIC LIST

Category 1 Procedures Diagnostic Laparoscopy and Thoracoscopy	**Category 2 Procedures** Laparoscopy Procedures other than Diagnostic
Standard Equipment Charges **Item 360:** Laparoscopic Equipment Fee per case INCLUDES reusable Laparoscopic Instrumen-tation per case. Instrumentation includes: - Light Guide cable - Hi –frequency cord - Basic scissors - Basic graspers - Basic dissectors - Electro surgical instrument	**Standard Equipment Charges:** **Item 364:** Laparoscopic Equipment Fee per case INCLUDES reusable Laparoscopic Instrumen-tation per case. Instrumentation includes: - Light Guide cable - Hi –frequency cord - Endoscopic needle holder - Basic scissors - Basic graspers - Basic dissectors - Suction irrigation shaft - Electro surgical instrument
Recoverable Disposable Products "single-use" allowed - Insuflation Needle - Trocars	**Recoverable Disposable Products "single–use" allowed** - Insuflation Needle -Trocars -Ligating Clip Appliers -Operating Instruments – Disposable -Ultrasonic Consumables -Electro surgical consumables -Endoscopic Staplers/Cutters
NOTE: Category 1 procedures are predominantly diagnostic and the listed reusable instruments are considered relevant and appropriate for category 1 procedures	NOTE: Should a diagnostic procedure move to a 'therapeutic intervention, then the procedure would become a category 2 procedure
Part Chargeable Products: - Ultrasonic Handpiece and Cable = 1%	

Note: 1) Refer also to detailed Endoscopic Disposable Product List, attached.
2) Procedure to be applied per CPT Code - List attached.

ANNEXURE B.3

ENDOSCOPIC DISPOSABLE PRODUCT LIST

Schedule of Products Representing Trade Names of the Disposable, Single-use Generic Products Currently Commercially Available.

Insuflation Needle (Cat 1 &	**Trocars (Cat 1 & 2)**	**Ligating Clip Appliers (Cat 2)**	**Instrumentation Disposable (Cat 2)**	**Ultrasonic Products (Cat 2)**	**Electro Surgical (ES) (Cat 2)**	**Endoscopic Staplers/ Cutters (Cat 2)**
Pneumo Needle Reflex Verres Needle Surgineedle **Verress Needle**	**Trocars** Audible-Dilating Trocar Balloon Bluntport Dexide Dilating Tip Innerdyne (STEP) Non-shielded Reflex Str Trocars Reflex Str Trocar Mini-kits Sensing tip Surgiport Surgispike Tristar Versaport **Optical trocars** Optiview ptical trocar Visiport Specialized Trocars Flexipath (thoracic) Pre-peritoneal balloon Large Trocar Kit (bowel) Trocar Extraction Cannullae Thoracoport **Trocar Sleeves** Reflex Stability Sleeve Reflex Trocar Sleeves Stability sleeve **Trocar accessories** Depth gauge Ring Multi-seal cap One-seal Reducer Reducer valve Reflex UCS Converter Reflex 5mm Converter pring Grip Surgigrip “Toilet Seat” **Universal Seal**	Clip Appliers **Accuclip** Allport Endoclip ERCA (ER320) Reflex ELC530 Disposable Reloads **Aesculap Applied Medical** Ligaclip	**10mm Instruments** Babcock Cherry Dissector (Cotton Peanut) Endo Babcock Endo Retractor Liver Retracror Lung Clamp **5mm Instruments** Babcock Curved Scissors Endo Clinch Endo Peanut Endo Shears Reflex Metzenbaum Scissor **Roticulator Grasper** **Roticulator Dissector** **Roticulator Shears** **Inserts** **Babcock** **Grasping Inserts** Accessories: **Suturing Devices** **10mm** Endostitch + Reloads **5mm** Suture assistant Reloads **Quik-Sticth reloads** Specimen Bags **Endo Pouch** **Endo Catch** Endo Bag	Ultrasonic Instruments Coagulating Shears Curved Straight Surgical blades **Hook** **Ball** **Curved**	Probe Plus II (Suction/ Irrigation/ES) ProbePlus Pistol/Pencil grip ProbePlus Hook/Curve/ Angle/ Needle Electrode Shaft Bipolar Forceps (micro/ macro) **Tripolar Forceps** **Argon Beam Coagulator** **Surgiwand**	**Staplers (eg. Hernia)** EMS Tacker & Reloads Protack **Cutters** Endo cutter & reloads Straight Articulating Reflex AEC

ANNEXURE C

MEDICALLY PRESCRIBED MEALS

ORAL SUPPLEMENTS (oral and tube feeds)	Standard	Ensure Fortisip Fortimel Fresubin Original drink (Vanilla) Nutren And Nutren Jnr (Gluten -free)
	Standard & Fibre	Ensure with Fibre Nutren with Fibre
	Isotonic	Fresubin Original
	Isotonic & Fibre	Fresubin Original Fibre Jevity Osmolite
	Low Residue	Modulen N Osmolite HN Peptamen & Peptamen Jnr
	High Energy, High Protein & Fibre	Fresubin Energy Fibre drink (Lemon, Banana, Chocolate & Cappuccino)
	High Energy & High Protein	Fresubin Energy drink (Strawberry & Vanilla)
TUBE FEEDS	Semi-Elemental	Alitraq Peptamen & Peptamen Jnr RTH Peptisorb Survimed OPD (Liquid) Vital
	Standard	Nutren RTH Nutrison Nutrison Energy Nutrison Paediatric
	High Energy & High Protein	Fresubin 750 MCT (HP Energy) Semi-Elemental High
	Protein & High Fibre	Perative, Nutren Fibre RTH
DISEASE SPECIFIC	Maximum Glucose Tolerance	Fresubin Diabetes Glucerna Nutren Diabetes
	Pulmonary Insufficiency	Pulmocare Supportan
	Renal Failure	Suplena
	HIV/Aids	Advera Survimed OPD Supportan
	Cancer Patients	Supportan drink (Milk Coffee), Stresson Multi Fibre, Peptisorb
MODULAR	Protein	Promod Protifar
	MCT Oil	MCT Oil Fresubin 750MCT(HP Energy)
	Glutamine	Glutapack-10 Dipeptiven 50ml & 100ml
	Food thickener	Thick & Easy
	Carbohydrate	Fantomalt Polycose

Note: Or generic equivalents. All tubes feeds subject to case management

MINISTRY OF LABOUR

No. 143 2003

EMPLOYEES' COMPENSATION ACT, 1941:
TARIFF OF FEES FOR MEDICAL AID

Under section 79 of the Employees' Compensation Act, 1941 (Act No. 30 of 1941) the Social Security Commission hereby, effective from 1 August 2003 -

(a) prescribes the Tarrif of Fees for Medical Aid and the general rules and general modifiers applicable thereto, as set out in the Schedule;

(b) repeals Government Notice 178 of 1999.

F. KAPOFI
CHAIRMAN OF THE
SOCIAL SECURITY COMMISSION Windhoek, 10 June 2003

SCHEDULE
INDEX

GENERAL INFORMATION

a) **Notes in respect of the Employees' Compensation Act 1941 (Act 30 of 1941)**

(i) **The Employee and the Medical Practitioner**

The injured employee is permitted to choose freely his/her own doctor, and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself/herself or the Compensation Fund. The only exceptions to this rule are those cases where employers, with the Commission's approval, provide their own medical aid facilities in toto, i.e. including hospital, nursing and other services in terms of section 81 of the Act.

In terms of section 60 either the Commission or an employer may send the injured employee to another doctor chosen by him/her (Commission or employer) for a special examination and report. Special fees are payable for this service.

In the event of a change of medical practitioners attending a case, the first practitioner in attendance will, except where the case is handed over to a specialist, be regarded as the principal, and payment will normally be made to him/her. To avoid disputes, medical practitioners should refrain from treating a case already under treatment without first discussing it with the first practitioner. As a general rule, changes of medical practitioners are not favoured.

If an injured employee is in need of emergency treatment, the medical practitioner should act in the same manner as he/she would to any patient who needs his/her urgent help. He/she should not, however, ask the Commission to authorize payment for such treatment before the claim has been admitted as falling within the scope of the Act. It should be remembered that an injured employee seeks medical advice at his/her own risk. If, therefore, an injured employee represents to his/her doctor that he/she is an Employees' Compensation Act case and yet fails to claim the benefits of the Act, leaving the Commission or his/her employer, in ignorance of any possible grounds for a claim, the Commission cannot accept any responsibility for any medical expenses incurred. In such circumstances the injured employee would be in the same position as any other member of the public as regards payment of his/her medical expenses.

(ii) Except where otherwise stated the fees charged for services of a general practitioner shall be two-thirds of the fees of a specialist for the same service

b) **Explanation and General Comments**

(i) In compiling this tariff the Commission has used the anatomical system established by the S.A. Medical Association, in which units have been allocated to each procedure, operation, consultation, etc. In order to calculate the fee for each service the number of units attached to the particular item is multiplied by the respective monetary value of the unit.

(ii) The monetary value of units for the various groups and sections is as follows:

1)	Anaesthesiology	N$ 44.00
2)	Anatomical Pathology, Cytology, Histology	N$ 8.30
3)	Clinical Pathology	N$ 8.10
4)	Clinical Procedures	N$ 9.10
5)	Computed Tomography	N$ 7.80
6)	Consultative Services	N$ 9.10
7)	Magnetic Resonance Imaging	N$ 7.20
8)	Radiation Oncology	N$ 8.50
9)	Radiology	N$ 9.00
10)	Ultrasound	N$ 6.50

Note**:** Monetary values have been rounded off on the basis that monetary values ending with a 1 to 4 cents value have been rounded off downwards, and that 5 to 9 cents have been rounded off upwards. This rule applies to all fees where the units have been converted to Namibian dollars and cents. Monetary values in respect of modifiers should be rounded off to the nearest one-cent on the basis that the third decimal ending with a 1 to 4 cents value should be rounded off downwards, and that 5 to 9 cents should be rounded off upwards:

(iii) Every medical practitioner must acquaint him/herself with the provisions of the Employees' Compensation Act 1941 (30 of 1941) and the regulations promulgated under the Act in connection with the rendering of accounts.

Every account shall be signed by the service provider and shall contain the following particulars:

1. The name, address and practice code number of the medical practitioner;
2. The surname, first name, date of birth, Social Security number of the injured employee and the date of accident;
3. The name, address and contact telephone number of the employer;
4. The nature of the treatment;
5. The date on which the service was rendered;
6. The tariff code number and fee for the procedure used in this schedule **and shall be accompanied by**
7. A copy of the completed "Employer's Report of Accident" (Form E.CL.2), page 1,
   and where applicable shall be accompanied by
8. A copy of the referral letter of the medical or dental practitioner concerned;
9. The First Medical Report and Account (Form E.CL.4);
10. The Final/Progress Medical Report (Form E.CL.5);
11. The Supplementary Report on Injury to Hand (Form E.CL.31);
12. The Final Report: Eye Injuries (Form E.CL.52);
13. The Dermatological Report (E.CL.53);
14. The Supplementary Report on Injury to Foot (E.CL. 221).

(See Annexure A for listing of Forms)

GENERAL RULES GOVERNING THE TARIFF

A. Consultations:

(i) First consultation: Refers to a situation where a medical practitioner personally takes down a patient's medical history, performs an appropriate clinical examination and, if indicated, prescribes or administers treatment.

(ii) Subsequent visits: Refers to a voluntarily scheduled consultation performed for the same condition within four (4) months after the first consultation (although the symptoms or complaints may differ from those presented during the first consultation). It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling.

(iii) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may he levied unless otherwise agreed upon with the Commission. Where no procedure or operation was carried out fees may be charged for hospital visits according to item 0109. Dates of hospital visits must be specified.

B. Normal hours and after hours: Normal working hours refer to the periods 08:00 to 17:00 on Mondays to Fridays and 08‘00 to 13:00 on Saturdays as well as all other periods voluntarily scheduled by a medical practitioner (even when for the convenience of the patient) by a medical practitioner for the rendering of services. All other periods are regarded as after-hours. Public holidays are not regarded as normal working days and work performed on these days is regarded as after-hours work.

C. The fee that may be charged in respect of the rendering of a service not listed in this tariff of fees shall be based on the fee in respect of a comparable service.

D. Cancellation of appointments: Unless timely steps are taken to cancel an appointment for a consultation the relevant consultation fee shall be payable by the injured employee. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall however; be considered on merit and, if circumstances warrant, no fee shall be charged.

E. Pre-operative care: The appropriate fee may be charged for all pre-operative consultations with the exception of a routine pre-operative visit at the hospital.

F. Where applicable fees for administering injections and/or infusions may only be charged when done by the practitioner him-/herself.

G. Post-operative care: Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding four months. Where the surgeon does not him-/herself complete the after-care, it shall be his/her responsibility to arrange for this to be done without extra charge: Provided that in the case of post-operative treatment of a prolonged or specialized nature, such fee as may be agreed upon between the surgeon and the Commission, may be charged. Where an employee met with an accident and received medical treatment away from home and afterwards has to be transferred to his hometown, treatment may be taken over by another doctor who will be entitled to further payment.

H. Removal of lesions: Items involving removal of lesions include follow-up treatment for four months.

I. Fees for all pathology investigations performed by members of other disciplines (where permissible): See section for Pathology. (Refer to modifier 0097).

J. In exceptional cases where the tariff fee is disproportionately low in relation to the actual services rendered by a medical practitioner a higher fee may be negotiated with the Commission. Conversely, if the fee is disproportionately high in relation to the actual services rendered a lower fee than that in the tariff should be charged.

K. Save in exceptional cases the services of a specialist shall be available on the recommendation of the attending general practitioner. Medical practitioners referring cases to other medical practitioners shall, if known to them, indicate in the reference 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 an initial or subsequent consultation, the fee for the consultation plus the fee for the procedure may be charged.

M. If such a procedure, planned at an initial or subsequent consultation, is performed at another time, the fee for the procedure only may be charged.

N. "Per consultation":

(a) No additional fee may be charged for services for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation performed at the time the condition is brought to the medical practitioner's attention**.**

(b) Where a fee for any service is prescribed herein, the medical practitioner shall not be entitled to payment calculated on a basis of visits or examinations made where such calculation would result in the prescribed fee being exceeded.

(c) The number of consultations must be in direct relation to the seriousness of the injury and should more than 20 consultations be necessary, the Commission must be furnished with a detailed motivation.

(d) A single fee for a consultation/visit shall be paid to a medical practitioner who gives a single treatment to an injured employee who thereafter passes to the permanent care of another medical practitioner, not being a partner or assistant of the first. The responsibility for furnishing the first medical report in such a case ordinarily rests with the second practitioner.

O. (a) An employee should be hospitalized only if and for such a period his/her condition justifies full-time "medical aid".

(b) Occupational Therapy/Physiotherapy: The same principles set out in modifier 0077 will apply when an employee is referred to a therapist.

(c) In the case of costly or prolonged medical services or procedures the medical practitioner shall first ascertain in writing from the Commission for what amount the Commission will accept responsibility in respect of such treatment.

P. Travelling fees

(a) Where, in case of emergency, a practitioner was called out from his residence or rooms to an employee's home or the hospital, travelling fees can be charged according to section IV if he/she had to travel more than 16 kilometres in total.

(b) If more than one injured employee would be attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees.

(c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his/her rooms.

(d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled).

(e) Where a practitioner conducts an itinerant practice, he/she is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled).

RULES GOVERNING SPECIFIC SECTIONS OF THE TARIFF

INTENSIVE CARE

Q. Units in respect of items 1204 to 1210 exclude the following:
(a) Anaesthetic and/or surgical fees for any condition or procedure.
(b) Costs of any drugs and/or materials.
(c) Any other cost which may be incurred before, during or after the consultation *and/or* the therapy.
(d) Blood gases and chemistry tests, including the arterial puncture to obtain the specimen.
(e) Procedural items 1212 to 1219.

R. Units for items 1208, 1209 and 1210 include resuscitation (i.e. item 1211).

S. Units for items 1212, 1213 and 1214 include the following**:**
(a) Measurement of minute volume, vital capacity, time and vital capacity studies.
(b) Testing and connecting the machine.
(c) Putting patient on machine: Setting machine, synchronizing patient with machine.
(d) Instruction to nursing staff.
(e) All subsequent visits within 24 hours.

T. Ventilation (items 1212 to 1214) does not form a part of normal post-operative care.

MAGNETIC RESONANCE IMAGING

U. In cases where a second Magnetic Resonance Imaging of the spine (items 6210, 6211, 6212 and 6213 refers) is deemed necessary, or a Magnetic Resonance Imaging of another anatomical region is requested, proper motivation must be submitted upon which the Commission will consider approval of payment.

MEDICAL PSYCHOTHERAPY

Va Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure.

Vb Except where otherwise indicated, the duration of a medical psychotherapeutic session is set at 20 minutes or part thereof provided that such a part comprises 50% or more of the time of a session. This set duration is also applicable for psychiatric examination methods.

RADIOLOGY

Y Except where otherwise indicated, radiologists are entitled to charge for contrast material used.

Z No fee is subject to more than one reduction

DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIOISOTOPES

AA Procedures to exclude cost of isotope.

RADIATION ONCOLOGY

BB The fees in this section (radiation oncology) do not include the cost of radium or isotopes.

ACUPUNCTURE

CC (a) Prior consent of the Commission is required for the payment of acupuncture treatment.
(b) When two separate acupuncture techniques are used, each treatment shall be regarded as a separate treatment for which fees may be charged for separately.
(c) Not more than two separate techniques may be charged for at each session.

(d) The maximum number of acupuncture treatments per course to be charged for is limited to 20. If further treatment is required at the end of this period of treatment, payment should be negotiated with the Commission.

(e) Item 0380 refers to scalp acupuncture as a treatment in its own right and not to the use of acupuncture points on the scalp.

ULTRASONIC EXAMINATIONS

EE (a) In case of a referral, the referring doctor must submit a letter of motivation to theradiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account rendered to the Commission (by the radiologist or the other practitioner doing the scan) as the case may be.

(b) In case of a referral to a radiologist, no motivation should be required from the radiologist.

URINARY SYSTEM

FF (a) When a cystoscopy precedes a related operation, modifier 0013: "Endoscopic examination done at an operation", applies, e.g. cystoscopy followed by transuretral (TUR) prostatectomy.

(b) When a cystoscopy precedes an unrelated operation, modifier 0005: "Multiple procedures/operations under the same anaesthetic", applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair.

(c) No modifier applies to item 1949: "Cystoscopy", when performed together with any of items 1951 to 1964.

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.

GENERAL MODIFIERS GOVERNING THE TARIFF

0001 For involuntarily scheduled after-hours emergency radiological services, the additional premium shall be 50% of the fee for the particular services (section 19.12 excluded). See General Rule B. For after-hours MR scans, a maximum levy of 100 radiological units (N$ 900.00) is applicable.

0002 Item 38/0101 is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him.

0005 Multiple procedures/operations under the same anaesthetic. Unless otherwise identified in the tariff, when multiple procedures/operations add significant time and/or complexity, and when each procedure/operation is clearly identified and defined, the following values shall prevail: 100% (full value) for the first or major procedure/operation, plus 50% (half of) the tariff fee in respect of each additional operation or procedure with a maximum of four additional operations or procedures. In the case of multiple fractures and/or dislocations the same values shall prevail.

Note:

a) When more than one small procedure is performed and the tariff makes provision for items for "subsequent" or "maximum for multiple additional procedures" (see section 2: Integumentary System) modifier 0005 is not applicable as the fee is already a reduced fee.

b) In the case of multiple fractures and/or dislocations the same values shall prevail.

0006 A 25% reduction in the fee for a subsequent operation for the same condition within one month shall be applicable if the operations are performed by the same surgeon (an operation subsequent to a diagnostic procedure is excluded).

After a period of one month the full fee is applicable.

0007 Remuneration for the use of any type of own equipment in the rooms for procedures performed under intravenous sedation or for procedures performed in a hospital or day-clinic theatre when appropriate equipment is not provided by the hospital: 15.00 clinical procedure units (N$ 136.50) irrespective of the number of items of equipment provided.

0008 Where a procedure requires a registered specialist surgeon assistant, the fee is 33,33% (1/3) of the fee for the specialist surgeon

0009 The fee for an assistant is 20% of the fee for the specialist surgeon, with a minimum of 36.00 clinical procedure units (N$327.60).

0010 A fee for a local anaesthetic administered by the operator may only be charged for an operation or a procedure having a value greater than 30.00 clinical procedure units (N$ 273.00) i.e. 31.00 or more clinical procedure units (N$ 282.10) allocated to a single item.
The fee shall be calculated according to the basic anaesthetic units for the specific operation. Anaesthetic time may not be charged for, but the minimum fee as per modifier 0036 shall be applicable in such a case. Not applicable to radiological procedures such as angiography and myelography.
No fee may be levied for topical application of local anaesthetic.

0011 The additional fee to all members of the surgical team for after-hours emergency surgery for theatre procedures shall be 12.00 clinical procedure units (N$ 109.20) for each half-hour or part thereof of the operation time. Normal hour fees to be charged in respect of injured employees on scheduled lists.

0013 Where a related endoscopic examination is done at an operation by the operating surgeon or the attending anaesthesiologist, only 50% of the fee for the endoscopic examination may be charged.

0014 Where an operation is performed which has been previously performed by another surgeon, e.g. a revision or repeat operation, the fee shall be calculated according to the tariff for the full operation plus an additional fee to be negotiated under General Rule J, except where already specified in the tariff.

MODIFIERS GOVERNING SPECIFIC SECTIONS OF THE TARIFF

INJECTIONS, INFUSIONS AND INHALATION SEDATION

0015 Where intravenous infusions (including blood and blood cellular products) are administered as part of the after-treatment after operation, no extra fees will be charged, as this is included in the global operative fees. Should the practitioner doing the operation prefer to ask another practitioner to perform postoperative intravenous infusions, then the practitioner him/herself (and not the Commission) shall be responsible for remunerating such practitioner for the infusion.

0017 Where desensitisation, intravenous, intra-muscular or subcutaneous injections are administered by the medical practitioner him/herself in respect of injured employees who attend the consulting rooms, a first injection forms part of the consultation and all subsequent injections for the same condition should be charged at 50% of the appropriate consultation fee for a general practitioner.

ADMINISTRATION OF ANAESTHETIC FOR ALL PROCEDURES AND OPERATIONS INCLUDED IN THIS TARIFF

0021 Anaesthetic fees are determined by obtaining the sum of the basic anaesthetic units plus the time units and the appropriate modifiers (see modifiers 0037 to 0039, 0041 and 0042). In cases of operative procedures on the musculo-skeletal system, open fractures and open reduction of fractures or dislocations add fees as laid down by modifiers 5441 to 5448.

0023 The basic anaesthetic units are laid down in the tariff. These basic anaesthetic units reflect the additional anaesthetic risk, the technical skill required of the anaesthesiologist and the scope of the surgical procedure, but exclude the value of the actual time spent administering the anaesthetic. The time units (indicated by "T') will be added to the listed basic anaesthetic units in all cases on the following basis:
Anaesthetic time: The remuneration for anaesthetic time shall be per 15 minute period or part thereof, calculated from the commencement of the anaesthetic i.e. 2.00 anaesthetic units (N$ 88.00) per 15 minute period or part thereof, provided that should the duration of the anaesthetic be longer than one hour the number of units shall, after one hour, be 3 anaesthetic units (N$ 132.00) per 15 minute period or part thereof.

0024 If a pre-operative assessment of a patient by the anaesthesiologist is not followed by an operation it will be regarded as consultation at the hospital or nursing home.

0025 Anaesthetic time is calculated from the time the anaesthesiologist 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 is no longer required to give his personal professional attention to the patient, i.e. when the patient may, with reasonable safety, be placed under the customary post-operative supervision. Where prolonged personal professional attention is necessary for the well-being and safety of such patient, the necessary time will be valued on the same basis as indicated above for the anaesthetic time.
The anaesthesiologist must show in his/her account the exact anaesthetic time and the supervision time spent with the patient.

0027 Where more than one operation is performed under the same anaesthetic, the basic value will be that of the major operation with the highest unit value.

0029 When rendered necessary by the scope of the anaesthetic an assistant anaesthesiologist may be employed. The remuneration of the assistant anaesthesiologist shall be calculated on the same basis as in the case where a general practitioner administers the anaesthetic.

0031 Treatment with intravenous drips and transfusions is considered part of the normal treatment in administering an anaesthetic. No additional fees may be charged for such services when rendered either prior to, or during actual theatre or operating time.

0032 Anaesthesia administered to patients in the prone position shall have a minimum of 4.00 basic anaesthetic units (N$ 176.00). When the basic anaesthetic units for the procedure are 3.00 (N$ 132.00), one extra anaesthetic unit may be added. If the basic anaesthetic units for the procedure are 4.00 (N$ 176.00) or more, no extra unit should be added.

0033 When an anaesthesiologist is required to participate in the general care of a patient during a surgical procedure, but does not administer the anaesthetic such services may be remunerated at full anaesthetic rate, subject to the provisions of modifier 0035.

0034 All anaesthetics administered for diagnostic, surgical or X-ray procedures on the head and neck shall have a minimum of 4.00 basic anaesthetic units (N$ 176.00). When the basic anaesthetic units for the procedure are 3.00 (N$

132.00), one extra anaesthetic unit should be added. If the basic anaesthetic units for the procedure are 4.00 (N$ 176.00) or more no extra units should be added.

0035 No anaesthetic administered by a specialist anaesthesiologist shall have a total value of less than 7.00 anaesthetic units (basic units plus time units) respectively N$ 308.00.

0036 Fees for an anaesthetic administered by a general practitioner shall be two-thirds (2/3) of the total number of units applicable to the specialist anaesthesiologist provided that no anaesthetic shall have a total value of less than 5 anaesthetic units (N$ 220.00). The monetary value of the unit is the same for both a specialist anaesthesiologist and a general practitioner anaesthetist.
Note: Modifying units may be added to the basic anaesthetic unit value according to the following modifiers: (0037-0042, 5441-5448)

0037 Utilization of total body hypothermia: Add 3 anaesthetic units (N$ 132.00).

0038 Peri-operative blood salvage: Add 4.00 anaesthetic units (N$ 176.00) for intra-operative blood salvage and 4.00 anaesthetic units (N$ 176.00) for post-operative blood salvage.

0039 Deliberate control of the blood pressure: All cases up to one hour: add 3 anaesthetic units (N$ 132.00), thereafter add 1 additional anaesthetic unit (N$ 44.00) per quarter-hour or part thereof.

0041 Utilization of hyperbaric pressurization: Add 3 anaesthetic units (N$ 132.00).

0042 Utilization of extra corporeal circulation: Add 3 anaesthetic units (N$ 132.00)

***ANAESTHETIC FEES FOR ORTHOPAEDIC OPERATIONS*:**

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). General practitioners refer to modifier 0036 (two-third).

5441 In all cases of open fractures, open reduction of fractures and dislocations: Add 1 (one) anaesthetic unit (N$ 44.00) except where the procedure refers to the bones named in modifiers 5442 to 5448

5442 Shoulder, scapula, clavicle, humerus, elbow joint, upper 1/3 tibia, knee joint, patella, mandible and temporo-mandibular joint: Add 2 (two) anaesthetic units (N$ 88.00).

5443 Maxillary and orbital bones: Add 3.00 anaesthetic units (N$ 132.00).

5444 Shaft of femur: Add 4.00 anaesthetic units (N$ 176.00)

5445 Spine (except coccyx), pelvis, hip, and neck of femur: Add 5.00 anaesthetic units (N$ 220.00).

5448 Sternum and/or ribs and musculo-skeletal procedures, which involve an intra-thoracic approach: Add 8.00 anaesthetic units (N$ 352.00).

POST-OPERATIVE ALLEVIATION OF PAIN

0045 (a) When a regional or nerve block procedure is performed, item 0109: "Hospital follow-up visit to patient in ward or nursing facility" may be charged, provided that it is not the primary anaesthetic technique.

(b) When a second medical practitioner has administered the regional or nerve block for post-operative alleviation of pain it shall be charged according to the particular procedure for instituting the therapy. Revisits shall be charged according to item 0109.
(c) None of the above is applicable to routine post-operative pain management.

ANAESTHESIOLOGIST OPERATING AN INTRA-AORTIC BALLOON PUMP (Cardiovascular System)

0100 Where an anaesthesiologist would be responsible for operating an intra-aortic balloon pump, a fee of 75.00 clinical procedure units (N$ 682.50) is applicable.

MUSCULO-SKELETAL SYSTEM

0046 Where in the treatment of a specific fracture or dislocation (compound or closed) an initial procedure is followed within one month by an open reduction, internal fixation, external skeletal fixation or bone grafting on the same bone, the fee for the initial treatment of the fracture or dislocation shall be reduced by 50%. Note: This reduction does not include the assistant's fee or after-hours levy where applicable. After one month, a full fee as the initial treatment is applicable.

0047 A fracture not requiring reduction shall be charged on a fee for service basis provided that the cumulative amount does not exceed the charges for a reduction.

0048 Where in the treatment of a fracture or dislocation an initial closed reduction is followed within one month by further closed reductions under general anaesthesia, the fee for such subsequent reductions will be 27 clinical procedure units respectively N$ 245.70 (not including after-care).

0049 Except where otherwise specified**,** in cases of compound fractures**,** 77.00 clinical procedure units (N$ 700.70) by specialists and 51.00 clinical procedure units (N$ 464.10) by general practitioners may be added to the units for the fractures including debridement.

0050 In cases of a compound fracture where a debridement is followed by internal fixation (excluding fixation with Kirschner wires as well as fractures of hands and feet), the full amount according to either modifier 0049 or 0051 may be added to the fee for the procedure involved, plus half of the amount according to the second modifier (either 0049 or 0051 as applicable).

0051 Except where otherwise specified in cases of fractures requiring open reduction, internal fixation, external skeletal fixation and/or bone grafting: Specialists add 77.00 clinical procedure units (N$ 700.70). General practitioners add 51.00 clinical procedure units (N$ 464.10).

0053 Fractures requiring percutaneous internal fixation: [Insertion and removal of fixatives (wires) in respect of fingers and toes included]: Specialists add 32 clinical procedure units (N$ 291.20) and general practitioners add 21.00 clinical procedure units (N$ 191.10).

0055 Dislocation requiring open reduction: Units for the specific joint plus 77.00 clinical procedure units (N$ 700.70) for specialists. General practitioners add 51.00 clinical procedure units (N$ 464.10).

0057 In multiple procedures on feet, fees for the first foot are calculated according to modifier 0005 "Multiple procedures/operations under the same anaesthetic". Calculate fees for the second foot in the same way reduce the total to 50% and add to the total for the first foot.

0058 Revision operation for total joint replacement and immediate resubstitution (infected or non-infected): per fee for total joint replacement plus 100%.

COMBINED PROCEDURES ON THE SPINE

0061 In cases of combined procedures on the spine, both the orthopaedic surgeon and the neurosurgeon are entitled to the full fee for the relevant part of the operation performed.

REPLANTATION OPERATION

0063 Where two specialists work together on a replantation procedure, each shall be entitled to two-thirds of the fee for the procedure.

0064 Where the replantation or toe to thumb transfer is unsuccessful, no further surgical fee is payable for amputation of the non-viable parts.

0065 Additional operative procedures by same surgeon (other than the first two items listed under this heading) within a period of 12 months: 75% of scheduled fee for the lesser procedure, except where otherwise specified elsewhere (refer to section 3.8.6)

LARYNX

0067 Microsurgery of the larynx: To the fee of the operation performed add 25%. For other operations requiring the use of an operation microscope, the fee shall include the use of the microscope, except where otherwise specified elsewhere in the Tariff.

0069 When endoscopic instruments are used during intra-nasal surgery: Add 10% of the fee for the procedure performed. Only applicable to items 1025, 1027 and 1035.

INTENSIVE CARE: RESPIRATORY, CARDIAC, GENERAL THERAPY

0070 Add 45 clinical procedure units (N$ 409.50) to procedure(s) performed through a thoroscope

GASTROENTEROLOGY PROCEDURES

0074 A reduction of 33,33% (one third) of the fee will apply to all fibre optic procedures performed by means of hospital equipment.

FIBRE OPTIC PROCEDURES

0075 The fee plus 21.00 clinical procedure units (N$191.10) will apply where fibre optic procedures are performed in rooms with own equipment.

PHYSICAL TREATMENT

0077
(a) When two separate areas are treated simultaneously for totally different conditions, such treatment shall be regarded as two treatments for which separate fees may be charged. (Only applicable if services are provided by a specialist in physical medicine).
(b) The number of treatments to a patient for which the Commission shall accept responsibility is limited to 20. If further treatments are necessary payment therefor must be arranged with the Commission.

TESTIS AND EPIDIDYMIS

0078 When testis biopsy is done combined with vasogram or seminal vesiculogram or epididymogram, add 50% of the units for the appropriate procedure.

MEDICAL PSYCHOTHERAPY

0079 When a first consultation proceeds into, or is immediately followed by a medical psychotherapeutic procedure, fees for the procedure shall be calculated according to item 2957: "Individual psychotherapy" (specify type) for a 20-minute session or part thereof, provided that such a part comprises 50% or more of the time of a session.

DIAGNOSTIC RADIOLOGY

0080 Multiple examinations: Full fee

0081 Repeat examinations: No reduction

0082 "+" Means that this item is complementary to a preceding item and is therefore not subject to reduction.

0083 When a radiologist makes use of hospital equipment, only 66.67% (2/3) of the fee for the examination is chargeable.

0084 In the case of radiological items where films are used practitioners should adjust the fee upward or downward in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit.

VASCULAR STUDIES

0086 Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to reduction (Modifier 0080).

VASCULAR STUDIES and INTERVENTIONAL RADIOLOGY PROCEDURES

6300 If a procedure lasts less than 30 minutes only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account).

6301 If a procedure is performed by a radiologist in a facility not owned by him/herself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)

6302 When the procedure is performed by non-radiologists, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)

6303 When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non-radiologist performing the procedure

6305 When multiple catheterization 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 (N$ 180.00) for each procedure after the initial catheterization. The first catheterization is charged at 100% of the unit value

COMPUTED TOMOGRAPHY

0088 Multiple selective catheterisations: For each additional selective catheterisation after the first selective catheterisation, reduce the fee by 25%.

ULTRASONIC INVESTIGATIONS

0160 Aspiration of biopsy procedure performed under direct ultrasonic control by an ultrasonic aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units.

0165 Use of contrast during ultrasound study: Add 6.00 ultrasound units (N$ 39.00)

MAGNETIC RESONANCE IMAGING

0090 Radiologist's fee for participation in a team: 30.00 radiology units (N$ 270.00) per 1/2 hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterization, CT-scanning, ultrasound scanning or X-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only).

6100 In order to charge the full fee of 600.00 magnetic resonance units (N$ 4320.00) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.

6101 Where a limited series of a specific anatomical region is performed (except bone tumor), e.g. a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.

6102 All post-contrast studies (except bone tumor) including perfusion studies, to be charged at 50% of the fee.

6103 Post-contrast study: Bone tumor: 100% of the fee.

6106 Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognized angiographic software package with reconstruction capability.

6107 Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognized angiographic software package with reconstruction capability.

6108 Where only a gradient echo series is performed with a machine without a recognized angiographic software package with reconstruction capability, 20% of the full fee is applicable specifying that it is a "flow sensitive series".

6109 Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.

6110 MRI spectroscopy: 50% of fee

RADIATION ONCOLOGY

0093 The fees for radiation oncology shall apply only where a specialist in radiation oncology uses his/her own apparatus.

0170 Multiple areas to a maximum of 3 areas treated in the same treatment session: Unless otherwise identified in the Tariff, where treating multiple treatment volumes/areas which add significant time and/or complexity, and when each treatment volume/area is clearly identified and defined, the following values shall prevail: 100% (full value) for the first volume/area, two-thirds for the second volume/area and one-third for the third volume/area. This modifier is applicable to sections 20.

PATHOLOGY

0097 Where items under Clinical Pathology and Anatomical Pathology fall within the province of other specialists or general practitioners, the fee is to be charged at two thirds of the pathologist's fee.

0099 For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos:

(a) Stat test requesting may only done by the referring practitioner and not by the pathologist.
(b) Specimens must be collected on a stat basis where applicable.
(c) Test must be performed on a stat basis.
(d) Documentation (or a copy thereof) relating to the request of the referring practitioner must be retained.

This modifier will only apply during normal working hours and will never be used in combination with item 4547.

LEGEND

10 Anaesthetics	22 Psychiatry	38 Radiology
12 Dermatology	23 Medical Oncology	40 Radiation Oncology
14 General Practitioner	24 Neurosurgery	42 Surgery
16 Gynaecology	25 Nuclear Medicine	44 Thoracic Surgery
17 Pulmonology	26 Ophthalmology	46 Urology
18 Physicians	28 Orthopaedics	52 Clinical Pathology
19 Gastroenterology	30 Otorhinolaryngology	53 Anatomical Pathology
20 Neurology	34 Physical Medicine	
21 Cardiology	36 Plastic and Reconstructive Surgery	

NOTES

ii Clinical units
iii Per service (specify)
iv Per service
v Per consultation
vi if required
vii By arrangement between medical practitioner and Commission
ix Consultative units
xi Consultation fee only.

I. CONSULTATIVE SERVICES

Note: The tariff fees in this section are calculated according to the monetary value of unit for consultative services.

RULES GOVERNING THIS SECTION OF THE TARIFF

A. CONSULTATIONS: DEFINITIONS

(i) First consultation: Refers to a situation where a medical practitioner personally takes down a patient's medical history, performs an appropriate clinical examination and, if indicated, prescribes or administers treatment.

(ii) Subsequent consultation: Refers to a voluntarily scheduled consultation performed for the same condition within four (4) months after the first consultation (although the symptoms or complaints may differ from those presented during the first consultation). It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling.

(iii) Hospital visits: Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and no fees may he levied unless otherwise agreed upon with the Commission. Where no procedure or operation was carried out fees may be charged for hospital visits according to item 0109. Dates of hospital visits must be specified.

B. Normal hours versus after hours: Normal working hours refer to the period 07:00 to 18:00 on Mondays to Fridays; and 7:00 to 13:00 on Saturdays; as well as all other periods voluntarily scheduled (even when for the convenience of the patient)

by a medical practitioner for the rendering of services. All other periods are regarded as after-hours. Public holidays are regarded as after-hours work. Where services are scheduled involuntarily for a special time for medical reasons. the medical practitioner should not render the service at an earlier or later opportunity.

C. The fee that may be charged in respect of the rendering of a service not listed in this tariff of fees shall be based on the fee in respect of a comparable service.

D. Unless timely steps are taken to cancel an appointment for a consultation the relevant consultation fee shall he payable by the employee injured on duty. In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall however; be considered on merit and, if circumstances warrant, no fee shall be charged.

E. The appropriate fee may be charged for all pre-operative consultations with the exception of a routine pre-operative visit at the hospital.

CONSULTATION	Anaesthetic	Dermatology	General Practitioner	Physicians	Neurologists	Psychiary	Neuro-Surgeon	Ophthalmology	Orthopaedics	Otorhinolaryngology	Physical Medicine	Plastic Surgery	Radiology	Radiotherapy	Surgery	Thoracic Surgery	Urology	Pathology: Clinical Pathology: Anatomical
	10	12	14	18	20	22	24	26	28	30	34	36	38	40	42	44	46	52/53
FIRST CONSULTATION:																		
Normal hours:																		
0101 At doctor's rooms or home:																		
Units	16.00	15.00	15.00	27.00	27.00	27.00	27.00	16.00	16.00	15.00	27.00	15.00	14.00	16.00	16.00	26.00	16.00	14.00
N$	145.60	136.50	136.50	245.70	245.70	245.70	245.70	145.60	145.60	136.50	245.70	136.50	127.40	145.60	145.60	236.60	145.60	127.40
0103 Away from doctor's rooms:																		
Units	22.00	21.00	18.00	33.00	33.00	33.00	33.00	22.00	22.00	21.00	33.00	21.00	20.00	22.00	22.00	32.00	22.00	20.00
N$	200.20	191.10	163.80	300.30	300.30	300.30	300.30	200.20	200.20	191.10	300.30	191.10	182.00	200.20	200.20	291.20	200.20	182.00
0102 Pre-anaesthetic assessment of patient in the ward (all hours) (includes the interpretation of an ECG and/or lung function test):																		
Units	16.00		16.00															
N$	145.60		145.60															
0104 Emergency attendance where doctor does not travel (all hours) (not applicable to facilities offering 24 hour services) -See General Rule B																		
Units	24.00	23.00	20.00	35.00	35.00	35.00	35.00	24.00	24.00	23.00	35.00	23.00		24.00	24.00	34.00	24.00	
N$	218.40	209.30	182.00	318.50	318.50	318.50	318.50	218.40	218.40	209.30	318.50	209.30		218.40	218.40	309.40	218.40	
0105 Pre-anaesthetic assessment of patient inside theatre suite (all hours) (includes the interpretation of an ECG and/or lung function test)																		
Units	10.00		10.00															
N$	91.00		91.00															
0106 Emergency attendance at facilities offering 24 hour services (all hours) – See General Rule B																		
Units	24.00	23.00	20.00	35.00	35.00	35.00	35.00	24.00	24.00	23.00	35.00	23.00		24.00	24.00	34.00	24.00	
N$	218.40	209.30	182.00	318.50	318.50	318.50	318.50	218.40	218.40	209.30	318.50	209.30		218.40	168.00	238.00	168.00	

CONSULTATION	Anaesthetic	Dermatology	General Practitioner	Physicians	Neurologists	Psychiatry	Neuro-Surgeon	Ophthalmology	Orthopaedics	Otorhinolaryngology	Physical Medicine	Plastic Surgery	Radiology	Radiotherapy	Surgery	Thoracic Surgery	Urology	Pathology: Clinical Pathology: Anatomical
	10	12	14	18	20	22	24	26	28	30	34	36	38	40	42	44	46	52/ 53
SUBSEQUENT VISITS: (within four months for the same condition - See Rule A)																		
0108 At rooms: Units	12.00	12.00	12.00	18.00	18.00	18.00	18.00	12.00	12.00	12.00	18.00	12.00	12.00	12.00	12.00	17.00	12.00	12.00
N$	109.20	109.20	109.20	163.80	163.80	163.80	163.80	109.20	109.20	109.20	163.80	109.20	109.20	109.20	109.20	154.70	109.20	109.20
0109 At hospital or nursing home (all hours):																		
Units	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00
N$	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00	91.00
0112 At patient's residence (all hours):																		
Units	17.00	16.50	15.00	22.50	22.50	22.50	22.50	17.00	17.00	16.50	22.50	16.50	16.00	17.00	17.00	22.00	17.00	16.00
N$	154.70	150.20	136.50	204.80	204.80	204.80	204.80	154.70	154.70	150.20	204.80	150.20	145.60	154.70	154.70	200.20	154.70	145.60
0114 Weekly maximum for 0112 for the first two weeks																		
Units	119.00	115.50	105.00	157.50	157.50	157.50	157.50	119.00	119.00	115.50	157.50	115.50	112.00	119.00	119.00	154.00	119.00	
N$	1082.90	1051.10	955.50	1433.30	1433.30	1433.30	1433.30	1082.90	1082.90	1051.10	1433.30	1051.10	1019.20	1082.90	1082.90	1401.40	1082.90	
0115 Weekly maximum for 0112 after first two weeks																		
Units	68.00	66.00	60.00	90.00	90.00	90.00	90.00	68.00	68.00	66.00	90.00	66.00	16.00	64.00	68.00	68.00	88.00	68.00
N$	618.80	600.60	546.00	819.00	819.00	819.000	819.00	618.80	618.80	600.60	819.00	600.60	145.60	582.40	618.80	618.80	800.80	618.80
FIRST CONSULTATION: After hours:																		
0116 Medical practitioner has to travel to venue (0101 +: Specialists 8 units (N$ 72.80), GP 6 units (N$54 60))																		
0118 Medical practitioner does not travel (0101 +: 8 units (N$72 80))																		
MISCELLEANOUS																		
0125 Prolonged visit: Emergency: After first half- hour, per hour or part thereof after hours: Units			6,70															
N$			61.00															

CONSULTATION	Anaesthetic	Dermatology	General Practitioner	Physicians	Neurologists	Psychiary	Neuro-Surgeon	Ophthalmology	Orthopaedics	Otorhinolaryngology	Physical Medicine	Plastic Surgery	Radiology	Radiotherapy	Surgery	Thoracic Surgery	Urology	Pathology: Clinical Pathology: Anatomical
	10	12	14	18	20	22	24	26	28	30	34	36	38	40	42	44	46	52/ 53
0127 Per week *Prolonged post-operative care in hospital exceeding four weeks. Per Week																		
Units								27.00										
N$								245.70										
0129 Prolonged first consultation (specialist) per 15-minutes (to be added to item 0101 or 0103 only if service extends 10 minutes or more into the next 15-minute period following on the first 60 mmutes.																		
Units	12.00	12.00		12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00	12.00
N$	109.20	109.20		109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20	109.20

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	CONSULTATIONS continued							
0130	Telephone consultation (all hours)	18.00	163.80	12.00	109.20			
0132	Consulting service e.g. writing of repeat scripts or requesting routine pre-authorisation with-out the physical presence of the patient (need not to be face to face contact	5.00	45.50	5.00	45.50			
0136	Special medical examination requested by the Commission (section 60 of the Act)		612.00					
	Note: The use of items 0141-0144 is limited to specialists only. General Practitioners: Refer to items 0181-0189							
0141	Consultation/visit for new patient with problem focused history, clinical examination and straightforward decision making for minor problem: Typically occupies the doctor face-to-face with the patient for between 10 and 20 minutes	22.00	200.20					
0142	Consultation/visit for new patient with detailed history, clinical examination and straightforward decision making and counselling: Typically occupies the doctor face-to-face with the patient for between 20 and 35 minutes	22.00	200.20					
0143	Consultation/visit for new patient with detailed history, complete clinical examination and moderately complex decision making and counselling: Typically occupies the doctor face-to-face with the patient for between 30 and 40 minutes	22.00	200.20					
0144	Consultation/visit for new patient with comprehensive history and clinical examination for complex problem requiring complex decision making and counseling: Typically occupies the doctor face-to-face with the patient for between 45 and 60 minutes	22.00	200.20					
0145	For consultation away from doctor's home or rooms: Add to any of items 0141-0144 (specialists) or items 0181-0189 (GP) as appropriate. Please note, that item 0145 is not applicable for pre-anaesthetic assessments and may not be added to any of items 0151-0153	6.00	54.60	6.00	54.60			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0146	For emergency consultation/ visit, all hours – see Rule B. (Not applicable to facilities offering 24-hour services). Add to any of items 0141-0144 (specialists: items 0150-0153 or items 0181-0189 (GP) as appropriate	8.00	72.80					
0147	For emergency or unscheduled consultation/visit away from the doctor's home or rooms, all hours: See Rule B. Add to any of items 0141-0144 (specialists: items 150-0153 or items 0181-0189 (GP) as appropriate	14.00	127.40	14.00	127.40			
0150	Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for up to 10 minutes			16.00	145.60	16.00	i i	14 5. 60
0151	Pre-anaesthetic assessment of patient (all hours). Problem focused history and clinical examination and straightforward decision making for minor problem. Typically occupies the doctor face-to-face with the patient for 10 to 20 minutes			16.00	145.60	16.00	i i	14 5. 60
0152	Pre-anaesthetic assessment of patient (all hours). Detailed history and clinical examination and straightforward decision making and counseling. Typically occupies the doctor face-to-face with the patient for 20 to 35 minutes			16.00	145.60	16.00	i i	14 5. 60
0153	Pre-anaesthetic assessment of patient or other consultative services. Consultation with detailed history, complete examination and moderate complex decision making and counseling. Typically occupies the doctor face-to-face with the patient for 30 to 45 minutes. Note: Item 0153 will be used for the evaluation of patients at chronic pain clinic. Only one of the items 0145, 0146 and 0147 may be charged and not a combination thereof.			16.00	145.60	16.00	i i	14 5. 60

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0181	Visit for a new problem/new patient with problem focused history, examination and management during which the doctor spend approx. up to 10 minutes with the patient			15.00	136.50			
0182	Visit for a new problem/new patient with expanded problem focused history, examination and management during which the doctor spends 10-20 minutes with the patient			15.00	136.50			
0183	Visit for a new problem/new patient with detailed history, examination and management during which the doctor spends 20-30 minutes with the patient			15.00	136.50			
0184	Visit for a new problem/new patient with comprehensive history, examination and management during which the doctor spends more than 30 minutes with the patient			15.00	136.50			
0186	Follow-up visit for the evaluation and management of a patient that may not require the presence of a general medical practitioner for up to 10 minutes with the patient			12.00	109.20			
0187	Follow-up visit for the evaluation and management of a patient during which the GP spends 10-20 minutes with the patient			12.00	109.20			
0188	Follow-up visit for the evaluation and management of a patient during which the GP spends longer than 20 minutes with the patient			12.00	109.20			

II. COST OF SUPPLIES, MATERIALS, SPECIAL MEDICINE and OWN EQUIPMENT USED IN TREATMENT

0200 Cost of prostheses and/or internal fixation apparatus: Cost price (VAT included, where applicable) plus 20% with a maximum mark-up of N$ 2420.40

0201 Cost of material and medicines used in treatment: This item provides for a charge for material and special medicine used in treatment. Material to be charged for at cost price plus 35% with a maximum mark up of N$ 2420.40 (VAT included, unless the service provider is not a registered VAT vendor).
Note: Item 0201 may not be used together with any pathology item**.**

(a) External fixation apparatus (disposable): An amount equivalent to 25% of the purchase price of the apparatus may be charged where such apparatus is used.
External fixation apparatus (non-disposable): An amount equivalent to 25% of the purchase price of the apparatus may be charged where such apparatus is used.

(b) In case of minor injuries requiring additional material (e.g. suturing material) payment shall be considered provided the claim is motivated.

(c) 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 this account. Charges for medicine used in treatment not to exceed the retail ethical price list.

0202 Setting of sterile tray: A fee of 10.00 clinical procedure units may be charged (N$ 91.00) 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.

0212 Cost of chemotherapy drugs: This item provides for a charge at cost price (VAT included) plus 10% for chemotherapy drugs used in chemotherapy. Where a condition necessitates the administration of a drug by any route of administration on a routine/continuous/schedules basis, the price of such drug must be calculated and billed per course/cycle of treatment for a given condition, and not per individual unit (tablet/capsule/ampoule/vial) of such drug.

OWN EQUIPMENT USED IN TREATMENT

III. PROCEDURES

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1.	**INJECTIONS, INFUSIONS AND INHALATION SEDATION TREATMENT**							
	INHALATION SEDATION							
0203	Use of analgesic nitrous oxide for alcohol and other withdrawal states: First quarter-hour or part thereof	6.00	54.60	6.00	54.60			
0204	Per additional quarter-hour or part thereof	3.00	27.30	3.00	27.30			
	INTRAVENOUS TREATMENT (See Note: How to charge for intravenous infusions)							
0206	Intravenous infusions (push-in): Insertion of cannula - chargeable once per 24 hours	6.00	54.60	6.00	54.60			
0207	Intravenous infusions (cutdown): Cutdown and insertion of cannula - chargeable once per 24 hours	8.00	72.80	8.00	72.80			
	VENESECTION							
0208	Therapeutic venesection (Not to be used when blood is drawn for the purpose of laboratory investigations)	6.00	54.60	6.00	54.60			
0211	Exchange transfusion: First and subsequent (including after-care)	80.00	728.00	53.00	482.30			
0213	Chemotherapy: Intra-muscular or subcutaneous: per injection.	5.00	45.50	5.00	45.50			
0214	Chemotherapy: Intravenous bolus technique: per injection.	9.00	81.90	9.00	81.90			
0215	Chemotherapy: Intravenous infusion technique: per injection.	14.00	127.40	14.00	127.40			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2.	**INTEGUMENTARY SYSTEM**							
2.1	**Allergy**							
	PATCH TESTS							
0217	First patch	4.00	36.40	4.00	36.40			
0219	Each additional patch	2.00	18.20	2.00	18.20			
	Fees for reading of test as per subsequent consultation							
	SKIN PRICK TESTS							
0218	Skin-prick testing: Insect vemon, latex and drugs	2.80	25.50	2.80	25.50			
0220	Immediate hypersensitivity testing (Type I reaction): per antigen: Inhalant and food allergens	1.90	17.30	1.90	17.30			
0221	Delayed hypersensitivity testing (Type IV reaction): per antigen	2.80	25.50	2.80	25.50			
2.2	**Skin (general)**							
	BIOPSY WITHOUT SUTURING							
0233	First lesion	6.00	54.60	6.00	54.60	3.00	T	132.00
0234	Subsequent lesions, each	3.00	27.30	3.00	27.30	3.00	T	132.00
0235	Maximum for multiple additional lesions.	18.00	163.80	18.00	163.80	3.00	T	132.00
0237	Deep skin biopsy by surgical incision with local anaesthetic and suturing.	12.00	109.20	12.00	109.20	3.00	T	132.00
	REMOVAL OF MALIGNANT LESIONS by curetting under local or general anaesthesia followed by electro-cautery							
0251	First Lesion.	30.00	273.00	30.00	273.00	3.00	T	132.00
0252	Subsequent lesions, each.	15.00	136.50	15.00	136.50	3.00	T	132.00
0255	Drainage of subcutaneous abscess onychia, paronychia, pulp space or avulsion of nail.	20.00	182.00	20.00	182.00	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
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	87.00	791.70	60.00	546.00	3.00	T	132.00
0259	Removal of foreign body superficial to deep fascia (except hands).	20.00	182.00	20.00	182.00	3.00	T	132.00
0261	Removal of foreign body deep to deep fascia (except hands). Note: See items 0922 and 0923 for removal of foreign bodies in hands	31.00	282.10	31.00	282.10	3.00	T	132.00
2.3	**Major plastic repair**							
0289	Large skin grafts, composite skin grafts, large full thickness free skin grafts.	234.00	2129.40	156.00	1419.60	4.00	T	176.00
0290	Reconstructive procedures (including all stages) and skin graft by myocutaneous or fasciocutaneous flap	410.00	3731.00	273.00	2484.30	4.00	T	176.00
0291	Reconstructive procedures (including all stages) grafting by microvascular reanastomosis.	800.00	7280.00	533.00	4850.30	4.00	T	176.00
0292	Distant flaps: First stage.	206.00	1874.60	137.00	1246.70	4.00	T	176.00
0293	Contour grafts (excluding cost of material)	206.00	1874.60	137.00	1246.70	4.00	T	176.00
0294	Vascularised bone graft with or without soft tissue with one or more sets microvascular anastomoses	1200.00	10920.00	800.00	7280.00	6.00	T	264.00
0295	Local skin flaps (large, complicated).	206.00	1874.60	137.00	1246.70	4.00	-	176.00
0296	Other procedures of major technical nature.	206.00	1874.60	137.00	1246.70	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0297	Subsequent major procedures for repair of same lesion.	104.00	946.40	69.00	627.90	4.00	T	176.00
2.4	**Lacerations, scars, tumours, cysts and other skin lesions**							
	STITCHING OF SOFT-TISSUE INJURIES							
0300	Stitching of wound (with or without local anaesthesia): Including normal after-care	14.00	127.40	14.00	127.40	3.00	T	132.00
0301	Additional wounds stitched at same session (each)	7.00	63.70	7.00	63.70	3.00	T	132.00
0302	Deep laceration involving limited muscle damage	64.00	582.40	60.00	546.00	4.00	T	176.00
0303	Deep laceration involving extensive muscle damage	128.00	1164.80	85.00	773.50	4.00	T	176.00
0304	Major debridement of wound, sloughectomy or secondary suture	50.00	455.00	50.00	455.00	3.00	T	132.00
0305	Needle biopsy - soft tissue	25.00	227.50	16.00	145.60	3.00	T	132.00
0307	Excision and repair by direct suture; excision nail fold or other minor procedures of similar magnitude	27.00	245.70	27.00	245.70	3.00	T	132.00
0308	Each additional small procedure done at the same time	14.00	127.40	14.00	127.40	3.00	T	132.00
0310	Radical excision of nail bed	38.00	345.80	38.00	345.80	3.00	T	132.00
0314	Requiring repair by large skin graft or large local flap or other procedures of similar magnitude	104.00	946.40	69.00	627.90	4.00	T	176.00
0315	Requiring repair by small skin graft or small local flap or other procedures of similar magnitude	55.00	500.50	55.00	500.50	3.00	T	132.00
2.6	**Burns**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0351	Major Burns: Resuscitation (including supervision and intravenous therapy - first 48 hours).	276.00	2511.60	184.00	1674.40	5.00	T	220.00
0353	Tangential excision and grafting: Small.	100.00	910.00	67.00	609.70	5.00	T	220.00
0354	Tangential excision and grafting: Large.	200.00	1820.00	133.00	1210.30	5.00	T	220.00
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	75.00	682.50	60.00	546.00	4.00	T	176.00
0357	Small skin graft in acute hand injury.	45.00	409.50	45.00	409.50	3.00	T	132.00
0359	Release of extensive skin contracture and or excision of scar tissue with major skin graft resurfacing	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0361	Z-plasty.	64.00	582.40	60.00	546.00	3.00	T	132.00
0363	Local flap and skin graft.	150.00	1365.00	100.00	910.00	3.00	T	132.00
0365	Cross finger flap (all stages).	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0367	Palmar flap (all stages).	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0369	Distant flap: First stage.	158.00	1437.80	105.00	955.50	3.00	T	132.00
0371	Distant flap: Subsequent stage (not subject to general modifier 0007)	77.00	700.70	60.00	546.00	3.00	T	132.00
0373	Transfer neurovascular island flap.	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0374	Syndactyly: Separation of, including skin graft for one web.	206.00	1874.60	137.00	1246.70	3.00	T	132.00
2.8	**Acupuncture**							
	Please note: General Rule M not applicable to section 2.8 of the tariff							
0377	Standard acupuncture.	10.00	91.00	10.00	91.00			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0380	Scalp acupuncture	10.00	91.00	10.00	91.00			
0381	Micro acupuncture	10.00	91.00	10.00	91.00			
3.	**MUSCULO-SKELETAL SYSTEM**							
3.1	**Bones**							
3.1.1	**Fractures (reduction under general anaesthetic)**							
0383	Scapula.	iii		iii		3.00	T+M	132.00
0387	Clavicle.	iii		iii		3.00	T+M	132.00
0389	Humerus.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0391	Radius and/or Ulna.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0392	Open reduction of both radius and ulna. (Modifier 0051 not applicable)	210.00	1911.00	140.00	1274.00	3.00	T+M	
0402	Carpal bone.	64.00	582.40	60.00	546.00	3.00	T+M	132.00
0403	Bennett's fracture/ dislocation	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0405	Metacarpal: Simple.	40.00	364.00	40.00	364.00	3.00	T+M	132.00
	FINGER PHALANX:							
	DISTAL							
0409	Simple.	iv		iv		3.00	TM[x]	132.00
0411	Compound.	52.00	473.20	52.00	473.20	3.00	T+M	132.00
	PROXIMAL OR MIDDLE							
0413	Simple.	48.00	436.80	48.00	436.80	3.00	T	132.00
0415	Compound.	102.00	928.20	68.00	618.80	3.00	T+M	132.00
	PELVIS							
0417	Closed.	iv		iii		3.00	T	132.00
0419	Operative reduction and fixation.	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0421	Femur: Neck or Shaft.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0425	Patella.	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0429	Tibia with or without fibula.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0433	Fibula shaft.	iii		iii		3.00	T+M	132.00
0435	Malleolus of ankle.	58.00	527.80	58.00	527.80	3.00	T+M	132.00
0437	Fracture/dislocation of ankle.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
0438	Open reduction Talus fracture (Modifier 0051 not applicable)	141.00	1283.10	111.00	1010.10	3.00		132.00
0440	Calcaneus reduction (Modifier 0051 not applicable)	141.00	1283.10	111.00	1010.10	3.00		132.00
	TOE PHALANX							
0443	Distal: Simple.	iii		iii		3.00	T	132.00
0443	Compound	32.00	251.20	32.00	251.20	3.00	T+M	132.00
	OTHER							
0447	Simple	26.00	291.20	26.00	291.20	3.00	T	132.00
0449	Compound	52.00	473.20	52.00	473.20	3.00	T+M	132.00
	STERNUM and (or) RIBS							
0451	Closed	iii		iii		3.00	T	132.00
0452	Open reduction and fixation of multiple fractured ribs for flail chest	230.00	2093.00	153.00	1392.30	3.00	T+M	132.00
	SPINE:							
	WITH OR WITHOUT PARALYSIS							
0455	Cervical	iii		iii		3.00	T+M	132.00
0456	Rest	iii		iii		3.00	T+M	132.00
	COMPRESSION FRACTURE							
0461	Cervical	iii		iv		3.00	T+M	132.00
0462	Rest	iv		iv		3.00	T+M	132.00
	SPINOUS OR TRANSVERSE PROCESSES							
0463	Cervical	iv		iv		3.00	T+M	132.00
0464	Rest	iv		iv		3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3.1.1.1	**Operations for fractures**							
0465	Fractures involving large joints (includes the item for the relative bone). This item may not be used as a modifier.	288.00	2620.80	192.00	1747.20	3.00	M	132.00
0473	Percutaneous insertion plus subsequent removal of Kirschner wires or Steinmann pins (no after-care). Modifier 0005 not applicable	32.00	291.20	32.00	291.20	3.00	T	132.00
	BONEGRAFTING OR INTERNAL FIXATION FOR MAL- OR NON-UNION							
0475	Femur, Tibia, Humerus, Radius and Ulna.	282.00	2566.20	188.00	1710.80	3.00	T+M	132.00
0479	Other bones.	154.00	1401.40	103.00	937.30	3.00	T+M	132.00
3.1.2	**Bony operations**							
3.1.2.1	**Bone grafting**							
0497	Resection of bone or tumour with or without grafting.	282.00	2566.20	188.00	1710.80	3.00	T+M	132.00
0499	Large bones.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0501	Small bones.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
0503	Cartilage graft.	206.00	1874.60	137.00	1246.70	3.00	T+M	132.00
0505	Inter-metacarpal bone graft	147.00	1337.70	98.00		3.00	T+M	132.00
0507	Removal of autogenous bone for grafting (not subject to general modifier 0005)	50.00	455.00	50.00	455.00	3.00	T+M	132.00
3.1.2.2	**Acute or chronic osteomyelitis**							
0509	Conservative treatment.	iii		iii				
0511	Operation: Tariff which would be applicable for compound fracture of the bone involved, including six weeks post-operative care							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0512	Sternum sequestrectomy and drainage, including six weeks after-care	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
3.1.2.3	**Osteotomy**							
0514	Sternum: Repair of pectus excavatum.	330.00	3003.00	220.00	2002.00	3.00	T+M	132.00
0515	Sternum: Repair of pectus carinatum.	330.00	3003.00	220.00	2002.00	3.00	T+M	132.00
0516	Pelvic.	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0521	Femoral: Proximal.	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0527	Knee region: one leg	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0528	Os Calcis (Dwyer operation).	115.00	1046.50	77.00	700.70	3.00	T+M	132.00
0530	Metacarpal and phalanx: Corrective for mal-union or rotation	120.00	1092.00	80.00	728.00	3.00	T+M	132.00
0532	Rotation osteotomies of the Radius, Ulna or Humerus	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0533	Osteotomy, single metatarsal	60.00	546.00	60.00	546.00	3.00	T+M	132.00
0534	Multiple metatarsal osteotomies.	150.00	1365.00	100.00	910.00	3.00	T+M	132.00
3.1.2.4	**Exostosis**							
0535	Excision: Readily accessible sites.	60.00	546.00	60.00	546.00	3.00	T+M	132.00
0537	Excision: Less accessible sites.	96.00	873.60	64.00	582.40	3.00	T+M	132.00
3.1.2.5	**Biopsy**							
0539	Needle Biopsy: Spine (no after-care). Modifier 0005 not applicable.	50.00	455.00	50.00	455.00	4.00	T	176.00
0541	Needle Biopsy: Other sites (no after-care). Modifier 0005 not applicable.	32.00	291.20	32.00	291.20	4.00	T	176.00
	OPEN (Modifier 0005 not applicable)							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0543	Readily accessible site.	64.00	582.40	60.00	546.00		Per bone	
0545	Less accessible site.	96.00	873.60	64.00	582.40		Per bone	
3.2	**Joints**							
3.2.1	**Dislocations**							
0547	Clavicle: either end.	38.00	345.80	38.00	345.80	3.00	T+M	132.00
0549	Shoulder.	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0551	Elbow.	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0552	Wrist.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0553	Perilunar trans-scaphoid fracture/dislocation	130.00	1183.00	87.00	791.70	3.00	T+M	132.00
0555	Lunate.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0556	Carpo-metacarpo dislocation	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0557	Metacarpo-phalangeal or interphalangeal joints (hand)	26.00	236.60	26.00	236.60	3.00	T+M	132.00
0559	Hip.	109.00	991.90	73.00	664.30	3.00	T+M	132.00
0561	Knee.	96.00	573.60	64.00	582.40	3.00	T+M	132.00
0563	Patella.	32.00	291.20	32.00	291.20	3.00	T+M	132.00
0565	Ankle.	90.00	819.00	60.00	546.00	3.00	T+M	132.00
0567	Sub-Talar dislocation.	90.00	819.00	60.00	546.00	3.00	T+M	132.00
0569	Intertarsal or tarsometa-tarsal or midtarsal.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0571	Metatarsophalangeal or interphalangeal joints (foot)	14.00	127.40	14.00	127.40	3.00	T+M	132.00
0573	Spine with or without paralysis.	iii		iii				
3.2.2	**Operations for dislocations**							
0578	Recurrent dislocation of shoulder	200.00	1820.00	133.00	1210.30	3.00	T+M	132.00
0579	Recurrent dislocation of all other joints.	161.00	1465.10	107.00	973.70	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3.2.3	**Capsular operations**							
0582	Capsulotomy or arthrotomy or biopsy or drainage of joint: Small joint (including three weeks after-care)	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0583	Capsulotomy or arthrotomy or biopsy or drainage of joint: Large joint (including three weeks after-care).	96.00	873.60	64.00	582.40	3.00	T+M	132.00
0585	Capsulectomy digital joint.	64.00	582.40	60.00	546.00	3.00	T+M	132.00
0586	Multiple percutaneous capsulotomies of meta-carpophalangeal joints.	90.00	819.00	60.00	546.00	3.00	T+M	132.00
0587	Release of digital joint contracture.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
3.2.4	**Synovectomy**							
0589	Digital joint.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0592	Large joint.	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0593	Tendon synovectomy.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
3.2.5	**Arthrodesis**							
0597	Shoulder.	224.00	2038.40	149.00	1355.90	3.00	T+M	132.00
0598	Elbow.	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
0599	Wrist.	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
0600	Digital joint.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
0601	Hip.	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0602	Knee.	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
0603	Ankle.	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
0604	Sub-talar.	130.00	1183.00	87.00	791.70	3.00	T+M	132.00
0605	Stabilization of foot (triple-arthrodesis).	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
0607	Mid-tarsal wedge resection	180.00	1638.00	120.00	1092.00	3.00	T+M	132.00
3.2.6	**Arthroplasty**							
0614	Debridement large joints	160.00	1456.00	107.00	973.70	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0615	Excision medial or lateral end of clavicle.	116.00	1055.60	77.00	700.70	3.00	T+M	132.00
0617	Shoulder: Acromioplasty.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0619	Shoulder: Partial replacement	277.00	2520.70	185.00	1683.50	5.00	T+M	220.00
0620	Shoulder: Total replacement.	416.00	3785.60	277.00	2520.70	5.00	T+M	220.00
0621	Elbow: Excision head of radius.	96.00	873.60	64.00	582.40	3.00	T+M	132.00
0622	Elbow: Excision.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0623	Elbow: Partial replacement	188.00	1710.80	125.00	1137.50	3.00	T+M	132.00
0624	Elbow: Total replacement.	282.00	2566.20	188.00	1710.80	3.00	T+M	132.00
0625	Wrist: Excision distal end of ulna.	96.00	873.60	64.00	582.40	3.00	T+M	132.00
0626	Wrist: Excision single bone	110.00	1001.00	73.00	664.30	3.00	T+M	132.00
0627	Wrist: Excision proximal row	166.00	1510.60	111.00	1010.10	3.00	T+M	132.00
0631	Wrist: Total replacement.	249.00	2265.90	166.00	1510.60	3.00	T+M	132.00
0635	Digital Joint: Total replacement.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0637	Hip: Total replacement	416.00	3785.60	277.00	2520.70	3.00	T+M	132.00
0639	Hip: Cup.	416.00	3785.60	277.00	2520.70	3.00	T+M	132.00
0641	Hip: Prosthetic replacement of femoral head.	288.00	2620.80	192.00	1747.20	3.00	T+M	132.00
0643	Hip: Girdlestone.	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
0645	Knee: Partial replacement	277.00	2520.70	185.00	1683.50	3.00	T+M	132.00
0646	Knee: Total replacement.	416.00	3785.60	277.00	2520.70	3.00	T+M	132.00
0649	Ankle: Total replacement	249.00	2265.90	166.00	1510.60	3.00	T+M	132.00
0650	Ankle: Astragalectomy.	154.00	1401.40	103.00	937.30	3.00	T+M	132.00
3.2.7	**Miscellaneous (joints)**							
0661	Aspiration of joint or intra-articular injection (not including after-care), Modifier 0005 not applicable.	9.00	81.90	9.00	81.90	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	MULTIPLE INTRA-ARTICULAR INJECTIONS FOR RHEUMATOID ARTHRITIS (excluding after-care). Modifier 0005 not applicable							
0669	Manipulation large joint under general anaesthetic (not including after-care). Modifier 0005 not applicable:							
	Hip	14.00	127.40	14.00	127.40	4.00	T	132.00
	Knee	14.00	127.40	14.00	127.40	3.00	T	132.00
	Shoulder	14.00	127.40	14.00	127.40	3.00	T	132.00
0670	The consultation fee only should be charged when manipulation of a large joint is performed with or without local anaesthetic:							
	Hip	v		iii		4.00	T	176.00
	Knee	v		v		3.00	T	132.00
	Shoulder	v		v		3.00	T	132.00
0673	Meniscectomy or operation for other internal de-rangement of knee.	109.00	991.90	73.00	664.30	3.00	T+M	132.00
3.2.8	**Joint ligament reconstruction or suture**							
0675	Ankle: Collateral.	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0677	Knee: Collateral.	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0678	Knee: Cruciate.	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0679	Ligament augmentation procedure of knee.	280.00	2548.00	187.00	1701.70	3.00	T+M	132.00
0680	Digital joint ligament.	140.00	93.00	93.00	846.30	3.00	T+M	132.00
3.3	**Amputations**							
3.3.1	**Specific Amputations**							
0682	Forequarter amputation.	294.00	2675.40	196.00	1783.60	9.00	T+M	396.00
0683	Through shoulder.	148.00	1346.80	99.00	900.90	5.00	T+M	220.00
0685	Upper arm or forearm.	116.00	1055.60	77.00	700.70	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0687	Partial amputation of the hand: One ray.	102.00	928.20	68.00	618.80	3.00	T+M	132.00
0691	Part of (or) whole of finger.	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0693	Hindquarter amputation.	420.00	3822.00	280.00	2548.00	6.00	T+M	264.00
0695	Through hip joint region.	192.00	1747.20	128.00	1164.80	6.00	T+M	264.00
0697	Through thigh	205.00	1865.50	137.00	1246.70	6.00	T+M	264.00
0699	Below knee, through knee or Syme.	194.00	1765.40	129.00	1173.90	6.00	T+M	264.00
0701	Trans metatarsal or trans tarsal.	142.00	1292.20	95.00	864.50	3.00	T+M	132.00
0703	Foot: One ray.	97.00	882.70	65.00	591.50	3.00	T+M	132.00
0705	Toe (skin flap included).	66.00	600.60	44.00	400.40	3.00	T+M	132.00
3.3.2	**Post-amputation reconstruction**							
0706	Skin flap taken from a site remote from the injured finger or in cases of an advanced flap e.g. Cutler	75.00	682.50	60.00	546.00	3.00	T+M	132.00
0707	Krukenberg reconstruction	206.00	1874.60	137.00	1246.70	3.00	T+M	132.00
0709	Metacarpal transfer.	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0711	Pollicization of the finger (to include all stages). (Prior arrangement with Commission required)	282.00	2566.20	188.00	1710.80	3.00	T+M	132.00
0712	Toe to thumb transfer. (Prior arrangement with Commission required	800.00	7280.00	533.00	4850.30	3.00	T+M	132.00
3.4	**Muscles, tendons and fasciae:**							
3.4.1	**Investigations:**							
0713	Electromyography.	75.00	682.50	50.00	455.00	3.00	T	132.00
0714	Electromyographic neuromuscular junctional study, including edrophonium response.	57.00	518.70	38.00	345.80	3.00	T	132.00
0715	Strength duration curve per session.	10.50	95.60	7.00	63.70	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0717	Electrical examination of single nerve or muscle.	9.00	81.90	6.00	54.60	3.00	T	132.00
0723	Tonometry with edrophonium	8.00	72.80	5.00	45.50	3.00	T	132.00
0725	Isometric tension studies with edrophonium.	10.00	91.00	7.00	63.70	3.00	T	132.00
	CRANIAL REFLEX STUDY SUPRA OCCULOFACIAL OR CORNEO-FACIAL OR FLABELLOFACIAL (both early and late responses)							
0727	Unilateral.	8.00	72.80	5.00	45.50	3.00	T	132.00
0728	Bilateral.	14.00	127.40	9.00	81.90	3.00	T	132.00
0729	Tendon reflex time.	7.00	63.70	5.00	45.50	3.00	T	132.00
0730	Limb/brain somatosensory studies: Per limb.	49.00	445.90	32.00	291.20			
0731	Visio and audio-sensory studies.	49.00	445.90	32.00	291.20			
0733	Motor nerve conduction studies (single nerve).	26.00	236.60	17.00	154.70			
0735	Examinations of sensory nerve conduction by sweep averages (single nerve)	31.00	282.10	21.00	191.10	3.00	T	132.00
0737	Biopsy for motor nerve terminals and end plates.	20.00	182.00	20.00	182.00	3.00	T	132.00
0739	Combined muscle biopsy with end plates and nerve terminal biopsy.	34.00	309.40	34.00	309.40	8.00	T	352.00
0740	Muscle fatigue studies.	20.00	182.00	20.00	182.00	3.00	T	132.00
0741	Muscle biopsy.	20.00	182.00	20.00	182.00	8.00	T	352.00
0742	Global fee for all muscle studies, including histochemical studies	262.00	2384.20					
	BIOCHEMICAL ESTIMATIONS ON MUSCLE BIOPSY SPECIMENS							
4701	Creatine kinase.	20.25	184.30					
4703	Adenylate kinase.	33.30	303.00					
4705	Pyruvate kinase.	5.70	51.90					
4707	Lactate dehydrogenase.	1.60	15.00					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
4709	Adenylate deaminase	9.90	90.10					
4711	Phosphoglycerate kinase.	13.70	124.70					
4713	Phosphoglycerate mutase.	25.90	235.70					
4715	Enolase.	32.70	297.60					
4717	Phosphofructokinase	37.70	343.10					
4719	Aldolase.	15.75	143.30					
4721	Glyceraldehyde 3 phosphate dehydrogenase.	11.06	100.70					
4723	Phosphorylase.	34.70	315.80					
4725	Phosphoglucomutase.	40.30	366.70					
4727	Phosphohexose Isomerase.	28.80	262.10					
3.4.2	**Decompression Operations**							
0743	Major compartmental decompression.	**132.00**	1201.20	88.00	800.80	3.00	T	132.00
0744	Fasciotomy only.	60.00	546.00	60.00	546.00	3.00	T	132.00
3.4.3	**Muscle and tendon repair**							
0745	Biceps humeri.	109.00	991.90	73.00	664.30	3.00	T	132.00
0746	Removal of calcification in Rotator cuff.	96.00	873.60	64.00	582.40	3.00	T+M	132.00
0747	Rotator cuff.	134.00	1219.40	89.00	809.90	4.00	T	176.00
0755	Infrapatellar or quadriceps tendon	128.00	1164.80	85.00	773.50	3.00	T	132.00
0757	Achilles tendon.	128.00	1164.80	85.00	773.50	4.00	T	176.00
0759	Other single tendon.	77.00	700.70	60.00	546.00	3.00	T	132.00
0763	Tendon or ligament injection	9.00	81.90	9.00	81.90	3.00	T	132.00
	HAND							
	FLEXOR TENDON SUTURE							
0767	Primary (per tendon).	128.00	1164.80	85.00	773.50	3.00	T	132.00
0769	Secondary (per tendon)	160.00	1456.00	107.00	973.70	3.00	T	132.00
	EXTENSOR TENDON SUTURE							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0771	Primary (per tendon).	64.00	582.40	60.00	546.00	3.00	T	132.00
0773	Secondary (per tendon).	80.00	728.00	60.00	546.00	3.00	T	132.00
0774	Repair of Boutonniere deformity or Mallet finger.	122.00	1110.20	81.00	737.10	3.00	T	132.00
3.4.4	**Tendon graft**							
0775	Free tendon graft.	160.00	1456.00	107.00	973.70	3.00	T	132.00
0776	Reconstruction of pulley for flexor tendon.	50.00	455.00	50.00	455.00	3.00	T	132.00
	FINGER							
0777	Flexor.	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0779	Extensor.	122.00	1110.20	81.00	737.10	3.00	T	132.00
0780	Two stage flexor tendon graft using silastic rod.	240.00	2184.00	160.00	1456.00	3.00	T	132.00
3.4.5	**Tenolysis**							
0781	Tendon freeing operation, except where specified elsewhere	64.00	582.40	60.00	546.00	3.00	T	132.00
0782	Carpal tunnel syndrome.	64.00	582.40	60.00	546.00	3.00	T	132.00
0783	De Quervain.	38.00	345.80	38.00	345.80	3.00	T	132.00
0784	Trigger finger.	38.00	345.80	38.00	345.80	3.00	T	132.00
0785	Flexor tendon freeing operation following free tendon graft or suture.	150.00	1365.00	100.00	910.00	3.00	T	132.00
0787	Extensor tendon freeing operation following graft or suture	115.00	1046.50	77.00	700.70	3.00	T	132.00
0788	Intrinsic tendon release per finger	64.00	582.40	60.00	546.00	3.00	T	132.00
0789	Central tendon tenotomy for Boutonniere deformity	64.00	582.40	60.00	546.00	3.00	T	132.00
3.4.6	**Tenodesis**							
0790	Digital joint.	90.00	819.00	60.00	546.00	3.00	T	132.00
3.4.7	**Muscle tendon and fascia transfer**							
0791	Single tendon transfer.	96.00	873.60	64.00	582.40	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0792	Multiple tendon transfer.	128.00	1164.80	85.00	773.50	3.00	T	132.00
0793	Hamstring to quadriceps transfer.	141.00	1283.10	94.00	855.40	3.00	T	132.00
0794	Pectoralis major or Latissimus dorsi transfer to biceps tendon	320.00	2912.00	213.00	1938.30	5.00	T	220.00
0795	Tendon transfer at elbow	116.00	1055.60	77.00	700.70	3.00	T	132.00
0796	Iliopsoas at hip.	224.00	2038.40	149.00	1355.90	5.00	T	220.00
0797	Knee (Eggers).	141.00	1283.10	94.00	855.40	3.00	T	132.00
	HAND TENDONS							
0803	Single tendon transfer (first)	96.00	873.60	64.00	582.40	3.00	T	132.00
0809	Substitution for intrinsic paralysis of hand.	224.00	2038.40	149.00	1355.90	3.00	T	132.00
0811	Opponens transfers.	128.00	1164.80	85.00	773.50	3.00	T	132.00
3.4.8	**Muscle slide operations and tendon lengthening**							
0812	Percutaneous Tenotomy: All sites.	38.00	345.80	38.00	345.80	3.00	T	132.00
0813	Torticollis.	96.00	873.60	64.00	582.40	5.00	T	220.00
0815	Scalenotomy.	132.00	1201.20	88.00	800.80	5.00	T	220.00
0817	Scalenotomy with excision of first rib.	190.00	1729.00	127.00	1155.70	3.00	T+M	132.00
0823	Excision or slide for Volkmann's Contracture.	192.00	1747.20	128.00	1164.80	3.00	T	132.00
0825	Hip: Open muscle release.	116.00	1055.60	77.00	700.70	7.00	T	308.00
0829	Knee: Quadricepsplasty.	160.00	1456.00	107.00	973.70	3.00	T	132.00
0831	Knee: Open tenotomy.	141.00	1283.10	94.00	855.40	3.00	T	132.00
0835	Calf.	96.00	873.60	64.00	582.40	4.00	T	176.00
0837	Open elongation tendon Achilles.	96.00	873.60	64.00	582.40	4.00	T	176.00
0845	Foot: Plantar fasciotomy.	70.00	637.00	60.00	546.00	3.00	T	132.00
3.5	**Bursae and ganglia**							
	EXCISION							
0847	Semi-membranosus.	90.00	819.00	60.00	546.00	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0849	Prepatellar.	45.00	409.50	45.00	409.50	3.00	T	132.00
0851	Olecranon.	45.00	409.50	45.00	409.50	3.00	T	132.00
0853	Small bursa or ganglion.	51.00	464.10	51.00	464.10	3.00	T	132.00
0855	Compound palmar ganglion or synovectomy.	128.00	1164.80	85.00	773.50	3.00	T	132.00
0857	Aspiration or injection (no after-care). Modifier 0005 not applicable	9.00	81.90	9.00	81.90	3.00	T	132.00
3.6	**Miscellaneous**							
3.6.1	**Leg equalisation and feet**							
0861	Leg lengthening.	416.00	3785.60	277.00	2520.70	3.00	T+M	132.00
3.6.2	**Removal of internal fixatives or prosthesis**							
0883	Readily accessible.	32.00	291.20	32.00	291.20	As per bone (specify)		
0884	Removal of internal fixatives or prosthesis: Less accessible	64.00	582.40	60.00	546.00	As per bone (specify)		
0885	Removal of prosthesis for infection soon after operation	128.00	1164.80	85.00	773.50	As per bone (specify)		
0886	Late removal of infected total joint replacement prosthesis (including six weeks after-care). Fee for total joint replacement of the specific joint: Plus	64.00	582.40	42.00	382.20	6.00	T+M	264.00
3.7	**Plasters** (exclusive of after-care) Note: The initial application of a plaster cast is included in the scheduled fee for the particular procedure, except for scoliosis							
0887	Limb cast (excluding after-care). Modifier 0005 not applicable.	13.00	118.30	13.00	118.30	3.00	T	132.00
0889	Spica, plaster jacket or hinged cast brace (excluding after-care).	32.00	291.20	32.00	291.20	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0891	Turnbuckle cast (excluding after-care).	51.00	464.10	51.00	464.10	5.00	T	220.00
0893	Adjustment or repair of turnbuckle cast (excluding after-care).	19.00	172.90	19.00	172.90	5.00	T	220.00
3.8	**Specific areas**							
3.8.1	**Foot and Ankle**							
0897	One foot.	140.00	1274.00	93.00	846.30	3.00	T+M	132.00
0901	Tenotomy, single tendon	38.00	345.80	38.00	345.80	3.00	T+M	132.00
0905	Fillet of Toe or Ruiz-Mora procedure	51.00	464.10	51.00	464.10	3.00	T+M	132.00
0906	Arthrodesis Hallux.	128.00	1164.80	85.00	773.50	3.00	T+M	132.00
0909	Excision arthroplasty.	77.00	700.70	60.00	546.00	3.00	T+M	132.00
0910	Cheilectomy or meta-tarsophangeal implant Hallux	192.00	1747.20	128.00	1164.80	3.00	T+M	132.00
0911	Metatarsal osteotomy or Lapidus or similar or Chevron	102.00	928.20	68.00	618.80	3.00	T+M	132.00
3.8.3	**Reimplantations**							
	Modifier 0063 and 0064 applicable							
0912	Replant of amputated upper limb proximal to wrist joint	730.00	6643.00	487.00	4431.70	3.00	T+M	132.00
0913	Replantation of thumb.	670.00	6097.00	447.00	4067.70	3.00	T+M	132.00
0914	Replantation of a single digit (to be motivated), for multiple digits, apply modifier 0005	580.00	5278.00	387.00	3521.70	3.00	T+M	132.00
0915	Replantation operation through the palm.	1270.00	11557.00	847.00	7707.70	3.00	T+M	132.00
3.8.4	**Hands** (Note: Skin: See Integumentary System)							
	TUMOURS							
0919	Epidermoid cysts.	35.00	318.50	35.00	318.50	3.00	T+M	132.00
0920	Ganglion or fibroma.	51.00	464.10	51.00	464.10	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	REMOVAL OF FOREIGN BODIES REQUIRING INCISION							
0922	Under local anaesthetic.	19.00	172.90	19.00	172.90	3.00	T+M	132.00
0923	Under general or regional anaesthetic.	32.00	291.20	32.00	291.20	3.00	T+M	132.00
	CRUSHED HAND INJURIES							
0924	Initial extensive soft tissue toilet under general anaesthetic (sliding scale).	37.00	336.70	37.00	336.70	3.00	T+M	132.00
0924	Note: The number of units chargeable under this item ranges from 37.00 to 110.00 for Specialists, and from 37.00 to 73.00 for General Practitioners.	110.00	1001.00	73.00	664.30			
0925	Subsequent dressing changes under general anaesthetic	16.00	145.60	16.00	145.60	3.00	T+M	132.00
3.8.5	**Spine**							
0927	Excision of one vertebral body, for a lesion within the body (no decompression)	207.00	1883.70	138.00	1255.80	3.00	T+M	132.00
0928	Excision of each additional vertebral segment for a lesion within the body (no decompression)	42.00	382.20	42.00	382.20	3.00	T+M	132.00
0929	Manipulation of spine under general anaesthetic: (no after-care), modifier 0005 not applicable.	14.00	127.40	14.00	127.40	5.00	T	220.00
0930	Posterior osteotomy of spine: One vertebral segment	339.00	3084.90	226.00	2056.60	3.00	T+M	132.00
0931	Posterior spinal fusion: One level.	385.00	3503.50	257.00	2338.70	3.00	T+M	132.00
0932	Posterior osteotomy of spine: Each additional vertebral segment	103.00	937.30	69.00	627.90	3.00	T+M	132.00
0933	Anterior spinal osteotomy with disc removal: One vertebral segment	315.00	2866.50	210.00	1911.00	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0936	Anterior spinal osteotomy with disc removal: Each additional vertebral segment	103.00	937.30	69.00	627.90	3.00	T+M	132.00
0938	Anterior fusion base of skull to C2	449.00	4085.90	299.00	2720.90	4.00	T+M	176.00
0939	Trans-abdominal anterior exposure of the spine for spinal fusion only if done by a second surgeon	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0940	Trans-thoracic anterior exposure of the spine only if done by a second surgeon	160.00	1456.00	107.00	973.70	3.00	T+M	132.00
0941	Anterior interbody fusion: One level	360.00	3276.00	240.00	2184.00	3.00	T+M	132.00
0942	Anterior interbody fusion: Each additional level	102.00	928.20	68.00	618.80	3.00	T+M	132.00
0944	Posterior fusion: Occiput to C2	390.00	3549.00	260.00	2366.00	4.00	T+M	176.00
0946	Posterior spinal fusion: Each additional level	111.00	1010.10	74.00	673.40	3.00	T+M	132.00
0948	Posterior interbody lumbar fusion: One level	364.00	3312.40	243.00	2211.30	3.00	T+M	132.00
0950	Posterior interbody lumbar fusion: Each additional inter-space	95.00	864.50	63.00	573.30	3.00	T+M	132.00
0959	Excision of coccyx.	96.00	873.60	64.00	582.40	3.00	T+M	132.00
0961	Costo-transversectomy.	198.00	1801.80	132.00	1201.20	3.00	T+M	132.00
0963	Antero-lateral decompression of spinal cord or anterior debridement	326.00	2966.60	217.00	1974.70	3.00	T+M	132.00
	Modifier 0061 applies to this section of the Tariff							
3.8.7	**All spinal problems**							
0960	Posterior non-segmental instrumentation	167.00	1519.70	111.00	1010.10	5.00	T+M	220.00
0962	Posterior segmental instrumentation: 2 to 6 vertebrae	176.00	1601.60	117.00	1064.70	5.00	T+M	220.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0964	Posterior segmental instrumentation: 7 to 12 vertebrae	201.00	1829.10	134.00	1219.40	5.00	T+M	220.00
0966	Posterior segmental instrumentation: 13 or more vertebrae	245.00	2229.50	163.00	1483.30	5.00	T+M	220.00
0968	Anterior instrumentation: 2 to 3 vertebrae	159.00	1446.90	106.00	964.60	5.00	T+M	220.00
0970	Anterior instrumentation: 4 to 7 vertebrae	185.00	1683.50	123.00	1119.30	5.00	T+M	220.00
0972	Anterior instrumentation: 8 or more vertebrae	206.00	1874.60	137.00	1246.70	5.00	T+M	220.00
0974	Additional pelvic fixation of instrumentation other than sacrum	108.00	982.80	72.00	665.20	5.00	T+M	220.00
5750	Reinsertion of instrumentation	276.00	2511.60	184.00	1674.40	6.00	T+M	264.00
5751	Removal of posterior non-segmental instrumentation	173.00	1574.30	115.00	1046.50	6.00	T+M	264.00
5752	Removal of posterior segmental instrumentation	175.00	1592.50	117.00	1064.70	6.00	T+M	264.00
5753	Removal of anterior instrumentation	204.00	1856.40	136.00	1237.60	6.00	T+M	264.00
5755	Laminectomy for spinal stenosis (exclude diskectomy, foraminotomy and spondylolisthesis): One or two levels	295.00	2684.50	197.00	1792.70	3.00	T+M	132.00
5756	Laminectomy with full decompression for spondylolisthesis (Gill procedure)	304.00	2766.40	203.00	1847.30	3.00	T+M	132.00
5757	Laminectomy for decompression without foraminotomy or diskectomy more than two levels	321.00	2921.40	214.00	1947.40	3.00	T+M	132.00
0943	Laminectomy with decompression of nerve roots and disc removal: One level.	240.00	2184.00	160.00	1456.00	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
5758	Laminectomy with decompression of nerve roots and disc removal: Each additional level	63.00	573.30	60.00	546.00	3.00	T+M	132.00
5759	Laminectomy for decompression diskectomy etc., revision operation	352.00	3203.20	235.00	2138.50	4.00	T+M	176.00
5760	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: One level	301.00	2739.10	201.00	1829.10	3.00	T+M	132.00
5761	Laminectomy, facetectomy, decompression for lateral recess stenosis plus spinal stenosis: Each additional level	68.00	618.80	60.00	546.00	3.00	T+M	132.00
5763	Anterior disc removal and spinal decompression cervical: One level	344.00	3130.40	229.00	2083.90	3.00	T+M	132.00
5764	Anterior disc removal and spinal decompression cervical: Each additional level	81.00	737.10	60.00	546.00	3.00	T+M	132.00
5765	Vertebral corpectomy for spinal decompression: One level	466.00	4240.60	311.00	2830.10	3.00	T+M	132.00
5766	Vertebral corpectomy for spinal decompression: Each additional level	88.00	800.80	60.00	546.00	3.00	T+M	132.00
5770	Use of microscope in spinal or intracranial procedures (modifier 0005 not applicable)	71.00	646.10	60.00	546.00			
0969	Skull or skull-femoral traction including two weeks after-care	64.00	582.40	60.00	546.00			
3.9	**Facial bone procedures** Note: Modifiers 0046 to 0058 are not applicable to this section of the Tariff							
0987	Repair of orbital floor (blowout fracture).	182.00	1656.20	121.00	1101.10	4.00	T+M	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
0988	Genioplasty.	263.00	2393.30	175.00	1592.50	4.00	T+M	176.00
	OPEN REDUCTION AND FIXATION OF CENTRAL MID-THIRD FACIAL FRACTURE WITH DISPLACEMENT							
0989	Le Fort I.	184.00	1674.40	123.00	1119.30	4.00	T+M	176.00
0990	Le Fort II.	302.00	2748.20	201.00	1829.10	4.00	T+M	176.00
0991	Le Fort III.	433.00	3940.30	289.00	2629.90	4.00	T+M	176.00
0992	Le Fort I Osteotomy.	970.00	8827.00	647.00	5887.70	4.00	T+M	176.00
0993	Palatal Osteotomy.	302.00	2748.20	201.00	1829.10	4.00	T+M	176.00
0994	Le Fort II Osteotomy (team fee).	1103.00	10037.30	735.00	6688.50	4.00	T+M	176.00
0995	Le Fort III Osteotomy (team fee).	1654.00	15051.40	1103.00	10037.30	4.00	T+M	176.00
0996	Fracture of maxilla without displacement.	v		iii				
	MANDIBLE: FRACTURED NOSE AND ZYGOMA							
0997	Open reduction and fixation.	302.00	2748.20	201.00	1829.10	3.00	T+M	132.00
0999	Closed reduction by inter-maxillary fixation.	184.00	1674.40	123.00	1119.30	3.00	T+M	132.00
1001	Temporo-mandibular joint: Reconstruction for dysfunction	206.00	1874.60	137.00	1246.70	4.00	T+M	176.00
1003	Manipulation: Immobilisation and follow-up of fractured nose.	35.00	318.50	35.00	318.50	3.00	T+M	132.00
1005	Nasal fracture without manipulation.	iii		iii				
1007	Mandibulectomy.	320.00	2912.00	213.00	1938.30	5.00	T+M	220.00
1009	Maxillectomy	336.00	3057.60	224.00	2038.40	4.00	T+M	176.00
1011	Bone graft to mandible.	206.00	1874.60	137.00	1246.70	4.00	T+M	176.00
1012	Adjustment of occlusion by ramisection.	227.00	2065.70	151.00	1374.10	4.00	T+M	176.00
1013	Fracture of arch of zygoma without displacement.	v		iii				

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1015	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures, recent fractures (within four weeks)	131.00	1192.10	87.00	791.70	3.00	T+M	132.00
1017	Fracture of arch of zygoma with displacement requiring operative manipulation but not including associated fractures; (after four weeks)	262.00	2384.20	175.00	1592.50	3.00	T+M	132.00
4.	**RESPIRATORY SYSTEM**							
4.1	**Nose and sinuses**							
1019	ENT endoscopy in rooms with rigid endoscope.	12.00	109.20					
1020	Septum perforation repair, by any method.	125.00	1137.50	83.00	755.30	4.00	T	176.00
1022	Functional reconstruction of nasal septum.	115.00	1046.50	77.00	700.70	5.00	T	220.00
1024	Insertion of silastic obturator into nasal septum perforation (excluding material)	30.00	273.00	30.00	273.00	4.00	T	176.00
1025	Intranasal antrostomy (modifier 0005 to apply to opposite side)	60.00	546.00	60.00	546.00	4.00	T	176.00
1027	Dacrocystorhinostomy.	210.00	1911.00	140.00	1274.00	5.00	T	220.00
1029	Turbinectomy, uni- or bilateral	45.00	409.50	45.00	409.50	4.00	T	176.00
1030	Endoscopic turbinectomy: laser or microdebrider	90.00	819.00	60.00	546.00	5.00	T	220.00
1034	Autogenous nasal bone transplant: Bone removal included	100.00	910.00	67.00	609.70	4.00	T	176.00
1035	Functional endoscopic sinus surgery: Unilateral	140.00	1274.00	93.00	846.30	4.00	T	176.00
1036	Bilateral functional endoscopic sinus surgery.	245.00	2229.50	163.00	1483.30	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	Modifiers governing nasal operations: 0069							
	Diathermy to nose or pharynx exclusive of consultation fee, uni- or bilateral							
1037	Under local anaesthetic	8.00	72.80	8.00	72.80			
1039	Under general anaesthetic	35.00	318.50	35.00	318.50	4.00	T	176.00
	SEVERE EPISTAXIS, REQUIRING HOSPITALISATION							
1041	Control severe epistaxis requiring hospitalisation: Anterior plugging	40.00	364.00	40.00	364.00	4.00	T	264.00
1043	Control severe epistaxis requiring hospitalisation: Anterior and posterior Plugging	60.00	546.00	60.00	546.00	6.00	T	264.00
1045	Ligation anterior ethmoidal artery.	59.00	536.90	59.00	536.90	6.00	T	264.00
1047	Caldwell-Luc operation (unilateral).	92.00	837.10	61.00	555.10	4.00	T	176.00
1049	Ligation internal maxillary artery.	130.00	1183.00	87.00	791.70	6.00	T	264.00
1054	Antroscopy through the canine fossa (uni- or bilateral)	40.00	364.00					
1055	External frontal ethmoidectomy	194.00	1765.40	129.00	1173.90	4.00	T	176.00
1057	External ethmoidectomy and/or sphenoidectomy	164.00	1492.40	109.00	991.90	4.00	T	176.00
1059	Frontal osteomyelitis.	194.00	1765.40	129.00	1173.90	4.00	T	176.00
1061	Lateral rhinotomy.	164.00	1492.40	109.00	991.90	4.00	T	176.00
1063	Removal of foreign bodies from nose at rooms.	10.00	91.00	10.00	91.00			
1065	Removal of foreign body from nose under general anaesthetic	35.00	318.50	35.00	318.50	4.00	T	176.00
1067	Proof puncture at rooms (unilatetal).	10.00	91.00	10.00	91.00	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1069	Proof puncture, uni- or bilateral under general anaesthetic	35.00	318.50	35.00	318.50	4.00	T	176.00
1071	Proetz treatment (consultation fee only to be charged for first treatment).	4.00	36.40	4.00	36.40			
1077	Proetz treatment (consultation fee only to be charged for first treatment).	8.00	72.80	8.00	72.80			
1079	Septum abscess, under general anaesthetic.	35.00	318.50	35.00	318.50	4.00	T	176.00
1081	Oro-antral fistula (without Caldwell-Luc).	86.00	782.60	60.00	546.00	4.00	T	176.00
1083	Choanal atresia: Intranasal approach.	113.00	1028.30	75.00	682.50	5.00	T	220.00
1084	Choanal atresia: Intranasal approach.	194.00	273.00	30.00	273.00	4.00	T	176.00
1085	Total reconstruction of the nose: including reconstruction of nasal septum (septumplasty) nasal pyramid (osteotomies) and nose tip	350.00	3185.00	233.00	2120.30	5.00	T	220.00
1087	Sub-total reconstruction consisting of any two of the following: septumplasty, osteotomies, nasal tip reconstruction	210.00	1911.00	140.00	1274.00	5.00	T	220.00
	FOREHEAD RHINOPLASTY (all stages)							
1089	Total.	52.00	5023.20	368.00	3348.80	5.00	T	220.00
1091	Partial.	414.00	3767.40	276.00	2511.60	5.00	T	220.00
4.3	**Larynx**							
1117	Laryngeal intubation.	10.00	91.00	10.00	91.00			
1118	Laryngeal stroboscopy with video capture	39.00	354.90	39.00	354.90	6.00	T	264.00
	LARYNGECTOMY							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1119	Laryngectomy without block dissection of the neck.	430.00	3913.00	287.00	2611.70	7.00	T	308.00
1127	Tracheotomy.	90.00	819.00	60.00	546.00	9.00	T	396.00
1129	External laryngeal operation e.g. laryngeal stenosis, laryngocele, abductor paralysis, laryngo- fissure.	197.00	1792.70	131.00	1192.10	8.00	T	352.00
	DIRECT LARYNGOSCOPY							
1130	Diagnostic laryngoscopy including biopsy (also to be applied when a flexible fibre-optic laryngoscope was used)	35.00	318.50	35.00	318.50	6.00	T	264.00
1131	Plus foreign body removal	46.00	418.60	46.00	418.60	6.00	T	264.00
4.4	**Bronchial procedures**							
	BRONCHOSCOPY							
	Note: Please specify on account if a biopsy was performed together with the bronchoscopy							
1132	Diagnostic bronchoscopy	65.00	591.50	43.00	391.30	6.00	T	264.00
1133	With removal of foreign body.	80.00	728.00	53.00	482.30	8.00	T	352.00
1134	Bronchoscopy with use of laser.	75.00	682.50			8.00	T	352.00
1135	With bronchography.	80.00	728.00	53.00	482.30	8.00	T	352.00
1136	Nebulisation (in rooms)	12.00	109.20	12.00	109.20	12.00	"	109.20
1137	Bronchial lavage.					8.00	T	352.00
1138	Thoracotomy: for broncho-pleural fistula (including ruptured bronchus, any cause)	350.00	3185.00	233.00	2120.30	12.00	T	528.00
4.5	**Pleura**							
1139	Pleural needle biopsy: (no after-care), modifier 0005 not applicable	50.00	455.00	50.00	455.00	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1141	Insertion of intercostal catheter (under water drainage)	50.00	455.00	50.00	455.00	6.00	T	264.00
1143	Paracentesis chest: Diagnostic.	8.00	72.80	8.00	72.80	3.00	T	132.00
1145	Paracentesis chest: Therapeutic.	13.00	118.30	13.00	118.30	3.00	T	132.00
1147	Pneumothorax: Induction (diagnostic).	25.00	227.50	25.00	227.50			
1149	Pleurectomy.	250.00	2275.00	167.00	1519.70	11.00	T	484.00
1151	Decortication of lung.	350.00	3185.00	233.00	2120.30	11.00	T	484.00
1153	Chemical pleurodesis (instillation silver nitrate, tetracycline, talc, etc)	55.00	500.50	55.00	500.50	3.00	T	132.00
4.6	**Pulmonary procedures**							
4.6.1.	**Surgical**							
1155	Needle biopsy lung: (no after-care) modifier 0005 not applicable	32.00	291.20	32.00	291.20	5.00	T	220.00
1157	Pneumonectomy.	350.00	3185.00	233.00	2120.30	11.00	T	484.00
1159	Pulmonary lobectomy.	350.00	3185.00	233.00	2120.30	11.00		484.00
1161	Segmental lobectomy.	365.00	3321.50	243.00	2211.30	11.00	T	484.00
	EXCISION TRACHEAL STENOSIS							
1163	Cervical.	375.00	3412.50	250.00	2275.00	8.00	T	352.00
1164	Intra thoracic.	350.00	3185.00	233.00	2120.30	12.00	T	528.00
1167	Thoracoplasty associated with lung resection or done by the same surgeon within 6 weeks.	215.00	1956.50	143.00	1301.30	12.00	T	528.00
1168	Thoracoplasty: Complete.	250.00	2275.00	167.00	1519.70	11.00	T	484.00
1169	Thoracoplasty: Limited/osteoplastic.	200.00	1820.00	133.00	1210.30	11.00	T	484.00
1171	Drainage empyema (including six weeks after treatment)	170.00	1547.00	113.00	1028.30	11.00	T	484.00
1173	Drainage of lung abscess (including six weeks after treatment)	170.00	1547.00	113.00	1028.30	11.00	T	484.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1175	Thoracotomy (limited): For lung or pleural biopsy.	115.00	1046.50	77.00	700.70	11.00	T	484.00
1177	Major: Diagnostic, as for inoperable carcinoma	215.00	1956.50	143.00	1301.30	11.00	T	484.00
1179	Thoracoscopy.	89.00	809.90	60.00	546.00	11.00	T	484.00
4.6.2.	**Pulmonary function tests**							
1186	Flow volume test: Inspiration/expiration.	30.00	273.00	20.00	182.00	30.00	ii	273.00
1188	Flow volume test: Inspiration/expiration pre- and post bronchodilator (to be charged for only with first consultation – thereafter item 1186 applies)	50.00	455.00	33.00	300.30	50.00	ii	455.00
1189	Forced expirogram only	10.00	91.00	10.00	91.00	10.00	ii	91.00
1191	N2 single breath distribution	10.00	91.00	10.00	91.00	10.00	ii	91.00
1197	Compliance and resistance, using oesophageal balloon	24.00	218.40	24.00	218.40	24.00	ii	218.40
1201	Maximum inspiratory/expiratory pressure.	5.00	45.50	5.00	45.50	5.00	ii	45.50
1193	Functional residual capacity or residual volume: helium, nitrogen open circuit, or other method	37.76	343.62					
1195	Thoracic gas volume	37.93	345.20					
1196	Determination of resistance to airflow, oscillatory or plethysmographic methods	45.31	412.30					
1198	Prolonged post exposure evaluation of bronchospasm with multiple spirometric determinations after antigen, cold air, methacholine or other chemical agent, with subsequent spirometrics	55.89	508.60					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1199	Pulmonary stress testing; simple (e.g. Prolonged exercise test for bronchospasm with pre- and post-spirometry)	96.50	878.20					
1200	Carbon monoxide diffusing capacity, any method	38.06	346.40					
4.7.	**Intensive care (in intensive care or high care unit): Respiratory, cardiac, general**							
4.7.2.	**Tariff items for Intensive Care**							
	Category 1: Cases requiring intensive monitoring (to include cases where physiological instability is anticipated, e.g. diabetic pre-coma, asthma, gastro-intestinal haemorrhage, etc). Please note that item 1204 may not be charged by the responsible surgeon for monitoring a patient post-operatively in ICU or in the high-care unit since post-operative monitoring is included in the fee for the procedure							
1204	Per Day	30.00	273.00	30.00	273.00	30.00	ii	273.00
	Category 2: Cases requiring active system support (where active specialised intervention is required in cases such as head injury, severe asthma, etc.) Ventilation may or may not be part of the active system support							
1205	First day	100.00	910.00	67.00	609.70	100.00	ii	910.00
1206	Subsequent days, per day.	50.00	455.00	50.00	455.00	50.00	ii	455.00
1207	After two weeks, per day.	30.00	273.00	30.00	273.00	30.00	ii	273.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	Note: The principal practitioner may charge items 1205 - 1207, other participating practitioners must charge the consultation item, e.g. item 0109							
	Category 3: Cases with multiple organ failure or Category 2 patients that may require multidisciplinary intervention							
1208	First day (principal practitioner).	137.00	1246.70	91.00	828.10	137.00	ii	1246.70
1209	First day (per involved practitioner).	58.00	527.80	58.00	527.80	58.00	ii	527.80
1210	Subsequent days (per involved practitioner).	50.00	455.00	50.00	455.00	50.00	ii	455.00
4.7.3.	**Procedures**							
1211	Cardio-respiratory resuscitation: Prolonged attendance in cases of emergency (not necessarily in ICU) – 50.00 clinical procedure units (N$455.50) per half hour or part thereof for the first hour per practitioner, thereafter 25.00 clinical procedure units (NS 227.50) per half hour up to a maximum of 150.00 clinical procedure (N$ 1365.00) units per practitioner. Resuscitation fee includes all necessary additional procedures e.g. infusion, intubation, etc.							
	VENTILATION							
1212	First day.	75.00	682.50	50.00	455.00	75.00	ii	682.50
1213	Subsequent days, per day.	50.00	455.00	50.00	455.00	50.00	ii	455.00
1214	After two weeks, per day.	25.00	227.50	25.00	227.50	25.00	ii	227.50
1215	Insertion of arterial pressure cannula.	25.00	227.50	25.00	227.50	25.00	ii	227.50
1216	Insertion of Swan Ganz catheter for haemodynamic monitoring.	50.00	455.00	50.00	455.00	50.00	ii	455.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1217	Insertion of central venous line via peripheral vein.	10.00	91.00	10.00	91.00	10.00	ii	91.00
1218	Insertion of central venous line via subclavian or jugular veins.	25.00	227.50	25.00	227.50	25.00	ii	227.50
1219	Hyperalimentation (daily tariff).	15.00	136.50	15.00	136.50	15.00	ii	136.50
1220	Patient-controlled analgesic pump: Hire fee: Per 24 hours (Cassette to be charged for according to item 0201 per patient).	30.00	273.00	30.00	273.00	30.00	ii	273.00
1221	Professional fee for managing a patient-controlled analgesic pump: Once off charge per patient.	30.00	273.00	30.00	273.00	30.00	ii	273.00

4.8 Hyperbaric Oxygen Therapy

Internationally recognized scientific indications for Hyperbaric Oxygen Therapy:

a. Arterial gas embolism (traumatic or iatrogenic).
b. Decompression sickness ('the bends')
c. Carbon monoxide poisoning
d. Gas gangrene
e. Crush injuries, compartment syndromes or acute traumatic ischaemias.
f. Problem wounds (selected diabetic wounds, complicated pressure sores, arterial and refractory venous stasis ulcers and non-union)
g. Necrotising soft tissue infections (e.g. necrotising fasciitis)
h. Refractory osteomyelitis
i. Bone and soft tissue radiation necrosis.
j. Compromised skin grafts and flaps.
k. Acute thermal burns.
l. Acute blood loss anaemia (transfusion is contraindicated - e.g. Jehovah's Witnesses or haemolytic anaemia).
m. Cerebral abscesses

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
4800	Pre-hyperbaric assessment of a patient away from the hyperbaric unit (all hours) (includes interpretation of ECG and/or lung function test)	16.00	145.60	16.00	145.60			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
4801	Pre-hyperbaric assessment of a patient in the hyperbaric unit (all hours) (includes interpretation of ECG and/or lung function test)	10.00	91.00	10.00	91.00			
4804	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): Low pressure table (1,5-1,8 ATA x 45-60 min)	45.00	409.50	30.00	273.00			
4805	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre-hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): Routine HBO table (2-2,5 ATA x 90-120 min)	90.00	819.00	60.00	546.00			
4806	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): Emergency HBO table (2,5-3 ATA x 90-120 min)	120.00	1092.00	80.00	728.00			
4809	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): USN TT5 (2,8 ATA x 135 min)	135.00	1228.50	90.00	819.00			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
4810	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): USN TT6 (2,8 ATA x 285 min)	285.00	2593.50	190.00	1729.00			
4811	Monitoring of a patient at the hyperbaric chamber during hyperbaric treatment (includes pre hyperbaric assessment and consultation regarding the indication for hyperbaric treatment provided in the hyperbaric unit): USN TT6ext/6A or Cx 30 (2,8-6 ATA x 305-490 min)	490.00	4459.00	327.00	2975.70			
4815	Prolonged attendance inside a hyperbaric chamber: 50.00 clinical units (N$ 455.00) per half hour or part thereof for the first hour, thereafter 25.00 clinical procedure units (N$ 227.50) per half hour; minimum 50.00 clinical procedure units (N$ 455.00); maximum 400,00 clinical procedure units (N$ 3640.00)							
5.	**MEDIASTINAL PROCEDURES**							
1223	Mediastinoscopy.	95.00	864.50	63.00	573.30	5.00	T	220.00
6.	**CARDIOVASCULAR SYSTEM**							
	Modifier 0100 applies to this section of the Tariff							
6.1.	**General**							
	General practitioner's fee for the taking of an ECG only:							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	Where ECG is done by a general practitioner but interpreted by a physician, the general practitioner is entitled to a consultation fee, plus half of fee determined for ECG							
1228	Without effort: 50% of item 1232.			4.50	41.00			
1229	Without and with effort: 50% of item 1233.			6.50	59.20			
	Note: Items 1228 and 1229 deal only with the fees for taking of the ECG, the consultation fee must still be added							
	Physician's fee for interpreting an ECG: A specialist physician is entitled to the following fees for interpretation of an ECG tracing referred for interpretation.							
1230	Without effort.	6.00	54.60					
1231	Without and with effort.	10.00	91.00					
	ELECTROCARDIOGRAM							
1232	Without effort.	9.00	81.90	9.00	81.90			
1233	Without and with effort.	13.00	118.30	13.00	118.30			
1234	Effort electrocardiogram with the aid of a special bicycle ergometer, monitoring apparatus and availability of associated apparatus	40.00	364.00	40.00	364.00			
1235	Multi-stage treadmill test.	60.00	546.00	60.00	546.00			
1240	Signal averaged ECG	80.00	728.00	53.00	482.30			
1271	Cardiological supervision of Dobutamine magnetic resonance stress testing							
1241	X-ray Screening: Chest.	4.00	36.40	4.00	36.40			
1245	Angiography cerebral: First two series.	34.30	312.10	34.30	312.10	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1246	Angiography peripheral: Per limb.	25.00	227.50	25.00	227.50	4.00	T	176.00
1248	Paracentesis of pericardium.	50.00	455.00	50.00	455.00	9.00	T	396.00
1322	Attendance at other operations or monitoring at bedside, by physician e.g. heart block etc.: Per hour.	20.00	182.00					
6.4	**Peripheral vascular system**							
6.4.3	**Arteries:**							
6.4.3.1	**Aorta-iliac and major branches**							
1373	Ruptured	600.00	5460.00	400.00	3640.00	15.00	T	660.00
6.4.3.2	**Iliac artery**							
1379	Prosthetic grafting and/or Thrombo-endarteriectomy	300.00	2730.00	200.00	1820.00	13.00	T	572.00
6.4.3.3	**Peripheral**							
1385	Prosthetic grafting.	255.00	2320.50	170.00	1547.00	5.00	T	220.00
1396	Suture major blood vessel (artery or vein) - trauma (major blood vessel are defined as aorta, in-nominate artery, carotid artery and vertebral artery, subclavian artery, axillary artery, illiac artery, common femoral and popliteal artery. The vertebral and popliteal arteries are included because of the relevant inaccessi-bility of the arteries and difficult surgical exposure.)	264.00	2402.40	176.00	1601.60	15.00	T	660.00
	GRAFTING VEIN							
1387	Vein grafting proximal to knee joint.	300.00	2730.00	200.00	1820.00	5.00	T	220.00
1388	Distal to knee joint	444.00	4040.40	296.00	2693.60	5.00	T	220.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1389	Endarterectomy when not part of another specified procedure	264.00	2402.40	176.00	1601.60	5.00	T	220.00
1390	Carotid endarterectomy.	321.00	2921.10	214.00	1947.40	15.00	T	660.00
	EMBOLECTOMY							
1393	Peripheral embolectomy transfemoral.	168.00	1528.80	112.00	1019.20	5.00	T	220.00
	MISCELLANEOUS ARTERIAL PROCEDURES							
1395	Arterial suture: trauma.	125.00	1137.50	83.00	755.30	5.00	T	220.00
1397	Profundoplasty.	210.00	1911.00	140.00	1274.00	5.00	T	220.00
1399	Distal tibial (Ankle region).	456.00	4149.60	304.00	2766.40	5.00	T	220.00
1401	Femoro-femoral.	254.00	2311.40	169.00	1537.90	5.00	T	220.00
1402	Carotid-subclavian.	288.00	2620.80	192.00	1747.20	8.00	T	352.00
1403	Axillo-femoral: (Bifemoral plus 50%).	288.00	2620.80	192.00	1747.20	8.00	T	352.00
6.4.4	**Veins**							
1407	Ligation of saphenous vain.	50.00	455.00	50.00	455.00	3.00	T	132.00
1408	Placement of Hickman catheter or similar.	91.00	828.10	61.00	555.10	4.00	T	176.00
	LIGATION OF INFERIOR VENA CAVA:							
1410	Abdominal.	180.00	1638.00	120.00	1092.00	8.00	T	352.00
	"UMBRELLA" OPERATION ON INFERIOR VENA CAVA							
1412	Abdominal.	100.00	910.00	67.00	609.70	8.00	T	352.00
	COMBINED PROCEDURE FOR VARICOSE VEINS: LIGATION OF SAPHENOUS VEIN, STRIPPING, MULTIPLE LIGATION INCLUDING OF PERFORATING VEINS:							
1413	Unilateral	141.00	1283.10	94.00	855.40	3.00	T	132.00
1415	Bilateral	247.00	2247.70	165.00	1501.50	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1417	Extensive sub-fascial ligation of perforating veins.	125.00	1137.50	83.00	755.30	3.00	T	132.00
1419	Lesser varicose vein procedure	31.00	282.10	31.00	282.10	3.00	T	132.00
	THROMBECTOMY							
1425	Inferior vena cava (Trans abdominal).	240.00	2184.00	160.00	1456.00	11.00	T	484.00
1427	Ilio-femoral.	175.00	1592.50	117.00	1064.70	6.00	T	264.00
7.	**LYMPHO-RETICULAR SYSTEM**							
7.1	**Spleen**							
	SPLENECTOMY							
1435	Splenectomy (in all cases)	175.00	1592.50	117.00	1064.70	9.00	T	396.00
	BONE MARROW BIOPSY							
1457	By trephine	13.00	118.30	13.00	118.30	3.00	T	132.00
1458	Simple aspiration of marrow by means of trocar or cannula	8.00	72.80	8.00	72.80			
8.	**DIGESTIVE SYSTEM**							
	Modifiers governing this specific section of the tariff: 0074, 0075							
8.1	**Oral cavity**							
1467	Drainage of intra-oral abscess.	31.00	282.10	31.00	282.10	4.00	T	176.00
1483	Alveolar periosteal or other flaps for arch closure	138.00	1255.80	92.00	837.20	4.00	T	176.00
8.2	**Lips**							
1485	Local excision of benign lesion of lip.	27.00	245.70	27.00	245.70	4.00	T	176.00
1499	Lip reconstruction following an injury: Direct repair	91.00	828.10	61.00	555.10	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	LIP RECONSTRUCTION following an injury or tumour removal							
1501	Flap repair.	206.00	1874.60	137.00	1246.70	4.00	T	176.00
1503	Total reconstruction (first stage).	206.00	1874.60	137.00	1246.70	4.00	T	176.00
1504	Subsequent stages (see item 0299).	104.00	946.40	69.00	627.90	4.00	T	176.00
8.3	**Tongue**							
1505	Partial glossectomy.	225.00	2047.50	150.00	1365.00	6.00	T	264.00
1507	Local excision of lesion of tongue.	27.00	245.70	27.00	245.70	4.00	T	176.00
8.4	**Palate, uvula and salivary glands**							
1531	Drainage of parotid abscess.	25.00	227.50	25.00	227.50	4.00	T	176.00
8.5	**Oesophagus**							
1545	Oesophagoscopy with rigid instrument: First and subsequent	47.00	427.70	47.00	427.70	4.00	T	176.00
1550	With removal of foreign body.	70.00	637.00	60.00	546.00	4.00	T	176.00
	HIATUS HERNIA AND DIAPHRAGMATIC HERNIA REPAIR							
1563	With anti-reflux procedure.	300.00	2730.00	200.00	1820.00	11.00	T	484.00
1565	With Collis Nissen oesophageal lengthening procedure	350.00	3185.00	233.00	2120.30	11.00	T	484.00
8.6	**Stomach**							
1587	Upper gastro-intestinal fibre-optic endoscopy: Own equipment	65.00	591.50	60.00	546.00	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1589	Endoscopic control of gastro-intestinal haemorrhage from upper gastrointestinal tact, intestines or large bowel by injection of vaso-constrictors and/or schleroses (endo-scopic haemostasis) to be added to gastroscopy (item 1587) or colonoscopy (item 1653): Add	15.00	136.50	15.00	136.50	6.00	T	264.00
1591	Upper gastro-intestinal endoscopy with removal of foreign bodies (stomach)	90.00	819.00	60.00	546.00	4.00	T	176.00
1597	Gastrostomy or Gastrotomy	116.00	1055.60	77.00	700.70	6.00	T	264.00
	VAGOTOMY							
1615	Suture of perforated gastric or duodenal ulcer or wound or injury	200.00	1820.00	133.00	1210.30	7.00	T	308.00
1617	Partial gastrectomy.	300.00	2730.00	200.00	1820.00	7.00	T	308.00
1619	Total gastrectomy	375.00	3412.50	250.00	2275.00	7.00	T	308.00
8.7	**Duodenum**							
1626	Endoscopic examination of the small bowel beyond the duodenojejunal flexure with biopsy with or without polypectomy or arrest of haemorrhage (enteroscopy)	120.00	1092.00	80.00	728.00	6.00	T	264.00
1627	Duodenal intubation (under X-ray screening)	8.00	72.80					
8.8	**Intestines**							
1634	Enterotomy or Enterostomy.	116.00	1055.60	77.00	700.70	6.00	T	264.00
1637	Operation for relief of intestinal obstruction	230.00	2093.00	153.00	1392.30	7.00	T	308.00
1639	Resection of small bowel with enterostomy or anastomosis	230.00	2093.00	153.00	1392.30	6.00	T	264.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1645	Suture of intestine (small or large): Perforated ulcer, wound or injury	116.00	1055.60	77.00	700.70	6.00	T	264.00
1647	Closure of intestinal fistula	258.00	2347.80	172.00	1565.20	6.00	T	264.00
	TOTAL FIBRE-OPTIC COLONOSCOPY							
1657	Right or left hemicolectomy or segmental colectomy.	325.00	2957.50	217.00	1974.70	6.00	T	264.00
1661	Colotomy: Including removal of tumour or foreign body.	135.00	1228.50	90.00	819.00	6.00	T	264.00
1663	Total colectomy.	390.00	3549.00	260.00	2366.00	6.00	T	264.00
1665	Colostomy or ileostomy isolated procedure.	196.00	1783.60	131.00	1192.10	6.00	T	264.00
1667	Colostomy Closure	150.00	1365.00	100.00	910.00	5.00	T	220.00
1668	Revision of ileostomy pouch	375.00	3412.50	250.00	2275.00	6.00	T	264.00
8.10	**RECTUM AND ANUS**							
1677	Sigmoidoscopy: First Aid and subsequent, with or without biopsy.	13.00	118.30	13.00	118.30	3.00	T	132.00
	REPAIR OF PROLAPSED RECTUM: ABDOMINAL							
1705	Incision and drainage of peri-anal abscess.	40.00	364.00	40.00	364.00	3.00	T	132.00
1707	Drainage of submucous abscess.	40.00	364.00	40.00	364.00	3.00	T	132.00
1735	Anal sphincteroplasty for incontinence.	120.00	1092.00	80.00	728.00	3.00	T	132.00
1737	Dilation of ano-rectal stricture.	12.50	113.80	12.50	113.80	3.00	T	132.00
8.11	**Liver**							132.00
1743	Needle biopsy of liver.	25.00	227.50	25.00	227.50	3.00	T	132.00
1745	Biopsy of liver by laparotomy.	90.00	819.00	60.00	546.00	4.00	T	176.00
1747	Drainage of liver abscess or cyst.	141.00	1283.10	94.00	855.40	7.00	T	308.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1748	Body composition measured by bio- electrical impedance	x		ii			ii	
	HEMI-HEPATECTOMY							
1749	Right.	440.00	4004.00	293.00	2666.30	9.00	T	396.00
1751	Left.	300.00	2730.00	200.00	1820.00	9.00	T	396.00
1753	Partial or segmental hepatectomy.	350.00	3185.00	233.00	2120.30	9.00	T	396.00
1757	Suture of liver wound or injury.	180.00	1638.00	120.00	1092.00	9.00	T	396.00
8.12	**Biliary tract**							
1763	Cholecystectomy with exploration of common bile duct.	275.00	2502.50	183.00	1665.30	6.00	T	264.00
1765	Exploration of common bile duct: Secondary operation	291.00	2648.10	194.00	1765.40	6.00	T	264.00
1767	Reconstruction of common bile duct.	400.00	3640.00	267.00	2429.70	6.00	T	264.00
8.13	**Pancreas**							
1778	Pancreas: ERCP: Endoscopy and catheterisation of pancreas duct or chole-dochus.	97.00	882.70	65.00	591.50	4.00	T	176.00
1779	Endoscopic exploration of the common vile duct performed following endoscopic retrograde choangiography to be added to ERCP (item 1778)	+10.00	91.00	+10.00	91.00	4.00	T	176.00
1783	Drainage of pancreatic abscess	180.00	1638.00	120.00	1092.00	6.00	T	264.00
1791	Local, partial or subtotal pancreatectomy.	250.00	2275.00	167.00	1519.70	8.00	T	352.00
1793	Distal pancreatectomy with internal drainage.	300.00	2730.00	200.00	1820.00	8.00	T	352.00
8.14	**Peritoneal cavity**							
	PNEUMO-PERITONEUM							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1797	First.	13.00	118.30	13.00	118.30	4.00	T	176.00
1799	Repeat.	6.00	54.60	6.00	54.60	4.00	T	176.00
1800	Peritoneal lavage.	20.00	182.00	20.00	182.00			
1801	Diagnostic paracentesis: Abdomen.	8.00	72.80	8.00	72.80			
1803	Therapeutic paracentesis: Abdomen.	13.00	118.30	13.00	118.30			
1807	Add to open procedure where procedure was performed through a laparoscope (for anaesthetic refer to modifier 0027).	45.00	409.50	45.00	409.50	5.00	T	220.00
1809	Laparotomy.	170.00	1547.00	113.00	1028.30	4.00	T	176.00
1811	Suture of burst abdomen	100.00	910.00	67.00	609.70	7.00	T	308.00
1812	Laparotomy for control of surgical haemorrhage.	105.00	955.50	70.00	637.00	9.00	T	396.00
1813	Drainage of subphrenic abscess.	180.00	1638.00	120.00	1092.00	7.00	T	308.00
	DRAINAGE OF OTHER INTRAPERITONEAL ABSCESS							
1815	Drainage of other intra-peritoneal abscess (excluding appendix abscess): Transabdominal	180.00	1638.00	120.00	1092.00	5.00	T	220.00
1817	Transrectal drainage of pelvic abscess.	75.00	682.50	60.00	546.00	4.00	T	176.00
9.	**HERNIAE**							
	INGUINAL OR FEMORAL HERNIA:							
1819	Inguinal or femoral hernia	125.00	1137.50	83.00	755.30	4.00	T	176.00
1825	Recurrent inguinal or femoral hernia.	155.00	1410.50	103.00	937.30	4.00	T	176.00
1827	Strangulated hernia requiring resection of bowel.	238.00	2165.80	159.00	1446.90	7.00	T	308.00
	UMBILICAL HERNIA							
1831	Umbilical hernia.	140.00	1274.00	93.00	846.30	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1835	Incisional hernia.	160.00	1456.00	107.00	973.70	4.00	T	176.00
10.	**URINARY SYSTEM**							
	Rules governing this section of the Tariff: Rule FF							
10.1	**Kidney**							
1839	Renal biopsy, per kidney, open.	71.00	646.10	60.00	546.00	5.00	T	220.00
1841	Renal biopsy (needle).	30.00	273.00	30.00	273.00	3.00	T	132.00
	PERITONEAL DIALYSIS							
1843	First day.	33.00	300.30	33.00	300.30			
1845	Every subsequent day.	33.00	300.30	33.00	300.30			
	HAEMODIALYSIS :							
1847	Per hour or part thereof.	21.00	191.10	21.00	191.10			
1849	Maximum: Eight hours.	168.00	1528.80	112.00	1019.20			
1851	Thereafter per week.	55.00	500.50	55.00	500.50			
1852	Continuous haemodiafiltration per day in intensive or high care unit	33.00	300.30	33.00	300.30			
	NEPHRECTOMY:							
1853	Primary nephrectomy.	225.00	2047.50	150.00	1365.00	5.00	T	220.00
1855	Secondary nephrectomy.	267.00	2429.70	178.00	1619.80	5.00	T	220.00
1863	Nephro-ureterectomy.	305.00	2775.50	203.00	1847.30	5.00	T	220.00
1865	Nephrotomy with drainage nephrostomy.	189.00	1719.90	126.00	1146.60	6.00	T	264.00
1873	Suture renal laceration (renorraphy).	193.00	1756.30	129.00	1173.90	6.00	T	264.00
1879	Closure renal fistula.	189.00	1719.90	126.00	1146.60	5.00	T	220.00
1881	Pyeloplasty.	252.00	2293.20	168.00	1528.80	5.00	T	220.00
1885	Pyelolithotomy	189.00	1719.90	126.00	1146.60	5.00	T	220.00
10.2	**Ureter**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1897	Ureterorrhaphy: Suture of ureter	147.00	1337.70	98.00	891.80	5.00	T	220.00
1898	Lumbar approach.	189.00	1719.90	126.00	1146.60	5.00	T	220.00
1899	Ureteroplasty.	181.00	1647.10	121.00	1101.10	5.00	T	220.00
1903	Ureterectomy only.	137.00	1246.70	91.00	828.10	5.00	T	220.00
	URETERO-ENTEROSTOMY							
1919	Closure of ureteric fistula.	147.00	1337.70	98.00	891.80	5.00	T	220.00
1921	Immediate deligation of ureter.	147.00	1337.70	98.00	891.80	5.00	T	220.00
10.3	**Bladder**							
1945	Instillation of radio-opaque material for cystography or urethrocystography.	5.00	45.50	5.00	45.50	3.00	T	132.00
1949	Cystoscopy using hospital equipment.	44.00	400.40	44.00	400.40	3.00	T	132.00
1951	And retrograde pyelography or retrograde ureteral catheterisation: Unilateral or bilateral	10.00	91.00	10.00		3.00	T	132.00
1952	J J Stent catheter.	44.00	400.40	44.00		3.00	T	132.00
1954	Urethroscopy.	35.00	318.50			3.00	T	132.00
1959	With manipulation of ureteral calculus.	20.00	182.00	20.00		3.00	T	132.00
1961	With removal of foreign body or calculus from urethra or bladder.	20.00	182.00	20.00		3.00	T	132.00
1964	And control of haemorrhage and blood clot evacuation	15.00	136.50	15.00		3.00	T	132.00
1976	Optic urethrotomy.	80.00	728.00	60.00	546.00	3.00	T	132.00
	INTERNAL URETHROTOMY							
1979	Female.	50.00	455.00	50.00	455.00	3.00	T	132.00
1981	Male.	50.00	455.00	50.00	455.00	3.00	T	132.00
	TRANSURETHERAL RE-SECTION OF BLADDERNECK:							
1985	Female.	105.00	955.50	70.00	637.00	5.00	T	220.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
1986	Male.	125.00	1137.50	83.00	755.30	5.00	T	220.00
1987	Litholapaxy.	80.00	728.00	60.00	546.00	5.00	T	220.00
1989	Cystometrogram.	25.00	227.50	25.00	227.50	3.00	T	132.00
1991	Flowmetric bladder, studies with videocystograph	40.00	364.00	40.00	364.00	3.00	T	132.00
1992	Without videocystograph.	25.00	227.50	25.00	227.50	3.00	T	132.00
1993	Voiding cysto-urethrogram.	21.00	191.10	21.00	191.10	3.00	T	132.00
1995	Percutaneous aspiration of bladder.	10.00	91.00	10.00	91.00	3.00	T	132.00
1996	Bladder catheterisation - male (not at operation)	6.00	54.60	6.00	54.60	3.00	T	132.00
1997	Bladder catheterisation - female (not at operation)	3.00	27.30	3.00	27.30			
1999	Percutaneous cystostomy.	24.00	218.40	24.00	218.40	3.00	T	132.00
	TOTAL CYSTECTOMY:							
2013	Diverticulectomy (independent procedure): Multiple or single.	137.00	1246.70	91.00	828.10	5.00	T	220.00
2015	Suprapubic cystostomy.	67.00	609.70	60.00	546.00	5.00	T	220.00
	RECONSTRUCTION OF ECTOPIC BLADDER EXCLUSIVE OF ORTHOPAEDIC OPERATION (IF REQUIRED							
2035	Cutaneous vesicostomy.	118.00	1073.80	79.00	718.90	5.00	T	220.00
2039	Operation for ruptured bladder.	137.00	1246.70	91.00	828.10	6.00	T	264.00
2047	Drainage of perivesical or prevesical abscess	64.00	582.40	60.00	546.00	5.00	T	220.00
	EVACUATION OF CLOTS FROM BLADDER:							
2049	Other than post-operative.	40.00	364.00	40.00	364.00	3.00	T	132.00
2051	Simple bladder lavage: including catheterisation.	12.00	109.20	12.00	109.20	3.00	T	132.00
10.4	**Urethra**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	DILATATION OF URETHRAL STRICTURE: BY PASSAGE SOUND:							
2063	Initial (male).	20.00	182.00	20.00	182.00	3.00	T	132.00
2065	Subsequent (male).	10.00	91.00	10.00	91.00	3.00	T	132.00
2067	By passage of filiform and follower (male).	20.00	182.00	20.00	182.00	3.00	T	132.00
2071	Urethrorraphy: Suture of urethral wound or injury	139.00	1264.90	93.00	846.30	4.00	T	176.00
	URETHRAPLASTY: PENDULOUS URETHRA							
2075	First stage.	71.00	646.10	60.00	546.00	4.00	T	176.00
2077	Second stage.	145.00	1319.50	97.00	882.70	4.00	T	176.00
2081	Reconstruction or repair of male anterior urethra (one stage).	160.00	1456.00	107.00	973.70	4.00	T	176.00
	RECONSTRUCTION OR REPAIR OF PROSTATIC OR MEMBRANOUS URETHRA							
2083	First stage.	168.00	1528.80	112.00	1019.20	6.00	T	264.00
2085	Second stage	168.00	1528.80	112.00	1019.20	6.00	T	264.00
2086	If done in one stage.	294.00	2675.40	196.00	1783.60	6.00	T	264.00
	TOTAL URETHRECTOMY							
2095	Drainage of simple localised perineal urinary extravasation	42.00	382.20	42.00	382.20	5.00	T	220.00
2097	Drainage of extensive perineal urinary extra-vasation.	137.00	1246.70	91.00	828.10	5.00	T	220.00
2103	Simple urethral meatotomy.	15.00	136.50	15.00	136.50	3.00	T	132.00
	INCISION OF DEEP PERI-URETHRAL ABSCESS							
2105	Female.	42.00	382.20	42.00	382.20	3.00	T	132.00
2107	Male	25.00	227.50	25.00	227.50	3.00	T	132.00
2109	Badenoch pull-through for intractable stricture or incontinence.	181.00	1647.10	121.00	1101.10	5.00	T	220.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2111	External sphincterotomy.	108.00	982.80	72.00	655.20	5.00	T	220.00
2115	Operation for correction of male urinary incontinence with or without introduction of prostheses (excluding cost of prostheses)	168.00	1528.80	112.00	1019.20	5.00	T	220.00
2116	Urethral meatoplasty.	44.00	400.40	44.00	400.40	3.00	T	132.00
2117	Closure of urethrostomy or urethro-cutaneous fistula (independent procedure).	29.00	263.90	29.00	263.90	3.00	T	132.00
11.	**MALE GENITAL SYSTEM**							
11.1	**Penis**							
	PLASTIC OPERATION ON PENIS							
2141	Plastic operation for insertion of prostheses.	101.00	919.10	67.00	609.70	3.00	T	132.00
2147	For injury: Including fracture of penis and skin graft if required.	168.00	1528.80	112.00	1019.20	3.00	T	132.00
	TOTAL AMPUTATION OF PENIS							
2161	Without gland dissection	210.00	1911.00	140.00	1274.00	4.00	T	176.00
2163	With gland dissection	336.00	3057.60	224.00	2038.40	6.00	T	264.00
	PARTIAL AMPUTATION OF PENIS							
2167	Without gland dissection	84.00	2038.40	60.00	546.00	4.00	T	176.00
11.2	**Testis and epididymis**							
	Modifier applicable to this section of the Tariff: 0078							
	ORCHIDECTOMY (TOTAL OR SUBCAPSULAR):							
2191	Unilateral.	98.00	891.80	65.00	591.50	3.00	T	132.00
2193	Bilateral.	147.00	1337.70	98.00	891.80	3.00	T	132.00
2195	Radical operation for malignant testis: Excluding gland dissection.	130.00	1183.00	87.00	791.70	6.00	T	264.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2213	Suture or repair of testicular injury.	34.00	309.40	34.00	309.40	4.00	T	176.00
2215	Incision and drainage of testis or epididymis e.g. abscess or haematoma.	90.00	819.00	60.00	546.00	4.00	T	176.00
2227	Incision and drainage of scrotal wall abscess.	17.00	154.70	17.00	154.70	3.00	T	132.00
11.3	**Prostate**							
2245	Trans-urethral resection of prostate.	252.00	2293.20	168.00	1528.80	6.00	T	264.00
14.	**NERVOUS SYSTEM**							
14.1	**Diagnostic procedures**							
2709	Full spinogram including bilateral median and posterior-tibial studies	140.00	1274.00					
2711	Electro-encephalography - Taking of record	36.10	328.50	36.10	328.50			
2712	Electro-encephalography - Interpretation.	12.00	109.20	12.00	109.20			
2713	Lumbar puncture and/or intrathecal injections.	15.00	136.50	15.00	136.50			
2714	Cisternal puncture and/or intrathecal injections.	15.00	136.50	15.00	136.50			
	ELECTROMYOGRAPHY							
2717	First	75.00	682.50	50.00	455.00			
2718	Subsequent	75.00	682.50	50.00	455.00			
	ANGIOGRAPHY CAROTIS							
2725	Unilateral.	25.00	227.50	25.00	227.50	4.00	T	176.00
2726	Bilateral.	44.00	400.40	44.00	400.40	4.00	T	176.00
2727	Vertebral artery: Direct needling.	50.00	455.00	50.00	455.00	4.00	T	176.00
2729	Vertebral catheterisation.	50.00	455.00	50.00	455.00	4.00	T	176.00
	AIR ENCEPHALO-GRAPHY AND POSTERIOR FOSSA TOMOGRAPHY							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2731	Injection of air (independent procedure).	14.50	131.95			4.00	T	176.00
2735	Posterior fossa tomography attendance by clinician	31.50	286.70	iii				
2737	Visual field charting on Bjerrum Screen.	7.00	63.70	7.00	63.70			
	VENTRICULAR NEEDLING WITHOUT BURRING							
2739	Tapping only.	16.00	145.60	16.00	145.60	4.00	T	176.00
2741	Plus introduction of air and/or contrast dye for ventriculography.	43.00	391.30	43.00	391.30	4.00	T	176.00
	SUBDURAL TAPPING:							
2743	First sitting.	15.00	136.50	15.00	136.50	4.00	T	176.00
2745	Subsequent.	10.00	91.00	10.00	91.00	4.00	T	176.00
14.2	**Introduction of burr holes**							
2747	Ventriculography.	150.00	1365.00	100.00	910.00	8.00	T	352.00
2749	Catheterisation for ventriculography and/or drainage	150.00	1365.00	100.00	910.00	8.00	T	352.00
2753	Subdural haematoma or hygroma.	150.00	1365.00	100.00	910.00	8.00	T	352.00
2755	Subdural empyema.	150.00	1365.00	100.00	910.00	8.00	T	352.00
2757	Brain abscess.	150.00	1365.00	100.00	910.00	8.00	T	352.00
14.3	**Nerve procedures:**							
2765	Nerve conduction studies (see item 0733 and 3285)	26.00	236.60	17.00	154.70	4.00	T	176.00
14.3.1	**Nerve repair or suture:**							
	SUTURE: LARGE NERVE:							
2769	Primary.	134.00	1219.40	89.00	809.90	5.00	T	220.00
2771	Secondary.	202.00	1838.20	135.00	1228.50	5.00	T	220.00
	DIGITAL NERVE:							
2773	Primary.	65.00	591.50	60.00	546.00	3.00	T	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2775	Secondary.	96.00	873.60	64.00	582.40	3.00	T	132.00
	NERVE GRAFT:							
2777	Simple.	202.00	1838.20	135.00	1228.50	4.00	T	176.00
	FASCICULAR:							
2779	First fasciculus.	202.00	1838.20	135.00	1228.50	4.00	T	176.00
2781	Each additional fasciculus.	50.00	455.00	50.00	455.00	4.00	T	176.00
2783	Nerve flap: To include all stages.	224.00	2038.40	149.00	1355.90	4.00	T	176.00
2787	Grafting of facial nerve.	215.00	1956.50	143.00	1301.30	5.00	T	220.00
14.3.2	**Neurectomy:**							
	PROCEDURES FOR PAIN RELIEF:							
2799	Intrathecal injections for pain.	36.00	327.60	36.00	327.60	4.00	T	176.00
2800	Plexus nerve block.	36.00	327.60	36.00	327.60	36.00	ii	327.60
2801	Epidural injection for pain. (See modifier 0045 for post-operative pain relief) (refer to modifier 0021 for epidural anaesthetic).	36.00	327.60	36.00	327.60			
2802	Peripheral nerve block.	25.00	227.50	25.00	227.50	25.00	ii	227.50
	ALCOHOL INJECTION IN PERIPHERAL NERVES FOR PAIN:							
2803	Unilateral.	20.00	182.00	20.00	182.00	3.00	T	132.00
2805	Bilateral.	35.00	318.50	35.00	318.50	3.00	T	132.00
2809	Peripheral nerve section for pain.	45.00	409.50	45.00	409.50	3.00	T	132.00
2815	Interdigital.	51.00	464.10	51.00	464.10	3.00	T	132.00
2825	Excision: Neuroma: Peripheral.	64.00	582.40	60.00	546.00	3.00	T	132.00
14.3.3	**Other nerve procedures:**							
2827	Transposition of ulnar nerve.	100.00	910.00	67.00	609.70	3.00	T	132.00
	NEUROLYSIS:							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2829	Minor.	51.00	464.10	51.00	464.10	3.00	T	132.00
2831	Major.	132.00	1201.20	88.00	800.80	3.00	T	132.00
2833	Digital.	96.00	873.60	64.00	582.40	3.00	T	132.00
2835	Scalenotomy.	132.00	1201.20	88.00	800.80	6.00	T	264.00
2837	Brachial plexus, suture or neurolysis (item 2767)	300.00	2730.00	200.00	1820.00	6.00	T	264.00
2839	Total brachial plexus exposure with graft, neurolysis and transplantation	450.00	4095.00	300.00	2730.00	6.00	T	264.00
2841	Carpal Tunnel.	64.00	582.40	60.00	546.00	3.00	T	132.00
	LUMBAR SYMPATHECTOMY:							
2843	Unilateral.	153.00	1392.30	102.00	928.20	4.00	T	176.00
2845	Bilateral.	268.00	2438.80	179.00	1628.90	6.00	T	264.00
	SYMPATHETIC BLOCK: OTHER LEVELS							
2849	Unilateral.	20.00	182.00	20.00	182.00	3.00	T	132.00
2851	Bilateral	35.00	318.50	35.00	318.50	3.00	T	132.00
14.4	**Skull procedures:**							
	REPAIR OF DEPRESSED FRACTURE OF SKULL:							
	Without brain laceration:							
2859	Major.	200.00	1820.00	133.00	1210.30	8.00	T	352.00
2860	Small.	170.00	1547.00	113.00	1028.30	8.00	T	352.00
	With brain lacerations:							
2861	Small.	200.00	1820.00	133.00	1210.30	8.00	T	352.00
2862	Major.	375.00	3412.50	250.00	2275.00	8.00	T	352.00
2863	Cranioplasty.	280.00	2548.00	187.00	1701.70	8.00	T	352.00
14.5	**Shunt procedures:**							
2875	Theco-peritoneal C.S.F. shunt.	280.00	2548.00	187.00	1701.70	8.00	T	352.00
14.7	**Posterior fossa surgery:**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	NEURECTOMY:							
2879	Glossopharyngeal nerve.	480.00	4368.00	320.00	2912.00	6.00	T	264.00
	EIGHTH NERVE:							
2881	Intracranial.	480.00	4368.00	320.00	2912.00	8.00	T	352.00
2887	Vestibular nerve.	480.00	4368.00	320.00	2912.00	9.00	T	396.00
14.7.1	**Supratentorial procedures**							
2899	Craniectomy for extra-dural haematoma or empyema	375.00	3412.50	250.00	2275.00	11.00	T	484.00
14.8	**Craniotomy:**							
2900	Extra-dural orbital decompression or excision of orbital tumour.	700.00	6370.00	467.00	4249.70	11.00	T	484.00
2903	Abscess, Glioma.	450.00	4095.00	300.00	2730.00	11.00	T	484.00
2904	Haematoma, foreign body: Cerebral or cerebellar.	450.00	4095.00	300.00	2730.00	11.00	T	484.00
2905	Focal epilepsy: Excision of cortical scar.	450.00	4095.00	300.00	2730.00	11.00	T	484.00
2906	With anterior fossa meningocoele and repair of bony skull defect.	375.00	3412.50	250.00	2275.00	11.00	T	484.00
2907	Temporal lobectomy.	450.00	4095.00	300.00	2730.00	11.00	T	484.00
2909	CSF-leaks.	450.00	4095.00	300.00	2730.00	11.00	T	484.00
14.8.1	**Stereo-tactic cerebral and spinal cord procedures:**							
2918	Non-operative supervision of paraplegics for all disciplines except urologists	iii		ii				
14.9	**Spinal operations:**							
	LAMINECTOMY:							
	See section 3.8.7 for laminectomy procedures.							
	CHORDOTOMY:							
2923	Unilateral	178.00	1619.80	119.00	1082.90	3.00	T+M	132.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2925	Open	350.00	3185.00	233.00	2120.30	3.00	T+M	132.00
	RHIZOTOMY:							
2927	Extradural, but intraspinal	320.00	2912.00	213.00	1938.30	3.00	T+M	132.00
2928	Intradural:	350.00	3185.00	233.00	2120.30	3.00	T+M	132.00
	EXTRAMEDULLARY, BUT INTRADURAL:							
2940	Lumbar osteophyte removal	187.00	1701.70	125.00	1137.50	3.00	T+M	132.00
2941	Cervical or thoracic osteophyte removal	285.00	2593.50	190.00	1729.00	3.00	T+M	132.00
14.10	**Arterial ligations:**							
	CAROTIS:							
2951	Trauma	120.00	1092.00	80.00	728.00	8.00	T	352.00
14.11	**Medical psychotherapy**							
	Note: Prior arrangement with the Commission is required							
2957	Individual psychotherapy (specific type): Per short session (20 minutes)	24.00	218.40	16.00	145.60			
2974	Individual psychotherapy (specific type): Per intermediate session (40 minutes)	48.00	436.80	32.00	291.20			
2975	Individual psychotherapy (specific type. Per extended session (60 minutes or longer)	72.00	655.20	48.00	436.80			
2958	Psychoanalytic therapy: Per 60-minute session	72.00	655.20	48.00	436.80			
2962	Directive therapy to family, parent(s), spouse: Per 20-minute session.	24.00	218.40	16.00	145.60			
2963	Pairs, marriage or sex therapy: Per 20-minute session	24.00	218.40	16.00	145.60			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2976	Intermediate treatment where either items 2962 or 2963 are used: Per 40-minute session.	48.00	436.80	32.00	291.20			
2977	Extended treatment where either items 2962 or 2963 are used: Per 60-minute session	72.00	655.20	48.00	436.80			
	Rules governing this section of the Tariff: Rules Va and Vb							
	Modifiers governing this section of the Tariff: 0079							
14.12	**Physical treatment methods**							
2970	Electro-convulsive treatment (ECT): Each time	25.00	227.50	79.04	719.30	3.00	T	132.00
2971	Intravenous anti-depressive medication through infusion: Per push-in (Maximum: 1 push- in per 24 hours)	6.00	54.60	18.60	169.30			
14.13	**Psychiatric examination methods:**							
2972	Narco-analysis (Maximum of 3 sessions per treatment): Per session	24.00	218.40	74.39	677.00			
2973	Psychometry (specify examination): Per session (Maximum of 3 sessions per examination)	24.00	218.40	74.39	677.00			
15.	**Endocrine system**							
15.5	**General:**							
3001	Implantation of pellets, excluding cost of material and after-care.	3.00	27.30	13.95	127.00			
16.	**Eye**							
16.1	**Procedures performed in rooms:**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	(a) Eye investigations and photography refer to both eyes except where otherwise indicated. No extra fee may be charged where each eye is examined separately on two different occasions (b) Material used is excluded (c) The tariff for photography is not related to the number of photographs taken							
3002	Gonioscopy.	7.00	63.70	7.00	63.70			
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.							
3013	Ocular motility assessment comprehensive examination	12.00	109.20	12.00	109.20			
3014	Tonometry per test with maximum of 2 tests for provocative tonometry (one or both eyes)	7.00	63.70	7.00	63.70			
3015	Charting of visual field with manual perimeter.	28.00	254.80	28.00	254.80			
3016	Retinal threshold test without storage facilities	30.00	273.00	30.00	273.00			
3017	Retinal threshold test inclusive of computer disc storage for Delta or Statpak programs.	74.00	673.40	60.00	546.00			
3018	Retinal threshold trend evaluation (additional to item 3017)	16.00	145.60	16.00	145.60			
	SPECIAL EYE INVESTIGATIONS:							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3020	Pachymetry: Only when own instrument is used, per eye. Only in addition to corneal surgery.	46.00	418.60	46.00	418.60			
3021	Retinal function assessment including refraction after ocular surgery (within four months), maximum two examinations	9.00	81.90	9.00	81.90			
3022	Digital fluorescein video angiography	68.00	618.80	60.00	546.00	9.00	T	396.00
3023	Digital indocyanine video angiography	110.00	1001.00	73.00	664.30	9.00	T	396.00
3025	Electronic tonography.	19.00	172.90	19.00	172.90			
3027	Fundus photography.	21.00	191.10	21.00	191.10			
3029	Anterior segment microphotography.	21.00	191.10	21.00	191.10			
3031	Fluorescein angiography, for one or both eyes in one sitting (excluding colour photography).	45.00	409.50	45.00	409.50			
3032	Eyelid and orbit photography.	9.00	81.90	9.00	81.90			
3033	Interpretation of items 3022, 3023 and 3031 referred by other clinician	16.00	145.60	16.00	145.60			
3034	Determination of lens implants power per eye.	15.00	136.50	15.00	136.50			
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.	22.00	200.20	22.00	200.20			
3036	Corneal topography: For pathological corneas only on special motivation. For refractive surgery - may be charged once pre-operative and once post- operative per sitting (for one or both eyes)	36.00	327.60	36.00	327.60			

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
16.2	**Retina:**							
3037	Surgical treatment of retinal detachment including vitreous replacement but excluding vitrectomy.	280.00	2548.00	187.00	1701.70	6.00	T	264.00
3039	Prophylaxis and treatment of retina and choroid by cryotherapy and/or diathermy and/or photocoagulation and/or laser per eye	105.00	955.50	70.00	637.00	6.00	T	264.00
3041	Pan retinal photo-coagulation (per eye): done in one sitting.	150.00	1365.00	100.00	910.00	6.00	T	264.00
3044	Removal of encircling band and/or buckling material	105.00	955.50	70.00	637.00	6.00	T	264.00
16.3	**Cataract:**							
3045	Intra-capsular.	210.00	1911.00	140.00	1274.00	7.00	T	308.00
3047	Extra-capsular (including capsulotomy).	210.00	1911.00	140.00	1274.00	7.00	T	308.00
3049	Insertion of lenticulus in addition to item 3045 or item 3047 (cost of lens excluded) (modifier 0005 not applicable)	57.00	518.70	57.00	518.70	7.00	T	308.00
3050	Repositioning of intra ocular lens							
3051	Needling or capsulotomy.	130.00	1183.00	87.00	791.70	4.00	T	176.00
3052	Laser capsulotomy.	105.00	955.50	70.00	637.00	4.00	T	176.00
3057	Removal of lenticulus.	210.00	1911.00	140.00	1274.00	7.00	T	308.00
3058	Exchange of intra ocular lens							
3059	Insertion of lenticulus when item 3045 or item 3047 was not executed (cost of lens excluded).	210.00	1911.00	140.00	1274.00	7.00	T	308.00
3060	Use of own surgical microscope for surgery or examination (not for slitlamp microscope) (for use by ophthalmologists only)	4.00	36.40					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
16.4	**Glaucoma:**							
3061	Drainage operation.	210.00	1911.00	140.00	1274.00	6.00	T	264.00
3062	Implantation of aqueous shunt device/set on in glaucoma, e.g. Ahmed or Molteno valve or Collagen implants. Additional to item 3061	64.00	582.40	60.00	546.00	6.00	T	264.00
3063	Cyclocryotherapy or cyclodiathermy.	105.00	955.50	70.00	637.00	6.00	T	264.00
3064	Laser trabeculoplasty.	105.00	955.50	70.00	637.00	6.00	T	264.00
3065	Removal of blood from anterior chamber.	105.00	955.50	70.00	637.00	4.00	T	176.00
3067	Goniotomy.	210.00	1911.00	140.00	1274.00	7.00	T	308.00
16.5	**Intra-ocular foreign body:**							
3071	Anterior to Iris.	127.00	1155.70	85.00	773.50	4.00	T	176.00
3073	Posterior to Iris (including prophylactic thermal treatment to retina)	210.00	1911.00	140.00	1274.00	6.00	T	264.00
16.6	**Strabismus:** (whether operation performed on one eye or both)							
3075	Operation on one or two muscles.	160.00	1456.00	107.00	973.70	5.00	T	220.00
3076	Operation on three or four muscles.	200.00	1820.00	133.00	1210.30	5.00	T	220.00
3077	Subsequent operation one or two muscles.	120.00	1092.00	80.00	728.00	5.00	T	220.00
3078	Subsequent operation on three or four muscles	150.00	1365.00	100.00	910.00	5.00	T	220.00
16.7	**Globe:**							
3080	Examination of eyes under general anaesthetic where no surgery is done	80.00	728.00	60.00	546.00	4.00	T	176.00
3081	Treatment of minor perforating injury	102.00	928.20	68.00	618.80	6.00	T	264.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3083	Treatment of major perforating injury	226.00	2056.60	151.00	1374.10	6.00	T	264.00
3085	Enucleation or Evisceration	105.00	955.50	70.00	637.00	5.00	T	220.00
3087	Enucleation or Evisceration with mobile implant: Excluding cost of implant and prosthesis	160.00	1456.00	107.00	973.70	5.00	T	220.00
3088	Hydroxyapetite insertion (additional to item 3087):	40.00	364.00	40.00	364.00	5.00	T	220.00
3089	Subconjunctival injection if not done at time of operation	10.00	91.00	10.00	91.00	5.00	T	220.00
3091	Retrobulbar injection (if not done at time of operation)	16.00	145.60	16.00	145.60	4.00	T	176.00
3092	External laser treatment for superficial lesions	53.00	482.30	53.00	482.30			
3096	Adding of air or gas in vitreous as a post-operative procedure or pneumoretinopexy	130.00	1183.00	87.00	791.70	7.00	T	308.00
3097	Anterior vitrectomy	280.00	2548.00	187.00	1701.70	6.00	T	264.00
3099	Posterior vitrectomy including anterior vitrectomy, encircling of globe and vitreous replacement	419.00	3812.90	279.00	2538.90	6.00	T	264.00
3100	Lensectomy done at time of posterior vitrectomy	30.00	273.00	30.00	273.00	7.00	T	308.00
16.8	**Orbit:**							
3101	Drainage of orbital abscess	105.00	955.50	70.00	637.00	5.00	T	220.00
3105	Exenteration	275.00	2502.50	183.00	1665.30	5.00	T	220.00
3107	Orbitotomy requiring bone flap	240.00	2184.00	160.00	1456.00	5.00	T	220.00
3108	Eye socket reconstruction	206.00	1874.60	137.00	1246.70	5.00	T	220.00
3109	Hydroxyapetite implantation in eye cavity when evisceration or enucleation was done previously	300.00	2730.00	200.00	1820.00	5.00	T	220.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3110	Second stage hydroxyapetite implantation	110.00	1001.00	73.00	664.30	5.00	T	220.00
16.9	**Cornea:**							
3111	Contact lenses: Assessment involving preliminary fittings and tolerance visits (costs of lenses borne by patient)	v		ii				
3113	Fitting of contact lenses and instructions to patient Includes eye: examination, first fitting of the contact lenses and further post-fitting visits for 1 year	200.00	1820.00	133.00	1210.30			
3115	Fitting of only one contact lens and instructions to the patient: eye examination, first fitting of the contact lens and further post-fitting visits for one year included	166.00	1510.60	111.00	1010.10			
3117	Removal of foreign body: On the basis of fee per consultation	ii		ii		4.00	T	176.00
3118	Curettage of cornea after removal of foreign body	10.00	91.00	10.00	91.00			
3119	Tattooing.	26.00	236.60	26.00	236.60	4.00	T	176.00
3121	Graft (Lamellar of full thickness)	289.00	2629.90	193.00	1756.30	6.00	T	264.00
3123	Insertion of intra-corneal or intrascleral prosthesis for refractive surgery.	254.00	2311.40	169.00	1537.90	6.00	T	264.00
3125	Keratectomy or conjuctival flap.	127.00	1155.70	85.00	773.50	6.00	T	264.00
3127	Cauterization of cornea (by chemical, thermal or cryo-therapy methods).	10.00	91.00	10.00	91.00	4.00	T	176.00
3130	Pterygium or conjunctival cyst or conjunctival tumour	53.00	482.30	53.00	482.30	4.00	T	176.00
3131	Paracentesis	53.00	482.30	53.00	482.30	4.00	T	176.00
16.10	**Ducts:**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3133	Probing and/or syringing, per duct	10.00	91.00	10.00	91.00	4.00	T	176.00
3135	Insertion of polythene tubes (additional): Unilateral	13.00	118.30	13.00	118.30	4.00	T	176.00
3137	Excision of lacrimal sac: Unilateral	132.00	1201.20	88.00	800.80	4.00	T	176.00
3139	Dacryocystorhinostomy (Single) with or without polythene tube	210.00	1911.00	140.00	1274.00	5.00	T	220.00
3141	Sealing of punctum.	20.00	182.00	20.00	182.00	4.00	T	176.00
3143	Three-snip operation.	10.00	91.00	10.00	91.00	4.00	T	176.00
	REPAIR OF CANALICULUS:							
3145	Primary procedure.	132.00	1201.20	88.00	800.80	4.00	T	176.00
3147	Secondary procedure.	175.00	1592.50	117.00	1064.70	4.00	T	176.00
16.11	**Iris:**							
3149	Iridectomy or iridotomy by open operation as isolated procedure.	132.00	1201.20	88.00	800.80	4.00	T	176.00
3153	Iridectomy or iridotomy by laser or photo-coagulation as isolated procedure (maximum one procedure)	105.00	955.50	70.00	637.00	4.00	T	176.00
3157	Division of anterior synechiae as isolated procedure	132.00	1201.20	88.00	800.80	4.00	T	176.00
16.12	**Lids:**							
3161	Tarsorrhaphy.	47.00	427.70	47.00	427.70	4.00	T	176.00
3165	Repair of skin lacerations of the lid.	47.00	427.70	47.00	427.70	4.00	T	176.00
3176	Lid operation for facial nerve paralysis including tarsorrhaphy but excluding cost of material.	187.00	1701.70	125.00	1137.50	4.00	T	176.00
16.12.1	**Entropion or ectropion:**							
3177	Cautery.	10.00	91.00	10.00	91.00	4.00	T	176.00
3179	Suture.	47.00	427.70	47.00	427.70	4.00	T	176.00
3181	Open operation.	105.00	955.50	70.00	637.00	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3183	Free skin, mucosal grafting or flap	206.00	1874.60	137.00	1246.70	4.00	T	176.00
16.12.2	**Reconstruction of eyelid:**							
	STAGED PROCEDURES FOR PARTIAL OR TOTAL LOSS OF EYE LID							
3185	First stage.	206.00	1874.60	137.00	1246.70	4.00	T	176.00
3187	Subsequent stage.	206.00	1874.60	137.00	1246.70	4.00	T	176.00
3189	Full thickness eyelid laceration for tumour or injury: Direct repair	132.00	1201.20	88.00	800.80	4.00	T	176.00
3191	Blepharoplasty: upper lid for improvement in function	132.00	1201.20	88.00	800.80	4.00	T	176.00
16.12.3	**Ptosis:**							
3193	Repair by superior rectus, levator or frontalis muscle operation	190.00	1729.00	127.00	1155.70	4.00	T	176.00
	PTOSIS: BY LESSER PROCEDURE e.g. SLING OPERATION:							
3195	Unilateral.	95.00	864.50	63.00	573.30	4.00	T	176.00
3197	Bilateral.	166.00	1510.60	111.00	1010.10	4.00	T	176.00
16.13	**Conjunctiva:**							
3199	Repair of conjunctiva by grafting.	132.00	1201.20	88.00	800.80	4.00	T	176.00
3200	Repair of lacerated conjunctiva.	47.00	427.70	47.00	427.70	4.00	T	176.00
16.14	**General:**							
	OWN EQUIPMENT USED IN TREATMENT:							
	Note: Only the owner of the equipment may charge hire fees for equipment used and not the person using the equipment.							
3196	Diamond knife: Use of own diamond knife during intraocular surgery: Add	12.00	109.20					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3198	Excimer laser: Hire fee (per eye).	284.13	2585.60					
3190	Holmium laser apparatus (ophthalmic): Hire fec for one or both eyes done in one sitting	109.00	991.90					
3201	Ophthalmic laser apparatus: Hire fee for one or both eyes done in one sitting (refer to item 5930 for surgical laser apparatus)	109.00	991.90					
3202	Phako emulcification apparatus: Hire fee	66.74	607.30					
3203	Vitrectomy apparatus: Hire fee	120.00	1092.00					
17.	**Ear**							
	Note: The items of this section are placed in a more logical order but will not follow in numerical order. A new range of numbers is added for section 17.6 Microsurgery of the skull base, namely items 5221 to 5252.							
17.2	**External ear canal:**							
3204	Removal of foreign body at rooms.	v		iii				
3205	Removal of forcign body under general anaesthetic	21.00	191.10	21.00	191.10	4.00	T	176.00
	MEATUS ATRESIA:							
3215	Repair of stenosis of cartilaginous portion	164.00	1492.40	109.00	991.90	4.00	T	176.00
3219	Removal of osteoma from meatus: Solitary.	77.00	700.70	60.00	546.00	4.00	T	176.00
3221	Removal of osteoma from meatus: Multiple.	215.00	1956.50	143.00	1301.30	4.00	T	176.00
17.3	**Middle ear:**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3206	Microscopic examination of tympanic membrane including microsuction	8.00	72.80	5.00	45.50			
3210	Microscope instrument fee used in consulting rooms							
3207	Unilateral myringotomy.	28.00	254.80	28.00	254.80	4.00	T	176.00
3209	Bilateral myringotomy.	34.00	309.40	34.00	309.40	4.00	T	176.00
3211	Unilateral myringotomy with insertion of ventilation tube	34.00	309.40	34.00	309.40	4.00	T	176.00
3212	Bilateral myringotomy with insertion of unilateral ventilation tube.	42.00	382.20	42.00	382.20	4.00	T	176.00
3213	Bilateral myringotomy with insertion of bilateral ventilation tubes.	65.00	591.50	60.00	546.00	4.00	T	176.00
3214	Reconstruction of middle ear ossicles (ossiculoplasty)							
3237	Exploratory tympanotomy	59.00	536.90	59.00	536.90	5.00	T	220.00
3243	Myringoplasty	138.00	1255.80	92.00	837.20	5.00	T	220.00
3245	Functional reconstruction of tympanic membrane	277.00	2520.70	185.00	1683.50	5.00	T	220.00
3249	Stapedotomy and stapedectomy.	277.00	2520.70	185.00	1683.50	5.00	T	220.00
3257	Cortical mastoidectomy.	130.00	1183.00	87.00	791.70	5.00	T	220.00
3259	Radical mastoidectomy (excluding minor procedures)	195.00	1774.50	130.00	1183.00	5.00	T	220.00
3263	Autogenous bone graft to mastoid cavity	180.00	1638.00	120.00	1092.00	5.00	T	220.00
3265	Reconstruction of posterior canal wall, following radical mastoid	320.00	2912.00	213.00	1938.30	5.00	T	220.00
3264	Tympanomastoidectomy.	375.00	3412.50	250.00	2275.00	5.00	T	220.00
17.4	**Facial nerve:**							
17.4.1	**Facial nerve tests:**							
3223	Percutaneous stimulation of the facial nerve.	9.00	81.90	9.00	81.90	4.00	T	176.00

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3224	Electroneurography (ENOG).	75.00	682.50	50.00	455.00	4.00	T	176.00
17.4.2	**Facial nerve surgery:**							
3227	Exploration of tympanomastiod segment.	277.00	2520.70	185.00	1683.50	5.00	T	220.00
3228	Grafting of the tympano-mastoid segment (including item 3227)	436.00	3967.60	291.00	2648.10	5.00	T	220.00
3230	Extratemporal grafting of the facial nerve.	436.00	3967.60	291.00	2648.10	5.00	T	220.00
3232	Facio-accessory or facio-hypoglossal anastomosis	124.00	1128.40	83.00	755.30	6.00	T	264.00
17.5	**Inner ear:**							
17.5.1	**Audiometry:**							
3273	Pure tone audiometry (air conduction)	6.50	59.20	4.30	39.10			
3274	Pure tone audiometry (bone conduction with masking).	6.50	59.20	4.30	39.10			
3275	Impedance audiometry (tympanometry).	6.50	59.20	4.30	39.10			
3277	Speech audiometry: Inclusive fee (speech audiogram, speech reception threshold, discrimination score).	10.00	91.00	6.70	61.00			
2693	A.E.P. Audiological examination: unilateral at a minimum of 4 decibels	60.00	546.00					
2696	Bilateral.	53.00	482.30					
2697	Mid- and long latency auditory evoked potentials: unilateral.	30.00	273.00					
2698	Bilateral.	53.00	482.30					
2699	Electro-cochleography: unilateral	50.00	455.00					
2700	Bilateral	88.00	800.80					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
2702	Total fee for audiological evaluation including bilateral A.E.P. and bilateral electro-cochleography	140.00	1274.00			4.00		176.00
3250	Otoacoustic emission (high risk patients only)	66.48	605.00	66.48	605.00			
17.5.2	**Balance tests:**							
3251	Minimal caloric test (excluding consultation fee).	10.00	91.00	10.00	91.00			
3252	Bithermal Halpike caloric test (excluding consultation fee)	20.00	182.00	20.00	182.00			
3253	Electro-nystagmography for spontaneous and positional nystagmus.	25.00	227.50	25.00	227.50			
3255	Caloric test done with electronystagmography	70.00	637.00	60.00	546.00			
3254	Video nystagmoscopy (monocular).	25.00	227.50	25.00	227.50			
3256	Video nystagmoscopy (binocular)	50.00	455.00	50.00	455.00			
3258	Otolith repositioning manoevre	14.00	127.40	14.00	127.40	4.00	T	176.00
17.5.3	**Inner ear surgery:**							
3233	Labyrinthectomy via the middle ear or mastoid.	277.00	2520.70	185.00	1683.50	5.00	T	220.00
3240	Endolymphatic sac surgery	277.00	2520.70	185.00	1683.50	4.00	T	176.00
3246	Cochlear implant surgery	277.00	2520.70	185.00	1683.50	5.00	T	220.00
3244	Fenestration and occlusion of the posterior semicircular canal (F.O.S.) for benign paroxysmal positioning vertigo (BPPV)	310.00	2821.00	207.00	1883.70	5.00	T	220.00
17.6	**Microsurgery of the skull base:**							

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
17.6.1	**Middle fossa approach (i.e. trans-temporal or supralabyrinthine):**							
3229	Facial nerve: Exploration of the labyrinthine segment	420.00	3822.00	280.00	2548.00	5.00	T	220.00
5221	Facial nerve: Grafting of labyrinthine segment (graft removal and exploration of labyrinthine segment included)	510.00	4641.00	340.00	3094.00	11.00	T	484.00
5222	Facial nerve surgery inside the internal auditory canal (if grafting required and harvesting of graft included)	620.00	5642.00	413.00	3758.30	11.00	T	484.00
17.6.2	**Translabyrinthine approach**							
5229	Facial nerve surgery in the internal auditory canal, translabyrinthine (if grafting and graft removal included)	660.00	6006.00	440.00	4004.00	11.00	T	484.00
17.6.7	**Subtotal petrosectomy:**							
5247	Subtotal petrosectomy for CSF leak and/or for total obliteration of the mastoid cavity	480.00	4368.00	320.00	2912.00	11.00	T	484.00
18.	**PHYSICAL TREATMENT:**							
3279	Domiciliary or nursing home treatment only applicable where a patient is physically incapable of attending the rooms, and the equipment has to be transported to the patient	0.75	6.83					
3280	Consultation units for specialists in physical medicine when treatment is given (per treatment)	13.50	122.90					
3281	Ultrasonic therapy.	10.00	91.00					
3282	Short-wave diathermy.	10.00	91.00					
3284	Sensory nerve conduction studies	31.00	282.10					
3285	Motor nerve conduction studies	26.00	236.60					

Code	PROCEDURE	SPECIALISTS		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3287	Spinal joint and ligament injection.	20.00	182.00	13.00	118.30			
3288	Epidural injection.	36.00	327.60					
3289	Multiple injections - First joint.	7.50	68.25					
3290	Each additional joint.	4.50	41.00					
3291	Tendon or ligament injection.	9.00	81.90					
3292	Aspiration of joint or intra-articular injection.	9.00	81.90					
3293	Aspiration or injection of bursa or ganglion	9.00	81.90					
3294	Paracervical nerve block.	20.00	182.00					
3295	Paravertebral root block - unilateral.	20.00	182.00					
3296	Paravertebral root block - bilateral.	30.00	273.00					
3297	Manipulation of spine performed by a specialist in Physical Medicine.	14.00	127.40					
3298	Spinal traction.	6.00	54.60					
3299	Manipulation of large joints under general anaesthesia: Hip	14.00	127.40			4.00	T	176.00
3300	Manipulation of large joints without anaesthetic	xi		ix				
3301	Muscle fatigue studies	20.00	182.00					
3302	Strength duration curve per session	10.50	95.60					
3303	Electromyography	75.00	682.50					
3304	All other physical treatments carried out: Complete physical treatment: specify treatment (for subsequent treatments by a general practitioner, for the same condition within 4 months after initial treatment: A fee for the treatment only, is applicable: See General Rule L and M)	10.00	91.00	10.00	91.00			

19. RADIOLOGY

DIAGNOSTIC PROCEDURES

Note: The calculated amounts in this section (except for sections 19.9 and 19.11) are calculated according to the radiology monetary unit values

RULES GOVERNING THIS SECTION OF THE TARIFF

Y Except where otherwise indicated, radiologists are entitled to charge for contrast material used.

Z No fee is subject to more than one reduction

GG Capturing and recording of examinations: Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.

Rules governing the section DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIO-ISOTOPES

AA Procedures to exclude cost of isotiope

Rules governing the section RADIATION ONCOLOGY

BB The fees in this section do not include the cost of radium or isotopes

Rules governing the section ULTRASONIC EXAMINATIONS

EE (a) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner doing the scan. A copy of the letter of motivation must be attached to the first account submitted to tgóìÇ¢¨J≠ission (by the radiologist or the other practitioner doing the scan) as the case may be.

(b) In case of a referral to a radiologist, no motivation should be required from the radiologist

MODIFIERS GOVERNING SPECIFIC SECTIONS OF THE TARIFF

DIAGNOSTIC RADIOLOGY

0001 For involuntarily scheduled after-hours emergency radiological services, the additional premium shall be 50% of the fee for the particular services (section 19.12 excluded). See General Rule B.
For after-hours MR scans (items 6200 to 6255), a maximum levy of 100.00 radiological units (N$900.00) is applicable.

0002 Item 38/0101 is applicable only where a radiologist is requested to give a written report on X-rays taken elsewhere and submitted to him/her.

0080 Multiple examinations: Full fee

0081 Repeat examinations: No reduction

0082 "+" means that this item is complementary to a preceding item and is therefore not subject to reduction.

0083 Where a radiologist makes use of hospital equipment only 66.67% of the fee for the examination is chargeable.

Note in respect of fees payable when general practitioners take X-rays.
If the services of a radiologist are normally available, it is expected that these services 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 him/herself provided he/she submits a certificate to the effect that it was in the best interest of the employee injured on duty for him/her to have

taken the plates. A radiologist who has to submit the relevant reports in the normal manner, however, must take subsequent X-rays of the same injury,)

1. When a general practitioner takes X-rays with his/her own equipment, if the services of a specialist radiologist are not available, he/she may claim at the prescribed fee for general practitioners.

2. (i) If a general practitioner orders an X-ray examination at a health facility where the services of a specialist radiologist are available, it is expected that the radiologist shall read the photos for which he may claim at one third of the prescribed fee.

(ii) If the radiographer of the hospital is not available and the general practitioner has to take the X-ray plate's him/herself, he/she may claim at 50% of the prescribed fee for that service. In that case, however, he/she should get confirmation of his/her X-ray findings in a report from the radiologist as soon as possible. The radiologist may then claim at one third of the prescribed fee for service.

3. If a general practitioner orders an X-ray examination at a health facility where there are no specialist radiological services available, he/she will not be paid for reading the plates as such a service is considered as an integral part of routine diagnosis, but if he/she is requested by the Commission to submit a written report on the case, he/she may claim at two thirds of the prescribed fee for such service.

4. If a general practitioner has to take and read X-ray plates at a health facility 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.

Note: Modifier 0083 is not applicable to section 19.8 (Vascular Studies) and section 19.14 (Interventional Radiological Procedures)

0084 In the case of radiological items where films are used practitioners should adjust the fee upwards or downwards in accordance with changes in the price of films in comparison with November 1979; the calculation must be done on the basis that film costs comprise 10% of the monetary value of the unit.

VASCULAR STUDIES

0086 Vascular groups: "Film series" and "Introduction of Contrast Media" are complementary and together constitute a single examination: neither fee is therefore subject to increase in terms of Modifier M0080.

VASCULAR STUDIES and INTERVENTIONAL RADIOLOGY PROCEDURES

6300 If a procedure lasts less than 30 minutes only 50% of the machine fees for items 3536-3550 will be allowed (specify time of procedure on account).

6301 If a procedure is performed by a radiologist in a facility not owned by him/herself, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)

6302 When the procedure is performed by non-radiologists, the fee will be reduced by 40% (i.e. 60% of the fee will be charged)

6303 When a procedure is performed entirely by a non-radiologist in a facility owned by a radiologist, the radiologist owning the facility may charge 55% of the procedure units used. Modifier 6302 applies to the non-radiologist performing the procedure

6305 When multiple catheterization 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 (N$ 180.00) for each procedure after the initial catheterization. The first catheterization is charged at 100% of the unit value

COMPUTED TOMOGRAPHY

0088 Multiple selective catheterisations: For each additional selective catheterisation after the first selective catheterisation, reduce the fee by 25%.

ULTRASONIC INVESTIGATIONS

0160 Aspiration of biopsy procedure performed under direct ultrasonic control by an ultrasonic aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units.

0165 Use of contrast during ultrasound study: Add 6.00 ultrasound units (N$ 39.00)

MAGNETIC RESONANCE IMAGING

0090 Radiologist's fee for participation in a team: 30.00 radiology units (N$ 270.00) per 1/2 hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterization, CT-scanning, ultrasound scanning or X-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only).

6100 In order to charge the full fee of 600.00 magnetic resonance units (N$ 4320.00) for an examination of a specific single anatomical region, it should be performed with the applicable radio frequency coil including T1 and T2 weighted images on at least two planes.

6101 Where a limited series of a specific anatomical region is performed (except bone tumor), e.g. a T2 weighted image of a bone for an occult stress fracture, not more than two-thirds (2/3) of the fee may be charged. Also applicable to all radiotherapy planning studies, per region.

6102 All post-contrast studies (except bone tumor) including perfusion studies, to be charged at 50% of the fee.

6103 Post-contrast study: Bone tumor: 100% of the fee.

6106 Where a magnetic resonance angiography (MRA) of large vessels is performed as primary examination, 100% of the fee is applicable. This modifier is only applicable if the series is performed by use of a recognized angiographic software package with reconstruction capability.

6107 Where a magnetic resonance angiography (MRA) of the vessels is performed additional to an examination of a particular region, 50% of the fee is applicable for the angiography. This modifier is only applicable if the series is performed by use of a recognized angiographic software package with reconstruction capability.

6108 Where only a gradient echo series is performed with a machine without a recognized angiographic software package with reconstruction capability, 20% of the full fee is applicable specifying that it is a "flow sensitive series".

6109 Very limited studies to be charged at 33,33% of the full fee e.g. MR urography for renal colic, diffusion studies of the brain additional to routine brain.

6110 MRI spectroscopy: 50% of fee

RADIATION ONCOLOGY

0093 The fees for radiation oncology shall apply only where a specialist in radiation oncology uses his/her own apparatus.

0170 Multiple areas to a maximum of 3 areas treated in the same treatment session: Unless otherwise identified in the Tariff, where treating multiple treatment volumes/ areas which add significant time and/or complexity, and when each treatment volume/area is clearly identified and defined, the following values shall prevail: 100% (full value) for the first volume/area, two-thirds for the second volume/area and one-third for the third volume/area.

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
19.1	**Skeleton:**							
19.1.1	**Limbs**							
3305	Finger, toe	9.50	85.50	6.30	56.70			
3307	Limb for region e.g. Shoulder, elbow, knee, foot, hand wrist or ankle (and adjacent part which does not require an additional set of views should not be added e.g. wrists or hand)	11.60	104.40	7.70	69.30			
3309	Smith-Petersen or equivalent control, in theatre.	58.00	522.00	38.70	348.30			
3311	Stress studies, e.g. joint.	11.60	104.40	7.70	69.30			
3313	Full length study, both legs	23.20	208.80	15.50	139.50			
3317	Skeletal survey over 5 years	42.00	378.00	28.00	252.00			
3319	Arthrography per joint	23.10	207.90	15.40	138.60			
3320	Introduction of contrast medium or air: Add	20.70+	186.30	13.80+	124.20			
19.1.2	**Spinal column:**							
3321	Per region, e.g. cervical, sacral, coccygeal, one region thoracic	16.60	149.40	11.00	99.00			
3325	Stress studies	16.60	149.40	11.00	99.00			
3331	Pelvis (Sacro-iliac or hip joints only to be added where an extra set of views is required).	16.60	149.40	11.00	99.00			
	Myelography:							
3333	Lumbar	43.30	389.70	28.90	260.10	4.00	T	176.00
3334	Thoracic	33.30	299.70	22.20	199.80	4.00	T	176.00
3335	Cervical	53.30	479.70	35.50	319.50	4.00	T	176.00
3336	Multiple (lumbar, thoracic, cervical): Same fee as for first segment (no additional introduction of contrast medium)							
3344	Introduction of contrast medium: Add	28.10+		18.70+				
3345	Discography.	51.90	467.10	34.60	311.40	4.00	T	176.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3347	Introduction of contrast medium per disc level: Add	42.30+	380.70	28.20+	253.80			
19.1.3	**Skull:**							
3349	Skull studies	23.50	211.50	15.70	141.30			
3351	Paranasal sinuses	16.50	148.50	11.00	99.00			
3353	Facial bones and/or orbits	18.90	170.10	12.60	113.40			
3355	Mandible	14.10	126.90	9.40	84.60			
3357	Nasal bone	11.70	105.30	7.80	70.20			
3359	Mastoid: Bilateral	27.00	243.00	18.00	162.00			
	Teeth:							
3361	One quadrant	5.50	49.50	3.70	33.30			
3363	Two quadrants	9.50	85.50	6.30	56.70			
3365	Full mouth	16.50	148.50	11.00	99.00			
3366	Rotation tomography of the teeth and jaws.	20.00	180.00	13.30	119.70			
3367	Temporo-mandibular joints: Per side.	16.50	148.50	11.00	99.00			
3369	Tomography: Per side	16.50	148.50	11.00	99.00			
3371	Localization of foreign body in the eye.	23.50	211.50	15.70	141.30			
3381	Ventriculography	40.90	368.10	27.30	245.70	4.00	T	176.00
3385	Post-nasal studies: Lateral neck	9.50	85.50	6.30	56.70			
3387	Maxillo-facial cephalometry	13.20	118.80	8.80	79.20			
3389	Dacryocystography.	16.55	149.00	11.00	99.00	4.00	T	176.00
3391	For introduction of contrast medium add	16.55+	149.00	11.00+	99.00			
19.2	**Alimentary tract:**							
3393	Bowel washout: Add	7.20+	64.80	4.80+	43.20			
3395	Sialography (plus 80% for each additional gland)	19.00	171.00	12.70	114.30			

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3397	Introduction of contrast medium (plus 80% for each additional gland): Add	16.60+	149.40	11.00+	99.00			
3399	Pharynx and oesophagus	19.00	171.00	12.70	114.30			
3403	Oesophagus, stomach and duodenum (control film of abdomen included) and limited follow through.	30.00	270.00	20.00	180.00			
3405	Double contrast: Add	11.00+	99.00	7.30+	65.70			
3406	Small bowel meal (control film of abdomen included except when part of item 3408)	30.00	270.00	20.00	180.00			
3408	Barium meal and dedicated gastro-intestinal tract follow through (including control film of the abdomen, oesophagus, duodenum, small bowel and colon)	43.30	389.70	28.90	260.10			
3409	Barium enema (control film of abdomen included)	27.50	247.50	18.30	164.70			
3411	Air contrast study: Add	29.00+	261.00	19.30+	173.70			
3416	Pancreas: E.R.C.P. hospital equipment: Choledogram and/or pancreatography screening included	23.30	209.70	15.50	139.50			
	Note: For items 3415 and 3416, Endoscopy: see item 1778							
3417	Gastric/oesophageal/duodenal intubation control	8.80	79.20	5.90	53.10			
3419	Gastric/oesophageal intubation insertion of tube Add	8.40+	75.60	5.60+	50.40			
3421	Duodenal intubation: Insertion of tube: Add	16.50+	148.50	11.00+	99.00			
3423	Hypotonic duodenography (item 3403 and item 3405 included): Add	44.00+	396.00	29.30+	263.70			
19.3	**Biliary tract:**							
	Cholangiography:							
3427	Intravenous	33.00	297.00	22.00	198.00			

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3431	Operative: First series: Add item 3607 only when the Radiologist attends personally in theatre	31.60	284.40	21.00	189.00			
3433	Post operative: T-tube	25.00	225.00	16.70	150.30			
3435	Introduction of contrast medium: Add	8.40+	75.60	5.60+	50.40			
3437	Trans hepatic, percutaneous	27.50	247.50	18.30	164.70			
3439	Introduction of contrast medium: Add.	49.70+	447.30	33.10+	297.90			
3441	Tomography of biliary tract: Add.	14.10+	126.90	9.40+	94.60			
19.4	**Chest:**							
3443	Larynx (Tomography included)	18.80	169.20	12.50	112.50			
3445	Chest (item 3601 included).	14.10	126.90	9.40	84.60			
3447	Chest and cardiac studies (item 3601 included)	18.90	170.10	12.60	113.40			
3449	Ribs	18.50	166.50	12.30	110.70			
3451	Sternum or sterno-clavicular joints	18.90	170.10	12.60	113.40			
	Bronchography:							
3453	Unilateral	18.90	170.10	12.60	113.40	8.00	T	352.00
3455	Bilateral	33.10	297.90	22.10	198.90	8.00	T	352.00
3457	Introduction of contrast medium included	53.60	482.40	35.70	321.30			
3461	Pleurography	18.90	170.10	12.60	113.40	3.00	T	132.00
3463	For introduction of contrast medium: Add	4.20	37.80	2.80+	25.20			
3465	Laryngography	16.50	148.50	11.00	99.00			
3467	For introduction of contrast medium: Add	15.00+	135.00	10.00+	90.00			
3468	Thoracic inlet	9.50	85.50	6.30	56.70			
19.5	**Abdomen:**							

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3477	Control films of the Abdomen (not being part of examination for barium meal, barium enema, pyelogram, cholecystogram, cholangiogram etc.)	14.10	126.90	9.40	84.60			
3479	Acute abdomen or equivalent studies	23.50	211.50	15.70	141.30			
19.6	**Urinary tract:**							
	Excretory Urogram:							
3487	Control film included and bladder views before and after micturition (intra-cncus pyelogram) (item 0206 not applicable)	37.60	338.40	25.10	225.90			
3493	Waterload test: Add.	18.30+	164.70	12.20+	109.80			
3497	Cystography only or urethrography only (retrograde).	29.00	261.00	19.30	173.70			
	Cysto-Urethrography:							
3499	Retrograde	47.80	430.20	31.90	287.10			
3503	Introduction of contrast medium: Add	5.50+	49.50	3.70+	33.30			
3505	Retrograde-prograde pyclography	27.50	247.50	18.30	164.70	3.00	T	132.00
3511	Aspiration renal cyst	27.60	248.40	18.40	165.60			
3513	Tomography of renal tract: Add	14.10+	126.90	9.40+	84.60			
19.8	**Vascular studies:**							
	Note: The item number in this section does not follow chronological order since this section was restructured.							
19.8.1	**Film Series**							
3536	Dedicated angiography suite: analogue monoplane unit. Once off charge per patient by owner of equipment	315.00	2835.00					

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3537	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment	617.00	5553.00					
3538	Analogue monoplane table with DSA attachment	315.00	2835.00					
3539	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment	829.00	7461.00					
3548	Analogue monoplane screening table	272.00	2448.00					
3550	Digital monoplane screening table	530.00	4770.00					
3545	Venography: Per limb	27.50	247.50	16.50	148.50			
	Note: The machine fee (items 3536 to 3550) may only be billed for as a once off fee per case per day by the owner of the equipment and is only applicable to radiology practices.							
3557	Catheterisation aorta or vena cava, any level, any route, with aortogram/cavogram	81.00+	729.00	48.60+	437.40	4.00	T	176.00
3558	Translumbar aortic puncture, with full study	116.00	1044.00	69.60	626.40	5.00	T	220.00
3559	Selective first order catheterisation, arterial or venous with angiogram/venogram	95.00	855.00	57.00	513.00	4.00	T	176.00
3560	Selective second order catheterisation, arterial or venous, with angiogram/venogram	109.00	981.00	65.40	588.60	4.00	T	176.00
3562	Selective third order catheterisation, arterial or venous, with angiogram / venogram	122.00	1098.00	73.20	658.80	4.00	T	176.00
3564	Direct femoral arterial or venous or jugular venous puncture	62.00	558.00	37.20	334.80			
3566	Guiding catheter placement, any site arterial or venous, for any intracranial procedure or anteriovenous mal-formation (AVM)	143.00	1287.00	85.80	772.20	5.00	T	220.00
3570	Microcatheter insertion, any cranial vessel and/or pulmonary vessel, arterial or venous (including guiding catheter placement)	218.00	1962.00	130.80	1177.20	5.00	T	220.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3572	Transcatheter selective blood sampling, arterial or venous	54.00	486.00	32.40	291.60			
3574	Spinal angiogram (global fee) including all selective catheterisations	800.00	7200.00	480.00	4320.00	5.00	T	220.00
19.8.2	**Introduction of contrast medium:**							
3563	Direct intravenous for limb: Add	11.10+	99.90	7.40+	66.60			
3575	"Cut-downs" for venography: Add	16.55+	149.00	11.00+	99.00			
19.9	**Tomography and Cinematography:**							
	Please note: The fees in this section are calculated according to the computed tomography unit values							
3577	Tomography (conventional except where otherwise specified): Add 100% provided that if it is more than one dimension fee shall be charged for the additional investigation at 50% of the tariff with a maximum of two additional investigations							
3579	Tomography (multi-dimensional in motion): Add 150%							
3581	Cinematography: For first series: Add 100%							
3583	Cinematography: For each series after the first: Add 80% of the primary fee							
19.9.1	**Computed Tomography:**							
3585	Head, single examination, full series	160.00	1248.00			5.00	T	220.00
3587	Head, repeat examination at the same visist, after contrast full series.	55.00	429.00			5.00	T	220.00
3589	Chest	185.00	1443.00			5.00	T	220.00
3591	Abdomen (including base of chest and/or pelvis)	215.00	1677.00			5.00	T	220.00
3593	Multiple examinations: For an additional part the lesser fee shall be reduced to	50.00	390.00			5.00	T	220.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3598	Electron beam computed tomography for assessment of coronary artery calcification (complete fee - no additions)	311.80	2432.00					
6400	Plus Spiral CT	50.00	390.00					
6401	Plus 3D reconstruction	50.00	390.00					
6402	Plus high resolution study	50.00	390.00					
6403	CT limb uncontrasted	200.00	1560.00			5.00	T	220.00
6404	CT limb with contrast only	200.00	1560.00			5.00	T	220.00
6405	CT Limb pre AND post contrast	250.00	1950.00			5.00	T	220.00
6406	CT joint uncontrasted	200.00	1560.00			5.00	T	220.00
6407	CT joint with contrast only	200.00	1560.00			5.00	T	220.00
6408	CT joint pre AND post contrast	250.00	1950.00			5.00	T	220.00
6409	CT brain uncontrasted (including posterior fossa)	210.00	1638.00			5.00	T	220.00
6410	CT brain with contrast only (including posterior fossa)	210.00	1628.00			5.00	T	220.00
6411	CT brain pre AND post contrast (including posterior fossa)	265.00	2067.00			5.00	T	220.00
6412	CT orbits complete study, axial OR coronal, uncontrasted	160.00	1248.00			5.00	T	220.00
6413	CT orbits complete study, axial AND coronal, uncontrasted	210.00	1638.00			5.00	T	220.00
6414	CT orbits complete study, axial OR coronal pre AND post contrast	215.00	1677.00			5.00	T	220.00
6415	CT orbits complete study, axial AND coronal pre AND post contrast	265.00	2067.00			5.00	T	220.00
6416	CT paranasal sinuses limited study axial OR coronal	50.00	390.00			5.00	T	220.00
6417	CT paranasal sinuses limited study axial AND coronal	100.00	780.00			5.00	T	220.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
6418	CT paranasal sinuses complete study, axial OR coronal, uncontrasted	160.00	1248.00			5.00	T	220.00
6419	CT paranasal sinuses complete study, axial AND coronal, uncontrasted	210.00	1638.00			5.00	T	220.00
6420	CT paranasal sinuses complete study, axial OR coronal, pre AND post contrast	215.00	1677.00			5.00	T	220.00
6421	CT paranasal sinuses complete study, axial AND coronal, pre AND post contrast	260.00	2028.00			5.00	T	220.00
6422	CT pituitary fossa, uncontrasted	160.00	1248.00			5.00	T	220.00
6423	CT pituitary fossa, pre AND post contrast	210.00	1638.00			5.00	T	220.00
6424	CT internal auditory meati, uncontrasted	100.00	780.00			5.00	T	220.00
6425	CT internal auditory meati, pre AND post contrast	150.00	1170.00			5.00	T	220.00
6426	CT mastoids	100.00	780.00			5.00	T	220.00
6427	CT ear structures, limited study	100.00	780.00			5.00	T	220.00
6428	CT middle AND inner ear, complete study including reconstructions	310.00	2418.00			5.00	T	220.00
6429	CT facial bones	210.00	1638.00			5.00	T	220.00
6430	CT neck soft tissue, uncontrasted	185.00	1443.00			5.00	T	220.00
6431	CT neck soft tissue with contrast only	185.00	1443.00			5.00	T	220.00
6432	CT neck pre AND post contrast	235.00	1833.00			5.00	T	220.00
6433	CT cervical spine uncontrasted	300.00	2340.00			5.00	T	220.00
6434	CT cervical spine pre AND post contrast	350.00	2730.00			5.00	T	220.00
6435	CT cervical spine post myelogram	150.00	1170.00			5.00	T	220.00
6436	CT dorsal spine uncontrasted	300.00	2340.00			5.00	T	220.00
6437	CT dorsal spine pre AND post contrast	350.00	2730.00			5.00	T	220.00
6438	CT dorsal spine post myelogram	150.00	1170.00			5.00	T	220.00
6439	CT lumbar spine uncontrasted	300.00	2340.00			5.00	T	220.00
6440	CT lumbar spine pre AND post contrast	350.00	2730.00			5.00	T	220.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
6441	CT lumbar spine post myelogram	150.00	1170.00			5.00	T	220.00
6442	CT pelvimetry (topogram only)	50.00	390.00			5.00	T	220.00
6443	CT chest uncontrasted	235.00	1833.00			5.00	T	220.00
6444	CT chest with contrast	235.00	1833.00			5.00	T	220.00
6445	CT chest pre AND post contrast	285.00	2223.00			5.00	T	220.00
6446	CT chest high resolution lungs, limited study	100.00	780.00			5.00	T	220.00
6447	CT high resolution lungs, complete study	235.00	1833.00			5.00	T	220.00
6448	CT abdomen uncontrasted	215.00	1677.00			5.00	T	220.00
6449	CT abdomen with contrast	215.00	1677.00			5.00	T	220.00
6450	CT abdomen pre AND post contrast	265.00	2067.00			5.00	T	220.00
6451	CT abdomen triphasic study	315.00	2457.00			5.00	T	220.00
6452	CT pelvis uncontrasted	215.00	1677.00			5.00	T	220.00
6453	CT pelvis with contrast	215.00	1677.00			5.00	T	220.00
6454	CT pelvis pre AND post contrast	265.00	2067.00			5.00	T	220.00
6455	CT abdomen AND pelvis uncontrasted	315.00	2457.00			5.00	T	220.00
6456	CT abdomen AND pelvis with contrast	315.00	2457.00			5.00	T	220.00
6457	CT abdomen AND pelvis pre AND post contrast	365.00	2847.00			5.00	T	220.00
6458	CT chest, abdomen AND pelvis with contrast	545.00	4251.00			5.00	T	220.00
6459	CT base of skull to symphysis pubis with contrast	735.00	5733.00			5.00	T	220.00
6460	CT for dental implants maxilla OR mandible	250.00	1950.00					
6461	CT for dental implants maxilla AND mandible	500.00	3900.00					
6462	CT angiography per limited region (including spiral, high resolution AND all reconstructions)	515.00	4017.00			5.00	T	220.00
6463	CT angiography per extensive region (including spiral, high resolution, 3D AND all other reconstructions)	615.00	4797.00			5.00	T	220.00

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
6464	CT limited study any region, may not be added to any other CT code and may only be used once	50.00	390.00			5.00	T	220.00
6465	CT guidance for aspiration, biopsy or drainage	100.00	780.00			11.00	T	484.00
6466	CT guidance for aspiration at time of CT diagnostic study	50.00	390.00					
6467	CT stereotactic localisation for biopsy	150.00	1170.00			11.00	T	484.00
6468	CT for radiotherapy planning (not to be used as an add-on)	160.00	1248.00					
6469	Quantitative CT for bone mineral density	97.00	756.60					
6470	Triphasic study of the liver with CT Abdomen and Pelvis pre and post contrast	415.00	3237.00			5.00	T	220.00
6471	CT of the Chest, triphasic study of the liver, abdomen and pelvis with contrast	595.00	4641.00			5.00	T	220.00
6472	Computer Aided Daignosis for Mammography	5.50	42.90					
3597	Contrast media: General Rule Y applies. (Please note: Item 0201 is not applicable for contrast media)							
3592	Where a fully digital C-arm portable X-ray unit, with anglography/interventional capability is used in hospital or theatre, per half hour.							
19.10	**Miscellaneous:**							
3601	Fluoroscopy: Per half hour: (not applicable for items 3445 and 3447) Add	11.60+	104.40	7.70+	69.30			
3602	Where a C-arm portable X-ray unit is used in hospital or theatre: Per half hour: Add	16.00	144.00	10.70	96.30			
3603	Sinography	27.70	249.30	18.40	165.60			
3600	Peripheral bone desitometry utilizing ionizing radiation	13.00	117.00	8.70	78.30			

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
3604	Bone densitometry (to be charged once only for one or more levels done at the same session)	77.00	693.00	51.00	459.00			
3607	Attendance at operation in theatre or at radiological procedure performed by a surgeon or physician in x-ray department except item 3309: Per half hour: Plus fee for examination performed. (Only to be used by radiological technical staff).	8.40	75.60	5.60	50.40			
3609	Foreign body localisation: Fee for part examined plus two-thirds for every additional series plus fluoroscopy fee if this is done.			5.60	50.40			
3611	Foreign body localisation: Introduction of sterile needle markers: Add	16.50+		11.00+				
3613	Setting of sterile trays	3.30		3.30				
5034	Fine needle aspiration or biopsy or core biopsy of mamma.	25.00		25.00		6.00	T	264.00
19.11	**Ultrasonic investigations:**							
	Please note: The fees in this section are calculated according to the ultrasound unit values.							
M/W 0160	Aspiration or biopsy procedure performed under direct ultrasonic control by an ultrasonic aspiration biopsy transducer (Static Realtime): Fee for part examined plus 30% of the units.							
0165	Use of contrast during ultrasound study: add 6.00 ultrasound units							
3621	Cardiac examination (M.Mode)	25.00	162.50	17.00	110.50			
3622	Cardiac examination: 2 Dimensional	50.00	325.00	33.00	214.50			
3623	Cardiac examination + effort : Add	10.00+	65.00	6.70+	43.60			
3624	Cardiac examinations + contrast : Add	10.00+	65.00	6.70+	43.60			
3625	Cardiac examinations + doppler : Add	50.00+	325.00	33.00+	214.50			

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC	
		UNITS	N$	UNITS	N$	UNITS	N$
3626	Cardiac examination + phono-cardiography : Add	10.00+	65.00	6.70+	43.60		
3627	Ultrasound examination includes whole abdomen and pelvic organs, where pelvic organs are clinically indicated (including liver, gall bladder, spleen, pancreas, abdominal vascular anatomy, para-aortic area, renal tract, pelvic organs)	60.00	390.00	40.00	260.00		
3628	Renal tract	50.00	325.00	33.00	214.50		
5101	Pleural space ultrasound	50.00	325.00	33.00	214.50		
5102	Ultrasound of joints (eg shoulder, hip knee), per joint	50.00	325.00	33.00	214.50		
5103	Ultrasound soft tissue, any region	50.00	325.00	33.00	214.50		
3629	High definition (small parts) scan: thyroid, breast lump, scrotum, etc.	50.00	325.00	33.00	214.50		
3631	Ophthalmic examination	50.00	325.00	33.00	214.50		
3632	Axial length measurement and calculation of intraocular lens power: per eye	50.00	325.00	33.00	214.50		
3635	+ Doppler	39.00	253.50	26.00	169.00		
3637	+ Colour Doppler (may be added onto any other regional exam, but not to be added to items 3605, 5110, 5111, 5112, 5113 or 5114.	78.00	507.00	52.00	338.00		
19.12	**Portable unit and theatre examinations:**						
3639	Where portable X-ray unit is used in the hospital or theatre: Add	10.00+	90.00	7.00+	63.00		
3640	Theatre investigations with fixed installation : Add	4.50+	40.50	3.00+	27.00		
	Note: In regard to multiple examinations see Modifier M 0080						
19.13	**Diagnostic procedures requiring the use of radio-isotopes:**						

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	Rule governing this sub-section of the tariff: AA							
3641	Tracer test	33.20	298.80	22.10	198.90			
3642	Repeat of further tracer tests for same investigation: Half of above fee	16.60	149.40	11.10	99.90			
3643	If both tracer and therapeutic procedures are done, half fee of tracer test to be charged plus therapeutic fee							
3645	Other organ scanning with use of relevant radio isotopes	82.20	739.80	54.80	593.20			
6474	Positron Emmission Tomography (PET) imaging of the whole body using a Coincidence Camera							
6475	Positron Emmission Tomography (PET) imaging of a limited body region using a Coincidence Camera							
19.14	**Interventional radiological procedures:**							
M/W 0090	Radiologist's fee for participation in a team: 30,00 radiology units (N$ 270.00) per 1/2 hour or part thereof for all interventional radiological procedures, excluding any pre- or post-operative angiography, catheterisation, CT-scanning, ultrasound-scanning or x-ray procedures. (Only to be charged if radiologist is hands-on, and not for interpretation of images only). Note: In regard to multiple examinations see modifier 0080							
5018	On-table thrombolysis/Transcatheter infusion performed in angiography suite	178.00	1602.00	106.80	961.20	5.00	T	220.00
5022	Embolisation non-intercranial, per vessel .	178.00	1602.00	106.80	961.20	9.00	T	396.00
5031	Antegrade ureteric stent insertion	116.00	1044.00	69.60	626.40	6.00	T	264.00
5033	Percutaneous cystostomy in radiology suite	50.00	450.00	30.00	270.00			

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
5035	Urethral balloon dilatation in radiology suite	38.00	342.00	22.80	205.20			
5036	Percutaneous abdominal/pelvis/other drain insertion, any modality.	57.00	513.00	34.20	307.80			
5037	Urethral stenting in radiology suite	171.00	1539.00	102.60	923.40			
5041	Balloon occlusion/Wada test	178.00	1602.00	106.80	961.20	9.00	T	396.00
5043	Intracranial angioplasty	341.00	3069.00	204.60	1841.40	13.00	T	572.00
5045	Hepatic arterial infusion catheter insertion	260.00	2340.00	156.00	1404.00	6.00	T	264.00
5047	Combined internal/external biliary drainage	171.00	1539.00	102.60	923.40	9.00	T	396.00
5049	Percutaneous gall bladder drainage	116.00	1044.00	69.60	626.40	9.00	T	396.00
5072	Tunnelled/Subcutaneous arteria	137.00	1233.00	82.20	739.80	5.00	T	220.00
5074	IVC filter insertion jugular or femoral route	260.00	2340.00	156.00	1404.00	9.00	T	396.00
5076	Intravascular foreign body removal, arterial or venous, any route	341.00	3069.00	204.60	1841.40	9.00	T	396.00
5078	Percutaneous sclerotherapy of an arteriovenous malformation (AVM) per session	117.00	1053.00	70.20	631.80	5.00	T	220.00
5080	Transjugular intrahepatic portosystemic shunt	559.00	5031.00	335.40	3018.60	13.00	T	572.00
5082	Transjugular liver biopsy	116.00	1044.00	69.60	626.40	9.00	T	396.00
5088	Oesophageal stent insertion in radiology suite	171.00	1539.00	102.60	923.40	6.00	T	264.00
5090	Tracheal stent insertion	171.00	1539.00	102.60	923.40	6.00	T	264.00
5091	GIT Balloon dilatation under fluoroscopy	111.00	999.00	66.60	599.40	6.00	T	264.00
5092	Other GIT stent insertion	171.00	1539.00	102.60	923.40	6.00	T	264.00
5093	Percutaneous gastrostomy in radiology suite	143.00	1287.00	85.80	772.90			
5094	Cutting needle biopsy with image guidance	38.00	342.00	22.80	205.20			
5095	Chest drain insertion in radiology suite	54.00	486.00	32.40	291.60			
5096	Percutaneous cyst or tumour ablation (non aspiration)	91.00	819.00	54.60	491.40			
5097	Vertebroplasty - Introduction of stabilising material under screening or CT control - per level							

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC		
		UNITS	N$	UNITS	N$	UNITS		N$
	Note: Items 5026 and 5034 have been moved to section 19.10: Miscellaneous							
19.15	**Magnetic Resonance Imaging:**							
	Note: The calculated amounts in this section are calculated according to the magnetic resonance imaging unit value.							
	Modifiers applicable to this section of the Tariff: 6100, 6101, 6102, 6103, 6109, 6110							
	Magnetic Resonance Imaging: per anatomical region:							
	Note: See modifier 6101 for limited examinations							
6210	Cervical vertebrae	600.00	4320.00	400.00	2880.00	5.00	T	220.00
6211	Thoracic vertebrae	600.00	4320.00	400.00	2880.00	5.00	T	220.00
6212	Lumbar vertebrae	600.00	4320.00	400.00	2880.00	5.00	T	220.00
6213	Sacrum.	600.00	4320.00	400.00	2880.00	5.00	T	220.00
	Magnetic Resonance Angiography **(See modifiers 6106 to 6108)**							
	Contrast Medium:							
6260	Current price according to the regular price list published by the Radiological Society of S A.							
	Low Field Strength Peripheral Joint Magnetic Resonance Imaging							
6270	Low field strength peripheral joint examination (feet, knees, hands, and elbows), in dedicated limb units not able to perform body, spine, or head examinations	105.00	756.00	70.00	504.00	5.00	T	220.00
20	**Radiation Oncology**							

Code	PROCEDURES	SPECIALISTS RADIOLOGIST		OTHER SPECIALISTS GENERAL PRACTITIONER		ANAESTHETIC	
		UNITS	N$	UNITS	N$	UNITS	N$
	Note : The calculated amounts in this section are calculated according to the radiotherapy unit values						
	Modifiers applicable to this section of the Tariff: 0093, 0094						
20.1	**Kilovolt therapy:**						
	Rule governing this sub-section of the Tariff: BB						
3657	First field (single field)	10.00	85.00				
5921	Kilovolt therapy (single field) maximum three areas to be charged per treatment session - TECHNICAL COMPONENT	20.00	170.00				
3658	Kilovolt therapy (multiple fields)	18.00	153.00				
5922	Kilovolt therapy (multiple fields) - maximum three areas to be charged per treatment session - TECHNICAL COMPONENT	36.00	306.00				

21. PATHOLOGY

DIAGNOSTIC PROCEDURES

Note: The tariff fees in this section are calculated according to the clinical pathology unit values. For tariffs for Histology and Cytology refer to items 4561-4593 under section 22: Anatomical Pathology.

MODIFIERS GOVERNING THIS SECTION OF THE TARIFF

0097 Where items under Pathology and Anatomical Pathology fall within the province of other specialists or general practitioners, the fee is to be charged at two-thirds of the pathologists' fee.

0099 For tests performed on a stat basis, an additional premium of 50% of the fee for the particular pathology service shall apply, with the following provisos:

(i) Stat tests requesting may only be done by the referring practitioner and not by the pathologist.

(ii) Specimen must be collected on a stat basis where applicable

(iii) Tests must be performed on a stat basis.

(iv) Documentation (or copy thereof) relating to the stat request of the referring practitioner must be retained

(v) This modifier will only apply during normal working hours and shall not be used in combination with item 4547.

Please note: Item 0201 may not be used together with any pathology item.

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3712	Antibody identification.	8.45	68.50	5.65	45.80
3713	Bleeding time (does not include the cost of the simplate device)	6.94	56.20	4.63	37.50
3715	Buffy layer examination.	19.90	161.20	13.27	107.50
3717	Bone marrow cytological examination only	19.90	161.20	13.27	107.50
3719	Bone marrow: Aspiration	8.40	68.00	5.60	45.40
3720	Bone marrow trephine biopsy.	32.60	264.10	21.70	175.80
3721	Bone marrow aspiration and trephine biopsy (excluding histology)	36.80	298.10	24.50	198.50
3722	Capillary fragility: Hess	2.02	16.40	1.35	11.00
3723	Circulating anticoagulants	5.85	47.40	3.90	31.60
3724	Coagulation factor inhibitor assay	57.56	466.20	38.37	310.80
3725	Clot retraction.	1.80	14.60	1.20	9.80
3726	Activated protein C resistance	26.00	210.60	17.30	140.10
3727	Coagulation time.	3.16	25.60	2.11	17.10
3728	Anti-factor Xa Activity	53.60	434.20	35.73	289.40
3729	Cold agglutinins.	3.60	29.20	2.40	19.40
3730	Protein S: Functional.	37.50	303.80	25.00	202.50
3731	Compatibility for blood transfusion	3.60	29.20	2.40	19.40
3733	Donath-Landsteiner: Qualitative	3.60	29.20	2.40	19.40
3734	Protein C (chromogenic)	30.29	245.40	20.19	164.50
3739	Erythrocyte count.	2.25	18.20	1.50	12.20
3740	Factors V and VII: Qualitative	7.20	58.30	4.80	38.90
3741	Coagulation factor assay: Functional	9.45	76.60	6.30	51.00
3742	Coagulation factor assay: Immunological	4.50	36.40	3.00	24.30
3743	Erythrocyte sedimentation rate.	2.50	20.30	1.67	13.50
3744	Fibrin stabilizing factor (urea test)	4.50	36.50	3.00	24.30
3745	Fibrinolysin.	4.50	36.50	3.00	24.30
3746	Fibrin monomers.	2.70	21.90	1.80	14.60

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3747	Folic acid clearance test.	16.20	131.20	10.80	87.50
3748	Plasminogen activator inhibitor (PAI-I)	65.95	534.20	43.97	356.20
3749	Folic acid absorption test.	16.20	131.20	10.80	87.50
3750	Tissue plasminogen Activator (TPA)	67.79	549.10	45.19	366.00
3751	Osmotic fragility (screen).	2.25	18.20	1.50	12.20
3753	Osmotic fragility (before and after incubation)	18.00	145.80	12.00	97.20
3755	Full blood count (including items 3739, 3762, 3783, 3785, 3791)	10.50	85.10	7.00	56.70
3756	Full cross match.	7.20	58.30	4.80	38.90
3757	Coagulation factors: Quantitative	32.20	260.80	21.47	173.90
3758	Factor VIII related antigen.	60.46	489.70	40.31	326.50
3759	Coagulation factor correction study	11.72	94.90	7.81	63.30
3761	Factor XIII related antigen	61.11	495.00	40.74	330.00
3762	Haemoglobin estimation	1.80	14.60	1.20	9.70
3763	Contact activated product assay	16.20	131.20	10.80	87.50
3764	Grouping: A B and O antigens.	3.60	29.20	2.40	19.40
3765	Grouping: Rh antigens	3.60	29.10	2.40	19.40
3766	PIVKA	43.49	352.20	28.99	234.80
3768	Haemoglobin A2 (column chromatography	15.00	121.50	10.00	81.00
3769	Haemoglobin electrophoresis.	26.82	217.20	17.88	144.80
3770	Haemoglobin-S (solubility test)	3.60	29.10	2.40	19.40
3773	Ham's acidified serum test	8.00	64.80	5.33	43.10
3775	Heinz bodies.	2.25	18.20	1.50	12.20
3776	Haemosiderin in urinary sediment	2.25	18.20	1.50	12.20
3777	Heparin estimation.	24.39	197.60	16.26	131.70
3779	Heparin-protamine titration.	7.20	58.30	4.80	38.90
3781	Heparin tolerance.	7.20	58.30	4.80	38.90
3783	Leucocyte differential count.	6.20	50.20	4.15	33.60

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3785	Leucocytes: total count	1.80	14.60	1.20	9.70
3786	QBC malaria concentration and fluorescent staining	25.00	202.50	16.70	135.30
3787	LE-cells	8.30	67.20	5.55	45.00
3788	Nitro blue tetrazolium leucocyte function	12.60	102.10	8.40	68.00
3789	Neutrophil alkaline phosphatase	28.00	226.80	18.70	151.50
3791	Packed cell volume: Haematocrit	1.80	14.60	1.20	9.70
3792	Plasmodium falciparum: Monoclonal immunological identification	9.00	72.90	6.00	48.60
3793	Plasma haemoglobin.	6.75	54.70	4.50	36.50
3794	Platelet sensitivities	18.64	151.00	12.43	100.70
3795	Platelet aggregation per aggregant	12.14	98.30	8.09	65.50
3796	Platelet antibodies: agglutination	5.40	43.70	3.60	29.10
3797	Platelet count.	2.25	18.20	1.50	12.10
3798	Platelet antibodies: Coombs' consumption	7.20	58.30	4.80	38.90
3799	Platelet adhesiveness	4.50	36.50	3.00	24.30
3801	Prothrombin consumption.	5.85	47.40	3.90	31.60
3803	Prothrombin determination (two stages)	5.85	47.40	3.90	31.60
3805	Prothrombin index.	6.00	48.60	4.00	32.40
3806	Therapeutic drug level: Dosage	4.50	36.50	3.00	24.30
3807	Recalcification time.	2.25	18.20	1.50	12.20
3809	Reticulocyte count	3.00	24.30	2.00	16.20
3811	Sickling test	2.25	18.20	1.50	12.20
3814	Sucrose lysis test for PNH.	3.60	29.20	2.40	19.40
3815	Strypven or reptilase time: each	19.70	159.60	13.13	106.40
3816	T and B-cells EAC markers (per marker)	20.25	164.00	13.50	109.40
3817	Thromboplastin generation.	13.05	105.70	9.00	72.90
3819	Thromboplastin inhibition.	16.20	131.20	10.70	86.70
3820	Thrombo – Elastogram	26.00	210.60	17.33	140.40

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3821	Viscosity: whole blood or plasma	3.60	29.20	2.40	19.40
3825	Fibrinogen titre.	3.60	29.20	2.40	19.40
3827	Fibrindex test.	3.60	29.20	2.40	19.40
3829	Glucose 6-phosphate-dehydrogenase: Qualitative	8.00	64.80	5.33	43.20
3830	Glucose 6-phosphate-dehydrogenase : Quantitative	16.00	129.60	10.70	86.70
3831	Red cell pyruvate kinase: Qualitative	8.00	64.80	5.33	43.10
3832	Red cell pyruvate kinase: Quantitative	16.00	129.60	10.70	86.70
3833	Glutatione: red cells	8.10	65.60	5.40	43.70
3834	Red cell Rhesus phenotype.	9.90	80.20	6.60	53.50
3835	Haemoglobin F in blood smear	5.85	47.40	3.90	31.60
3837	Partial thromboplastin time.	5.85	47.40	3.90	31.60
3839	Plasminogen assay.	12.60	102.10	8.40	68.00
3841	Thrombin time (screen)	7.16	58.00	4.77	38.60
3843	Thrombin time (serial)	7.65	62.00	5.10	41.30
3845	Thromboplastin generation (screen)	11.95	96.80	7.97	64.60
3847	Haemoglobin H.	2.25	18.20	1.50	12.20
3849	Fibrinolysin: diffusion plate.	5.85	47.40	3.90	31.60
3851	Fibrin degradation products (diffusion plate)	10.35	83.80	6.90	55.90
3853	Fibrin degradation products (latex slide)	4.50	36.50	3.00	24.30
3854	XDP (Dimer test or equivalent latex slide test)	8.50	68.90	5.67	45.90
3855	Haemagglutination inhibition.	9.90	80.20	6.60	53.50
3858	Heparin Removal	28.88	233.90	19.25	155.90
21.2	**Microscopic and miscellaneous tests:**				
3863	Autogenous vaccine	12.60	102.10	8.40	68.00
3865	Parasites in blood smear	5.60	45.40	3.73	30.20
3866	Bilharzia: Hatch test.	3.00	24.30	2.00	16.20
3867	Miscellaneous (body fluids urine exudate fungi pus scraping, etc)	4.90	39.70	3.30	26.70

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3868	Fungus identification	8.30	67.20	5.50	44.60
3869	Faeces (including parasites).	4.90	39.70	3.27	26.50
3870	Rectal biopsy.	3.50	28.30	2.35	19.00
3871	Addis count.	5.85	47.40	3.90	31.60
3873	Transmission electron microscopy	85.00	688.50	57.00	461.70
3874	Scanning electron microscopy	100.00	810.00	67.00	542.70
3875	Inclusion bodies.	4.50	36.50	3.00	24.30
3878	Crystal identification polarized light microscopy	4.50	36.50	3.00	24.30
3879	Campylobacter in stool: fastidious culture	9.90	80.20	6.60	53.50
3880	Antigen detection with polyclonal antibodies	4.50	36.50	3.00	24.30
3881	Mycobacteria.	3.00	24.30	2.00	16.20
3882	Antigen detection with monoclonal antibodies	10.80	87.50	7.20	58.30
3883	Concentration techniques for parasites	3.00	24.30	2.00	16.20
3884	Dark field, phase - or interference contrast microscopy, Nomarski or Fontana	6.30	51.00	4.20	34.00
3885	Cytochemical stain.	5.45	44.20	3.65	29.60
21.3	**Bacteriology:**				
4650	Antibiotic MIC per organism per antibiotic	8.00	64.80	5.33	43.20
4651	Non-radiometric automated blood cultures	13.90	112.60	9.27	76.00
4652	Rapid automated bacterial identification per organism	15.00	121.50	10.00	81.00
4653	Rapid automated antibiotic susceptibility per organism	17.00	137.70	11.33	91.80
4654	Rapid automated MIC per organism per antibiotic	17.00	137.70	11.33	91.80
3887	Antibiotic susceptibility test: per organism	8.00	64.80	5.33	43.20
3889	Clostridium difficile toxin : monoclonal immunological	12.40	100.40	8.27	67.00
3890	Antibiotic assay of tissues and fluids	13.90	112.60	9.27	76.00
3891	Blood culture: aerobic.	5.85	47.40	3.90	31.60
3892	Blood culture: anaerobic.	5.85	47.40	3.90	31.60
3893	Bacteriological culture: miscellaneous	6.30	51.00	4.20	34.00

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3894	Radiometric blood culture.	10.80	87.50	7.20	58.30
3896	In vivo culture: bacteria.	16.00	129.60	10.65	86.30
3897	In vivo culture: virus	16.00	129.60	10.65	86.30
3898	Bacterial exotoxin production (in vitro assay)	4.50	36.50	3.00	24.30
3899	Bacterial exotoxin production (in vivo assay)	20.70	167.70	13.80	111.80
3901	Fungal culture	4.50	36.50	3.00	24.30
3903	Antibiotic level: biological fluids	11.70	94.80	7.80	63.20
3905	Identification of virus or rickettsia	20.70	167.70	13.80	111.80
3906	Identification: chlamydia	16.00	129.60	10.65	86.30
3907	Culture for staphylococcus aureus	2.25	18.20	1.50	12.20
3908	Anaerobe culture: comprehensive	9.90	80.20	6.60	53.50
3909	Anaerobe culture: limited procedure	4.50	36.50	3.00	24.30
3910	Biological fluid assay: Bact. Stat and percentage killed	11.25	91.10	7.50	60.80
3912	Bacteriophage typing.	4.50	36.50	3.00	24.30
3915	Mycobacterium culture	4.50	36.50	3.00	24.30
3917	Mycoplasma culture: limited.	2.25	18.20	1.50	12.20
3918	Mycoplasma culture: comprehensive	9.90	80.20	6.60	53.50
3919	Identification of mycobacterium.	9.90	80.20	6.60	53.50
3920	Mycobacterium: antibiotic sensitivity	9.90	80.20	6.60	53.50
3921	Antibiotic synergistic study	20.70	167.70	13.80	111.80
3922	Viable cell count.	1.35	10.90	0.90	7.30
3923	Biochemical identification of bacterium: abridged	3.15	25.50	2.10	17.00
3924	Biochemical identification of bacterium: extended	12.50	101.30	8.33	67.50
3925	Serological identification of bacterium: abridged	3.15	25.50	2.10	17.00
3926	Serological identification of: bacterium: extended	10.20	82.60	6.80	55.10
3927	Grouping for streptococci.	7.30	59.10	4.85	39.30
3928	Antimicrobic substances	3.80	30.80	2.50	20.30

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3929	Radiometric mycobacterium identification	14.00	113.40	9.30	75.30
3930	Radiometric myobacterium antibiotic sensitivity	25.00	202.50	16.70	135.30
21.4	**Serology:**				
3933	IgE: total: EMIT or ELISA.	11.70	94.80	7.80	63.20
3934	Auto antibodies by labelled antibodies	16.00	129.60	10.65	86.30
3938	Precipitation test per antigen.	4.50	36.50	3.00	24.30
3939	Agglutination test per antigen.	5.50	44.60	3.67	29.80
3940	Haemagglutination test: per antigen	9.90	80.20	6.60	53.50
3941	Modified Coombs' test for brucellosis	4.50	36.50	3.00	24.30
3943	Antibody titer to bacterial exotoxin	3.60	29.20	2.40	19.40
3944	IgE: specific antibody titer: ELISA/EMIT: per Ag	12.40	100.40	8.27	67.00
3945	Complement fixation test.	5.85	47.40	3.90	31.60
3946	IgM: specific antibody titer: ELISA/EMIT: Per AG	14.05	113.80	9.37	75.90
3947	C-reactive protein.	3.60	29.20	2.40	19.40
3948	IgG: specific antibody titer: ELISA/EMIT: per Ag	12.95	104.90	8.63	69.90
3949	Qualitative Kahn, VDRL or other flocculation	2.25	18.20	1.50	12.20
3950	Neutrophil phagocytosis.	25.20	204.10	16.80	136.10
3951	Quantitative Kahn, VDRL or other flocculation	3.60	29.20	2.40	19.40
3952	Neutrophil chemotaxis.	67.95	550.40	45.30	366.90
3953	Tube agglutination test.	4.15	33.60	2.76	22.40
3954	Neutrophil killing ability.	36.00	291.60	24.00	194.40
3955	Paul Bunnell: presumptive.	2.25	18.20	1.50	12.20
3956	Infectious mononucleosis latex slide test (Monospot or equivalent)	8.50	68.90	5.67	45.90
3957	Paul Bunnell: absorption.	4.50	36.50	3.00	24.30
3961	Slide agglutination test.	2.63	21.30	1.75	14.20
3962	Rebuck skin window	5.40	43.70	3.60	29.20
3963	Serum complement level: each component	3.15	25.50	2.10	17.00

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
3964	Stimulated NBT test	6.30	51.00	4.20	34.00
3967	Auto-antibody: sensitized erythrocytes	4.50	36.40	3.00	24.30
3969	Western blot technique	74.00	599.40	49.00	396.90
3970	Epstein-Barr virus antibody titer	6.75	54.70	4.50	36.50
3971	Immuno-diffusion test: per antigen	3.15	25.50	2.10	17.00
3973	Immuno electrophoresis: per immune serum	9.45	76.60	6.30	51.00
3975	Indirect immuno-fluorescence test (bacterial, viral, parasitic)	12.00	97.20	8.00	64.80
3976	LIF or MIF production: per stimulant	78.70	637.50	52.50	425.30
3977	Counter immuno-electrophoresis	6.75	54.70	4.50	36.50
3978	Lymphocyte transformation.	51.70	418.80	34.50	279.50
4601	Panel typing: antibody detection: Class I	36.00	291.60	24.00	194.40
4602	Panel typing: antibody detection: Class II	44.00	356.40	29.30	237.30
4607	Crossmatching T-cells (per tray)	18.00	145.80	12.00	145.80
4608	Crossmatching B-cells.	38.00	307.80	25.30	281.10
4609	Crossmatching T- & B-cells.	48.00	388.80	32.00	281.10
21.5	**Skin tests:**				
	For skin-prick allergy tests, please refer to items 0218, 0220 and 0221 in Section 2: Integumentary Section				
21.6	**Biochemical tests: Blood**				
3991	Abnormal pigments: Qualitative	4.50	36.50	3.00	24.30
3993	Abnormal pigments: Quantitative	9.00	72.90	6.00	48.60
3995	Acid phosphatase.	5.18	42.00	3.45	28.00
3997	Acid phosphatase fractionation	1.80	14.60	1.20	9.70
3998	Amino acids Quantitative (Post derivatisationHPLC)	78.12	632.77	52.08	421.90
3999	Albumin	4.80	38.90	3.20	25.90
4000	Alcohol	12.40	100.40	8.27	67.00
4001	Alkaline phosphatase.	5.18	42.00	3.45	28.00

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4002	Alkaline phosphatase-iso-enzymes	11.70	94.80	7.80	63.20
4003	Ammonia: enzymatic.	7.71	62.50	5.14	41.60
4004	Ammonia: monitor.	4.50	36.50	3.00	24.30
4005	Alpha-1-antitrypsin.	7.20	58.30	4.80	38.90
4006	Amylase	5.18	42.00	3.45	28.00
4007	Arsenic in blood, hair or nails	36.25	293.60	24.17	195.80
4009	Bilirubin: total.	4.77	38.60	3.18	25.80
4010	Bilirubin: conjugated.	3.62	29.30	2.41	19.50
4014	Cadmium: atomic absorption.	18.12	146.80	12.08	97.90
4016	Calcium: ionized .	6.75	54.70	4.50	36.50
4017	Calcium: spectrophotometric.	3.62	29.30	2.41	19.50
4018	Calcium: atomic absorption	7.25	58.70	4.83	39.10
4019	Carotene	2.25	18.20	1.50	12.20
4023	Chloride	2.59	21.00	1.73	14.00
4027	Cholesterol total.	5.34	43.30	3.56	28.90
4028	HDL cholesterol.	6.90	55.90	4.60	37.30
4029	Cholinesterase: serum or erythrocyte: each	7.48	60.60	4.99	40.40
4030	Cholinesterase phenotype (Dibucaine or fluoride each)	9.00	72.90	6.00	48.60
4031	Total CO2	5.18	42.00	3.45	28.00
4032	Creatinine.	3.62	29.30	2.41	19.50
4040	Homocysteine (random).	15.30	123.90	10.20	82.60
4041	Homocysteine (after Methionine load)	18.10	146.60	12.06	97.70
4042	D-Xylose absorption test: two hours	13.15	106.50	8.75	70.90
4045	Fibrinogen: Quantitative	3.60	29.10	2.40	19.40
4047	Hollander test	24.75	200.50	16.50	133.70
4049	Glucose tolerance test (2 specimens)	8.97	72.70	5.98	48.40
4050	Glucose strip-test with photometric reading	1.80	14.60	1.20	9.80

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4051	Galactose.	11.25	91.10	7.50	60.80
4052	Glucose tolerance test (3 specimens)	13.17	106.70	8.78	71.10
4053	Glucose tolerance test (4 specimens)	17.37	140.70	11.58	93.80
4057	Glucose: Quantitative.	3.62	29.30	2.41	19.50
4061	Glucose tolerance test (5 specimens)	21.56	174.60	14.37	116.40
4064	Glycosylated haemoglobin: chromatography	7.20	58.30	4.80	38.90
4067	Lithium: flame ionization.	5.18	42.00	3.45	28.00
4068	Lithium: atomic absorption.	7.48	60.60	4.99	40.40
4071	Iron	6.75	54.70	4.50	36.50
4073	Iron-binding capacity.	7.65	62.00	5.10	41.30
4075	Blood gases: Panel 1: Astrup/pO2. This panel includes items 4077, 4078 and 4121.	22.00	178.20	14.67	118.80
4076	Blood gases: Panel 2: Panel 1 (4075) & ancillary tests. This item also includes items 4077, 4078, 4121, calcium: ionized, Na, K, Glucose, Hb. Item 4076 may be billed once or twice to a maximum of twice per day. The combined items 4075 and 4076 may only be billed to a maximum of 8 times per day.	34.00	1577.90	22.67	1052.20
4078	Oximetry analysis: MetHb, COHb O2Hb RHb SulfHb	6.75	54.70	4.50	36.50
4079	Ketones in plasma: Qualitative	2.25	18.20	1.50	12.20
4081	Drug level-biological fluid: Quantitative	10.80	87.40	7.20	58.30
4085	Lipase	5.18	42.00	3.45	28.00
4091	Lipoprotein electrophoresis.	9.00	72.90	6.00	48.60
4093	Osmolality: serum or urine	6.75	54.70	4.50	36.50
4094	Magnesium: spectrophotometric	3.62	29.30	2.41	19.50
4095	Magnesium: atomic absorption.	7.25	58.70	4.83	39.10
4096	Mercury: atomic absorption.	18.12	146.80	12.08	97.90
4097	Copper: spectrophotometric.	3.62	29.30	2.41	19.50
4098	Copper: atomic absorption.	18.12	146.80	12.08	97.90

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4105	Protein electrophoresis.	9.00	72.90	6.00	48.60
4106	IgG sub-class 1,2,3 or 4: Per sub-class	20.00	162.00	13.20	106.90
4109	Phosphate	3.62	29.30	2.41	19.50
4111	Phospholipids.	3.15	25.50	2.10	17.00
4113	Potassium	3.62	29.30	2.41	19.50
4114	Sodium.	3.62	29.30	2.41	19.50
4117	Protein: total.	3.11	25.20	2.07	16.80
4121	pH, pCO2 or pO2: each.	6.75	54.70	4.50	36.50
4123	Pyruvic acid.	4.50	36.50	3.00	24.30
4125	Salicylates.	4.50	36.50	3.00	24.30
4126	Secretin-pancreozymin response	26.10	211.40	17.40	140.90
4127	Caeruloplasmin.	4.50	36.50	3.00	24.30
4128	Phenylalanine: Quantitative.	11.25	91.10	7.50	60.80
4129	Glutamate dehydrogenase (GDH).	5.40	43.70	3.60	29.20
4130	Aspartate aminotransferase (AST).	5.40	43.70	3.60	29.20
4131	Alanine aminotransferase (ALT).	5.40	43.70	3.60	29.20
4132	Creatine kinase (CK)	5.40	43.70	3.60	29.20
4133	Lactate dehydrogenase (LD)	5.40	43.70	3.60	29.20
4134	Gamma glutamyl transferase (GGT).	5.40	43.70	3.60	29.20
4135	Aldolase.	5.40	43.70	3.60	29.20
4136	Angiotensin converting enzyme (ACE).	9.00	72.90	6.00	48.60
4137	Lactate dehydrogenase isoenzyme	10.80	87.50	7.20	58.30
4139	Adenosine deaminase.	5.40	43.80	3.60	29.20
4142	Red cell enzymes: each.	7.80	63.20	5.20	42.10
4143	Serum/plasma enzymes: each.	5.40	43.70	3.60	29.20
4144	Transferrin.	11.70	94.80	7.80	63.20
4145	Lead: spectrophotometric.	4.50	36.50	3.00	24.30

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4146	Lead: atomic absorption.	15.00	121.50	10.00	81.00
4147	Triglyceride	7.93	64.20	5.29	42.90
4151	Urea.	3.62	29.30	2.41	19.50
4154	Myoglobin quantitative: monoclonal immunological	12.40	100.40	8.27	67.00
4155	Uric acid.	3.78	30.60	2.52	20.40
4157	Vitamin A-saturation test.	15.30	123.90	10.20	82.60
4158	Vitamin E (tocopherol).	3.60	29.20	2.40	19.40
4159	Vitamin A.	6.30	51.00	4.20	34.00
4160	Vitamin C (ascorbic acid).	2.25	18.20	1.50	12.20
4171	Sodium + potassium + chloride + CO2 + urea	15.84	128.30	10.56	85.50
4172	ELISA/EMIT technique	12.42	100.60	8.28	67.10
4181	Quantitative protein estimation: Mancini method	7.76	62.90	5.17	41.90
4182	Quantitative protein estimation: nephelometer or turbidometeric method	8.28	67.10	5.52	44.70
4183	Quantitative protein estimation: labelled antibody	12.42	100.60	8.28	67.10
4185	Lactose	10.80	87.50	7.20	58.30
4187	Zinc: atomic absorption.	18.12	146.80	12.08	97.90
21.7	**Biochemical tests: Urine**				
4188	Urine dipstick, per stick (irrespective of the number of tests on stick)	1.50	12.20	1.00	8.10
4189	Abnormal pigments.	4.50	36.50	3.00	24.30
4193	Alkapton test: homogentisic acid	4.50	36.50	3.00	24.30
4194	Amino acids: Quantitative (Post derivatisation HPLC)	78.12	632.80	52.08	421.90
4195	Amino laevulinic acid.	18.00	145.80	12.00	97.20
4197	Amylase.	5.18	42.00	3.45	28.00
4198	Arsenic	18.12	146.80	12.08	97.90
4199	Ascorbic acid.	2.25	18.20	1.50	12.20

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4201	Bence-Jones protein.	2.70	21.90	1.80	14.60
4202	Bence-Jones protein: Bradshaw's test	2.25	18.20	1.50	12.20
4203	Phenol	3.60	29.20	2.40	19.40
4204	Calcium: atomic absorption	7.25	58.70	4.83	39.10
4205	Calcium: spectrophotometric	3.62	29.30	2.41	19.50
4206	Calcium: absorption and excretion studies	25.00	202.50	16.70	135.30
4207	Catecholamines fluorimetric screen test	11.25	91.10	7.50	60.80
4209	Lead: atomic absorption.	15.00	121.50	10.00	81.00
4211	Bile pigments: Qualitative.	2.25	18.20	1.50	12.20
4213	Protein: Quantitative.	2.25	18.20	1.50	12.20
4214	Mercury.	7.25	58.70	4.83	39.10
4216	Mucopolysaccharides: Qualitative	3.60	29.20	2.40	19.40
4217	Oxalate/Citrate: enzymic each.	9.38	76.00	6.25	50.60
4218	Glucose: Quantitative.	2.25	18.20	1.50	12.20
4219	Steroids: chromatography (each)	7.20	58.30	4.80	38.90
4221	Creatinine.	3.62	29.30	2.41	19.50
4223	Creatinine clearance.	7.65	62.00	5.10	41.30
4225	Xylose	3.15	25.50	2.10	17.00
4227	Electrophoresis: Qualitative.	4.50	36.50	3.00	24.30
4229	Uric acid clearance.	7.65	62.00	5.10	41.30
4237	5-Hydroxy-indole-acetic acid: Screen test	2.70	21.90	1.80	14.60
4239	5-Hydroxy-indole-acetic acid: Quantitative	6.75	54.70	4.50	36 50
4245	Vitamin A-screen test.	5.40	43.70	3.60	29.20
4247	Ketones: excluding dip-stick method	2.25	18.20	1.50	12.20
4248	Reducing substances.	1.80	14.60	1.20	9.80
4249	Melanogen (melanin).	4.50	36.50	3.00	24.30
4251	Metanephrines: column chromatography	22.05	178.60	14.70	119.10

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4253	Aromatic amines (gaschromatography/mass spectrophotometry)	27.00	218.70	18.00	145.80
4254	Nitrosonaphtol test for tyrosine	2.25	18.20	1.50	12.20
4263	pH: Excluding dip-stick method	.90	7.30	.60	4.90
4265	Thin layer chromatography: one way	6.75	54.70	4.50	36.50
4266	Thin layer chromatography: two way	11.25	91.10	7.50	60.80
4267	Total organic matter screen: infrared	31.25	253.10	20.83	168.70
4268	Organic acids: Quantitative: GCMS	109.38	886.00	72.92	590.70
4269	Phenylpyruvic acid: ferric chloride	2.25	18.20	1.50	12.20
4271	Phosphate excretion index.	22.05	178.60	14.70	119.10
4283	Magnesium: spectrophotometric	3.62	29.30	2.41	19.50
4284	Magnesium: atomic absorption	7.25	58.70	4.83	39.10
4285	Identification of carbohydrate.	7.65	62.00	5.10	41.30
4287	Identification of drug: Qualitative	4.50	36.50	3.00	24.30
4288	Identification of drug: Quantitative	10.80	87.50	7.20	58.30
4293	Urea clearance	5.40	43.70	3.60	29.20
4297	Copper: spectrophotometric.	3.62	29.30	2.41	19.50
4298	Copper: atomic absorption	18.12	146.80	12.08	97.90
4299	Indoles: Quantitative.	6.75	54.70	4.50	36.50
4300	Indican or indole: Qualitative.	3.15	25.50	2.10	17.00
4301	Chloride	2.59	21.00	1.73	14.00
4307	Ammonium chloride loading test	22.05	178.60	14.70	119.10
4309	Urobilinogen: Quantitative.	6.75	54.70	4.50	36.50
4313	Phosphate.	3.62	29.30	2.41	19.50
4315	Potassium.	3.62	29.30	2.41	19.50
4316	Sodium.	3.62	29.30	2.41	19.50
4319	Urea.	3.62	29.30	2.41	19.50
4321	Uric acid.	3.62	29.30	2.41	19.50

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4322	Fluoride.	5.18	42.00	3.45	28.00
4323	Total protein and protein electrophoresis	11.25	91.10	7.50	60.80
4325	VMA: Quantitative.	11.25	91.10	7.50	60.80
4327	Immunofixation: Total protein IgG, IgA, IgM, Kappa, Lambdal	46.88	379.70	31.25	253.10
4335	Cystine: Quantitative.	12.60	102.10	8.40	68.00
4336	Dinitrophenol hydrazine test: ketoacids	2.25	18.20	1.50	12.20
4337	Hydroxyproline: Quantitative	18.90	153.10	12.60	102.10
4338	Hydroxyproline: Qualitative.	6.75	54.70	4.50	36.50
21.8	**Biochemical tests: Faeces**				
4339	Chloride.	2.59	21.00	1.73	14.00
4343	Fat: Qualitative.	3.15	25.50	2.10	17.00
4345	Fat: Quantitative.	22.05	178.60	14.70	119.10
4347	pH.	.90	7.30	.60	4.90
4351	Occult blood: chemical test.	2.25	18.20	1.50	12.20
4352	Occult blood: Monoclonal antibodies	10.00	81.00	6.67	54.00
4357	Potassium.	3.62	29.30	2.41	19.50
4358	Sodium.	3.62	29.30	2.41	19.50
4361	Stercobilin.	2.25	18.20	1.50	12.20
4363	Stercobilinogen: Quantitative.	6.75	54.70	4.50	36.50
4365	Tryptic activity: digestive.	2.25	18.20	1.50	12.20
21.9	**Biochemical tests: Miscellaneous**				
4370	Drug level in biological fluid: monoclonal immunological	12.40	100.44	8.27	67.00
4371	Amylase in exudate.	5.18	42.00	3.45	28.00
4372	Fluoride in biological fluids and water	15.62	126.50	10.41	84.30
4374	Trace metals in biological fluid: atomic absorption	18.13	146.90	12.09	97.90
4375	Calcium in fluid: spectrophotometric	3.62	29.30	2.41	19.50
4376	Calcium in fluid: atomic absorption	7.25	58.70	4.83	39.10

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4388	Gastric contents: maximal stimulation test	27.00	218.70	18.00	145.80
4389	Gastric fluid: total acid per specimen	2.25	18.20	1.50	12.20
4391	Renal calculus: chemistry.	5.40	43.70	3.60	29.20
4392	Renal calculus: crystallography.	16.25	131.60	10.80	87.50
4393	Saliva: potassium.	3.62	29.30	2.41	19.50
4394	Saliva: sodium	3.62	29.30	2.41	19.50
4395	Sweat:sodium.	3.62	29.30	2.41	19.50
4396	Sweat: potassium.	3.62	29.30	2.41	19.50
4397	Sweat: chloride.	2.59	21.00	1.73	14.00
4399	Sweat collection by iontophoresis (excluding collection material)	4.50	36.50	3.00	24.30
4400	Tryptophane loading test.	22.05	178.60	14.70	119.10
21.10	**Cerebrospinal fluid:**				
4401	Cell count	3.45	28.00	2.30	18.60
4407	Cell count, protein, glucose and chloride	7.65	62.00	5.10	41.30
4409	Chloride	2.59	21.00	1.73	14.00
4415	Potassium.	3.62	29.30	2.41	19.50
4416	Sodium.	3.62	29.30	2.41	19.50
4417	Protein: Qualitative.	.90	7.30	.60	4.90
4419	Protein: Quantitative.	3.11	25.20	2.07	16.80
4421	Glucose.	3.62	29.30	2.41	19.50
4423	Urea	3.62	29.30	2.41	19.50
4425	Protein electrophoresis	12.60	102.10	8.40	68.00
21.12	**Immunology:**				
4466	Beta-2-microglobulin.	12.42	100.60	8.28	67.10
4479	Vitamin B12-absorption: Shilling test	11.70	94.80	7.80	63.20
4480	Serotonin.	18.75	151.90	12.50	101.30

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
4481	Thyroxine (T4).	12.42	100.60	8.28	67.10
4482	Free thyroxine (FT4).	17.48	141.60	11.65	94.40
4483	T3-resin uptake	8.10	65.60	5.40	43.80
4485	Insulin	12.42	100.60	8.28	67.10
4491	Vitamin B12.	12.42	100.60	8.28	67.10
4493	Drug concentration: Quantitative	12.42	100.60	8.28	67.10
4499	Cortisol.	12.42	100.60	8.28	67.10
4500	DHEA sulphate	12.42	100.60	8.28	67.10
4507	Thyrotropin (TSH).	19.60	158.80	13.07	105.90
4509	Free tri-iodothyronine (FT3).	17.48	141.60	11.65	94.40
4510	Total tri-iodotironien (T3).	12.42	100.60	8.28	67.10
4511	Renin activity.	18.90	153.10	12.60	102.10
4516	Follitropin (FSH)	12.42	100.60	8.28	67.10
4517	Lutropin (LH).	12.42	100.60	8.28	67.10
4523	ACTH.	21.74	176.10	14.49	117.40
4528	Ferritin.	12.42	100.60	8.28	67.10
4531	Hepatitis: per antigen or antibody	14.49	117.40	9.66	78.30
4533	Folic acid.	12.42	100.60	8.28	67.10
4535	Unsaturated iron binding capacity	12.42	100.60	8.28	67.10
4536	Erythrocyte folate.	17.48	141.60	11.65	94.40
4537	Prolactin.	12.42	100.60	8.28	67.10
21.13	**Miscellaneous:**				
4544	Attendance in theatre	27.00	218.70		
4547	After hour services: Monday to Friday 17h00 to 7h00, Saturday 13h00 to Monday 07h00 and public holidays				
	Tariff + 50%				
4548	Minimum fee: normal hours	3.00	24.30		
4555	Where pharmacological preparations (hormones, etc) are administered as part of metabolic function tests, the cost of such				

Code	PROCEDURE	PATHOLOGISTS		OTHER SPECIALISTS GENERAL PRACTITONERS	
		UNITS	N$	UNITS	N$
	preparation shall be charged separately				
22.	**ANATOMICAL PATHOLOGY**				
	Please note: The tariff fees in this section are calculated according to the Anatomical Pathology unit values.				
22.1	**Exfoliative cytology:**				
	SPUTUM, ALL BODY FLUIDS AND TUMOUR ASPIRATES:				
4561	First unit.	13.40	111.20	8.90	73.90
4563	Each additional unit.	7.80	64.70	5.20	43.20
4564	Perfomance of fine-needle aspiration for cytology	15.00	124.50		
4565	Examination of fine needle aspiration in theatre	49.00	406.70	32.70	271.40
22.2	**Histology:**				
4567	Histology per sample/specimen each	20.00	166.00	13.30	110.40
4571	Histology per additional block, each	11.60	96.30	7.70	63.90
4575	Histology and frozen section in laboratory	22.70	188.40	15.10	125.30
4577	Histology and frozen section in theatre	49.00	406.70	32.70	271.40
4578	Second and subsequent frozen sections, each	20.00	166.00	13.40	111.20
4579	Attendance in theatre - no frozen section performed	26.30	218.30	17.50	145.30
4582	Serial step sections (including item 4567)	23.30	193.40	15.60	129.50
4584	Serial step sections per additional block, each	13.50	122.10	9.00	74.70
4587	Histology consultation.	10.10	83.80	6.70	55.60
4589	Special stains.	6.70	55.60	4.50	37.40
4591	Immunofluorescence studies.	20.70	171.80	13.80	114.50
4593	Electron microscopy.	94.00	780.20	63.00	522.90

IV. TRAVELLING EXPENSES
RULES GOVERNING THIS SECTION OF THE TARIFF:

P. (a) Where, in case of emergency, a practitioner was called out from his residence or rooms to an employee's home or the hospital, travelling fees can be charged according to section IV if he/she had to travel more than 16 kilometres in total.

(b) If more than one injured employee would be attended to during the course of a trip, the full travelling expenses must be divided pro rata between the relevant employees.

(c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his/her rooms.

(d) Where a practitioner's residence would be more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such hospitals, except in cases of emergency (services not voluntarily scheduled).

(e) Where a practitioner conducts an itinerant practice, he/she is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled).

TRAVELLING COSTS AND/OR TRAVELLING TIME

When in cases of emergency (refer to general rule P), a medical or dental practitioner has to travel more than 16 kilometers in total to visit an employee inured on duty, travelling costs and/or travelling time can be charged and shall be calculated as follows:

Consultation, visit or surgical fee plus

5001 Cost of public transport and travelling time or item 5003.

5003 N$ 1.50 for each kilometre in excess of 16 kilometres total travelled in own car. The fees shall be calculated as follows, where a practitioner has to travel 19 kilometres in total: 19 – 16 = 3 x 1.50 = N$ 4.50.
Note: Travelling time *is o*nly applicable when public transport is used.

5005 Specialist: 18 clinical procedure units (N$163.80) per hour or part thereof.

5007 General practitioner: 12 clinical procedure units (N$109.20) per hour of part thereof.

5009 After hours: Specialist: 27 clinical procedure units (N$245.10) per hour or part thereof.

5010 After hours: General Practitioner: 18 clinical procedure units (N$163.80) per hour or part thereof.

5013 Travelling fees are not payable to medical practitioners when they travel from a distance to assist at an operation on cases referred to surgeons by them.

"ANNEXURE A: FORMS" FORM E.CL.2

PART A PAGE 1

EMPLOYEES COMPENSATION ACT, 1941
(Section 51 - Regulation 9(2) - Annexure 10)
EMPLOYERS' REPORT OF ACCIDENT

(For official use only)
Claim No .....

DECLARATION BY EMPLOYER

I hereby declare that the particulars, shown in items 1 to 13 of this report, of an alleged injury on duty, are to the best of my knowledge and belief true and accurate.

Signed on this ..... day of ..... 20 ....

IMPORTANT ➡ Capacity ..... **SIGNATURE OF EMPLOYER**

1. EMPLOYER:

Registered name with the Socia
Security Commission (block letters) .....
Postal Address ..... Town/City .....
Residential Address ..... Telephone ..... Fax No .....
Nature of business, trade or industry .....
Plant, or particular section in which employee is employed .....
Situation of business/farm/region .....
Your registration number as allocated by the SocialSecurity Commission to this Business/Farming/ Household undertaking must be filled in. ➡

REGISTRATION NO.										

2. EMPLOYEE:

Surname (block letters) ..... Social Security No.: .....
First names (block letters) .....
Residential Address .....
..... Postal code .....
Identity No ..... Company No./Sal.Ref. No.: .....
Date of birth ..... Sex ..... Married or Single ..... Occupation .....

EARNINGS (at the time of the accident):

		If paid per WEEK N$	If paid per MONTH N$
(a)	Gross cash earnings including average payments for overtime and or commission of a constant character		
(b)	Allowances of a recurrent nature		
	(i) Bonuses		
	(ii) Other allowance (specify nature)		
	.....		
(c)	Cash value of free food		
(d)	Cash value of free quarters		

3. ACCIDENT

(a) Date of accident ..... 20 ..... Time .....
(b) Place of accident ..... Region .....
(c) Date employee reported the accident ..... 20 ..... Time .....
(d) How did the accident occur and what was the employee doing at the time? .....
.....
.....
(Describe the accident fully, stating whether the injured person fell or was stuck, etc. and all the factors contributing to the accident).
(e) Was his/her action at the time of the accident in connection with your trade or business? .....
(f) Are you satisfied that the employee was injured in the manner alleged by him/her (If not, please give reasons) .....
(g) Nature of injury sustained by the employee (e.g. broken left leg, index finger or right hand crushed, cut to head or pieces of metal in eye) .....

4. Is the injured person a working director or the owner of, or a partner in the business? .....

PART A PAGE 2 Must also be completed, please.

FORM E.CL.4

EMPLOYEES COMPENSATION ACT, 1941

FIRST MEDICAL REPORT AND ACCOUNT

CLAIM No.: .....

Surname of Employee: .....

First Name(s) .....

Address: .....

Name of Employer: .....

Address: .....

1. Date of Accident: ..... Date of your first consultation: .....
2. How did the alleged accident happen? .....
   .....
3. Full clinical description of Injury(ies) (precision is essential, and technical terms may be used).
   (See pages 3 and 5 of Handbook:) .....
   .....
   .....
4. In your opinion, is the employee's condition due to the accident described in item 2 above? .....
   .....
5. Describe briefly any pre-existing defect(s) or disease - Dates: .....
6. X - Rays Date: ..... By whom: .....
   (Attach report if available)
7. Surgical Procedures or Reduction: Date: ..... By whom: .....

   Brief description: .....
   .....
8. Anaesthetics: Local: ..... General: ..... Duration: ..... By whom: .....
9. (a) Consultation: Yes/No: ..... With whom: ..... Date: .....
   (b) Is physiotherapy ordered? Yes/No: ..... Physiotherapist: .....
10. Is employee unfit for duty? Yes/No: ..... Possible date fit for: Light duty: ..... Normal duty: .....

** A**ccount i.r.p. first consultation or procedure(s)**

Your account No.: ..... Practice No.: .....

Description of service	Place and dates of treatment or visits	Item of tariff	N$	c

I certify that I have by examination, satisfied myself that the injury(ie) of the employees is the result of the accident as described above.

Date (important): .....

.....
Signature of Medical Practitioner

Name (Printed) : .....

Registered address : .....
.....
.....
.....

N.B.: This report must be handed to the injured employee or sent to his/her employer without delay.

**** Please submit separate accounts for further services.**

FORM E.CL.5

EMPLOYEES COMPENSATION ACT, 1941

* FINAL/PROGRESS MEDICAL REPORT

(*Delete which is not applicable)

Surname of injured Employee .....
(BLOCK LETTERS)

Christian Names: .....

Name of Employer: .....

Date of Accident: .....

Describe any operation(s) or procedures carried out and date(s) .....

.....

.....

.....

.....

.....

.....

Prognosis and further treatment? .....

.....

.....

.....

(a) From what date has the employee been fit for his./her normal work? .....

or

(b) On what date is he likely to be fit for his/her normal work? .....

Has the employee's condition become stablised? .....

If so, describe in detail any present permanetn anatomical defect and/or impairment of functions as a result of the accident

.....

.....

.....

.....

.....

.....

.....

.....

.....

Printed name: .....
Address .....
.....
.....

Signature: General Practitioner/Specialist

Date: .....

FORM E.CL.31

Claim No. .....

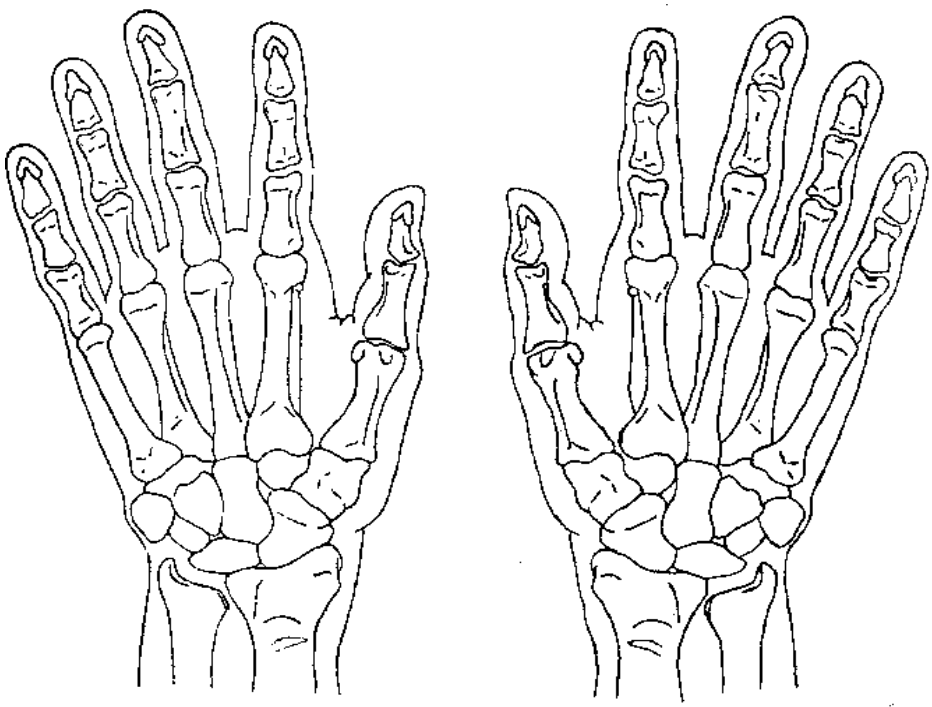
EMPLOYEES COMPENSATION ACT, 1941

SUPPLEMENTARY REPORT ON INJURY TO HAND

Employee ..... Date of Accident .....

Employer .....

NOTE:- Please indicate on the sketch below the exact nature and location of any permanent injury(ies) sustained by the employee



LEFT RIGHT

State whether LEFT or RIGHT hand .....

Remarks .....

Date .....

Address .....

Postal Code .....

.....
Medical Practitioner

FORM E.CL.52

EMPLOYEES COMPENSATION ACT, 1941

FINAL REPORT: EYE INJURIES

Claim No. [ ]

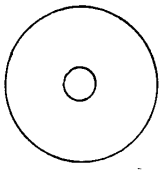
Name of Employee: .....

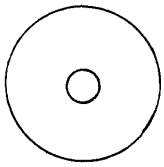
Date of Accident .....

Name of Employer .....

Please give as accurately as possible the final state of eye(s), and indicate clearly on the following diagrams the effect or result of the accident on the present state of the eye(s).

1. RIGHT LEFT





.....

.....

2. VISUAL ACUITY OF EACH EYE SEPARATELY

(a) Without correction of refractive errors

R ..... L .....

(b) Without correction of refractive errors

R ..... L .....

3. In your opinion has the use of glasses become necessary as a result of the injury?
.....

4. When there is damage to eye and/or adnexa with loss of V.E then indicate this, e.g. synblepharon, chronic conjunctivitis, injury to lachrymal apparatus, etc.
.....

5. Were any operations performed? If so, state nature and result
.....

6. (a) From what date has employee been fit for this normal work?
.....

(b) On what date is he likely to be fit for his normal work?
.....

7. If there has been any disturbance ofthe motility of the eye or the field of vision, please describe in detail, and state residual visual efficiency. Relevant diagrams should be attached.
.....
.....

Date: ....
Specialist/Medical Practitioner

FORM E.CL.53

EMPLOYEES COMPENSATION ACT, 1941

DERMATOLOGICAL REPORT

(May be used by Dermatologist in lieu of first medical report, E.C1 4)

Claim No. [ ]

Surname of injured employee (block letters) .....

Christian Name (Names) .....

Name of Employer .....

Date of first consultation or first consultation after recurrence .....

---

1. Employees occupation (and how long so employed) .....
.....

2. Past history with reference to condition .....
.....

3. Present history .....
.....

4. Clinic findings .....
.....

5. Patch tests and results .....
.....

6. Other investigations done .....
.....

7. Diagnosis .....
.....

8. Opinion on attributability of condition .....
.....

9. Treatment .....

10. Date of return to work .....

11. Preventive measures recommended (including comments on any skin cleansers to be used in occupation) .....

Date: ....
General Practitioner/Dermatologist

Registered Address: .....
.....
Code: .....

FORM E.CL.221

EMPLOYEES COMPENSATION ACT, 1941

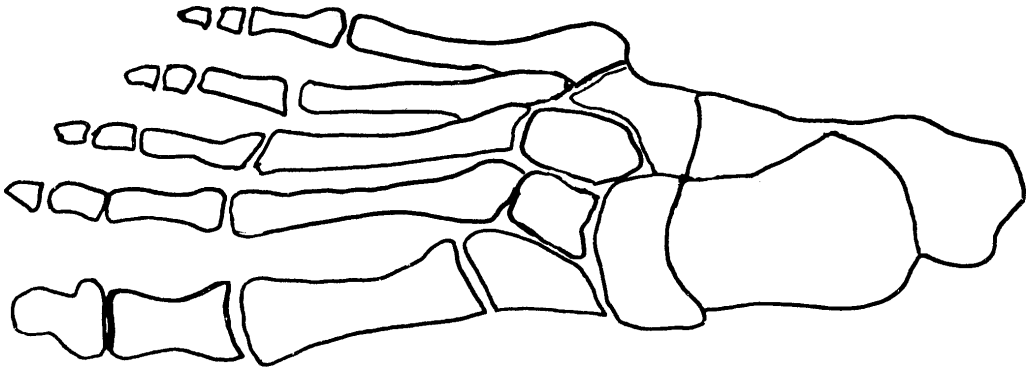
SUPPLEMENTARY REPORT ON INJURY TO FOOT

Claim No .....

Employee ..... Date of accident .....

Employer .....

NOTE:- Please indicate on the sketch below the exact nature and location of any permanent injuries sustained by the employee.



State whether Left or Right foot .....

Remarks .....

.....

.....

.....

Date .....

Address .....

.....

.....

.....

.....
Medical Practitioner