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Contents

DEPARTMENT OF EMPLOYMENT AND LABOUR

GENERAL NOTICE 158 OF 2021

DOCTORS GAZETTE 2021.

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993
(ACT 130 OF 1993 as amended by Act 61 of 1997)

NOTICE ON ANNUAL INCREASE IN MEDICAL TARIFFS PAYABLE UNDER SECTION 76 OF THE COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT AS AMENDED

1.

I, Thembelani Thulas Nxesi, Minister of Employment & Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2021.

2.

Medical Tariffs increase for **2021** is **5.47%**

3.

The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2021** and Exclude **15% Vat.**

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 2021/01/25

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

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

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

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

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

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

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

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

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

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

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

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

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

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

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

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

MINIMUM REQUIREMENTS FOR INVOICE RENDERED

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

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

BILLING PROCEDURE

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

1.1 Medical reports should always have a clear and detailed clinical description of injury and related ICD 10 Code.
1.2 In a case where a surgical procedure is done, an operation report is required
1.3 Only one medical report is required when multiple procedures are done on the same service date
1.4 A medical report is required for every invoice submitted covering every date of service.
1.5 Referrals to another medical service provider should be indicated on the medical report.
1.6 Medical reports, referral letters and all necessary documents should be uploaded on the Compensation Fund claims system.

NOTE: Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.

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

2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.
2.3 Service providers may capture and submit medical invoices directly on the Compensation Fund system online application.

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

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

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

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

6. Service providers should not generate the following:

   a. Multiple invoices for services rendered on the same date i.e. one invoice for medication and a second invoices for other services.
   b. Cumulative invoices – Submit a separate invoice for every month.

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

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

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

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

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

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

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

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

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

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

		Specialist Spesialis		General practitioner Algemene		Anaesthetic Narkose		
		U/E	R	U/E	R	U/E	R	T/M
	RULES GOVERNING THE TARIFF							
	PLEASE NOTE: The interpretations/comments as published in the SAMA Medical Doctors' Coding Manual (MDCM) must also be adhered to when rendering health care services under the Compensation for Occupational Injuries and Diseases Act, 1993							
A.	**Consultations: Definitions**							
	(a) **New and established patients:** A consultation/visit refers to a clinical situation where a medical doctor personally obtains a patient's medical history, performs an appropriate clinical examination and, if indicated, administers treatment, prescribes or assists with advice. These services must be face-to-face with the patient and excludes the time spent doing special investigations which receives additional remuneration							
	(b) **Subsequent visits:** Refers to a voluntarily scheduled visit performed within four (4) months after the first visit. It may imply taking down a medical history and/or a clinical examination and/or prescribing or administering of treatment and/or counselling							
	(c) **Hospital visits:** Where a procedure or operation was done, hospital visits are regarded as part of the normal after-care and not be coded(unless otherwise indicated). Where no procedure or operation was carried out, a hospital visit according to the appropriate hospital or inpatient follow-up visit may be coded.							
B.	**Normal hours and after hours:** Normal working hours comprise the periods 08:00 to 17:00 on Mondays to Fridays, 08:00 to 13:00 on Saturdays, and all other periods voluntarily scheduled (even when for the convenience of the patient) by a medical 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. Services are scheduled involuntarily for a specific time, if for medical reasons the doctor should not render the service at an earlier or later opportunity. Please note: Items 0146 and 0147 (emergency consultations) as well as modifier 0011 (emergency theatre procedures) are only applicable in the after hours period)							
C.	**Comparable services:** The fee that may be charged in respect of the rendering of a service not listed in this tariff of fees or in the SAMA guideline, shall be based on the fee in respect of a comparable service. For procedures/services not in this tariff of fees but in the SAMA guideline, item 6999 (unlisted procedure or service code), should be used with the SAMA code. Motivation for the use of a comparable item must be provided. Note: Rule C and item 6999 may not be used for comparable pathology services (sections 21, 22 and 23)							
D.	**Cancellation of appointments:** Unless timely steps are taken to cancel an appointment for a consultation the relevant consultation fee may be charged. In the case of an injured employee, the relevant consultation fee is payable by the employee.) In the case of a general practitioner "timely" shall mean two hours and in the case of a specialist 24 hours prior to the appointment. Each case shall, however, be considered on merit and, if circumstances warrant, no fee shall be charged. If a patient has not turned up for a procedure, each member of the surgical team is entitled to charge for a visit at or away from doctor's rooms as the case may be							

			Specialist Spesialis		General practitioner Algemene		Anaesthetic Narkose		
			U/E	R	U/E	R	U/E	R	T/M
E.	**Pre-operative visits:**The appropriate consultation may be coded for all pre-operative visits with the exception of a routine pre-operative visit at the hospital, since that routine pre-operative visit is included in the global surgical period for the procedure.								
F.	**Administering of injections and/or infusions:** Where applicable, administering injections and/or infusions may only be coded when done by the medical doctor him-/herself								
G.	**Post-operative care** (a) Unless otherwise stated, the fee in respect of an operation or procedure shall include normal after-care for a period not exceeding FOUR months (after-care is excluded from pure diagnostic procedures during which no therapeutic procedures were performed) ● Tensy anders vermeld, sluit die gelde ten opsigte van 'n operasie of prosedure normale nasorg in oor 'n tydperk wat nie VIER maande oorskry nie (nasorg is uitgesluit van suiwer diagnostiese prosedures waartydens geen terapeutiese prosedures uitgevoer is nie)								
	(b) If the normal after-care is delegated to any other registered health professional and not completed by the surgeon it shall be his/her own responsibility to arrange for the service to be rendered without extra charge								
	(c) When the care of post-operative treatment of a prolonged or specialised nature is required, such fee as may be agreed upon between the surgeon and the Compensation Fund may be charged								
	(d) Normal aftercare refers to uncomplicated post-operative period not requiring any further surgical incision								
	(e) Abnormal aftercare refers to post-operative complications and treatment not requiring any further incisions and will be considered for payment								
H.	**Removal of lesions:** Items involving removal of lesions include follow-up treatment for four months								
I.	**Pathological investigations performed by clinicians:** Fees for all pathological investigations performed by members of other disciplines (where permissible) - refer to modifier 0097: Items that resort under Clinical and Anatomical Pathology: See section for Pathology								
J.	**Disproportionately low fees:** In exceptional cases where the fee is disproportionately low in relation to the actual services rendered by a medical practitioner, a higher fee may be negotiated. 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.	**Services of a specialist, upon referral:** Save in exceptional cases the services of a specialist shall be available only on the recommendation of the attending general practitioner. Medical practitioners referring cases to other medical practitioners shall, if known to them, indicate in the referral letter that the patient was injured in an "accident" and this shall also apply in respect of specimens sent to pathologists								
L.	**Procedures performed at time of visits:** If a procedure is performed at the time of a consultation/visit, the fee for the visit PLUS the fee for the procedure is charged								
M.	**Surgical procedure planned to be performed later:** In cases where, during a consultation/visit, a surgical procedure is planned to be performed at a later occasion, a visit may not be charged for again, at such a later occasion								
N.	**Rendering of accounts for occupational injuries and diseases**								

		Specialist Spesialis		General practitioner Algemene		Anaesthetic Narkose		
		U/E	R	U/E	R	U/E	R	T/M
	(a) "Per consultation": No additional fee may be charged for a service for which the fee is indicated as "per consultation". Such services are regarded as part of the consultation/visit performed at the time the condition is brought to the doctor's attention							
	(b) Where a fee for a service is prescribed in this guideline, the medical practitioner shall not be entitled to payment calculated on a basis of the number of visits or examinations made where such calculation would result in the prescribed fee being exceeded							
	(c) The number of consultations/visits must be in direct relation to the seriousness of the injury and should more than 20 visits be necessary, the Compensation Fund must be furnished with a detailed motivation							
	(d) A single fee for a consultation/visit shall be paid to a medical practitioner for the once-off treatment of an injured employee who thereafter passes into the permanent care of another medical practitioner, not a partner or assistant of the first. The responsibility of furnishing the First Medical Report in such a case rests with the second practitioner							
O.	**Costly or prolonged medical services or procedures** (a) An employee should be hospitalised only when and for the length of period that his condition justifies full-time medical assistance							
	(b) Occupational therapy/Physiotherapy: The same principals as set out in modifier 0077: Two areas treated simultaneously for totally different conditions, will apply when an employee is referred to a therapist							
	(c) In case of costly or prolonged medical services or procedures the medical practitioner shall first ascertain in writing from the Compensation Fund if liability is accepted for such treatment							
P.	**Travelling fees** (a) Where, in cases of emergency, a practitioner was called out from his residence or rooms to a patient's home or the hospital, travelling fees can be charged according to the section on travelling expenses (section IV) if the practitioner had to travel more than 16 kilometres in total							
	(b) If more than one patient is attended to during the course of a trip, the full travelling expenses must be divided between the relevant patients							
	(c) A practitioner is not entitled to charge for any travelling expenses or travelling time to his rooms							
	(d) Where a practitioner's residence is more than 8 kilometres away from a hospital, no travelling fees may be charged for services rendered at such a hospital, except in cases of emergency (services not voluntarily scheduled)							
	(e) Where a practitioner conducts an itinerant practice, he is not entitled to charge fees for travelling expenses except in cases of emergency (services not voluntarily scheduled)							
	INTENSIVE CARE							
	RULES GOVERNING THIS SPECIFIC SECTION OF THE TARIFF CODE							
Q.	**Intensive care/High care:** Units in respect of item codes 1204 to 1210 (Categories 1 to 3) EXCLUDE the following (a) Anaesthetic and/or surgical fees for any condition or procedure, as well as a first consultation/visit fee for the initial assessment of the patient, while the daily intensive care/high care fee covers the daily care in the intensive care/high care unit							
	(b) Cost of any drugs and/or materials							

		Specialist Spesialis		General practitioner Algemene		Anaesthetic Narkose		
		U/E	R	U/E	R	U/E	R	T/M
	(c) Any other cost that may be incurred before, during or after the consultation/visit and/or the therapy (d) Blood gases and chemistry tests, including arterial puncture to obtain specimens (e) Procedural item codes 1202 and 1212 to 1221 **but INCLUDE the following** (f) Performing and interpreting of a resting ECG (g) Interpretation of blood gases, chemistry tests and x-rays (h) Intravenous treatment (item codes 0206 and 0207)							
R.	**Multiple organ failure:** Units for item codes 1208, 1209 and 1210 (Category 3: Cases with multiple organ failure) include item 1211: Cardio-respiratory resuscitation							
S.	**Ventilation:** Units for item codes 1212, 1213 and 1214 (ventilation) include the following (a) Measurement of minute volume, vital capacity, time- and vital capacity studies (b) Testing and connecting the machine (c) Setting up and coupling patient to machine: setting machine, synchronising patient with machine (d) Instruction to nursing staff (e) All subsequent visits for the first 24 hours							
T.	Ventilation (item codes 1212 to 1214) does not form part of normal post-operative care, but may not be added to item code 1204: Catogory 1: Cases requiring intensive monitoring							
	RULES GOVERNING THE SECTION RADIOLOGY: MAGNETIC RESONANCE IMAGING							
NOTE	In the event of Complex medical cases(Poly-trauma, Traumatic Brain injury, Spinal injuries, etc.), the first Radiological investigations(e.g MRI, CT scan, Ultrasound and Angiography), Authorisation will not be required provided there was a valid indication. All second and Subsequent specialised Radiological investigations for Complex medical cases,will need a pre-authorisation. Non-Complex medical cases/elective cases will need pre-authorisation for all specialised radiological invetigations.							
W.	(a) Complete Annexure A and Annexure B, submit report of the investigation and an invoice. (b) Item code 6270 - Proper motivation must be submitted upon which the Compensation Fund will consider approval for payment (Remove)							
	RULES GOVERNING THE SECTION MEDICAL PSYCHOTHERAPY **Note** (a) Prior approval must be obtained from the Compensation Fund before any treatment resorting under this section is carried out (b) Where approval has been obtained, treatment must be limited to 12 sessions only, after which the patient must be referred back to the referring doctor for an evaluation and report to the Compensation Fund							
Va.	**Electro-convulsive treatment:** Visits at hospital or nursing home during a course of electro-convulsive treatment are justified and may be charged for in addition to the fees for the procedure							

			Specialist Spesialis		General practitioner Algemene		Anaesthetic Narkose		
			U/E	R	U/E	R	U/E	R	T/M
Vb.	When adding psychotherapy items to a first or follow-up consultation item, the clinician must ensure that the time stipulated in the psychotherapy items are adhered to (i.e. item 2957 - minimum 10 minutes, item 2974 - minimum 30 minutes, and item 2975 - minimum 50 minutes)								
	RULES GOVERNING THE SECTION RADIOLOGY								
Y.	Except where otherwise indicated, radiologists are entitled to charge for contrast material used								
Z.	No fee is to subject to more than one reduction								
	RULE GOVERNING THE SUBSECTION ON DIAGNOSTIC PROCEDURES REQUIRING THE USE OF RADIO-ISOTOPES								
AA.	Procedures exclude the cost of isotope used								
	RULE GOVERNING THE SECTION RADIATION ONCOLOGY								
BB.	The units in the radiation oncology section do NOT include the cost of radium or isotopes								
	RULE GOVERNING ULTRASOUND EXAMINATIONS								
EE.	(a) In case of a referral, the referring doctor must submit a letter of motivation to the radiologist or other practitioner performing the scan. A copy of the letter of motivation must be attached to the first account rendered to the Compensation Fund by the radiologist								
	(b) In case of a referral to a radiologist, no motivation is required from the radiologist himself								
	RULES GOVERNING THE SECTION URINARY SYSTEM								
FF.	(a) When a cystoscopy precedes a related operation, modifier 0013: Endoscopic examination done at an operation, applies, e.g. cystoscopy followed by transuretral (T U R) prostatectomy								
	(b) When a cystoscopy preceeds an unrelated operation, modifier 0005: Multiple procedures/operations under the same anaesthetic, applies, e.g. cystoscopy for urinary tract infection followed by inguinal hernia repair								
	(c) No modifier applies to item code 1949: Cystoscopy, when performed together with any of item codes 1951 to 1973								
	RULE GOVERNING THE SECTION RADIOLOGY								
GG.	**Capturing and recording of examinations:** Images from all radiological, ultrasound and magnetic resonance imaging procedures must be captured during every examination and a permanent record generated by means of film, paper, or magnetic media. A report of the examination, including the findings and diagnostic comment, must be written and stored for five years.								

This schedule must be used in conjunction with the Radiological Society of S A Guidelines. Please refer to the PET guidelines in Annexure D.

Code Structure Framework
a.The tariff code consists of 5 digits
i.1st digit indicates the main anatomical region or procedural category.
•0 = General (non specific)
•1 = Head
•2 = Neck
•3 = Thorax
•4 = Abdomen and Pelvis (soft tissue)
•5 = Spine, Pelvis and Hips
•6 = Upper limbs
•7 = Lower limbs
•8 = Interventional
•9 = Soft tissue regions (nuclear medicine)
•eg "Head" = 1xxxx

ii.2nd digit indicates the sub region within a main region or category eg.
•"Head / Skull and Brain" = 10xxx

iii.3rd digit indicates modality
•1 = General (Black and White) x-rays
•2 = Ultrasound
•3 = Computed Tomography
•4 = Magnetic Resonance Imaging
•5 = Angiography
•6 = Interventional radiology
•9 = Nuclear Medicine (Isotopes)
eg:
"Head / Skull and Brain / General x-ray" = 101xx

iv.4th and 5th digits are specific to a procedure / examination, eg
"Head / Skull and Brain / General / X-ray of the skull" = 10100.

Guidelines for use of coding structure
•The vast majority of the codes describe complete procedures / examination and their use for the appropriate studies is self-explanatory.
•Some codes may have multiple applications and their use is described in notes associated with each code
•Codes 00510 to 00560 (Angiography machine codes) may only be used by owners of the equipment and who have registered such equipment with the Board of Healthcare Funders / RSSA.
•The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be added to 60540, 60550, 70530, 70535 (Antegrade Venography, upper and lower limbs)
•Where public sector hospital equipment is used for a procedure, the units will be reduced by 33.33%.

Consumables
•Contrast Medium
oPrior to the implementation of Act 90, contrast will be billed according to the official 2004 RSSA reimbursement price list, without mark up.
oAfter the implementation of Act 90, contrast medium will be billed according to the suppliers' list price, without mark up.
•Angiography catheters, angioplasty balloons, stents, coils and other embolisation materials, guide wires and drains are

General Comments on Procedural Codes
•All x-ray tomography codes are stand alone studies and may be used as a unique study or in combination with the appropriate regional study if done simultaneously. May not be added to 20130, 42110, 42115.
•Setting of sterile tray is included in all appropriate procedure codes.
•Where introduction of contrast is necessary eg. sialography, arthrography, angiography, etc, the codes used for the procedures are comprehensive and include the introduction of contrast or isotopes.
•The use of Doppler or Colour Doppler as an adjunct to a study (eg small parts thyroid) is included in the code for that study.
•CT Angiography (10330, 20330, 32300, 32310, 44300, 44310, 44320, 44330, 60310, 70310, 70320) are stand alone studies and may not be added to the regional contrasted studies (see 10335, 20340, 20350, 44325 for combined studies).
•Angiography and interventional procedures include selective and super selective catheterization of vessels as are necessary to perform the procedures.
Codes 00230 (Ultrasound guidance), 00320 (CT guidance) and 00430 (MR guidance) are stand alone procedures that include the regional study and may not be added to any of the ultrasound, CT or MR regional studies

General Codes

Modifiers

00091	Radiology and nuclear medicine services rendered to hospital inpatients
00092	Radiology and nuclear medicine services rendered to outpatients
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used

Equipment / Diagnostic

00090	Consumables used in radiology procedures: cost price PLUS 26% (up to a maximum of R26,00). (Where applicable, VAT should be added to the above).

Appropriate code to be provided. See separate codes for contrast and isotopes

00110	X-ray skeletal survey under five years	6.26

			Other specialist / General Practitioner		Specialist	
			U/E	R	U/E	
00090	Consumables used in radiology procedures					
00091	Radiology and nuclear medicine services rendered to hospital inpatients					
00092	Radiology and nuclear medicine services rendered to outpatients					
00093	A reduction of one third (33.33%) will apply to radiological examinations where hospital equipment it used					
00115	X-ray skeletal survey over five years		-	-	10.40	**2 012.30**
00120	X-ray sinogram any region		-	-	10.89	**2 107.11**
00130	X-ray with mobile unit in other facility		-	-	1.90	**367.63**
	To be added to applicable procedure codes eg 30100.		-	-		
00135	X-ray control view in theatre any region		-	-	5.26	**1 017.76**
00140	X-ray fluoroscopy any region		-	-	2.26	**437.29**
	May only be added to the examination when fluoroscopy is not included in the standard procedure code. May not be added to: • any angiography, venography, lymphangiography or interventional codes. • any contrasted fluoroscopy examination.		-	-		
00145	X-ray fluoroscopy guidance for biopsy, any region		-	-	5.30	**1 025.50**
	Add to the procedure eg. 80600, 80605, 80610.		-	-		
00150	X-ray C-Arm (equipment fee only, not procedure) per half hour		-	-	2.42	**468.25**
	Only to be used if equipment is owned by the radiologist.		-	-		
00155	X-ray C-arm fluoroscopy in theatre per half hour (procedure only)		-	-	2.30	**445.03**
00160	X-ray fixed theatre installation (equipment fee only)		-	-	2.26	**437.29**
	Only to be used if equipment is owned by the radiologist.		-	-		
00190	X-ray examination contrast material		-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.		-	-		
00210	Ultrasound with mobile unit in other facility		-	-	1.84	**356.02**
	Add to the relevant ultrasound examination codes eg 10200.		-	-		
00220	Ultrasound intra-operative study		-	-	7.32	**1 416.35**
	Covers all regions studied. Single code per operative procedure.		-	-		
00230	Ultrasound guidance		-	-	12.10	**2 341.23**
	guidance. Guided procedure code to be added eg. 80600, 80605, 80610.		-	-		
00240	Ultrasound guidance for tissue ablation		-	-	11.24	**2 174.83**
	Comprehensive ultrasound code including regional study and guidance. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. Guided procedure code to be added if performed by a radiologist. 80620 or 80630.		-	-		
00250	Ultrasound limited Doppler study any region		-	-	6.50	**1 257.69**
	Stand alone code may not be added to any other code.		-	-		
00290	Ultrasound examination contrast material		-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.		-	-		
00310	CT planning study for radiotherapy		-	-	21.37	**4 134.88**
00320	CT guidance (separate procedure)		-	-	16.92	**3 273.85**
	Comprehensive CT code including regional study and guidance. Guided procedure code to be added eg 80600, 80605, and 80610.		-	-		
00330	CT guidance, with diagnostic procedure		-	-	8.46	**1 636.93**
	To be added to the diagnostic procedure code. Guided procedure code to be added eg 80600, 80605, 80610.		-	-		
00340	CT guidance and monitoring for tissue ablation		-	-	21.15	**4 092.31**
	May only be used once per procedure for a region. Radiologist assistance (01030) may be added if procedure is performed by a non-radiologist. If performed by radiologist, add procedural code 80620, or 80630.		-	-		
00390	CT examination contrast material		-	-		

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	-	-		
00420	MR Spectroscopy any region	-	-	28.90	5 591.86
	May be added to the regional study, once only.	-	-		
00430	MR guidance for needle replacement	-	-	42.56	8 234.93
	Comprehensive MRI code including region studied and guidance. Guided procedure code to be added eg 80600, 80605, 80610.	-	-		
00440	MR low field strength imaging of peripheral joint any region	-	-	12.00	2 321.88
00450	MR planning study for radiotherapy or surgical procedure	-	-	36.00	7 352.62
00455	MR planning study for radiotherapy or surgical procedure, with contrast	-	-	47.00	9 094.03
00490	MR examination contrast material	-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	-	-		
00510	Analogue monoplane screening table	-	-	41.01	7 935.02
	A machine code may be added once per complete procedure / patient visit.	-	-		
00520	Analogue monoplane table with DSA attachment	-	-	47.50	9 190.78
	A machine code may be added once per complete procedure / patient visit.	-	-		
00530	Dedicated angiography suite: Analogue monoplane unit. Once off charge per patient by owner of equipment.	-	-	47.50	9 190.78
	A machine code may be added once per complete procedure / patient visit.	-	-		
00540	Digital monoplane screening table	-	-	79.92	15 463.72
	A machine code may be added once per complete procedure / patient visit.	-	-		
00550	Dedicated angiography suite: Digital monoplane unit. Once off charge per patient by owner of equipment.	-	-	93.03	18 000.37
	A machine code may be added once per complete procedure / patient visit.	-	-		
00560	Dedicated angiography suite: Digital bi-plane unit. Once off charge per patient by owner of equipment.	-	-	125.00	24 186.25
	A machine code may be added once per complete procedure / patient visit.	-	-		
00590	Angiography and interventional examination contrast material	-	-		
	Identification code for the use of contrast with a procedure. Appropriate codes to be supplied.	-	-		
00900	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton	-	-	34.92	6 756.67
00903	Nuclear Medicine study - Bone, whole body, appendicular and axial skeleton and SPECT	-	-	48.33	9 351.37
00906	Nuclear Medicine study - Venous thrombosis regional	-	-	21.54	4 167.77
00909	Nuclear Medicine study - Tumour whole body	-	-	34.15	6 607.68
00912	Nuclear Medicine study - Tumour whole body multiple studies	-	-	47.56	9 202.38
00915	Nuclear Medicine study - Tumour whole body and SPECT	-	-	47.56	9 202.38
00918	Nuclear Medicine study - Tumour whole body multiple studies & SPECT	-	-	60.98	11 799.02
00921	Nuclear Medicine study – Infection whole body	-	-	31.45	6 085.26
00924	Nuclear Medicine study – infection whole body with SPECT	-	-	44.86	8 679.96
00927	Nuclear Medicine study – infection whole body multiple studies	-	-	44.86	8 679.96
00930	Nuclear Medicine study – infection whole body with SPECT multiple studies	-	-	58.27	11 274.66
00933	Nuclear Medicine study - Bone marrow imaging limited area	-	-	24.10	4 663.11
00936	Nuclear Medicine study - Bone marrow imaging whole body	-	-	37.51	7 257.81
00939	Nuclear Medicine study - Bone marrow imaging limited area multiple studies	-	-	37.51	7 257.81
00942	Nuclear Medicine study - Bone marrow imaging whole body multiple studies	-	-	50.92	9 852.51
00945	Nuclear Medicine study - Spleen imaging only - haematopoietic	-	-	24.10	4 663.11
00960	Nuclear Medicine therapy – Hyperthyroidism	-	-	11.99	2 319.95

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
00965	Nuclear Medicine therapy - Thyroid carcinoma and metastases	-	-	6.47	1 251.88
00970	Nuclear Medicine therapy – Intra-cavity radio-active colloid therapy	-	-	6.47	1 251.88
00975	Nuclear Medicine therapy - Interstitial radio-active colloid therapy	-	-	6.47	1 251.88
00980	Nuclear Medicine therapy - Intravascular radio pharmaceutical therapy particulate	-	-	6.47	1 251.88
00985	Nuclear Medicine therapy - Intra-articular radio pharmaceutical therapy	-	-	6.47	1 251.88
00990	Nuclear Medicine Isotope	-	-		
	Identification code for the use of isotope with a procedure. Appropriate codes to be supplied.	-	-		
00991	Nuclear Medicine Substrate	-	-		
00956	PET/CT scan whole body without contrast	-	-	165.13	31 951.00
00957	PET/CT scan whole body with contrast	-	-	163.19	31 575.63
00951	PET/CT local	-	-	120.00	23 218.80
00952	PET/CT local with contrast	-	-	124.68	24 124.33
	Call and assistance	-	-		
	•Emergency call out code 01010 only to be used if radiologist is called out to the rooms to report on an examination after normal working hours. May not be used for routine reporting during extended working hours. •Emergency call out code 01020 only to be used when a radiologist reports on subsequent cases after having been called out to the rooms to report an initial after hours procedure. This code may also be used for home tele-radiology reporting of an emergency procedure. May not be used for routine reporting during normal or extended working hours. •Radiologist assistance in theatre code 01030 only to be used if the radiologist is actively involved in assisting another radiologist or clinician with a procedure. •Radiographer assistance in theatre 01040 may not be used for procedures performed in facilities owned by the radiologist; ie only for attendance in hospital theatres etc. Does not apply to Bed Side Unit (BSU) examinations. •Second opinion consultations only to be used if a written report is provided as indicated in codes 01050, 01055, 01060. Not intended for ad hoc verbal consultations.	-	-		
01010	Emergency call out fee, first case	-	-	3.00	580.47
01020	Emergency call out fee, subsequent cases same trip	-	-	2.00	386.98
01030	Radiologist assistance in theatre, per half hour	-	-	6.00	1 160.94
01040	Radiographer attendance in theatre, per half hour	-	-	1.60	309.58
01050	Written report on study done elsewhere, short	-	-	1.50	290.24
01055	Written report on study done elsewhere, extensive	-	-	4.20	812.66
01060	Written report for medico legal purposes, per hour	-	-	9.72	1 880.72
01070	Consultation for pre-assessment of interventional procedure	-	-	4.86	940.36
01100	X-ray procedure after hours, per procedure	-	-	2.00	386.98
01200	Ultrasound procedure after hours, per procedure	-	-	4.00	773.96
01300	CT procedure after hours, per procedure	-	-	10.00	1 934.90
01400	MR procedure after hours, per procedure	-	-	14.00	2 708.86
01500	Angiography procedure after hours, per procedure	-	-	20.00	3 869.80
01600	Interventional procedure after hours, per procedure	-	-	26.00	5 030.74
01970	Consultation for nuclear medicine study	-	-	2.20	425.68
	Monitoring	-	-		
	•ECG / Pulse oximetry monitoring (02010). Use for monitoring patients requiring conscious sedation during imaging procedure. Not to be used as a routine.	-	-		
02010	ECG/pulse Oximeter monitoring	-	-	2.00	386.98
	Head	-	-		
	Skull and Brain	-	-		
	Codes 10100 (skull) and 10110 (tomography) may be combined.	-	-		
10100	X-ray of the skull	-	-	3.86	746.87

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
10110	X-ray tomography of the skull	-	-	4.30	832.01
10120	X-ray shuntogram for VP shunt	-	-	15.36	2 972.01
10200	Ultrasound of the brain – Neonatal	-	-	7.38	1 427.96
10210	Ultrasound of the brain including doppler	-	-	13.22	2 557.94
10220	Ultrasound of the intracranial vasculature, including B mode, pulse and colour doppler	-	-	15.04	2 910.09
10300	CT Brain uncontrasted	-	-	22.65	4 382.55
10310	CT Brain with contrast only	-	-	33.28	6 439.35
10320	CT Brain pre and post contrast	-	-	40.48	7 832.48
10325	CT brain pre and post contrast for perfusion studies	-	-	49.10	9 500.36
	Stand alone code may not be added to any other CT studies of the brain, except for code 10330	-	-		
10330	CT angiography of the brain	-	-	77.58	15 010.95
10335	CT of the brain pre and post contrast with angiography	-	-	97.91	18 944.61
10340	CT brain for cranio-stenosis including 3D	-	-	34.16	6 609.62
10350	CT Brain stereotactic localisation	-	-	19.36	3 745.97
10360	CT base of skull coronal high resolution study for CSF leak	-	-	34.90	6 752.80
10400	MR of the brain, limited study	-	-	43.56	8 428.42
10410	MR of the brain uncontrasted	-	-	63.80	12 344.66
10420	MR of the brain with contrast	-	-	75.94	14 693.63
10430	MR of the brain pre and post contrast	-	-	104.04	20 130.70
10440	MR of the brain pre and post contrast, for perfusion studies	-	-	107.44	20 788.57
10450	MR of the brain plus angiography	-	-	92.20	17 839.78
10460	MR of the brain pre and post contrast plus angiography	-	-	121.23	23 456.79
10470	MR angiography of the brain uncontrasted	-	-	58.50	11 319.17
10480	MR angiography of the brain contrasted	-	-	74.02	14 322.13
10485	MR of the brain, with diffusion studies	-	-	79.00	15 285.71
10490	MR of the brain, pre and post contrast, with diffusion studies,	-	-	110.64	21 407.73
10492	MR study of the brain plus angiography plus diffusion, uncontrasted	-	-	95.00	18 381.55
10495	MR of the brain pre and post contrast plus angiography and diffusion	-	-	125.44	24 271.39
10500	Arteriography of intracranial vessels: 1 - 2 vessels	-	-	48.60	9 403.61
10510	Arteriography of intracranial vessels: 3 - 4 vessels	-	-	82.33	15 930.03
10520	Arteriography of extra-cranial (non-cervical) vessels	-	-	48.44	9 372.66
10530	Arteriography of intracranial and extra-cranial (non-cervical) vessels	-	-	118.09	22 849.23
10540	Arteriography of intracranial vessels (4) plus 3 D rotational angiography	-	-	97.57	18 878.82
10550	Arteriography of intracranial vessels (1) plus 3D rotational angiography	-	-	37.29	7 215.24
10560	Venography of dural sinuses	-	-	52.23	10 105.98
10900	Nuclear Medicine study – Bone regional, static	-	-	21.50	4 160.04
10905	Nuclear Medicine study – Bone regional, static, with flow	-	-	27.53	5 326.78
10910	Nuclear Medicine study – Bone regional, static with SPECT	-	-	34.92	6 756.67
10915	Nuclear Medicine study – Bone regional, static, with flow, with SPECT	-	-	40.94	7 921.48
10920	Nuclear Medicine study – Brain, planar, complete, static	-	-	16.92	3 273.85
10925	Nuclear Medicine study – Brain complete static with vascular flow	-	-	22.95	4 440.60
10930	Nuclear Medicine study – Brain, planar, complete, static, with SPECT	-	-	30.33	5 868.55
10935	Nuclear Medicine study – Brain, planar, complete, static, with flow, with SPECT	-	-	36.36	7 035.30
10940	Nuclear Medicine study - CSF flow imaging cisternography	-	-	21.60	4 179.38
10945	Nuclear Medicine study – Ventriculography	-	-	13.41	2 594.70
10950	Nuclear Medicine study - Shunt evaluation static, planar	-	-	13.41	2 594.70
10955	Nuclear Medicine study - CFS leakage detection and localisation	-	-	13.41	2 594.70
10960	Nuclear medicine study - CSF SPECT	-	-	13.41	2 594.70
10971	PET/CT scan of the brain uncontrasted	-	-	110.12	21 307.12

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
10972	PET/CT of the brain contrasted	-	-	116.11	22 466.12
10981	PET/CT perfusion scan of the brain	-	-	131.07	25 360.73
	Facial bones and nasal bones	-	-		
	Codes 11100 (facial bones) and 11110 (tomography) may be combined	-	-		
11100	X-ray of the facial bones	-	-	3.93	760.42
11110	X-ray tomography of the facial bones	-	-	4.30	832.01
11120	X-ray of the nasal bones	-	-	2.39	462.44
11300	CT of the facial bones	-	-	20.96	4 055.55
11310	CT of the facial bones with 3D reconstructions	-	-	30.40	5 882.10
11320	CT of the facial bones/soft tissue, pre and post contrast	-	-	41.26	7 983.40
11400	MR of the facial soft tissue	-	-	62.40	12 073.78
11410	MR of the facial soft tissue pre and post contrast	-	-	100.60	19 465.09
11420	MR of the facial soft tissue plus angiography, with contrast	-	-	110.30	21 341.95
11430	MR angiography of the facial soft tissue	-	-	74.02	14 322.13
	Orbits, lacrimal glands and tear ducts	-	-		
	Code 12130 (tomography) may be added to 12100 or 12110 or 12120 (orbits) or 12140 (dacrocystography).	-	-		
12100	X-ray orbits less than three views	-	-	3.56	688.82
12110	X-ray of the orbits, three or more views, including foramina	-	-	5.30	1 025.50
12120	X-ray of the orbits for foreign body	-	-	3.56	688.82
12130	X-ray tomography of the orbits	-	-	4.30	832.01
12140	X-ray dacrocystography	-	-	11.20	2 167.09
12200	Ultrasound of the orbit/eye	-	-	5.13	992.60
12210	Ultrasound of the orbit/eye including doppler	-	-	10.97	2 122.59
12300	CT of the orbits single plane	-	-	15.70	3 037.79
12310	CT of the orbits, more than one plane	-	-	20.59	3 983.96
12320	CT of the orbits pre and post contrast single plane	-	-	36.03	6 971.44
12330	CT of the orbits pre and post contrast multiple planes	-	-	39.70	7 681.55
12400	MR of the orbits	-	-	62.46	12 085.39
12410	MR of the orbitae, pre and post contrast	-	-	100.64	19 472.83
12900	Nuclear Medicine study – Dacrocystography	-	-	20.77	4 018.79
	Paranasal sinuses	-	-		
	Code 13120 (tomography) may be added to 13100, 13110 (paranasal sinuses), 13130 (nasopharyngeal).	-	-		
13100	X-ray of the paranasal sinuses, single view	-	-	2.74	530.16
13110	X-ray of the paranasal sinuses, two or more views	-	-	3.66	708.17
13120	X-ray tomography of the paranasal sinuses	-	-	4.30	832.01
13130	X-ray of the naso-pharyngeal soft tissue	-	-	2.74	530.16
13300	CT of the paranasal sinuses single plane, limited study	-	-	7.20	1 393.13
13310	CT of the paranasal sinuses, two planes, limited study	-	-	12.40	2 399.28
13320	CT of the paranasal sinuses, any plane, complete study	-	-	15.42	2 983.62
13330	CT of the paranasal sinuses, more than one plane, complete study	-	-	20.77	4 018.79
13340	CT of the paranasal sinuses, any plane, complete study: pre and post contrast	-	-	34.74	6 721.84
13350	CT of the paranasal sinuses, more than one plane, complete study; pre and post contrast	-	-	41.01	7 935.02
13400	MR of the paranasal sinuses	-	-	60.27	11 661.64
13410	MR of the paranasal sinuses, pre and post contrast	-	-	96.59	18 689.20
	Mandible, teeth and maxilla	-	-		

			Other specialist / General Practitioner		Specialist	
			U/E	R	U/E	
	Code 14110 (orthopantomogram) may be combined with 14100 (mandible) if two separate studies are performed. Code 14110 (orthopantomogram) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14160 (tomography) may be combined with 14130 or 14140 or 14150 (teeth). Code 14160 (tomography) may be combined with 15100 and / or 15110 (TM joint) if complete separate studies are performed. Code 14330 and 14340 (Dental implants) may be combined if mandible and maxilla are examined at the same visit.		-	-		
14100	X-ray of the mandible		-	-	3.66	**708.17**
14110	X-ray orthopantomogram of the jaws and teeth		-	-	4.06	**785.57**
14120	X-ray maxillofacial cephalometry		-	-	2.77	**535.97**
14130	X-ray of the teeth single quadrant		-	-	2.00	**386.98**
14140	X-ray of the teeth more than one quadrant		-	-	2.53	**489.53**
14150	X-ray of the teeth full mouth		-	-	3.62	**700.43**
14160	X-ray tomography of the teeth per side		-	-	3.23	**624.97**
14300	CT of the mandible		-	-	22.28	**4 310.96**
14310	CT of the mandible, pre and post contrast		-	-	41.26	**7 983.40**
14320	CT mandible with 3D reconstructions		-	-	30.40	**5 882.10**
14330	CT for dental implants in the mandible		-	-	27.45	**5 311.30**
14340	CT for dental implants in the maxilla		-	-	27.45	**5 311.30**
14400	MR of the mandible/maxilla		-	-	63.80	**12 344.66**
14410	MR of the mandible/maxilla, pre and post contrast		-	-	98.64	**19 085.85**
	TM Joints		-	-		
	Code 15100 (TM joint) and 15120 (tomography) may be combined. Code 15110 (TM joint) and 15130 (tomography) may be combined. Code 15140 (arthrography) and 15120 (tomography) may be combined. Code 15150 (arthrography) and 15130 (tomography)may be combined. Codes 15320 (CT arthrogram) and 15420 (MR arthrogram) include introduction of contrast (00140 may not be added).		-	-		
15100	X-ray tempero-mandibular joint, left		-	-	3.56	**688.82**
15110	X-ray tempero-mandibular joint, right		-	-	3.56	**688.82**
15120	X-ray tomography tempero-mandibular joint, left		-	-	4.30	**832.01**
15130	X-ray tomography tempero-mandibular joint, right		-	-	4.30	**832.01**
15140	X-ray arthrography of the tempero-mandibular joint, left		-	-	15.41	**2 981.68**
15150	X-ray arthrography of the tempero-mandibular joint, right		-	-	15.41	**2 981.68**
15200	Ultrasound tempero-mandibular joints, one or both sides		-	-	6.56	**1 269.29**
15300	CT of the tempero-mandibular joints		-	-	25.38	**4 910.78**
15310	CT of the tempero-mandibular joints plus 3D reconstructions		-	-	34.50	**6 675.41**
15320	CT arthrogram of the tempero-mandibular joints		-	-	35.96	**6 957.90**
15400	MR of the tempero-mandibular joints		-	-	63.80	**12 344.66**
15410	MR of the tempero-mandibular joints, pre and post contrast		-	-	100.84	**19 511.53**
15420	MR arthrogram of the tempero-mandibular joints		-	-	74.71	**14 455.64**
	Mastoids and internal auditory canal		-	-		
	Code 16100 (mastoids) and 16120 (tomography) may be combined. Code 16110 (mastoids bilat) and 16130 (tomography) may be combined Code 16140 (IAM's) and 16150 (tomography) may be combined.		-	-		
16100	X-ray of the mastoids, unilateral		-	-	3.59	**694.63**
16110	X-ray of the mastoids, bilateral		-	-	7.18	**1 389.26**
16120	X-ray tomography of the petro-temporal bone, unilateral		-	-	4.30	**832.01**
16130	X-ray tomography of the petro-temporal bone, bilateral		-	-	8.60	**1 664.01**
16140	X-ray internal auditory canal, bilateral		-	-	5.23	**1 011.95**
16150	X-ray tomography of the internal auditory canal, bilateral		-	-	4.30	**832.01**

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
16300	CT of the mastoids	-	-	12.60	2 437.97
16310	CT of the internal auditory canal	-	-	21.47	4 154.23
16320	CT of the internal auditory canal, pre and post contrast	-	-	34.20	6 617.36
16330	CT of the ear structures, limited study	-	-	13.40	2 592.77
16340	CT of the middle and inner ear structures, high definition including all reconstructions in various planes	-	-	43.35	8 387.79
16400	MR of the internal auditory canals, limited study	-	-	43.56	8 428.42
16410	MR of the internal auditory canals, pre and post contrast, limited study	-	-	68.93	13 337.27
16420	MR of the internal auditory canals, pre and post contrast, complete study	-	-	102.64	19 859.81
16430	MR of the ear structures	-	-	64.40	12 460.76
16440	MR of the ear structures, pre and post contrast	-	-	102.64	19 859.81
	Sella turcica	-	-		
	Code 17100 (sella) and 17110 (tomography) may be combined.	-	-		
17100	X-ray of the sella turcica	-	-	3.08	595.95
17110	X-ray tomography of the sella turcica	-	-	4.30	832.01
17300	CT of the sella turcica/hypophysis	-	-	17.45	3 376.40
17310	CT of the sella turcica/hypophysis, pre and post contrast	-	-	42.26	8 176.89
	Salivary glands and floor of the mouth	-	-		
	Neck	-	-		
	Code 20120 (laryngography) includes fluoroscopy (00140 may not be added). Code 20130 (speech) includes tomography and cinematography (00140 may not be added). Code 20450 (MR Angiography) may be combined with 10410 (MR brain).	-	-		
20100	X-ray of soft tissue of the neck	-	-	2.74	530.16
20110	X-ray of the larynx including tomography	-	-	9.39	1 816.87
20120	X-ray laryngography	-	-	8.28	1 602.10
20130	X-ray evaluation of pharyngeal movement and speech by screening and / or cine with or without video recording	-	-	8.30	1 605.97
20200	Ultrasound of the thyroid	-	-	6.56	1 269.29
20210	Ultrasound of soft tissue of the neck	-	-	6.56	1 269.29
20220	Ultrasound of the carotid arteries, bilateral including B mode, pulsed and colour doppler	-	-	15.00	2 902.35
20230	Ultrasound of the entire extracranial vascular tree including carotids, vertebral and subclavian vessels with B mode, pulse and colour doppler	-	-	21.84	4 225.82
20240	Ultrasound study of the venous system of the neck including pulse and colour Doppler	-	-	10.80	2 089.69
20300	CT of the soft tissues of the neck	-	-	18.25	3 531.19
20310	CT of the soft tissues of the neck, with contrast	-	-	38.15	7 381.64
20320	CT of the soft tissues of the neck, pre and post contrast	-	-	43.81	8 476.80
20330	CT angiography of the extracranial vessels in the neck	-	-	79.36	15 355.37
20340	intracranial vessels of the brain	-	-	107.50	20 800.18
20350	CT angiography of the extracranial vessels in the neck and intracranial vessels of the brain plus a pre and post contrast study of the brain	-	-	124.43	24 075.96
20400	Mr of the soft tissue of the neck	-	-	63.60	12 305.96
20410	MR of the soft tissue of the neck, pre and post contrast	-	-	102.04	19 743.72
20420	MR of the soft tissue of the neck and uncontrasted angiography	-	-	92.60	17 917.17
20430	MR angiography of the extracranial vessels in the neck, without contrast	-	-	59.60	11 532.00
20440	MR angiography of the extracranial vessels in the neck, with contrast	-	-	74.02	14 322.13
20450	MR angiography of the extra and intracranial vessels with contrast	-	-	116.05	22 454.51
20460	MR angiography of the intra and extra cranial vessels plus brain, without contrast	-	-	135.17	26 154.04
20470	MR angiography of the intra and extra cranial vessels plus brain, with contrast	-	-	156.05	30 194.11
20500	Arteriography of cervical vessels: carotid 1 - 2 vessels	-	-	44.43	8 596.76

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
20510	Arteriography of cervical vessels: vertebral 1 - 2 vessels	-	-	50.73	**9 815.75**
20520	Arteriography of cervical vessels: carotid and vertebral	-	-	77.63	**15 020.63**
20530	Arteriography of aortic arch and cervical vessels	-	-	91.97	**17 795.28**
20540	Arteriography of aortic arch, cervical and intracranial vessels	-	-	108.87	**21 065.26**
20550	Venography of jugular and vertebral veins	-	-	48.95	**9 471.34**
	Thyroid (Nuclear Medicine)	-	-		
21900	Nuclear Medicine study - Thyroid, single uptake	-	-	9.68	**1 872.98**
21910	Nuclear medicine study - Thyroid, multiple uptake	-	-	14.69	**2 842.37**
21920	Nuclear medicine study - Thyroid imaging with uptake	-	-	17.72	**3 428.64**
21930	Nuclear medicine study - Thyroid imaging	-	-	12.72	**2 461.19**
21940	Nuclear medicine study - Thyroid imaging with vascular flow	-	-	18.74	**3 626.00**
21950	Nuclear medicine study - Thyroid suppression/stimulation	-	-	12.72	**2 461.19**
29961	PET/CT scan of the soft tissue of the neck uncontrasted	-	-	105.87	20 484.79
29962	PET/CT scan of the soft tissue of the neck contrasted	-	-	111.69	21 610.90
	Thorax	-	-		
	Chest wall, pleura, lungs and mediastinum	-	-		
	Code 30140 (tomography) may be combined with 30100 or 30110 (chest) or 30150 or 30155 (ribs) or 30160 (thoracic inlet). Codes 30170 (Sterno-clavicular) and 30175 (tomography) may be combined. Code 30180 (sternum) and 30185 (tomography) may be combined. Code 30340 (CT limited high resolution) may be combined with 30310 or 30320 or 30330 (CT chest). Motivation may be required. Code 30350 (high resolution) is a stand alone study. Code 30360, (CT chest for pulmonary embolism) is a complete examination and includes the preceding uncontrasted CT scan of the chest, and may not be combined with 40330 or 40333 (CT abdomen and pelvis). Code 30370 (CT pulmonary embolism plus CT venography) may not be combined with 70230 (Doppler).	-	-		
30100	X-ray of the chest, single view	-	-	3.04	**588.21**
30110	X-ray of the chest two views, PA and lateral	-	-	3.84	**743.00**
30120	X-ray of the chest complete with additional views	-	-	4.24	**820.40**
30130	X-ray of the chest complete including fluoroscopy	-	-	4.48	**866.84**
30140	X-ray tomography of the chest	-	-	4.30	**832.01**
30150	X-ray of the ribs	-	-	4.79	**926.82**
30155	X-ray of the chest and ribs	-	-	6.42	**1 242.21**
30160	X-ray of the thoracic inlet	-	-	2.56	**495.33**
30170	X-ray of the sterno-clavicular joints	-	-	4.21	**814.59**
30175	X-ray tomography of the sterno-clavicular joint	-	-	4.30	**832.01**
30180	X-ray of the sternum	-	-	4.21	**814.59**
30185	X-ray tomography of the sternum	-	-	4.30	**832.01**
30200	Ultrasound of the chest wall, any region	-	-	6.56	**1 269.29**
30210	Ultrasound of the pleural space	-	-	6.56	**1 269.29**
30220	Ultrasound of the mediastinal structures	-	-	6.56	**1 269.29**
30300	CT of the chest, limited study	-	-	9.50	**1 838.16**
30310	CT of the chest uncontrasted	-	-	26.60	**5 146.83**
30320	CT of the chest contrasted	-	-	42.43	**8 209.78**
30330	CT of the chest, pre and post contrast	-	-	45.70	**8 842.49**
30340	CT of the chest, limited high resolution study	-	-	11.20	**2 167.09**
30350	CT of the chest, complete high resolution study	-	-	24.01	**4 645.69**
30355	prone and expiratory studies	-	-	33.30	**6 443.22**
30360	CT of the chest for pulmonary embolism	-	-	57.12	**11 052.15**
30370	CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	-	-	80.28	**15 533.38**
30400	MR of the chest	-	-	63.60	**12 305.96**
30410	MR of the chest with uncontrasted angiography	-	-	92.60	**17 917.17**
30420	MR of the chest, pre and post contrast	-	-	102.04	**19 743.72**

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
30900	Nuclear Medicine study - Lung perfusion	-	-	21.54	4 167.77
30910	Nuclear Medicine study - Lung ventilation, aerosol	-	-	21.50	4 160.04
30920	Nuclear Medicine study - Lung perfusion and ventilation	-	-	42.03	8 132.38
30930	Nuclear Medicine study - Lung ventilation using radio-active gas	-	-	14.17	2 741.75
30940	Nuclear Medicine study - Lung perfusion and ventilation using radio active gas	-	-	34.69	6 712.17
30950	Nuclear medicine study - Muco-ciliary clearance study dynamic	-	-	26.51	5 129.42
30960	Nuclear medine study - alveolar permeabillity	-	-	26.51	5 129.42
	Stand alone code. Not to be combined with 30910.	-	-		
30970	Nuclear medicine study - quantitative evaluation of lung perfusion and ventilation	-	-	6.02	1 164.81
	Stand alone code. Not to be combined with 30920.	-	-		0.00
30981	PET/CT scan of the chest uncontrasted	-	-	111.44	21 562.53
30982	PET/CT scan of the chest contrasted	-	-	117.42	22 719.60
30983	PET/CT scan of the chest pre and post contrast	-	-	148.32	28 698.44
	Oesophagus	-	-		
	may not be added).	-	-		
31100	X-ray barium swallow	-	-	6.60	1 277.03
31105	Xray 3 phase dynamic contrasted swallow	-	-	12.60	2 437.97
31110	X-ray barium swallow, double contrast	-	-	7.92	1 532.44
31120	X-ray barium swallow with cinematography	-	-	10.07	1 948.44
	Aorta and large vessels	-	-		
	Codes 32210 and 32220 (Ivus) may be combined	-	-		
32200	intervention, once per complete procedure	-	-	4.20	812.66
32210	Ultrasound intravascular (IVUS) first vessel	-	-	8.44	1 633.06
32220	Ultrasound intravascular (IVUS) subsequent vessels	-	-	5.30	1 025.50
32300	CT angiography of the aorta and branches	-	-	79.08	15 301.19
32305	CT angiography of the thoracic and abdominal aorta and branches	-	-	105.50	20 413.20
32310	CT angiography of the pulmonary vasculature	-	-	79.08	15 301.19
32400	MR angiography of the aorta and branches	-	-	78.50	15 188.97
32410	MR angiography of the pulmonary vasculature	-	-	105.27	20 368.69
32500	Arteriography of thoracic aorta	-	-	28.26	5 468.03
32510	Arteriography of bronchial intercostal vessels alone	-	-	50.15	9 703.52
32520	Arteriography of thoracic aorta, bronchial and intercostal vessels	-	-	67.43	13 047.03
32530	Arteriography of pulmonary vessels	-	-	63.27	12 242.11
32540	Arteriography of heart chambers, coronary arteries	-	-	44.27	8 565.80
32550	Venography of thoracic vena cava	-	-	28.38	5 491.25
32560	Venography of vena cava, azygos system	-	-	56.31	10 895.42
32570	Venography patency of A-port or other central line	-	-	19.64	3 800.14
	Heart	-	-		
	Codes 33300 (CT anatomy / function) and 33310 (CT Angiography) may be done as stand alone studies or as additive studies if both are performed at the same time.	-	-		
33205	Ultrasound study of the heart for foetal or paediatric cases including doppler	-	-	12.30	2 379.93
	or 33210. This code is intended for paediatric and foetal cases only	-	-		
33200	Ultrasound study of the heart, including Doppler	-	-	8.20	1 586.62
33210	Ultrasound study of the heart trans-oesophageal	-	-	10.52	2 035.51
33220	Ultrasound intravascular imaging to guide placement of intracoronary stent once per vessel	-	-	5.20	1 006.15
33300	CT anatomical/functional study of the heart	-	-	34.61	6 696.69
33310	CT angiography of heart vessels	-	-	81.28	15 726.87
33970	Nuclear Medicine study - Multi stage treadmill ECG test	-	-	6.66	1 288.64
	Abdomen and Pelvis	-	-		
	Abdomen/stomach/bowel	-	-		

			Other specialist / General Practitioner		Specialist	
			U/E	R	U/E	
	Code 40120 (tomography) may be combined with 40100 or 40105 or 40110 (abdomen). Codes 40140 to 40190 (barium studies) include fluoroscopy (00140 may not be added). Code 40190 (intussusception) is a stand alone code and may not be combined with 40160 or 40165 (barium enema), (00140 may not be added).		-	-		
40100	X-ray of the abdomen		-	-	3.32	**642.39**
40105	X-ray of the abdomen supine and erect, or decubitus		-	-	5.36	**1 037.11**
40110	X-ray of the abdomen multiple views including chest		-	-	8.10	**1 567.27**
40120	X-ray tomography of the abdomen		-	-	4.30	**832.01**
40140	X-ray barium meal single contrast		-	-	8.87	**1 716.26**
40143	X-ray barium meal double contrast		-	-	11.99	**2 319.95**
40147	X-ray barium meal double contrast with follow through		-	-	15.80	**3 057.14**
40150	X-ray small bowel enteroclysis (meal)		-	-	25.45	**4 924.32**
	intubation) may be added.		-	-		
40153	X-ray small bowel meal follow through single contrast		-	-	19.55	**3 782.73**
40157	X-ray small bowel meal with pneumocolon		-	-	25.63	**4 959.15**
40160	X-ray large bowel enema single contrast		-	-	12.97	**2 509.57**
40165	X-ray large bowel enema double contrast		-	-	19.63	**3 798.21**
40170	X-ray guided gastro oesophageal intubation		-	-	1.60	**309.58**
40175	X-ray guided duodenal intubation		-	-	2.80	**541.77**
40180	X-ray defaecogram		-	-	12.97	**2 509.57**
40190	X-ray guided reduction of intussusception		-	-	16.27	**3 148.08**
40200	Ultrasound study of the abdominal wall		-	-	5.54	**1 071.93**
40210	Ultrasound study of the whole abdomen including the pelvis		-	-	8.24	**1 594.36**
40300	CT study of the abdomen		-	-	26.41	**5 110.07**
40310	CT study of the abdomen with contrast		-	-	44.82	**8 672.22**
40313	CT study of the abdomen pre and post contrast		-	-	52.99	**10 253.04**
40320	CT of the pelvis		-	-	26.13	**5 055.89**
40323	CT of the pelvis with contrast		-	-	47.48	**9 186.91**
40327	CT of the pelvis pre and post contrast		-	-	53.87	**10 423.31**
40330	CT of the abdomen and pelvis		-	-	38.50	**7 449.37**
40333	CT of the abdomen and pelvis with contrast		-	-	62.17	**12 029.27**
40337	CT of the abdomen and pelvis pre and post contrast		-	-	67.43	**13 047.03**
40340	CT triphasic study of the liver, abdomen and pelvis pre and post contrast		-	-	74.11	**14 339.54**
40345	CT of the chest, abdomen and pelvis without contrast		-	-	70.12	**13 567.52**
40350	CT of the chest, abdomen and pelvis with contrast		-	-	88.35	**17 094.84**
40355	CT of the chest triphasic of the liver, abdomen and pelvis with contrast		-	-	93.05	**18 004.24**
40360	CT of the base of skull to symphysis pubis with contrast		-	-	102.73	**19 877.23**
40365	CT colonoscopy		-	-	34.78	**6 729.58**
	Stand alone study, may not be added to any code between 40300 and 40360		-	-		
40400	MR of the abdomen		-	-	64.58	**12 495.58**
40410	MR of the abdomen pre and post contrast		-	-	100.84	**19 511.53**
40420	MR of the pelvis, soft tissue		-	-	64.58	**12 495.58**
40430	MR of the pelvis, soft tissue, pre and post contrast		-	-	102.04	**19 743.72**
40900	Nuclear Medicine study - Gastro oesophageal reflux and emptying		-	-	21.50	**4 160.04**
40905	Nuclear Medicine study - Gastro oesophageal reflux and emptying multiple studies		-	-	34.92	**6 756.67**
40910	Nuclear Medicine study - Gastro intestinal protein loss		-	-	21.50	**4 160.04**
40915	Nuclear Medicine study - Gastro intestinal protein loss multiple studies		-	-	34.92	**6 756.67**
40920	Nuclear Medicine study – Acute GIT bleed static/dynamic		-	-	21.50	**4 160.04**
40925	Nuclear medicine study – Acute GIT bleed multiple studies		-	-	34.92	**6 756.67**
40930	Nuclear medicine study - Meckel's localisation		-	-	20.77	**4 018.79**
40935	Nuclear medicine study - Gastric mucosa imaging		-	-	20.77	**4 018.79**
40940	Nuclear medicine study - colonic transit multiple studies		-	-	44.86	**8 679.96**
	Stand alone code		-	-		

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
40951	PET/CT scan of the abdomen and pelvis uncontrasted	-	-	119.53	23 127.86
40952	PET/CT scan of the abdomen and pelvis contrasted	-	-	129.31	25 020.19
40953	PET/CT scan of the abdomen and pelvis pre and post contrast	-	-	140.50	27 185.35
	Liver, spleen, gall bladder and pancreas	-	-		
	Code 41110, 41120 and 41130 (cholangiography) include fluoroscopy (00140 may not be added).	-	-		
41100	X-ray ERCP including screening	-	-	18.90	3 656.96
41105	X-ray ERCP reporting on images done in theatre	-	-	2.40	464.38
41110	X-ray cholangiography intra-operative	-	-	8.45	1 634.99
41120	X-ray T-tube cholangiography post operative	-	-	14.05	2 718.53
41130	X-ray transhepatic percutaneous cholangiography	-	-	32.34	6 257.47
41200	Ultrasound study of the upper abdomen	-	-	7.00	1 354.43
41210	Ultrasound doppler of the hepatic and splenic veins and inferior vena cava in assessment of portal venous hypertension or thrombosis	-	-	9.80	1 896.20
	Code 41210 is a stand alone study and may not be added to 40200, 40210, 41200 or 42200	-	-		
41300	CT of the abdomen triphasic study – liver	-	-	54.90	10 622.60
41400	MR study of the liver/pancreas	-	-	64.78	12 534.28
41410	MR study of the liver/pancreas pre and post contrast	-	-	100.84	19 511.53
41420	MRCP	-	-	49.20	9 519.71
41430	MR study of the abdomen with MRCP	-	-	92.98	17 990.70
41440	MR study of the abdomen pre and post contrast with MRCP	-	-	133.60	25 850.26
41900	Nuclear Medicine study - Liver and spleen, planar views only	-	-	21.50	4 160.04
41905	Nuclear Medicine study - Liver and spleen, with flow study	-	-	27.53	5 326.78
41910	Nuclear Medicine study - Liver and spleen, planar views SPECT	-	-	34.92	6 756.67
41915	Nuclear Medicine study - Liver and spleen, with flow study and SPECT	-	-	40.94	7 921.48
41920	Nuclear Medicine study - Hepatobiliary system planar static/dynamic	-	-	21.50	4 160.04
41925	Nuclear Medicine study – hepatobiliary tract including flow	-	-	26.51	5 129.42
41930	Nuclear medicine study – Hepatobiliary system planar, static/dynamic multiple studies	-	-	34.92	6 756.67
41935	Nuclear medicine study – Hepatobiliary tract including flow multiple studies	-	-	39.92	7 724.12
41940	Nuclear medicine study - Gall bladder ejection fraction	-	-	6.02	1 164.81
41945	Nuclear medicine study – Biliary gastric reflux study	-	-	20.77	4 018.79
	Renal tract	-	-		
42100	X-ray tomography of the renal tract	-	-	4.30	832.01
	Code 42100 (tomography) may not be added to 42110 or 42115 (IVP). Codes 42115 (IVP), 42120 (cystography), 42130 (urethography), 42140 (MCU), 42150 (retrograde), and 42160 (prograde) include fluoroscopy (00140 may not be added).	-	-		
42110	X-ray excretory urogram including tomography	-	-	24.86	4 810.16
42115	X-ray excretory urogram including tomography with micturating study	-	-	32.86	6 358.08
42120	X-ray cystography	-	-	15.05	2 912.02
42130	X-ray urethrography	-	-	15.37	2 973.94
42140	X-ray micturating cysto-urethrography	-	-	19.30	3 734.36
42150	X-ray retrograde/prograde pyelography	-	-	12.53	2 424.43
42155	X-ray retrograde/prograde pyelography reporting on images done in theatre	-	-	2.41	466.31
42160	X-ray prograde pyelogram – percutaneous	-	-	32.67	6 321.32
42200	Ultrasound study of the renal tract including bladder	-	-	7.42	1 435.70
42205	Ultrasound doppler for resistive index in vessels of transplanted kidney	-	-	3.80	735.26
	Code 42205 is a stand alone study and may not be added to 42200	-	-		
42210	Ultrasound study of the renal arteries including Doppler	-	-	10.60	2 050.99
42300	CT of the renal tract for a stone	-	-	25.15	4 866.27

			Other specialist / General Practitioner		Specialist	
			U/E	R	U/E	
42400	MR of the renal tract for obstruction		-	-	47.00	9 094.03
42410	MR of the kidneys without contrast		-	-	64.58	12 495.58
42420	MR of the kidneys pre and post contrast		-	-	102.24	19 782.42
42900	Nuclear Medicine study - Renal imaging, static (e.g. DMSA)		-	-	21.94	4 245.17
42905	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with flow		-	-	27.96	5 409.98
42910	Nuclear Medicine study - Renal imaging, static (e.g. DMSA) with SPECT		-	-	35.35	6 839.87
42915	Nuclear Medicine study - Renal imaging, static (e.g. DMSA), with flow, with SPECT		-	-	41.37	8 004.68
42920	Nuclear Medicine study - Renal imaging dynamic (renogram) and vascular flow		-	-	26.51	5 129.42
42930	Nuclear Medicine study – Renovascular study, baseline		-	-	26.51	5 129.42
42940	Nuclear Medicine study – Renovascular study, with intervention		-	-	26.51	5 129.42
42950	Nuclear medicine study - indirect voiding cystogram		-	-	6.02	1 164.81
	Aorta and vessels		-	-		
	Code 44400 (MR Angiography) may be combined with 40400 (MR abdomen).		-	-		
44200	Ultrasound study of abdominal aorta and branches including doppler		-	-	18.32	3 544.74
44205	Ultrasound study of the IVC and pelvic veins including Doppler		-	-	14.00	2 708.86
	This is a stand alone code and may not be added to 44200.		-	-		0.00
44300	CT angiography of abdominal aorta and branches		-	-	76.72	14 844.55
44305	CT angiography of the abdominal aorta and branches and pre and post contrast study of the upper abdomen		-	-	94.32	18 249.98
44310	CT angiography of the pelvis		-	-	78.64	15 216.05
44320	CT angiography of the abdominal aorta and pelvis		-	-	89.54	17 325.09
44325	CT angiography of the abdominal aorta and pelvis and pre and post contrast study of the upper abdomen and pelvis		-	-	119.15	23 054.33
44330	CT portogram		-	-	74.40	14 395.66
44400	MR angiography of abdominal aorta and branches		-	-	76.64	14 829.07
44500	Arteriography of abdominal aorta alone		-	-	28.12	5 440.94
44503	Arteriography of aorta plus coeliac, mesenteric branches		-	-	75.63	14 633.65
44505	Arteriography of aorta plus renal, adrenal branches		-	-	63.01	12 191.80
44507	Arteriography of aorta plus non-visceral branches		-	-	60.79	11 762.26
44510	Arteriography of coeliac, mesenteric vessels alone		-	-	64.35	12 451.08
44515	Arteriography of renal, adrenal vessels alone		-	-	49.49	9 575.82
44517	Arteriography of non-visceral abdominal vessels alone		-	-	54.91	10 624.54
44520	Arteriography of internal and external iliac vessels alone		-	-	56.72	10 974.75
44525	Venography of internal and external iliac veins alone		-	-	62.11	12 017.66
44530	Corpora cavernosography		-	-	25.06	4 848.86
44535	Vasography, vesciculography		-	-	29.19	5 647.97
44540	Venography of inferior vena cava		-	-	26.12	5 053.96
44543	Venography of hepatic veins alone		-	-	53.77	10 403.96
44545	Venography of inferior vena cava and hepatic veins		-	-	68.91	13 333.40
44550	Venography of lumbar azygos system alone		-	-	43.89	8 492.28
44555	Venography of inferior vena cava and lumbar azygos veins		-	-	65.46	12 665.86
44560	Venography of renal, adrenal veins alone		-	-	43.99	8 511.63
44565	Venography of inferior vena cava and renal/adrenal veins		-	-	68.39	13 232.78
44570	Venography of spermatic, ovarian veins alone		-	-	40.39	7 815.06
44573	Venography of inferior vena cava, renal, spermatic, ovarian veins		-	-	73.99	14 316.33
44580	Venography indirect splenoportogram		-	-	48.67	9 417.16
44583	Venography direct splenoportogram		-	-	31.59	6 112.35
44587	Venography transhepatic portogram		-	-	66.75	12 915.46
	Soft Tissue		-	-		
	Spine, Pelvis and Hips		-	-		
	Code 51340 (CT myelography, cervical), 52330 (CT myelography thoracic) and 53340 (CT myelography lumbar) are stand alone studies and may not be combined with the conventianla myelography codes viz. 51160, 52150, 53160		-	-		

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
	General	-	-		
	Code 50130 (Lumbar puncture) and 50140 (cisternal puncture) include fluoroscopy and introduction of contrast (00140 may not be added).	-	-		
50100	X-ray of the spine scoliosis view AP only	-	-	7.00	**1 354.43**
50105	X-ray of the spine scoliosis view AP and lateral	-	-	12.00	**2 321.88**
50110	X-ray of the spine scoliosis view AP and lateral including stress views	-	-	18.54	**3 587.30**
50120	X-ray bone densitometry	-	-	11.52	**2 229.00**
50130	X-ray guided lumbar puncture	-	-	4.80	**928.75**
50140	X-ray guided cisternal puncture cisternogram	-	-	22.98	**4 446.40**
50300	CT quantitive bone mineral density	-	-	11.83	**2 288.99**
50500	Arteriogram of the spinal column and cord, all vessels	-	-	127.23	**24 617.73**
50510	Venography of the spinal, paraspinal veins	-	-	58.45	**11 309.49**
	Cervical	-	-		
	Code 51100 (stress) is a stand alone study and may not be added to 51110, 51120 (cervical spine), 51160 (myelography) and 51170 (discography). Code 51140 (tomography) may be combined with 51110 or 51120 (spine). Code 51160s (myelography) and 51170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 51300 (CT) limited - limited to a single cervical vertebral body. Code 51310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 51320 (CT) complete study - an extensive study of the cervical spine. Code 51340 (CT myelography) – post myelographic study and includes all disc levels, includes fluoroscopy and introduction of contrast (00140 may not be added).	-	-		
51100	X-ray f the cervical spine, stress views only	-	-	4.14	**801.05**
51110	X-ray of the cervical spine, one or two views	-	-	3.01	**582.40**
51120	X-ray of the cervical spine, more than two views	-	-	4.28	**828.14**
51130	X-ray of the cervical spine, more than two views including stress views	-	-	7.58	**1 466.65**
51140	X-ray Tomography cervical spine	-	-	4.30	**832.01**
51160	X-ray myelography of the cervical spine	-	-	27.46	**5 313.24**
51170	X-ray discography cervical spine per level	-	-	25.17	**4 870.14**
51300	CT of the cervical spine limited study	-	-	9.50	**1 838.16**
51310	CT of the cervical spine – regional study	-	-	13.91	**2 691.45**
51320	CT of the cervical spine – complete study	-	-	37.13	**7 184.28**
51330	CT of the cervical spine pre and post contrast	-	-	58.85	**11 386.89**
51340	CT myelography of the cervical spine	-	-	47.19	**9 130.79**
51350	CT myelography of the cervical spine following myelogram	-	-	21.69	**4 196.80**
51400	MR of the cervical spine, limited study	-	-	44.40	**8 590.96**
51410	MR of the cervical spine and cranio-cervical junction	-	-	64.82	**12 542.02**
51420	MR of the cervical spine and cranio-cervical junction pre and post contrast	-	-	102.14	**19 763.07**
51900	Nuclear Medicine study – Bone regional cervical	-	-	21.50	**4 160.04**
51910	Nuclear Medicine study – Bone tomography regional cervical	-	-	13.41	**2 594.70**
51920	Nuclear Medicine study – with flow	-	-	6.02	**1 164.81**
	Thoracic	-	-		

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
	Code 52120 (tomography) may be combined with 52100 or 52110 (spine). Code 52150 (myelography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 52300 (CT) limited study – limited to a single thoracic vertebral body. Code 52305 (CT) regional study - 2 vertebral bodies and intervertebral disc paces. Code 52310 (CT) complete study - an extensive study of the thoracic spine. Code 52330 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	-	-		
52100	X-ray of the thoracic spine, one or two views	-	-	3.21	**621.10**
52110	X-ray of the thoracic spine, more than two views	-	-	4.00	**773.96**
52120	X-ray tomography thoracic spine	-	-	4.30	**832.01**
52140	X-ray of the thoracic spine, more that two views including stress views	-	-	6.64	**1 284.77**
52150	X-ray myelography of the thoracic spine	-	-	18.62	**3 602.78**
52300	CT of the thoracic spine limited study	-	-	9.50	**1 838.16**
52305	CT of the thoracic spine – regional study	-	-	13.91	**2 691.45**
52310	CT of the thoracic spine complete study	-	-	35.78	**6 923.07**
52320	CT of the thoracic spine pre and post contrast	-	-	58.85	**11 386.89**
52330	CT myelography of the thoracic spine	-	-	48.09	**9 304.93**
52340	CT myelography of the thoracic spine following myelogram	-	-	20.37	**3 941.39**
52400	MR of the thoracic spine, limited study	-	-	46.60	**9 016.63**
52410	MR of the thoracic spine	-	-	64.34	**12 449.15**
52420	MR of the thoracic spine pre and post contrast	-	-	101.42	**19 623.76**
52900	Nuclear Medicine study – Bone regional dorsal	-	-	21.50	**4 160.04**
52910	Nuclear Medicine study – Bone tomography regional dorsal	-	-	13.41	**2 594.70**
52920	Nuclear Medicine study – with flow	-	-	6.02	**1 164.81**
	Lumbar	-	-		
	Code 53100 (stress) is a stand alone study and may not be added to 53110, 53120 (lumbar spine), 53160 (myelography) and 53170 (discography). Code 53140 (tomography) may be combined with 53110 or 53120 (spine). Codes 53160 (myelography) and 53170 (discography) include fluoroscopy and introduction of contrast (00140 may not be added). Code 53300 (CT) limited study – limited to a single lumbar vertebral body. Code 53310 (CT) regional study - 2 vertebral bodies and intervertebral disc spaces. Code 53320 (CT) complete study - an extensive study of the lumbar spine. Code 53340 (CT myelography) - post myelographic study and includes all disc levels, fluoroscopy and introduction of contrast (00140 may not be added).	-	-		
53100	X-ray of the lumbar spine – stress study only	-	-	4.14	**801.05**
53110	X-ray of the lumbar spine, one or two views	-	-	3.56	**688.82**
53120	X-ray of the lumbar spine, more than two views	-	-	4.46	**862.97**
53130	X-ray of the lumbar spine, more that two views including stress views	-	-	7.52	**1 455.04**
53140	X-ray tomography lumbar spine	-	-	4.30	**832.01**
53160	X-ray myelography of the lumbar spine	-	-	23.94	**4 632.15**
53170	X-ray discography lumbar spine per level	-	-	25.17	**4 870.14**
53300	CT of the lumbar spine limited study	-	-	9.50	**1 838.16**
53310	CT of the lumbar spine – regional study	-	-	13.91	**2 691.45**
53320	Ct of the lumbar spine complete study	-	-	37.64	**7 282.96**
53330	CT of the lumbar spine pre and post contrast	-	-	58.85	**11 386.89**
53340	CT myelography of the lumbar spine	-	-	49.11	**9 502.29**
53350	CT myelography of the lumbar spine following myelogram	-	-	23.46	**4 539.28**

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
53400	MR of the lumbar spine, limited study	-	-	46.20	**8 939.24**
53410	MR of the lumbar spine	-	-	64.32	**12 445.28**
53420	MR of the lumbar spine pre and post contrast	-	-	103.29	**19 985.58**
53900	Nuclear medicine study – Bone regional lumbar	-	-	21.50	**4 160.04**
53910	Nuclear medicine study – Bone tomography regional lumbar	-	-	13.41	**2 594.70**
53920	Nuclear medicine study – with flow	-	-	6.02	**1 164.81**
	Sacrum	-	-		
	Code 54120 (tomography) may be combined with 54100 (sacrum) or 54110 (SI joints). Code 54300 (CT) limited study - limited to single sacral vertebral body. Code 54310 (CT) complete study - an extensive study of the sacral spine.	-	-		
54100	X-ray of the sacrum and coccyx	-	-	3.58	**692.69**
54110	X-ray of the sacro-iliac joints	-	-	4.10	**793.31**
54120	X-ray tomography – sacrum and/or coccyx	-	-	4.30	**832.01**
54300	CT of the sacrum – limited study	-	-	7.60	**1 470.52**
54310	CT of the sacrum – complete study – uncontrasted	-	-	25.61	**4 955.28**
54320	CT of the sacrum with contrast	-	-	46.93	**9 080.49**
54330	CT of the sacrum pre and post contrast	-	-	52.97	**10 249.17**
54400	MR of the sacrum	-	-	65.00	**12 576.85**
54410	MR of the sacrum pre and post contrast	-	-	101.04	**19 550.23**
	Pelvis	-	-		
	Codes 55110 (tomography) and 55100 (pelvis) may be combined. Code 55300 (CT) limited study – limited to a small region of interest of the pelvis eg. ascetabular roof or pubic ramus.	-	-		
55100	X-ray of the pelvis	-	-	3.66	**708.17**
55110	X-ray tomography – pelvis	-	-	4.30	**832.01**
55300	CT of the bony pelvis limited	-	-	9.50	**1 838.16**
55310	CT of the bony pelvis complete uncontrasted	-	-	25.61	**4 955.28**
55320	CT of the bony pelvis complete 3D recon	-	-	37.47	**7 250.07**
55330	CT of the bony pelvis with contrast	-	-	46.93	**9 080.49**
55340	CT of the bony pelvis – pre and post contrast	-	-	52.97	**10 249.17**
55400	MR of the bony pelvis	-	-	65.00	**12 576.85**
55410	MR of the bony pelvis pre and post contrast	-	-	102.24	**19 782.42**
55900	Nuclear medicine study – Bone regional pelvis	-	-	21.50	**4 160.04**
55910	Nuclear medicine study – Bone tomography regional pelvis	-	-	13.41	**2 594.70**
55920	Nuclear medicine study – with flow	-	-	6.02	**1 164.81**
	Hips	-	-		
	Code 56130 (tomography) may be combined with 56100 or 56110 or 56120 (hip). Code 56140 (stress) may be combined with 56100 or 56110 or 56120 (hip). Code 56150 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 56160 (introduction of contrast into hip joint) to be used with 56310 (CT hip) and 56410 (MR hip) and includes fluoroscopy. The combination of 56150 and 56310 and 56410 is not supported except in exceptional circumstances with motivation. Code 56300 (CT) study limited to small region of interest eg part of femur head.	-	-		
56100	X-ray of the left hip	-	-	3.18	**615.30**
56110	X-ray of the right hip	-	-	3.18	**615.30**
56120	X-ray pelvis and hips	-	-	6.02	**1 164.81**
56130	X-ray tomography – hip	-	-	4.30	**832.01**
56140	X-ray of the hip/s – stress study	-	-	4.38	**847.49**
56150	X-ray arthrography of the hip joint including introduction contrast	-	-	15.75	**3 047.47**
56160	X-ray guidance and introduction of contrast into hip joint only	-	-	7.41	**1 433.76**
56200	Ultrasound of the hip joints	-	-	6.50	**1 257.69**

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
56300	CT of hip – limited	-	-	9.50	1 838.16
56310	CT of hip – complete	-	-	27.37	5 295.82
56320	CT of hip – complete with 3D recon	-	-	39.78	7 697.03
56330	CT of hip with contrast	-	-	43.26	8 370.38
56340	CT of hip pre and post contrast	-	-	47.88	9 264.30
56400	MR of the hip joint/s, limited study	-	-	44.90	8 687.70
56410	MR of the hip joint/s	-	-	64.10	12 402.71
56420	MR of the hip joint/s, pre and post contrast	-	-	101.64	19 666.32
56900	Nuclear medicine study – Bone regional pelvis	-	-	21.50	4 160.04
56910	Nuclear medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
56920	Nuclear medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Upper limbs	-	-		
	General	-	-		
	[illegible] combined with other codes. Code 60110 (tomography) may be combined with any one of the defined regional x-ray studies of the upper limb. Motivation may be required for more than one regional tomographic study per visit. Code 60200 (U/S) may only be used once per visit. Code 60300 (CT) limited study – limited to a small region of interest eg. part of humeral head. Code 60400 (MR limited) may only be used once per visit.	-	-		
60100	X-ray upper limbs - any region - stress studies only	-	-	4.52	874.57
60110	X-ray upper limbs - any region – tomography	-	-	4.30	832.01
60200	Ultrasound upper limb – soft tissue - any region	-	-	7.38	1 427.96
60210	Ultrasound of the peripheral arterial system of the left arm including B mode, pulse and colour doppler	-	-	13.64	2 639.20
60220	Ultrasound of the peripheral arterial system of the right arm including B mode, pulse and colour doppler	-	-	13.64	2 639.20
60230	Ultrasound peripheral venous system upper limbs including pulse and colour doppler for deep vein thrombosis	-	-	12.54	2 426.36
60240	Ultrasound peripheral venous system upper limbs including pulse and colour doppler	-	-	17.26	3 339.64
60300	CT of the upper limbs limited study	-	-	9.50	1 838.16
60310	CT angiography of the upper limb	-	-	78.28	15 146.40
60400	MR of the upper limbs limited study, any region	-	-	44.80	8 668.35
60410	MR angiography of the upper limb	-	-	74.66	14 445.96
60500	Arteriogram of subclavian, upper limb arteries alone, unilateral	-	-	45.67	8 836.69
60510	Arteriogram of subclavian, upper limb arteries alone, bilateral	-	-	82.67	15 995.82
60520	Arteriogram of aortic arch, subclavian, upper limb, unilateral	-	-	56.75	10 980.56
60530	Arteriogram of aortic arch, subclavian, upper limb, bilateral	-	-	88.11	17 048.40
60540	Venography, antegrade of upper limb veins, unilateral	-	-	26.12	5 053.96
60550	Venography, antegrade of upper limb veins, bilateral	-	-	49.43	9 564.21
60560	Venography, retrograde of upper limb veins, unilateral	-	-	31.01	6 000.12
60570	Venography, retrograde of upper limb veins, bilateral	-	-	54.81	10 605.19
60580	Venography, shuntogram, dialysis access shunt	-	-	23.79	4 603.13
60900	Nuclear medicine study – Venogram upper limb	-	-	37.12	7 182.35
	Shoulder	-	-		
	Code 61160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 61170 (introduction of contrast into the shoulder joint) may be combined with 61300 and 61305 (CT), or 61400 and 61405 (MR). The combination of 61160 (arthrography) and 61300 and 61305 (CT) or 61400 and 61405 (MR) is not supported except in exceptional circumstances with motivation.	-	-		
61100	X-ray of the left clavicle	-	-	3.04	588.21
61105	X-ray of the right clavicle	-	-	3.04	588.21
61110	X-ray of the left scapula	-	-	3.04	588.21
61115	X-ray of the right scapula	-	-	3.04	588.21
61120	X-ray of the left acromio-clavicular joint	-	-	3.14	607.56
61125	X-ray of the right acromio-clavicular joint	-	-	3.14	607.56
61128	X-ray of acromio-clavicular joints plus stress studies bilateral	-	-	7.68	1 486.00

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
61130	X-ray of the left shoulder	-	-	3.48	673.35
61135	X-ray of the right shoulder	-	-	3.48	673.35
61140	X-ray of the left shoulder plus subacromial impingement views	-	-	5.92	1 145.46
61145	X-ray of the right shoulder plus subacromial impingement views	-	-	5.92	1 145.46
61150	X-ray of the left subacromial impingement views only	-	-	3.24	626.91
61155	X-ray of the right subacromial impingement views only	-	-	3.24	626.91
61160	X-ray arthrography shoulder joint including introduction of contrast	-	-	15.83	3 062.95
61170	X-ray guidance and introduction of contrast into shoulder joint only	-	-	7.41	1 433.76
61200	Ultrasound of the left shoulder joint	-	-	6.50	1 257.69
61210	Ultrasound of the right shoulder joint	-	-	6.50	1 257.69
61300	CT of the left shoulder joint – uncontrasted	-	-	24.36	4 713.42
61305	CT of the right shoulder joint – uncontrasted	-	-	24.36	4 713.42
61310	CT of the left shoulder – complete with 3D recon	-	-	37.66	7 286.83
61315	CT of the right shoulder – complete with 3D recon	-	-	37.66	7 286.83
61320	CT of the left shoulder joint - pre and post contrast	-	-	48.63	9 409.42
61325	CT of the right shoulder joint - pre and post contrast	-	-	48.63	9 409.42
61400	MR of the left shoulder	-	-	64.64	12 507.19
61405	MR of the right shoulder	-	-	64.64	12 507.19
61410	MR of the left shoulder pre and post contrast	-	-	101.04	19 550.23
61415	MR of the right shoulder pre and post contrast	-	-	101.04	19 550.23
	Humerus	-	-		
62100	X-ray of the left humerus	-	-	2.94	568.86
62105	X-ray of the right humerus	-	-	2.94	568.86
62300	CT of the left upper arm	-	-	24.36	4 713.42
62305	CT of the right upper arm	-	-	24.36	4 713.42
62310	CT of the left upper arm contrasted	-	-	39.97	7 733.80
62315	CT of the right upper arm contrasted	-	-	39.97	7 733.80
62320	CT of the left upper arm pre and post contrast	-	-	48.58	9 399.74
62325	CT of the right upper arm pre and post contrast	-	-	48.58	9 399.74
62400	MR of the left upper arm	-	-	64.20	12 422.06
62405	MR of the right upper arm	-	-	64.20	12 422.06
62410	MR of the left upper arm pre and post contrast	-	-	102.04	19 743.72
62415	MR of the right upper arm pre and post contrast	-	-	102.04	19 743.72
62900	Nuclear medicine study – Bone limited/regional static	-	-	21.50	4 160.04
62905	Nuclear medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
62910	Nuclear medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Elbow	-	-		
	Code 63120 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 63130 (introduction of contrast) may be combined with 63300 and 63305 (CT) or 63400 and 63405 (MR). The combination of 63120 (arthrography) and 63300 and 63305 or 63400 and 63405 (MR) is not supported except in exceptional circumstances with motivation.	-	-		
63100	X-ray of the left elbow	-	-	3.14	607.56
63105	X-ray of the right elbow	-	-	3.14	607.56
63110	X-ray of the left elbow with stress	-	-	4.34	839.75
63115	X-ray of the right elbow with stress	-	-	4.34	839.75
63120	X-ray arthrography elbow joint including introduction of contrast	-	-	15.89	3 074.56
63130	X-ray guidance and introduction of contrast into elbow joint only	-	-	7.41	1 433.76
63200	Ultrasound of the left elbow joint	-	-	6.50	1 257.69
63205	Ultrasound of the right elbow joint	-	-	6.50	1 257.69
63300	CT of the left elbow	-	-	24.36	4 713.42
63305	CT of the right elbow	-	-	24.36	4 713.42
63310	CT of the left elbow – complete with 3D recon	-	-	37.66	7 286.83
63315	CT of the right elbow – complete with 3D recon	-	-	37.66	7 286.83

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
63320	CT of the left elbow contrasted	-	-	39.97	7 733.80
63325	CT of the right elbow contrasted	-	-	39.97	7 733.80
63330	CT of the left elbow pre and post contrast	-	-	48.63	9 409.42
63335	CT of the right elbow pre and post contrast	-	-	48.63	9 409.42
63400	MR of the left elbow	-	-	64.64	12 507.19
63405	MR of the right elbow	-	-	64.64	12 507.19
63410	MR of the left elbow pre and post contrast	-	-	101.04	19 550.23
63415	MR of the right elbow pre and post contrast	-	-	101.04	19 550.23
63905	Nuclear medicine study – Bone limited/regional static	-	-	21.50	4 160.04
63910	Nuclear medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
63915	Nuclear medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Forearm	-	-		
64100	X-ray of the left forearm	-	-	2.94	568.86
64105	X-ray of the right forearm	-	-	2.94	568.86
64110	X-ray peripheral bone densitometry	-	-	1.96	379.24
64300	CT of the left forearm	-	-	24.36	4 713.42
64305	CT of the right forearm	-	-	24.36	4 713.42
64310	CT of the left forearm contrasted	-	-	39.97	7 733.80
64315	CT of the right forearm contrasted	-	-	39.97	7 733.80
64320	CT of the left forearm pre and post contrast	-	-	48.58	9 399.74
64325	CT of the right forearm pre and post contrast	-	-	48.58	9 399.74
64400	MR of the left forearm	-	-	64.20	12 422.06
64405	MR of the right forearm	-	-	64.20	12 422.06
64410	MR of the left forearm pre and post contrast	-	-	98.04	18 969.76
64415	MR of the right forearm pre and post contrast	-	-	98.04	18 969.76
64900	Nuclear medicine study – Bone limited/regional static	-	-	21.50	4 160.04
64905	Nuclear medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
64910	Nuclear medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Hand and Wrist	-	-		
	Code 65120 (finger) may not be combined with 65100 or 65105 (hands). Codes 65130 and 65135 (wrists) may be combined with 65140 or 65145 (scaphoid) respectively if requested and additional views done. Code 65160 (arthrography) includes fluoroscopy and the introduction of contrast (00140 may not be added). Code 65170 (contrast) may be combined with 65300 and 65305 (CT) or 65400 and 65405 (MR). The combination of 65160 (arthrography) and 65300 and 65305 or 65400 and 65405 is not supported except in exceptional circumstances with motivation.	-	-		
65100	X-ray of the left hand	-	-	3.08	595.95
65105	X-ray of the right hand	-	-	3.08	595.95
65110	X-ray of the left hand – bone age	-	-	3.08	595.95
65120	X-ray of a finger	-	-	2.67	516.62
65130	X-ray of the left wrist	-	-	3.18	615.30
65135	X-ray of the right wrist	-	-	3.18	615.30
65140	X-ray of the left scaphoid	-	-	3.30	638.52
65145	X-ray of the right scaphoid	-	-	3.30	638.52
65150	X-ray of the left wrist, scaphoid and stress views	-	-	7.56	1 462.78
65155	X-ray of the right wrist, scaphoid and stress views	-	-	7.56	1 462.78
65160	X-ray arthrography wrist joint including introduction of contrast	-	-	15.93	3 082.30
65170	X-ray guidance and introduction of contrast into wrist joint only	-	-	7.41	1 433.76
65200	Ultrasound of the left wrist	-	-	6.50	1 257.69
65210	Ultrasound of the right wrist	-	-	6.50	1 257.69
65300	CT of the left wrist and hand	-	-	24.36	4 713.42
65305	CT of the right wrist and hand	-	-	24.36	4 713.42
65310	CT of the left wrist and hand - complete with 3D recon	-	-	37.66	7 286.83
65315	CT of the right wrist and hand - complete with 3D recon	-	-	37.66	7 286.83
65320	CT of the left wrist and hand contrasted	-	-	39.97	7 733.80

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
65325	CT of the right wrist and hand contrasted	-	-	39.97	7 733.80
65330	CT of the left wrist and hand pre and post contrast	-	-	48.63	9 409.42
65335	CT of the right wrist and hand pre and post contrast	-	-	48.63	9 409.42
65400	MR of the left wrist and hand	-	-	64.64	12 507.19
65405	MR of the right wrist and hand	-	-	64.64	12 507.19
65410	MR of the left wrist and hand pre and post contrast	-	-	101.04	19 550.23
65415	MR of the right wrist and hand pre and post contrast	-	-	101.04	19 550.23
65900	Nuclear Medicine study – bone limited/regional static	-	-	21.50	4 160.04
65905	Nuclear Medicine study – bone limited static plus flow	-	-	27.53	5 326.78
65910	Nuclear Medicine study – bone tomography regional	-	-	13.41	2 594.70
	Soft Tissue	-	-		
69900	Nuclear medicine study – Tumour localisation planar, static	-	-	20.74	4 012.98
69905	Nuclear medicine study – Tumour localisation planar, static, multiple studies	-	-	35.17	6 805.04
69910	Nuclear medicine study – Tumour localisation planar, static and SPECT	-	-	34.15	6 607.68
69915	Nuclear medicine study – Tumour localisation planar, static, multiple studies and SPECT	-	-	47.56	9 202.38
69920	Nuclear medicine study – Infection localisation planar, static	-	-	18.04	3 490.56
69925	Nuclear medicine study – Infection localisation planar, static, multiple studies	-	-	31.45	6 085.26
69930	Nuclear medicine study – Infection localisation planar, static and SPECT	-	-	31.45	6 085.26
69935	Nuclear medicine study – Infection localisation planar, static, multiple studies and SPECT	-	-	44.86	8 679.96
69940	Nuclear medicine study – Regional lymph node mapping dynamic	-	-	6.02	1 164.81
69945	Nuclear medicine study – Regional lymph node mapping, static, planar	-	-	24.10	4 663.11
69950	Nuclear medicine study – Regional lymph node mapping, static, planar, multiple	-	-	37.51	7 257.81
69955	Nuclear medicine study – Regional lymph node mapping SPECT	-	-	13.41	2 594.70
69960	Nuclear medicine study – Lymph node localisation with gamma probe	-	-	13.41	2 594.70
	Lower Limbs	-	-		
	General	-	-		
	Code 70100 (stress) is a stand alone study and may not be combined with other codes. Code 70110 (tomography) may be combined with any one of the defined regional x-ray studies of the lower limb. Motivation may be required for more than one regional tomographic study per visit. Code 70200 (U/S) may only be billed once per visit. Code 70300 ((CT) limited study – limited to a small region of interest eg part of condyle of the knee. Codes 70310 and 70320 (CT angiography) may not be combined. Code 70400 (MR limited) may only be used once per visit. Code 70410 and 70420 (MR angiography) may not be combined.	-	-		
70100	X-ray lower limbs - any region- stress studies only	-	-	4.52	874.57
70110	X-ray lower limbs - any region-tomography	-	-	4.30	832.01
70120	X-ray of the lower limbs full length study	-	-	6.46	1 249.95
70200	Ultrasound lower limb – soft tissue - any region	-	-	7.38	1 427.96
70210	Ultrasound of the peripheral arterial system of the left leg including B mode, pulse and colour Doppler	-	-	13.64	2 639.20
70220	Ultrasound of the peripheral arterial system of the right leg including B mode, pulse and colour Doppler	-	-	13.64	2 639.20
70230	Ultrasound peripheral venous system lower limbs including pulse and colour doppler for deep vein thrombosis	-	-	13.64	2 639.20
70240	Ultrasound peripheral venous system lower limbs including pulse and colour doppler in erect and supine position including all compression and reflux manoeuvres, deep and superficial systems bilaterally	-	-	19.66	3 804.01

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
70300	CT of the lower limbs limited study	-	-	9.50	1 838.16
70310	CT angiography of the lower limb	-	-	79.43	15 368.91
70320	CT angiography abdominal aorta and outflow lower limbs	-	-	98.34	19 027.81
70400	MR of the lower limbs limited study	-	-	46.40	8 977.94
70410	MR angiography of the lower limb	-	-	76.66	14 832.94
70420	MR angiography of the abdominal aorta and lower limbs	-	-	118.86	22 998.22
70500	Angiography of pelvic and lower limb arteries unilateral	-	-	40.59	7 853.76
70505	Angiography of pelvic and lower limb arteries bilateral	-	-	75.92	14 689.76
70510	Angiography of abdominal aorta, pelvic and lower limb vessels unilateral	-	-	61.23	11 847.39
70515	Angiography of abdominal aorta, pelvic and lower limb vessels bilateral	-	-	85.66	16 574.35
70520	Angiography translumbar aorta with full peripheral study	-	-	45.68	8 838.62
70530	Venography, antegrade of lower limb veins, unilateral	-	-	25.46	4 926.26
70535	Venography, antegrade of lower limb veins, bilateral	-	-	49.43	9 564.21
70540	Venography, retrograde of lower limb veins, unilateral	-	-	31.17	6 031.08
70545	Venography, retrograde of lower limb veins, bilateral	-	-	56.79	10 988.30
70560	Lymphangiography, lower limb, unilateral	-	-	51.04	9 875.73
70565	Lymphangiography, lower limb, bilateral	-	-	83.97	16 247.36
70900	Nuclear medicine study – Venogram lower limb	-	-	37.12	7 182.35
	Femur	-	-		
71100	X-ray of the left femur	-	-	2.94	568.86
71105	X-ray of the right femur	-	-	2.94	568.86
71300	CT of the left femur	-	-	24.52	4 744.37
71305	CT of the right femur	-	-	24.52	4 744.37
71310	CT of the left upper leg contrasted	-	-	41.83	8 093.69
71315	CT of the right upper leg contrasted	-	-	41.83	8 093.69
71320	CT of the left upper leg pre and post contrast	-	-	49.71	9 618.39
71325	CT of the right upper leg pre and post contrast	-	-	49.71	9 618.39
71400	MR of the left upper leg	-	-	64.80	12 538.15
71405	MR of the right upper leg	-	-	64.80	12 538.15
71410	MR of the left upper leg pre and post contrast	-	-	102.04	19 743.72
71415	MR of the right upper leg pre and post contrast	-	-	102.04	19 743.72
71900	Nuclear Medicine study – bone limited/regional static	-	-	21.50	4 160.04
71905	Nuclear Medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
71910	Nuclear Medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Knee	-	-		
	Codes 72140 and 72145 (patella) may not be added to 72100, 72105, 72110, 72115, 72130, 72135 (knee views) Code 72160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 72170 (introduction of contrast) may be combined with 72300 and 72305 (CT) or 72400 and 72405 (MR). The combination of 72160 (arthrography) and 72300 and 72305 (CT) or 72400 and 72405 (MR) is not supported except in exceptional circumstances with motivation.	-	-		
72100	X-ray of the left knee one or two views	-	-	2.77	535.97
72105	X-ray of the right knee one or two views	-	-	2.77	535.97
72110	X-ray of the left knee, more than two views	-	-	3.32	642.39
72115	X-ray of the right knee, more than two views	-	-	3.32	642.39
72120	X-ray of the left knee including patella	-	-	4.62	893.92
72125	X-ray of the right knee including patella	-	-	4.62	893.92
72130	X-ray of the left knee with stress views	-	-	5.82	1 126.11
72135	X-ray of the right knee with stress views	-	-	5.82	1 126.11
72140	X-ray of left patella	-	-	2.77	535.97
72145	X-ray of right patella	-	-	2.77	535.97
72150	X-ray both knees standing – single view	-	-	2.80	541.77
72160	X-ray arthrography knee joint including introduction of contrast	-	-	15.81	3 059.08
72170	X-ray guidance and introduction of contrast into knee joint only	-	-	7.41	1 433.76
72200	Ultrasound of the left knee joint	-	-	6.50	1 257.69

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
72205	Ultrasound of the right knee joint	-	-	6.50	1 257.69
72300	CT of the left knee	-	-	24.52	4 744.37
72305	CT of the right knee	-	-	24.52	4 744.37
72310	CT of the left knee complete study with 3D reconstructions	-	-	35.93	6 952.10
72315	CT of the right knee complete study with 3D reconstructions	-	-	35.93	6 952.10
72320	CT of the left knee contrasted	-	-	41.83	8 093.69
72325	CT of the right knee contrasted	-	-	41.83	8 093.69
72330	CT of the left knee pre and post contrast	-	-	49.76	9 628.06
72335	CT of the right knee pre and post contrast	-	-	49.76	9 628.06
72400	MR of the left knee	-	-	64.10	12 402.71
72405	MR of the right knee	-	-	64.10	12 402.71
72410	MR of the left knee pre and post contrast	-	-	100.84	19 511.53
72415	MR of the right knee pre and post contrast	-	-	100.84	19 511.53
72900	Nuclear Medicine study – Bone limited/regional static	-	-	21.50	4 160.04
72905	Nuclear Medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
72910	Nuclear Medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Lower Leg	-	-		
73100	X-ray of the left lower leg	-	-	2.94	568.86
73105	X-ray of the right lower leg	-	-	2.94	568.86
73300	CT of the left lower leg	-	-	24.52	4 744.37
73305	CT of the right lower leg	-	-	24.52	4 744.37
73310	CT of the left lower leg contrasted	-	-	41.83	8 093.69
73315	CT of the right lower leg contrasted	-	-	41.83	8 093.69
73320	CT of the left lower leg pre and post contrast	-	-	49.71	9 618.39
73325	CT of the right lower leg pre and post contrast	-	-	49.71	9 618.39
73400	MR of the left lower leg	-	-	64.20	12 422.06
73405	MR of the right lower leg	-	-	64.20	12 422.06
73410	MR of the left lower leg pre and post contrast	-	-	102.04	19 743.72
73415	MR of the right lower leg pre and post contrast	-	-	102.04	19 743.72
73900	Nuclear Medicine study – bone limited/regional static	-	-	21.50	4 160.04
73905	Nuclear Medicine study – bone limited static plus flow	-	-	27.53	5 326.78
73910	Nuclear Medicine study – bone tomography regional	-	-	13.41	2 594.70
	Ankle and Foot Code 74145 (toe) may not be combined with 74120 or 74125 (foot). Code 71450 (sesamoid bones) may be combined with 74120 or 74125 (foot) if requested. Codes 74120 and 74125 (foot) may only be combined with 74130 and 74135 (calcaneus) if specifically requested. Code 74160 (arthrography) includes fluoroscopy and introduction of contrast (00140 may not be added). Code 74170 (introduction of contrast) may be combined with 74300 and 74305 (CT) or 74400 and 74405 (MR). The combination of 74160 (arthrography) and 74300 and 74305 (CT) or 74400 and	-	-		
74100	X-ray of the left ankle	-	-	3.32	642.39
74105	X-ray of the right ankle	-	-	3.32	642.39
74110	X-ray of the left ankle with stress views	-	-	4.52	874.57
74115	X-ray of the right ankle with stress views	-	-	4.52	874.57
74120	X-ray of the left foot	-	-	2.80	541.77
74125	X-ray of the right foot	-	-	2.80	541.77
74130	X-ray of the left calcaneus	-	-	2.74	530.16
74135	X-ray of the right calcaneus	-	-	2.74	530.16
74140	X-ray of both feet – standing – single view	-	-	2.80	541.77
74145	X-ray of a toe	-	-	2.67	516.62
74150	X-ray of the sesamoid bones one or both sides	-	-	2.80	541.77
74160	X-ray arthrography ankle joint including introduction of contrast	-	-	15.91	3 078.43
74170	X-ray guidance and introduction of contrast into ankle joint	-	-	7.41	1 433.76
74210	Ultrasound of the left ankle	-	-	6.50	1 257.69
74215	Ultrasound of the right ankle	-	-	6.50	1 257.69
74220	Ultrasound of the left foot	-	-	6.50	1 257.69

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
74225	Ultrasound of the right foot	-	-	6.50	1 257.69
74290	Ultrasound bone densitometry	-	-	2.04	394.72
74300	CT of the left ankle/foot	-	-	24.52	4 744.37
74305	CT of the right ankle/foot	-	-	24.52	4 744.37
74310	CT of the left ankle/foot – complete with 3D recon	-	-	37.81	7 315.86
74315	CT of the right ankle/foot – complete with 3D recon	-	-	37.81	7 315.86
74320	CT of the left ankle/foot contrasted	-	-	41.83	8 093.69
74325	CT of the right ankle/foot contrasted	-	-	41.83	8 093.69
74330	CT of the left ankle/foot pre and post contrast	-	-	49.71	9 618.39
74335	CT of the right ankle/foot pre and post contrast	-	-	49.71	9 618.39
74400	MR of the left ankle	-	-	64.10	12 402.71
74405	MR of the right ankle	-	-	64.10	12 402.71
74410	MR of the left ankle pre and post contrast	-	-	100.64	19 472.83
74415	MR of the right ankle pre and post contrast	-	-	100.64	19 472.83
74420	MR of the left foot	-	-	64.20	12 422.06
74425	MR of the right foot	-	-	64.20	12 422.06
74430	MR of the left foot pre and post contrast	-	-	102.04	19 743.72
74435	MR of the right foot pre and post contrast	-	-	102.04	19 743.72
74900	Nuclear Medicine study – Bone limited/regional static	-	-	21.50	4 160.04
74905	Nuclear Medicine study – Bone limited static plus flow	-	-	27.53	5 326.78
74910	Nuclear Medicine study – Bone tomography regional	-	-	13.41	2 594.70
	Soft Tissue	-	-		
79900	Nuclear Medicine study – Tumour localisation planar, static	-	-	20.74	4 012.98
79905	Nuclear Medicine study – Tumour localisation planar, static, multiple studies	-	-	35.17	6 805.04
79910	Nuclear Medicine study – Tumour localisation planar, static and SPECT	-	-	34.15	6 607.68
79915	Nuclear Medicine study – Tumour localisation planar, static, multiple studies & SPECT	-	-	47.56	9 202.38
79920	Nuclear Medicine study – Infection localisation planar, static	-	-	18.43	3 566.02
79925	Nuclear Medicine study – Infection localisation planar, static, multiple studies	-	-	31.84	6 160.72
79930	Nuclear Medicine study – Infection localisation planar, static and SPECT	-	-	31.84	6 160.72
79935	Nuclear Medicine study – Infection localisation planar, static, multiple studies and SPECT	-	-	45.25	8 755.42
79940	Nuclear Medicine study – Regional lymph node mapping dynamic	-	-	6.02	1 164.81
79945	Nuclear Medicine study – Regional lymph node mapping, static, planar	-	-	24.10	4 663.11
79950	Nuclear Medicine study – Regional lymph node mapping, static, planar, multiple studies	-	-	37.51	7 257.81
79955	Nuclear Medicine study – Regional lymph node mapping and SPECT	-	-	13.41	2 594.70
79960	Nuclear Medicine study – Lymph node localisation with gamma probe	-	-	13.41	2 594.70
	Intervention	-	-		
	General	-	-		
	Codes 80600, 80605, 80610, 80620, 80630, 81660, 81680, 82600, 84660, 85640, 85645, 86610, 86615, 86620, 86630, (aspiration / biopsy / ablations etc) may be combined with the relevant guidance codes (fluoroscopy, ultrasound, CT, MR) as previously described. The machine codes 00510, 00520, 00530, 00540, 00550, 00560 may not be combined with these codes. If ultrasound guidance (00230) is used for a procedure which also attracts one of the machine codes (00510, 00520, 00530, 00540, 00550, 00560), it may not be billed for separately. Codes 80640, 80645, 87682, 87683 include fluoroscopy. Machine fees may not be added. All other interventional procedures are complete unique procedures describing a whole comprehensive procedure and combinations of different codes will only be supported when motivated.	-	-		

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
80600	Percutaneous abscess, cyst drainage, any region	-	-	9.37	1 813.00
80605	Fine needle aspiration biopsy, any region	-	-	4.22	816.53
80610	Cutting needle, trochar biopsy, any region	-	-	6.36	1 230.60
80620	Tumour/cyst ablation chemical	-	-	25.37	4 908.84
80630	Tumour ablation radio frequency, per lesion	-	-	21.21	4 103.92
80640	Insertion of CVP line in radiology suite	-	-	8.99	1 739.48
80645	Peripheral central venous line insertion	-	-	12.12	2 345.10
80650	Infiltration of a peripheral joint, any region	-	-	6.40	1 238.34
	May be combined with relevant guidance (fluoroscopy, ultrasound, CT and MR). May not be combined with machine codes 00510, 00520, 00530, 00540, 00550, 00560 or 86610 (facet joint or SI joint) or arthrogram codes.	-	-		
	Neuro intervention	-	-		
81600	Intracranial aneurysm occlusion, direct	-	-	214.52	41 507.47
81605	Intracranial arteriovenous shunt occlusion	-	-	254.82	49 305.12
81610	Dural sinus arteriovenous shunt occlusion	-	-	264.33	51 145.21
81615	Extracranial arteriovenous shunt occlusion	-	-	157.28	30 432.11
81620	Extracranial arterial embolisation (head and neck)	-	-	163.12	31 562.09
81625	Caroticocavernous fistula occlusion	-	-	192.29	37 206.19
81630	Intracranial angioplasty for stenosis, vasospasm	-	-	126.92	24 557.75
81632	Intracranial stent placement (including PTA)	-	-	133.72	25 873.48
81635	Temporary balloon occlusion test	-	-	83.42	16 140.94
	Code 81635 does not include the relevant preceding diagnostic study and may be combined with codes 10500, 10510, 10530, 10540, 10550.	-	-		
81640	Permanent carotid or vertebral artery occlusion (including occlusion test)	-	-	178.18	34 476.05
81645	Intracranial aneurysm occlusion with balloon remodelling	-	-	216.35	41 861.56
81650	Intracranial aneurysm occlusion with stent assistance	-	-	230.45	44 589.77
81655	Intracranial thrombolysis, catheter directed	-	-	58.94	11 404.30
	Code 81655 may be combined with any of the other neuro interventional codes 81600 to 81650	-	-		
81660	Nerve block, head and neck, per level	-	-	7.66	1 482.13
81665	Neurolysis, head and neck, per level	-	-	20.14	3 896.89
81670	Nerve block, head and neck, radio frequency, per level	-	-	19.04	3 684.05
81680	Nerve block, coeliac plexus or other regions, per level	-	-	9.28	1 795.59
	Thorax	-	-		
82600	Chest drain insertion	-	-	8.82	1 706.58
82605	Trachial, bronchial stent insertion	-	-	30.36	5 874.36
	Gastrointestinal	-	-		
83600	Oesophageal stent insertion	-	-	31.22	6 040.76
83605	GIT balloon dilation	-	-	24.36	4 713.42
83610	GIT stent insertion (non-oesophageal)	-	-	32.02	6 195.55
83615	Percutaneous gastrostomy, jejunostomy	-	-	25.36	4 906.91
	Hepatobiliary	-	-		
84600	Percutaneous biliary drainage, external	-	-	33.98	6 574.79
84605	Percutaneous external/internal biliary drainage	-	-	37.21	7 199.76
84610	Permanent biliary stent insertion	-	-	51.22	9 910.56
84615	Drainage tube replacement	-	-	20.22	3 912.37
84620	Percutaneous bile duct stone or foreign object removal	-	-	49.98	9 670.63
84625	Percutaneous gall bladder drainage	-	-	29.58	5 723.43
84630	Percutaneous gallstone removal, including drainage	-	-	69.25	13 399.18
84635	Transjugular liver biopsy	-	-	24.93	4 823.71
84640	Transjugular intrahepatic Portosystemic shunt	-	-	119.47	23 116.25
84645	Transhepatic Portogram including venous sampling, pressure studies	-	-	81.89	15 844.90
84650	Transhepatic Portogram with embolisation of varices	-	-	100.81	19 505.73
84655	Percutaneous hepatic tumour ablation	-	-	15.68	3 033.92
84660	Percutaneous hepatic abscess, cyst drainage	-	-	13.20	2 554.07
84665	Hepatic chemoembolisation	-	-	59.44	11 501.05

		Other specialist / General Practitioner		Specialist	
		U/E	R	U/E	
84670	Hepatic arterial infusion catheter placement	-	-	60.30	11 667.45
	Urogenital	-	-		
85600	Percutaneous nephrostomy, external drainage	-	-	29.97	5 798.90
85605	Percutaneous double J stent insertion including access	-	-	40.82	7 898.26
85610	Percutaneous renal stone, foreign body removal including access	-	-	66.79	12 923.20
85615	Percutaneous nephrostomy tract establishment	-	-	29.27	5 663.45
85620	Change of nephrostomy tube	-	-	15.90	3 076.49
85625	Percutaneous cystostomy	-	-	16.52	3 196.45
85630	Urethral balloon dilatation	-	-	14.24	2 755.30
85635	Urethral stent insertion	-	-	31.22	6 040.76
85640	Renal cyst ablation	-	-	11.92	2 306.40
85645	Renal abscess, cyst drainage	-	-	15.16	2 933.31
85655	Fallopian tube recanalisation	-	-	45.06	8 718.66
	Spinal	-	-		
86600	Spinal vascular malformation embolisation	-	-	275.16	53 240.71
86605	Vertebroplasty per level	-	-	22.30	4 314.83
86610	Facet joint block per level, uni- or bilateral Code 86610 may only be billed once per level, and not per left and right side per level	-	-	9.54	1 845.89
86615	Spinal nerve block per level, uni- or bilateral	-	-	8.16	1 578.88
86620	Epidural block	-	-	9.42	1 822.68
86625	Chemonucleolysis, including discogram	-	-	18.32	3 544.74
86630	Spinal nerve ablation per level	-	-	11.60	2 244.48
	Vascular Code 87654 (Thrombolysis follow up) may only be used on the days following the initial procedure, 87650 (thrombolysis). If a balloon angioplasty and / or stent placement is performed at more that one defined anatomical site at the same sitting the relevant codes may be combined. However multiple balloon dilatations or stent placements at one defined site will only attract one procedure code.	-	-		
87600	Percutaneous transluminal angioplasty: aorta, IVC	-	-	56.56	10 943.79
87601	Percutaneous transluminal angioplasty: iliac	-	-	55.76	10 789.00
87602	Percutaneous transluminal angioplasty: femoropopliteal	-	-	60.16	11 640.36
87603	Percutaneous transluminal angioplasty: subpopliteal	-	-	73.34	14 190.56
87604	Percutaneous transluminal angioplasty: brachiocephalic	-	-	67.12	12 987.05
87605	Percutaneous transluminal angioplasty: subclavian, axillary	-	-	60.16	11 640.36
87606	Percutaneous transluminal angioplasty: extracranial carotid	-	-	71.62	13 857.75
87607	Percutaneous transluminal angioplasty: extracranial vertebral	-	-	73.30	14 182.82
87608	Percutaneous transluminal angioplasty: renal	-	-	87.69	16 967.14
87609	Percutaneous transluminal angioplasty: coeliac, mesenteric	-	-	87.69	16 967.14
87620	Aorta stent-graft placement	-	-	120.75	23 363.92
87621	Stent insertion (including PTA): aorta, IVC	-	-	73.87	14 293.11
87622	Stent insertion (including PTA): iliac	-	-	76.37	14 776.83
87623	Stent insertion (including PTA): femoropopliteal	-	-	77.97	15 086.42
87624	Stent insertion (including PTA): subpopliteal	-	-	84.55	16 359.58
87625	Stent insertion (including PTA): brachiocephalic	-	-	98.47	19 052.96
87626	Stent insertion (including PTA): subclavian, axillary	-	-	86.69	16 773.65
87627	Stent insertion (including PTA): extracranial carotid	-	-	106.99	20 701.50
87628	Stent insertion (including PTA): extracranial vertebral	-	-	100.55	19 455.42
87629	Stent insertion (including PTA): renal	-	-	98.59	19 076.18
87630	Stent insertion (including PTA): coeliac, mesenteric	-	-	98.59	19 076.18
87631	Stent-graft placement: iliac	-	-	76.37	14 776.83
87632	Stent-graft placement: femoropopliteal	-	-	77.97	15 086.42
87633	Stent-graft placement: brachiocephalic	-	-	98.47	19 052.96
87634	Stent-graft placement: subclavian, axillary	-	-	82.77	16 015.17
87635	Stent-graft placement: extracranial carotid	-	-	120.43	23 302.00
87636	Stent-graft placement: extracranial vertebral	-	-	114.73	22 199.11

			Other specialist / General Practitioner		Specialist	
			U/E	R	U/E	
87637	Stent-graft placement: renal		-	-	98.59	19 076.18
87638	Stent-graft placement: coeliac, mesenteric		-	-	98.59	19 076.18
87650	Thrombolysis in angiography suite, per 24 hours		-	-	45.82	8 865.71
	Code 87650 may be combined with any of the relevant non neuro interventional angiography and interventional codes 10520, 20500, 20510, 20520, 20530, 20540,32500,32530,44500, 44503, 44505, 44507, 44510, 44515, 44517, 44520, 60500, 60510, 60520, 60530, 70500, 70505, 70510, 70515, 87600 to 87638.		-	-		
87651	Aspiration, rheolytic thrombectomy		-	-	77.67	15 028.37
87652	Atherectomy, per vessel		-	-	91.89	17 779.80
87653	or other line insertion		-	-	28.15	5 446.74
87654	Thrombolysis follow-up		-	-	23.57	4 560.56
87655	Percutaneous sclerotherapy, vascular malformation		-	-	21.10	4 082.64
87660	Embolisation, mesenteric		-	-	100.43	19 432.20
87661	Embolisation, renal		-	-	99.36	19 225.17
87662	Embolisation, bronchial, intercostal		-	-	108.34	20 962.71
87663	Embolisation, pulmonary arteriovenous shunt		-	-	103.22	19 972.04
87664	Embolisation, abdominal, other vessels		-	-	101.44	19 627.63
87665	Embolisation, thoracic, other vessels		-	-	97.60	18 884.62
87666	Embolisation, upper limb		-	-	90.92	17 592.11
87667	Embolisation, lower limb		-	-	92.14	17 828.17
87668	Embolisation, pelvis, non-uterine		-	-	117.12	22 661.55
87669	Embolisation, uterus		-	-	113.88	22 034.64
87670	Embolisation, spermatic, ovaria veins		-	-	85.82	16 605.31
87680	Inferior vena cava filter placement		-	-	61.84	11 965.42
87681	Intravascular foreign body removal		-	-	85.03	16 452.45
87682	Revision of access port (tunnelled or implantable)		-	-	14.12	2 732.08
87683	Removal of access port (tunnelled or implantable)		-	-	11.12	2 151.61
87690	Superior petrosal venous sampling		-	-	73.01	14 126.70
87691	Pancreatic stimulation test		-	-	89.79	17 373.47
87692	Transportal venous sampling		-	-	76.95	14 889.06
87693	Adrenal venous sampling		-	-	55.01	10 643.88
87694	Parathyroid venous sampling		-	-	86.66	16 767.84
87695	Renal venous sampling		-	-	55.01	10 643.88

COIDA Tariff for Medical Practitioners

THE UNIT VALUES FOR THE VARIOUS GROUPS AND SECTIONS AS FROM 1 APRIL 2021 ARE AS FOLLOWS:

	Groups and Sections	Unit Value
1.	Consultation Services codes 0146 & 0109	R 28.37
	Consultation Services: codes 0181; 0182; 0183, 0184, 0186, 0151	R 28.90
2.	Clinical procedures	R 28.37
3.	Anaesthetics	R 132.56
4.	Radiology & MRI	R 29.67
5.	Radiation Oncology	R 31.21
6.	Ultrasound	R 28.03
7.	Computed Tomography	R 28.51
8.	Clinical Pathology	R 29.52
9.	Anatomical Pathology	R 29.14
10	5 Digit Radiology (SP)	R 193.49

Note : The unit value and amounts published in the tariff is **VAT Exclusive**

SYMBOLS USED IN THIS PUBLICATION

•	Per service (specify)
ß	Per service
Φ	Per consultation

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

Select the appropriate injury, modality and indication to be used in conjuction with a MRI.

Annexure A ⟹ *MRI motivation form.*

Annexure B ⟹ *COIDA & RSSA indication for MRI.*

Annexure C ⟹ *Indications for plexus and peripheral nerve block.*

Annexure D ⟹ *System format.*

Annexure: A
The Department of Labour: Compensation Fund

MRI Motivation Form for Employee's Injured on Duty

Claim Number:

Employee's Name:

Employees ID No:

Name of Employer:

Date of Accident / Injury:

Type of Injury:

Brief description of how injury occurred:

Previous clinic / imaging investigations done, and dates:

Imaging investigation required:

Motivation / Clinical indications for the investigation:

Requesting Doctors Name:

Practice Number:

Date of Referral

This form should preferably be typed.

ANNEXURE :B

COIDA & RSSA– Indications for MR Imaging of Injury on Duty Patients

Select the appropriate injury, modality and indication. To be used in conjunction with a MRI / CT motivation. Refer also to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients"

☐ **Head Injury - Acute** (1) (Acute regarded as within first week of date of injury)

- ☐ CT
  - ☐ Reduced level of consciousness (1.i.a)
  - ☐ Seizures (1.i.b)
  - ☐ Neurological deficit (1.i.c)
  - ☐ Skull or facial bone fractures (1.i.d)

☐ **Head + Cervical Spine Injury – Acute** (2)

- ☐ CT
  - ☐ Head as above (2.i)
  - ☐ CT Spine (bone or joint injury) depending on result spine x-ray (2.ii)
- ☐ MRI – in selected cases following a CT (2.iii)

☐ **Head Injury – Sub acute**

- ☐ MRI
  - ☐ Rotational axonal injury (2.d)
  - ☐ Chronic subdural haemorrhage

☐ **Head Injury - long term sequela** (3)

- ☐ CT
  - ☐ If convulsions present in semi acute phase, do CT first (3.b)
- ☐ MRI
  - ☐ Epilepsy (contrast and additional sequences often required) (3.a)
  - ☐ Long term structural changes (3.c)

☐ **Spine – Acute**

- ☐ CT
  - ☐ Bone or joint injury (4.i)
- ☐ MRI
  - ☐ Cord compression (5.i)
  - ☐ Neurological signs (nerve root) (5.ii)
  - ☐ Vertebral body fracture (selected cases) (5.iii)

☐ **Spine – sub acute and long term sequela**

- ☐ MRI
  - ☐ Cord injury (6.i)
  - ☐ Disc herniation (6.ii)
  - ☐ Post operative assessment (selected cases) (6.iii)

☐ **Chest / Body Injury** (7)

- ☐ CT
  - ☐ Sternal fracture
  - ☐ Vascular of lung
  - ☐ Other organs / soft tissue

☐ **Extremities**

- ☐ CT
  - ☐ Complicated fractures and dislocations (10)
- ☐ MRI
  - ☐ Muscle distal biceps insertion (9)
  - ☐ Cartilage, tendons, labrum, soft tissue of, joints (8.iii.a)
  - ☐ Planning repair of joints (8.iii.b)
  - ☐ Knee, elbow, ankle (usually no contrast) (8.iii.d)
  - ☐ Shoulder, wrist, hip (usually with contrast) (8.iii.c)

The numbers after the indications refer to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients". The above indications are not exhaustive, and are merely a selection of the more common indications.

ANNEXURE :B

COIDA & RSSA– Indications for MR Imaging of Injury on Duty Patients

Select the appropriate injury, modality and indication. To be used in conjunction with a MRI / CT motivation. Refer also to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients"

☐ **Head Injury - Acute** (1) (Acute regarded as within first week of date of injury)

- ☐ CT
  - ☐ Reduced level of consciousness (1.i.a)
  - ☐ Seizures (1.i.b)
  - ☐ Neurological deficit (1.i.c)
  - ☐ Skull or facial bone fractures (1.i.d)

☐ **Head + Cervical Spine Injury – Acute** (2)

- ☐ CT
  - ☐ Head as above (2.i)
  - ☐ CT Spine (bone or joint injury) depending on result spine x-ray (2.ii)
- ☐ MRI – in selected cases following a CT (2.iii)

☐ **Head Injury – Sub acute**

- ☐ MRI
  - ☐ Rotational axonal injury (2.d)
  - ☐ Chronic subdural haemorrhage

☐ **Head Injury - long term sequela** (3)

- ☐ CT
  - ☐ If convulsions present in semi acute phase, do CT first (3.b)
- ☐ MRI
  - ☐ Epilepsy (contrast and additional sequences often required) (3.a)
  - ☐ Long term structural changes (3.c)

☐ **Spine – Acute**

- ☐ CT
  - ☐ Bone or joint injury (4.i)
- ☐ MRI
  - ☐ Cord compression (5.i)
  - ☐ Neurological signs (nerve root) (5.ii)
  - ☐ Vertebral body fracture (selected cases) (5.iii)

☐ **Spine – sub acute and long term sequela**

- ☐ MRI
  - ☐ Cord injury (6.i)
  - ☐ Disc herniation (6.ii)
  - ☐ Post operative assessment (selected cases) (6.iii)

☐ **Chest / Body Injury** (7)

- ☐ CT
  - ☐ Sternal fracture
  - ☐ Vascular of lung
  - ☐ Other organs / soft tissue

☐ **Extremities**

- ☐ CT
  - ☐ Complicated fractures and dislocations (10)
- ☐ MRI
  - ☐ Muscle distal biceps insertion (9)
  - ☐ Cartilage, tendons, labrum, soft tissue of, joints (8.iii.a)
  - ☐ Planning repair of joints (8.iii.b)
  - ☐ Knee, elbow, ankle (usually no contrast) (8.iii.d)
  - ☐ Shoulder, wrist, hip (usually with contrast) (8.iii.c)

The numbers after the indications refer to the document "Guidelines for Imaging of MRI and other studies for Injury on Duty Patients". The above indications are not exhaustive, and are merely a selection of the more common indications.

ANNEXURE: C

Item 2800 and 2802 as part of anaesthesia

2800 – Plexus nerve block
2802 – Peripheral nerve block

The motivation for the use of one of these codes in addition to that for the "normal" anaesthesia is that it controls post operative pain and minimises the use of pain injections / medication and encourages early mobilisation.

It is reasonable if the injury / surgery is of sufficient nature to expect much pain post operatively, such as in the fracture of a long bone that was surgically reduced and fixated.

It is however not reasonable in cases of a simple fracture to a hand bone / foot bone or uncomplicated amputation of a finger / toe or other simple procedures.

Examples of claims where the use is reasonable:

- open reduction / internal fixation of a femur / tibia – fibula / humerus / radius – ulna
- total knee replacement / total hip replacement

Examples where the use of the codes is not reasonable:

- one fracture in the hand / foot treated surgically
- amputation finger / toe or part of finger / toe
- arthroscopy of the ankle / knee / shoulder

The use of this codes could also be reasonable were a "crushed foot" injury because of many fractures and multiple procedures in one operation.

Item 2800 and 2802 as part of treatment

There also are instances where the use of the codes is part of the treatment (no surgery performed and is not part of general anaesthesia as such). This is why the codes were put into the tariff structure in the first place.
Multiple rib fractures are treated with a nerve block for pain management and that would be acceptable.

1

labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

COMPEASY ELECTRONIC INVOICING FILE LAYOUT

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

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

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

TRAILER

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